

# Balancing Incentive Program Application

Department of Health and Mental Hygiene

State of Maryland

Submission Date: February 10, 2012

Contact person:

Eric Saber

Office of Health Services

Department of Health and Mental Hygiene

201 West Preston Street

Baltimore, Maryland 21201

[esaber@dhmh.state.md.us](mailto:esaber@dhmh.state.md.us)

410-767-1458

**This page is intentionally left blank.**



STATE OF MARYLAND  
**DHMH**

---

Maryland Department of Health and Mental Hygiene  
201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

February 10, 2012

Ms. Jennifer Burnett  
Centers for Medicare & Medicaid Services  
Disabled and Elderly Health Programs Group  
7500 Security Boulevard  
Mail Stop: S2-14-26  
Baltimore, MD 21244-1850

Dear Ms. Burnett:

The State of Maryland is pleased to submit this application for the Balancing Incentive Program. The purpose of this program is to promote a series of rebalancing objectives that will increase the use of home and community-based services in Maryland.

In accepting the additional two percent federal matching funds, Maryland will reinforce its ongoing commitment to serving individuals in the most integrated setting. This commitment is apparent in the State's existing policies and programs, including participation in the Money Follows the Person (MFP) federal demonstration, Maryland's pre-existing "Money Follows the Individual" policy, and the five home and community-based services (HCBS) waivers that 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 application, the State will use stakeholder input and lessons learned in the implementation of MFP to improve upon current rebalancing initiatives, including creating a conflict-free case management system, a robust no wrong door/single entry point system, and utilizing a statewide core standardized assessment.

The contact for the Balancing Incentive Program is Eric Saber and I will serve as the principal investigator. Cooperating entities will include: Maryland Department of Aging (MDOA), Developmental Disabilities Administration (DDA), Aging and Disability Resource Centers locally known as Maryland Access Point (MAP) sites, Maryland Department of Disabilities (MDOD), Mental Hygiene Administration (MHA), Department of Budget and Management (DBM), and the Money Follows the Person (MFP) Demonstration Stakeholder Group.

Sincerely,

Charles J Milligan, Jr.  
Deputy Secretary, Health Care Financing

**This page is intentionally left blank.**

## Table of Contents

Project Abstract .....	7
Letters of Endorsement .....	8
Work Plan.....	13
Application Narrative .....	17
Section A. Understanding of Balancing Incentive Program Objectives .....	17
Section B. Current System’s Strengths and Challenges .....	20
Section C. No Wrong Door/Single Entry Point - Maryland Access Point .....	34
Section D. No wrong door/Single entry point Person Flow .....	36
Section E. NWD/SEP Data Flow.....	41
Section F. Potential Automation of Initial Assessment.....	43
Section G. Potential Automation of Core Standardized Assessment .....	44
Section H. Incorporation of a CSA in the Eligibility Determination Process .....	45
Section I. Staff Qualifications and Training .....	48
Section J. Location of SEP Agencies .....	50
Section K. Outreach and Advertising .....	53
Section L. Funding Plan .....	55
Section M. Challenges.....	57
Section N. NWD/SEP’s Effect on Rebalancing.....	60
Section O. Other Balancing Initiatives .....	62
Section P. Technical Assistance.....	69
Financial Reporting Form.....	70

**This page is intentionally left blank.**

## Project Abstract

According to FY 2009 expenditure reports, the State of Maryland (the State) expended 36.8 percent (\$780 million out of \$2.12 billion) of its total Medicaid long term care budget to home and community-based long term services and supports (LTSS) versus services in institutions. The Centers for Medicare and Medicaid Services assigned a two percent federal enhanced match for those states that spend between 25% and 50% that agree to comply with federal regulations under the Balancing Incentive Program. Maryland's application is based on structural changes and recommendations from the Long Term Care (LTC) Reform Workgroup. The LTC Reform Workgroup was developed pursuant to State legislation that required the Department to convene a workgroup that would make recommendations on LTSS.

In compliance with the Balancing Incentive Program guidance, the Department will move forward with structural changes to improve how services are accessed and delivered, many of which coincide with recommendations from the LTC Reform Workgroup. The Department will expand its current use of its No Wrong Door/Single Entry Point (NWD/SEP) agencies known as Maryland Access Point (MAP) sites, implement a core standardized assessment (including a screen) and remediate all case management contracts and regulations that do not align with the Balancing Incentive Program requirements.

Specifically, Maryland is expanding MAP sites across the State under the leadership of the Maryland Department of Aging (MDoA) and the Department of Health and Mental Hygiene (the Department). Statewide access will be available in the summer of 2012 and the role of the MAP sites will expand with the adoption of a screening tool integrated with a core standardized assessment. The Department has selected a core standardized assessment and plans on hosting a pilot in calendar year 2012 and implementing statewide in January 2013. Throughout 2012, the Department will also begin review of all case management practices for each program that provides LTSS and remediate contracts. The Department will ensure that all LTSS case management services will be conflict free by September 30, 2015.

The Department will finance the initial costs of structural changes through the Money Follows the Person (MFP) Demonstration. The MFP program's revised operational protocol was approved in January 2012. The operational protocol explicitly states each program and activity that will help Maryland develop a balanced system of offering and providing LTSS in a home or community-based setting. The MFP program projects spending of up to \$8,286,000 on structural changes related to the core requirements of the Balancing Incentive Program. In total, Maryland will reinvest approximately \$52 million in rebalancing funds during the MFP extension period.

Additional financial support through the expansion of the waiver programs in the State's proposed FY 2013 Medicaid budget and the expansion of services under a planned Community First Choice option will not only balance expenditures for LTSS, but shift Maryland's focus towards home and community-based services and supports.

## Letters of Endorsement

Martin O'Malley  
Governor

Gloria Lawlab  
Secretary

Anthony G. Brown  
Lt. Governor



## DEPARTMENT OF AGING

*Choice, Independence and Dignity for Older Marylanders*

January 30, 2012

Jennifer Burnett,  
Centers for Medicare & Medicaid Services  
Disabled and Elderly Health Programs Group  
7500 Security Boulevard  
Mail Stop: S2-14-26  
Baltimore, MD 21244-1850

Dear Ms. Burnett:

I am writing this letter to support the Maryland Department of Health and Mental Hygiene's (DHMH) application for participation in the State Balancing Incentive Payments Program (BIPP). The Department of Aging (MDoA) began developing Maryland's Aging and Disability Resource Center (ADRC) known as Maryland Access Point (MAP) in 2003. Beginning with two local MAP sites in 2004, the program has grown to sixteen sites in 2011 and will be statewide with 20 sites providing access to all Maryland citizens by June 30, 2012. The MAP program has worked closely with DHMH, our state Medicaid Agency, to build the MAP program into a strong infrastructure that provides a statewide No Wrong Door/Single Entry Point (NWD/SEIP) for individuals seeking long term supports, services and information. Our local MAP sites work through formal partnerships with local agencies and organizations serving individuals with disabilities and provide the single-entry-point for individuals seeking to transition from nursing homes into the community under the Money Follows the Person Demonstration. The MAP program operates a statewide public web-based resource directory providing information, opportunity for self-assessment and contacts for assistance with long term support needs and which will be used to guide individuals to local MAP options counselors under the BIPP program.

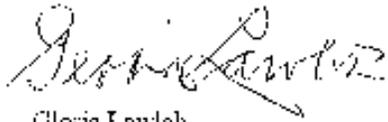
My Department in collaboration with the federal Administration on Aging has committed itself to assisting people in need of long term supports to remain in the community for over thirty years. Our MAP program has accelerated that commitment and allowed us to develop a number of federally funded innovative programs designed to divert people from nursing homes and Medicaid spenddown, e.g. the Community Living Program, the Person Centered Hospital

301 West Preston Street • Suite 1007 • Baltimore, Maryland 21201-2374  
Local: 410 767-1100 • Toll Free: 1-800 243 3425 • TTY users call via Maryland Relay  
Fax: 410 333-7943 • [www.mdoa.state.md.us](http://www.mdoa.state.md.us)

Discharge Program, the Veteran Directed Home and Community Based Services Program and several Care Transitions Program. We are pleased to be part of Maryland's BIPP plans which will further increase access to non-institutionally based long term services by way of increased Federal Medical Assistance Percentage. We will cooperate fully with DHMH in establishing the BIPP structural changes: including continued efforts to strengthen our (NWD/SEP), Conflict-free Case Management, and the development and use of a Core Standardized Assessment Instrument.

We look forward to this funding opportunity and the significant results it will produce for the citizens of our state.

Sincerely,

A handwritten signature in cursive script, appearing to read "Gloria Lawlah".

Gloria Lawlah  
Secretary



DEPARTMENT OF  
BUDGET & MANAGEMENT

MARTIN O'MALLEY  
Governor  
ANTHONY BROWN  
Lieutenant Governor

T. ELOISE FOSTER  
Secretary  
DAVID C. ROMANS  
Deputy Secretary

February 6, 2012

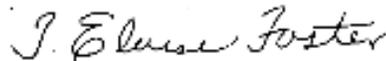
Ms. Jennifer Burnett  
Centers for Medicare & Medicaid Services  
Disabled and Elderly Health Programs Group  
7500 Security Boulevard  
Mail Stop: S2-14-26  
Baltimore, MD 21244-1850

Dear Ms. Burnett:

Please accept this letter of support for the State Balancing Incentive Payments Program (BIPP) initiative aimed toward increasing access to non-institutionally based long-term services. The Maryland Department of Budget and Management is encouraged by the new BIPP structural changes, including the No Wrong Door/Single Entry Point System (NWD/SEP), Conflict-free Case Management, and the development and use of a Core Standardized Assessment Instrument. The implementation of a new assessment tool, along with developing our Maryland Access Point (MAP) sites to more efficiently act as a single entry point, will allow the Department of Health and Mental Hygiene to strengthen the process by which people are evaluated and entered into the most appropriate home and community based services.

We are encouraged that the Maryland Medicaid Program is committed to pursuing this grant program for the additional federal 2% percent match. We look forward to this funding opportunity that will allow the state to reinforce ongoing commitments toward rebalancing.

Sincerely,



T. Eloise Foster  
Secretary

cc: Joshua M. Sharfstein, M.D., Secretary, Department of Health & Mental Hygiene

Catherine Raggio, Secretary  
George P. Failla, Jr., Deputy Secretary



Martin O'Malley, Governor  
Anthony G. Brown, Lt. Governor

February 7, 2012

Jennifer Burnett  
Centers for Medicare & Medicaid Services  
Disabled and Elderly Health Programs Group  
7500 Security Boulevard  
Mail Stop: S2-14-26  
Baltimore, MD 21244-1850

Dear Ms. Burnett:

Please accept this letter as an indication of support for the State Balancing Incentive Payment Program (BIPP) aimed toward increasing access to home and community based long-term services and supports. The structural changes required by BIPP; including No Wrong Door/Single Entry Point System, Conflict-free Case Management, and the development and use of a Core Standardized Assessment Instrument, will strengthen services delivered by the Department of Health and Mental Hygiene and the Maryland Department of Disabilities (MDOD). The goals of the State Balancing Incentive Program are also well aligned with the Community Living initiatives outlined in Maryland's 2012-2015 State Disabilities Plan.

MDOD regularly collaborates with federal, regional, and local units of government to enhance the effectiveness of the provision and funding of support to individuals with disabilities. Continued development of Maryland's network of Aging and Disability Resource Centers, known locally as Maryland Access Points (MAP), to more efficiently act as single entry points will allow us to better serve individuals with disabilities by assuring that they are connected to the appropriate agencies and community based supports and services.

We are encouraged that the Maryland Medicaid Program is committed to pursuing this program to expand services and strengthen the infrastructure that provides support for people with disabilities. MDOD looks forward to this funding opportunity that will allow us to build new relationships and strengthen the MAP sites in order to streamline access to person-centered, long term services and supports for Marylanders.

Sincerely,

A handwritten signature in black ink that reads "Catherine A. Raggio". The signature is written in a cursive style.

Catherine A. Raggio  
Secretary

217 EAST REDWOOD STREET, SUITE 1300, BALTIMORE, MARYLAND 21202  
VOICE/TTY 410-767-3680 VOICE/TTY 1-800-637-4113 FAX 410-333-6674 EMAIL [mdod@mdod.state.md.us](mailto:mdod@mdod.state.md.us)

# Work Plan

Table 1.

Category	Major Objective / Interim Tasks	Due Date	Status of Task	Deliverables	Comment
General No Wrong Door/ Single Entry Point (NWD/SEP) Structure	<b>All individuals receive standardized information and experience the same eligibility determination and enrollment process.</b>				
	Develop standardized informational materials that NWD/SEPs provide to individuals	January-2013	In development	Updated "Blue Books" for FY14. Maryland's source for information on all HCBS services	Current materials are in distribution; they will be updated to include information on all programs
	Train all participating staff on eligibility determination and enrollment processes	January-2014	In process	Completed training sessions	County by county rollout beginning in January 2013; potential for ongoing e-training
	<b>A single eligibility coordinator, "case management system," or otherwise coordinated process guides the individual through the entire functional and financial eligibility determination process. Functional and financial assessment data or results are accessible to NWD/SEP staff so that eligibility determination and access to services can occur in a timely fashion.</b>				
	Design system (initial overview)	February-2012	Complete	Balancing Incentive Program Application	Completed Balancing Incentive Program application with summary of person flow
	Design system (final detailed design)	March-2012	In development	Work Plan	Working with Maryland Department of Aging and stakeholders to Include detail on how NWD/SEP will include disabilities partners.
	Select vendor	January-2012	Selected	MAP site staff as Navigators; MOU with Hilltop Institute for an automated Core Standardized Assessment (CSA) and tracking system.	The Hilltop Institute at UMBC will develop and maintain the data tracking system.
	Implement and test system	July-2012	In development	Beta Testing in July 2012	The initial beta version is due to the Department July 2012. Testing by the Department and pilot counties will begin immediately.
	System goes live	January-2013	In development	Production due January 2013	Once beta version is approved and corrections are made, the system will go live and additional training will be provided as necessary.
	System updates	Ongoing	In development	Ongoing	Ongoing maintenance provided within contract.
NWD/SEP	<b>State has a network of NWD/SEPs and an Operating Agency with the Medicaid Agency as the Oversight Agency.</b>				
	Identify the Operating Agency	January-2012	Complete	MDoA	Maryland Medicaid is the oversight agency for all structural changes.

	Identify the NWD/SEPs	January-2012	Complete	Maryland Access Point (MAP) sites	Maryland will use the MAP sites, also known as ADRC sites.
	Develop and implement a MOU across agencies	January-2013	In development	Signed MOU's with all sites	Maryland will update signed business agreements with current MAP sites
	<b>NWD/SEPs have access points where individuals can inquire about community LTSS and receive comprehensive information, eligibility determinations, community LTSS program options counseling and enrollment assistance</b>				
	Identify service and coverage of all NWD/SEPs	August-2012	16 of 21 completed	All MAP sites will be open for business	MAP sites are planned to be available statewide in summer 2012.
	Ensure NWD/SEPs are accessible to older adults and individuals with disabilities	January-2014	Under review	Site review	Maryland will be conducting a review of all sites and their accessibility. Once this review is completed, all potential problems will be remediated.
	<b>The NWD/SEP system includes an informative community LTSS website - Website lists 1-800 number for NWD/SEP system</b>				
<b>Website</b>	Identify or develop URL	January-2012	Complete	<a href="http://www.marylandaccesspoint.info">www.marylandaccesspoint.info</a>	Website was developed and implemented in 2010.
	Develop and incorporate content	January-2012	Complete	<a href="http://www.marylandaccesspoint.info">www.marylandaccesspoint.info</a>	Additional content will be updated as new programs are created
	Incorporate the Level 1 screen (recommended)	July-2015	Under review	Updated website	The current website has a survey for additional resources which will be updated. Maryland will seek further assistance in including a Level 1 screen that will complement the phone screen being implemented.
	<b>Single 1-800 number where individuals can receive information about community LTSS options in the State, request additional information and schedule appointments at local NWD/SEPs for assessments</b>				
<b>1-800 Number</b>	Contract 1-800 number service	January-2013	In development	Contract for 1-800 number	Maryland will develop a 1-800 number
	Train staff on answering phones, providing information and conducting the Level 1 screen	January-2013	In development	Trainings conducted statewide	The state will design and conduct a statewide training for all county MAP sites
	<b>State advertises the NWD/SEP system to help establish it as the "go to system" for community LTSS</b>				
<b>Advertising</b>	Develop advertising plan	July-2012	In development	Advertising work plan	MDoA already has plans for advertisement for the current MAP sites.
	Implement advertising plan	January-2013	In development	Materials produced and distributed	Medicaid and MDoA will collaborate on further promotion of the 1-800 number and use of the MAP website

<b>A CSA which supports the purposes of determining eligibility, identifying support needs and informing service planning, is used across the State and across a given population. The Level 2 assessment is completed in person, with the assistance of a qualified professional. The CSA must capture the CMS (required domains and topics).</b>					
<b>Core Standardized Assessment (CSA)</b>	Develop questions for the Level 1 screen	March-2012	In development	interRAI-Home Care and phone screen tool	Maryland has chosen to move forward with the interRAI-HC and the accompanying phone screen. Each cover all domains necessary. Maryland Medicaid is developing financial questions within its Office of Eligibility and will include them in the Level 1 screen.
	Fill out CMS crosswalk (see Appendix H) to determine if the State's current assessments include required domains and topics		CMS-approved assessment	interRAI-Home Care	The interRAI-HC covers all domains required within the Balancing Incentive Program manual. Maryland can submit any additional information required.
	Incorporate additional domains and topics if necessary (stakeholder involvement is highly recommended)	January-2013	In development	Automation of interRAI-Home Care	Throughout the automation process, Maryland will host pilot programs throughout the State. During this process, additional information, questions and domains will be added to the tool.
	Train staff members at MAPs to coordinate the CSA	January-2013	In development	Trainings conducted statewide	
	Identify qualified personnel to conduct the CSA	March-2012	Under review	Train all current local health department staff conducting level of care assessments to complete the interRAI-HC.	The State will design and conduct a statewide training for all county health departments and other staff which currently complete nursing facility level of care forms.
	Continual updates	Ongoing	Ongoing		
	<b>States must establish conflict of interest standards for the Level 1 screen, the Level 2 assessment and plan of care processes. An individual's plan of care must be created independently from the availability of funding to provide services.</b>				
<b>Conflict-Free Case Management</b>	Describe current case management system, including conflict-free policies and areas of potential conflict	January-2013	Under review	Report on each agency case management practices.	The State will plan and review each program under the Balancing Incentive Program that will receive an enhanced match and conduct a review of current case management practices.
	Establish protocol for removing conflict of interest	July-2013	Under review	Work Plan to remediate conflict from regulations.	The State will review all regulations that allow for conflict in case management services and remediate each program.
<b>Data</b>	<b>States must report service, outcome and quality measures data to CMS in an accurate and timely manner.</b>				

<b>Collection and Reporting</b>	Identify data collection protocol for service data	July-2013	In development	Static report from LTSS tracking system development.	The State will use MMIS, its current MFP tracking system and the expanded LTSS tracking system being developed to report data on HCBS. The State will use the MMIS system along with the LTSS tracking system to collect service data. Quality and Outcomes data will be deduced from the interRAI assessment.
	Identify data collection protocol for quality data	July-2013	In development	Static report from LTSS tracking system development.	
	Identify data collection protocol for outcome measures	July-2013	In development	Static report from LTSS tracking system development.	
	Report updates to data collection protocol and instances of service data collection	July-2014	In development	Service data report	
	Report updates to data collection protocol and instances of quality data collection	July-2014	In development	Quality data report	
	Report updates to data collection protocol and instances of outcomes measures collection	July-2014	In development	Outcomes data report	
<b>Sustainability</b>	<b>States should identify funding sources that will allow them to build and maintain the required structural changes.</b>				
	Identify funding sources to implement the structural changes	January-2012	Budget request complete	MFP Operational Protocol and use of MFP rebalancing funds approved.	The State will use MFP rebalancing funding for the initial structural changes. The State has requested funding to complete all projects through the duration of the MFP Demonstration.
	Develop sustainability plan	July-2012	In development	Work plan	The State will fund start-up costs for all structural changes through MFP and will use State funding to ensure programs are sustained after implementation.
<b>Exchange IT Coordination</b>	<b>States must make an effort to coordinate their NWD/SEP system with the Health Benefit Exchange IT system.</b>				
	Describe plans to coordinate the NWD/SEP system with the Health Benefit Exchange IT system	July-2012	In development	Work plan with Health Benefit Exchange Board of Trustees	Maryland Medicaid will work with the Health Benefit Exchange Board of Trustees to ensure linkage between the Health Benefit Exchange and the Single Entry Point for LTSS services.
	Provide updates on coordination, including the technological infrastructure	January-2013	Ongoing	Report on collaboration with Health Benefit Exchange Board of Trustees	

# Application Narrative

## **Section A. Understanding of Balancing Incentive Program Objectives**

Maryland has been working for many years to improve the balance of LTSS and enhance home and community-based service options. Along with a State Plan personal care program, Maryland currently has nine home and community-based services waiver programs serving over 25,000 people as an alternative to institutionalization. In 2002 the State legislature passed a Money Follows the Individual policy that allows an individual who is institutionalized to apply for a home and community-based services waiver regardless of budgetary caps on HCBS programs. In 2007, the Department of Health and Mental Hygiene (the Department) successfully applied for the Money Follows the Person Demonstration and has transitioned over 1,160 MFP participants to date. In 2009, a Long Term Care (LTC) Reform Workgroup was established to evaluate options to improve access to and quality of HCBS as institutional alternatives.

In 2010 and 2011, the LTC Reform Workgroup met thirteen times to review the current system, discuss strengths and weaknesses, and make recommendations for reform. The workgroup was made up of 38 members representing advocates, participants in current Medicaid programs, health care professionals, state legislators, local health departments, attorneys, and providers of long term services and supports. The major recommendations were to analyze and pursue opportunities within the Affordable Care Act, develop a participant-friendly point of entry to break down silos between populations and programs, develop a uniform assessment to be used across populations, participate in the extension of the MFP Demonstration, and improve Maryland's capacity to provide increased access to LTSS.

The Department will meet the goals outlined by the LTC Reform Workgroup while also achieving the three primary goals within the Balancing Incentive Program: No Wrong Door/ Single Entry Point (NWD/SEP), core standardized assessment and conflict-free case management. With the structural changes discussed throughout this application, as well as the emphasis and increased availability of providing services in the community, the State will balance its expenditures for LTSS and increase the proportion of spending on HCBS to at least 50 percent. Funding approved by the Centers for Medicare and Medicaid Services (CMS) for the MFP Demonstration is earmarked to fund structural changes while the enhanced match available through the Balancing Incentive Program will further expand community capacity and shift expenditures from institutions to home and community-based services.

### **Commitment to Balancing Incentive Program Goals**

With the support of stakeholders, the Department is committed to fundamentally changing LTSS in the State. Since 2008, Maryland has made great strides to increase transitions from institutions to the community and must now emphasize the importance of not only transitioning residents, but ensuring equal access to home and community-based care prior to entering a facility.

As of December 2011, the MFP Demonstration has transitioned 1,160 people since its inception. While expenditures have increased for people living in the community, they have not kept up with increasing expenditures for nursing facility services. The Department must now focus on equity in access to community LTSS at a person's point of need, not solely after the person has entered a nursing facility or other institution.

The Department is making several shifts in policy based on rebalancing and building further capacity to serve people in the community. Independent of the Balancing Incentive Program, the Department intends to consolidate certain personal care waiver services and the State Plan Personal Care Program into the ACA's Community First Choice program. This change alone will expand access to personal care services for Maryland's citizens and make one program with consistent service delivery.

For the Community First Choice program to be successful, the Department is dedicated to expanding its capacity by embracing Balancing Incentive Program requirements. Without a well-designed and functional single-entry point, access to community services will forever be an afterthought to entering an institution. Maryland Access Point (MAP) sites, federally referred to as Aging and Disability Resource Centers, will constitute the core of the NWD/SEP required by the Balancing Incentive Program. MAP site staff will conduct a screen for Medicaid and non-Medicaid LTSS offered in the State of Maryland as well as any local or county-specific programs. As a one-stop-shop, the MAP site staff will help a person navigate the system and will have knowledge of available services, how to apply for those services and make referrals for to receive those services.

In order to ensure Maryland's citizens access LTSS through each MAP site located statewide, the Department will create a 1-800 number that connects directly to the MAP. Through the 1-800 number, local MAP site staff will complete a telephone screen that will triage a person into LTSS, focusing on person-centered reporting and providing direct access to a functional and financial assessment when appropriate. The use of county-specific staff will aid in helping a person identify various services that are locally funded and geographically accessible to the person. Maryland will conduct extensive advertisement of the 1-800 number as well as outreach in institutions and other programs. Please refer to Section K for more information on outreach and advertising.

For a true NWD, anyone seeking information on LTSS will receive person-centered, in-depth, accurate information from any of the MAP site staff and a direct link to assistance in accessing those needed supports. The MAP site acts as the entry point. An informative MAP website currently exists which allows for a person to find information specific to his or her needs and location.

In addition to the single entry point, the Department has selected a core standardized assessment that will replace current assessment instruments and track data across all populations. The core standardized assessment meets all requirements within the Balancing Incentive Program, gathers the baseline information necessary to prioritize need in the community, and includes algorithms to measure quality of services and successful outcomes over time.

The Department has also begun automating a LTSS tracking system that will combine LTSS participant information under one program. This program will house a general participant profile, history in LTSS, screen, assessment, application information (financial and functional) and all program information for which they are receiving services. The LTSS tracking system is designed so that program staff will have access to appropriate and necessary information to ensure coordination of programs and quality of service delivery. Alerts are needed and sent to pertinent staff regarding a person's path through LTSS.

Overall, the increased role of the NWD/SEP along with increased coordination between screens, assessments and programs aims to reduce institutionalization and improve access to care.

The Department will also review each LTSS program's case management system to identify potential conflicts. This review process will be followed with specific action plans to remediate any identified conflicts. Case management systems will be reviewed during contract renewals to ensure that action plans have successfully been followed to establish conflict-free case management systems. The Department has listed a general timeline for this review within its work plan. This review includes all LTSS programs covered under the appropriate CMS 64 line items including all waivers, case management, PACE, personal care, rehab services and mental health.

The Department is the oversight agency for all Balancing Incentive Program services and structural changes. Through the NWD/SEP development and the development of a LTSS tracking system, the Department will have oversight to ensure completion of Balancing Incentive Program funding tasks within the program period ending September 30, 2015.

## **Section B. Current System's Strengths and Challenges**

Currently, when a person is interested in receiving long term services and supports, they can access services through various programs. Specifically, services cover these populations: people with intellectual disabilities, physical disabilities, mental illness, autism, and older adults.

### **Entering LTSS for Older Adults and Individuals with Disabilities**

The majority of older adults and individuals with disabilities receive services through four major programs: Medical Assistance Personal Care (MAPC) program, the Living at Home (LAH) Waiver, the Waiver for Older Adults (OAW) and the Medical Day Care Waiver. There is also a smaller Waiver for Adults with Traumatic Brain Injury (TBI) and a newly developed Increased Community Services (ICS) program.

The Department is developing a Community First Choice program which will consolidate overlapping services under one program. Each of these programs has different entry points and provides similar, but not identical services.

#### *Medical Assistance Personal Care (MAPC) Program*

The MAPC program is a State Plan service available to all community-eligible Medicaid recipients who need assistance with activities of daily living (ADL). A community eligible Medicaid recipient must meet federal poverty level financial criteria. A recipient must contact the local health department in his or her jurisdiction to access personal care services. A nurse case monitor will conduct an assessment to determine eligibility for the service. A plan of care is developed by the nurse case monitor when a participant is determined eligible. A participant may elect to receive services from an independent personal care provider or through an agency. The nurse case monitor assists the participant with selecting a provider. There are four levels of reimbursement and providers are paid a per diem rate for each level. The level of reimbursement is determined by the nurse case monitor and is not tied to a nursing facility level of care determination.

Some of the current challenges within this program are the per diem rates which are not directly connected to hours and may be inadequate of a person's needs. These rates are also dramatically lower than their waiver program counterparts. This creates an issue with provider capacity as few agency providers will accept the lower MAPC rate. The Department will institute an incremental rate, less than daily, with the inception of the Community First Choice program described later on in this section.

Another concern for this program is that tracking and reporting is mostly paper based and very little, if anything, is entered electronically. A major concern moving forward is the training of staff to use automated systems and the initial upload of paper forms. The MAPC program will become part of the LTSS tracking system to share data and ensure coordination of services.

By the end of the Balancing Incentive period, the MAPC program will be linked to the single entry point and core standardized assessment. With these changes, the Department will be able to collect and compare data across programs and better coordinate care.

#### *Living at Home Waiver*

The Living at Home (LAH) waiver program is a concurrent 1915 b/c waiver that serves adults aged 18 to 64 (or 65 or older if the person has enrolled prior to turning 65) and provides a wide array of HCBS including attendant care, case management, home delivered meals, personal emergency response systems, assistive technology, medical day care, environmental accessibility adaptation and more. LAH participants receive a wider range of services than MAPC participants and their provider reimbursement rates are considerably higher.

LAH waiver participants must meet nursing facility level of care and receive a medical and functional assessment completed by staff from the Adult Evaluation and Review Services (AERS) in one of the 24 local health departments prior to service provision. The Department also maintains a contract with a utilization control agent (UCA), whose function is to determine the functional eligibility for applicants and participants, as well as conduct periodic review of medical records. Using a person centered-planning process, the waiver case manager and the applicant create a waiver plan of service based on the recommendations of the AERS evaluation. The current evaluation instrument will be replaced by the core standardized assessment during the Balancing Incentive Program period. Financial eligibility is completed by the Division of Eligibility Waiver Services (DEWS). This process is updated and tracked in the current LAH tracking system and will continue under the Balancing Incentive Program.

A challenge within this program is the limited access to the program from the community prior to institutionalization. Currently, LAH waiver participants must enter the program from a nursing facility via the Money Follows the Individual policy as the program has reached its capacity for funded waiver slots. A limitation of slots has kept the program from significantly expanding in recent years. There are currently 3,968 people in the community on an interest list for LAH waiver services.

Another challenge is the unequal distribution of service dollars based on the subjectivity of a plan of service. The Department is concerned with inflated plans of service and hours being provided. An objective, standardized assessment will assist in improved resource allocation and relieve some of this concern. The Department is also working on education and technical assistance to program providers developing POS's.

Case management services are provided through a statewide provider for all clients. The Department will be working with the LAH program to ensure any conflicts are identified and mediated.

#### *Older Adults Waiver*

The Older Adults Waiver is another concurrent 1915 b/c waiver that provides personal care, assisted living, medical day care, assistive technology, environmental modifications, personal emergency

response systems, etc, to older adults aged 50 and over. OAW participants may receive either personal care services in the home or reside in an assisted living setting. The waiver is administered by the Maryland Department of Aging (MDoA) under the authority of Medicaid. The service availability under OAW is similar to that of LAH with the addition of assisted living. OAW participants either transition from a Medicaid paid stay in a nursing facility through the “Money Follows the Individual” policy and may apply from a registry on a first-come, first-served basis as attrition slots become available. Registry applicants may reside in the community prior to waiver enrollment.

Like LAH, OAW participants must meet a nursing facility level of care to be in the program and are assessed for medical needs through an evaluation conducted by the AERS program at the local health department. The Department also maintains a contract with a utilization control agent (UCA), whose function is to determine the medical eligibility for applicants and participants, as well as conducts periodic review of medical records. The current AERS evaluation instrument will be replaced by the core standardized assessment. Financial eligibility is completed by the Division of Eligibility Waiver Services (DEWS). This process will continue under the Balancing Incentive program.

Case management services are provided by the Area Agencies on Aging (AAAs) currently. The Department will review case management practices within its work plan and remediate any conflicts after further analysis. In CY 2012, OAW added case management as a waiver service.

Challenges of this program include variability in resource allocation due to multiple case management agencies with varying training and philosophy, and limited slots for community applicants due to funding limitations. There are currently 18,491 people on the interest list for this program.

#### *Medical Day Care Waiver*

The purpose of the Medical Day Care (MDC) Services Waiver is to provide community-eligible Medicaid recipients who require a nursing facility level of care an alternative to institutional care. By offering medical day care, the waiver is able to serve individuals age 16 or older allowing participants to stay connected to family and their community. Each participant has an individualized service plan designed to support their health and safety while remaining cost effective to Medicaid.

Nurses and social workers in the Adult Evaluation and Review Services (AERS) unit within one of the 24 local health departments conduct comprehensive social and medical evaluations of waiver applicants to assess initial eligibility. As in LAH and OAW, a UCA conducts periodic reviews of medical records. The current Plan of Care assessment tool utilized within this program is the Adult Day Care Assessment and Planning System (ADCAPS). A new ADCAPS tool is completed every 90 days. Under the Balancing Incentive Program, MDC would use the core standardized assessment which will replace most sections. Additional sections within the ADCAPS will continue to be used.

MDC providers must be licensed by the DHMH Office of Health Care Quality (OHCQ). Waiver services are approved by Medicaid according to provider standards developed by the program. All waiver services must be authorized through the service plan process.

Eligible individuals are enrolled in the waiver program on a first-come, first-served basis until the annual cap on the unduplicated number of participants or the maximum number of participants on waiver participation is reached. The MDC Waiver has been a consistent way of expanding the availability of community-based care and projects an increase in funded and approved waiver slots each year.

Note: The medical day care service is a covered service under six other HCBS waivers. A recipient's case manager authorizes the service in the six HCBS waivers.

#### *Waiver for Adults with Traumatic Brain Injury (TBI)*

The Mental Hygiene Administration is the administering agency for the Waiver for Adults with Traumatic Brain Injury which provides services if the applicant 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. Services include case management, day habilitation, individual support services, residential habilitation, supported employment, and medical day care. To be eligible, individuals must be between the ages of 22 and 64; be financially eligible for the waiver; and be diagnosed with a traumatic brain injury and need the level of care required to qualify for nursing facility or chronic hospital services.

#### *Increased Community Services (ICS)*

To begin in calendar year 2012, the Department will be creating up to 30 slots to serve those who would otherwise be receiving services in a nursing home. Medicaid will pay for home and community-based services for ICS enrollees up to the amount that was being paid for nursing facility services, after patient resource contributions averaging \$2,200 per participant per month. This program will be inclusive of all services allowed under OAW and LAH waivers.

#### *Community First Choice*

Section 2401 of the Affordable Care Act added a new section 1915(k) to the Social Security Act and created Community First Choice, which offers the option to provide person-centered home and community-based services and supports. This new State Plan option is designed to assist individuals with activities of daily living and health related tasks. Services include voluntary training on how to select, manage, and fire direct care workers; personal emergency backup services; transition costs such as rental and utility deposits, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from an institution to the community; and other supports that can increase independence or substitute for human assistance. CMS offers states a 6 percent increase in Federal Medical Assistance Percentage (FMAP) for services provided under CFC.

The Department developed a proposal to utilize CFC to consolidate, under one State Plan program, personal care services across three existing programs. The existing programs, from which personal care and designated services would be consolidated under this proposal, are the State Plan Medical Assistance Personal Care (MAPC) program, the Living at Home Waiver, and the Older Adults Waiver. The Department will offer all required and optional services allowed under CFC in a self-direction or agency model. Specifically, CFC will offer personal care, personal emergency response systems, voluntary training for participants, transition services, and services that increase independence or substitute for human assistance. This expansion in the current service package for many State Plan-only participants will increase access to vital services that prevent institutionalization and hospitalization.

In addition to services offered under CFC, the Department will also be able to provide enhanced quality assurance, a provider registry, trainings to providers, coordinated rates across programs (including improved rates for current State Plan personal care providers), and an emergency back-up system for personal care. These additional quality measures were supported and recommended by the MFP Workgroup. Initial start-up costs will be paid for using MFP funding and the program will be sustained through the 6 percent enhanced match on CFC services.

A key requirement of the CFC regulations is to establish a Development and Implementation Council that is comprised of a majority of individuals with disabilities, older adults, and their personal representatives. This council offers guidance and consultation to the Department in the development of the program and its implementation. The Department established the council in December of 2011 and began regular meetings with the group in January, 2012. Members of the Long Term Care (LTC) Workgroup and other long term care stakeholders were invited to apply or nominate participants for this Council. The prime function of the council is to develop a statewide self-directed option for personal care services. Self-direction options are very limited under current programs. This represents a major expansion for the State of Maryland in providing person-centered planning and direction of services.

Community First Choice will utilize the core standardized assessment selected. This will allow a comparison between programs as monitoring, quality and outcomes data can be collected and analyzed.

Under the consolidated program, the Department will also mediate any potential issues regarding conflict-free case management in regulations. With the use of a standardized assessment, case managers will be able to focus case management on a plan of care developed by one consistent instrument that generates referrals and service recommendations. This transition will ensure equity between participants with similar needs. However, this may be a major challenge to our current case management system in which case managers in certain programs may have influence on the number of hours of personal care a person receives. The Department will work with stakeholders to determine best practices.

The Balancing Incentive Program enhanced match will be used to ensure rates are consistent during the transition of the programs under CFC. This will increase expenditure to home and community-based services and increase alternatives to institutionalization.

Over the next year, the Department will continue developing the Community First Choice program with the assistance of the implementation council and will submit a State Plan amendment to CMS prior to implementation.

**Table 2.**

Program	Populations Served	Assessment	Balancing Incentive Program Assessment	Date of Transition
MAPC	Aging/Disabled	DHMH 302	interRAI-HC	January 2013
OAW	Aging/Disabled	STEPS / 3871B	interRAI-HC	January 2013
LAH	Aging/Disabled	STEPS	interRAI-HC	January 2013
ICS	Aging/Disabled	STEPS	interRAI-HC	January 2013
CFC	Aging/Disabled		interRAI-HC	July 2013
MDC	Aging/Disabled	3871B / ADCAPS	interRAI-HC	January 2013

*Private Duty Nursing*

Persons exiting a hospital or nursing facility requiring skilled shift-nursing services receive private duty nursing. These services are provided under the Rare and Expensive Case Management (REM) program and the Model Waiver for Fragile Children. For persons 21 and over, PDN is provided through the Rare and Expensive Case Management REM program and for a few adults who turned 21 years old while receiving services through the Model Waiver for Fragile Children. For those 20 and under, PDN is an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program State plan service. Persons entering these programs have significant medical needs but the program does not use a common assessment as other Medicaid LTSS programs. Participants in the Model Waiver require a nursing facility level of care, however REM and EPSDT do not.

By including private duty nursing within the Balancing Incentive Program, the core standardized assessment will be used to track quality and outcomes for many receiving private duty nursing. Certain participants receiving private duty nursing may transfer to different waivers by either “aging out” or improving their condition. Maintaining one core standardized assessment in the LTSS tracking system will help ensure a smooth transition independent of the program a person enters or may transfer into. Currently, the Model Waiver includes participants that complete a Departmental 3871B form which is used in determining nursing facility level of care. This form will become obsolete with the core standardized assessment and the tracking system will capture and track more people receiving LTSS. The Department has a timeline to continue review of PDN services and how these programs will further interact with Balancing Incentive Program requirements.

The Department believes that using a common assessment may lead to a better use of staff and services provided through the private duty nursing program. It will also help to better prepare youth transitioning into waiver programs when they can no longer receive PDN under EPSDT. While many

transition to REM, some do not and plans for these persons should be made well in advance to provide services through another program.

Also, while there are similarities between the services provided by home health aides under private duty nursing and those services provided under personal care, there are distinct rate differences. Using Balancing Incentive Program funding, the Department will establish consistency between these rate structures.

One concern of the Department is the case management process which will be reviewed in 2012 and remodeled based on a work plan.

#### *Program of All-Inclusive Care for the Elderly*

The PACE program in the State of Maryland is based at Johns Hopkins Bayview Medical Center campus. The PACE program provides wrap-around services to aging populations including day care, personal care, nursing care, transportation, meals, medication, and more. The goal of the PACE program is to provide an all-inclusive service package that will sustain a person in the community. To be eligible for the program, a person must meet nursing facility level of care, be over the age of 55 and living in a catchment zone surrounding Johns Hopkins Bayview.

The PACE program uses the 3871B form which is used to determine nursing facility level of care. This form will be replaced by the core standardized assessment. The PACE program also uses a program-specific form. The Department will work with the PACE program on coordinating the new assessment and ensuring that participants in the PACE program do not go through unnecessary assessments.

#### **Entering LTSS for People with Intellectual Disabilities**

The Department is working to integrate key aspects of LTSS to track and compare populations based on similar assessment data. Within one tracking system, the State can also ensure that participants are not receiving unnecessary, duplicative services. The Department will include DDA in all aspects of the development of LTSS tracking system. Coordination of LTSS will improve dramatically based on the Balancing Incentive Program.

The Developmental Disabilities Administration (DDA) operates two LTSS waiver programs, Community Pathways and New Directions, on behalf of Medicaid. DDA has a high proportion of persons who live in the community. Expenditure towards institutionalization is small in comparison. The Department will include a trigger in its screening tool to refer to the DDA for an eligibility determination and services within the waiver or State funded programs.

Currently, DDA has been piloting the Supports Intensity Scale (SIS) throughout the State. DDA will continue this pilot program with funding through the Money Follows the Person (MFP) Demonstration. The DDA began exploring various tools that were being used by other states to assess the level of needs for people with developmental disabilities. After thorough research and analysis of various

assessments, discussions with other States, and discussions with DDA stakeholders, the DDA determined that the SIS was the appropriate tool to pilot. The American Association on Intellectual and Developmental Disabilities (AAIDD)'s web site ([www.aaidd.org](http://www.aaidd.org)) defines the Supports Intensity Scale (SIS) as a tool that "... measures the individual's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports an individual requires. The SIS was designed to be part of person-centered planning processes that help all individuals identify their unique preferences, skills, and life goals." This tool was developed over a five-year period by AAIDD and published in January 2004. 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 information regarding these support needs in these life activities, behavioral and medical areas is gathered during an interview with the person and those who know the person well. The SIS assessment ranks each activity according to how often (*frequency*), how much (*amount*), and what kind (*type*) of support the person needs for that particular activity. These rankings create an overall score based on the person's total support needs. This is a standardized score generated from scores on all of the items assessed by the Scale.

Medicaid will review all assessment options with DDA to ensure collaboration and a coordinated referral process. DDA has been involved with reviewing alternative assessments for intellectual disabilities and the Department has planned a review process for selection. The Department has chosen to move forward with the interRAI-HC tool for the initial screening and for the other targeted populations. The State will explore initial screening data sharing opportunities for people referred to the DDA.

The Department has also planned a review of case management services within the two DDA waiver programs. This service is known as resource coordination. The analysis will be used to assess any remediation that may be necessary to exclude resource coordination agencies from the provision of other services within a participant's plan.

### *New Directions*

The New Directions waiver allows individuals to direct a number of their own services utilizing a Fiscal Management Service (FMS) and support brokerage. The support broker assists the individual in the management of their services and assists the individual to gain skills necessary to manage their own services. Support Brokerage is complementary of Resource Coordination in that it performs more day-to-day program management functions compared to the overarching planning, referral, and quality assurance duties of Resource Coordination. New Directions is offered to individuals statewide and of any age meeting the level of care and financial eligibility criteria.

Services available through New Directions are those services individuals may need to live successfully in their own home or family home. Consumer-directed services include Respite, Supported Employment, Employment Discovery and Customization Services, Community Learning Services, Community Supported Living Arrangements (CSLA), Transportation, Environmental Accessibility Adaptations, Family and Individual Support Services, Transition Services, Support Brokerage, and Assistive Technology and

Adaptive Equipment. Other services available under New Directions include Resource Coordination, Day Habilitation, Medical Day Care and Behavioral Supports.

Individuals, with support from their Resource Coordinator, Support Broker and with the participation of anyone invited by the individual, develop an Individual Plan and Budget, which includes a person-centered plan, individual plan (plan of care), and individual budget. The person-centered plan is the basis of the annual plan of care. A standard methodology is used to determine an individual's overall budget. The individualized budget will be approved by the individual (along with his/her family or guardian, Resource Coordinator, and other team members) and the State.

### *Community Pathways*

Community Pathways covers services such as residential, CSLA, day and supported employment services. Additionally, it covers Family and Individuals Support Services for eligible individuals. Community Pathways covers all age groups and provides services throughout a person's life.

### **Entering LTSS for Mental Health**

Currently in Maryland, separation exists between programs that provide LTSS for older adults and individuals with disabilities and those that receive mental health services, even though overlap exists. Mental health is a major concern for some older adults and individuals with disabilities in Maryland. Without collaboration between population-specific programs, problems of mental health may be ignored or misdiagnosed.

### *Mental Hygiene Administration*

Maryland citizens can self-refer but are generally referred for mental health services through a physician and enter care through ValueOptions, Maryland's entry point for eligibility. Unfortunately, there are system barriers to monitoring services or in developing a continuum of services for dual diagnosis participants. Currently, ValueOptions does not offer a uniform assessment but does other analysis and referral for treatment.

Within the Balancing Incentive Program, the Department will consult with the Mental Hygiene Administration (MHA) and ValueOptions, and review ways to integrate care. To begin, the Department has planned collaborative meetings to pursue a referral process stemming from the no wrong door's screening tool. A person triggering a question regarding needing mental health or psychiatric resources may be referred to ValueOptions. The Department has requested materials on implementing the interRAI-Community Mental Health (CMH). This would give the MHA the ability to collect and organize data in a uniform manner. MHA is not required to use this assessment and the Department will support any decision to collect the required domains within the Balancing Incentive Program.

Currently, only the Psychiatric Rehabilitation Program within MHA uses case management services. These services are guided by Maryland regulations which ensure conflict-free case management. The

Department will work with MHA to review all regulations to ensure compliance. These programs are vital to potential LTSS participants and the ability to access mental health services through a no-wrong door screening tool would help effectively coordinate services. Outpatient services, which make up a significant part of the rehab services on the CMS 64, are also planned for review. The Department will coordinate a review of the assessment and referral process, as well as the case management process.

#### *MFP and Behavioral Health*

In June 2011, MFP contracted with a Behavioral Health Consultant to reconvene and lead the behavioral health workgroup, analyze the gaps in the existing service system, research best practices nationwide, and present recommendations for new services along with an action plan for implementation. The reconvened work group has held several meetings and the consultant is in the process of interviewing state agency representatives, consumers, and advocates for the service system analysis.

In order to provide support at the consumer level, MFP hired a behavioral health specialist to work with MFP applicants, participants, their representatives, and case managers in order to coordinate available mental health services. The specialist also acts as a liaison for MFP with MHA and the local mental health authorities.

#### **Core Standardized Assessment**

The Department currently has a fragmented system of collecting functional assessment information. Under the Balancing Incentive Program, Maryland has selected to use the interRAI-HC assessment and phone screen to satisfy the required domains listed in the Balancing Incentive Program manual. interRAI-HC has been identified by CMS as satisfying these requirements and is used across the United States and the world. As listed above, the core standardized assessment will replace all existing assessments for the older adults and individuals with disabilities. A more in-depth analysis of the selection and planned implementation of the interRAI assessments is listed in Section H.

#### **Conflict-Free Case Management**

The Department understands the need for conflict-free case management. Each program included for enhanced federal match under the Balancing Incentive Program will undergo a review process to analyze the system in place. Specifically, the Department will focus on case management agencies that provide services, staff that conducts eligibility requirements, the process that establishes funding levels and resource allocation for participants and will ensure that persons related to a participant by blood or marriage or who are a paid caregiver are not performing evaluations, assessments or a plan of care for that participant.

The Department has developed a timeline to review each program within its work plan and will complete a report and next steps to ensure any potential problems are resolved within the duration of the Balancing Incentive Program.

### *Eligibility*

Currently, the Department has an explicit separation between its functional eligibility process and the participant. The Department and its utilization control agent determine medical eligibility by reviewing approved Department forms. The implementation of the core standardized assessment will make this process easier by ensuring one, reliable and valid test is completed with an assigned scale to predict nursing facility level of care.

The Department will, however, undergo a process to review its regulations to ensure that family members and paid caregivers abstain from this process when unless absolutely necessary. This may require language revisions.

### *Separation of case management from direct service provision*

Currently the Department is providing case management as a service under various programs. The design of services within a participant's plan of care must match the recommendations and services based off of the assessment. Eliminating conflict of interest from this process will be challenging, however, with the many programmatic changes being implemented the Department believes that they can be easily mediated through program design and regulations.

The Department will closely review case management services, especially in certain rural counties in which a single provider offers both case management and other Medicaid services. The Department will work with rural providers and CMS to ensure that all potential conflicts are reduced or removed and are acceptable for the Balancing Incentive Program.

### *Resource Allocation and Case-Mix*

The Department is interested in using the interRAI-HC assessment to designate a case-mix and provide guidance to the number of hours and dollar amount available for each individual. By using a case-mix option based on Resource Utilization Groups (RUGs), the Department will have an objective method by which to assign hours based on need and will ensure that the per person expenditure would be consistent geographically and across populations.

The RUG grouping for home and community-based services would work similar to the Medicare RUGs system. RUG grouping under the interRAI-HC has already been developed by interRAI and the Department will use the algorithm during automation of the assessment. The Department will then crosswalk each RUG with our current reimbursement methodology to ensure budget neutrality. A person's RUG will also help determine how the Community First Choice program operates its self-direction program for allocating resources.

By moving to a RUG system for home and community-based services, the Department will reduce conflict between a person completing an assessment and the actual resources allocated per person. The current system's assignment of hours is dependent on subjective decisions and leaves potential for

inflated care plans of service. The Department is also considering a time-per-task methodology however time limitations can also be subjective and limiting and would prove hard to implement based on consumer feedback.

The Department acknowledges disconnect between an algorithm's result compared to the outcomes from a person-centered plan of care. Any transition to a system of assigning resources would be accompanied by the development of a person-centered plan of care with the participant to ensure all needs are met.

## **Other Strengths**

### *Legislative and State Agency Leadership*

The Maryland Access Point (MAP), currently led by the Maryland Department of Aging has built support and partnerships with state executive staff and legislators since the program began in 2004. The Governor's budget has provided annual funding of \$250,000 since 2006. Executive staff of the Maryland Departments of Health and Mental Hygiene (Maryland's Medicaid Agency), Disabilities, Human Resources, Housing and Community Development, Education, Veterans Affairs and Aging participate on the State MAP Advisory Board and workgroups. The relationship between the Maryland Medicaid Agency and the MAP program has expanded significantly through the Maryland Money Follows the Person (MFP) Demonstration. The MAP program is a significant component in Maryland's rebalancing efforts and is receiving MFP funding to assist with MFP functions and to support and expand the MAP program. MFP and Medicaid staffs participate on steering committees for all MAP initiatives such as the Person Centered Hospital Discharge Program and the Options Counseling Program.

### *Stakeholder Support*

The MAP State Advisory Board membership includes consumers and stakeholders from the aging and disability networks, e.g. Centers for Independent Living (CILs), Area Agencies on Aging (AAAs), local MAP sites, Behavioral Health and Alzheimer's associations, the Maryland Disability Law Center (Maryland's Protection and Advocacy Agency), Legal Aid, AARP and service providers. The Board meets at least twice annually, and routinely works through special sub-groups to assist in developing new programs and reviewing the MAP operations and strategic plans. The Board members act as ambassadors for the MAP program and attend special MAP events. The MAP program works closely with the MFP stakeholder work group which meets at least monthly with attendance ranging from 34 to 50 consumers, staff, providers, and advocates from the aging and disability networks. MAP grants and projects involve formal, funded relationships between local MAP sites and regional CILs. This pattern of stakeholder involvement is reflected in both the state and local MAP Advisory Boards.

### *Community Input and Support for Long Term Care Reform*

As noted earlier, in 2010 and 2011, the Department hosted a Long Term Care work group of 38 members representing advocates, participants and providers. Including stakeholders in each part of the

process ensures their support and willingness to proceed with major reforms presented to the work group. With feedback given at each meeting, including public comment, the Department is comfortable moving forward with its plan for long term care reform and has full support from advocates, participants and providers.

### *The Maryland Health Benefit Exchange*

The Affordable Care Act (ACA) requires states to either establish and operate a Health Insurance Exchange by 2014 or participate in the federal Exchange. Maryland's Health Benefit Exchange will allow Marylanders to compare rates, benefits, and quality among plans to help individuals and small employers find an insurance product that best suits their needs. Maryland is ahead of most states. We have State legislation to establish the exchange and we are the first Department in the nation to appoint an Exchange board; a step critical to the Affordable Care Act's purpose of putting more Marylanders in charge of their own health care by making health insurance more affordable to many more families.

As a leader in this respect, the Department will ensure that eligibility for Medicaid and Long Term Services and Supports is connected to its single entry point.

### **Challenges**

Collaboration with other administrations is a priority during rebalancing. Maryland's system of LTSS and ensuring citizens get the appropriate services is the paramount goal of any change being implemented. Together with the many changes planned for the older adults and individuals with disabilities, the Department is making it a priority to link services to the developmentally disabled and citizens seeking mental health services. The Department has made initial contact and has been successful in bridging certain gaps in providing a continuum of services for all participants that have existed for decades. During the initial planning stages, the Department will work with representatives from all programs to ensure the screening process includes a referral prompt with contact information to ensure a person gets the right information. As the needs of each person vary, the Department will ensure linkages within the assessment process and ensure that core data on domains is collected.

In particular, the Department has received various complaints regarding the application process for Medicaid. While the Stage 1 process will include help from a Navigator, it is of concern that any extended period of time awaiting application approval will delay vital services for a person in need of immediate care. The Department of Human Resources has been leading a stakeholder group to address these issues and progress is being made. Ensuring timely eligibility determinations is important for people entering LTSS to ensure services begin before a condition or problem worsens.

Another challenge will be the implementation of a core standardized assessment. While the Department is well on its way and has the support of stakeholders, there will be many challenges in the automation, testing and training of staff to implement a new statewide assessment. The Department has a Memorandum of Understanding (MOU) with the Hilltop Institute to ensure automation is tested and completed within a projected timeline before the statewide implementation. The Department also

acknowledges the extent to which all current staff conducting assessments will have to be trained, not only to conduct a new assessment, but also on person-centered planning and entering data into a computer program. The Department will work with its contractor on training staff on new technology, conducting face-to-face statewide training seminars on completing the interRAI screen and assessment, as well as developing an e-training tool. The Department is also aware of potential user availability issues and will work with its contractor on compliance with Section 508 and Web Content Accessibility Guidelines (WCAG).

While the Department of Maryland is a leader in its development of a Health Exchange, we believe it will be a challenge for the Department to ensure connection to LTSS and will maintain close contact with the Exchange Board throughout the development of the exchange. The Department plans to maintain a direct link to LTSS from the exchange.

The majority of waiver programs in the Department of Maryland are consistent with conflict-free case management. The Department however has a set a timeline to review compliance with conflict-free case management in all programs under the Balancing Incentive Program.

## **Section C. No Wrong Door/Single Entry Point - Maryland Access Point**

Maryland is one of 54 states and territories funded by the Administration on Aging (AoA) 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, it is referred to as the Maryland Access Point (MAP)) and is also supported by Department general funds. The goals of MAP are to streamline access to LTSS information and eligibility for 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 local MAP sites including co-location of the different agencies involved in coordinating eligibility for Medicaid services and all Department funded long-term care services. MAP currently has sixteen local operational and developing sites, and will expand to 20 sites providing statewide coverage by July, 2012. Each site will 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 will expand statewide with support from the MFP demonstration and will continue to be an integral part of Maryland's rebalancing efforts.

Maryland's approach to the SEP system is to assure that individuals seeking assistance from historical and traditional entry points either receive the same information from those traditional entry points or are easily connected to a Map Navigator. MAP requires formal partnerships between traditional entry points and designated MAP sites to assure that information is standardized and that "warm hand offs" can be made between MAP partners as appropriate. This No Wrong Door approach assures that regardless of where the person enters the system, they will be assisted by people who can access supports from across programs and agencies. As the screen is transitioned statewide and as the public becomes more familiar and comfortable with the MAP as a single entry point, we expect the majority of requests for information and assistance to be directed to MAP sites. Trainings for MAP site staff will include conducting a screen for all LTSS offered in the State of Maryland as well as any local or county-specific programs. As a one-stop-shop, the MAP site staff will help a person navigate the system and will have knowledge of all available services.

The Department, through training and collaboration with the Centers for Independent Living, will ensure that equal emphasis on serving the aging population as well as people with disabilities. Stakeholder feedback has expressed concern that any major shifts to aging-oriented sites without the necessary training may limit access to people with disabilities. The Department will work with all partners to ensure this does not happen.

While MAP sites are statewide and are accessible to the community, Maryland will be reviewing each site to ensure physical accessibility. Currently, the physical locations that exist are ADA compliant, but all sites are working with their disability partners to assure full accessibility beyond the ADA requirements. Through this analysis, the Department will seek necessary changes for each site. Please see Section J for more information.

The Maryland Department of Aging hosts the MAP website and will continue to maintain the site through their current contract. The website ([www.marylandaccesspoint.info](http://www.marylandaccesspoint.info)) contains state and county-specific information and maintains a resource directory. The website also contains a self-evaluation of needs which refer to county-specific programs. This website will be integrated with the 1-800 number and other Medicaid program information. This integration will ensure that anyone seeking LTSS can review an online directory of services, as well as access a 1-800 number that will begin the eligibility determination and enrollment process.

Local health department AERS staff will conduct the Level 2 assessment. Utilizing a core standardized assessment within one LTSS tracking system, the Department can track the programs each person is entering and follow-up to ensure adequate and appropriate services are being provided. Any duplicate files, services or applications will be limited with this information consolidated into one system. The Level 2 assessment will help focus the development of a plan of care, allocate resources and function as the Department's nursing facility level of care assessment tool. Having assessment information as well as nursing facility level of care determinations in one tracking system will enable streamlined transitions to a program without duplicative efforts that are currently made by various program and nursing facility staff.

The assessment will also ensure that State-only funds are allocated more effectively. The interRAI assessment will identify those people with a high risk of entering an institution. Using this information, MAP staff will be able to refer a person to various programs that may benefit them outside of Medical Assistance.

## **Section D. No wrong door/Single entry point Person Flow**

In Maryland's NWD/SEP process, all persons interested in LTSS will enter in the same manner and receive the same information regarding Medicaid services independent of where they are calling from. Maryland Medicaid will be the Oversight Agency while delegating the operation of the MAP sites to the Maryland Department of Aging.

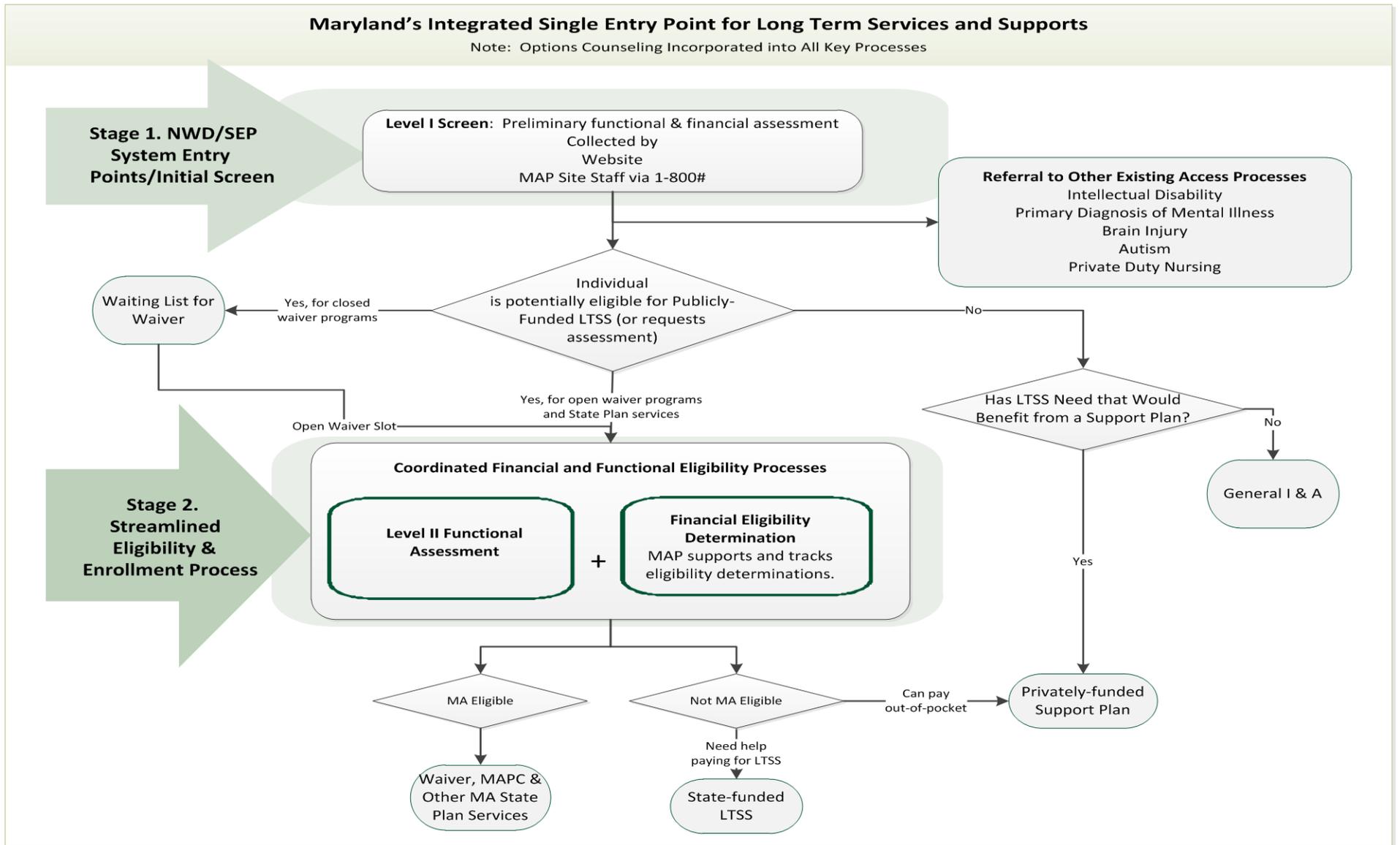
Through the use of a "navigator" system, MAP site staff conducting Level 1 screens will guide the individual throughout the process of entering a LTSS program. Using one tracking system, the navigator and program staff will be able to understand where the person is in the system and track updates. If the person needs additional services, their files will be maintained and updated accordingly. This ensures that the person only has to tell their story once.

### **Stage 1. The MAP Site**

Maryland is developing a system in which any person can get access to state and local programs by making one phone call. It is important for Maryland's citizens that the person they contact on the phone is familiar with the county in which the person lives. We plan on directing all 1-800 number calls to the appropriate county MAP site. Currently one county is running a pilot Options Counseling program in which the person at the MAP site will complete a survey and act as a Navigator through the system. The Department will expand this partnership with the MAP sites and design a consistent statewide process. By the end of implementation, a person will be able to contact a Navigator in their own county and receive immediate referrals, a screen for additional Medicaid services and help with applying for Medicaid eligibility or for a waiver. Figure 1 shows the person flow for entering the system.

When calling a Navigator, a person will have a guided conversation about their current situation to ensure the screen captures the true needs of the individual. Navigators will undertake a day-long training on how to conduct the conversation and complete the screen associated with it. An important aspect of having a single entry point is the ability for anyone to contact the 1-800 line and be directed to the right place. During our review of potential screens, we wanted to ensure that people that have mental health diagnoses, intellectual disabilities, brain injuries, or that may qualify for another waiver not intended for a nursing facility population, receive a proper referral that will get them services as soon as possible. Triggers are laid out within the Level 1 screen to ensure referrals and all Navigators will be equipped with the correct contact information for all such referrals.

Figure 1.



In addition to the screen, the Navigator will request certain financial information to determine how to refer the person. The Maryland Department of Aging currently collects financial information that has been vetted through a stakeholder process that the Department may use to help in referrals. The Department has developed draft financial questions with its Office of Eligibility to ensure that a person receives assistance to complete the correct application when necessary.

Maryland will host day-long trainings for each region or specific MAP site (dependent on size and location of the site(s)) to ensure that each Navigator is knowledgeable about the services they are referring to and will be able to complete a screen electronically. Our goal is to be able to conduct a screen within a 15-minute phone conversation.

Navigators will be able to track the process for the person entering care. For instance, a navigator would not be able to review specific financial or medical conditions of a person because it is not appropriate to grant them this access to private information. The goal is for the Navigator to be the point of contact to ensure that a person does not “fall through the cracks.” For a person requesting additional information, applying for a waiver, submitting financial eligibility information for Medicaid or a current Medicaid participant trying to access a new program, they will have one phone number to contact. The Department has also ensured that within its tracking system, all MAP site staff will have access to necessary information on each client within their jurisdiction in case a person’s Navigator is not available.

The tracking system will contain both the Level 1 screen and the Level 2 assessment. These tools complement each other and will be on the same technology platform to ensure that a screen can pre-populate the assessment so that an individual will not have to answer duplicate, time-consuming questions. Security and Health Insurance Portability and Accountability Act (HIPAA) compliance is of high concern for the Department. We are working with a contractor to allow levels of access for each participant record dependent on the minimum necessary information to ensure high quality of care.

## **Stage 2. Streamlined Eligibility and Enrollment**

Once the person has completed the first stage, a few things may happen:

*1. The person has ADL /IADL needs, appears to be financially eligible for a waiver, but not financially eligible for Community Medicaid.*

If, after completing the screen, the person has ADL/IADL needs, does not meet community Medicaid financial eligibility but may meet waiver financial eligibility, the person will be assigned to a waiting list for additional waiver slot availability. The waiting list will be prioritized based on need. People with higher needs will be prioritized first. The Department, through a contractor, will maintain the waiting list. When a waiver slot becomes available, the contractor will contact the person to verify their continued interest and refer for a full assessment. Once a person is called upon from the waiting list, they will apply for a waiver and receive application assistance.

The Department cannot deny a person their right to apply immediately to join a waiver, however they will be informed that without being called upon from the waiting list, they will not be approved for a waiver.

*2. The person has few or no ADL needs and does not appear to be financially eligible for waiver or community Medicaid eligibility.*

The Navigator will be able to tell the person that they do not appear to be qualified to receive additional assistance from the State at that time, however they may choose to remain on the waiting list. The Navigator will have knowledge of State-only programs and other resources, including private pay, which may be of assistance to the person. The Navigator will give information and assistance as necessary and appropriate.

*3. The person has ADL/IADL needs and is currently community Medicaid eligible.*

If a person has a Medicaid ID, the Navigator can call the Maryland eligibility verification system hotline 24/7 and determine if they are eligible to receive State Plan services. If a person is community Medicaid eligible, they will be directly referred to the local health department for follow-up and a Level 2 assessment. They may also be referred for MDC waiver if they meet NF LOC. They may receive all State Plan services, including personal care through the MAPC program. The Department's intent is to replace the MAPC program with the Community First Choice program in July 2013, until then, a person will be referred to the existing MAPC program. A person enters the MAPC program through the local health department.

*4. The person has ADL/IADL needs and appears to be community Medicaid eligible but has not applied.*

If the person appears to meet financial criteria but has not applied for Medicaid, the Navigator will direct them to the Maryland Service Access and Information Link (SAIL) website, hosted by the Department of Social Services. The SAIL website is an online portal that a person can complete and submit an application for Medicaid eligibility. The Navigator will assist the person in completing the form. Once the person is approved for Medicaid, they will be eligible to receive all State Plan services described above. If the person is denied, the person will remain on the waiting list for waiver services and receive other information and assistance as necessary and appropriate.

*5. The person has ADL/IADL needs and is currently community Medicaid eligible, but also requests to be included in the waiver waiting list to receive additional services.*

The current State Plan Personal Care program does not offer services beyond personal care. The Department intends to implement the Community First Choice program and include additional services. At this time it may make sense for someone to also request to be put onto a waiver waiting list while receiving State Plan Personal Care. When that person is selected from the waiting list, the person will apply for financial eligibility and receive an updated assessment.

*6. The person's responses trigger a referral to an alternative program.*

Within the screen, certain questions will trigger a referral for alternative services such as mental health, intellectual disabilities, brain injury, autism or private duty nursing. If any of these are triggered by answers given in the screen, a protocol will appear at the end of the screening with specific instructions and contact information for the referral. This will make it easy for a Navigator to ensure that the person is directed to the right place with the right contact information. The Department will work with each program it will be referring to in order to maintain a collaborative approach to providing services and link the tracking system when appropriate.

*7. The person is in an institution and wants to transition into HCBS.*

The Money Follows the Person Options Counseling program works within institutions to transition people into HCBS. Currently, a person entering the system from an institution can move into a waiver directly. This person would only complete State 2 of the person-flow process shown in Figure 1.

**Final Eligibility Determination**

Within the tracking system, the Department, as well as case managers, nurse monitors and agencies completing assessments can track financial and functional assessment status for waiver applicants as well as client history. While financial and functional assessments occur on a parallel track, it is important to know the status at each stage of the process. The Division of Eligibility Waiver Services (DEWS) conducts the financial eligibility determination for waiver applicants only after technical eligibility has been met. Throughout the process, they can send alerts and updates in the tracking system acknowledging each step they are taking until a final decision is made.

An AERS evaluation is triggered each time a waiver application is being processed, at the annual waiver redetermination, or when a person in the community requests additional services based on a physical or cognitive need. These divisions are currently staffed and trained accordingly to complete an evaluation and will transition to the interRAI-HC when it has been automated within the tracking system and pilot programs are completed.

For those participants receiving Community Medicaid, eligibility status is updated in the Medicaid Management Information System (MMIS) and can be checked through the Eligibility Verification System (EVS). Once approved, no additional applications are necessary and the participant can begin receiving MAPC State Plan services through their local health department. The tracking system being developed will be linked to the MMIS system. Certain fields are pre-populated within the tracking system to reduce data entry when it is unnecessary and improve coordination with other Maryland information systems.

## **Section E. NWD/SEP Data Flow**

Maryland will use an automated, state-wide, secure, web-based tracking system to house information. The tracking system will contain both the Level 1 screen and the Level 2 assessment. These tools complement each other and will be on the same technology platform to ensure that a screen can pre-populate the assessment. Security and Health Insurance Portability and Accountability Act (HIPAA) compliance is of high concern for the Department. We are working with a contractor to allow levels of access for each participant record dependent on the minimum necessary information to ensure high quality of care.

The interRAI assessment will be used as the standard for all nursing facility level of care determinations. This will mean utilizing the interRAI tool and may include certain additional questions that are specific to someone living in an institution. The goal of integrating the two systems is to better identify those residents who may be able to move back to the community and to use any existing history and background information to develop a plan of care. The Department believes that the more integrated and consistent the system is, the more likely it is for people to easily transition back into the community.

### **Eligibility Determinations**

As a person enters a State Plan service or is approved functionally or financially, an update is entered in the tracking system and alerts are given to the appropriate program. This ensures that once eligibility is determined, a person will begin services immediately.

The interRAI-HC and the federally-mandated MDS 3.0 information already collected by nursing facilities contain the same core questions and the Department will work with its contractor to alleviate any duplication of reporting by pre-populating assessments. Currently, the Hilltop Institute is contracted to complete the tracking system. Hilltop has access to Maryland MMIS as well as a data use agreement with CMS through the Maryland Office of Health Care Quality for MDS data. Linking these databases will ensure the tracking system is used to its fullest extent possible.

Specifically, the automated system will be designed to track and record services, quality and outcomes data.

### **Services Data**

Service data is currently collected in the Medicaid Management Information System (MMIS) and will be available through the tracking system. Of specific importance to the Department, is the ability to use data recorded in the tracking system and create program specific as well as all LTSS reports. This encounter data will be used to trend service delivery. The LTSS tracking system will be populated by MAP sites, local health departments, the Department and program staff as well as the MMIS system and a call-in system for service providers to collect electronic timesheets. Through MMIS and the LTSS tracking system, Maryland will be able to generate service reports for all aspects of care.

## **Quality Data**

The Department will review the Medicaid Adult Health Quality Measures and ensure that a quality indicator report will be developed by the tracking system. The interRAI assessment consists of quality indicators within its algorithm and this information will be used to measure quality and investigate providers with participants where quality of care issues have been identified.

A significant benefit from implementing a call-in program for service provision is also the assurance that all providers are entering and exiting a participant's home and adhering to the participant's plan of care. This data will be stored in the LTSS tracking system and used when reviewing service delivery.

## **Outcome Measures**

The interRAI assessment will be the only assessment used to determine nursing facility level of care and will be required annually. The Department will be able to track characteristics of and outcomes for each participant and ensure those people with deteriorating conditions over time have their problems addressed. State reports as well as ad hoc reports are available under a reporting database linked to the tracking system can be trended and assessed.

## **Section F. Potential Automation of Initial Assessment**

As mentioned in Section E, the Department will use a state-wide tracking system for the collection of all assessment information. Currently, the MAP website contains a section entitled “Assess Your Needs” in which a person can enter certain data and have access to a resource directory specific to the needs they entered. Initial changes for the website however include the addition of a 1-800 number that is clearly presented on the MAP website homepage. The Department will also seek to add a “request for more information” entry form. This will allow a person to enter his or her name and zip code and be contacted by MAP staff that will assist them in information and assistance, referrals to non-MA services, and a screen for additional services or placement onto the waiver waiting list.

In accordance with recommendations from CMS, the Department will develop a plan to collect certain screening criteria from the MAP website. This would offer Maryland residents a 24/7 option to not only find resources (which is currently available) but also to submit initial data that may populate the screen. Several challenges exist with duplicating data and verifying accurate completion of a screen. The Department will work with its contractors within the Balancing Incentive Program timeframe to determine the feasibility of this option.

## **Section G. Potential Automation of Core Standardized Assessment**

As stated in section E and F, Maryland will use an automated, state-wide, secure, web-based tracking system to house information. The tracking system will contain both the Level 1 screen and the Level 2 assessment. These tools complement each other and will be on the same technology platform to ensure that a screen can pre-populate the assessment so that an individual will not have to answer duplicate, time-consuming questions.

The interRAI assessment will be used as the standard for all nursing facility level of care determinations in both the community and in nursing facilities. As mentioned in Section E., integrating nursing facility Minimum Data Set (MDS) information with the LTSS tracking system will better identify those residents who may be able to move back to the community. The interRAI-HC and the MDS utilize the same questions for much of the assessments and the Department will ensure collaboration between the two systems. All nursing facility residents and HCBS participants would already have a history and background information within the LTSS tracking system from MDS data submitted by a facility or through the assessment given by a local health department. The Department believes that the more integrated and consistent the system is, the more likely it is for the Department to identify people who can move back into the community.

The Department will seek to procure and purchase tablet computers for all local health department nurses and social workers responsible for completing interRAI assessments in the community. The tablet would be linked to a web-based program, which will also be available offline in case internet service is not available. When service is available, the assessment will be uploaded in real time for immediate review. The Department has already discussed with its contractor that the tracking system created must be compliant with software available on a tablet. The Department will identify the costs of purchasing and maintenance of the tablets.

The main challenges to implementation of a new assessment with automation are testing and training. During the pilot of the interRAI assessment, the Department will conduct extensive training and refine the process further based on stakeholder input. Many local health department providers may need extensive training on the use of a tablet or computer software. The Department also acknowledges that the current State Plan Personal Care program is largely a paper process and the implementation of an all-electronic system will result in extensive training needs in addition to the time it will take to input existing data.

## **Section H. Incorporation of a CSA in the Eligibility Determination Process**

### **Current Assessments**

Under the current programs, various assessments exist and many overlap certain domains but are not inclusive of all Balancing Incentive Program requirements.

The Department's 3871 and 3871B forms are used primarily in the determination of a nursing facility level of care. These are completed for a variety of programs that require nursing facility level of care (Medical Day Care, Model Waiver, PACE, Living at Home, Older Adults Waiver, Traumatic Brain Injury) and are reviewed by the Department's utilization control agent (UCA). Nursing facility level of care is not determined based on a scale or the answer to specific questions. The Department has released transmittals giving specific guidance on how to determine a recipient's level of care based on their assessed functional (ADL and IADL), cognitive, behavioral and medical needs.

The State-wide Evaluation and Planning Services (STEPS) evaluation is completed by local health departments for several home and community-based waivers including the Living at Home Waiver, Older Adults Waiver. This evaluation is a comprehensive assessment that assists with developing plans of care in the community. It includes information on the individual's performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLS). This instrument is not used to determine nursing facility level of care.

As noted in Section B, the Developmental Disabilities Administration (DDA) is currently piloting the Supports Intensity Scale (SIS). The SIS has been recommended by Mission Analytics Group as meeting all requirements under the Balancing Incentive Program. The Department is working with DDA to ensure full adoption of an approved standardized assessment and will work on integrating the LTSS tracking system to ensure collaboration.

Nursing facility level of care is not required for a MAPC program recipient. The MAPC program uses the DHMH 302 form to assess a recipient's functional, cognitive, behavioral and medical needs. The Department plans to assess a MAPC recipient's need with using the core standardized assessment tool.

Other State-only programs such as Senior Care and the In-Home Aide Services use the STEPS and the 515B form, which is similar to the STEPS assessment, respectively. The Department will work with agencies in which the STEPS assessment is being used and plan a transition to the core standardized assessment within the LTSS tracking system.

The Mental Hygiene Administration, through ValueOptions, does not offer a uniform assessment but does other analysis and referral for treatment. The Department understands the varying needs of people accessing mental health services and will work with the Mental Hygiene Administration to determine a standardized assessment that will work best for their populations. Currently, the Department plans on working on the potential adoption of the interRAI-Community Mental Health assessment and integrating it within the LTSS tracking system.

For children and adults receiving private duty nursing services, each case management agency has developed their own assessment which requires approval upon completion. The Department will be reviewing the assessment process for private duty nursing and evaluating steps to implement the core standardized assessment.

### **Core Standardized Assessment**

The LTC Reform work group recommended that a uniform clinical assessment tool may be one way to help Maryland improve access to services. In 2011, the Department hired two additional staff to work on the review, analysis and implementation of a core standardized assessment. Using information gathered from the Balancing Incentive Program manual and other sources, staff reviewed multiple assessment tools and presented findings at two public comment meetings. The meetings were made available statewide through a webinar and video conference hosted at 7 local health departments around the state. Local health departments (including nurses and social workers), advocates and participants in programs all received an analysis of three tools that the Department determined were most advantageous: interRAI, the Minnesota MN Choices and the Supports Intensity Scale (SIS).

As well as completing extensive literature reviews and collecting information on each assessment, the Department invited Dr. Brant Fries, the founder of interRAI and a professor at the University of Michigan, to present interRAI's work regarding clinical assessment tools in both 2010 and 2011. Dr. Fries has spent a great deal of time developing assessment tools to use across various settings. Specifically, the interRAI-HC (home care) assessment tool has been validated by an international panel of experts and is being used, in some form, by numerous U.S. states and in over 30 countries.

The Department also reviewed the MN Choices assessment and discussed the strategies taken to implement the assessment with HCBS Strategies, Inc. on the creation and development of the assessment. HCBS Strategies worked with Minnesota on the crosswalk between their current assessment process as well as the transition to a new system.

Through public comment, the Department collected recommendations from stakeholders regarding concerns about moving to a new assessment, the referral process from a Level 1 screen to a Level 2 assessment, and certain sets of questions that should be considered for inclusion in a final tool (e.g., brain injury, caregiver needs assessment, mental health, and substance abuse). The advantage of interRAI compared to other available assessment tools is that interRAI has been validated through meticulous research. It would permit Maryland to compare its population against people in other states that use this model. InterRAI also shares common data elements with the Minimum Data Set (MDS), which means there is consistency between nursing home assessments and community-based assessments. This allows the Department to compare participant needs across settings.

A major concern is altering the current standards to meet medical eligibility. The Department has developed an Assessment Workgroup of doctors, nurses and our utilization control agent (a hired contractor that determines nursing facility level of care and handles appeals) to ensure that the change in assessments will have minimal impact on medical eligibility. Maryland will maintain its current

medical eligibility requirements and will also work with stakeholders to ensure acceptance of the interRAI-HC tool. The Workgroup will be responsible for implementing the core standardized assessment. Currently the workgroup is performing a cross-walk with the interRAI-HC tool and all assessment tools used in various programs.

In addition to the assessment workgroup, the Department will schedule public meetings to review the assessment with plans to pilot. The interRAI tool has also been adapted into a phone screen which would act as a Level 1 screen for the State. The Department has conducted phone interviews with New Jersey, Michigan, Arkansas and Louisiana and has been in consistent contact with South Dakota regarding their uses of the phone screen. We are confident the implementation of the phone screen will be successful based on each state's experiences.

The Department will move forward with the interRAI-HC tool based on its reliability and validity across populations. The Department was pleased with its replication across various states and countries and acknowledges the pitfalls of a homegrown assessment in both time required for development and automation. The interRAI-HC tool was evaluated by Mission Analytics Group and was determined to meet all required domains set forth in the Balancing Incentive Program manual.

Measures will be instituted to maintain nursing facility level of care determinants. Both the Level 1 phone screen scoring and training will also be determined by this group.

A pilot workgroup, consisting of many of the same people, has also been established to focus both on the Level 1 screen and the Level 2 assessment. The Department is working with the Hilltop Institute to track and record data as well as discussing policy and research decisions on designing the pilot. Considerations for which counties are chosen will include MAP staffing and AERS staffing availability and willingness to participate, as well as population size as it relates to reliability and validity. The pilot will begin with a paper version of the Level 1 phone screen and information gathered from the Level 2 assessment will be organized in Excel before being transferred to the completed tracking system. To minimize discrepancies, training for both the Level 1 screen and Level 2 assessment will be developed by June 2012 and will be delivered to pilot locations together. Each pilot program will ensure that training of staff is successful and that people that are being assessed for a nursing facility level of care determination receive the same results using both the existing assessments and the interRAI tool. Methods to gather data for testing purposes and quality assurance will be built into the tool. A Beta version of the test will be tested prior to the Implementation of the new instrument in January, 2013.

## **Section I. Staff Qualifications and Training**

Currently, MDoA is piloting an Options Counseling program in Howard County, Maryland. This Options Counseling pilot contains the guiding principles for which the single-entry point will look like statewide. MDoA has created a training program that teaches MAP staff to conduct a conversation with a person seeking additional LTSS information and assistance/referral. The MAP staff within the Options Counseling pilot currently complete a homegrown screening tool including certain financial information. The results of this screen are not connected with the Medicaid program, however the Options Counseling program will adopt the interRAI screen with financial indicators once it is automated. Using the existing training and the pre-trained staff for a similar purpose will help ease the State into a functional single-entry point that uses the Level 1 screen. The Department will incorporate partnerships with other agencies to ensure adequate training on both aging and people with disabilities.

After piloting the program in select counties, the Department will conduct face-to-face statewide trainings for each MAP site and will seek to develop an e-training in which ongoing training could occur year round. The Department acknowledges that this process may be time-consuming and will plan a phase-in of the training to each county dependent on the qualifications and current training level of the MAP staff. The Department will develop training curricula for all potential staff completing the screen and assessment, establish minimum educational or experience requirements and will determine other requirements such as being AIRS (Alliance of Information and Referral Services) certified.

The Department must also train local health department AERS staff to conduct the interRAI assessment and complete it electronically. Staff currently conducting assessments are licensed nurses and/or social workers who have experience completing assessments. These staff will continue to conduct the assessment process and the Department will confirm all regulations regarding minimum educational and experience requirements. The Department will develop an e-training, manual for completion as well as host face-to-face trainings statewide. The training will be modeled after other states. All new staff at the local health department who complete the assessment will be required to complete this training and meet minimum qualifications. It is the Department's goal to phase-in the assessment during initial application of new participants or at a person's scheduled annual assessment. The Department will complete a random sample review to ensure quality and accuracy of assessments. Through the LTSS tracking system, the Department will be able to identify those jurisdictions with anomalies in their submissions. This will help ensure quality and that accurate data are submitted.

One of the most important aspects of implementing the interRAI-HC assessment is objectively determining nursing facility level of care based on current standards. Guidelines exist in which staff from the Department's utilization control agent and Departmental doctors determine nursing facility level of care. Translating these guidelines to specific questions that can be objectively answered within the interRAI assessment is important to ensure consistency during the transition. Nursing facility level of care determinations will be scrutinized during the piloting of the assessment. Accurate and reliable completion of each assessment is of utmost importance. The goal of the interRAI-HC assessment is to make determinations for nursing facility level of care that are above a certain threshold based on

Department guidance on meeting nursing facility level of care. In addition, those scores that are within a range that may meet nursing facility level of care will be reviewed by the Department or its contractor. Any assessment not meeting these standards will be denied, however, the person will be made aware of an appeal process to submit further documentation.

**Section J. Location of SEP Agencies**

MAP is Maryland’s version of an Aging and Disability Resource Center (ADRC), an effort co-sponsored by CMS and the Administration on Aging (AoA). AoA has established a set of guidelines that they define as a “fully-functioning ADRC.” The Maryland Department of Aging (MDoA) is required to meet these criteria as a condition of a current grant and for future AoA grants. The Department contracted with HCBS Strategies to assist in developing strategic plans for the integration of the Money Follows the Person (MFP) initiative within the MAP system infrastructure. MAP locations as of January 2012 are listed below.

Core MDoA expectations for MAP sites include the following:

- MAP sites must establish formal partnership agreements with governmental and non-governmental disability service agencies. MDoA requires that the MAP provides funding to non-governmental disability agencies for MAP related services.
- MAP sites must review, update, and cleanse data in the statewide MAP website and both MAP and partner agency staff should use the website as part of the information and assistance functions.
- MAPs and partner agencies should provide person-centered options counseling, including applying Department standards when they are developed.
- MAP sites must have a MAP brochure and a dedicated phone line and participate in statewide effort to market MAP.

Table 3 shows all counties within the State of Maryland and their current MAP status.

**Table 3.**

County	Active MAP Sites	ADA Compliant Building	Distance - Public Transport	Outreach Centers
Allegany County	Allegany Human Resources Development Commission, a non-profit Community Action agency	Yes	In front of building	Yes
Anne Arundel	Anne Arundel County Department of Aging and Disabilities	Yes	Local transit in front of building	Yes
Baltimore City	Office of Aging and Care Services and the Division of Advocacy Services within the Baltimore City Health Department	Yes	15 feet in front of building	Yes
Baltimore County	Baltimore County Department of Aging	Yes – updating signs	0.3 miles from bus stop	No
Calvert County	Calvert County Office on Aging which is part of the Department of Community Resources.	Yes	In front of building	Yes
Carroll County	Carroll County Department of Citizen Services; Carroll County Bureau of Aging & Disabilities	Yes	Local transit – Front door	Yes
Cecil County	Application Pending	Yes	Public transport	Yes

			stop	
Charles County	Charles County Aging and Senior Programs which is part of the Department of Community Services	Yes	On transit route, can wait indoors	Yes – Tentative locations
Frederick County	Frederick County Dept. of Aging within the County Citizen Services Division	Yes	100 Yards, Para-transit front door, curb cutouts	Yes
Garrett County	Garrett County Community Action Committee, private non-profit which acts as the AAA for the county	Yes	Door to door transit	Yes
Harford County	Harford County Office on Aging, a division of the Department of Community Services	Yes	Public transit curbside	No
Howard County	Howard County Office on Aging within Department of Citizen Services	Yes, Outreach as well	On bus route, Para-transit front door, curb cutouts	Yes
Somerset, Wicomico, Dorchester Counties	MAC (Maintaining Active Citizens) Inc., a separate non-profit agency	Yes	On bus route	No
Montgomery County	MAP is within the Department of Health and Human Services and the unit that manages it is Senior Community Services in Aging and Disability Services in the Department of Health and Human Services, which is a county agency.	Yes	Couple hundred feet	Yes
Prince Georges County	Prince Georges County Aging Services Division, within the Department of Family Services	Installing automatic doors and will be ADA compliant.	In front of building (30 yards)	Yes
Queen Anne's County	Queen Anne's County AAA within Department of Community Service	Yes	On bus route, Can wait indoors	No
St. Mary's County	St. Mary's County Department of Aging	Yes	Next to building	No
Washington County	Washington County Commission on Aging, a separate non-profit agency	Yes	Public transit across street	Yes
Worcester County	MAP falls under three entities Worcester Commission on Aging, Health Department, and DSS. Also works with MAC Inc.	Yes	20 Yards	Yes
Caroline, Kent and Talbot Counties	Upper Shore Aging, Inc. a separate non-profit agency	Yes	Clients transported by Contractor	Yes (Caroline and Kent Counties); No (Talbot County)

Each MAP should have a single clearly identifiable telephone number, sufficient capacity to handle call volume, and mechanisms for individuals to leave messages. More advanced ADRCs also have automated call distribution (ACD) telephone systems that are set up to track call volume, length, and the number of dropped calls. This information can be used to improve operations. In almost all cases, the active and developing MAPs reported having sufficient capacity to handle the number of calls they received and were able to receive messages during off hours. A single statewide 800 number will be prominently featured on the MAP website and serve to meet single entry point standards. The intention is that callers to this number will be routed to the local MAP site.

At this time, there are sixteen local MAP sites covering twenty jurisdictions and 90percent of the State's population. Applications are pending from four additional counties (Garrett, Cecil, Calvert and St. Mary's) which will make twenty MAP sites covering all 24 of Maryland's jurisdictions by the end of FY 2012. Fourteen counties have a MAP site within the county, typically located within the AAA (Worcester MAP located at the local health department). Dorchester, Somerset and Wicomico counties are served by MAC (Maintaining Active Citizens) Inc., a separate non-profit agency located in Wicomico County; Caroline, Kent and Talbot Counties are served by the Upper Shore Aging, Inc. a separate non-profit agency located in Kent County.

## **Section K. Outreach and Advertising**

### **General Outreach**

Programs throughout the state, especially Area Agencies on Aging (AAAs) have extensive outreach efforts including participation in health and senior fairs, presentations to local groups, newspaper and television advertisements and columns/programs. The active MAP sites included MAP as the central part of these communications. The Department and MDoA will continue to reinforce the message that MAP should be the central component of outreach efforts.

### **Linkages to Hospitals and Hospital Discharge Planners**

Hospital stays are often a major pathway to long term supportive services. The Hilltop Institute reported that 70 percent of nursing facility admissions came from a hospital. Individuals leaving a hospital after events such as a stroke or breaking a bone often need LTSS. Thus, it is important that MAP sites have working relationships with hospital staff, especially hospital discharge planners so that they will make referrals for MAP services. The degree to which the MAP sites have established linkages to hospitals varies statewide. Some sites are educating hospital discharge planners about MAP services on a regular basis, while others had more informal linkages with hospital staff. Some of the MAP sites participate in the Person-Centered Hospital Discharge Planning effort. Under this effort, these MAPs had staff that were co-located or regularly visited the hospitals to identify individuals who could benefit from MAP services and to provide on-going case management and support services upon discharge.

The Department will emphasize the need to work with hospital discharge planners and will encourage sites to provide regular training to hospital discharge planners about MAP services. The Department will seek to adopt a formal process for hospital discharge planners to refer for home and community-based services and may include a portion of the automation of its tracking system to include hospital discharges. This will help demonstrate how MAP services and the single entry point has affected key outcomes, such as streamlining the discharge process preventing readmissions and avoiding discharges to nursing homes that can result in long term stays in nursing homes.

### **Linkages to Nursing Facilities**

The Peer Outreach component of Maryland's MFP effort is linking many nursing facility residents with MFP options counseling and other MAP services. In addition, Maryland is developing and implementing plans to use data from the MDS Section Q to identify additional residents who want to receive information on returning to the community. Section Q addresses the resident's desire to return to the community. Currently, nursing facilities should be manually referring residents who are interested in exploring community options to the local AAAs. The Department is in the process of building a system in which these data would automatically be electronically referred.

The AAAs all have relationships with the nursing facilities in their areas. The most frequent point of contact is through the Ombudsman and many of the information and assistance staff that are more closely associated with the MAP effort have working relationships with nursing facility social workers that also result in referrals.

HCBS Strategies has recommended that the Department establish a mandatory preadmission counseling program. Under this program, nursing facilities would be required to make a referral to the MAP site for all individuals inquiring about residency and could significantly increase the volume of referrals received by the MAPs. The Department will consider such action in the future to ensure that all Maryland citizens entering a nursing facility are aware of their home and community-based service options.

### **Money Follows the Person - Outreach and Marketing**

The Department is implementing 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, nor will the Department target individuals based on length of stay. Everyone in a facility should have the opportunity to explore options for receiving services in the community.

The Department will provide ongoing outreach via peer supports contracts that will reach all institutions, residents, and staff. The Maryland Department of Disabilities (MDOD) will lead the peer supports efforts for people in nursing facilities. Peer support includes peers developing relationships in nursing facilities with residents, family members, nursing staff, social workers, administrators, and family and resident councils. Peers will refer interested individuals to options counseling and, at the request of the individual, will maintain relationships throughout the application process for Home and Community-Based Services. Peers will work with institutional residents, family members, guardians, and facility staff. Outreach will be provided through marketing materials developed by the Department 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 Network newsletters, and through Department-sponsored trainings for providers. The Department will develop alternative formats for all MFP outreach materials and other MFP materials as requested, including audio recordings, captioning, large print, and electronic versions. 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. The Department will partner with the MAP program to ensure that MFP related materials are accessible through local MAP sites and the MAP website.

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.

## **Section L. Funding Plan**

CMS approved the MFP Operational Protocol to provide funding for all of the required structural changes within the Balancing Incentive Program. Funding has also been allocated to support rebalancing efforts as well as the development of a LTSS tracking system that will contain the automation of the screen and assessment. The following details a listing of approved items within the MFP Operational Protocol and the contracts that relate directly to rebalancing and structural changes required in the Balancing Incentive Program.

### **Contracts**

*MAP Initiatives – Information Technology* – The local MAP sites currently use a unique system for tracking their efforts and incoming inquiries about LTSS. A single, statewide database is necessary to monitor inquiries about LTSS and standardize data collection and reporting. The unified system will share data with the Medicaid long-term care tracking system, facilitating referrals for support and generating vital data on service demand. Costs include the procurement of a vendor and software, training to all users, and the connection to the Medicaid tracking system. The total cost for CY2012 is \$250,000 and the total cost over the 5 year extension period is \$1,250,000.

*The Hilltop Institute and the Core Standardized Assessment and Tracking System* – The Department will utilize an MOU with the Hilltop Institute for two separate activities, both of which include data management and analysis. During the initial years of MFP implementation, Hilltop built a web-based tracking system for MFP in order to track services and administrative activities related to potential and enrolled MFP participants. Ongoing IT support for data management and analysis will be necessary to complete all mandatory reporting requirements. Hilltop is developing a new unified LTSS tracking system that will consolidate the existing MFP and waiver tracking systems, add quality monitoring components such as reportable events, and expand to include other waivers and community-based supports. It will also include data from MMIS, the MDS 3.0, and other data sources.

The cost of the instrument, software, technology, and initial training for the users in CY2012 is \$2,000,000 and the total cost over the 5 year extension period is \$3,000,000.

*Aging and Disability Resource Center Liaison* – A contract with a liaison to assess existing MAP sites for their capacity to integrate MFP services and identify structural, staffing, and funding barriers. The liaison will develop action plans for MAP sites to facilitate the incorporation of MFP services and Balancing Incentive Program requirements and overcome identified barriers and will develop a State-level action plan.

*Prioritize Current Waiver Registries (waiting list)* – MFP has approved funding to assess all individuals on the Living at Home and Older Adults waiver registries using the new core standardized assessment instrument and prioritize based on risk of institutionalization rather than date of application.

*Maryland Department of Aging* – The Department will utilize an MOU with the Department of Aging to provide options counseling to nursing facility residents. This agreement will also provide funding for MAP site development. MDoA provides ongoing administrative support to the demonstration through monitoring of services, billing, and technical assistance. The MOU includes funding to help support these administrative functions.

**Table 4.**

	<b>Total Cost CY 2012</b>	<b>Total Cost Over 5 Year Extension</b>
<b>MAP information technology</b>	\$250,000	\$1,250,000
<b>Core Standardized Assessment</b>	\$2,000,000	\$3,000,000
<b>Tracking System – Ongoing Maintenance</b>	\$160,000	\$800,000
<b>Aging and Disability Resource Center Liaison</b>	\$218,724	\$218,724
<b>Prioritize Current Waiver Registries</b>	N/A	\$4,000,000
<b>Options Counseling and MAP Site Development</b>	\$4,768,841	\$15,768,841.

## **Section M. Challenges**

### **Current Culture of Institutionalization**

Nursing homes account for approximately 85 percent of the total expenditure for LTSS for the aging and people with physical disabilities. Maryland's proclivity to institutionalization, not including people with intellectual disabilities has led to the systematic use of nursing facilities as the natural venue to receive services related to long term care. Maryland's goal is to ensure that all families and participants are informed of their options. By expanding capacity to provide supports in a person's desired setting, the Department believes that there will be an increased demand for community services and will avoid, or at least delay, the need for hospitalization or institutionalization.

### **Problems Entering into the Long Term Care System**

Currently, a Maryland resident can access personal care services through multiple programs. Each program has different eligibility criteria, service models and rates of reimbursement. A major issue with the MAPC program is reimbursement to providers. The current reimbursement rate is paid on a per diem basis and does not accurately reflect the number of hours spent at a person's home. The system is based on four levels of care which determine basic needs and per diem rates of pay. Ensuring that qualified providers receive an adequate payment is a concern with the current system. For the reasons mentioned there are inequities in the delivery of the service to the Medicaid and waiver populations. To resolve these inequities the Department plans to offer the service under Community First Choice.

Additionally, a recipient entering into a nursing facility may have no prior knowledge that receiving personal care in the community may have been an option. After entering the facility, Maryland relies on the MFP program's peer outreach and program education workers to assist in transitioning people back to the community. Under Community First Choice, the interRAI-HC will be conducted for all recipients. Once the assessment is completed a recipient will be informed of options available to assist with transitioning back to the community.

The MAPC program is available to all Medicaid-eligible individuals. The program, however, provides only personal care services and does not offer any other wrap-around services that may help keep a person living in the community. Services such as assistive technology and home modifications are very useful to participants and many would rely on them if they were to reside at home. Without consistency in providing home and community based care, Maryland struggles to link people to the appropriate program. Maryland's work plan to increase capacity will help develop a strong program that provides a continuum of services, rather than stand-alone services.

### **Inconsistent Reimbursement Methodology**

Maryland's three programs that serve older adults and individuals with disabilities in the community all have a different rate structure. The rate structure is based on agency or independent providers,

receiving medication or not receiving medication, level of care for the person and mixture of all of the above. Certain providers within one waiver will receive a higher rate compared to their analogous provider in a different program. Maryland aims to simplify the rate structure in the Community First Choice program by consolidating services into one program and enrolling all providers in one program and creating one provider registry. This process of evening the rate structure may be difficult. While the lowest paid providers will receive an increase in reimbursement, matching Maryland's current highest rates may not be attainable.

### **Accessible, Affordable Housing**

Housing is one of the main barriers to community living, and housing assistance may greatly increase the number of people that are able to make the transition. In 2009 and 2010, housing training was provided through the MFP demonstration to develop housing expertise among waiver case managers and MAP partners who provide information about types of housing options, the availability of housing, and the housing subsidy systems. Maryland continues to be concerned that participants that enter a nursing facility have given up their previous housing, making it harder to ensure a safe transition back into the community. The Department has used MFP rebalancing funds to support creative housing solutions.

Feedback ascertained from stakeholders noted that housing assistance should be provided by individuals with housing knowledge and expertise, MFP housing specialist positions were created and staffed at the Department in order to work with applicants, their supporters, case managers, housing authorities, and landlords. In February of 2011, Maryland was awarded 112 category II vouchers for non-elderly disabled individuals transitioning from institutions. As of December 2011, 75 vouchers had been awarded due to partnerships between the MFP demonstration, local housing authorities, and waiver case management providers.

While MFP initiatives focus on maximizing available housing and subsidies, support is needed to develop additional housing units. The Maryland Department of Disabilities (MDoD) will hire two (2) housing developers to focus on transit-oriented development, which is a current State focus related to the Base Realignment and Closure (BRAC) and land-use planning. These staff will act as liaisons between MDOD, Medicaid, the housing finance agency, and the Department of Transportation, establish partnerships with developers, and educate all partners on the needs of individuals with disabilities and older adults to increase available affordable and accessible housing units.

Maryland successfully applied for a Real Choice Systems Change Grant titled, Building Sustainable Partnerships for Housing. Maryland's proposal, Maryland Partnerships for Affordable Housing (MPAH), is a joint effort of Medicaid, the Department of Disabilities, the Department of Housing and Community Development, the Mental Hygiene Administration, DDA, Centers for Independent Living, disability advocates, consumers, and other community service providers. MPAH is a one year grant that will assist Maryland in developing strong relationships and a competitive application for funding through the Department of Housing and Urban Development's revised 811 rental assistance program. It is anticipated that any new funds received will be dedicated to affordable and accessible housing for

persons with disabilities and targeted to individuals who are institutionalized or at risk for institutionalization.

## **Section N. NWD/SEP's Effect on Rebalancing**

The Maryland Department of Aging is currently implementing seven federal grant programs related to the MAP program. The grants are to: develop statewide options counseling standards for MAP sites for individuals seeking information and assistance with long term supports and services; implement a collaborative program between the Baltimore City MAP and the Johns Hopkins Physicians Practice to expand the nationally recognized Guided Care Program; expand the Medicare Improvements for Patients and Providers Act (MIPPA) program through local MAP sites; provide infrastructure to develop a statewide MAP program with consistent standards; implement a person-centered hospital discharge program; and implement a community-based service program with a flexible self-directed benefit structure. In addition, the MAP program is implementing a flexible self-directed benefit program for the federal Veterans' Administration. Several of these grants directly relate to the NWD/SEP system working toward achieving rebalancing goals.

MAP is central to Maryland's efforts to rebalance LTSS expenditures from high cost institutional settings to HCBS and to expand the availability of community-based LTSS. MAP and AAA's partner with local disability organizations to provide counseling and assistance to individuals in nursing homes who wish to transition back to the community into one of Maryland's Medicaid HCBS waivers through MFP Program. MAP provides a one-stop, front line place where people needing LTSS information can find counseling on their options, assistance in applying for publically funded service programs and short term assistance in planning for services. This one-stop, no wrong door service is one of the core functions required for Maryland's successful application for the Balancing Incentive Program.

As stated in the MFP Operational Protocol, options counseling for individuals aged 49 years or younger will be performed by the local disability partner and for individuals aged 65 and over, will be performed by the AAA. For individuals ages 50 to 64, the options counseling will be a collaborative effort between the aging and disability partners.

After training and collaborative relationships are developed, options counseling may be divided differently among the aging and disability partners. All staff providing options counseling will meet minimum qualifications and training requirements. Shared training between local aging and disability partners will be conducted and the same information will be provided, regardless of which partner conducts the options counseling.

The development of a person-centered hospital discharge planning model began in February of 2010 with Worcester County. This initiative was created with the intention of informing those who are hospitalized or in nursing facilities of all appropriate options available to them for community living in order to remain safely in their own homes. The referrals for the program come from the hospital census and/or discharge case manager (for the hospital) and from consultation with the social workers (for the nursing facility). The county health department nurse then completes an assessment working with the client and/or family member. Referrals are made to community agencies and social networks. Follow up contact happens within three weeks, which may result in further referrals. Statistical information is kept

on each client. With the continued development of the MAP sites, there can be communication between the county nurse and the MAP Intake Coordinator with potential clients to note if they have been seen before, are already receiving services, and to gather any other pertinent information. This program is currently available in Worcester and Harford Counties. An additional goal of the Balancing Incentive Program might include the expansion of this service to serve more individuals throughout the State of Maryland.

## **Section O. Other Balancing Initiatives**

### **Money Follows the Person Demonstration**

The MFP demonstration will complement ongoing rebalancing efforts in Maryland as well as support research, development, and implementation of new opportunities the Department chooses to pursue that were authorized as part of the ACA.

Under MFP, the Department receives additional funds for services provided under the demonstration. To date, the increased funds associated with the MFP demonstration have been used to enhance community based services available through the existing waiver programs by adding additional services and supports that were identified by the stakeholders. These additional services are available to all waiver participants and will continue past the MFP demonstration. In addition, the funds sponsored pilot programs to enhance outreach and transition services. These pilot programs produced data that has been used to study their efficacy through measured outcomes. Based on the outcomes of the pilot projects to date, changes are being made to several of Maryland's rebalancing initiatives effective January 1, 2012.

Peer outreach workers were employed to staff a statewide outreach campaign to nursing facility residents, informing individuals (or their legal guardians) of the option to receive LTSS in the community. Over 20,000 contacts were made with nursing facility residents and their representatives. MFP funding enhanced an existing peer mentoring program for State Residential Center (SRC) residents and created a new family mentoring initiative. A peer mentoring service was created for nursing facility residents as well. However, utilization has been so low that sufficient data are not available to quantify and evaluate the outcomes for the mentoring services. Maryland remains committed to using peers to perform outreach and provide support to institutional residents. These peer initiatives have been redesigned to promote increased participation and overcome challenges identified during the initial demonstration period.

In addition to the peer outreach and mentoring, program education and application assistance were offered to nursing facility residents through the MFP demonstration. AAA's receive referrals from peers, facility staff, ombudsman, and the MDS Section Q and then provided in-depth education on the services available in the community. Assistance in completing and submitting a waiver application was also provided when requested. Since July of 2009, 5,309 people have received program education and 1,836 of those individuals also received application assistance for one of the HCBS waivers. The number of waiver applicants has increased tremendously based on the outreach, education, and application assistance available through MFP. The education and application assistance will be integrated into Options Counseling in the future to further streamline the entry into LTSS.

MFP has funded training for its partners and providers. Specifically, transitional case managers received training on person-centered planning, which was designed to educate case managers on the philosophy and specific planning tools that can be used to guide the process. Housing training was also provided in

order to provide basic housing information and assistance to all residents of qualified institutions seeking independent housing. The housing training was open to anyone working with MFP and was also attended by MAP staff, disability partners working at Centers for Independent Living, and consumers.

MFP housing specialist positions were created and staffed at the Department in order to work with applicants, their supporters, case managers, housing authorities, and landlords. These housing specialists work closely with housing staff at one of the case management providers for the Living at Home waiver, The Coordinating Center. In February of 2011, Maryland was awarded 112 category II vouchers for non-elderly disabled individuals transitioning from institutions.

Additional funding has been approved in the MFP Operational Protocol specific to rebalancing efforts. Below is a summary of each initiative.

- Maryland Department of Disabilities – The Department will utilize an MOU with the Department of Disabilities to fund peer supports activities for nursing facility residents and an MOU to fund housing development. The first MOU includes funding for MDOD’s administrative costs related to the implementation of the peer supports program. Within the second MOU, MDOD will hire two (2) housing developers to focus on transit-oriented development and partnerships with developers to increase available affordable and accessible housing units.

- Training Initiatives – Provider, Partner and Person-Centered Planning Training – Three contractors will host trainings for various persons and agencies throughout the State. Provider training for community personal care 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 and Substance Abuse Training as well as training on quality. A partner training contractor will host outreach and in-service trainings for MFP partners, including discharge planners, MAP staff, and ombudsmen on topics such as quality requirements, opportunities, and supports available in the community. The contract will also include person centered planning in order to increase self-direction. The third training on Person Centered Planning will be an intensive person-centered planning process for SRC residents transitioning to the community through MFP.

- Complaints and Surveillance Unit – MFP requires enhanced quality monitoring beyond what is currently in place for the existing HCBS waivers. A new Complaints and Surveillance Unit is proposed to triage and respond to emergency backup calls. The unit would be responsible for establishing a call-in number for emergencies, 24 hours per day. Three staff would be needed to answer calls and respond to or triage the emergency situation.

- DDA Initiatives – Rebalancing Budget Allocations – DDA pilot of the Supports Intensity Scale with SRC residents to develop individualized budgets. A new DDA Data Management system also will improve information technology systems to increase quality monitoring capabilities and drive quality improvement activities. Any new system will be integrated with the LTSS tracking system.

- Support Initiatives – Personal Care Back-up Agency – This agency would respond to emergency back up calls from the Complaints and Surveillance unit. In-home Supports Assurance System – cost of procuring a vendor, software, technology upgrades, and user training for key stakeholders, including participants, providers, case managers, and administrators.
- Schaefer Center for Public Policy – The Department will utilize an MOU with the Schaefer Center for Public Policy in order to administer the Quality of Life (QoL) Survey. The Schaefer Center will administer QoL surveys to MFP participants at baseline in the institution and again one and two years after their transition and provides relevant data to the Department regarding survey results and follow-up needs.
- Evaluation of Current Diversion Efforts – The State currently has several institutional diversion programs that use different models and have varying outcomes. A one year evaluation of the current local programs, and complementary research of national models and evidence-based practices, is necessary to consolidate the evaluation across efforts of the various Departments and agencies.
- Nursing Facility/Hospital Initiatives – Nursing Facility Expansion to HCBS – Pilot projects that encourage institutional providers to expand their business model to include home and community-based services can increase consumer choice and expand the pool of HCBS providers, especially in rural areas. Working with institutions to change their business models is an important part of transitions and rebalancing efforts and increasing those efforts is crucial to meeting the goals of MFP. Examples include training and outreach to NF providers, Continuity of Care Pilot, or Bed Restructuring Incentives. Bed Closure Incentives – The goal is to provide incentive payments to nursing facilities for the permanent, voluntary closure of unused beds. Hospital Outreach – An expansion of the nursing facility peer outreach model to hospitals in order to provide training for hospital discharge planners on available community options.
- Bridge Subsidy Rental Assistance Program – Additional funding to create availability of rental assistance through the Bridge Subsidy program for MFP participants.
- Provider Registry – Creation of an online, searchable database of providers of HCBS. This type of registry would allow participants to search for qualified, pre-screened providers and increase ease of access to support.
- 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.
- Community First Choice Implementation – MFP will fund the start-up administrative costs such as staffing, technology, training, and outreach.

**Table 5. MFP Approved Expenditures**

	<b>Total Cost CY 2012</b>	<b>Total Cost Over 5 Year Extension</b>
<b>Maryland Department of Disabilities - Peer</b>	\$700,000	\$4,025,517

<b>Supports</b>		
<b>Maryland Department of Disabilities – Housing Developers</b>	\$215,228	\$1,076,140
<b>Provider Training</b>	\$125,000	\$625,000
<b>Partner Training</b>	\$125,000	\$625,000
<b>Person Centered Planning</b>	N/A	\$93,000
<b>Complaints and Surveillance Unit</b>	\$230,000	\$1,245,753
<b>Rebalancing Budget Allocations</b>	N/A	\$750,000
<b>DDA Data Management</b>	N/A	\$93,000
<b>Personal Care Back-up Agency</b>	\$200,000	\$1,000,000
<b>In-home Supports Assurance System</b>	\$1,000,000	\$3,000,000
<b>Schaefer Center for Public Policy</b>	\$363,097	\$2,448,125
<b>Evaluation of Current Diversion Efforts</b>	\$75,000	\$75,000
<b>Nursing Facility Expansion</b>	N/A	\$2,000,000
<b>Hospital Diversion Model</b>	\$75,000	\$175,000
<b>Bed Closure Incentives</b>	N/A	\$1,000,000
<b>Hospital Outreach</b>	\$200,000	\$1,000,000
<b>Assisted Living Provider Incentives</b>	N/A	\$1,000,000
<b>Behavioral Health Group Homes</b>	N/A	\$200,000
<b>Pilot HCBS Services</b>	N/A	\$1,000,000
<b>Bridge Subsidy Registry</b>	\$5,300,000	\$5,300,000
<b>Provider Registry</b>	N/A	\$500,000
<b>State Residential Center Peer Support</b>	\$36,000	\$36,000
<b>Community First Choice Implementation</b>	N/A	\$2,000,000

### **Community First Choice**

As written in Section B, the State Department plans on implementing a CFC Program.

Over the next year, the Department will pursue development of the Community First Choice program with the assistance of the council and will submit a State Plan amendment to CMS prior to implementation.

### **In-Home Supports and Assurance System (ISAS)**

The Department will be implementing a new system for assuring that home and community-based services are provided as outlined in person-centered plans of service. An automated monitoring and authorization system will provide documented evidence through a call in system to validate the provision of services to recipients for the appropriate length of time and also generate an electronic claim. The Department is in the process of creating electronic plans of service for all in home services and will have electronic plans of service for all personal care services included in the Living at Home Waiver Program, Older Adults Waiver Program and Personal Care Program by June 2012. Developing In-Home Supports Assurance System (ISAS) will require that personal care and other in-home service providers call-in to an automated system when providing services in a participant's home. The system will compare service calls to the individuals support plan and document provider time in the home to automate billing. This system will ensure that providers are paid for the time they are actually in the home providing services.

Personal care providers and their union representative have requested the Department seek to decrease the time between the submission of a paper bill and payment. An automated system will dramatically cut that time.

### **Community Living Program**

In addition to the Maryland Access Point project, Maryland received grant funding from the Administration on Aging for the Community Living Program. This grant is designed to: (1) develop a targeting and assessment protocol for identifying those 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 services and service 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 as well as provide a model for expansion. There is also a State-only funded program that supports nurses working in local hospitals to divert individuals from long-term nursing facility stays after a hospital discharge. Two counties currently participate in this program with the Department.

### **Real Choice Systems Change Grant - Building Sustainable Partnerships for Housing**

In addition to these efforts, Maryland successfully applied for a Real Choice Systems Change Grant titled, Building Sustainable Partnerships for Housing. Maryland's proposal, Maryland Partnerships for Affordable Housing (MPAH), is a joint effort of Medicaid, the Department of Disabilities (MDOD), the Department of Housing and Community Development (DHCD), the Mental Hygiene Administration (MHA), the Developmental Disabilities Administration (DDA), Centers for Independent Living (CILs),

disability advocates, consumers, and other community service providers. MPAH is a one year grant that will assist Maryland in developing strong relationships and a competitive application for funding through the Department of Housing and Urban Development's (HUD) revised 811 rental assistance program. It is anticipated that any new funds received will be dedicated to affordable and accessible housing for persons with disabilities and targeted to individuals who are institutionalized or at risk for institutionalization.

### **Health Homes**

Section 2703 of the Affordable Care Act established Health Homes for Enrollees with Chronic Conditions, a new State Plan option that offers additional federal support to enhance the integration and coordination of primary, acute, behavioral health, and long-term services and supports. To be eligible, a Medicaid recipient must have two or more chronic conditions, one condition and the risk of developing another, or at least one serious and persistent mental health condition. The health home services include care management, health promotion, transitional care from inpatient to other settings, individual and family support, and the use of health information technology. The option allows states to target certain groups with chronic conditions and limit the availability of service geographically. It also offers states an enhanced FMAP of 90 percent for the first 8 quarters of participation. However, there is no ongoing enhanced funding available.

The Office of the Deputy Secretary for Behavioral Health and Disabilities is exploring the use of the Health Home option to coordinate mental health and substance abuse services for individuals with these diagnoses. The Department hosted an informational session for providers in September and will continue to work with stakeholders and providers to develop pilot models of a chronic health home.

### **1915(i) as modified through the ACA**

Section 1915(i) was established by the Deficit Reduction Act of 2005 and modified through the ACA. This State Plan option allows states to offer home and community-based services through the State but does not require that recipients meet an institutional level of care, as is required under other types of Medicaid long-term care waivers. This option allows targeting of populations and expanded service definitions, but does not allow states to cap enrollment or limit services geographically. The option also does not offer any enhanced Federal funds.

The Department, through the Mental Hygiene Administration, is considering pursuing a 1915(i) option for adults to include two services; supported employment and psychiatric rehabilitation. As discussed with the Workgroup, additional 1915(i) options will be explored as specific needs are identified. However, any new 1915(i) would represent an unfunded expansion in services. While workgroup members expressed an interest in exploring additional 1915(i) options, no specific recommendations were made for expansion.

### **State Fiscal Year 2013 Budget**

The governor's proposed budget for SFY 2013 has several increases emphasizing rebalancing. The proposed budget will increase payments for LAH, OAW, MDC and MAPC by 1.5 percent. The State is also proposing to invest 18 million in total funds to add 480 waiver slots in the LAH and OAW programs. The Department and State of Maryland's trend towards increasing expenditure to HCBS is further evidence of a shift in emphasis to balance LTSS.

### **Commitment from the State Legislative – State-Specific Reporting Requirements**

The Maryland General Assembly has taken particular notice to Maryland's LTSS programs. In 2007, House Bill 594 required the Department 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. The Department 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 LTSS were passed during 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 was submitted to the General Assembly on October 1, 2010. The report included plans to continue to work with stakeholders on rate reform issues. House Bill 113 required that the Department consult with stakeholders to evaluate the feasibility of submitting a federal waiver application for a coordinated LTSS program. The final report on feasibility was submitted to the legislature December 1, 2010 and recommended that the group continue to review further study options available in the Affordable Care Act. The LTC3 Reform workgroup was reconvened in August of 2011 to review Community First Choice, the Balancing Incentive Program, Health Homes, and revisions to the 1915(i) option. In 2012, the large workgroup was replaced by subgroups based on the ACA options Maryland pursues.

## **Section P. Technical Assistance**

### **Balancing Incentive Program Technical Assistance**

The Department's Office of Finance and has been in contact with CMS regarding reporting, the increased federal match and programs involved within the Balancing Incentive Program. The Department will continue to be in contact with CMS regarding the Long Term Services and Supports budget.

The Department has also conducted a two hour-long technical assistance call with CMS and HSRI Analytics regarding the Balancing Incentive Program manual and application process. Prior to submission of the final work plan, the Department will be in consistent contact with CMS regarding submission requirements to ensure accurate and timely completion of the work plan.

The Department can foresee the need to be in contact with CMS regarding additional issues after submission of the Balancing Incentive Program application. These include, but are not limited to, receiving technical assistance regarding connecting the Single Entry Point with the health benefit exchange and ongoing technical assistance regarding the tracking system and implementing an online version of the Level 1 screen. The Department will also request assistance in assuring all data reporting on quality and outcomes is sufficient and acceptable with CMS.

### **Community First Choice**

The Department will be conducting ongoing meetings with CMS on the implementation of the Community First Choice program. With its goal of consolidation, the Department is designing a new program that will reshape how long term supports and services are provided. The Department has already identified areas of concern. Specifically, CMS has already provided information on self-directed models currently being run through 1915(J) State Plan services. The Department will also seek additional information on service provision and allowable administrative costs.

### **Money Follows the Person**

The Department has an ongoing relationship with CMS regarding all MFP initiatives and will continue to consult with and report to CMS all aspects delineated within the MFP Operational Protocol. In collaboration with New Editions (CMS provided TA contractor), Maryland's 2012 MFP TA plan was finalized in January 2012.

# Financial Reporting Form

Department of Health and Human Services  
Centers for Medicare and Medicaid Services  
Balancing Incentive Payments Program (Balancing Incentive Program) Applicant Funding Estimates  
Long Term Services and Supports

State	Maryland	State FMAP Rate	50%
Agency Name	Department of Health and Mental Hygiene	Extra Balancing Incentive Program Portion (2 or 5%)	2%
Quarter Ended	March 2012		
Year of Service (1-4)	1		

LTSS					Projected LTSS Spending*			
	Total Service Expenditures	Regular FEDERAL Portion	Regular STATE Portion	Amount Funded by Balancing Incentive Program (4 year total)	Year 1 (April 12 - September 12)	Year 2	Year 3	Year 4
	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Line 12 – Home Health Services	\$11,091,426	\$5,545,713	\$5,545,713	\$221,829	\$1,446,516	\$3,025,516	\$3,211,173	\$3,408,221
Line 19A – Home and Community-Based Services – Regular Payment (Waiver)	\$3,126,599,464	\$1,563,299,732	\$1,563,299,732	\$62,531,989	\$442,506,350	\$909,280,684	\$880,435,263	\$894,377,166
Living at Home Waiver	\$57,707,158	\$28,853,579	\$28,853,579		\$16,880,002	\$26,983,527	\$11,145,276	\$2,698,353
Older Adults Waiver	\$197,507,147	\$98,753,573	\$98,753,573		\$50,598,145	\$80,883,665	\$41,760,236	\$24,265,100
Increased Community Services	\$6,541,440	\$3,270,720	\$3,270,720		\$0	\$2,100,000	\$2,168,460	\$2,272,980
Medical Day Care Waiver	\$232,893,074	\$116,446,538	\$116,446,538		\$30,486,380	\$64,978,670	\$67,096,975	\$70,331,049
New Directions Waiver	\$11,064,695	\$5,532,347	\$5,532,347		\$1,448,401	\$3,087,121	\$3,187,761	\$3,341,411
Community Pathways	\$2,478,701,150	\$1,239,350,575	\$1,239,350,575		\$324,481,019	\$691,577,224	\$714,112,820	\$748,530,087
Traumatic Brain Injury	\$15,016,416	\$7,508,208	\$7,508,208		\$1,965,693	\$4,189,677	\$4,326,260	\$4,534,786
Autism Waiver	\$123,935,837	\$61,967,919	\$61,967,919		\$16,223,561	\$34,578,898	\$35,706,170	\$37,427,208
Model Waiver for Fragile Children	\$3,232,549	\$1,616,274	\$1,616,274		\$423,150	\$901,902	\$931,304	\$976,193
Line 22 – Programs Of All-Inclusive Care Elderly	\$24,567,801	\$12,283,900	\$12,283,900	\$491,356	\$3,204,071	\$6,701,598	\$7,112,832	\$7,549,300
Line 23A – Personal Care Services – Regular Payment	\$68,703,391	\$34,351,696	\$34,351,696	\$1,374,068	\$20,489,899	\$32,142,328	\$16,071,164	\$0
Line 24A – Targeted Case Management Services – Community Case-Management	\$32,016,693	\$16,008,347	\$16,008,347	\$640,334	\$4,175,537	\$8,733,505	\$9,269,424	\$9,838,228
Line 40 – Rehabilitative Services (non-school-based)	\$1,257,593,478	\$628,796,739	\$628,796,739	\$25,151,870	\$175,593,773	\$355,208,871	\$360,638,899	\$366,151,935
Psychiatric Rehabilitation Services	\$481,930,852	\$240,965,426	\$240,965,426		\$67,621,534	\$136,663,121	\$138,098,084	\$139,548,113
Line 41 – Private Duty Nursing (Model Waiver for Fragile Children and REM)	\$353,029,993	\$176,514,997	\$176,514,997	\$7,060,600	\$46,041,285	\$96,299,424	\$102,208,698	\$108,480,587
Community First Choice**	\$443,326,195	\$248,262,669	\$195,063,526	\$8,866,524	\$0	\$55,003,250	\$165,009,750	\$223,313,195
<b>TOTALS</b>	<b>\$5,316,928,442</b>	<b>\$4,489,328,952</b>	<b>\$4,436,129,809</b>	<b>\$106,338,569</b>	<b>\$693,457,430</b>	<b>\$1,466,395,176</b>	<b>\$1,543,957,203</b>	<b>\$1,613,118,634</b>

\* MCHP and CHIP PREM FMAP at 65% have been removed from Projected LTSS Spending.

\*\* Community First Choice Projected Expenditure based on implementation in SFY 2014 and SFY 2015.

All right-aligned and shaded information are programmatic projections based on overall Line-Item Projections.