

# MARYLAND

## Money Follows the Person

Operational Protocol



Submitted April 22, 2009

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## **I. Required Contents of the Operational Protocol**

### **A. Project Introduction**

#### *Maryland's Money Follows the Person*

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, a law passed by the U.S. Congress. The purpose of the demonstration is to promote a series of rebalancing objectives written in the statute. The term “rebalancing” refers to efforts to reduce or eliminate barriers to receiving long-term care services in home and community settings, rather than in institutional settings.

The Department of Health and Mental Hygiene (DHMH) administers Medicaid in Maryland. In accepting the Money Follows the Person (MFP) award, Maryland reinforced its ongoing commitment to serving individuals in the most integrated setting. This commitment is apparent in the State's existing policies and programs, including the Money Follows the Individual policy and the five home- and community-based services (HCBS) waivers that will serve MFP participants. Maryland is also fortunate to have a vibrant community of advocates and consumers who push the State to continue to improve its efforts. With the approval of this operational protocol, the State will embark on a variety of new rebalancing initiatives that complement current programs and lay the groundwork for progress into the future.

#### *Overview of MFP Demonstration Programs*

The goal of the MFP demonstration in Maryland is to encourage rebalancing by improving the transition process from an institution to community living through increasing outreach and decreasing barriers to transition. New efforts under MFP include peer outreach and mentoring, enhanced transition assistance including housing assistance, flexible transition funds, and the addition of waiver services to existing waivers.

Peer mentors will provide outreach, education, advocacy, and peer support. Peer support will be available for institutional residents and their families through local peer mentoring contractors that will provide support during and after the transition for nursing facility (NF) residents. New funding will enhance an existing peer mentoring program for State Residential Center (SRC) residents.

A statewide network of Aging and Disability Resource Centers, locally known as Maryland Access Point (MAP) sites, will be created to improve the processes by which individuals learn about and access long-term care services. An MFP demonstration service will be created to provide enhanced transition services to NF residents interested in transitioning to the community through one of the participating home and community based services waivers. Transitional case managers will also provide housing assistance to all residents of qualified institutions seeking independent housing. In addition, MAP staff will monitor and work towards developing housing opportunities for persons with disabilities by collaborating with local and State agencies.

Flexible funds will be offered through the MFP demonstration and administered by the transitional case managers to further address barriers to transitioning. These supplemental

services include funds for groceries, transportation, and other needed goods and services that could not otherwise be funded by Medicaid.

The Developmental Disabilities Administration (DDA) has existing Community Placement Teams that will be enhanced to support residents of SRCs as they transition from Maryland's intermediate care facilities for the mentally retarded (ICFs/MR) to the community. These teams will include new staff positions. At the state level, the SRC Transition Coordinator will work on addressing systemic barriers to transition. The SRC Transition Coordinator will also track data for the MFP demonstration and oversee the peer mentoring project in SRCs. Two other new positions will be created and titled Community Placement Specialists. These Specialists will work on individual transitions and enhance the existing Community Placement Teams that include Regional Office staff, Resource Coordinators that serve as case managers, the SRC residents and their families, SRC staff, and the peer mentors. The new Community Placement Specialists will develop relationships with residents, families and SRC staff to facilitate communication and to develop solutions to individual barriers to transition.

The Mental Hygiene Administration administers the Waiver for Adults with Traumatic Brain Injury, which is expected to at least double in size by the end of the MFP Demonstration Project. An expansion of the Brain Injury Resource Coordination Program will provide outreach to individuals in institutions, application assistance, and enhanced transitional case management services to individuals who apply for the program. Resource Coordinators will assist with outreach to residents in CARF accredited Chronic Hospitals and State owned and operated nursing facilities as well as to their family, guardians, and other supporters to provide education and support in making decisions about pursuing community living, application assistance and coordination of needed community resources and supports for the individual, enhanced transitional case management to ensure successful transitions to the community.

In the community, MFP demonstration participants will access services through five of Maryland's existing home- and community-based services (HCBS) waiver programs:

- The Living at Home (LAH) waiver serves persons between the ages of 18 and 64 and provides attendant care, case management, environmental accessibility adaptations, and nurse monitoring as part of its service package.
- The Older Adults Waiver (OAW) serves adults over the age of 50 and provides services similar to those available through the Living at Home waiver, but also includes assisted living, home-delivered meals, and environmental assessments.
- The Traumatic Brain Injury (TBI) waiver serves adults with TBI and provides day habilitation, family and individual support services, supported employment, and residential rehabilitation. This waiver is available to MFP participants that are transitioning from the two State owned and operated nursing facilities or Commission on Accreditation of Rehabilitation Facilities (CARF) accredited chronic hospitals.<sup>1</sup>

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<sup>1</sup> COMAR 10.09.46.03.B.4 cites the technical eligibility requirements for the TBI waiver as follows. *An applicant or participant shall be determined... to meet the waiver's technical eligibility criteria if the individual: (4) Is receiving: (a) Care in a State psychiatric hospital that is determined to be inappropriate because the individual does not need that level of care; (b) Traumatic brain injury community placement funded by the MHA with all-State funds; (c) Care in a nursing facility owned and operated by the State or an out-of-State rehabilitation institution funded by the Program; or (d) Care in a Maryland licensed special hospital for chronic disease accredited by CARF in brain injury inpatient rehabilitation.*

- The Community Pathways (CP) waiver serves adults with developmental disabilities and provides personal supports, case management, day habilitation, environmental modifications, and a wide variety of other support services offered through the Developmental Disabilities Administration (DDA).
- The New Directions (ND) waiver provides the same services available through Community Pathways, but allows participants to self-direct those services.

These waivers all require institutional level of care and have financial eligibility requirements. For details of the services available through each of these waiver programs, please contact [MFP@dhhm.state.md.us](mailto:MFP@dhhm.state.md.us).

The MFP demonstration will add services to several of the existing waivers to enhance the service package available to individuals who use these programs. Specifically, MFP will add environmental assessments, nutritionist/dietician services, and home delivered meals to the Living at Home waiver and add transition services to the Older Adults Waiver.

#### *MFP Rebalancing Initiatives*

Under MFP, the State receives additional funds for services provided under the demonstration. The increased funds associated with the MFP demonstration will be used to enhance community based services available through the existing waiver programs by adding additional services that were identified by the stakeholders. These additional services will be available to all waiver participants and continue past the MFP demonstration. In addition, the funds will sponsor pilot programs to enhance outreach and transition services. The pilot programs will produce data that can be used to prove their efficacy through measured outcomes. Based on the outcomes of the pilot projects, peer mentoring, enhanced transition coordination services, and comprehensive education and outreach may be built into the budget for future years. The budget that is developed by the State in 2011 may include additional funds to continue successful initiatives and will be incorporated into the State's budget for FY2012. DHMH will submit a supplemental budget request in State budget year 2012 to fund the programs and services that prove effective based on outcomes gathered through the demonstration.

*New Waiver Services.* The MFP demonstration will add services to several of the existing waivers to enhance the service package available to individuals who use these programs. Specifically, MFP will add environmental assessments, nutritionist /dietician services, and home delivered meals to the Living at Home waiver and add transition services to the Older Adults Waiver (See B.5.4). The clubhouse model of services, a self-directed day setting that focuses on social, financial, and vocational goals will also be added to the TBI waiver as an alternative to day habilitation. These additional services, which were identified by stakeholders, will be available to all waiver participants and continue past the MFP demonstration.

*Increasing Use of HCBS.* Of the four federal goals for the MFP program, Maryland's MFP program focuses on increasing the use of home- and community-based services (HCBS) by streamlining and supporting transitions from institutions to the community. The State's Money

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Follows the Individual policy ensures that funding for waiver slots is made available to individuals who transition from a nursing facility. The Money Follows the Individual Act, House Bill 478 is codified in the Annotated Code of Maryland, Health General §15–137 which states that:

*The Department may not deny an individual access to a home- and community-based services waiver due to a lack of funding for waiver services if:*

- (1) The individual is living in a nursing home at the time of the application for waiver services;*
- (2) The nursing home services for the individual were paid by the Program for at least 30 consecutive days immediately prior to the application;*
- (3) The individual meets all of the eligibility criteria for participation in the home- and community-based services waiver; and*
- (4) The home- and community-based services provided to the individual would qualify for federal matching funds.*

Therefore, capacity in the waivers does not need to be reserved for individuals transitioning from nursing facilities to the community through the MFP demonstration. Individuals transferring from a nursing facility to a community residence will not be placed on a waiting list. Additional slots will be requested each year according to the number of slots needed to continue serving individuals who transition onto the waivers under MFP. This policy will be expanded to include all institutional placements so that individuals in IMDs and chronic hospitals can apply for the waivers without accessing the registry as well.

On January 15, 2008, Governor Martin O'Malley announced his intention to close the Rosewood State Residential Center. The first 18 months of Maryland's efforts to transition individuals out of ICF/MRs will be focused on the closure of the Rosewood State Residential Center. The proposed budget for State FY2009 contains funds to assist with these transitions and serve MFP participants who transition out of Rosewood to community-based services.

Beyond the closure of Rosewood, the Waiting List Equity Fund (WLEF) will be utilized to fund services for individuals transitioning out of other SRCs in the State. Code of Maryland regulation 10.22.15.03 states:

The waiting list equity fund is a nonlapsing fund established to ensure that when an individual leaves the State residential center to be served in the community, the net average cost of serving the individual in the SRC is applied to: (1) The individual's community placement; (2) Community services needed to sustain the individual's community placement; and (3) Provide community-based services to individuals not yet receiving services.

The eligibility criteria for individuals to access this fund are cited in COMAR 10.15.22.06, which states:

To be eligible for services funded from the waiting list equity fund, an individual shall:  
(1) Be a resident of Maryland; (2) Have an appropriate evaluation that finds that the

individual: (a) Has a developmental disability, or (b) Is eligible for support services; (3) Leave a State residential center on or after October 1, 1994, to be served in community-based services.

Traditionally, the WLEF has been used to fund services for individuals on the waiting list who have older caregivers (currently age 69 and above). However, the regulations for the funds allow them to be used on individuals who are transitioning out of institutions and these funds will be available to MFP participants who are not required to be placed on the Waiting List for DDA services. Further, the Developmental Disabilities Administration's waivers will be submitted for renewal by April 1, 2008 and will include requests for additional slots. These waiver slots do not expire with the demonstration, guaranteeing the continued provision of services in the community after the demonstration.

*Streamline Eligibility.* The MFP administrative budget includes funds to support the Division of Waiver Eligibility Services (DEWS) which determines financial eligibility for the LAH and OAW waiver programs. This financial support is intended to improve processing time by increasing appropriate staff. Stakeholders have suggested that the State alter the current system to reduce processing time while simplifying the process for consumers. The MFP Stakeholder Advisory Group and staff from the Office of Eligibility will evaluate proposed alternatives to this process.

*Information Systems.* The State plans to develop an information technology component of MFP that will assist in communication and reporting by tracking the processes shared among all partners of the demonstration. The vision includes developing a web-based tracking system compatible with the existing tracking systems for the Older Adults and Living at Home waivers that will be accessible by peer mentors, the MAP sites, case managers, DEWS, Adult Evaluation and Review Services (AERS), the Maryland Department of Aging, and DHMH. The web-based tracking system will track an individual from initial contact through transition and throughout their participation in the HCBS waivers. The information stored in the system will be used to identify barriers in the transition process and reasons for reinstitutionalization, while promoting quality, timeliness, and accountability. The DDA and MHA also plan to enhance data tracking systems to improve quality management.

MFP plans to partner with the Maryland Access Point program (described below) to support the development of a statewide, web-based, searchable database that will provide comprehensive, accurate, and user friendly information about long-term care planning, programs, and services. The site will help consumers, providers, and advocates quickly access information and connect with appropriate programs and providers.

*Behavioral Health.* Some stakeholders expressed concerns about the availability of and access to the current community-based behavioral health services including supports for mental illness, dementia, cognitive behavioral disabilities including brain injury, and co-occurring physical, cognitive, mental health, or behavioral health diagnoses. Specific concerns expressed were the need for improved behavioral health services, lack of access to existing supports, lack of adequate supports, and the lack of a mechanism through which to serve individuals transitioning out of Institutions for Mental Disease (IMDs). As a result, the State will convene a parallel stakeholder group to further investigate and address these concerns with the goal of enhancing screening, increasing community capacity, and providing comprehensive behavioral health

supports to individuals receiving long-term care services in the community. One of the primary goals of this group will be to develop recommendations for improving behavioral health services in the community for all individuals in need of those services. Some of the suggestions that this group will evaluate include using the 1915(i) option or another waiver to serve the IMD population and others in need of behavioral health supports, adding additional behavioral supports to the existing waivers, and developing alternative payment rates for home based mental health services. This group will be led by Alyce Beman-Pearsall of DHMH, will meet regularly for the first six months of the MFP demonstration, and will develop recommendations to be presented to the State and the larger MFP Advisory Group in July 2008.

The MFP Behavioral health workgroup met regularly through August of 2008 and developed a list of recommendations for the Department to better serve individuals with behavioral health needs (Appendix L). These recommendations were delivered to the advisory bodies for the LAH, OAW, and TBI waivers and the Aging in Place Task Force. These existing groups will advocate for the implementation of these recommendations.

#### *Ongoing Efforts to Rebalance*

The MFP demonstration will complement ongoing rebalancing efforts in Maryland. Internally, DHMH has reorganized and established a new Office of Eligibility Services. The Department recognizes the importance of determining eligibility for Medicaid clients and the need for the process to be more effective and efficient. The Office has a new Executive Director who is an experienced eligibility professional, charged with effecting systems change for Medicaid eligibility in Maryland.

Maryland is one of 43 states funded by the Administration on Aging and CMS to develop a program to streamline access to long-term care information and community-based services. The federal program is the Aging and Disability Resource Center initiative. In Maryland, the program is called Maryland Access Point (MAP). The MAP program also is supported by General State funds. The goals of MAP are to streamline access to long-term care information and streamline eligibility and access to services in order to help redirect long-term care from institutions to the community. The MAP program has developed recommendations for best practices within the six local MAP sites including co-location of the different agencies involved in coordinating eligibility for Medicaid services and all State funded long-term care services. MAP currently has six local sites each of which provide coordinated front-line assistance for people seeking alternatives to institutional long-term care. At the State level, MAP is working through an executive level interagency work group to address systems changes in the way people access long-term care information and the speed with which community options can be explored prior to institutionalization. The MAP project plans to expand statewide with support from the MFP demonstration and will continue to be an integral part of Maryland's rebalancing efforts.

In addition to the Maryland Access Point project, Maryland recently received a Nursing Home Diversion Modernization Grant from the Administration on Aging. This grant is designed to: (1) develop a targeting and assessment protocol for identifying older adults who are at high risk of Medicaid spend down and placement in a nursing home; (2) prioritize those individuals for access to non-Medicaid funded State long-term care service programs; (3) offer them an opportunity for a flexible benefit under which they or their families can self-direct care and care providers; and (4) encourage and measure the informal supports that assist with community-

based care and living. The targeting and assessment protocol and the prioritization of high risk individuals will contribute significantly to Maryland's efforts to divert people from institutional settings as well as Medicaid spend down. This essential diversion program will increase the number of individuals who can remain in their homes and receive services, thereby reducing the need for facility-based care and expenditures and it will provide a model for expansion.

Another project affecting long-term care rebalancing efforts is House Bill 594 (Chapter 244, Laws of Maryland 2007). This bill requires DHMH to analyze options to increase access to long-term care services, including home and community-based services for individuals at high risk of institutionalization because of cognitive impairments, mental illness, traumatic brain injury, or other conditions. DHMH has committed to review the practices of other states, to study options for revising the current level of care determination, and to cost out other options for increasing access to long term care services. The final report, submitted December 1, 2007, influenced changes to the level of care determination process that occurred in 2008. The Department revised the nursing facility level of care criteria which resulted in fewer denials and an expanded group of eligible individuals.

Two additional bills regarding long-term care were passed in Maryland's 2009 legislative session. House Bill 782 requires the Department to consult with nursing facilities and other stakeholders to assess the State's long-term care reimbursement methodology and consider alternative reimbursement mechanisms. A report on the evaluation is due to the General Assembly on October 1, 2010 and will influence future long-term care reforms. House Bill 113 requires that the Department consult with stakeholders to evaluate the feasibility of submitting a federal waiver application for a coordinated long-term care program. The final report on feasibility is due to the legislature December 1, 2010.

## **1. Case Study**

### **1.1 Calvin – NF Transition**

Calvin is a 56-year-old man currently living in a nursing facility. Calvin had lived in his own apartment and worked as a tow truck driver for the past 25 years. He owned his own truck and contracted with a local apartment complex to tow cars for them at night. He was diagnosed with Type II diabetes 10 years ago. Calvin worked hard to maintain his diet and exercise routine to stay healthy, although he struggled with his weight for most of his life. Two years ago, Calvin had an accident while towing a car and severely injured both of his legs and one arm. He was hospitalized for over a week and went home with some supplies and instructions to care for his wounds. Calvin wasn't able to go back to work right away and his legs weren't healing like the doctors had hoped. Within 3 months, Calvin found himself back in the hospital to have both of his legs amputated below the knee. From the hospital, he was transferred to a rehabilitation facility to improve the use of his left arm and learn how to use a wheelchair. Calvin experienced some complications during his recovery and transferred facilities, this time moving into a long-term care nursing facility.

Calvin did not have health insurance as he was self-employed and his medical bills were piling up. The social worker at the hospital helped him apply for and receive Medical Assistance. But Calvin still wasn't able to pay for his rent since he wasn't working while in the hospital, so he asked a friend to put his belongings in storage and talk to his landlord to get out of his lease.

However, over the following months in rehab and the nursing facility, Calvin lost touch with his friend and his belongings were auctioned from the storage unit.

Calvin is now sharing a room in a nursing facility with an elderly gentleman with dementia. He receives wound care and assistance with transferring and bathing. Calvin is independent in most of his daily tasks but continues to have difficulties with his arm, which he now wears in a sling. He uses a manual wheelchair to get around the facility, but isn't confident in using it outside on the streets. Calvin's tow truck is parked in the lot at the nursing facility and he talks often about getting it modified so he can drive again. He sometimes enjoys the facility's bingo games and movie nights, but misses having more privacy and being able to work or go to the mall.

One afternoon, a peer outreach partner, who is also a wheelchair user, knocked on the door of Calvin's room at the facility and asked him if he wanted to hear information about moving into the community. Calvin wasn't very interested at first, but was bored at the time, so accepted the offer. The peer introduced himself as a person who had previously lived in Calvin's facility but who had moved into his own apartment two years ago on the Living at Home waiver. He showed Calvin a video on a portable DVD player about others who had transitioned and how their lives had changed. Calvin wasn't sure he was ready to be back on his own again, but accepted a flyer about community options and the peer's offer to keep in touch. The peer documented the encounter with Calvin in the MFP Tracking System.

Calvin read the flyer later and started thinking about living on his own, but he had a lot of questions and concerns about how he could get help if he needed it and how he would get around on his own. Calvin went to his social worker at the facility and talked with her about his concerns. The social worker gave Calvin more information and some pamphlets about the Older Adults and Living at Home waivers. The next time the peer came to Calvin's facility, he was ready with questions about taking the bus and getting groceries. The peer answered Calvin's questions and referred him to the MAP partner responsible for program education and application assistance in that area for help with applying to participate in a waiver and learning more about his options. He thought about calling the number on the flyer the peer left him. At the peer's next visit to the facility, the peer went to see if Calvin had thought more about moving to the community. This time Calvin was ready with questions, some of which the peer was able to answer, and a few about financial eligibility that the peer was not sure about. Since Calvin was ready to take the next step in exploring community options, the peer indicated Calvin's interest in additional information and assistance in the MFP Tracking System.

A few days later, an education specialist from the MAP came to see Calvin. The specialist talked for over an hour with Calvin about the two HCBS waivers that he might be eligible for, including their similarities and differences, the eligibility criteria, the community-based services that are available, and his housing options. Calvin had a lot of questions about how he would pay for housing since he was not able to drive his truck and he was relying on a small Social Security Disability Insurance (SSDI) check each month. The education specialist told Calvin about several community housing options including local housing authority subsidies and their wait list times, the Bridge Subsidy program, local housing for people with disabilities and seniors, and assisted living options available through the Older Adults Waiver. The specialist carefully explained the types of housing that would qualify him for participation in the MFP Demonstration as well. The specialist helped Calvin take virtual tours of apartments on a laptop

and gave him brochures from several apartment buildings in the area where Calvin wanted to live.

Calvin decided to take a few days to think about all of the possibilities. He called his cousin to ask her advice and discussed his options with his favorite nursing aide at the facility. He even went to the social work office at the facility to ask questions. The social worker had heard about the MFP demonstration and the waivers through a training and was able to talk to Calvin about the options. Less than a week later, the specialist called Calvin to see if he had more questions and he reported that he wanted to try to move out. Calvin said he wanted to try to live in one of the local building for seniors and persons with disabilities because he liked the idea of the chore and meal services that came with that building and that the desk always had a staff person available. He also knew another resident in the facility that had lived there and liked it. Calvin chose to apply for the Older Adults Waiver because he wanted the option of moving to an assisted living if his situation changed.

The specialist came back to Calvin's facility and helped him fill out the application for the waiver. The specialist helped Calvin get copies of the supporting documents for his application from the facility social worker and from his cousin, who had some of Calvin's bank statements. The specialist took Calvin's applications and materials and submitted them to be processed. She entered Calvin's application into the tracking system, which triggered the financial and medical eligibility determinations. The Division of Eligibility Waiver Services (DEWS) received the application materials from the transition specialist and began the process to establish his financial eligibility. A nurse from the local Adult Evaluation and Review Services (AERS) saw Calvin's application in the tracking system and went to the facility to complete an AERS assessment. The AERS nurse met with Calvin to talk about his care needs and reviewed his chart. The nurse then sent the completed AERS evaluation to the Older Adults transition coordinator, who went to meet with Calvin to develop the provisional plan of care for the Older Adults Waiver.

The transition coordinator told Calvin many details about the Older Adults Waiver including the emergency back-up plans and reportable events policy and asked Calvin to sign the waiver consent forms. He was also given information about the MFP demonstration supplemental services and Quality of Life survey and was asked to sign the MFP demonstration consent form (Section B.2.1). The transition coordinator helped Calvin fill out the application for the identified housing building and encouraged him to apply for other housing options since there was a wait list for the chosen apartments. But Calvin only felt comfortable with that building since it was close to the mall and where he used to live.

Calvin and the transition coordinator reviewed the nurse's recommendations and discussed how many hours of attendant care he would need per day, the types of medical equipment he needed, and other details of how his services would be provided in the community. Once the plan of care was approved to meet cost neutrality and his financial eligibility was verified by DEWS, he received the advisory opinion letter that gave him six months of eligibility. The transition coordinator also determined that Calvin was eligible to be an MFP Demonstration participant as he chose a qualified residence and had been in the facility for more than 6 months.

The transition coordinator called the apartment building where Calvin applied to make sure his name was on the list, to check the time frame associated with the waiting list, and then gave

Calvin the phone number and name of the person to call to check on his status whenever he liked. Calvin was excited about moving and called the apartment building every week to see if he had moved up on the list.

Two months came and went without Calvin's name coming up on the waiting list at the apartment building where he applied. Discouraged, he called the transition coordinator, who reviewed other housing options, such as different buildings, getting roommates, or assisted living. Calvin decided to expand his options and apply for other housing. The transition coordinator came back to the facility and met with Calvin to assist him in filling out additional applications, mailing them in, and creating a list of contacts to call about his applications. Calvin submitted five additional housing applications with the assistance of the transition coordinator. However, he was surprised when his apartment in the building for seniors and people with disabilities was ready a few weeks later.

Now that housing was identified, the transition coordinator offered Calvin the opportunity to work with a peer mentor who could help him learn how to navigate the community. Calvin welcomed the assistance and was referred for peer mentoring services. Within a few days, Calvin was assigned a peer mentor who met with Calvin at the facility to talk about his upcoming move and develop a community integration plan. The peer mentor offered to go with Calvin to the mall and other areas of the neighborhood to which he was moving to help him get used to living on his own. Calvin accepted the offer and spent a few afternoons in the community with his peer mentor learning how to navigate a shopping cart in the grocery store and use the local bus route that goes to his cousin's house. Calvin also called the peer mentor from time to time to ask questions.

Now that Calvin had a place to move into, the transition coordinator met with Calvin again to review and revise the initial plan of care and begin helping Calvin identify providers. The transition coordinator made sure that Calvin knew all about the Older Adults Waiver, its services and benefits, the reportable events policy and process, and the emergency back-up plans associated with his plan of care. The transition coordinator also used the MFP Tracking System to trigger a referral for Calvin to complete the MFP Quality of Life survey. A surveyor contacted Calvin and met with him to complete the survey. The surveyor explained that they would be asking him to complete the survey twice more, once when he had been living in the community for a full year, and then one last time a year after that. They explained that the survey was designed to measure his personal satisfaction with his life both inside the nursing facility and then out in the community to see if things were better for him in his own home. Calvin was relieved that the survey only took 15 minutes.

Through the Older Adults Waiver, Calvin had access to transition funds to pay for his security deposit and basic items like linens, furniture, and dishes. Through the MFP Demonstration, Calvin had access to supplemental services including a food card, some flexible funds, and transportation funds. Calvin needed to use transportation funds to pay for specialized transportation to the mall, where he shopped with the transition coordinator for his household goods. Calvin was able to pick out his furniture, sheets, and towels and arrange for a delivery date. The transition coordinator handled the payment for these items and helped to hook up his phone and utility services. He used some of his flexible funds to pay for an old utility bill that went unpaid when he lost his apartment.

The next week, the week of his move, the peer mentor met Calvin at the facility and took him on the local paratransit system to the mall so Calvin could practice his skills out in the community. After this successful trip, Calvin was able to go to the apartment on his own to sign the final paperwork. He also met the transition coordinator at the local grocery store to shop for groceries and last minute items with his food card from the MFP Demonstration.

There were several people working together to make Calvin's transition a success. The facility social worker had ordered a hospital bed to be delivered the day of the move, the peer mentor was helping Calvin feel comfortable navigating his new neighborhood, the transition coordinator was helping with planning, shopping, and identifying and hiring providers for his personal care. The aides and some of his friends from the facility even threw Calvin a party the week before he left to congratulate him and say goodbye.

On the day of the move, the facility provided Calvin with a ride to his new apartment. Calvin's cousin was there waiting to help him arrange his belongings and to make sure everything went smoothly. The attendant care agency sent the attendant and a supervisor to meet with Calvin and discuss details of his care and schedule. Calvin had a busy day with the deliveries of furniture and the service person coming in to hook up the phone. Over the next few days, Calvin was on the go making sure everything was in its place. He called the transition coordinator and his peer mentor several times with questions. The transition coordinator met with Calvin at the local Department of Social Services to help him apply for food stamps and other benefits.

During his second week in the community, Calvin's peer mentor stopped by to see how he was doing. They talked about the community resources in the area, including the local Center for Independent Living, the Division of Rehabilitation Services that might be able to help Calvin get back to driving his truck, and a nearby amputee support group. Calvin found a local church on his own and began attending weekly. He even expressed to his peer mentor that he might want to be a mentor for someone else living in the facility someday.

After a year had passed, Calvin's MFP eligibility expired, but he didn't notice, since none of his services or supports through the Older Adults Waiver were affected. He was attending classes to learn some computer skills to help him at his part-time job as a dispatcher with a towing company. He had lost touch with his peer mentor, but still had the peer's business card on his refrigerator and received mailings about community events that he could attend. He was surprised to get a phone call about taking another Quality of Life survey around that time, but remembered it was short and wouldn't take up too much of his time. Since his schedule of working and classes was pretty full, he was offered the option of taking the survey over the phone, and finished it in-between calls at work.

## 1.2 Julia – SRC Transition Case Study

Julia is a 46-year-old woman who has resided in the State's largest State Residential Center (SRC) since she was admitted at age 17. Julia enjoys the company of other residents, loves animals, engages in arts and crafts activities, and works in the SRC's workshop. She has significant intellectual disabilities, a seizure disorder, does not communicate with words (but uses a communication board to make choices), and when unhappy has self-injurious behaviors including banging her head against any readily available surface. Julia's parents passed away several years ago, but her older brother, Matt, acts as her legal guardian.

In 2007, an independent resource coordinator and the SRC's psychologist created a Written Plan of Habilitation for Julia which included recommendations regarding the most integrated setting for Julia to receive both day and residential supports. The independent resource coordinator determined that the community was the most integrated living and work environments, while the SRC psychologist determined that the SRC was the most suitable placement for her. Barriers to community integration were identified, including stabilization of her seizure disorder, challenging behaviors, and family opposition. Staff at the SRC began to work on reducing her seizures using new medications, developed a new behavior support plan that gave Julia more control and addressed her communication and sensory needs, and informed Julia's brother about community options. Within the year, Julia was using her new communication system and indicated a desire to move into the community. The independent resource coordinator and SRC psychologist conducted an annual review of Written Plan of Habilitation for Julia and both recommended that the most integrated setting for both living and working was the community.

Upon this recommendation, the MFP statewide SRC Transition Coordinator identified Julia as a candidate to work with a MFP Community Placement Specialist and referred her to DDA's peer mentoring contractor. A peer mentor from the Community Connections program was assigned to Julia. The peer mentor met with Julia on a biweekly basis to talk with her about living in the community. On several occasions, staff from the SRC supported Julia to visit her peer mentor's home in the community, attend a movie, go for ice cream, and attend a meeting of the statewide self-advocacy group.

Despite the recommendation for community placement and Julia's choice to live and work in the community, Julia's brother continued to oppose community placement. He had promised his parents that he would take care of Julia when they passed away and trusted that she was receiving the best care possible at the SRC. The thought of community placement evoked both feelings of guilt due to his promise to his parents and fear that Julia's safety and welfare would not be protected in a small residential setting. He worried that her seizure disorder would become unstable due to this significant change in her life and that the staff who would support her in the community would never know her as well as the staff at the SRC. As part of the MFP Friends and Family Ties project, Julia's brother was contacted by a family mentor. The mentor, Ruth, was a mother whose adult daughter moved to the community from Great Oaks Center when this SRC closed in 1996. She too initially opposed her daughter's movement to the community, fearing that she would no longer be safe and that her needs would not be met. She also actively resisted the closure of Great Oaks. However, DDA Regional Office staff worked with Ruth to explore her concerns and alleviate her fears. Just prior to the closing of Great Oaks, Ruth selected a community service provider who she felt could meet her daughter's needs. Within the first year, Ruth and her daughter became dissatisfied with this provider but were able to find a new provider and were now extremely pleased with services. Knowing the great amount of fear and concern other families may have when considering the community placement of their loved ones, Ruth agreed to act as a mentor to other families in similar situations. She received training to assist her in being a mentor and was connected with Julia's brother. She talked with Matt about her experience and about his fears. She was able to help Matt understand the way services are provided in the community and the quality assurance safeguards that are in place. Matt became more open to talking about community placement, although he continued to worry about Julia's vulnerabilities and health issues. Ruth continued to be available to him whenever he wanted to talk.

As part of the planning process for community placement, Julia and the people who know her best participated in an Essential Lifestyle Plan (ELP). This plan included information about Julia's hopes and dreams, her fears and concerns and the elements that would best meet her wants and needs when she moves to the community. Matt attended this meeting, and afterward asked Ruth to review it with him so that he could better understand how to make the plan become a reality.

The DDA had developed a new data management system that was able to track Julia's transition process, integrate data with the Maryland MFP tracking system automatically, record her progress on the goals and outcomes in her ELP, track the funding she would be provided when she moved to the community and track any significant reportable incidents that may happen to her once she was living in the community. Matt talked with Ruth and the Community Placement Specialist about this data system, and they were able to help him understand that it would be a valuable tool in assuring the quality of her services. The Community Placement Specialist entered the new information recorded at Julia's ELP in the data system and used it to track the progress with transitioning Julia to her community placement.

As part of the MFP project, the MFP Community Placement Specialist spent many hours with Julia and her brother, getting to know Julia's strengths and needs, and discussing Matt's concerns about her. Over time a relationship of trust was developed and Julia's brother was able to express his concerns about Julia's health and safety, as well as his feelings that if she were to move he was breaking a promise to his deceased parents. Julia's Community Placement Specialist provided information to Julia, Matt and her team about opportunities for Julia to become involved in activities she would enjoy in the community. The Community Placement Specialist and Julia's resource coordinator also informed Julia and Matt about the two home and community-based Medicaid waivers that Julia was eligible for and explained the differences in provider and self-directed services. Julia and her brother attended orientation training on self-direction, but felt that a service provider was a necessary component of Julia's service plan. For this reason, they chose to apply for the Community Pathways waiver. Julia had indicated in her ELP that she would prefer to rent her own apartment, which meant that she would be receiving services under the Community Supported Living Arrangement model. Julia's resource coordinator reviewed the ELP with Matt and Julia and provided them with a list of possible service providers who could meet Julia's needs.

Matt and Julia began to investigate the suggested list of service providers. Julia had indicated a desire to live in a rural area where she could have a dog, and that was away from the congestion of urban and suburban areas which Julia found over-stimulating and noisy. She also wanted to live near Matt, who resided in Carroll County. A provider in Carroll County, Your Way, Inc.(YWI), indicated great interest in helping Julia put together a life in that county which met her wants and needs. Julia's resource coordinator contacted DDA to learn about possible rental assistance opportunities, and learned that the Bridge Subsidy Program was available in Carroll County. The resource coordinator submitted an application for Bridge Subsidy and with assistance from Matt and YWI, searched for an apartment. They were able to find a one-bedroom apartment in the loft of a carriage house on a farm not far from a large town in Carroll County. The apartment landlord was willing to accept the Bridge Subsidy rental assistance as well as the Housing Choice Voucher Julia would receive within 3 years to continue her rental assistance indefinitely. Julia visited the apartment and just loved it! She began to communicate more often with her communication board and asked daily to look at pictures of dogs.

Once a provider was chosen, the Community Placement Specialist pulled together Julia's planning team, adding a staff member from the provider agency, and began the planning process. The Community Placement Specialist facilitated these team meetings, ensured that the provider was given full access to Julia's records, and with the team arranged for several visits to the provider so that Julia could get to know the community and the home to which she was moving. Julia often invited her peer mentor on these visits as well. The resource coordinator worked with Julia and her brother to fill out necessary waiver application forms and worked with the service provider to develop an Individual Plan.

During the community placement planning process, Matt learned that DDA was holding a Town Hall Meeting to obtain input into its strategic planning process. Matt attended this meeting and was pleased to hear about the possible systemic improvements DDA was considering. He talked about his experiences as Julia's guardian while she lived at Rosewood and about the process for planning her life in the community. Matt also filled out a survey that DDA posted on its website. Shortly after the Town Hall Meeting, Matt was contacted by a consultant that had been retained by DDA to evaluate the role of the SRC in a redesigned service system. Having input from family members of SRC residents was invaluable to DDA in the strategic planning process.

Now that Julia and Matt had selected a service provider and an apartment, the service provider began the process of developing Julia's individualized budget. While the ELP and Julia's annual Individual Plan (IP) identified her wants and needs, the individualized budget process required a method for determining the types of services and supports Julia would need and the number of hours of supports she would need. As part of DDA's strategic planning process, they were piloting the use of a needs assessment tool called the Supports Intensity Scale (SIS). This tool measures support requirements in 57 life activities and 28 behavioral and medical areas, and generates a standard score which was used to develop Julia's individualized budget.

Julia's ELP and IP identified the need for her to have supports for her self-injurious behavior. While at Rosewood, Julia was occasionally restrained by staff when she banged her head on hard surfaces. Matt was always uneasy about this intervention, and noticed that Julia tended to be nervous when around staff who had restrained her in the past. Matt talked with the psychologist about his observations and his feeling that this may also be a result of trauma Julia experienced many years ago when she was sexually assaulted by another individual residing at Rosewood. The MFP Community Placement Specialist informed Matt that DDA was implementing a behavior supports project that would provide training for staff in preventing the use of restraints and a team of behavioral supports professionals, including a psychology associate, psychiatrist, occupational therapist and speech pathologist who would develop a comprehensive plan for decreasing Julia's self-injurious behavior and increasing functional alternatives to that behavior. Matt felt reassured that the behavior supports Julia would receive were comprehensive and had quality assurance measures in place.

Matt and Julia had a tradition of spending one month together at Matt's home every summer. They loved this time together; however, it was sometimes difficult for Matt to take care of some of his needs while caring for Julia. Matt had a new consulting business and knew that he would need to be away for a few days while Julia was in his care. The Community Placement Specialist informed Matt that a Rural Respite Care Consortium had been developed to provide in-home supports for families who needed respite from their care-giving responsibilities. Matt

was assured that he would be able to access the consortium and make arrangements in advance for a trained respite care giver to support Julia for short periods of time in his home.

As the time for Julia's move to her new apartment drew closer, the MFP Community Placement Specialist contacted Matt and Julia to inform them about the MFP project and to request Matt's consent for Julia to become a MFP participant. Matt understood that Julia and he would be contacted to complete a MFP Quality of Life survey just prior to Julia's move, and at one and two year intervals following her community placement. The MFP Community Placement Specialist explained that the survey was designed to measure Julia's personal satisfaction with her life both at the SRC and then in the community to see if things were better for her in her own home. Julia would also be eligible for MFP Flexible Funds as an MFP participant, and the Community Placement Specialist explained that these funds could only be used for items or services not covered through the Community Pathways waiver. Matt agreed to sign the MFP consent form, and Julia and her team made plans to use the flexible funds to pay for some of the household items Julia would need in her new apartment. They also planned to use the funds to purchase the dog Julia wanted so badly to keep her company.

Julia continued to meet with her peer mentor, who gave her information about the Ask Me! quality of life survey. This survey has been administered for several years by DDA to individuals receiving supports in the community through a contract with an independent organization. In addition to the MFP Quality of Life survey, DDA was interested in conducting Ask Me! surveys for individuals moving from SRCs and comparing these results with the MFP Quality of Life survey. They were also interested in comparing these results with Ask ME! data for individuals living in the community. Knowing that conducting two surveys could be a burden, DDA decided to conduct the Ask Me! survey well in advance of Julia's move. Consent to administer the survey was obtained from Matt, and an Ask Me! peer interviewer soon conducted the survey with Julia. Julia will complete another Ask Me! survey at one and two year intervals following her move.

During the time that Julia was planning for community placement, DDA announced that Rosewood Center would be closing. A Human Resources consultant had been retained by DDA to help staff with the process of finding employment following the closure of Rosewood, and discussed the possibility of staff being employed by some of the community providers that would be supporting individuals who transitioned from Rosewood to the community. Several of the staff from Rosewood who knew Julia well and enjoyed supporting her expressed an interest in continuing to work with her in the community. Matt had been expressing many concerns about the staff that would support Julia in her new home, and was comforted to learn that it may be possible for some of the staff from Rosewood to continue to support her in the community. Interviews with YWI were arranged for these staff by the Human Resources consultant, and sufficient staff was hired to provide for Julia's support needs in her new home.

The staff that would support Julia in her new home would need to receive training in the core competencies for direct support staff. DDA had recently purchased a statewide license to conduct a pilot of the College of Direct Support, an internet based direct support staff training program. This program was considered to be a leader in direct support staff training, and Matt was pleased to know that YWI has participating in the pilot, and that Julia's staff would receive this high quality training. Matt was also reassured that staff would continue to receive training in Julia's specific needs.

Julia indicated in her ELP that she would like to have a job in the community working with animals. While Julia loved animals, she had not received any training in animal care and was not prepared to seek employment in this field. The SRC had recently received consultation from a national expert in job development, and the SRC staff was eager to put together a plan for Julia to achieve this goal. To that end, the SRC provided an opportunity for Julia to shadow a veterinary assistant at a local animal shelter. With the support of a job coach, over the ensuing months Julia was able to learn many skills needed to work at an animal hospital or shelter. Her team began to plan for her supported employment opportunities in the community, and learned that an animal shelter was located very close to Julia's new apartment. With the assistance of her job coach, Julia interviewed for a part-time position feeding and grooming the animals. Julia began her employment at the shelter two months before she transitioned to the community and was very pleased with her workday. Given Julia's new skills, her job coach decided to approach the owner of the farm where Julia was going to live to inquire about part-time work feeding the animals on the farm. Julia's landlord was willing to give this a try on a volunteer basis, and really hoped it would work out given the difficulty he frequently had with getting reliable help on the farm.

On the day of the move, a staff member from the SRC who was going to continue to support Julia gave her with a ride to her new home. Julia's brother was there waiting to help her get settled, along with staff from YWI. Together they all sat down for dinner and celebrated Julia's new home. Julia settled in and began to decorate her bedroom. Her brother gave her a CD player and several CDs as a housewarming present. She was looking forward to picking up her new dog, a year old poodle that Matt arranged to rescue from the Humane Society.

The next week, Julia's peer mentor stopped by to see how she was doing. They talked about the community resources in the area, including the local self-advocacy group that met monthly, an arts and crafts center nearby and a canine club that helped people learn to care for their new dog. Julia's peer mentor reassured her that she would continue to see her and help her get to know her new community for several months to come. Ruth, the family mentor, made contact with Matt to provide reassurance to him. She let him know that if he had any problems she would be there and would check in with him each month.

As the year progressed, the Community Placement Specialist and resource coordinator checked on Julia's progress using the data management system and through visits to Julia's provider and to her home. In addition, the resource coordinator and family mentor talked with Matt periodically to see if he had any questions or concerns about the supports Julia was receiving in her new home.

After a year had passed, Julia's MFP eligibility expired, but she and her brother didn't notice, since none of her services or supports through the Community Pathways waiver were affected. An Ask Me! peer surveyor contacted Julia and Matt to let them know it was time for her first year survey. In addition, a MFP Quality of Life surveyor contacted Matt and Julia to arrange for this brief survey. Julia was happy to report that she was volunteering at the farm and working 20 hours a week at the animal shelter. She and her dog were constant companions. Julia was in good health and was able to get the medical supports she needed from the nurse that visited her home and from the medical center in the large town near the farm. Julia was no longer banging her head on hard surfaces, and the frequency and intensity of all of her self-injurious behavior had decreased significantly. Julia also had joined the local recreation center and was taking

swimming lessons and pottery classes. Julia's brother had joined the Board of the provider agency and was actively involved in the organization's quality assurance committee.

## 2. Benchmarks

Each year of the demonstration, the State will report on its progress in transitioning individuals and rebalancing the long-term care system. CMS requires each proposed measure to include annual targets that are measurable, achievable, and realistic.

### 2.1 Required Benchmarks

**Benchmark 1: The projected number of eligible individuals in each target group of eligible individuals to be assisted in transitioning from an inpatient facility to a qualified residence during each calendar year of the demonstration<sup>1</sup>.**

*Table A.2.1* Benchmark 1: Projected Transitions in Each Calendar Year

	CY 2008	CY 2009	CY 2010	CY 2011	TOTAL
<i>Elderly</i>	50	100	130	170	450
<i>Physically Disabled</i>	64	108	140	182	494
<i>Other: Brain Injury</i>	2	5	10	10	27
<i>MR/DD</i>	50	75	75	50	250
<b>Total Transitions</b>	<b>166</b>	<b>288</b>	<b>355</b>	<b>412</b>	<b>1221</b>

Maryland's original MFP application projected a higher number of individuals transitioning through the demonstration. This number has dropped as the initial application assumed a full five year demonstration period in which to transition individuals and was predicated on the approval and implementation of Maryland's 1115 waiver application for *CommunityChoice*. In the absence of that waiver, which Maryland is no longer pursuing, the State had to reevaluate the number of possible transitions using current waiver mechanisms and the actual four year timeframe for the demonstration. Delays in implementing planned MFP initiatives have caused a reduction in the projected number of transitions as well. With these factors in mind, the State believes that the current goals for MFP are ambitious and consistent with the spirit of the initial application.

**Benchmark 2: The projected increase in qualified expenditures for all HCBS.**

In the context of MFP, qualified expenditures are those waiver and State Plan services for which the State will seek an enhanced match. The table contains the projected costs of these services for all individuals in the given year.

<sup>1</sup> Though Maryland intends to transition individuals in IMDs and chronic hospitals during the period of the MFP demonstration, currently there is no mechanism through which to serve them in the community. The State will submit an update to the Operational Protocol before transitioning these individuals. Benchmark 1 will be amended to include IMD and chronic hospital transition targets when a service mechanism is chosen (Section B.1.1).

Table A.2.1 Total Projected HCBS Expenditures by Calendar Year

CY 2007	CY 2008	CY 2009	CY 2010	CY 2011	TOTAL
\$729,907,896	\$795,424,086	\$866,976,858	\$945,130,594	\$1,030,502,887	\$4,367,942,321

The projected annual increase in total HCBS funding is based on historical data for each HCBS service category trended forward with an increase in waiver spending growth based on MFP transitions.

2.2 Maryland’s Benchmarks

*System-wide Rebalancing*

**Benchmark 3: The percent of all Medicaid long-term care services that are provided in the community each year.**

This benchmark is calculated by dividing the days of long-term care services provided in the community by the total number of days of long-term care service provided (institutional plus community). For example, if Medicaid served a total of 100 people, and 40 people received services for a year in the community and 60 received services the same year in a nursing facility, the benchmark would be 40.0% (40 people \* 365 community days) / (100 people \* 365 days).

This benchmark is intended to capture the progress in system-wide rebalancing of long-term care based on the days of service in each setting. The HCBS days are for all services, both waiver and State plan. More days of service provided in the community and fewer provided in an institutional setting leads to a larger percentage in the benchmark. The days used in the analysis are based on claims data and provide an unduplicated count of days of service. If Medicaid served only one individual in a year and that individual received services for 200 days in the community and 165 in a nursing facility, the benchmark would be 54.8% (200 community days / 365 total days). The actual benchmark represents the projected days of service for all Medicaid long-term care recipients in the given year. These estimates are based on current efforts toward rebalancing and new initiatives under MFP. Future long-term care reforms could accelerate these changes.

Table A.2.2 Percent of Medicaid Long-term Care Services Provided in the Community

	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011
<b>All HCBS Days / Total Days</b>	<b>56.2%</b>	<b>57.0%</b>	<b>58.0%</b>	<b>59.1%</b>	<b>60.3%</b>
Without DD Waivers and SRCs	39.2%	40.2%	41.5%	42.9%	44.4%
Only DD Services and SRCs	96.3%	96.5%	96.8%	97.0%	97.3%

This benchmark reflects Maryland’s goal to increase the proportion of long-term care services provided in the community rather than in institutions. The State has already made considerable progress in rebalancing the system through which individuals with developmental disabilities

receive services. While continuing to build on this progress, the State hopes to accelerate rebalancing in the other long-term care service delivery systems.

*Progress with Transitions*

**Benchmark 4: Percentage of MA eligible nursing facility residents informed of their community care options through peer outreach each year.**

This benchmark reflects the percentage of MA-eligible nursing facility residents who are contacted through peer outreach in each year. The State will determine the number of MA-eligible through MMIS, provide the data to peer outreach contractors, and require the contractor to document contacts with the MA-eligible residents.

*Table A.2.4 Percentage of MA-eligible nursing facility residents contacted by peer outreach*

<b>CY 2008</b>	<b>CY 2009</b>	<b>CY 2010</b>	<b>CY2011</b>
0%	35%	75%	85%

Though this benchmark is more process oriented, the State believes that the central goal of the peer outreach program is to provide information about options for receiving community services to as many potentially eligible individuals as possible. Based on the current number of Medicaid eligible individuals in nursing facilities, the State anticipates that peer outreach will document contacts with approximately 10,000 nursing facility residents per year when fully implemented across the State.

**Benchmark 5: Number of participants that secure community housing each year.**

This benchmark intends to measure the effectiveness of housing assistance provided through the demonstration. The measure reflects the number of individuals who secure housing with assistance from transition coordinators in a given year. It is estimated that one-fifth of those that receive housing assistance will successfully secure housing within one year. In an effort to measure overall rebalancing through MFP initiatives, individuals who are determined ineligible for MFP after receiving housing assistance will be counted in this benchmark (e.g., if an individual transitioned after less than six months in the institution or if they selected a non-qualified assisted living facility after receiving housing assistance). These numbers also reflect that not every individual who transitions will need or request housing assistance.

*Table A.2.5 Number of individuals securing community housing*

<b>CY 2008</b>	<b>CY 2009</b>	<b>CY 2010</b>	<b>CY2011</b>
0	106	138	179

These numbers have been modified to reflect delays in implementation. It is estimated that 75% of LAH participants and 25% of OAW participants will access community housing with support from transition coordinators.

**B. Demonstration Implementation Policies and Procedures**

In recent years, Maryland has successfully transitioned many individuals from institutional settings to the community. Maryland’s Money Follows the Individual (MFI) policy enables the

State to use existing home and community based services (HCBS) waivers to serve individuals transitioning from nursing facilities to the community. Maryland will expand the MFI policy to include residents of other long term care institutions in order to offer HCBS waivers to all institutional residents regardless of budgetary caps on enrollment. The MFP demonstration will help the State further reduce barriers to receiving services in the community. Specifically, the State intends to use the MFP demonstration to enhance outreach through a new contract to recruit, train, and manage peer outreach for NFs. The State will enhance and expand peer mentoring efforts for residents of SRCs to include all facilities and create family peer mentors. The State will also enhance outreach to chronic hospitals through Resource Coordination for the TBI waiver. The State will enhance transitional case management services to assist individuals residing in nursing facilities in the transition process with supports and services. Additional contracts will create three new staff positions to assist SRC residents and chronic hospital residents in the transition process.

This section of the protocol outlines the State's policies and procedures as envisioned once the MFP demonstration is fully implemented. Individuals interested in pre-existing policies and procedures may request details by contacting [MFP@dhmh.state.md.us](mailto:MFP@dhmh.state.md.us).

## **1. Participant Recruitment and Enrollment**

### **1.1 Eligibility for the Demonstration**

The populations that will be transitioned through the demonstration are:

- Elderly and disabled adults residing in Medicaid nursing facilities (NFs)
- Adults with developmental disabilities residing in intermediate care facilities for the mentally retarded (ICFs/MR), also known as State Residential Centers (SRCs)
- Adults 65 years and older residing in institutions for mental disease (IMDs)<sup>1</sup>
- Adults residing in chronic hospitals

Maryland will adopt the least restrictive MFP eligibility criteria permitted by the authorizing legislation:

- One month prior Medicaid eligibility
- Six months residence in a qualifying institutional setting (or settings)

### **1.2 Qualified Institutions**

All Medicaid-licensed nursing facilities (NFs), institutions for mental disease (IMDs), chronic hospitals, and public intermediate care facilities for the mentally retarded (ICFs/MR) in the State of Maryland will be included in the demonstration, regardless of geographic location. The State will focus on developing the capacity to provide outreach to all eligible institutional residents as described above. All Medicaid-licensed NFs meet the statutory definition of a qualified institution (section 6071(b)(3), "inpatient facility", of the Deficit Reduction Act of 2005). All

Medicaid-licensed ICFs/MR, institutions for mental disease (IMDs), and chronic hospitals also meet the statutory definition of a qualified institution.

### 1.3 Recruitment Efforts

*Peer Outreach for NF Residents.* The State will offer regional peer outreach contracts to identify and refer individuals who wish to transition to the community from nursing facilities. A separate effort will expand support for the current peer mentoring process for the developmentally disabled (DD) population described below, to include a family mentoring component. The peer outreach contractors will be required to recruit, train, and maintain a cadre of peers. These peers will be persons with non-professional life experience with disability, in particular experience transitioning from an institutional setting, and/or in assisting others in transitioning. The State will develop training materials, outreach materials, and guidelines for the peer outreach contractors. The peer outreach contractors will be responsible for intensive outreach in each NF and collecting and reporting data such as numbers of residents contacted, numbers of referrals, and other information as required by the State. Peers will be responsible for contacting residents and presenting brief information about community living options. This information about community living can be conveyed using any of the State prepared materials in an individual or group setting.

The State will approve all training material for the peers to ensure accuracy in presentation of the information and materials regarding community living options to persons of all abilities, including guardians. The State will ensure availability of alternative formats for all MFP outreach materials and other MFP materials as requested, including audio recordings, captioning, large print, and electronic versions.

The peers will have access to these materials, including informational flyers about each waiver and video presentations about the transition process with examples of individuals successfully living in the community. The peers themselves can draw on their own experiences with transition and community living to provide additional information as appropriate. Peers will describe the current efforts to provide opportunities for community living, examples of others who have successfully transitioned to community living (including age and disability sensitive examples), how the basic process of transitioning works, and the community-based supports and services available. Peers may then provide a referral to get the process started.

The State and peer outreach contractors will help peers develop positive working relationships with facility staff. Peers will be expected to schedule their visits and to identify themselves when visiting a facility.

Peer mentoring will also be offered to nursing facility residents via a demonstration service provided by Centers for Independent Living (CILs). CILs provide peer mentoring as one of their four core services and have well established peer networks. Peer mentors from the CILs may provide ongoing support, for example through community integration activities, during the transition process and after the transition to community living at the discretion of the individual. The peer mentor contractor may provide opportunities for volunteer mentors within the peer mentoring roles.

*Peer Mentoring for SRCs.* Maryland currently contracts with a nonprofit advocacy organization for peer mentoring. Community Connections is a peer mentoring initiative where individuals

with developmental disabilities who live in the community (referred to as Community Connectors) are paired with individuals who live at the Rosewood Holly Centers. The Arc of Maryland's Self Advocacy Network (SAN) staff matches the two individuals and helps them to get to know each other. The goal is for the person who lives in the community to share personal experiences about life in the community with the person living at the SRC. People typically meet a few times each month. Referrals are received from SRCs and day programs that SRC residents attend. The person living in the community is paid to make this connection. This effort will be expanded to provide opportunities for individuals to spend additional time with their Community Connector in the community prior to community placement, to increase peer mentors, to expand access to peers to all of the SRCs, to continue peer mentoring opportunities for 6 months following transition to the community and to address family needs for mentoring from families of former SRC residents. Opposition by family members and/or legal guardians is the most commonly identified barrier to community placement and thus a family-to-family peer mentoring program, called Friends and Family Ties, is vital to the success of Maryland's MFP project for SRC residents. Peer Mentors for individuals living in SRC's will also discuss career possibilities and the benefits of working in the community. This component will be added to the current Community Connections initiative, focusing on employment. Family mentors will also address concerns that families share about their loved ones working in the community, such as the loss of health benefits and services, safety while working in the community, transportation to and from work, and assurances that medical needs will be met during working hours. To address these and similar fears, family-to-family peer mentoring will provide a forum to share fears openly with other families, a guided discussion on the benefits and effects of employment, and the possibility that their loved one CAN work, which may not otherwise have been considered.

*Chronic Hospital Outreach.* Maryland created a pilot resource coordination program in 2003 for individuals with acquired brain injuries to assist them with accessing services and supports that they need in the community, transitioning out of long term care facilities and/or diverting them from institutional care. Resource Coordinators assist individuals with accessing entitlements, finding housing, accessing clinical services, organizing their homes and finances, obtaining employment services and linking with other needed supports in the community so that the individuals can live as independently as possible in their own homes. Maryland's Traumatic Brain Injury Advisory Board, which reports to the Governor and Maryland's General Assembly, recommends expansion of the program statewide. MFP savings will be used to expand the Brain Injury Resource Coordination program to additional jurisdictions. Resource Coordinators will assist with outreach to residents in CARF accredited Chronic Hospitals and State owned and operated nursing facilities as well as to their family, guardians, and other supporters to provide education and support in making decisions about pursuing community living and offer application assistance for the TBI waiver.

*Access to Facilities and Residents.* Prior to the implementation of peer outreach in nursing facilities, a letter from DHMH will be sent to each Medicaid licensed facility to announce the demonstration, its goals and objectives, and the methods of communicating with facility residents. The letter will require that NFs allow peers to have access to residents in order to offer information about community-based living options. The letter will include assurances of the privacy of the residents' personal information and that no resident will be compelled or coerced to participate in any discussion or effort to transition to the community. The letter will also

include a process for reporting concerns to DHMH about peers and their access to facilities. The peer outreach contractors will also receive this letter and have the ability to report concerns about access through the same reporting mechanism. Facility representatives currently on the stakeholder advisory group will have the opportunity to participate in reviewing the letter and to assist in disseminating information to their partners throughout the State. DHMH will continue to include the nursing home providers on its ongoing advisory committee, seek out their input, and ensure that the interests of the facilities are respected during the demonstration.

The Developmental Disabilities Administration (DDA) will send a similar letter to SRCs and their staff will be urged to work collaboratively with the expanded Community Connections peer mentoring program. A quarterly newsletter to family members, guardians, and support staff of SRC residents is published on a quarterly basis. This newsletter will promote the peer mentoring services, as well as inform readers about the HCBS waiver programs, waiver quality standards, and benefits of community-based services. The DDA will also contract with a marketing firm to create an outreach campaign primarily targeted for individuals in SRC's and those that are currently being served in segregated community day programs to help individuals understand the benefits of employment. Marketing will include themes such as career possibilities, available employment services and supports, and benefits planning.

*Targeting.* As the State plans to develop a comprehensive outreach program to reach each NF resident through peer outreach contracts as described above, the only targeting criterion used for this population will be Long Term Care Medicaid (LTCMA) eligibility. Data on LTCMA eligibles from the Medicaid Management Information System (MMIS) will be used. The names of LTCMA applicants and eligible residents will be given to the peers performing outreach at each facility so that residents may be contacted and informed of their options. The peer contractor will be required to contact the identified eligibles at a minimum, but may provide outreach to any resident.

For residents of SRCs, Written Plans of Habilitation will be used to identify individuals for whom the community has been determined to be the most integrated setting. MFP activities will build upon existing processes for identifying SRC residents ready to move into the community, the details of which are included below, in Section B.1.5 State Residential Center Participant Enrollment.

#### 1.4 Enrollment in MFP from a Nursing Facility

*Enhanced Transitional Case Management.* As part of the MFP demonstration, the State will increase funding and training for waiver case managers to deploy transition coordinators to assist in transitioning individuals from institutions. These transition coordinators will assist potential MFP participants throughout the transition process. The transition coordinators will be highly knowledgeable about community living and resources, including but not limited to: housing options, home health providers, disability specific resources, assistive technology, medical equipment and supplies, and other local area resources, as well as Maryland Medicaid, including its programs, services, medical and financial eligibility criteria, complaint and fair hearing processes, and administrative processes. The transition coordinators will have access to the State-generated training and informational materials as well.

In addition to developing waiver transition coordinators, Maryland will direct funding to the development of a statewide network of MAP sites to serve as single points of entry into the long-term care service system. All MFP service providers will be MAP partners and collaborate to provide a wide array of options to individuals who seek assistance. For individuals in institutions, the process begins with a referral to the local MAP. Anyone may make a referral, including the individual; however, the majority of referrals are likely to come from peer outreach staff, facility staff, and family members.

*Consumer Education.* After receiving a referral, an education specialist affiliated with the MAP will contact the individual in the institution to discuss his or her options. The education specialist will provide further program information about each of the home- and community-based services (HCBS) waivers for which the individual may be eligible and assist the individual in understanding his or her options. The information can be shared with other interested people at the resident's request, such as family members, guardians, and other supporters.

*Application Assistance.* If the individual wishes to apply to receive services through the Living at Home waiver or the Older Adults Waiver, the education specialist will provide assistance with completing the application, including providing assistance in obtaining needed supporting documents. As some residents of NFs may be more appropriately served through the TBI or DDA waivers, individuals who meet the technical eligibility criteria and wish to apply for the Traumatic Brain Injury, New Directions, or Community Pathways waivers will be referred to the TBI case manager or Statewide SRC Transition Coordinator..

*Medicaid Eligibility.* Once the education specialist completes and submits the Living at Home or Older Adults Waiver application, they will document its completion in the MFP tracking system and export the information to the appropriate waiver tracking system. This will trigger the DEWS (Division of Eligibility Waiver Services) and AERS (Adult Evaluation and Review Service) processes. The DEWS eligibility process establishes financial eligibility for the waivers. AERS completes an assessment and recommends services needed by the individual in the community. The AERS assessment is then forwarded to the waiver transition coordinator who will use it to develop a plan of service/plan of care with the resident that details the waiver services and budget. As the last part of the eligibility process, this plan is then approved by DHMH for the Living at Home waiver and by MDoA or its designee for the Older Adults Waiver. A letter of waiver eligibility called a Waiver Advisory Opinion Letter is then sent to the resident and states the six month eligibility period for transition. A letter of denial will be sent to the applicant if the person is determined not eligible, as is the current practice.

*Housing Assistance.* One of the major roles of the transition coordinator is the provision of housing assistance. As housing is one of the main barriers to community living, housing assistance may greatly increase the number of people that are able to make the transition. Housing training will be provided through the MFP demonstration to develop housing expertise among waiver case managers and MAP partners who will provide information about types of housing options, the availability of housing, and the housing subsidy systems. They will also provide intensive support to complete applications, acquire needed documentation, and secure housing. Housing assistance may also include opportunities for MFP participants to visit potential houses using their supplemental service funds (Section B.5.4). In addition to this individual assistance, the MAP partners will be responsible for monitoring and working to improve the housing situation for MFP demonstration participants. MAP partners will develop

relationships with local housing authorities, developers, and other partners working on the same goals to increase housing opportunities and to more efficiently identify and access housing as it becomes available. This service will be vital to those seeking independent community housing.

*MFP Eligibility Determination.* Once an individual is determined eligible for the waiver, the transition coordinator will determine whether the individual is eligible for the MFP demonstration and its supplemental services. It is estimated that only a fraction of the individuals who apply for waiver services will meet the eligibility criteria for the demonstration. In order to verify that the individual has six months of residence in an institution or institutions, the transition coordinator will use data from current and former facilities of residence. This data can include admission and discharge dates. MFP participants may be eligible for enhanced transition services, but the State will in no way discourage MFP ineligible individuals who meet the waiver eligibility requirements from transitioning to the community.

*Transition Coordination.* The waiver transition coordinator is responsible for assisting individuals during the period of transition and will coordinate community services, assist the individual with securing providers for the approved waiver services, and administer waiver transition funds and MFP flexible funds available for demonstration participants up to 60 days after the day of transition.

#### 1.5 Enrollment in MFP from a State Residential Center

*Relevant Legislation.* In July 2005, Maryland House Bill 794, entitled *Developmental Disability – Written plan of Habilitation – State Residential Centers*, was passed requiring independent resource coordinators to be part of the development of a Written Plan of Habilitation for all individuals residing in State Residential Centers. The Written Plan of Habilitation is developed by the individual, an independent resource coordinator, and a treating professional designated by the SRC facility Director on an annual basis or as requested. The plan includes recommendations from both the treating professional and the resource coordinator regarding the most integrated setting appropriate for the individual. As of February 2007, there were 127 individuals for whom both the treating professional and resource coordinator recommended community living options as the most integrated setting for residential services. These 127 individuals will be the first targeted for movement into community-based services. By February 2008, it is expected that nearly 90% of SRC residents will be identified as able to receive services in the community.

A related bill passed in 2007, Maryland House Bill 970, entitled *Rosewood Center – Plan for Services to Residents*, requires the Department to develop a recommendation for each resident that includes “a timetable for making the transition.” A report is due to the Maryland General Assembly on December 31, 2007 and will further assist the SRC Transition Coordinator in identifying individuals for transition.

Due to the inherent costs in funding dual systems of care while moving individuals from SRCs into the community, the SRC Transition Coordinator will prioritize the closure of cottages to move more quickly towards rebalancing.

*Community Placement Teams.* For persons with developmental disabilities residing in SRCs, the Community Placement Teams will be utilized to assist in the process of moving into community-based services. Each Community Placement Team will include the SRC resident, an experienced Resource Coordinator (case manager), a community placement specialist, SRC staff, family,

guardians, peer mentors from Community Connections, and others as identified by the individual. The Resource Coordinators are case managers who are knowledgeable about Developmental Disabilities Administration (DDA) processes, Medicaid HCBS and State Plan services, and community living options and resources. The Resource Coordinators will complete the application and eligibility process with the residents and their families. The community placement specialist will be an experienced professional with knowledge of SRCs and the transition process who is hired by DDA. The community placement specialist will visit the SRCs, develop relationships with the residents, the center staff, the residents' families, and other interested parties in order to facilitate transition planning. This Specialist will be an essential member of the Community Placement Team who will identify barriers to transitioning for an individual and develop solutions. The Resource Coordinators will complete the application with the residents and their families. The DDA Regional Offices will continue to complete the eligibility process. DDA learned a great deal from the experience of downsizing and eventually closing the Great Oaks Center in 1996 and the movement of all but two of its residents into community placements, including the importance of developing very close relationships with families who have concerns about moving their loved ones into the community. The community placement specialist will be a key figure in determining the root concerns of families and working to alleviate those concerns.

#### *Enhanced Resource Coordination*

The DDA has begun the closure of the Rosewood Center which is expected to be completed by June 30, 2009 and is moving individuals from the Rosewood Center into community-based settings chosen by individuals, their families, and their support teams. Intensive transitional case management, called Resource Coordination in the DDA system, is required to assist in these efforts. Beyond normal transitional case management services, Resource Coordinators participate in the Essential Lifestyle Planning process, provide information and support to worried individuals and families, and conduct follow-up visits to assess the success of the transition and quality of care 30, 90, and 120 days after the transition in addition to regularly scheduled resource coordinator visits required under DDA's HCBS waiver and DDA regulations. The process of moving over 150 individuals within an 18-month period is intensive and MFP rebalancing funds will be used to pay for enhanced Resource Coordination for closure of the Rosewood Center.

#### *Essential Lifestyle Planning*

Essential Lifestyle Planning is a highly effective person-centered planning process that helps to identify, organize, and communicate what is important to an individual who needs support services. Essential Lifestyle Plans (ELPs) that are generated through this planning process incorporate the individual's priorities into the service plan. ELPs have been used to help people with developmental disabilities make the transition from institutional care to home and community-based services for many years and have demonstrated increased success in the community for individuals who need intensive behavioral supports.

As people transition out of Maryland's State Residential Centers and into home and community-based services, person-centered planning is crucial to determining high quality services in the most integrated setting of choice. In order to ensure each individual has input into their service plan and that their values are respected, ELPs will be completed with all Rosewood Center residents prior to the development of their service plan for transition. Mr. Michael Smull, one of

the founders of Essential Lifestyle Planning, will serve as a consultant and assist in completing ELPs for all residents leaving the Rosewood Center prior to its closure in June of 2009.

#### *Budget Allocations*

The Supports Intensity Scale (SIS) measures support requirements in 57 life activities and 28 behavioral and medical areas. The SIS measures support needs in the areas of home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. The Scale ranks each activity according to *frequency* (none, at least once a month), *amount* (none, less than 30 minutes), and *type* of support (monitoring, verbal gesturing). Finally, a Supports Intensity Level is determined based on the Total Support Needs Index, which is a standard score generated from scores on all the items tested by the Scale.

As part of MFP rebalancing, the DDA will pilot the use of the SIS with 100 SRC residents and 100 individuals in the community, work with the American Association on Intellectual and Developmental Disabilities (AAIDD) to adapt the SIS for specific health and safety-related support needs (ie. choking risk, etc), develop a valid and reliable link between SIS scores and individualized budgets, and replace the IIRS with the SIS on a system-wide basis. Initial piloting on individuals in SRCs and in community settings will form the basis for budget allocations that meet the needs of individuals with severe disabilities in the community.

#### *Ask Me! Surveys*

Maryland MFP Stakeholder Advisory Group expressed many concerns about the national Quality of Life survey tool that is required as a part of the MFP demonstration, particularly that it was not an effective tool for assessing quality of life for people with significant intellectual disabilities. In Maryland, the Ask Me! Survey has been used annually since 2002 to collect information from people receiving community-based services through Developmental Disabilities Administration (DDA). The Ask Me! Survey measures people's perceptions of the quality of their lives and allows people with intellectual disabilities to define quality of life for themselves. People with intellectual disabilities helped develop the survey instrument and procedures, promote the survey, and conduct the interviews. The Ask Me! Project has demonstrated that people with intellectual disabilities elicit and provide data on quality of life that are valid, reliable, and useful for program enhancement. As Maryland has already been using an effective tool for measuring quality of life and has historical data on people receiving supports in the community, DDA has chosen to administer the Ask Me! survey to people who transition out of institutions through h MFP. This survey will be conducted in addition to the MFP Quality of Life survey and will provide additional information about the individual's experience that can be compared to baseline data collected in previous years. The surveyors will follow policies similar to those established for the MFP Quality of Life survey and will respect a person's choice to refuse to take the survey.

#### 1.6 Enrollment in the TBI Waiver

Resource Coordinators will assist with outreach to residents in CARF accredited Chronic Hospitals and State owned and operated nursing facilities as well as to their family, guardians, and other supporters to provide education and support in making decisions about pursuing community living, application assistance and coordination of needed community resources and

supports for the individual, and enhanced transitional case management to ensure successful transitions to the community.

*Provider Incentives.* As the capacity of the waiver has increased and more people are accessing services in the State, provider capacity has become an increasing issue. Currently, individuals in institutions must wait for an opening with a provider in order to transition and moves are sometimes delayed by lack of capacity in the system. Also, there are less than 10 waiver providers in the State, which limits the individual's choice of provider. In order to overcome these limitations as the waiver grows, increasing provider capacity is essential. While there are many high-quality providers in the community, many of them are unwilling to become waiver providers as the start-up costs are prohibitive. In an effort to overcome this barrier, the Department will offer a one-time only incentive payment of \$25,000 to providers who open a new qualified residential site to offset the costs of provider start-up. Start-up costs covered by the incentive payment may cover costs such as environmental modifications to a group home, modifying a vehicle for accessibility, recruiting and training staff, and or furnishing a residence.

#### Clubhouse Model of Day Services

Maryland intends to develop and pilot the Clubhouse Model of day services as an alternative to traditional day programs for TBI waiver participants. The Clubhouse model is designed to facilitate the work-ordered day and convey a sense of respect and dignity to its members. The work-ordered day engages members and staff together, side-by-side, in the running of the Clubhouse and focuses on strengths, talents and abilities. All work in the Clubhouse is designed to help members regain self-worth, purpose and confidence. The Clubhouse enables its members to return to paid work through Transitional Employment, Supported Employment and Independent Employment. The Clubhouse assists and supports members to secure, sustain and better their employment. It also assists in supporting members to secure volunteer and other means of productive activities in their community. Community support activities of the Clubhouse model are centered in the work unit structure. They include helping with personal support, transportation, advocacy, and promoting health lifestyles. The Clubhouse also offers recreational and social programs during evenings and on weekends. See Appendix L for International Standards of the Clubhouse Model.

#### 1.7 Reenrollment and Reinstitutionalization Policies

*Reenrollment.* If a demonstration participant must return to an institution for more than 30 days prior to the completion of the 12 month demonstration period, the individual may re-enter the demonstration upon return to the community and participate for the unexpended duration of the demonstration period for that individual. If an individual must return to an institution for less than 30 days, they will continue to be participants in MFP while in the institution.

If an individual completes 12-months of participation in the demonstration, and, for whatever reason, returns to a NF, chronic hospital, IMD, or SRC, the individual may return to the community as a demonstration participant if he or she meets the same initial demonstration

requirements: six months of continuous residency in the institution, is Medicaid eligible in the month prior to participating, and returns to a qualifying residence.

*Reinstitutionalization.* For each individual that is reinstitutionalized and is referred to the local MAP site, TBI Resource Coordination, or Community Placement Team for transition back to community living, the MAP or Community Placement Team will be responsible for identifying reasons for reinstitutionalization and addressing them to the extent possible. The State will track reasons for reinstitutionalization through the tracking system, determine trends, and develop remediation and improvements strategies in accordance with the Waiver Quality Council.

### 1.8 Ensuring Informed Choices about Care

Participants in the Maryland Money Follows the Person Demonstration will receive home- and community-based services through the existing and ongoing 1915(c) waivers that are currently in place. These waivers all require institutional level of care and participants are re-evaluated annually for medical eligibility. Therefore, an individual participating in a HCBS waiver remains eligible to receive their long-term care services in an institutional setting and can choose to utilize institutional services rather than community-based services at any time. Maryland's HCBS waivers are voluntary and the participant is informed of their options for care by the waiver transition case manager during the enrollment process and indicates their preference for services on the informed consent form.

MFP applicants will be provided with information about the Division of Waiver Programs' Reportable Events Policy and the Developmental Disabilities Administration's Policy on Reportable Incidents and Investigations which outline policy and process information concerning the consumer's protections from abuse, neglect, and exploitation. These policies also include information about notifying appropriate authorities or entities when abuse, neglect, or exploitation is experienced.

For NF residents, transition coordinators will be providing this information regarding choices about care and protections from abuse, neglect, and exploitation, including notification information, at the time of application. For SRC residents, the Resource Coordinator will furnish this information at the time of application to the HCBS waiver program. This information will also be discussed and reviewed during the annual review of the plan of care/service by the waiver case managers.

## **2. Informed Consent and Guardianship**

### 2.1 Informed Consent Procedures

MFP participants will utilize the same consent procedures that are used for HCBS waiver participants. Currently, waiver applicants (and as appropriate, family members, guardians, etc.) are provided the information needed to understand what they are applying for, how the process works, and what their options are for receiving care. Individuals are also informed that they may at any time choose to return to the institutional setting. The consent forms for each waiver are provided in Appendix B. Under MFP, the waiver transition coordinator or DDA/TBI Resource Coordinator will provide consumer education and materials prior to asking applicants or guardians to sign consent forms. The waiver transition coordinator will manage the informed consent process for MFP eligible residents of nursing facilities during the program education and

application assistance process. Resource Coordinators contracted through DDA or MHA will manage the informed consent process for residents of SRCs and their representatives.

The consent form for MFP demonstration participants is below in Table B.2.1. It will include a description of what constitutes a “qualified residence” so that participants understand the types of residences they may choose under MFP. Older adults in particular, will need to understand that if they choose congregate housing, their residence cannot serve more than four unrelated individuals in order to be eligible for the MFP demonstration. Individuals with developmental disabilities moving from SRCs will have the choice of moving into Alternative Living Units (ALUs) of no more than three residents, to their own home, or to their family’s home. The MFP consent form will also describe the services available only to demonstration participants and information about the Quality of Life evaluation.

The State currently does not have a statutory or regulatory basis for determining who can and cannot provide informed consent without a formal adjudication process. Thus, in most instances, informed consent is a process where there is agreement that the person involved is aware and is making an express choice to live in the community.

*Table B.2.1. Consent Form for MFP Participation*

Consent Form for Money Follows the Person

I freely choose to participate in the Money Follows the Person program. I understand that this program allows me to receive a limited amount of flexible funds for expenses related to my transition from the facility where I currently live to a new home in the community. I understand these funds may be used for groceries, transportation expenses, and other costs directly related to my transition. I understand that my transition coordinator will help me access and document my use of these funds. I understand these funds are available only after I am determined eligible for the Money Follows the Person program and up to 60 days after I transition to the community. I understand that I will receive no additional benefits or services under the Money Follows the Person program beyond the flexible funds.

I understand that agreeing to participate in the Money Follows the Person program has no impact on my eligibility for any other program, meaning that I will continue to receive other services for which I am eligible regardless of my Money Follows the Person program eligibility. I understand that there are no additional risks anticipated based on my participation in the Money Follows the Person program beyond the risks related to receiving services in a community setting, for which I have already provided my consent.

In order to participate in the Money Follows the Person program, I have been informed that I must meet all of the eligibility requirements specific to the Money Follows the Person program, which include six (6) months living in a qualified institution, such as a nursing facility or State Residential Center, one (1) month of Medicaid eligibility prior to my date of transition to the community, and finally that I must choose to live in a qualified residence, defined as:

1. A home owned or leased by myself or a family member;
2. An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which myself or my family has domain and control.

3. A residence, in a community-based residential setting, in which no more than 3 other unrelated individuals reside.

As an MFP participant, I will be asked to complete three short surveys about my quality of life. I will still be eligible to receive flexible funds for transition even if I do not complete the surveys.

My signature below indicates that I agree to participate in the Money Follows the Person program if I am determined eligible and that any questions that I may have about the program have been answered.

Printed Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ MA#: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

During the informed consent process participants will receive information about the complaint process and procedures that are associated with the waiver to which they are applying. The complaint process for the waivers that MFP participants may access are as follows:

The complaint process for participants of the OAW and LAH waivers is governed by the Reportable Event Policy and Procedure as found in Appendix C-1. The Division of Waiver Programs (DWP) shares oversight responsibility with the Administering State Agencies (ASAs) for the OAW and LAH waivers. The Maryland Department of Aging (MDoA) is the ASA for the OAW and the Maryland Department of Health and Mental Hygiene (DHMH) is the ASA for the LAH Waiver. Under the Reportable Events Policy and Procedure, a complaint is defined as any communication, oral or written, from a participant, participant’s representative, provider, or other interested party to any employee of the DWP or ASA, a Case Manager/Service Coordinator, or waiver providers, etc., expressing dissatisfaction with any aspect of the program’s operations, activities, or an individual’s behavior. All entities associated with the waivers, including DWP, ASA Case manager/service coordinators (CM/SC), and waiver providers are required to report real or alleged reportable events in full on the Reportable Event Form. All incidents of alleged or actual abuse, neglect, or exploitation must be immediately reported to Adult Protective Services and the ASA. All complaints and reportable events are forwarded to the CM/SC, who will work with the participant to resolve the complaint and take immediate action to resolve health and safety issues, if necessary. For example, if the complaint involves an absent attendant care provider, the CM/SC can work to resolve the issue immediately by contacting emergency back-up providers. All Reportable Events are then submitted to the ASA and are logged into the Reportable Event database and reviewed to determine if further action is needed. If further review is needed, the ASA shall follow up with appropriate parties, determine and implement appropriate action involving the participant and/or waiver provider, request a corrective action plan from the provider if deemed necessary, send a status letter to the participant or authorized representative regarding the review within 7 calendar days, and summarize the findings on the Reportable Event Review form. The ASA compiles monthly summary reports of all events and submits the reports to the DWP for review. The DWP compiles a consolidated report containing analysis of the reportable events data and makes recommendations for improvement. Please see the attached Reportable Event Policy and Procedure in Appendix C-1 for additional details.

The New Directions, Community Pathways, and TBI waivers utilize DDA's Reportable Incidents policy to monitor quality and manage the complaint process. Appendix C-2 includes the Policy on Reportable Incidents and Investigations that is used for the CP and ND waivers. Self-reported incidents and complaints are reviewed upon receipt by the Office of Health Care Quality (OHCQ) to ensure that those incidents posing immediate jeopardy to the individual are immediately investigated. A triage specialist reviews each report and notifies the DDA Investigations Unit manager of the need to evaluate the report for appropriate assignment based upon the severity and scope of the incident. Incidents are prioritized on a scale of one to six with one being an incident that presents immediate jeopardy. OHCQ responds based on the severity rating and responses range from an on-site investigation within 2 days to providing referrals. Please see Appendix 6 to the Policy on Reportable Incidents and Investigations in Appendix C-2 for details. Incidents or complaints that have not been acted upon are reviewed weekly by the Incident Screening Committee at OHCQ. Further, DDA Regional Quality Assurance Teams conduct site visits, review quality assurance plans, and provide technical assistance to providers to improve quality assurance and ensure that systems are in place for preventing the reoccurrence of incidents and complaints.

## 2.2 Guardianship under MFP

In Maryland, there are two types of guardianship, Guardian of the Person and Guardian of the Property. A Guardian of the Person makes decisions about medical and personal care and decides where the person will live. As this type of guardian has the authority to make decisions about place of residence, Guardians of the Person will be able to sign the informed consent form for the MFP demonstration.

A Guardian of the Property manages the money, assets and property for another. Estates & Trusts sec. 13-201(c)(2) describes a general guardianship of the property as including power over "property or benefits which require proper management." Thus, a guardian of the property, unless limited by the language of the specific court order, would ordinarily be in charge of managing the MA benefit, including switching between institutional long term care and a waiver program, especially since there may be more than one waiver option to consider. Therefore, a guardian of the property will be asked to sign the MFP application form along with the resident. If the guardian of the property refuses to sign the consent form with the resident, the State may seek redress to the court that appointed the guardian.

In all other cases, the resident of the institution will be the person providing the signature for the MFP consent form. However, other individuals who are representative payees or other legal representatives associated with the individual will be contacted by the transition coordinator or community placement specialist at the time of referral so that representatives can be involved in the process of planning for transition. As noted on the diagram relating to nursing facility transition coordination (Appendix A), the guardians and other interested parties identified by the individual will be an ongoing part of the transition planning process.

The State requires that the guardians have a known relationship with the person and that the person must interact with the individual. The law states that guardians "shall maintain appropriate records to document the care and maintenance services provided directly to the disabled person to receive any payment under this subsection" (Annotated Code of Maryland, Estates and Trusts Article § 13-708. Rights, duties and powers of guardians). The state does not

have a specific visitation requirement for non-public guardians. However, non-public guardians are required to report on their activities at least annually to the court that appointed them. This current reporting practice will serve to fulfill any requests for information from CMS regarding MFP participants.

For most individuals residing in SRCs, family members act as guardians. However, on occasions where a family member is unavailable and some manner of guardianship is necessary, a public guardian is appointed. The Area Agencies on Aging (AAAs) and the Department of Human Resources (DHR) serve as public guardians for many people with disabilities, including some individuals currently living in nursing facilities and SRCs. The AAAs are required to visit those for whom they serve as guardians at least quarterly, and DHR is required to visit at least every six months. The AAAs and DHR maintain their own records of their contacts and will provide information on recent visits to the transition coordinator or community placement specialist at the time of application when the guardian signs the consent form for demonstration participation. Private guardians will be encouraged to visit individuals for whom they have been awarded guardianship and to provide information on the frequency of their visits to the transition coordinator or community placement specialist at the time of application. The MFP project does not have the legal authority to compel private guardians to provide visitation data. It is the court's responsibility to ensure that guardians meet their obligations. If the project staff have reason to believe that a private guardian is not acting in the best interests of the demonstration participant, the State may seek redress to the court that appointed the guardian.

Additional information about the guardianship laws in Maryland can be accessed using the resource list included in Appendix H.

### **3. Outreach / Marketing / Education**

#### **3.1 Outreach and Marketing**

The State intends to implement an intensive outreach and marketing program that will reach institutional residents and staff, community providers, and many other interested parties including guardians and families. There will be no geographical targeting for this outreach as the State intends to transition individuals statewide, nor will the State target individuals based on length of stay. Everyone in a facility should have the opportunity to explore options for receiving services in the community.

To reach institutional residents and staff, the State will provide extensive outreach via peer outreach contracts that will reach all institutions, residents, and staff. These peers will use materials currently being developed by the State. Outreach materials will consist primarily of a general informational flyer and handouts from the Maryland Medicaid Home and Community-Based Long Term Care Services booklet, or "blue book," of information distributed by the Department of Health and Mental Hygiene each year. Attached is the 2007 informational booklet that will be used during the outreach and marketing of services to institutional residents (Appendix D). The general informational flyer will include information about the peer outreach in facilities to inform residents of their community-based care options, the assistance available to assist with the transition, and contact information for additional questions or assistance. The materials will be provided to CMS upon completion. Additional information on peer outreach contracts is detailed in Section B.1.3.

In addition to the peer outreach in institutions, outreach to facility staff will be provided through marketing materials developed by the State and will be disseminated through letters to the institutional providers, educational articles in industry publications such as the Health Facilities Association of Maryland (HFAM) and LifeSpan newsletters, and through State-sponsored trainings for providers. The State will develop alternative formats for all MFP outreach materials and other MFP materials as requested, including audio recordings, captioning, large print, and electronic versions.

Family members, guardians, community providers, and the general community will be targets for outreach as well. The peer outreach and education specialist will communicate with family members and other individuals as requested by the institutional residents. Advertisements will be taken out in local publications such as the *PennySaver* magazine and the *Gazette* newspaper, and in other related provider and advocate newsletters such as those of disability-specific organizations like the MS Society, the Spinal Cord Injury Network and local Centers for Independent Living. Informational articles may be included in the new DDA newsletter, *Perspectives*, which specifically targets families and guardians of SRC residents and SRC staff members. Individuals will also be able to access the outreach materials for MFP and the waiver programs through the MAP website. This site will serve as a web-based single point of entry for information about available programs and services in Maryland. DHMH will partner with the MAP to ensure that MFP related materials are accessible through this site.

Outreach materials and advertisements will describe how individuals with significant disabilities live successfully in the community and have transitioned from an institutional setting into the community. Other materials will provide information on services available through waivers, basic financial and medical eligibility, and guidance on how to request additional information and application assistance.

### 3.2 Training Professionals

Trainings relevant to MFP will be offered for health care providers and professionals working with persons with disabilities. Trainings will include information about MFP initiatives, affordable and accessible housing, and person-centered planning. The trainings will be extensively advertised through licensing and professional organizations such as the National Association of Social Workers (NASW) and the MFP stakeholder Advisory Group. The State will work with a local college to provide CEUs for attending the training program as an incentive for professionals to attend. During the first year of the MFP Demonstration, the State will host one training in each geographic region. In subsequent years, the free training will be hosted quarterly with additional trainings hosted upon request for individual organizations or institutions.

Interactive forums with SRC staff will assess their needs and concerns as the State continues to serve fewer individuals through SRCs. The State will hire a consultant with knowledge of human resources and human service systems to facilitate these forums, make recommendations to DHMH, and help the staff find new opportunities in a changing work environment, including the possibility of becoming community-based providers.

*College of Direct Support*

Quality training for direct support staff is a critical component in ensuring the availability of staff to provide supports to individuals with developmental disabilities in community settings. Quality training is based on core competencies and skill standards, and results in a more competent and effective workforce. The College of Direct Support (CDS) training program is based on the Community Support Skill Standards which were developed by Human Services Research Institute. These skill standards were developed with input from direct support professionals, consumers, trainers, agency administrators, educators and others interested in the quality of services. CDS provides a validated curriculum which has been demonstrated to improve the quality of supports, as well as to improve retention of staff, job satisfaction, training satisfaction and to decrease provider costs associated with high staff turnover rates. The CDS courses, lessons and management, and human resource tools have been directly linked to the CMS Quality Framework Quality Factors and Desired Outcomes. In addition, CDS is provided as a web-based learning tool and is available to staff 24 hours a day. CDS includes valuable management and human resource tools which assist states and licensed providers with tracking and recording all training and assessment activities. Finally, the CDS curricula can be easily adapted to meet state and provider specific training needs and priorities.

The Developmental Disabilities Administration (DDA) proposes to purchase a state license for The College of Direct Support (CDS). A state license will ensure that the same high quality, competency-based training is available to all of the staff that supports the more than 16,000 individuals who receive direct support professional services funded by the DDA. It is also hoped that the same increases in the quality of staff supports and interactions, retention rates, training satisfaction and job satisfaction that have been reported in other states can be realized in Maryland. The DDA will purchase an annual license to provide training for staff supporting 16,000 individuals at a cost of \$30.00 per individual. In addition, the DDA will purchase 5 administrator rights at an annual cost of \$2, 800 per administrator. This will allow the DDA management and training coordinators to access and analyze training data on an ongoing basis. The Regional Training Coordinator administrators will also provide support and technical assistance to the licensed providers who do not have a CDS administrator within their organization. Larger providers, including those who support more than 300 individuals, will be asked to fund an internal CDS administrator.

#### *Behavioral Supports and Restraint Elimination*

The Developmental Disabilities Administration has also embarked on an initiative to eliminate the use of restraints for behavioral purposes in Maryland. A National Association of State Mental Health Program Directors curriculum on Trauma Informed Care was adapted by the DDA and has been used in training staff, providers, advocates, families and individuals with disabilities during the past year. Currently, a Task Force is working to better understand the use of restraints in Maryland, and to provide recommendations to the DDA in the fall of 2009 for accomplishing the goal of restraint elimination. It is anticipated that resources for training and behavioral support will be needed to realize this goal. The DDA will provide training resources for crisis prevention and intervention, and financial assistance for providers to initially acquire these training resources; develop an ongoing and available peer support network for professionals who develop and implement behavior support plans and safety support plans; establish a process for a professional review board to review and approve behavior support plans containing restrictive procedures; and establish professional development resources for persons who develop behavior and safety plans

*Supported Employment*

A training and technical assistance institute primarily targeted at community-based provider staff but inclusive of other audiences, covering strategies for job development, building natural and co-worker support models, converting sheltered workshop services to community based employment services, effective on the job training, and other best practice employment models will also be developed to encourage employment as the first option for MFP participants who transition into the DDA service system.

*Behavioral Health Provider Training*

Stakeholders identified behavioral health as an area in need of additional provider training. There are several existing trainings including The Alzheimer's Association of Maryland's training program on dementia for care providers, Maryland's Work FORCE Promise's online training program on the recovery model of treatment for mental illness, and the Maryland Coalition on Mental Health and Aging's training for care providers. Existing trainings such as those listed above will be used to educate providers about co-occurring mental, cognitive, and behavioral health issues of those they serve. They will be advertised and sponsored by the MFP demonstration to increase the numbers of providers who know about and access these trainings in order to become more qualified to serve individuals with co-occurring physical and behavioral health disabilities. Again, the professional organizations and local media outlets will be utilized to advertise the trainings.

Some stakeholders suggested that these trainings were not adequate to address the need for increased screening and diagnosis of mental and behavioral health disorders such as brain injury, mental illness, and dementia in persons living in nursing homes and SRCs. Maryland currently uses the Pre-Admission Screening and Resident Review (PASRR) to screen for mental health issues at intake into a facility or when transferring facilities. The State also uses a mini-mental exam on its 3871b form that evaluates level of care needs annually for individuals in institutions. Stakeholders were also concerned that the existing behavioral health services available in the community would be inadequate to serve individuals with co-occurring physical, cognitive, mental or behavioral health disabilities transitioning out of institutions and that those in need of behavioral support services would not be able to access them.

A parallel stakeholder group to the current MFP Stakeholder Advisory Group was formed by DHMH to further investigate and address these concerns. Some of the suggestions that this group evaluated include using the 1915(i) option or another waiver to serve the IMD population and others in need of behavioral health supports, adding additional behavioral supports to the existing waivers, and developing alternative payment rates for home based mental health services. The group was led by DHMH staff member Alyce Beman-Pearsall, met regularly, and developed recommendations to address these concerns in August 2008. The recommendations of the group were distributed to other advisory groups for further action. Recommendations for service changes to the waiver programs were presented to the waiver advisory committees while recommendations for the mental health service system were presented to the Aging in Place Taskforce and Traumatic Brain Injury Advisory Board. MFP stakeholders who attended the behavioral health workgroup meetings were tasked with following up on the recommendations presented to each group and reporting back to the larger MFP Stakeholder Advisory Group.

### 3.3 Geographic Areas

The entire state will be targeted for dissemination of information. Particular emphasis will be placed on dissemination efforts in rural areas including far western Maryland, the Eastern Shore of Maryland and the farthest southern areas of the State. The State is committed to the MFP demonstration project being a statewide program that accelerates the transitioning of persons in all NFs and SRCs, not just those located in the urban and suburban areas of the Washington-Baltimore corridor.

### 3.4 Bilingual Materials and Interpretation Services

Currently, the MA program provides bilingual and alternate format materials and interpretation services. Materials are provided in Spanish in areas of the state where Spanish is a prevalent language, and interpretation assistance is provided to individuals who need translation assistance when none is routinely available (e.g., Russian, Chinese, or another language where materials in those languages are not routinely available). These services will continue to be available to MFP demonstration participants.

### 3.5 Cost Sharing

There will be no cost sharing as set forth at section 1902(a)(14) for Maryland participants as part of the MFP demonstration.

## **4. Stakeholder Involvement**

### 4.1 Stakeholder Involvement in Demonstration Planning

Maryland's initial application for the MFP demonstration was based on stakeholder input. Once the grant was received, an announcement was posted on the DHMH website, and the State engaged in an extensive process to convene, listen to, and respond to stakeholder concerns, questions, and recommendations that continued throughout the planning process. This operational protocol is a direct product of that process.

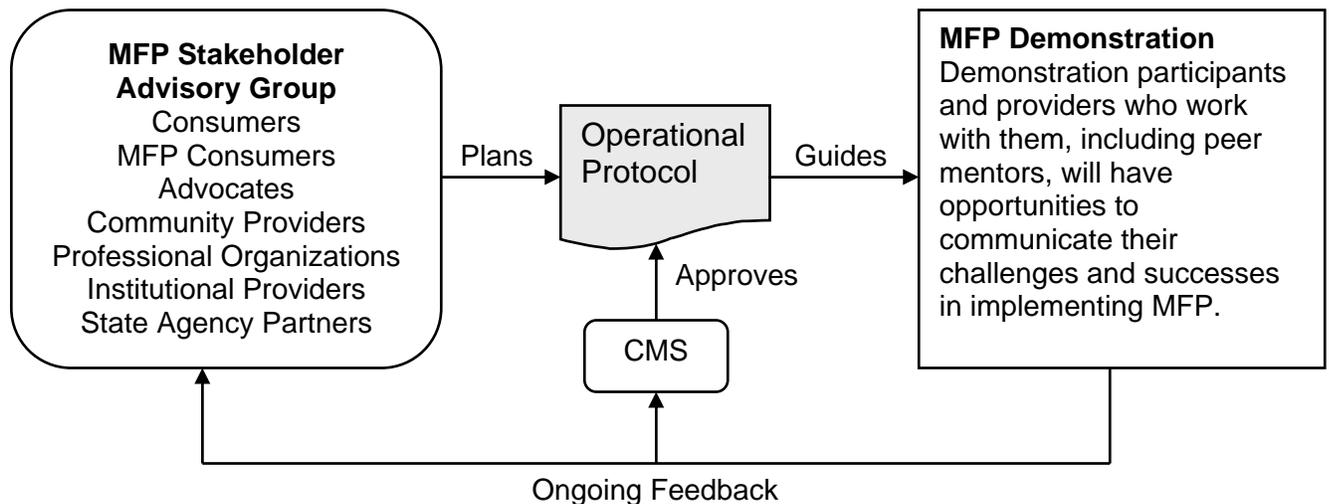
*MFP Stakeholder Advisory Group.* Following the grant award in January 2007, the State formed the MFP Stakeholder Advisory Group to guide the creation of the operational protocol. The State encouraged stakeholders and stakeholder groups already organized around various issues to nominate individuals to discuss policy and administrative issues related to the demonstration. The Advisory Group is made up of consumers, advocates, community providers, professional organizations, institutional providers, State staff, and representatives from various organizations. The State would like to have at least one participant or family member from each waiver participate on the advisory group. Expense vouchers and transportation assistance are offered to consumers and families to allow for their full participation. The advisory group does not currently have consumer representatives from the OAW or TBI waivers although there are six active members representing the aging community and one representative for persons with brain injury. As the waiver for persons with TBI is limited to 30 individuals, the small pool of individuals has presented a challenge in finding a consumer representative for the advisory group. DHMH continues to actively seek consumer and family representatives for the advisory committee. A list of current members and their affiliations is provided below in Section B.4.6.

During the planning process, the Advisory Group met bimonthly. All meetings were open to the public, and people attending the meetings were given opportunities to raise their issues to the group. Each meeting was also broadcast through a toll-free number for interested parties who could not attend the meetings. In the first months, the group discussed the many issues raised by the MFP demonstration and how the State should address them in the operational protocol. When the group decided to explore issues surrounding the availability of housing in more depth, the State hosted an MFP Housing Day, a full day of training and brainstorming about increasing the availability of affordable and accessible housing options. As the protocol submission date grew nearer, the group’s focus shifted to reviewing specific plans for implementation and then drafts of the protocol. The stakeholders received and reviewed 4 drafts of the operational protocol prior to its submission to CMS and were able to monitor the incorporation of their suggested edits into the draft that was submitted to CMS on November 1, 2007.

Current consumer advisory group members will be encouraged to continue participating in the advisory group. Consumers and their families will continue to be welcomed to the advisory group to collaborate on the demonstration as it progresses.

*MFP Project Director.* The State’s search for the MFP Project Director culminated in the selection of Lorraine Nawara who was at the time serving on the MFP Stakeholder Advisory Group as a representative of Independence Now, the Center for Independent Living serving Montgomery and Prince George’s counties. Ms. Nawara brings a consumer advocacy background to the MFP demonstration project. She encourages all stakeholders to contact her directly by email or phone. Regular updates about the demonstration are sent by email to 220 people who have asked to be notified.

4.2 Diagram of Stakeholder Influence during the Demonstration



4.3 Ongoing Stakeholder Input

The MFP Stakeholder Advisory Group has continued to meet at least monthly and continues to provide advice and recommendations. Once the demonstration begins, the State will seek MFP demonstration participants to serve as members of the group. The State will also convene an additional group to address issues related to behavioral health, including serving individuals

transitioning from IMDs with complex behavioral and physical needs, enhancing existing community-based services, and improving behavioral health screening.

The State will continue to provide transportation and any other necessary accommodations to enable group members to participate in its meetings.

#### 4.4 Specific Roles for Consumers

Maryland is fortunate to have many consumers, advocates, and advocacy organizations that ensure a range of consumer voices are heard. Within the demonstration, consumers will continue to serve as members of the MFP Stakeholder Advisory Group to provide input and feedback into the demonstration as it progresses. Consumers have played an active role in the planning process through the advisory group by reviewing the operational protocol and making suggestions for the demonstration. It was the consumer advocates that proposed and supported the idea of using peers to provide outreach to institutional residents. It was disability advocates that suggested broadening the role of peers to include ongoing mentoring support as is reflected in the operational protocol. Another significant contribution from consumers and disability advocates is the aggressive projection of numbers of transitions. It is with the encouragement of the consumer advocates that the State has maintained such aggressive growth and transition projections for the demonstration.

Consumers will also play a role in assisting individuals during their transition out of institutions. Consumers may be identified by institutional residents and participate in the transition process as a mentor. More formally, these consumers with experience in transitioning and/or the waiver programs will be ideal candidates to act as peer mentors. The peer mentoring contractors are likely to employ current consumers and their families in the role of peer mentors so that consumers and advocates will have a direct role in the outreach and marketing of Maryland's community-based care options and in the direct support of individuals who are seeking to transition. This will provide an avenue for consumers to directly influence the process and better inform the Advisory group of transition challenges and successes. Consumers will continue to be involved through the Advisory Group and may assist the process by including advertisements and articles in their publications regarding the MFP demonstration. These publications may help to educate consumers and families while promoting the goals of the demonstration.

#### 4.5 Specific Roles for Institutional Providers

Institutional providers are an essential element of the MFP demonstration. They will continue to provide care for their residents as well as play a role in the transition process for those individuals who pursue community living. Direct care staff at facilities often advise residents and inform nurses about elements of care that will be needed in the community. In addition, direct care staff of the SRCs may participate in trainings and be encouraged to pursue employment as community providers in order to continue supporting the individuals whom they serve as they move to a new setting. Nurses who develop institutional plans of care may be consulted in the process of developing the community plan of care. Social workers at the facilities will be providing direct assistance to the residents in the transition process by helping to secure needed documentation, such as prescriptions from doctors and copies of medical records, and will be helping to obtain durable medical equipment needed prior to and at the time of transitions. The cooperation of all staff working with residents at institutions will be required to facilitate a

smooth transition and continuity of care between settings. Institutional administrators will need to understand and support the MFP demonstration so that they can assist in disseminating the information and encourage facility staff to fully participate in the process. The professional organizations that represent the staff at facilities may help support the project by allowing advertisements and articles about MFP in their newsletters and websites.

#### 4.6 List of MFP Stakeholders and Affiliations

<b>Name</b>	<b>Title</b>	<b>Affiliations</b>
Sarah Sorensen	Assistant Director	The Arc of Maryland; Maryland Commission on Disabilities; Maryland ADAPT
John Burleigh	Administrator of Ridgeway Manor	Health Facilities Association of Maryland (HFAM)
Ken Capone	Co-Leader / Public Policy Coordinator	Cross Disability Rights Coalition; People on the Go of Maryland
Will Fields	Consumer Representative	New Directions waiver participant, ADAPT member
Jamey George	Executive Director	The Freedom Center, the Center for Independent Living for Frederick and Carroll counties
Gayle Hafner	Senior Attorney	Maryland Disability Law Center; Medicaid Matters! Maryland
Floyd Hartley	Consumer Representative	Living at Home waiver participant
Laura Howell	Executive Director	Maryland Association of Community Services for Persons with Developmental Disabilities (MACS); Developmental Disabilities Coalition
Teresa Jeter-Cutting	Division Chief of Client Services	Baltimore City Commission on Aging and Retirement (CARE)
Danna Kauffman	Vice President of Public Policy	LifeSpan Network, facility provider representative
Carol Lienhard	Co-Chair	Maryland Senior Citizens Action Network
Carol Marsiglia	Division Director	The Coordinating Center
Sylvia Matthews	Consumer Representative	Maryland ADAPT; Cross Disability Rights Coalition; Sunshine Folks
Michelle Mills	Administrator	Levindale Medical Adult Day Center ; MAADS - Maryland Association of Adult Day Services
Vicki Mills	Consumer Representative	People on the Go of Maryland
Ethan Moore	Director, Health Policy	Health Facilities Association of Maryland (HFAM); MAADS - Maryland Association of Adult Day Services
Charles Thomas	Treasurer	United Seniors of Maryland; National Association of Active and Retired Federal Employees (NARFE)

<b>Name</b>	<b>Title</b>	<b>Affiliations</b>
Diane Triplett	Executive Director	Brain Injury Association of Maryland
Rhonda Workman	Director of Service Development	Elizabeth Cooney Personnel Agency, Inc., nursing care provider
Mary Ann Wilkinson	Older Adult Specialist	Humanim, Mental Health Association of Maryland, Maryland Mental Health and Aging Coalition
Beth Wiseman	President	BCASCO (Baltimore County Association of Senior Citizens Organizations, Inc.)

MFP Behavioral Health Workgroup Participants

<b>Name</b>	<b>Affiliations</b>
Alyce,Beman-Pearsall	DHMH
Beth Wiseman	Baltimore County Association of Senior Community Organizations
Denise Christopher	Mosaic Community Services
Diane Triplett	Brain Injury Association of Maryland
Donna Riebel	Springfield Hospital Center
Gayle Hafner	Maryland Disability Law Center
Georgia Stevens	Baltimore Mental Health Services
Gerri Gray	National Alliance of the Mentally Ill of Maryland
Herb Cromwell	Community Behavioral Health
Janet Edelman	National Alliance for the Mentally Ill of Maryland
Jim MacGill	MHA Transformation Grant
Jim Reinsel	Maryland Department of Disabilities
Joelle Ridgeway	Mary T Maryland; Brain Injury Provider
Ken Wireman	On Our Own of Maryland
Kim Burton	Mental Health Association of Maryland
Lisa Sarro	Legal Aid Bureau
Marge Mulcare	Mental Hygiene Administration
Marie Ickrath	Baltimore Mental Health System
Marsha Ansel	Howard County Mental Health Authority
Mike Drummond	Arundel Lodge, Inc
Mary Ann Wilkinson	Humanim, Mental Health Association of Maryland, Maryland Mental Health and Aging Coalition
Michele Douglas	Ciekot & Elliott; Advocate Organization
Rhonda Workman	Elizabeth Cooney Agency; Staffing Agency
Richard Bearman	Community Behavioral Health; Mental Health Professional Association
Stefani O'Dea	Mental Hygiene Administration; TBI Waiver
Stefanie Rupertus	GUIDE Independence; Mental Health Provider

Name	Affiliations
Susan Panek	DHMH; Long Term Care Financing
Suzanne Keller	The Coordinating Center; Case Management Provider
Sylvia Matthews	Consumer Advocate

4.7 List of State Agency Partners

- Maryland Department of Health and Mental Hygiene (DHMH)
  - Developmental Disabilities Administration
  - Mental Hygiene Administration
  - Healthcare Financing/Medical Assistance
  - Office of Health Care Quality
  - Developmental Disabilities Administration (DDA)
- Maryland Department of Aging (MDoA)
- Maryland Department of Disabilities (MDoD)
- Maryland Department of Housing and Community Development (DHCD)
- Maryland Department of Human Resources (DHR)

**5. Benefits and Services**

5.1 Benefits of MFP for Demonstration Participants

The primary benefits associated with the MFP Demonstration are peer outreach and mentoring, program education, application assistance, housing assistance, enhanced transition assistance, one time only transition funds, and enhancements to the existing waiver programs. These priorities were identified through the stakeholder process to assist individuals in transitioning into the community.

The peer outreach program is an administrative activity designed to provide outreach and education about community living to institutionalized persons and their families in a comprehensive and accessible way. Peers will be able to reach out to individuals and share information about choices, opportunities, and challenges associated with leaving an institution in a personal and accessible format through sharing their own experiences. In addition, regionally based peer mentors funded through a MFP demonstration service will enhance the connection to the local community and the option of ongoing peer support will assist institutionalized individuals gain comfort, knowledge, and skills in accessing and navigating their communities while in the process of transitioning and throughout their year of MFP eligibility. The State intends to build in the cost of successful initiatives from the demonstration into the budget in 2011 so that the services may be funded by the State in FY 2012.

Individual and family mentoring for SRC residents will be created through both a contract enhancement for the existing peer mentoring services provided to the residents of SRCs and a new contract. These activities will be funded as administrative contracts. Currently, the Self-Advocacy Network (SAN) is under contract with the Developmental Disabilities Administration to provide peer mentoring services to residents of 2 SRCs. The MFP demonstration has expanded this contract to include peer mentoring at all SRCs. A separate RFP was developed to identify a contractor to perform family mentoring functions. Family Mentors will be paid for

their activities as a means of addressing continuity and quality. DDA sees family mentoring as integral to the success of the MFP project, due in large part to the significant level of family opposition to movement to community services, and has thus decided that family mentoring must be compensated. As with other MFP demonstration services, peer and family mentoring may be built into the budget for FY 2012 if successful and deemed necessary after the demonstration.

Program education and application assistance will aid individuals in learning more about community options and increase access to the current home- and community-based services. These services are also administrative activities.

As housing is one of the main barriers to community living, housing assistance may greatly increase the number of people that are able to make the transition. Housing training will provide transitional case managers with information about types of housing options, the availability of housing, and the housing subsidy systems. They will educate applicants and provide intensive support to complete applications, acquire needed documentation, and secure housing. Housing training will also extend to DDA's service coordinators who will provide housing assistance to residents of SRCs who identify independent community housing as their preference. Any member of the Community Placement Team may attend housing trainings.

In addition to this individual assistance, the MAP partners will be responsible for monitoring and working to improve the statewide housing situation for persons with disabilities. The MAP sites will develop relationships with local housing authorities, developers, and other partners to increase housing opportunities and to more efficiently identify and access housing as it becomes available. This will be vital to those seeking independent community housing during and after the MFP demonstration.

Transitional waiver case managers will be responsible for the administration of transition funds, another key support for a successful transition into the community. Assistance in identifying needs and paying for security deposits, utility hook ups, and other needed household items will facilitate transitions.

For MFP Demonstration participants there are also one-time only funds available to assist at the time of transition. This service includes up to \$700 in flexible funds to pay for an initial supply of groceries when they transition, for transportation that will allow an individual to attend housing interviews and run errands related to the transition, and to allow provision of needed goods or services that are not otherwise available.

These services will utilize different mechanisms for implementation and have varying timelines. The contract for peer outreach will begin May 1, 2009. Program education, application assistance, and enhanced transitional case management will begin in the summer of 2009.

For SRC residents, Community Placement Specialists and a Transition Coordinator will be created to enhance community placement efforts. During the demonstration these positions will be funded through the enhanced federal match received through the demonstration and be billed as an administrative cost, not as a waiver service. The State proposes to transition 250 individuals out of SRCs and further rebalance the DDA system so that over 97% of consumers will be receiving community-based services by the end of the demonstration period. As the system will have less than 3% of consumers in institutional settings, there will no longer be a need for these positions and they will not continue. However, the knowledge and skills gained

through the project will enhance the capacity of the DDA Regional Offices and Resource Coordinators to continue deinstitutionalization work for SRC residents.

The State will add services to the waivers, specifically home delivered meals, dietician and nutritionist services, and environmental assessments to the Living at Home waiver and transition services to the Older Adults Waiver. A request to add these services received CMS approval and regulation changes were submitted to finalize the addition of these services to the waivers. Maryland anticipates the additional services will be available by July 1, 2009 after providers have been enrolled. Clubhouse services will be added to the TBI waiver during 2009. Additionally, Maryland changed the funding structure for Medical Day Services in 2008. Adult Medical Day Care was previously offered as a State Plan Service. It is currently being offered as a HCBS waiver and was added as a service to existing HCBS waivers to ensure that all participants could continue to receive the service with the new funding structure. Waiver amendments are currently in process and in varying stages of approval as demonstrated in the following service charts in Section 5.4.

Respite care is currently offered as a waiver service for Community Pathways participants. In some rural areas of Maryland, respite care is primarily provided at institutions due to lack of community capacity to provide respite care in the individual's home. At times, an individual remains in the institution after a respite care stay due to increased support needs or changes in the community services available during the respite stay. DDA will also to develop a Rural Respite Care Consortium to build the capacity of community-based providers in rural regions of Maryland thereby limiting the need for institutionally-based respite care. The Eastern Shore and Western Maryland DDA Regional Offices will work with the provider community to establish a consortium of providers that can offer in-home and out-of-home respite care for individuals with significant disabilities who might otherwise be provided respite care in an institution. MFP savings will be used to develop the consortium and its respite programming, provide needed training for staff, and provide respite care to individuals living in rural communities in the rural catchment areas of DDA's institutions.

There will be no additional medical qualifications used to determine eligibility for demonstration services. There will be no additional provider criteria associated with these services except as outlined in the peer outreach contracts.

## 5.2 Continuous Case Management

The waiver case management services for demonstration participants will be the same as those that are currently offered to all waiver participants. For the Older Adults and Living at Home waivers that will be serving nursing facility residents who have transitioned, case managers are required to complete an annual review of the plan of service. The Living at Home case managers are required to have monthly contact and quarterly face-to-face visits with each participant. These case management services are provided through a contract. The Older Adults Waiver participants receive case management services through the local Area Agencies on Aging who are required to have quarterly contact with participants.

For the Community Pathways and New Directions waivers that will be serving individuals discharged from the SRCs, the Resource Coordinators (case managers) are required to have contact a minimum of twice per year and complete new plans of care annually with the

individual. The DDA Regional Offices contract with case management agencies to provide Resource Coordination services to participants of these waivers.

For individuals transitioning onto the Traumatic Brain Injury waiver, the Mental Hygiene Administration will provide waiver case management services. Quarterly face-to-face visits with the participant and an annual review of the plan of service are required as part of the ongoing case management services.

### 5.3 Receiving Services in the Community

Maryland has chosen to offer MFP demonstration participants services primarily through five existing HCBS waivers. On the day of transition to the community, an individual will use a slot in one of the waivers. As noted in the Project Introduction, MFP Rebalancing Initiatives on pages six and seven, Maryland's Money Follows the Individual policy and Waiting List Equity Fund assure that anyone transitioning from an institution who meets the eligibility criteria for a waiver will be able to access the waiver program, regardless of caps or waiting lists. As part of their enrollment in the waiver, individuals may access any of the approved waiver services as well as any services available through the State Plan. Prior to their transition date, all MFP participants may access the supplemental and demonstration services available only to demonstration participants. All demonstration participants will have access to acute care services through current Medicaid programs, but these acute care services will not be included as demonstration services in accordance with current CMS guidelines.

The State chose to add three additional qualified HCBS services as part of the MFP demonstration based on stakeholder feedback. These new services are labeled "New" in *Table B.5.4 Qualified Home and Community-Based Services by Waiver*.

Peer Mentoring for nursing facility residents will be added as a demonstration service provided by the Centers for Independent Living. Offering this service through the demonstration will provide an evidence base for its efficacy and outcomes. At the end of the demonstration it may be added as a permanent waiver service with any willing provider. A service description is attached in Appendix J-1. Enhanced transitional case management will also be added as a demonstration service for applicants of the Older Adults waiver. The Older Adults waiver continues to fund case management administratively and will offer enhanced transitional case management as an MFP demonstration service. A service description is attached in Appendix J-2. Demonstration and Supplemental Services are outlined below in Table B.5.4.2.

The State will offer the transitional case management and peer mentoring services under the authority of the MFP demonstration. These initiatives will receive funding as demonstration services. Peer outreach, program education, and application assistance will be funded as MFP administrative costs. As outreach activities that will reach many more individuals than those that will transition under MFP, these activities will be funded entirely through MFP administrative funds. Administrative Activities are outlined below in Table B.5.4.3.

On Day 366, MFP demonstration participation ends, but waiver and State Plan services continue uninterrupted. From the perspective of the individual, there will be no difference in the services available once they are no longer MFP participants.

5.4 Table B.5.4.1

Service Type	Service	OAW	LAH	CP	ND	TBI
<b>Home and Community Based Services</b>	Assisted Living	X				
	Assistive Devices / Equipment / Technology	X	X	X	X	
	Attendant Care / Personal Care / Personal Supports/CSLA	X	X	X	X	
	Behavior Consultation/Supports	X		X	X	
	Case Management / Service Coordination / Resource Coordination	X	X	X	X	
	Clubhouse Model of Day Supports					New <sup>2</sup>
	Day Habilitation			X	X	X
	Dietitian / Nutritionist Services	X	New <sup>1</sup>		X	
	Environmental Accessibility Modifications	X	X	X	X	
	Environmental Assessments	X	New <sup>1</sup>	X	X	
	Family and Individual Support Services			X	X	X
	Family and/or Consumer Training	X	X		X	
	Fiscal Intermediary		X		X	
	Home-Delivered Meals	X	New <sup>1</sup>			
	Medical Day Care	X	X	X	X	
	Nurse Monitoring for Personal Care Services	X	X	X	X	
	Personal Emergency Response System	X	X	X	X	
	Residential Habilitation			X		X
	Respite Care	X		X	X	
	Senior Center Plus	X				
Supported Employment				X	X	X
Supports Brokerage					X	
Transition services	New <sup>1</sup>	X	X	X		
Transportation				X	X	
<b>State Plan Services</b>	Medical Assistance Personal Care (MAPC) Program	X	X	X	X	X
	Disposable Medical Supplies / Durable Medical Equipment	X	X	X	X	X
	Home Health	X	X	X	X	X
<b>Demonstration Services</b>	Peer Mentoring for NF Residents	New <sup>3</sup>	New <sup>3</sup>			
	Transitional Case Management	New <sup>3</sup>				
<b>Supplemental Services</b>	MFP Flexible Funds	New <sup>3</sup>				

1. Implementation target is July 1, 2009; LAH waiver amendments submitted March 2009; OAW amendment approved in May 2009

2. Implementation target July 1, 2010; waiver amendment to be submitted in 2009

3. Implementation target of July 1, 2009

Table B.5.4.2 Demonstration and Supplemental Services Detail

Service Type	Service	Waivers Affected	Provider	Rate	Caps on Utilization	Start Date
<b>Demonstration</b>	Peer Mentoring	LAH, OAW	Centers for Independent Living	\$7.78 per 15 minute unit	192 units per person	July 1, 2009
	Comprehensive Transitional Case Management	OAW	Area Agencies on Aging	\$13.25 per 15 minute unit	None	July 1, 2009
<b>Demonstration Administrative Cost</b>	Administrative Transitional Case Management	OAW	Area Agencies on Aging	\$13.25 per 15 minute unit	None	July 1, 2009
<b>Supplemental</b>	MFP Flexible Funds	All	Case Management Entities	Actual Expenses	Up to \$700	June 1, 2009

Table B.5.4.3 Administrative Activities

Service Type	Service	OAW	LAH	CP	ND	TBI	Provider	Rate	Start Date
<b>Administrative Activities for Nursing Facility Residents</b>	Peer Outreach for Nursing Facilities	X	X				Contract		5/1/09
	Program Education	X	X				AAA	\$100 per occurrence	7/1/09
	Application Assistance	X	X				AAA	\$150 per occurrence	7/1/09
	Enhanced Transitional Medicaid Case Management	X	X	X	X	X	Existing CMs		7/1/08 to 7/1/09
<b>Administrative Activities for ICF/MR residents</b>	Peer Mentoring for ICF/MRs			X	X		Contract		7/1/08
	Family Mentoring for ICF/MRs			X	X		Contract		11/1/08

## 6. Consumer Supports

As demonstration participants are utilizing the existing waiver programs for community-based services and support, the current systems for consumer supports that are approved and in place will be used by the demonstration participants as well.

It is expected that the service coordinators and transitional case managers providing direct transition assistance will meet standards similar to the current LAH case management contractor: a bachelor's degree in human services or related field and two years of experience providing similar services with a maximum case load ratio of 1 staff person to 25 applicants.

Standards for other services are outlined in service descriptions, provider qualifications, and the contracting process. Peer outreach contracts secured through the RFP process include definitions of peers and staffing standards to adequately support outreach activities.

### 6.1 Back-up systems

As individuals receiving peer outreach, program education, application assistance, peer mentoring and transitional case management services prior to transition will be institutional residents, the institutional provider will be expected to provide critical back-up services. After the individual transitions to the community, the program through which the individual is receiving services will be responsible for providing, documenting, and reporting requests for critical back-up. Please see Section B.2 Informed Consent and Guardianship, for details of the State's Reportable Events Policy and other procedures for complaints that will be available to MFP participants.

The emergency back-up systems for the different waivers that are accessible to MFP participants are similar in their first two levels of back-up. For each participant, the first level of back-up is identified on the plan of care/service as a list of alternate providers for services vital to health and safety. The second level of back-up is the case management provider. If the back-up provider on the plan of care/service is not able to resolve the issues for the participant, the case manager is contacted for assistance as the second level of back-up. There is some variation among the waivers for the third and fourth levels of back-up for participants.

For the LAH and OAW waivers, the third level of back-up consists of the emergency or crisis services available to them through the Department of Human Resources (DHR). DHR maintains a 1-800 number for Adult Protective Services, which provides crisis intervention services to vulnerable adults. The statewide number for this service is 1-800-91 PREVENT (1-800-917-7383). Several jurisdictions in Maryland have yet another level of back-up through their local crisis centers housed at the local departments of social services. For example, the Montgomery County Crisis Center provides immediate responses to crisis situations for all residents of Montgomery County, Maryland. The Center provides goal-oriented crisis intervention, brief crisis stabilization, and help in obtaining services for individuals and families with a mental health crisis or experiencing other crisis situations. Case managers are responsible for providing information about local crisis resources to LAH and OAW waiver participants as a 4<sup>th</sup> level of back-up.

Maryland's CP and ND waivers utilize DDA Regional Offices as their third level of back-up in the event that both the first and second level of back-up fail. DDA Regional Office staff have an on-call person covering hours after normal business hours, including evenings and weekends.

#### *Educational Materials*

During application to one of the HCBS waiver programs, educational materials about the waiver and its supports and services are provided to the participant. For the Older Adults, Living at Home, Traumatic Brain Injury, Community Pathways, and New Directions waivers, the case management agency provides detailed information about the waiver, the case management agency, contacting the case manager, reporting complaints and incidents, and emergency procedures, including what to do in case of emergency and how to access back-up systems. This information is provided at the time the initial plan of care/service is developed. This process will not change during the MFP Demonstration as the waiver case manager will be actively involved in revising the plan of care/service with the participant just prior to the transition to the community.

#### *Transportation*

There is currently not one universal back-up system for transportation available to waiver participants as local transportation options are varied. DHMH developed a comprehensive list of transportation options available to Medical Assistance 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 will be made available to participants of all waivers through waiver case managers in the future so that demonstration participants will be assured access to this information.

For individuals with developmental disabilities in the Community Pathways waiver, community-based service providers are responsible for transportation necessary to implement the individual's plan of care. For individuals with developmental disabilities in the New Directions waiver, the plan of care may include various forms of transportation and the movement of funds is flexible, allowing for easy access to primary and back-up transportation services.

#### *Direct Service Workers*

For current participants of the HCBS waivers, back-up plans for direct care workers are included in the plans of service or plans of care. An alternate provider is identified as an emergency back-up at the time that the initial plans are written with the case manager. Individuals with developmental disabilities choosing to self-direct their services through the New Directions waiver are required to have a two-level back-up system as part of their approved plan of care. For individuals transitioning to group homes, alternative living units, or assisted living facilities of four persons or less, the emergency back-up plans are explained to the individual as part of the intake process and are contained in the administrative policies and procedures of the service provider.

#### *Repair or replacement of durable medical and other equipment*

For the current HCBS waivers, persons in need of durable medical and other equipment are provided with information about their choices for providers in their area during the development of their plan of care or plan of service. This information is disseminated by the case manager

during coordination efforts. The participant is given the contact information for the equipment provider and at least one alternate provider in their area. The case manager is responsible for assisting participants in locating and accessing repair to or replacement of medical equipment as needed. Again, lists of available providers may be given to the participant and case manager assistance in coordinating the repair may be provided.

#### *Access to medical care*

When waiver participants become eligible for community MA through a waiver program they also become eligible for State Plan services. These State Plan services include access to routine medical care such as physician visits and specialists. Some individuals access these services through managed care organizations (MCOs). The MCOs are responsible for maintaining an adequate number of qualified providers for participants in their regions of service. The participants in the waivers choose an MCO and are sent an informational packet that includes information about accessing medical care through their chosen MCO including the appointment scheduling and referral process. In addition, information about contacting the MCO and any back-up systems that are in place are provided to the participant by the MCO at the time of enrollment.

All others access the State Plan services through fee for service, including dual-eligibles and participants in the REM program. DHMH is responsible for maintaining an adequate number of providers and communicating relevant information about back-up and complaint systems to these participants.

#### *Demonstration Support Services*

MFP demonstration services available to MFP participants include transitional case management for Older Adult Waiver applicants and peer mentoring. Transitional case management will be provided by existing waiver case managers and will be subject to the waiver Reportable Events Policy (Appendix C-1). As this service is provided while individuals are still institutionalized, the institutional provider will be responsible for emergency back-up for services vital to health and safety and institutional services remain subject to a variety of quality management processes.

Peer mentoring services will be provided both pre and post transition. All peer mentoring services will be subject to the Reportable Events policy. For services provided to MFP participants in the community, the peer mentoring service will be included on the individual's plan of care or plan of service and therefore be subject to the existing waiver quality management process as described below in Section 8.1 Quality, including the Quality of Care Review Team process.

#### *Supplemental Support Services*

The only supplemental services available to demonstration participants are the one time only funds available to assist in the process of transitioning to a qualified community residence. These include a food card, transportation funds, and flexible funds. These services are provided by the transitional case manager prior to and during transition and are not ongoing. Information about accessing these services will be provided by the transitional case manager during the development of the plan of care or plan of service.

## 6.2 Complaint Resolution Process and Remediation

The HCBS waivers have implemented Reportable Events and Reportable Incidents policies as described in Section B.2.1, that serve as the mechanism for reporting complaints and incidents, including failure of back-up systems in place and other issues related to waiver services and supports. Waiver case managers will utilize the Reportable Events policy for complaint reporting and remediation. Critical incidents involving residents of institutions who are waiver applicants will follow the institutional incident reporting and remediation policies.

## 7. **Self-Direction**

The five HCBS waivers that MFP participants will use to access community-based services offer a variety of self-direction opportunities that vary with each waiver. The Older Adults, Community Pathways, and Traumatic Brain Injury Waivers have the fewest opportunities for self-direction, incorporating the consumer in the care planning process but not offering additional self-direction options. The Living at Home Waiver offers participant centered planning, the consumer employed model of attendant care, and optional self-delegated care. The New Directions waiver offers the most opportunities for self-direction, including support brokerage, supported employment, community supported living arrangements (personal supports), assistive technology, accessibility adaptations, and transportation.

### *Living at Home*

The Living at Home waiver offers two levels of self-direction for attendant care. The first is the consumer-employed model in which the consumer hires and trains the attendant. COMAR 10.09.55.02 states that the ‘Consumer-employed model’ means the delivery of attendant care services when: (a) A waiver participant chooses the attendant who will render services; (b) The attendant is a self-employed Medicaid provider; and (c) The participant utilizes services of a fiscal intermediary. This type of attendant has a nurse monitor that creates a plan of care and is responsible for training the attendant to provide appropriate care to the consumer.

The second option for self-direction offered through the Living at Home waiver is the consumer-employed and self-directed model in which the consumer hires and trains the attendant care provider and waives the nurse monitoring of the attendant. In this model, the consumer develops their own plan of care and is responsible for monitoring their care. Both models of care require the use of a fiscal intermediary that is responsible for reviewing the time sheets of the attendant, withholding taxes, and arranging payment for the services provided. The LAH waiver currently uses PPL as the fiscal intermediary. There is no cost to the consumer for fiscal intermediary services. Individuals choosing self-delegated care through the Living at Home waiver can also begin, discontinue or resume self-delegation at any time.

For LAH participants choosing to self-delegate care, involuntary termination from self-delegation may be pursued by the service coordinator. If there is a concern that the participant’s health is in jeopardy, a meeting will be held with the participant, service coordinator, LAH RN Clinical Supervisor, and provider to discuss concerns and options. If the strategies are determined not to meet the participant’s health and safety needs, the Service Coordinator will inform the participant that the Living at Home Waiver Division will be notified. Once notified, the LAH Waiver Division will review the information provided by the Service Coordinator and, if necessary, complete the reduction/denial of services form to discontinue self-delegation of

attendant care services. The form and appeal rights will be forwarded to the participant. The participant may appeal any decision regarding his/her ability to self-delegate attendant care services under the waiver. The Policy for Self-Delegated Care is attached as Appendix E.

The Living at Home service coordinator monitors service utilization and issues relating to health and safety through monthly contacts and quarterly visits with the participant. The service coordinator helps to facilitate resolution if there are issues between the consumer-directed attendant and the participant.

### *DDA Waivers*

Individuals transitioning from a State Residential Center will work with their resource coordinator to develop their Plan of Service using the Essential Lifestyle Planning tool described in Section B.1. MFP participants with developmental disabilities may choose to enter either the Community Pathways waiver (provider-directed services) or New Directions waiver (self-directed services). Self-directed services under the New Directions waiver include: support brokerage, supported employment, community supported living arrangements (personal supports), assistive technology, accessibility adaptations, and transportation. Traditionally implemented services under the New Directions waiver include day habilitation, resource coordination (case management), behavioral support services, and transition services.

Any individual self-directing their services through the New Directions waiver can elect to change to provider-directed services through the Community Pathways waiver at any time. A participant of the New Directions waiver shall be disenrolled from self-directed services when either: the participant voluntarily elects to disenroll or the Developmental Disabilities Administration determines that: a) the individual no longer meets eligibility criteria for self-directed services through the New Directions waiver; b) the health and safety of the participant may be threatened; c) a significant amount of the services outlined in the approved New Directions Individual Plan and Budget are not being provided to the individual; d) the Individual Plan and Budget is not being implemented as approved; e) the participant's expenditures or attempts to expend funds are inconsistent with the approved New Directions Individual Plan and Budget; f) there is mismanagement of funds; g) funds have been used fraudulently or for illegal purposes or; h) the individual has been without a certified Support Broker for more than 30 days.

Under New Directions, a Support Broker is hired by and works for the participant. They assist the individual to develop the individual plan, coordinate supports and services to implement the plan, develop and manage the participant's budget, develop an emergency back-up plan, and help an individual to recruit, hire and supervise staff. Support brokers may also help to locate data about who provides services, their location and "fair market" costs, etc.; and/or technical assistance with implementation of contractual agreements with service providers; adjusting for changing needs including exceptional circumstances; conflict resolution and mediation; monitoring of service arrangements; identifying alternative services and supports, or stimulating the development of new options; and ensuring that mechanisms are in place for financial administration of individualized funding. The primary aim of these supports is to assist the participant and their family to capably use funding to get the best services or supports to meet individual needs. The process is intended to increase personal confidence and competencies, resulting in real participation in the community, in ways that are meaningful to the individual. The participant can hire and train the person that they choose to be their support broker. It can be

a member of their family, although only certain members can be paid, a trusted friend, or anyone that is trusted who meets the requirements.

DDA has developed a three-part 10-hour training series for individuals, families, and Support Brokers in the New Directions waiver – 1) New Directions Orientation, 2) Support Broker Training, and 3) Technical Assistance Training. Select key concepts addressed as part of the trainings include:

- Introduction to Medicaid
- Acute vs HCBS services
- Goal of waivers
- Community Pathways and New Directions
- Eligibility for New Directions
- Services under New Directions
- Application and Approval process
- Principles of Self-determination
- Person-Centered Planning
- Increasing individualization, control, flexibility, creativity
- Leveraging resources and natural supports
- Budget setting for individuals new to DDA services
- Budget setting for individuals in DDA services
- Legal obligations/ nondiscrimination/ fair labor standards
- Workers Compensation/Liability Insurance
- Emergency back-up
- Roles and Responsibilities (Individual, Resource Coordinator, Support Broker, FMS, Staff)
- Assisting individuals to reach their personal goals
- Hiring, firing, training, scheduling, evaluating staff and all associated paperwork
- Monitoring individual's health and safety; ensuring health and safety needs are met
- Fiscal Accountability: joint responsibility of the individual, the family, and the support broker to ensure fiscally responsible; Medicaid fraud

Each staff member hired by New Directions participants must undergo a Criminal Background Check and complete First Aide/CPR training and Policy on Reportable Incidents training, as well as, as necessary, Medication Technician training along with training individualized to the waiver participant (ie. positive behavior supports, managing seizures, etc.)

Having a Fiscal Management Service (FMS) is a requirement of the New Directions waiver. The State has two FMS that manage funds for New Directions participants that assist individuals/families to fulfill employer responsibilities by setting up employment forms and deductions, paying taxes, unemployment, workman's comp, etc. on behalf of the individual/family. The FMS pays employees and vendors for New Directions participants, produces and disseminates a budget statement each month (which is sent to the individual, the Support Broker, the Resource Coordinator, and DDA), verifies provider qualifications, and secures criminal background checks on providers. The FMS provides no other services to the New Directions participant.

MFP participants who decide to self-direct their services through the New Directions waiver will be provided with information and training about self-directed services, including information about the role of the FMS and available FMS providers. Information about FMS providers is also available at each DDA Regional office and on the DDA website. DDA recommends that individuals/families meet with each of the FMS providers to find the best “fit”. It is then up to the individual/family, with any desired assistance from the Resource Coordinator and Support Broker, to make the choice. The individual/family will notify the FMS of their choice and plan for that expense during the development of the New Directions Individual Plan & Budget. The FMS receives a copy of the award letter after it is signed by the DDA Director. Upon receipt of that letter the FMS works with the individual/family to set up all the necessary paperwork, provide any necessary/desired education and begin managing funds on the participant’s behalf. Each FMS receives funds from DDA headquarters based upon the New Directions Individual Plan & Budgets for the individuals for whom they provide FMS services. The FMS receives reimbursement for all criminal background checks completed on behalf of New Directions participants. That expense is not charged to/included in the individual’s budget. The FMS is responsible for the claiming of all waiver services.

Each individual transitioning to community services, whether in traditional or self-directed services, is assigned a Resource Coordinator. In the New Directions waiver, the role of the Resource Coordinator includes: coordinating the planning and budgeting process, assisting the individual/family to interview & choose a support broker, assisting the individual/family to choose a Fiscal Management Service (FMS), assisting in the development of the New Directions Individual Plan and Budget and ensuring that it includes all essential elements (i.e., services to ensure health and safety, emergency back-up plans), monitoring individual health, safety, and satisfaction, monitoring monthly budget statements, and monitoring Emergency Back-Up usage.

### *MFP*

Through the MFP demonstration, opportunities for self-direction will continue. Transitional case managers will use participant-centered planning as it is used to develop initial plans of care/service for the LAH, OAW, and TBI waivers. Resource Coordinators will continue to utilize person-centered planning as is their current practice for the CP waiver. In creating the transitional case management demonstration service, the MFP demonstration will require case managers to utilize a participant-centered service plan development process for all participants who receive transitional case management services. The participant or a chosen representative may direct the components of the Plan of Care, including the choice to reduce services to meet cost neutrality, as long as health and safety assurances are met. Transition coordinators will also apply principles of self-direction to the use of supplemental and waiver transition funds, allowing the participant to spend funds on qualified expenditures of their choosing.

## **8. Quality**

Maryland is offering MFP demonstration participants services through five existing HCBS waivers. On the day of transition to the community, an individual will use a slot in one of the existing waivers. Each waiver has a comprehensive quality management system which includes emergency back-up systems and incident reporting and management strategies. Maryland’s Community Pathways and New Directions waivers recently revised their quality plans with technical assistance from CMS’s contractor, Human Services Research Institute (HSRI), for

submission with its recent waiver renewals that were submitted at the end of March 2008. Maryland's Living at Home waiver received technical assistance from Thomson Medstat for submission of its waiver renewal on April 1, 2009. The State assures that all MFP demonstration participants will receive the same level of quality assurance and improvement activities described in the existing 1915(c) HCBS waiver applications during the 12 month demonstration and throughout their participation in the waiver.

### 8.1 Existing Programs

Each of the 5 HCBS waivers that MFP participants may access for community-based care currently have comprehensive quality plans in place. These plans include the details of the quality assurances developed and implemented by the State, including the policy and process in place to ensure quality of individual plans of care and participant's health and welfare. The Older Adults, Community Pathways, and New Directions waivers currently have a CMS approved 1915(c) Appendix H. The Living at Home waiver recently submitted a waiver renewal to CMS that includes a new Appendix H. It is expected that this quality plan will be approved and in place by July 1, 2009. For the waivers that will be utilized by MFP demonstration participants that do not have a new Appendix H approved by CMS, the quality assurances are described in more detail below.

#### *TBI Waiver*

To assure quality in care planning and assure the health and safety of participants of the TBI waiver, the case manager, waiver coordinator and the DWP work together. The case manager is responsible for developing the plan of care with the participant, monitoring its implementation, reviewing it for appropriateness on an ongoing basis, and revising the plan as needed but at least annually. The case manager is also responsible for conducting face to face visits with participants each quarter, following up on incidents and complaints, and completing Participant Experience Surveys (PES) with 100% of participants each year. The Mental Hygiene Administration (MHA) Waiver Coordinator reviews participant's records and evaluates 5% or 15 plans of care, whichever is greater, on an annual basis. The Waiver Coordinator writes plans of correction, as needed, based on their review. MHA's Director of Adult Services or their designee then monitors the plans of correction to ensure resolution of any issues discovered, reviews the PES results, reviews critical incidents reports, reviews any grievances or complaints relating to the case manager, writes letters of recommendation to waiver providers, initiates provider sanctions if needed, and develops quarterly reports to trend and track quality in the waiver program. The Director of Adult Services also leads annual provider visits with the Waiver Coordinator and case manager to ensure that providers are in compliance with regulations, including maintaining appropriate staffing ratios. The TBI waiver quality plan is attached in Appendix F.

#### *LAH Waiver*

In the LAH waiver, the case manager is responsible for monitoring the health and safety of participants. The case manager assures the health and welfare of their participants through the development of the plan of service, reviewing and updating the plan and the emergency back-up mechanism in the plan as needed, initiating reviews of health and safety by AERS as needed, and utilizing the State's Reportable Events policy. The case manager develops the plan of service

with the participant using the AERS plan of care recommendations. The case manager monitors the implementation of the plan during quarterly visits, evaluates its appropriateness on an ongoing basis, and revises the plan at least annually and as needed.

The LAH Waiver Division, approves all plans of service and revisions, compares the plan to the AERS nurse recommendations, and ensures that the plan assures health and safety of the participant. The LAH Waiver Division also reviews Reportable Event (RE) forms to assure that the policies, procedures, and timelines are followed appropriately, then submits quarterly reports to the Division of Waiver Programs (DWP). The DWP monitors the implementation of the RE policy through the quarterly reports, aggregates and analyzes data from the RE forms, and coordinates the Waiver Quality Council.

A Quality Care Review (QCR) Team contracted by the State also audits the plans of service and reviews a random sample of the plans each year. The QCR team is responsible for auditing the files for any participant who has died or been discharged in the past year as well. The QCR team performs a record review, interviews the case manager and provider, observes the participant, compares the plan to the AERS nurse recommendations, determines if the case manager visits regularly, reviews plan of care/service revisions for appropriateness, and administers a participant survey. The QCR Team then compiles results from these activities, drafts a report, and submits the report to the Division of Waiver Programs and the LAH Waiver Division. Remediation of issues identified by the QCR team can include corrective action plans, provider sanctions, or other actions as deemed appropriate by the DWP.

Quality Strategies for State Plan Services

## 8.2 MFP Quality Strategies

Additional quality assurances and improvement activities will be developed for peer mentoring, transitional case management, and supplemental services as described below. The State is moving toward a more comprehensive quality management system across all HCBS 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 reestablished the Waiver Quality Council with representatives from each waiver administering agency, the Office of Healthcare Quality, and Medicaid, who will work towards these goals over the next year. The Waiver Quality Council brings together these groups to discuss waiver quality management policies and procedures, the aggregate data analysis from the Division of Waiver Programs, and consumer experiences in an effort to develop recommendations for improving data collection and remediation processes. The council is currently working towards improving data collection across waivers to capture meaningful and

uniform information on reports so that data analysis can be more efficient and useful to improving quality of care.

As DDA works to rebalance its service delivery system to decrease institutional placements and increase community supports and services there is an increased focus on quality improvement in community-based services tied to the six HCBS waiver assurances required by the Centers for Medicare and Medicaid Services (CMS). As part of a comprehensive quality assurance system there is a need for an information and data system that is transparent to individuals, families, and providers that tracks activities related to quality of care and outcomes in community-based services. The availability of such a system will provide information to drive quality improvement in community-based services and assist individuals and families in making choices about community-based care and supports. It may also increase the comfort level of those in institutions and their families that quality support systems in community-based services can address their health and safety needs in the most integrated setting.

In order to make the community a viable alternative for individuals currently residing in institutions whose families are resistant to change, quality systems must tie directly to their loved one's Individual Plan (Plan of Care) and the services and programming for that individual. As part of MFP rebalancing activities, the DDA will issue an RFP for a quality information and data system tied to Individual Plans and individual outcomes. The system will drive quality improvement activities at the individual, provider, regional, and state levels.

As DDA develops its Strategic Plan to rebalance its service delivery systems, it is expected that consultant services may be required to address specific issues related to such topics as institutional closure, institutional downsizing, services for individuals dually diagnosed with developmental disabilities and mental illness, services for medically fragile individuals, services for aging individuals with developmental disabilities, improvements to resource coordination (case management), developing community capacity, and enhancing supported employment resources and self-direction for individuals with significant disabilities. The DDA projects to use consultants to assist it in its efforts to reform and rebalance its service systems and underlying infrastructure to improve quality.

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.

#### *MFP Demonstration Services*

*Peer Mentoring.* Peer mentoring quality assurances and improvement strategies have not yet been fully developed. The peer mentoring service will include specific performance measures and quality indicators, which will be tracked in the MFP Tracking System, described below. The identified providers will also be required to participate in quality activities as developed and required by CMS and the Quality Technical Assistance Contractor.

*Transitional Case Management.* The identified providers will also be required to participate in quality activities as developed and required by CMS and the Quality Technical Assistance

Contractor. The transitional case managers will utilize the State's Reportable Events Policy (Appendix C-1) to monitor quality and address complaints.

*New HCBS Waiver Service.* For each of the new services added to existing HCBS waivers through the MFP demonstration, a comparable service already exists in another waiver as noted in Table B.5.4.1. Quality assurances for each of the new services exist in other waivers and will be replicated in the waivers that do not yet provide those services. Each waiver's quality plan is attached for reference (Appendix F).

*Supplemental Services.* As noted in section B.5.4, Maryland's MFP demonstration participants will be able to access food cards, transportation, and flexible funds, as supplemental services to support their transition to the community. These one time only supplemental services will be administered by the transitional case managers. MFP participants will have the ability to submit complaints related to these services and will participate in waiver quality processes as described above.

*MFP Tracking System.* Maryland will develop a web-based tracking system to assist in fulfilling CMS reporting requirements and evaluation. The system will track activities and performance of MAP partners, service providers, and contractors. The system will track the number of peer outreach contacts, the number of referrals to program education, application assistance, transitional case management, and peer mentoring, as well as track the services each potential participant receives. The system will also track when participants make the transition to the community and if they are re-admitted to an institution for more than 30 days for any reason. The available data will be analyzed along with historical data to analyze the impact of MFP initiatives.

## **9. Housing**

### **9.1 Defining and Documenting Qualified Residences**

There are three types of qualified residences in which MFP participants can choose to reside:

1. A home owned or leased by the individual or the individual's family member;
2. 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.
3. A residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.

The Code of Maryland Regulations defines five residential settings that may serve small groups of unrelated individuals:

**Alternative Living Unit** – Code of Maryland Regulations 10.22.01.01 B(2)

(1) "Alternative living unit" means a residence that:

- (a) Provides residential services for individuals who, because of developmental disabilities, require specialized living arrangements;
- (b) Admits not more than 3 individuals; and
- (c) Provides 10 or more hours of supervision per unit per week.

Regulated by the Department of Health and Mental Hygiene, Developmental Disabilities Administration and the Office of Health Care Quality

**Group Home** - Code of Maryland Regulations 10.09.26.01 B(10)

"Group home" means a residence that:

- (a) Provides residential services for individuals who, because of developmental disability, require specialized living arrangements;
- (b) Admits at least 4 but not more than 8 individuals; and
- (c) Provides 10 or more hours of supervision per home, per week.

Regulated by the Department of Health and Mental Hygiene, Developmental Disabilities Administration, and the Office of Health Care Quality

**Adult Foster Care Home** - Code of Maryland Regulations 07.06.16.02 B(1)

"Adult Foster Care" means a program that provides a family setting in the community for an aged adult or an adult with disabilities who requires:

- (a) Protective oversight;
- (b) Assistance with the activities of daily living; and
- (c) Room and board.

Regulated by Department of Human Resources

**CARE Homes** – Code of Maryland Regulations 07.06.15.02 B(3)

"CARE home" means a certified adult residential environment home that provides a resident with a supportive housing arrangement, help in reaching community resources, and protective oversight; and is licensed or has an application pending for licensure and has not been denied a license as an assisted living program under COMAR 10.07.14. A CARE home includes a:

- (a) Private home which is the provider's residence and serves a maximum of three residents;
- (b) Supervised home which is not the provider's residence but may have live-in staff and serves not more than three residents; or
- (c) Group home which may be the provider's residence, has live-in staff, and serves four to eight residents.

**Assisted Living Facility** - Code of Maryland Regulations 10.07.14.02 B(10)

"Assisted living program" means a residential or facility-based program that provides housing and supportive services, supervision, personalized assistance, health-related services, or a combination of these services to meet the needs of residents who are unable to perform, or who need assistance in performing, the activities of daily living or instrumental activities of daily living, in a way that promotes optimum dignity and independence for the residents.

Regulated by the Department of Health and Mental Hygiene, Office of Health Care Quality

Each of these types of residences as defined in the regulations has the potential to serve as a qualified residence for an MFP eligible individual provided that the residence serves no more than 4 unrelated individuals. For example, an assisted living facility that is licensed to serve 4 or

fewer individuals may be chosen by an MFP participant and would meet the standards for a qualified residence. The transitional case managers and the community placement specialists will document the type of qualified residence where each MFP participant chooses to live. Staff will verify that homes or apartments meet the statutory definitions under MFP. Verifications may be based on a visit to the residence, a report of the consumer or representative, information obtained from the property manager or landlord, licensure information, or information from a local housing authority. For community-based settings serving four or fewer individuals, the transitional case manager will document the type of setting based on the definitions in the Code of Maryland Regulations. For assisted living facilities, this means verifying with the Office of Health Care Quality that the facility is licensed to serve four or fewer individuals. For Alternative Living Units, the staff need only verify the type of setting, since by definition this residence serves 3 or fewer individuals. Maryland expects that few MFP participants will choose to live in a Group Home or Adult Foster Care Home. Information about the community residence chosen by each participant will be documented in the MFP tracking system and reported to the State in periodic required reports.

## 9.2 Strategies to Meet the Projected Housing Need

The lack of affordable and accessible housing is a major barrier to community transition. The MFP demonstration will employ a variety of strategies to address this barrier. These strategies coordinate with broader efforts to assure an adequate supply of quality housing for Marylanders that are described in Appendix G: Current Housing Strategies.

*Housing Assistance.* One of the major components of transitional case management is the provision of housing assistance. Case managers will provide information about types of housing options, the availability of housing, and the housing subsidy systems. They will also provide intensive support to complete applications, acquire needed documentation, and secure housing. It may also include opportunities for MFP participants to visit different housing options using their supplemental service funds (Section B.5.4). Housing assistance will be available to residents of SRCs who indicate a preference for independent community housing instead of an Alternative Living Unit and will be provided by their Service Coordinators.

*The Bridge Subsidy.* The Bridge Subsidy Demonstration Program provides State-funded short-term rental assistance (up to three years) for individuals with disabilities while they await permanent housing assistance. Participants are selected based on specified criteria by the State's Developmental Disabilities Administration, Mental Hygiene Administration and private non-profit signatories to the Memorandum of Understanding (MOU). All Public Housing Authorities (PHAs) received an invitation to participate in the Demonstration and those who elected to sign the MOU agreed to administer the bridge subsidy payments to the landlords, accept a participant on their waiting list, and provide a preference for a participant under their Annual Plan if the participant did not otherwise reach the top of the waiting list within their three-year term on the Demonstration Program. Participants are required to abide by certain standards to remain in the Program, including receiving tenant and financial training and participating in a service plan. The State FY08 MFP budget includes funds to support the Bridge Subsidy program. MFP will expand support for this program if more subsidies become available.

MHA intends to fund approximately 14 rental subsidies through the MFP demonstration at a total cost of \$300,000 (\$7,500/year for 3 years per consumer). Individuals transitioning from

institutions will be prioritized for the Bridge Subsidy Program, to include chronic hospitals, nursing home facilities and state psychiatric facilities. Another priority group for the MFP Demonstration and funded with the Bridge Subsidy Program would be individuals moving from an Alternative Living Unit (ALU) or Residential Rehabilitation Program (RRP). These individuals would move into independent or supported housing and create capacity in a community program for an individual moving from an institution. Finally, individuals in danger of institutional placement due to homelessness will be prioritized with the Bridge Subsidy Program

DDA intends to fund a total of approximately 45 subsidies through the MFP demonstration at a total cost of \$1,000,000 for the project. The cost per individual rental assistance is projected to be \$7,500. Individuals who are transitioning out of institutions will be prioritized, including those transitioning out of SRCs and nursing facilities. Individuals who are moving out of an Alternative Living Unit that will create capacity in that unit for an individual moving out of institution will be in the next priority group for the MFP funded Bridge Subsidies. Finally, individuals who are in danger of institutional placement due to homelessness will be prioritized.

*Statewide Housing Consultant.* The State hired a contractor to make strategic recommendations about housing for MFP populations. This contractor developed the Strategic Plan for Housing that will guide housing activities at the MAP sites in the future. This plan is attached as Appendix K.

### 9.3 Relationship between MFP Program and State/Local Housing Authorities

The State recognizes that working in partnership with housing professionals is essential to assuring a supply of accessible and affordable housing options. The Director of Multifamily Housing from the Department of Housing and Community Development (DHCD) and the President of the Maryland Association of Housing and Redevelopment Agencies (MAHRA) reaffirmed the importance of these partnerships at the MFP Housing Day. With leaders in the housing sector supportive of the MFP program, the next step is to target the local level. Building on the supportive letters of Housing and Urban Development's (HUD) Secretary Jackson, the MFP program will work in partnership with the local MAP sites and stakeholders to promote MFP goals through changes in housing policy at the local level.

The State hopes to increase the availability of affordable housing, improve links between institutionalized individuals and available housing opportunities, and create increased awareness of HCBS programs amongst housing providers by providing individual housing assistance to applicants, hiring a housing consultant to develop a plan for housing activities, and identifying and supporting leaders at each MAP site that are focused on developing housing opportunities

## **10. Continuity of Care Post the Demonstration**

Participants in the Maryland Money Follows the Person Demonstration will receive home and community based services through the existing and ongoing 1915(c) waivers that are currently in place. Any additional services received through participation in the MFP Demonstration are one-time only and not ongoing services. Therefore, participants will continue to receive services without interruption or modification at the end of their participation in the demonstration via the HCBS waiver in which they are enrolled. Participants of the HCBS waivers are re-evaluated

annually for medical, financial, and technical eligibility. Redeterminations for waiver services will likely coincide with expiration of MFP demonstration eligibility as the time periods are the same. MFP participation and eligibility will not affect the redetermination process.

As noted in the Project Introduction; MFP Rebalancing Initiatives on pages six and seven, Maryland has developed a policy in accordance with the Money Follows the Individual Act. This policy allows any individual who has been a nursing home resident, paid for by Medicaid, for at least 30 consecutive days to apply for the Living at Home or Older Adult waiver programs even if those waivers are “closed”.

In Maryland, waivers have higher income and asset limits than other eligibility categories. Though the State anticipates that potentially all individuals transitioning under MFP will utilize waiver programs, an individual who would be eligible for Medicaid in the community could transition under MFP and receive State Plan services such as DMS/DME or Home Health. Similarly, if an individual was no longer eligible for a waiver, but did meet community eligibility for Medicaid, that individual could access State Plan services after leaving a waiver.

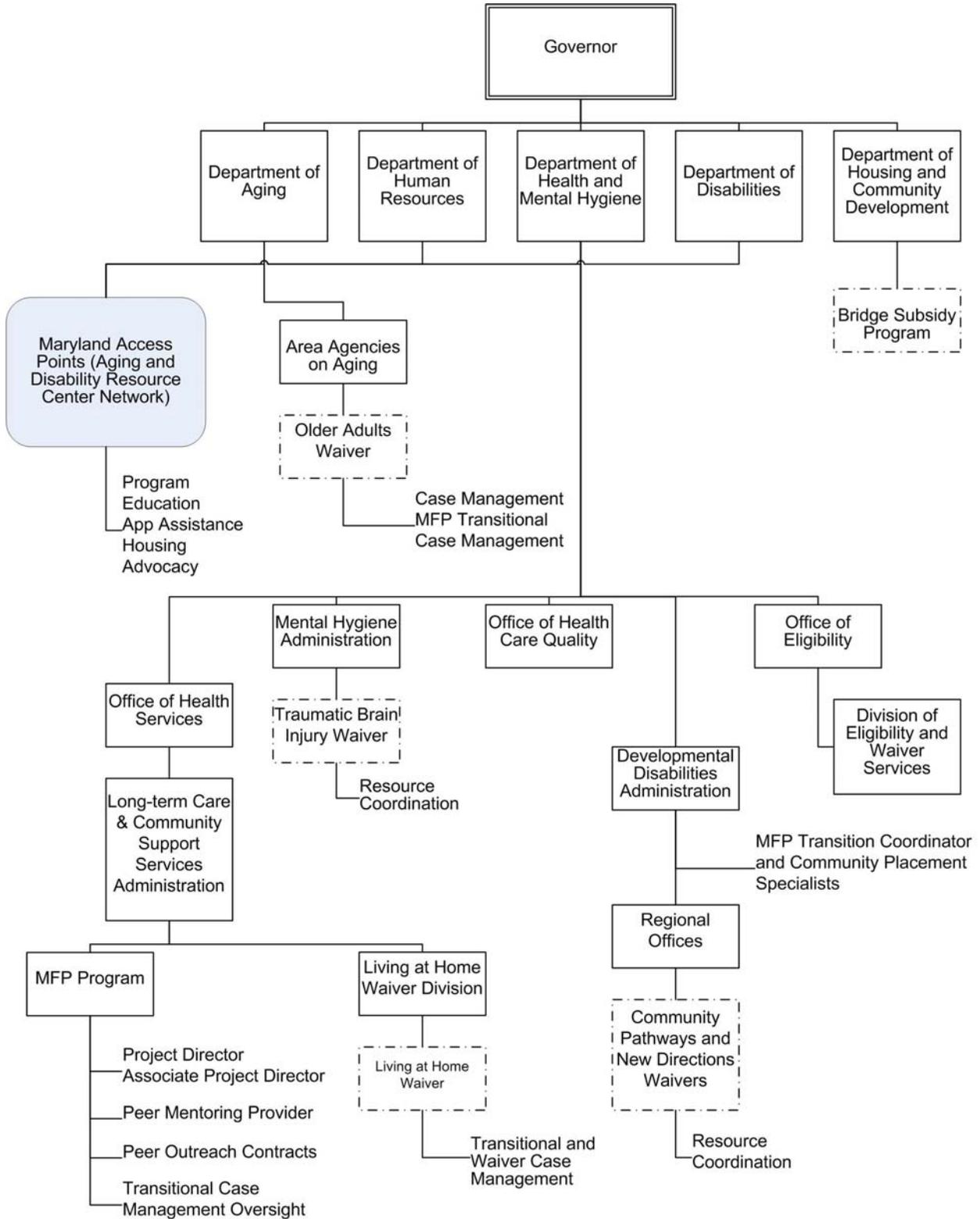
The central goal of the MFP program is to serve people in the community rather than in institutional settings. Recently, Maryland Medicaid recipients in nursing facilities were unable to transition to the community despite a strong desire to do so because their income was a few dollars over the 300% SSI income limit for our waiver programs. Maryland’s MFP program would like to help these individuals transition to the community using the MFP demonstration authority.

These individuals would receive services through Maryland’s 1915(c) waivers for the 365 days provided in the MFP statute. In order to maintain eligibility for the waiver on day 366, they would be required to meet all waiver rules in place at that time. Prior to the transition, the Department will explain to the recipient and any representatives the requirements for waiver eligibility at the end of the MFP demonstration period, and the potential outcomes if the individual is determined ineligible at that time.

Maryland’s Medicaid program has no means of continuing to provide services for an individual who is no longer eligible for Medicaid at the conclusion of the demonstration.

**C. Organization and Administration**

**1. Organizational Structure**



**2. Staffing Plan**

There are two dedicated positions for the MFP Demonstration that are paid for by the grant, the MFP Project Director and the MFP Associate Project Director. They are full time positions in the Office of Health Services, Long Term Care and Waiver Services. 100% of these positions are dedicated to the MFP Demonstration.

The primary role and responsibility of the Project Directors is to direct or assist the activities for Maryland’s Money Follows the Person demonstration. This will include: reviewing and developing policies; serving as liaisons with interested groups, individuals, agencies, and the legislature concerning the demonstration; developing and implementing rules, regulations, standards, and controls for carrying out and completing the demonstration; preparing the budget for the assigned programs; completing required federal reporting; and performing other related duties. The Project Director was hired as of 8/15/07. The Associate Project Director was hired 11/5/08.

There are many other positions within DHMH that are providing in-kind support to the project but that are not directly paid for by the MFP Demonstration grant. These positions were existing prior to the demonstration are fully staffed. The positions providing support are outlined in the chart below.

Positions Providing In-Kind Support

Name	Title	Roles and Responsibilities
S. Orion Courtin	Health Policy Analyst	Ascertain information about impact of program, budget, and services on other programs and Medicaid in general; to discuss program implementation activities; and to report and discuss evaluation data
Stacey Davis	Deputy Director Program Evaluation and Legislation	Ascertain information about impact of program, budget, and services on other programs and Medicaid in general, to discuss program implementation activities; and to report and discuss evaluation data
Tricia Roddy	Director Planning	Discuss program implementation activities, report and discuss evaluation data
Susan Tucker	Executive Director, Office of Health Services	Discuss program implementation activities, report and discuss evaluation data
Mark Leeds	Director of Long Term Care and Community Support Services	Discuss program implementation activities, report and discuss evaluation data

Sandra Brownell	Deputy Director of Long Term Care and Waiver Services	Directly supervise the MFP Project Director, discuss program implementation activities, report and discuss evaluation data
Susan Panek	Deputy Director Long Term Care Financing	Discuss program implementation activities, discuss evaluation
Cheryl Camillo	Executive Director, Office of Eligibility Services	Ascertain relevant information about the impact of program, budget, and services on other programs and Medicaid in general; discuss implementation activities
Stephanie Hull	Chief of Housing Services, Maryland Department of Aging	Ascertain information about impact of program, budget, and services on other programs; discuss implementation activities; liaison for the MAP initiative
Kelli Cummings	Director of Community Living Policy, Maryland Department of Disabilities	Ascertain information about impact of program, budget, and services on other programs; discuss implementation activities; liaison for the MAP initiative

*Contractual Staff*

As the Demonstration progresses, there will be many positions that are contracted to perform essential functions. There will be a total of 36 contractors over the life of the demonstration, although most contractors will serve for limited periods of time. The State will contract with the following: 2 Staff from the Hilltop Institute to assist in writing the operational protocol and analyzing data related to the demonstration, 1 statewide housing consultant to develop strategies for increasing available affordable and accessible housing for demonstration participants, 1 information technology (IT) contractor to develop the website and provide assistance as needed, 1 Provider Training contractor to host mental health trainings for direct care providers and sponsor professional trainings to other providers, 1 human resources consultant for SRC Staff to develop a plan for outreach and education of SRC staff as outlined in Section B, 1 SRC Family Mentoring contractor to assist the families of SRC residents preparing to transition, 1 SRC Peer Mentoring contractor, 5 Peer Outreach Contractors that will complete outreach services, 19 contracts with the local Area Agencies on Aging to complete transitional case management tasks outlined in Section B and participate in MAP site development, and three DDA staff positions – 1 Transition Coordinator at the state level fulfilling a coordinating role and 2 community placement specialists working with individuals and as part of the Community Placement Teams.

*Staffing Time Line*

The MFP Project Director and staff that are providing in-kind support are currently in place. The contractual staff will be identified at the time that they are needed for the project, as defined in the chart below.

Contractor	Request for Bid/Proposal	Contractor Begins
2 Hilltop Institute Staff	Ongoing contractor	1/1/07
1 Statewide Housing Consultant	12/15/07	2/1/08
1 IT Contractor for the Tracking System	Ongoing Contractor	2/1/08
1 Provider Training Contractor	4/1/09	5/1/09
1 HR Consultant for SRC Staff	7/15/09	9/1/09
1 SRC Family Mentoring Contractor	8/15/08	11/1/08
1 SRC Peer Mentoring Contractor	5/1/08	10/1/08
5 Peer Outreach Contractors	11/15/08	5/1/09
19 AAA contracts for transitional case management and MAP site development	2/1/09	7/1/09
1 DDA SRC Transition Coordinator	1/15/08	7/1/08
2 DDA Community Placement Specialists	1/15/08	8/1/08
1 Quality of Life Survey Contractor	6/1/07	3/109

*Performance Assessment*

The Department of Health and Mental Hygiene will be responsible for evaluating the performance of staff related to the demonstration. The MFP Project Director will be responsible for evaluating the performance of contractual staff.

**3. Billing and Reimbursement**

*MFP Billing*

All new services offered under MFP will comply with the Department’s existing guidelines to prevent duplication of services, fraud, and abuse. The State plans to operate the MFP demonstration within current guidelines and procedures, and to monitor and pay for all new services through the MMIS claims system. In addition to submitting claims through this State’s MMIS claims system, the transitional case managers will be required to validate the supplemental flexible funds with receipts.

*Fraud Control Provisions and Monitoring*

Maryland Medicaid programs have several layers of protection from fraud and abuse including internal programmatic audits, oversight by the Office of the Inspector General, and accountability to the Department of Legislative Services Office of Legislative Audits. The mission of the Office of the Inspector General (OIG) is to protect the integrity of the Department of Health and Mental Hygiene (DHMH) and promote standards that benefit the citizens of Maryland and program beneficiaries. The OIG has a responsibility to report to both the Secretary and Program Managers any problems and make recommendations. The OIG's duties are carried out primarily through audits, reviews, investigations, and trainings. The OIG is comprised of six divisions: Corporate Compliance, Privacy Office, Internal Audits, Institutional Review Board, Program Integrity, and Ethics. The OIG supports a toll-free hotline through which to report fraud, waste and abuse.

The Office of Legislative Audits (OLA) is part of the Maryland General Assembly's Department of Legislative Services. Their mission is to serve the General Assembly and the citizens of Maryland by providing independent, objective, and non-partisan audits and evaluations of State government agencies. OLA operates under the authority of the State Government Article, Sections 2-1217 through 2-1227 of the Annotated Code of Maryland and reports to the General Assembly's Joint Audit Committee. OLA is responsible for performing fiscal compliance audits of State agencies to evaluate fiscal operations and determine compliance with laws and regulations conducting performance audits to evaluate whether a State agency or program is operating in an economic, efficient and effective manner, operating a fraud hotline for reporting fraud, waste, and abuse of State resources, monitoring the financial reporting practices and financial condition of local governments, and conducting special reviews and investigations requested by the Joint Audit Committee.

OLA's audits are conducted in accordance with Generally Accepted Government Auditing Standards issued by the United States Government Accountability Office.

**D. Evaluation**

Maryland is not pursuing additional evaluation of unique design elements of its MFP Demonstration program.

**E. Final Budget**

A considerable amount is included in the budget to enhance the transition process. Specifically, over the life of the demonstration, we estimate more than \$10 million will be spent on peer mentoring and transition assistance. These initiatives are designed to address two areas of particular concern for the stakeholder group. The details and specific duties of the transitional case managers and peer and family mentoring contractors may be found throughout the protocol.

A detailed description of the personnel and contractual costs follows. The total estimated administrative budget for FY 10 is \$2,792,783. In addition to administrative costs, the transitional case management and peer mentoring will incorporate MFP demonstration service dollars estimated at \$418,352 in FY 10.

*Personnel*

The total budget for salaries, fringe and indirect costs for the four years is \$2,040,060. Full-time staff supporting the implementation of the demonstration include:

- *Project Director and Associate Project Director*– The Project Directors will oversee the day to day operation of the demonstration. The project director will be responsible for CMS reporting, MFP contract management, and overseeing the stakeholder process.
  - \* The total cost for CY 2008 is \$142,200.
  - \* The total cost over the life of the demonstration is \$782,100.
- *Division of Eligibility Waiver Services (DEWS)* – Two additional staff are needed for DEWS to address the increased volume of individuals applying for waiver services and to assist with tracking MFP demonstration eligibility. If the volume of applications increases as proposed, current staffing is not adequate to produce timely eligibility determinations.
  - \* The total cost for CY 2008 is \$76,730.
  - \* The total cost over the life of the demonstration is \$415,045.
- *State Residential Center Transition Staff* – Three additional staff are necessary to work with families during the transition from State Residential Centers to the community. One individual will work centrally to coordinate transitions. The other two staff will provide direct assistance to consumers during the transition process.
  - \* The total cost for CY 2008 is \$169,440.
  - \* The total cost over the life of the demonstration is \$677,760.
- The State has negotiated a 28.5 percent indirect cost rate for salaries.
  - \* The total cost for CY 2008 is \$67,455.

- \* The total cost over the life of the demonstration is \$333,927.

*Contracts*

*Memorandums of Understanding*

- *Office of Health Care Quality (OHCQ)* – Contractual support will be provided to the OHCQ to monitor quality in assisted living facilities with four beds or less. Currently the OHCQ has regulations and policies guiding the oversight of assisted living facilities. Additional administrative support is necessary to ensure that the office continues to meet their quality review standards.
  - \* The total cost over the life of the demonstration is \$496,519.
- *Bridge Subsidy Administrative Support* – Additional housing support may be provided to demonstration participants by increasing the number of Bridge Subsidy slots available. Financial support for the Public Housing Authorities is necessary to administer the program if additional slots become available.
  - \* This funding would begin in CY 2009 with a budget of \$50,000.
  - \* The total cost over the life of the demonstration is \$130,000.
- *Bridge Subsidy Rental Assistance Program* – Additional funding to create availability of rental assistance through the Bridge Subsidy program for MFP participants.
  - \* The total cost over the life of the demonstration is \$1,300,000.
- *State Residential Center Peer Support* – Additional funds will be provided to enhance the existing peer mentoring efforts for individuals residing in State Residential Centers. This support will expand the availability of peer supports to all SRC residents.
  - \* The total cost over the life of the demonstration is \$215,506.
- *Data Management and Analysis* – The Department plans to work with an IT specialist to develop a tracking system for MFP demonstration participants. Ongoing IT support for data management and analysis will be necessary to complete all mandatory reporting requirements.
  - \* The total cost for CY 2008 is \$300,000.
  - \* The total cost over the life of the demonstration is \$740,000.
- *TBI Waiver Tracking System* – creation of a web-based tracking system to reduce delays in eligibility determination and increase quality monitoring abilities.
  - \* The total cost over the life of the demonstration is \$50,000
- *Maryland Department of Aging* – The Department will utilize and MOU with the Department of Aging to fund program education and application assistance to nursing

facility residents. Administrative transitional case management services provided by the local Area Agencies on Aging will also be funded through this MOU.

- \* The total cost for CY 2009 is \$1,223,467.
- \* The total cost over the life of the demonstration is \$8,550,450.

*Contracts – Requests for Proposals*

The Department will issue requests for proposals (RFP) for peer outreach in nursing facilities, family mentoring for SRC residents, administration of Quality of Life surveys, and the Transition Center. Given the length of the process for awarding RFPs, the estimates only include six months of costs and transitions in CY 08. The costs below are based on the number of transitions estimated annually for the Living at Home, Traumatic Brain Injury, and Older Adults Waivers. The estimates assume that the average time to transition will be six months. In addition, the estimate assumes that for every five people seeking transition assistance, three will complete the application process and one will transition to an MFP qualified residence.

*SRC Family Mentoring* – families of former SRC residents who have been through the transition process will provide mentoring to families of current SRC residents in the process of transition. The contract will include:

- Family Peer Support – monthly payments will be made to the contractor to provide support to families of SRC residents throughout the transition process.
  - \* The total estimated cost for CY 2008 is \$75,000.
  - \* The total estimated cost over the life of the demonstration is \$375,000.

*Nursing Facility Peer Outreach* – peers will provide outreach to Medicaid-eligible nursing facility residents quarterly to generate interest in HCBS.

- \* The total estimated cost over the life of the demonstration is \$1,780,000.

*SRC Human Resources Consultant* – this consultant will host interactive forums with SRC staff to assess needs and concerns, assist in managing changing work environments, and educate staff about becoming community-based providers. Major components of the contract include:

- Facilitating interactive forums with SRC staff
- Providing information to the staff about becoming community-based providers
- Acting as a liaison between SRC staff and DHMH
  - \* The total estimated cost for CY 2008 is \$60,000
  - \* The total estimated cost over the life of the demonstration is \$60,000

*DDA Strategic Planning* – comprehensive strategic planning process to chart the course of system-wide change over the next 5 to 10 years.

- \* The total cost over the life of the demonstration is \$70,000

*Quality of Life (QOL) Survey Administration* – this contractor will administer QOL surveys to MFP participants at baseline in the institution and again one and two years after their transition

and provide relevant data to the State regarding survey results and follow-up needs. The key elements of the contract are as follows:

- Start-up Costs – to support the contractor in developing the necessary infrastructure for quick and efficient implementation of services and to develop tracking and reporting capabilities as needed for the demonstration
- Survey Completion – locate and contact individuals, complete surveys, compile results, and report findings to the State beginning in February of 2009
  - \* CMS has committed to provide the State with \$100 per completed survey

*Ask Me Surveys* – measure quality of life for people with intellectual disabilities.

- \* The total cost over the life of the demonstration is \$89,500

*Provider Training* – this contractor will host trainings for providers in areas identified by stakeholders as important to improving quality of services and ensuring successful implementation of the MFP demonstration. The contract will include:

- Mental Health Training - identify existing mental health training programs for direct care staff and arrange the expansion of the training opportunities to reach a greater number of providers across the state
- Housing Training – develop housing expertise in case management systems and at MAP sites
- Person Centered Planning – develop expertise among waiver case managers, advocates, and consumers to increase self-direction
  - \* The total estimated cost for CY 2009 is \$100,000
  - \* The total estimated cost over the life of the demonstration is \$400,000

*Training for Direct Support Staff* – College of Direct Support license and training support for direct support staff in the DDA service system.

- \* The total cost over the life of the demonstration is \$1,482,000

*Rebalancing Budget Allocations* –DDA pilot of the Supports Intensity Scale with SRC residents to develop individualized budgets.

- \* The total cost over the life of the demonstration is \$350,000.

*Essential Lifestyle Planning* – intensive person-centered planning process for SRC residents transitioning to the community through MFP.

- \* The total cost over the life of the demonstration is \$93,000

*Rural Respite Care Consortium* – build capacity of community-based respite providers to reduce reliance on institutional respite care.

- \* The total cost over the life of the demonstration is \$208,000.

*Rosewood Closure Resource Coordination* – intensive transitional case management for residents of the Rosewood Center to support the transition to the community.

- \* The total cost over the life of the demonstration is \$530,000

*Behavioral Supports for Restraint Elimination* – establish a consortium to provide behavioral supports, training, peer support, and crisis response to eliminate the use of restraints in the DDA service system.

- \* The total cost over the life of the demonstration is \$390,000

*Supported Employment Initiatives* – Outreach, peer mentoring, family mentoring, provider training, and consultation to increase the employment opportunities for former SRC residents.

- \* The total cost over the life of the demonstration is \$200,000

*DDA Data Management* – improved information technology systems to increase quality monitoring capabilities and drive quality improvement activities.

- \* The total cost over the life of the demonstration is \$300,000

*DDA Consultation* – consultation on specific issues identified through the strategic planning process.

- \* The total cost over the life of the demonstration is \$120,000

*TBI Provider Incentives* – to increase the availability of providers for the TBI waiver and increase choice of providers for participants.

- \* The total cost over the life of the demonstration is \$200,000

*TBI Resource Coordination* – outreach, application assistance, and transitional case management for chronic hospital and TBI waiver eligible nursing facility residents.

- \* The total cost over the life of the demonstration is \$300,000

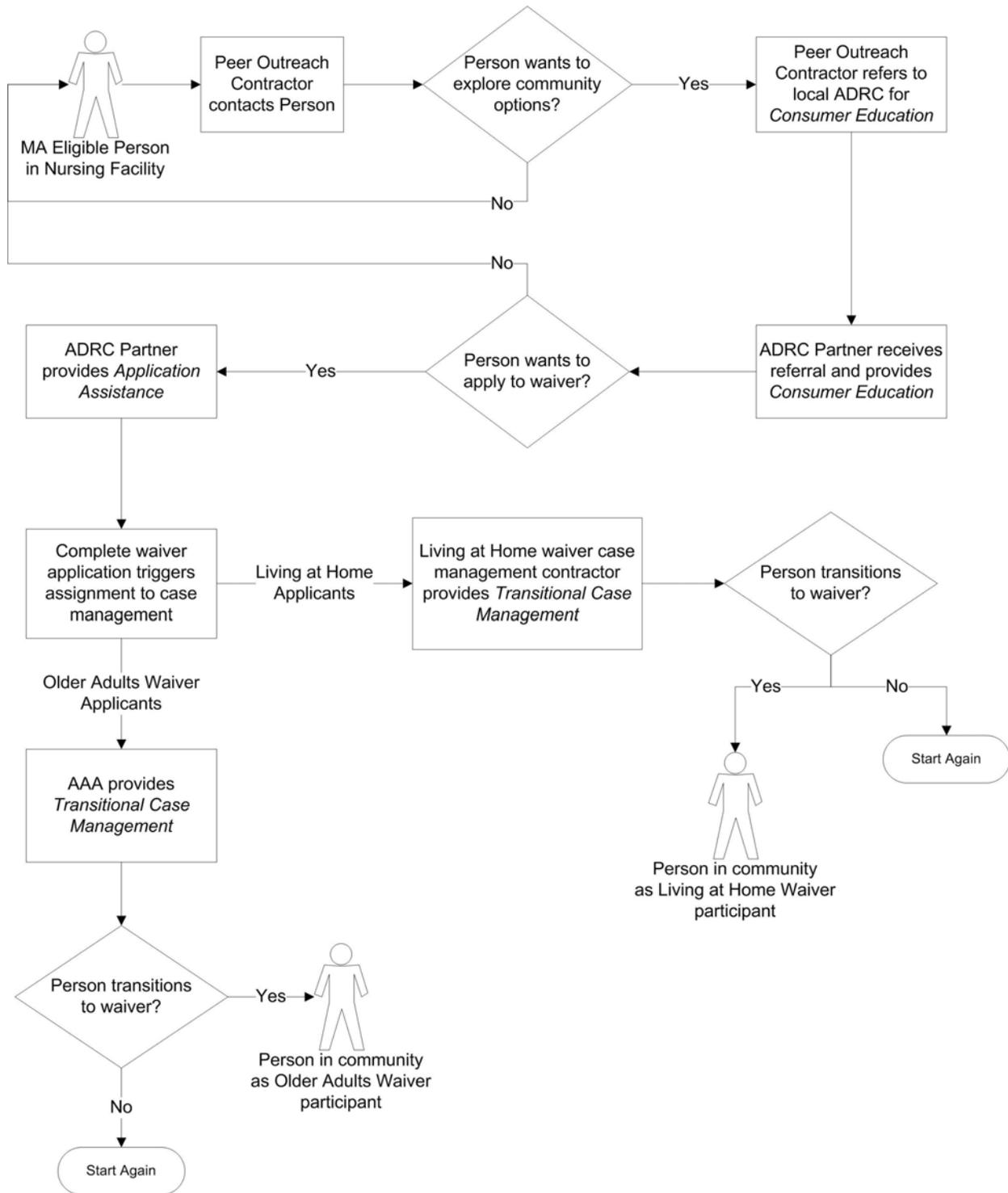
*TBI Waiver Clubhouse Model* – establish a consumer-driven alternative to day programs for TBI waiver participants.

- \* The total cost over the life of the demonstration is \$100,000

The terms and conditions of the demonstration state that Maryland spend no more than \$2500 per person transitioned to the community for administrative functions. The State has not exceeded this limit for items that are purely for demonstration administration.

Financial forms are included as Appendix I.

# Appendix A: NF Transition Process Diagram



## Consent Form for Waiver Services

- I freely choose to accept home and community-based services under the Living at Home Waiver Program Home and Community Based Services Waiver for Adults with Physical Disabilities. I understand that there are alternative services for which I am eligible, including services in a nursing facility. The waiver will offer me home and community based services as an alternative to a nursing facility.

1. I have been informed that if I am eligible for the waiver, I will have my choice of selecting one of two service options for managing the delivery of my attendant services: consumer-employed or agency-employed. Also, I will participate fully as a co-planner in developing my plan of services. I understand and considered my options, which have been explained to me. It is my wish to receive home and community-based services under the Living at Home Waiver Program Home and Community-Based Services Waiver for Adults with Physical Disabilities.

2. I further understand that in order to continue to receive home and community-based services, I must meet all of the eligibility criteria of the Maryland Medical Assistance program and the Waiver. I also understand that I can change my mind about my choice of options at any time simply by contacting my case manager.

- I choose to receive services in a nursing facility.
  
- I choose neither of these service options. Explanation:

My signature below indicates that I have been informed of the various options available for my choice and that any questions that I may have about my options have been answered.

Printed Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**HOME AND COMMUNITY-BASED SERVICES WAIVER FOR OLDER ADULTS  
MARYLAND MEDICAL ASSISTANCE PROGRAM  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE**

**Participant Consent Form**

\_\_\_\_\_ I choose to receive home and community-based services under the Maryland Medical Assistance Programs Home and Community-Based Services Waiver for Older Adults, as an alternative to long-term care institutional services in a nursing facility. I understand and have considered my options, which have been explained to me. I further understand that in order to qualify, and continue to qualify, for the waiver program, I must meet all the eligibility criteria of the Maryland Medicaid Program and the Waiver.

\_\_\_\_\_ I choose to receive long-term care institutional services in a nursing facility, rather than services in the Maryland Medical Assistance Programs Home and Community-Based Services Waiver for Older Adults. I understand and have considered my options, which have been explained to me. I further understand that in order to qualify, and continue to qualify, for Medicaid coverage in the nursing facility, I must meet all the eligibility criteria for the Maryland Medicaid Program and for the nursing facility services.

\_\_\_\_\_ I choose neither of these service options.  
Explanation:

Individual's Name: \_\_\_\_\_

Signature: \_\_\_\_\_  
Individual

or \_\_\_\_\_  
Legally Authorized Representative

Date Signed: \_\_\_\_\_

**MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER  
FOR ADULTS WITH TRAUMATIC BRAIN INJURY  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE**

**Consent Form for TBI Waiver Services**

\_\_\_\_\_ I choose to receive home and community-based services under the Medicaid Waiver for Adults with Traumatic Brain Injury, as an alternative to long-term care institutional services in a hospital or nursing facility. I understand and have considered my options, which have been explained to me. I further understand that in order to qualify, and continue to qualify, for the waiver program, I must meet all the eligibility criteria of the Maryland Medicaid Program and the Waiver.

\_\_\_\_\_ I choose to receive long-term care institutional services in a hospital or nursing facility, rather than services in the Medicaid Waiver for Adults with Traumatic Brain Injury. I understand and have considered my options, which have been explained to me. I further understand that in order to qualify, and continue to qualify, for Medicaid coverage in the institution, I must meet all the eligibility criteria for the Maryland Medicaid Program and for the institutional services.

\_\_\_\_\_ I choose neither of these service options. Explanation:

Individual's Name: \_\_\_\_\_

Individual's Signature: \_\_\_\_\_

**or**

Legally Authorized Representative: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Appendix B-4: Community Pathways / New Directions Waiver Consent Form

INTERPRETIVE INTERVIEW: COMMUNITY PATHWAYS WAIVER

Individual Name: \_\_\_\_\_

1. Assessment results and individual needs have been discussed with the Individual and/or family on (date) \_\_\_\_\_ by (name and title)
2. Alternative plans for meeting individual needs have been discussed and a choice of services, ICF/MR or community waiver services has been presented to the individual and/or family on (date) \_\_\_\_\_ by (name and title)
3. Individual and/or family has chosen:  
 Waiver Services                       ICF/MR Institution
4. The Individual Plan has been developed prior to placement date.
5. The signature below indicates approval of the services identified based on assessment results which will be developed into an Individual Plan.

Check only one of the boxes and complete:

Capable Individual	Date	Witness to Individual's Signature	Date
--------------------	------	-----------------------------------	------

\_\_\_\_\_  
Relationship to Individual

Guardian/Parent of under 18 Yr. Old Individual	Date	Witness to Guardian/Parent	Date
---	------	----------------------------	------

I was present

I could not be present but I have been involved in the interpretive interview process and fully understand the results of my choice on the Individual's behalf.

Individual for Incapable Person	Witness	Date
---------------------------------	---------	------

Relationship \_\_\_\_\_

I was present

I could not be present but I have been involved in the interpretive interview process and fully understand the results of my choice on the Individual's behalf.

All other parties present at this Interpretive Interview should sign here:

Resource/Service Coordinator/Case Manager	Date	Other/Relationship	Date
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## Appendix C-1: DHMH Reportable Events Policy

See attached PDF file:

[Appendix C-1 Reportable Events.pdf](#)

Also Available:

[http://www.dhmh.state.md.us/mma/waiverprograms/pdf/HCBS\\_RE111705.pdf](http://www.dhmh.state.md.us/mma/waiverprograms/pdf/HCBS_RE111705.pdf)

## **DEVELOPMENTAL DISABILITIES ADMINISTRATION POLICY ON REPORTABLE INCIDENTS AND INVESTIGATIONS**

Diane K. Coughlin, Director  
Developmental Disabilities Administration  
Department of Health and Mental Hygiene  
201 West Preston Street  
Baltimore, MD 21201  
Effective Date: April 15, 2003  
Revised: March, 2003

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### **BACKGROUND AND INTENT**

To protect the rights of individuals with developmental disabilities, community agencies that are licensed by DDA and State Residential Centers (SRC's) that are operated by the Developmental Disabilities Administration (DDA) are required to identify, report, investigate, review, correct and monitor situations and events that threaten the health, safety or well-being of individuals receiving services (individuals). The purpose of these activities is to protect individuals from harm and enhance the quality of services provided to them. The purpose of this policy is to inform community agency, SRC, DDA, and Office of Health Care Quality (OHCQ) staff of problems, to insure that corrective measures are taken and to minimize the potential for recurrence of similar events in the future. For example, the prompt reporting and investigation of

## Appendix C-2: DDA Reportable Incidents and Investigations Policy

the alleged abuse of an individual can ensure that immediate steps are taken to protect that individual and others from being exposed to the same or similar risk. Uniform reporting of incidents assists in identifying trends in community agencies or SRC's across the service delivery system. This information can be used to develop preventive strategies.

**This policy applies to all community agencies and SRC's licensed by DDA.** It describes the types of incidents that the community agency/ SRC is required to review internally, as well as those that shall be reported to external entities, such as DDA's regional office, OHCQ, etc. It includes specific time frames for reporting and investigating certain incidents. This policy also briefly outlines the respective roles of OHCQ and the DDA with regard to incident investigations. This policy does not mandate that OHCQ or DDA investigate every incident, event or problem involving an individual in a community agency or SRC. However both OHCQ and DDA have the prerogative and authority to investigate any incident, including those which are not officially reported to OHCQ and/or DDA. The requirements that are set forth in this policy pertain to any incident that harms or has the potential for harming an individual. This may include incidents which have not been specifically described in the policy. Each community agency/ SRC shall develop and implement internal operating procedures for identifying and addressing any situation that has or could have an undesirable outcome for the individuals it serves.

### GENERAL REQUIREMENTS

1. Appendix 1 of this policy contains the most common types of incidents that the community agency/ SRC shall report. There may be other unusual events or situations that have not been described in the policy. Therefore each community agency/ SRC shall determine if there are other incidents that should be reported and investigated. The failure to identify a specific type of incident within this policy does not relieve the community agency/ SRC of its reporting responsibilities.
2. Every community agency/ SRC shall develop an internal protocol to ensure compliance with this policy. The protocol shall establish operating procedures, to include the definition of responsibilities of employees, interns, volunteers, consultants and contractors with regard to identifying, reporting, investigating, receiving, addressing and monitoring the follow-up of reportable incidents. The protocol shall also include provisions for a standing committee.
3. Every community agency/ SRC director shall provide a copy of this policy and the community agency/ SRC's internal protocol on handling incidents to employees, interns, volunteers, consultants and contractors, as well as individuals receiving services, their parents or guardians and advocates. The community agency/ SRC shall also provide telephone numbers to the above-listed persons, including numbers for emergency contacts within the community agency/ SRC as well as the appropriate DDA regional office and the OHCQ.
4. Each community agency/ SRC shall institute measures to reduce the potential for retaliation against any person reporting an incident.
5. For the purpose of this policy, working days are Monday through Friday, excluding holidays.
6. This policy reflects a two-level approach to reviewing, reporting and investigating incidents.

#### a. SERIOUS REPORTABLE INCIDENTS

(1) Serious reportable incidents are significant events or situations that, because of the severity or the sensitivity of the situation, shall be reported within prescribed time frames to OHCQ and the

## Appendix C-2: DDA Reportable Incidents and Investigations Policy

DDA regional office. The community agency/ SRC shall notify family and/or advocates as identified by the interdisciplinary team for all serious reportable incidents. Some serious reportable incidents shall also be reported to other external entities such as MDLC, law enforcement, etc.

(2) Appendix 1 includes examples of events and situations categorized as serious reportable incidents.

(3) The community agency/ SRC director shall be advised of all incidents in this category immediately upon discovery. The director shall immediately assure the health, safety and/or well-being of any involved individuals. The director shall also assure that all required parties are notified of the incident as defined by the policy.

(4) Reporting requirements for serious reportable incidents are defined in Appendix 2.

(5) As specified in Appendix 2, some types of incidents shall be reported to OHCQ and the DDA regional office immediately either verbally, by facsimile, or e-mail using Appendix 4. Within 1 working day of the discovery of the incident, the community agency/ SRC shall forward a completed Appendix 4 for each serious reportable incident to OHCQ and the DDA regional office. **Please note, verbal notification is not a substitute for the completed Appendix 4.**

(6) The community agency/ SRC shall investigate each incident following their internal protocol. The licensee shall confirm with the outside agency, i.e., law enforcement, fire department, Protective Services, etc.) if the licensee should initiate/continue its investigation. The community agency/ SRC shall complete its investigation and send its Agency Investigation Report to OHCQ and the regional office within 21 working days. It should be noted that an Agency Investigation Report (21 day report) is required even if the licensee is instructed by the outside agency not to initiate/continue its investigation.

(7) The community agency/ SRC shall provide follow-up and any actions necessary to resolve the incident. This may include corrective, preventive or disciplinary actions, as indicated by the community agency/ SRC investigation and/or OHCQ and/or outside agency (i.e., law enforcement, Protective Services).

(8) The Agency Investigation Report (21 day report) shall include:

(a) A chronology of what was alleged to have occurred, to include where the incident took place, and any significant history/background (e.g., whether the individual had been ill prior to a death or hospitalization).

(b) The level of supervision at the time of the incident.

(c) The community agency/ SRC's immediate response to the incident, i.e., how was the incident handled? What was the agency's internal procedure for handling this type of incident? (Agency may attach and refer to copy of existing procedure, if available). Did staff follow the procedure? If not, explain.

(d) How the investigation was conducted. Include who conducted the investigation, who was questioned after the incident, when they were questioned and the information provided by them.

(e) The findings and conclusions of the investigation.

(f) What follow-up was/is being conducted, i.e., what corrective, preventative, and/or disciplinary action was/will be implemented? What on-going monitoring will occur to reduce or eliminate the opportunity for recurrence of this or a similar incident?

(g) The current status of the involved individuals, i.e., where and how is he/she now.

### b. INTERNALLY INVESTIGATED INCIDENTS

## Appendix C-2: DDA Reportable Incidents and Investigations Policy

- (1) Internally investigated incidents are those significant events or situations that shall be reported to designated authorities within the community agency/ SRC. The community agency/ SRC is responsible for reviewing and investigating each of these incidents.
- (2) Appendix 1 includes examples of events and situations categorized as internally investigated incidents.
- (3) The community agency/ SRC director shall take whatever action is necessary to assure the health, safety and/or well-being of any involved individuals.
- (4) Internally investigated incidents shall be reported to the community agency/ SRC director, or designee, within 1 working day of discovery. In addition, the community agency/ SRC shall immediately investigate each incident. The method for reporting and investigating shall be in accordance with the community agency/ SRC's internal protocol. Within 21 working days, an internal final report shall be completed by the community agency/ SRC using a format of its choice. This final report shall be forwarded to the community agency/ SRC's standing committee for review. The final report shall include:
  - (a) The name or names of all involved individuals;
  - (b) Date of incident;
  - (c) Date incident was discovered;
  - (d) Date incident was reported;
  - (e) Where the incident occurred;
  - (f) Name of community agency/ SRC reporting incident and name and address of any other facility involved (SEE ITEM #3 UNDER IRREGULAR SITUATIONS SECTION OF THIS POLICY);
  - (g) Classification of event/situation, e.g., the unexpected or unauthorized absence of an individual for less than 4 hours, and description of incident;
  - (h) Summary of how investigation was conducted, findings and conclusions;
  - (i) Any corrective, preventive and/or disciplinary actions that have been or will be taken; and
  - (j) An explanation of how the situation will be monitored to prevent or reduce possibility of future recurrence, including any systemic changes. **If the investigation reveals that an injury was the result of abuse, neglect, or restraint, this information shall be reflected in the agency internal report and must be reported as a serious reportable incident following Appendix 2 reporting procedures for abuse, neglect or restraint.**
- (5) Each incident shall be resolved by the community agency/ SRC.
- (6) Each community agency/ SRC shall submit to DDA and OHCQ a listing of all internally investigated incidents which occurred during the prior quarterly period. The report is due January 15, April 15, July 15, and October 15. The report shall be in the DDA format, Appendix 5. The report due January 15 shall include a listing of all internally investigated incidents occurring during the time period from October 1 through December 31; the report due April 15 shall include internally investigated incidents occurring during the time period from January 1 through March 31; the report due July 15 shall include internally investigated incidents occurring April 1 through June 30; and the report due October 15 shall include internally investigated incidents occurring during the time period from July 1 through September 30.
- (7) In the event that 3 or more internally investigated incidents occur within a 4 week time frame for the same individual, the most recent incident must be reported as a serious reportable incident and investigated accordingly. Documentation regarding the other incidents shall be included in this report.

## Appendix C-2: DDA Reportable Incidents and Investigations Policy

(8) Files containing incident reports, any investigatory materials, meeting minutes, records of interviews, documented disciplinary actions, etc. shall be kept on file by the community agency/SRC for a minimum of 5 years.

### c. INTERNALLY REVIEWED INCIDENTS

- 1) The planned use of restraints, the use of a mechanical device or physical intervention that is approved as part of an individual's behavior plan which has been reviewed and approved by the standing committee, is an internally reviewed incident.
- 2) As an internally reviewed incident, each occasion of planned restraint use, as part of an approved behavior plan, must be documented in the individual's record. All documentation must contain, at a minimum, the individual's name, date of restraint use and type of restraint used.
- 3) If a physical intervention is used documentation must also include the reason for the restraint use and the length of time used.
- 4) If a mechanical device is used documentation must also include a record of:
  - a) staff checks of the individual every 15 minutes
  - b) staff escorting the individual to the bathroom and offering of fluids at least every two hours
  - c) staff providing the individual the opportunity for motion and exercise for a period of not less than 10 minutes during each 2 hours in which the restraint is used.
  - d) staff providing the individual meals at regularly scheduled hours.
  - e) review by a licensed health care practitioner who authorized the use of the mechanical device at a minimum of every 90 days documenting the effectiveness and whether continuation is indicated.
- 5) The Community Agency/SRC shall submit their internal reviews of planned use of restraints to their standing committees for review at least quarterly.
- 6) The Community Agency/SRC shall document on the Appendix 5, Quarterly Incident Report for Internally Investigated/Reviewed Incidents, and submit to OHCQ and the DDA Regional Office, the type of restraint used for each individual and the number of times the restraint was used during that quarter. If an individual's behavior plan utilized more than one type of restraint each type of restraint would be listed and the number of times that each restraint was used would be listed for that individual.
- 7) Additionally, for planned use of restraints only, the Community Agency/SRC shall submit a copy of the standing committee's review of planned restraint use, with the Appendix 5, Quarterly Incident Report for Internally Investigated/Reviewed Incidents, for each individual that required the use of planned restraint during that quarter.
- 8) Within fifteen days of receiving the quarterly reports from the Community Agency/SRC, DDA will summarize the planned restraint use and provide this information to MDLC.

### IRREGULAR SITUATIONS

1. If an incident is alleged for an individual living with a community agency/ SRC, but not while under its direct supervision, e.g., during a family visit, at another facility, in school, at a camp or while on a vacation trip: a. the community agency/ SRC shall report to authorities and community resources, as indicated, e.g., law enforcement authorities, Protective Services, etc. and investigate per their direction.
2. If an individual attends a DDA-licensed day program and/or receives a support service and an incident is alleged to have occurred while the individual was not participating in the program/receiving the support service, e.g., while at a relative's home, a friend's home, etc:

## Appendix C-2: DDA Reportable Incidents and Investigations Policy

- a. the community agency/ SRC director shall evaluate the information and determine the need for any immediate and subsequent actions.
  - b. the community agency/ SRC shall investigate and follow-up to the extent possible, involving other authorities and/or community resources as indicated, e.g., law enforcement authorities, Protective Services, etc.
  3. If an incident is alleged for an individual who is receiving service from a community agency/ SRC while the individual was under the supervision of another facility e.g., if day program staff allege that an incident occurred at a residential site or residential staff allege that an incident occurred at a day program site:
    - a. the discovering community agency/ SRC shall document the allegation using the method determined in their internal protocol;
    - b. the discovering community agency/ SRC shall notify the other SRC/community agency of the allegation;
    - c. the community agency/ SRC where the alleged incident occurred shall report the incident, and shall investigate, correct and monitor the situation and inform the discovering community agency/ SRC of the progress and outcome of those activities.
- The Appendix 4 and Agency Investigation Report (21 day report) are to be submitted to OHCQ and the DDA regional office, as dictated by other requirements of this policy. If the discovering community agency/ SRC is not satisfied that the event/situation is being handled appropriately, it shall bring the event/situation to the attention of OHCQ and the appropriate DDA regional office. OHCQ and DDA shall follow-up and take steps to assure appropriate action by the community agency/ SRC agency.
4. If an incident involves more than one individual receiving DDA services, it shall be considered as one event, e.g., if John Doe hits Joe Smith and Joe Smith hits John Doe, it is not two separate incidents.

### **INVESTIGATION, FOLLOW-UP AND RECORDS MAINTENANCE REQUIREMENTS**

1. The primary concern of the community agency/ SRC regarding reportable incidents shall be the health, safety and/or well-being of the individual. The director shall always assure prompt treatment and care and the protection of all individuals from further harm.
2. No one may participate in an investigation of an incident in which there is a conflict of interest, such as an incident in which (s)he was directly involved or in which a spouse or other family member was involved.
3. No member of a standing committee of a community agency/ SRC may participate in the decision making process for any incident in which there is a conflict of interest, or in which the committee member was involved.
4. All documentation regarding incidents shall be retrievable by the complete name of the individual and, if used, by a file number or other identification code. When an event/situation involves more than one individual, records shall also be retrievable by incident in addition to being retrievable by each individual's name.
5. Any incident report and/or documentation of an investigation shall be maintained confidentially except when reporting to appropriate internal community agency/ SRC staff and external authorities as indicated in this policy.
6. All relevant records, including, but not limited to, reports, investigations, interview notes and meeting minutes shall be available to OHCQ and/or DDA staff upon request. Any appropriate internal or external authorities may interview any individual, staff or other relevant parties

## Appendix C-2: DDA Reportable Incidents and Investigations Policy

regarding an internal or serious reportable incident. Reviews and/or investigations conducted by OHCQ and/or DDA shall assure confidentiality, except when reporting to other authorities as indicated in this policy.

7. All records relevant to an internally investigated or a serious reportable incident, including but not limited to, reports, investigations, meeting minutes, interview records and documentation of corrective, preventive and/or disciplinary action or any other follow-up activity shall be submitted to the community agency/ SRC 's standing committee within 7 calendar days of the closure of the matter. For internally investigated incidents, closure means the completion of the agency investigation; for serious reportable incidents, this means the completion of the OHCQ investigation. The community agency/ SRC should also share any information regarding unusual incidents not addressed in the policy and follow-up actions to inform the committee how the community agency/ SRC addressed those matters.

## Appendix D: Blue Book – Outreach Materials

See attached PDF file:

[Appendix D Blue Book.pdf](#)

**Policy for Participants to Self-Delegate Care**

Participants in the Living at Home Waiver (LAH), may if cognitively capable, choose to direct the independent attendant care provider to assist the participant with routine care and self-administration of medication. The Board of Nursing regulations (COMAR 10.07.11.01D) support this policy.

Process:

- The Service Coordinator will share a self-delegation packet with the participant/applicant during their quarterly/initial meeting. These documents will assist the participant/applicant in making an informed decision regarding the direction of his/her care. The packet will include:
  - ✓ A booklet called “Attendant Care Services and You: Partners in Community Living” which describes the models of attendant care services and other useful information
  - ✓ Self-Delegation Fact Sheet
- After reviewing these documents, the Service Coordinator will ask the participant/applicant if they are interested in directing their own attendant care without the standard oversight of a nurse monitor or requesting the oversight of a nurse monitor for a specified period of time before beginning to self-delegate.
- The participant and the Service Coordinator (if requested) will identify the tasks that will be self-delegated.
- The participant and the Service Coordinator (if requested) will develop a job description and back-up plan for the attendant(s).
- The participant and the Service Coordinator (if requested) will discuss and develop a plan for hiring, screening, interviewing, and training the attendant(s).
- Once a potential attendant has been identified, the participant will direct him/her to the Living at Home Waiver Division to complete the provider enrollment process (if necessary).
- If the participant and Service Coordinator agree that they are ready to move forward, a Self-Delegation of Attendant Care Agreement will be provided to the participant for signature.

## Appendix E: LAH Participant Delegation Policy

- ✓ The Agreement will state that the participant will be responsible for the direction and oversight of the attendant(s) and that the Plan of Service (POS) supports the participant's needs while receiving LAH waiver services in the community.
  - ✓ ***The Agreement should only be signed when the participant is ready for total self-delegation.***
  - ✓ ***The Agreement will include the time frame for review of the agreement, but minimally, the participant and the Service Coordinator will review it on an annual basis at redetermination.***
  - ✓ ***Details of the independent delegation agreement will be indicated on the waiver participant's POS.***
  - ✓ Attendant care service tasks shall be noted on the Caregiver Service Plan.
- 
- The Agreement, POS and Caregiver Service Plan can be modified at any time.
  
  - If the Service Coordinator determines that the participant's health is in jeopardy, a meeting will be held with the participant, Service Coordinator, LAH RN Clinical Supervisor and provider to discuss concerns and options. Strategies to address concerns will be developed. Strategies may include, but are not limited to: consumer training, education provided by a nurse monitor, follow-up training by the nurse monitor, temporary nurse monitoring and/or identification of a new attendant care provider.
  
  - If the strategies are determined not to meet the participant's health and safety needs, the Service Coordinator will inform the participant that the Living at Home Waiver Division will be notified. Once notified, the LAH Waiver Division will review the information provided by the Service Coordinator and, if necessary, complete the reduction/denial of services form to discontinue self-delegation of attendant care services. The form and appeal rights will be forwarded to the participant. The participant may appeal any decision regarding his/her ability to self-delegate attendant care services under the waiver.

Appendix F: Waiver Quality Plans

Appendix F: TBI Quality Plan

See attached PDF file:

[Appendix F TBI Quality.pdf](#)

### **Current Housing Strategies**

The Maryland Governor's Commission on Housing Policy, formed in 2003, brought together experts in the housing field to share ideas with local governments, housing agencies, non-profit organizations, financial institutions, advocacy groups for senior citizens and individuals with disabilities, rental property owner organizations, real estate agents, homebuilders and developers. The Commission requested a typology for the application and allocation of State housing and community development programs and resources to reflect the diverse range of conditions and needs across the State and ensure that the appropriate resources are available and used to address problems identified by the Commission.

The typology including the needs of individuals with disabilities and concluded that over the next 10 years, Maryland faces an overall shortage of 157,000 units of affordable and accessible housing. Of these 157,000 units:

- Seniors: 25,000
- Individuals with Disabilities: 29,000
- Families: 103,000

In 2007, the Department of Housing and Community Development partnered with SocialServe to development an online searchable database of affordable and accessible rental units. The goal is to help Marylanders find rental housing that meets their needs. Prospective renters can use the web site or call a toll-free telephone number to search up-to-date listings based on criteria including cost, neighborhood or accessibility. An additional outcome of the database is property owners can use the site to manage their inventory of properties and the State of Maryland can begin to get a picture of the inventory of available affordable and accessible rental housing.

Maryland's strategy to expand the availability of affordable and accessible housing includes increasing the availability of rental housing; homeownership opportunities and ability to make home modifications; and the construction of community based residential settings.

#### *Rental Housing*

The Department of Housing and Community Development has collaborated with other state agencies that serve individuals with disabilities and advocacy groups to devise an innovative three-pronged approach that builds on existing programs and resources to help individuals with disabilities find quality affordable housing. The approach offers incentives for developers to market tax credit units to individuals with disabilities, State-funded deferred loans to reduce construction costs of the targeted units, and State-funded "bridge" rental assistance for use while the disabled individual awaits permanent housing assistance.

#### **I. Incentives under the Qualified Allocation Plan (QAP) for Tax Credits**

DHCD added bonus points in the competition for federal Low Income Housing Tax Credits (LIHTC) and DHCD-controlled gap financing to applicants committing to target and market units to individuals with disabilities. To receive the bonus points, applicants must commit to set aside and market up to 10 percent of a project's units to individuals with disabilities for at least 30 days, commencing at 80 percent construction completion. Additionally, upon vacancy the unit must again be marketed for 30 days solely to individuals with disabilities. The application

## Appendix G: Housing Strategies

must document that the applicant has made contact with care providers or advocacy groups and that these groups have agreed to refer clients to the targeted units. A marketing strategy is required and the obligation is memorialized in the property's regulatory agreement. Failure to comply with the terms of the regulatory agreement can constitute default and subject the owner to disincentives in future LIHTC competitions. In the 2007 Qualified Allocation Plan, providing more time to market for individuals with disabilities to identify our available units was allocated.

The result of this targeted initiative is increased availability of independent housing units – 663 units in 76 projects – dispersed throughout the State that offer individuals with disabilities quality housing of choice at tax credit rents. Units include newly rehabilitated and newly constructed units. All of this is accomplished as an integral part of the affordable housing development process without the need for additional financial resources or by imposing additional mandates on the development community. The decision to target units to individuals with disabilities remains with the developer.

### II. Bridge Subsidy Demonstration Program

Building on the success of its efforts to encourage developers to market units to individuals with disabilities, the DHCD partnered with the disability community and other State agencies to address the affordability issue for many individuals who rely on Supplemental Security Income (SSI) or social Security Disability Income (SSDI) as their sole source of income. While traditional permanent housing solutions such as the Section 8 Housing Choice Voucher and the Public Housing Program are viable options, waiting lists are long. Implementing a December 2005 recommendation of the Governor's Commission on Housing Policy, the Department opened its Bridge Subsidy Demonstration Program in January 2006 under a Memorandum of Understanding (MOU) signed by 13 participating entities including State agencies overseeing Housing, Health, Disability and Aging; private nonprofit disability advocacy and service agencies; and public housing authorities located throughout the State.

The Bridge Subsidy Demonstration Program provides State-funded short-term rental assistance (up to three years) for individuals with disabilities while they await permanent housing assistance. Participants are selected based on specified criteria by the State's Developmental Disabilities Administration, Mental Hygiene Administration and private non-profit signatories to the MOU. All Public Housing Authorities (PHAs) received an invitation to participate in the Demonstration and those who elected to sign the MOU agreed to administer the bridge subsidy payments to the landlords, accept a participant on their waiting list, and provide a preference for a participant under their Annual Plan if the participant did not otherwise reach the top of the waiting list within their three-year term on the Demonstration Program. Participants are required to abide by certain standards to remain in the Program, including receiving rental training, credit counseling, and complying with a service plan.

### III. Partnership Rental Housing Program – Occupancy Restrictions for Individuals with Special Needs

The Partnership Rental Housing Program is a State-funded program created in 1990 to provide capital funds for the construction of income-restricted housing owned in whole or in part by local governments. Repayment of a loan under the Program is required only if the local government ceases to operate the property as affordable housing in accordance with Program requirements. (loans are essentially deferred in perpetuity). A valuable tool for developing housing for very

## Appendix G: Housing Strategies

low-income tenants, the Program's usefulness in many parts of the State was limited because it required local government ownership. At the same time, it held a proprietary interest for those few local governments willing to assume the ownership role to access funds.

Working in partnership with disability advocates and local governments, DHCD was successful in streamlining the Program while expanding the types of housing eligible for funding. Passed unanimously in both houses of the State legislature and signed by the Governor, Senate Bill 126 allows the Program to provide loans to private developers to construct, acquire, or renovate rental housing units as part of a larger undertaking, as long as the units financed using Partnership funds are occupied by a lower-income household that includes one or more individuals with disabilities or special needs. The legislative changes became effective in October 2006, and DHCD committed its first funds under the new initiative in June 2007. Fourteen units dispersed in four tax credit projects received \$75,000 per unit in exchange for a long-term restriction on occupancy of the units to individuals with disabilities. All fourteen units are restricted at 30% of area median income and comprise no more than 5% of the total units at any property.

An important benefit of this initiative has been improved communication and cooperation among housing developers, public housing agencies, officials, service providers, and disability advocates. DHCD's website provides key information. Public and private agencies working with individuals with disabilities have been educated about these new units and can call the Department or check the website. Service providers have learned to call the developers to determine time frames for lease-up and get their clients on waiting lists. Increased informal networking among all parties has enhanced understanding and exchange of ideas and information across disciplines and has created sound solutions to the lack of affordable and accessible housing for individuals with disabilities.

### *Homeownership*

DHCD's Homeownership Program for Individuals with Disabilities started in 1998 from a collaborative effort among various state agencies and disability advocacy groups. In the 2007 DHCD met with disability advocates to review changes and update the program the result were some key changes that expand the eligibility of the program to include families with disabilities. One of the borrowers, or a child of one of the borrowers (who resides with and is principally cared for by one of the borrowers), must have a disability. The income and maximum purchase price of homes that qualify for the program were also increased to reflect current market trends.

DHCD in partnership with the Maryland Department of Aging (MDoA), coordinated a pilot project called Accessible Homes for Seniors to promote accessibility related improvements to the homes of seniors that are key for seniors to remain in their home and maintain their independence. The program provides zero percent interest, deferred loans for a term of 30 years to finance accessibility improvements. The program will be funded by DHCD and is initially targeted in eleven counties throughout the State and marketed through the Area Agencies on Aging.

The Maryland Housing Rehabilitation Program- Single Family (MHRP-SF) provides loan funds for the rehabilitation of single family owner-occupied homes and one-to-four unit rental properties. MHRP-SF is designed to bring properties up to applicable building codes and

## Appendix G: Housing Strategies

standards including: accessible modifications; correct health and safety violations; improve weatherization and energy conservation; and correct lead-based paint violations.

### *Community Based Residential Settings*

The Group Home Financing Program assists with the construction or acquisition and modification of existing housing to serve as a group home for income-eligible persons with special housing needs. Nonprofits and individuals who are serving a special needs population in a group home setting qualify and the loan can be used for acquisition or renovation of the home.

The Maryland Department of Health and Mental Hygiene Bond Bill Program provides capital grant funds for Federally Qualified Health Centers and for community programs providing mental health, developmental disabilities, addictions, and adult day care services. The Bond Bill Program prioritizes community-based services and provides funds for counties, municipalities and nonprofit agencies in the private sector for the acquisition, construction, or renovation of eligible projects.

## Appendix H: Guardianship Resources

### **Guardianship Resources**

#### The Guardianship Handbook

<http://www.peoples-law.org/health/disability/adult-guardian/toc.htm>

#### Code of Maryland Regulations (COMAR)

07.06.14.11 Guardianship Procedures

<http://www.dsd.state.md.us/comar/07/07.06.14.11.htm>

#### Annotated Code of Maryland

Estates and Trusts Article §§ 13-704 through 13-710

<http://michie.lexisnexis.com/maryland/lpExt.dll?f=templates&eMail=Y&fn=main-h.htm&cp=mdcode/e431/e983/eada/eaec/eaf2>

#### Maryland Rules of Procedure

Title 10 Guardians and Other Fiduciaries

<http://www.michie.com/maryland/lpExt.dll?f=templates&eMail=Y&fn=main-h.htm&cp=mdrules/8/abc>

## Appendix I: Financial Forms

### Appendix I-1: MFP Budget Form

See attached PDF File:

[Maryland MFP Budget Form.pdf](#)

See attached XLS File:

[Maryland MFP Budget Form.xls](#)

### Appendix I-2: 424a Fund Request

See attached PDF File:

[Maryland - SF424a Modified - MFP Supplemental Award Request.pdf](#)

See attached XLS File:

[Maryland - SF424a Modified - MFP Supplemental Award Request.xls](#)

### [Appendix I-3: Annual Budget Projections](#)

[See attached PDF File:](#)

[Maryland MFP Annual Budget Projections.pdf](#)

## Appendix J: Service Descriptions

### Appendix J-1: Peer Mentoring Demonstration Service

The Peer Mentoring for Nursing Facility Residents program is designed to support individuals who are transitioning to homes in the community and will support inclusion and connections in the local community.

The goals of the program are to:

- Promote socialization, community inclusion, and the development of community roles;
- Promote self-advocacy, defined as an individual's ability to make informed, independent choices, ask questions, and voice opinions;
- Assist in the development of natural, unpaid supports and social support networks;
- Aid in the development of community-living skills;
- Increase awareness of community activities and opportunities;
- Support vocational choices; and
- Promote effective use of service delivery systems and natural resources in the community.

Peer mentoring will include an assessment of support needs, a person-centered, individualized goal plan with regular goal review, and will incorporate individual interaction in the community, drop-in centers, telephone support, and group training and activities. Peer mentoring will begin two to three months prior to an individual's transition with assessment and goal development. Active work on goal attainment will occur after goal planning and may be provided in the community as long as the individual remains in the MFP demonstration.

From training and through life experiences, all peer mentors will have sufficient knowledge and skills to use community resources necessary for independent living, the ability to teach independent living skills to others, knowledge and skills to engage in problem solving and conflict resolution strategies, experience in utilizing community-based supports such as personal care, accessible transportation, and support groups.

Peer mentoring will be provided as an MFP demonstration service and may be added to the Living at Home and Older Adults waivers as a waiver service if it proves to be cost-effective and successful in fostering community inclusion. Peer mentoring will be provided by the Centers for Independent Living across the State. Peer mentors will be reimbursed for mentoring provided to MFP participants at a rate of \$31.11 per hour or \$7.78 per 15 minute billable unit. This rate was developed based on the same rate setting methodology used to develop Maryland's transitional case management rate. Please see the attached rate setting methodology. Peer mentoring providers will also be reimbursed a flat rate of \$100 for the initial assessment and goal plan. Peer mentoring services will capped at 48 hours (192 units) per person, plus the assessment cost. It is estimated that peer mentoring will be utilized by approximately 500 MFP participants who transition from nursing facilities throughout the demonstration at a maximum cost of \$1,593 per person.

## Appendix J: Service Descriptions

### Appendix J-2: Transitional Case Management Demonstration Service

The existing Older Adults waiver case managers will provide transitional case management to MFP participants who are OAW applicants during the 180 days immediately prior to the transition to the community. These services include developing a plan of care; coordinating providers for all community based services; monitoring the eligibility process; collaborating with family, legal representatives, guardians, facility staff, and provider agencies; and utilizing transition and supplemental funds to secure needed goods related to the transition.

Transitional case management will be split into two categories, administrative case management and comprehensive case management services. Administrative case management services will include activities related to accessing Medicaid home and community-based services, including eligibility determination and the coordination of Medicaid services. Comprehensive case management will include activities related to accessing non-Medicaid services and supports including community-based housing, food stamps, and utility assistance.

All case management activities will be tracked by the provider in 15 minute increments in the web-based tracking system and be categorized either as administrative or comprehensive case management. These services will be provided by the current waiver case management providers only rather than any willing provider. Transitional case managers will bill monthly for all administrative case management services provided to MFP applicants. Once an applicant transitions to the community and becomes a MFP participant, they may bill for comprehensive case management services provided to the participant in the 180 days prior to the transition.

Providers will receive a rate of \$13.25 per 15 minute unit for this service. It is estimated that MFP participants will receive approximately 45 hours of case management services during this 180 day period, i.e. \$2,385 per person.

It is estimated that some individuals will not transition in the 180 day period and that providers may bill for administrative activities for that time. It is estimated that MFP participants will receive 25.5 hours of administrative case management outside of the 180 days prior to transition at a cost of \$1,351.50 per person.

## Appendix K: Housing Strategic Plan

See attached PDF File:

MFP Housing Strategy, Final Report, 06-19-08.pdf

## Appendix L: Behavioral Health Workgroup Recommendations

### To the Aging in Place Task Force

- Develop a residential model of integrated somatic and behavioral health supports
- Present this model as a pilot in assisted living facilities through the Older Adults Waiver
- Enhance Residential Rehabilitation Program (RRP) rates for programs that incorporate this integrated model of care
- Increase transitional case management for individuals leaving IMDs
- Increase behavioral health training opportunities for somatic care providers including attendant care, assisted living, and medical day care providers
- Add peer supports as a Public Mental Health System (PMHS) service
- Ensure Psychiatric Rehabilitation Program (PRP) services are provided to OAW and LAH waiver participants as needed
- Increase utilization of PMHS short-term intensive support services
- Enhance caregiver and staff supports
- Develop in-home respite care services
- Encourage RRP to become licensed as Assisted Living Facilities (ALFs)
- Collect Data on consumers with brain injury
- Enhance access to assistive technology
- Advocate for changes in Medical Assistance Personal Care (MAPC) to allow services in RRP >3
- Develop increased options for nurse delegation

### To the Brain Injury Advisory Board

- Add a behavioral consultation service to the current TBI waiver
- Enhance Assistive technology available to waiver participants
- Add a short-term intensive support service that includes specialized staffing
- Provide education and support to families and representatives of consumers
- Increase outreach into the chronic hospitals
- Monitor brain injury data collection efforts in the MFP demonstration
- Expand eligibility for the TBI waiver to include all brain injury and all institutional settings

## Appendix L: Behavioral Health Workgroup Recommendations

*If the waiver is expanded consider the following:*

*Add financial management or rep payee service*

*Add peer support service*

*Add in-home respite care*

*Add specialized training for consumer-directed attendants*

*Move to aggregate cost neutrality*

### To the Living at Home Advisory Committee

Behavioral Consultation Services

Residential or Supportive Housing Option

Enhanced attendant care rates for attendants with specialized behavioral health training

Short-term intensive support by a behavioral health professional

Financial representatives to assist with money management

Peer support services

Increase availability of behavioral health training for attendant care providers

Enhance access to assistive technology

Collect data on LAH applicants with a history of brain injury

Move to aggregate cost neutrality

### To the Older Adult Advisory Committee

Enhanced rates for assisted living providers with specialized behavioral health training

Enhanced attendant care rates for attendants with specialized behavioral health training

Short-term intensive support by a behavioral health professional

Financial representatives to assist with money management

Peer support services

Increase availability of behavioral health training for attendant care providers

Enhance access to assistive technology

Collect data on OAW applicants with a history of brain injury

## Appendix L: Behavioral Health Workgroup Recommendations

Move to aggregate cost neutrality