

Money Follows the Individual Accountability Act Report December 2006

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

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

This report is intended to satisfy these reporting requirements.

BACKGROUND

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

Since that time, the Department of Health and Mental Hygiene (DHMH) and the Department of Human Resources (DHR) have sponsored several efforts to reach out to nursing facility residents:

- Granted funds to the Statewide Independent Living Council to implement "Operation Alpha" by conducting peer-to-peer outreach to nursing facility residents and collecting data on residents who are interested in moving back to the community;
- Sponsored a "Lessons Learned" conference for outreach workers to share best practices and discuss barriers to helping people leave nursing facilities;
- Funded outreach efforts through federal grants awarded to DHR and Making Choices for Independent Living. Transition specialists with the Centers for Independent Living (CILs) have made hundreds of presentations and visits to nursing facility residents, their families, and nursing facility staff. They have also developed a resource guide on moving to the community.
- Contracted with the Maryland Disability Law Center to conduct training sessions for nursing facility outreach workers. Trainings provided an opportunity for outreach

workers to network with colleagues from around the State and helped educate outreach workers on community resources and legal issues.

- Implemented HB 752 (2002), which required nursing facility social workers to share information about community programs with their residents. DHMH developed and distributed a fact sheet and transmitted information to providers on the requirements of the law. DHMH updated the fact sheet in accordance with HB 946/SB620 in 2004 and again in 2006.

Medicaid's home and community-based services waivers are limited by enrollment caps and budget allocations. Since the Living at Home and Older Adults waivers began, they have been inundated with applications – most of them from individuals who live in the community, but some from individuals who live in nursing facilities. As a result, the Living at Home Waiver closed in December 2002 and the Older Adults waiver closed in May 2003 to applicants from the community. Since that time, both waivers have only enrolled a limited number of applicants from the community.

As the Living at Home Waiver approached its enrollment cap in November 2002, the Department announced a new “money follows the individual” policy for the Living at Home Waiver and Waiver for Older Adults programs. Under this policy, Medicaid recipients leaving nursing facilities can enroll in the Waiver for Older Adults or Living at Home Waiver even if, due to budget constraints, the waivers have closed to people currently living in the community.

EFFORTS TO PROMOTE HOME AND COMMUNITY-BASED SERVICES

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

Linking consumers with community supports

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

Now, nurses from the UCA identify residents that have expressed a preference to move to the community, and the nurses discuss home and community-based options with those residents. If a resident so desires, the UCA nurse will make a referral to the agency that administers a Medicaid waiver program appropriate to the resident's needs. The UCA nurses saw their first clients in September 2004 and have since made more than 380 referrals to either the Waiver for Older Adults or the Living at Home Waiver.

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

In 2003, the Department implemented a hospital discharge planning initiative to provide augmented discharge planning services for patients at risk of nursing facility placement. The initiative was financed through the Department's federally-funded Real Choice Systems Change Grant and operated in three Maryland jurisdictions – Baltimore City, Harford County, and Worcester County. The Department committed to continuing this program in Worcester and Harford Counties after grant funding ended.

In each jurisdiction, nurses paid for by grant funds worked directly with patients and family members, prior to the patient's discharge from a hospital, to make arrangements or referrals for services that they would need when they return home. The hospital discharge planning initiative was designed to reduce unnecessary nursing home admissions and utilization. Although the Department continues to collect and analyze data on the outcomes of the project, we have anecdotal evidence that this initiative has already become a valuable resource in each of its three sites. Its impact goes beyond the clients it serves. Hospital staffs in the pilot jurisdictions learned more about available community resources. Over time, this initiative will help bring about culture change for both hospital and nursing facility staff.

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

The workshops were financed through the federally-funded Real Choice Systems Change Grant and a partnership with Johns Hopkins. The Department is planning to hold additional workshops during 2007. The goal of the workshops is to give practical, user-friendly information about programs and services in the community that are available to assist low-income older adults and people with disabilities. Attendees receive CEU credit for completing the day-long workshop.

Information on Medicaid's community-based services. DHMH continues to offer a booklet that describes all of the long term care community-based services that are

available through the Medicaid program. The booklet is designed to provide basic information for health care professionals, consumers, and families to assist them in making decisions about long term care services. In 2005 and 2006, The Real Choice Systems Change Grant covered the printing and distribution costs for this project, and the Department sent copies to nursing facilities, hospitals, local government agencies, advocacy groups, and State legislators. The Department plans to continue producing this popular resource on a yearly basis. The information is also available online. (<http://www.dhmf.state.md.us/mma/pdf/2006booklet.pdf>)

Rate increases for personal care providers. This year payment rates were increased under the State Plan personal care program. The Department implemented regulatory changes, effective July 1, 2006, to include provisions to allow an annual increase in personal care services per diem rates by a percentage of annual increase in the March Consumer Price Index. This is the second year in a row that the Department has increased reimbursement rates by an average of 10%.

Rate increases for DDA providers. This year, the Department is devoting more than \$16.2 million to fund the fifth year of its initiative to increase the wages for direct care workers.

Enrolling individuals from the Waiver Services Registry. Since the Living at Home and Older Adults waivers initially closed to community applicants, DHMH has maintained the Waiver Services Registry. The Registry is a central clearinghouse that collects contact information on individuals interested in receiving waiver services. Throughout 2006, DHMH enrolled individuals from the Registry into the Waiver for Older Adults on a first come, first served basis to take the place of individuals who have left the program. In the second half of 2006, new funding enabled the Department to begin enrolling individuals from the Registry into the Living at Home Waiver .

Expanding the Waiver for Older Adults. New funding in the fiscal year 2007 budget allows the Department to serve more people in the Waiver for Older Adults. By the end of the fiscal year, the waiver will serve 3750 participants, up from 3575 in fiscal year 2006.

Expanding the Living at Home Waiver. New funding in the fiscal year 2007 budget allows the Department to serve 66 more individuals. By the end of the fiscal year, the waiver will serve 500 participants.

Quality improvement efforts.

The Waiver Quality Council meets regularly to address quality issues, share program experiences and information, and further refine the waiver quality assurance management systems. Implemented in August 2005, the Waiver Quality Council developed a policy for waiver providers, case managers, and State agencies to discover, report, and remedy

reportable events (i.e., incidents or complaints) involving home and community-based services waiver participants in a timely manner.

Beyond providing appropriate safeguards for participants, documenting and investigating reportable events is essential to assure that the appropriate agencies receive information that can ultimately be used for system improvements. We are analyzing information from reportable events to enhance coordination of program services and consolidate processes. The policy describes the process, monitoring, reporting, and oversight of reportable events for home and community-based services waiver programs.

The next areas the Waiver Quality Council will work on are provider education, provider training and developing materials for provider audits. Throughout the year the waiver programs held provider and case management trainings on a variety of topics, ranging from helping providers understand their responsibilities and program regulations, to assistance with completing forms detailing the services they provide to participants. Each waiver has developed a proactive program to audit providers to ensure they are properly credentialed and appropriately skilled to provide services to waiver participants.

In 2006, DHMH contracted with the University of Baltimore to re-implement the Participant Experience Survey (PES), an in-person interview tool to measure the experiences of participants in home and community-based services waivers. The PES results are reported in each of four domains: access to care, choice and control, respect and dignity, and community integration. Maryland was one of the first states to use the PES, and was the first state to use the electronic version. In 2005, 547 participants of the Older Adults and Living at Home waiver programs across 15 counties and Baltimore City, were surveyed. Data collected from the 2004 and 2005 surveys provides a solid baseline of the experiences of participants in these 2 waivers and the results continue to be used to highlight areas in need of intervention.

Systems Reform.

In August 2005, the Department submitted an application to the federal government for permission to implement the CommunityChoice program, a capitated, managed long term care program to be piloted in two areas in Maryland. The proposal calls for a fundamental change in Medicaid financing, with the intent of promoting community-based long term care services, reducing avoidable hospitalizations and nursing facility placements, improving outcomes, and reducing the rate of cost growth in the Medicaid program. The Department has held multiple stakeholder meetings regarding CommunityChoice, and has selected pilot areas and a preliminary framework for implementation. Currently, the Department is awaiting a response from the Centers for Medicare and Medicaid Services (CMS) on the CommunityChoice waiver application.

Collaboration with other State Agencies

Nursing Facility Transition Grant. The federal government awarded the Nursing Facility Transition Grant to the Department of Human Resources in 2001. Through the grant,

DHR contracted with Centers for Independent Living to share information about community-based options, provide education about various community services, locate suitable housing and provide assistance and funding to enable individuals to transition out of nursing facilities. The target population was individuals aged 21 to 65 years with physical disabilities who receive or are eligible for Medicaid and desire to move out of the nursing facility.

The original goal of the project was to help 150 individuals transition back to the community. By the time the grant expired in June 2005, 193 individuals with physical disabilities had transitioned from nursing facilities to community settings.

DHMH collaborated with DHR through a shared consumer advisory committee and sharing information on nursing facilities and Medicaid nursing facility utilization. On several occasions, DHMH staff mediated situations where a nursing facility refused to allow outreach workers to enter a facility.

Maryland Commission on Disabilities. DHMH participates on the Maryland Commission on Disabilities, established pursuant to Senate Bill 188 (2004). Promoting community integration is a major priority for the group.

Personal Assistance Services Advisory Committee. DHMH participates on the newly formed Personal Assistance Services Advisory Committee, established pursuant to House Bill 1542 (2005). This Committee has recommended to the Department of Disabilities ways to improve attendant care services funded by all State agencies, including Medicaid.

Coordinating Committee for Human Services Transportation. DHMH participates on the Maryland Coordinating Committee for Human Services Transportation. The Committee, staffed by the Department of Transportation, studies ways to coordinate and improve the availability of transportation for older adults and people with disabilities. The Department of Disabilities, Department of Human Resources, and various human services agencies also participate on the Committee.

Money Follows the Person Demonstration Proposal. In 2006, DHMH applied for a grant allowing an enhanced federal Medicaid match to assist qualified individuals who choose to transfer from long term care facilities to the community. The Department, in conjunction with the Department of Aging and the Department of Disabilities, held multiple stakeholders meetings to discuss and explain the benefits of the program. Currently, the Department is awaiting a response from CMS regarding the proposal, and should be notified by the end of 2006.

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

The Minimum Data Set is a federal assessment for all nursing facility residents. The MDS assessments conducted at admission and annually ask whether or not the resident has expressed a preference to return to the community. A resident is defined as any

person staying within the nursing facility, regardless of their expected duration of stay, or if they maintain another official residence elsewhere. To determine the number of individuals expressing a preference to return to the community, the Department analyzed the records for residents who were in nursing facilities at the end of March 2006.¹

The Department’s analysis indicates that 5,596 out of 24,454 total (23%) residents expressed a preference to return to the community. The numbers differ markedly when grouped by Medicare payer status. Medicare-covered stays are typically short term and associated with an acute hospital stay. Non-Medicare-covered stays can be more commonly defined as long-term care. Medicaid covered residents are also significantly less likely to express a desire to leave a nursing facility when compared to non-Medicaid residents during similar types of stays. Of the 24,454 total residents, 17,209 were identified as Medicaid recipients. The percentage of Medicaid recipients wishing to return to the community was slightly higher in 2006 compared to the previous year, while all other rates remained steady. The 2006 results are categorized in the table below.

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

**MDS survey results
March, 2006**

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

Since the Living at Home Waiver closed to community applicants in December 2002, 234 individuals have transitioned from nursing facilities to the community through the waiver.

¹ Our approach largely replicates the approach that CMS uses for public reporting of these results on their website, using MDS assessments for currently active residents but looking back to the last assessment with a response for MDS question Q1a (even if that assessment was well before the first quarter of CY 2006).

Since the Waiver for Older Adults closed to community applicants in May 2003, approximately 1,400 individuals have transitioned from nursing facilities to the community through the waiver.

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

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

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

The difficulty for low-income people with disabilities in obtaining affordable and accessible housing has been documented by the Technical Assistance Collaborative in *Priced Out in 2000: The Crisis Continues*. Housing is considered affordable when an individual spends less than 30% of their income on housing. According to the report, the rental cost for an average one-bedroom housing unit in Maryland exceeds 145% of the income of a person receiving SSI. Many individuals are otherwise eligible and prepared to participate in the home and community-based services waivers, but they lack a place to live outside of a nursing facility.

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

Information and communication. Many health care professionals do not fully appreciate the range of services and supports that are available to help people with disabilities live in the community. We consistently hear anecdotes about nursing facility employees who do not think any of their residents can move into the community. Likewise, many consumers and family members are unaware of community options.

Medicaid financing. The current Medicaid and Medicare systems pay providers for delivering specific services. For most providers, there are no financial rewards for helping people stay healthy and independent. There are also many points – the hospital discharge process, for example – where the lack of coordination between Medicare and Medicaid can work against community integration.

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

Housing. Governor Ehrlich established a housing commission early in his administration to develop solutions and strategies to address the shortage of affordable and accessible housing in Maryland, including funding options for housing for people whose income is at SSI levels. In its final report, several of the commission's recommendations address concerns of the disability community, including the development of the Bridge Subsidy Demonstration Program. DHMH will continue to collaborate with DHCD and other agencies to identify housing resources for older adults and people with disabilities.

Transportation. DHMH will continue to collaborate with MDOT and other agencies that fund human services transportation through participation on the Maryland Coordinating Committee for Human Services Transportation.

Information and communication. In 2006, DHMH arranged two continuing education courses for nurses and social workers to learn about community support services. In addition, former nursing facility residents can create a great learning opportunity by returning to visit their old facility to show off how much they enjoy life in their own home. Both staff and residents can see first hand that people can live with greater independence without negative outcomes. Over time, we can help more and more people realize that a nursing facility is not just a place to go and stay, but is only one point on an overall continuum of care.

Medicaid financing. By changing the financing of services, we can create incentives to promote health, prevent unnecessary hospitalizations and nursing facility placements, and use the most cost effective means of care. Integrating Medicare and Medicaid financing would help foster a continuum of care that offers the right service at the right time in the right place. The Department feels strongly that the proposed CommunityChoice program can dramatically improve the financial incentives built into our health care system and, in turn, create a Medicaid program that better promotes community integration for older adults and people with disabilities. The CommunityChoice program would bring about a lasting systems change to improve the availability of home and community-based services.