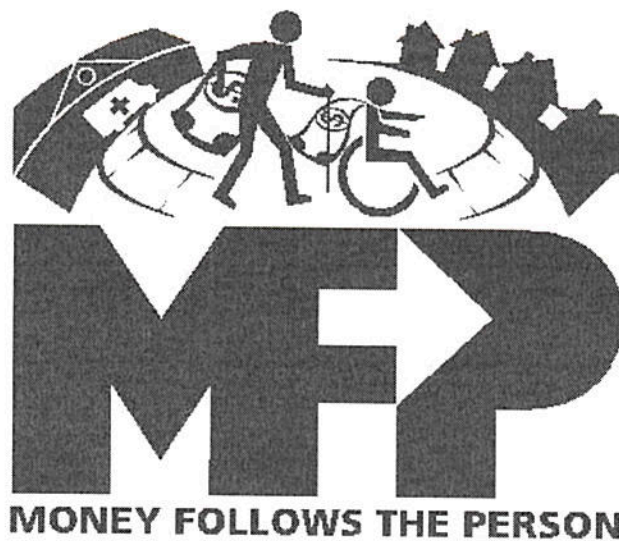


# MARYLAND

## Money Follows the Person

Operational Protocol



Submitted December 9, 2011

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## I. Required Contents of the Operational Protocol

### A. Project Introduction

The Money Follows the Person Rebalancing Demonstration (MFP), offered through the Centers for Medicare and Medicaid Services (CMS), was created as part of the Deficit Reduction Act of 2005, a law passed by the U.S. Congress. Originally set to end in 2011, the passage of the Affordable Care Act of 2010 extended the demonstration until 2016. The purpose of the demonstration is to promote a series of rebalancing objectives written in the statute. The term “rebalancing” refers to efforts to minimize or eliminate barriers to individuals receiving long-term supports and services in home and community settings, rather than in institutional settings.

The Department of Health and Mental Hygiene (DHMH) administers Medicaid in Maryland. In accepting the Money Follows the Person (MFP) award, Maryland reinforced its ongoing commitment to serving individuals in the most integrated setting. This commitment is apparent in the State’s existing policies and programs, including the Money Follows the Individual policy and the five home- and community-based services (HCBS) waivers that will serve MFP participants. Maryland is also fortunate to have a vibrant community of advocates and consumers who push the State to continue to improve its efforts. With the approval of this operational protocol, the State will use lessons learned in the first four years of MFP implementation to improve upon current rebalancing initiatives, as well as support the Department in exploring new options authorized in the Affordable Care Act (ACA).

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

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

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

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

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

*Increasing Use of HCBS.* Of the four federal goals for the MFP program, Maryland's MFP program focuses on increasing the use of home- and community-based services (HCBS) by streamlining and supporting transitions from institutions to the community. The State's Money Follows the Individual policy ensures that funding for waiver slots is made available to individuals who transition from an institution. The Money Follows the Individual Act is codified in the Annotated Code of Maryland, Health General §15-137 which states that:

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

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

While the law only references nursing facilities, the Departmental policy includes all institutions. Therefore, capacity in the waivers does not need to be reserved for individuals transitioning from institutions to the community through the MFP demonstration. Individuals transferring from an institution to a community residence will not be placed on a waiting list. Additional slots will be requested each year according to the number of slots needed to continue serving individuals who transition onto the waivers under MFP.

Beyond the MFI policy, the Waiting List Equity Fund (WLEF) will be utilized to fund services for individuals transitioning out of ICFs/MR, called State Residential Centers (SRCs) in the State. The Code of Maryland Regulations (COMAR) 10.22.15.03 states:

The waiting list equity fund is a nonlapsing fund established to ensure that when an individual leaves the State residential center to be served in the community, the net average cost of serving the individual in the SRC is applied to: (1) The individual's community placement; (2) Community services needed to sustain the individual's



community placement; and (3) Provide community-based services to individuals not yet receiving services.

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

To be eligible for services funded from the waiting list equity fund, an individual shall: (1) Be a resident of Maryland; (2) Have an appropriate evaluation that finds that the individual: (a) Has a developmental disability, or (b) Is eligible for support services; (3) Leave a State residential center on or after October 1, 1994, to be served in community-based services.

Traditionally, the WLEF has been used to fund services for individuals on the waiting list who have older caregivers (currently age 69 and above). However, the regulations for the funds allow them to be used on individuals who are transitioning out of institutions and these funds will be available to MFP participants who are not required to be placed on the Waiting List for DDA services.

#### *Ongoing Efforts to Rebalance and Divert from Institutional Placement*

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. These and other efforts are described below.

Maryland is one of 43 states funded by the Administration on Aging and CMS to develop a program to streamline access to long-term care information and community-based services. The federal program is the Aging and Disability Resource Center initiative. In Maryland, the program is called Maryland Access Point (MAP). The MAP program also is supported by General State funds. The goals of MAP are to streamline access to long-term care information and streamline eligibility and access to services in order to help redirect long-term care from institutions to the community. The MAP program has developed recommendations for best practices within the ten local MAP sites including co-location of the different agencies involved in coordinating eligibility for Medicaid services and all State funded long-term care services. MAP currently has 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 anticipates that MAP will constitute the core of the Single Entry Point required by BIPP if that ACA provision is adopted by Maryland as part of the State's LTSS reform plan.

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 older adults who are at high risk of Medicaid spend down and placement in a nursing home; (2) prioritize those individuals for access to non-Medicaid funded State long-term care service programs; (3) offer them an



opportunity for a flexible benefit under which they or their families can self-direct services and services providers; and (4) encourage and measure the informal supports that assist with community-based care and living. The targeting and assessment protocol and the prioritization of high risk individuals will contribute significantly to Maryland's efforts to divert people from institutional settings as well as Medicaid spend down. This essential diversion program will increase the number of individuals who can remain in their homes and receive services, thereby reducing the need for facility-based care and expenditures and it will provide a model for expansion. 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 DHMH.

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

Two additional bills regarding long-term care were passed in Maryland's 2009 legislative session. House Bill 782 requires the Department to consult with nursing facilities and other stakeholders to assess the State's long-term care reimbursement methodology and consider alternative reimbursement mechanisms. A report on the evaluation was submitted to the General Assembly on October 1, 2010. The report included plans to continue work with stakeholders on rate reform issues. House Bill 113 requires that the Department consult with stakeholders to evaluate the feasibility of submitting a federal waiver application for a coordinated long-term care program. The final report on feasibility was submitted to the legislature December 1, 2010 and recommended that the group continue to further study options available in the Affordable Care Act. The Long-term Care Reform workgroup was reconvened in August of 2011 to review Community First Choice, the Balancing Incentives Payment Program, Health Homes, and revisions to the 1915(i) option. The group currently meets monthly and will advise the Department on pursuing options authorized by the ACA. In 2012, the large workgroup will be replaced by subgroups based on the ACA options Maryland pursues.

One of the recommendations of previous stakeholder groups has been to develop a single standardized assessment instrument to be used across programs. An instrument that is evidence-based and tested for validity and reliability could improve the quality of community support plans and reduce the effects of the programmatic silos. DHMH has already invested, outside of MFP, in two (2) full-time staff that will research existing evidence-based instruments and make recommendations for moving to a new assessment tool in 2012. These staff will host focus groups to review assessment options with stakeholders. The staff will also ensure that the new instrument meets the requirements for a Core Standardized Assessment as outlined in the Balancing Incentive Program Implementation Manual released on October 14, 2011 to ensure Maryland's eligibility for the program, should an application be pursued. MFP will use rebalancing funds to fund the initial costs to finance the implementation of the tool.



Maryland is also exploring the implementation of a new system for assuring that home and community-based services are provided as outlined in person-centered plans of service. The 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. Although the effort was initiated outside of the MFP demonstration process, MFP rebalancing funds may be used to support the start-up costs as the effort is focused on improving HCBS and quality. The system is expected to be implemented in 2013.

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.

*Where We've Been, Overview of MFP Demonstration Program to date*

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

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

When MFP began, there were 331 people living in Maryland's State Residential Centers. Under Governor Martin O'Malley's leadership, the Rosewood State Residential Center was closed and 168 residents transitioned to the community. Brandenburg, a second SRC, was closed in 2011. As of this writing, there are now 141 individuals in SRCs, in contrast to 11,751 DDA waiver



participants being served in the community. Less than 2% of the people being served by DDA remain in institutional settings.

The Mental Hygiene Administration administers the Waiver for Adults with Traumatic Brain Injury, which is expected to more than double in size by the end of the MFP Demonstration, and has already grown from 33 to 57 participants since the demonstration began. An expansion of MHA's Brain Injury Resource Coordination Program provides outreach to individuals in institutions, application assistance, and enhanced transitional case management services to individuals who apply for the TBI waiver program. Resource Coordinators assist with outreach to residents in CARF accredited Chronic Hospitals and State owned and operated nursing facilities as well as to their family, guardians, and other supporters. Resource Coordinators provide education and support in making decisions about pursuing community living, application assistance, coordination of needed community resources and supports for the individual, and enhanced transitional case management to ensure successful transitions to the community.

### *MFP Rebalancing Initiatives*

Under MFP, the State 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 will be 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 long term supports and services 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 is 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. The new peer support model is described in detail in section 1.3 Recruitment Efforts.

In addition to the peer outreach and mentoring, program education and application assistance were offered to nursing facility residents through the MFP demonstration. Professional staff of the local Area Agencies on Aging (AAAs) received 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. Details of Options Counseling services are in section 1.4 Enrollment in MFP from a Nursing Facility.

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 CILs, 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. The Coordinating Center has taken the lead role in assisting eligible MFP applicants in accessing these vouchers. As of this writing, 75 vouchers have been awarded.

MFP also supported the development of the statewide network of MAP sites. To improve the processes by which individuals learn about and access long-term care services, MFP assists the statewide network of MAP sites in two ways. First, an ADRC liaison contract was awarded in 2011 and the contractor is in the process of assessing existing and developing MAP sites for their capacity to integrate MFP services within the MAP structure, and identify existing structural, staffing, and funding barriers. The liaison will develop action plans for MAP sites to facilitate the incorporation of MFP services and overcome identified barriers and will develop a State-level action plan, as well as action plans for local MAP sites in order to facilitate the incorporation of MFP services and overcome identified barriers. Technical assistance to developing MAP sites will be provided in order to implement the action plans. The second way MFP supports MAP is by providing funding support to individual sites to help them modify their models to accommodate MFP service provision.

In addition to the ADRC Liaison, MFP will support the evaluation of the MAP-based Community Living Program and the parallel DHMH hospital diversion program. These pilot models need to be evaluated for best practices and standardized so that they can be expanded. This evaluation has not previously been funded as MDoA grants only support their programs, thereby excluding the DHMH grant programs. After an evaluation of current diversion efforts and national models, Maryland will work to implement a statewide nursing home diversion program.

*New Services.* The MFP demonstration added services to several of the existing waivers to enhance the service package available to individuals who use these programs. In the first phase of MFP, environmental assessments, nutritionist/dietician services, and home delivered meals were added to the Living at Home waiver and add transition services were added to the Older Adults Waiver. An MFP demonstration service was created to provide enhanced transition services to nursing facility (NF) residents interested in transitioning to the community through one of the participating home and community based services waiver. Peer mentoring was



created as an MFP demonstration service and will continue to be a demonstration service during the extension (See B.5.4).

The clubhouse model of services will also be added to the TBI waiver as an alternative to day habilitation or as a modification to the day habilitation service. This service, which was identified by stakeholders as an area of need, will be available to all TBI waiver participants and will continue past the MFP demonstration.

A new service called *flexible funds* was offered through the MFP demonstration and administered by the transitional case managers to further address barriers to transitioning. This MFP supplemental service includes funds for groceries, transportation, and other needed items that could not otherwise be funded by Medicaid. While the funds are designed to cover a wide array of goods and services needed at the time of transition, they have primarily been used to pay for groceries.

*Information Systems.* During the first phase of MFP, the State developed a web-based tracking system to assist in communication and reporting by tracking the processes shared among all partners of the demonstration. The tracking system is compatible with the existing tracking systems for the Older Adults and Living at Home waivers and is accessible by case managers, DDA, MDoA, MDOD, and DHMH. The web-based tracking system tracks an individual from initial contact through transition. While the information stored in the system can be used to identify barriers in the transition process and store reasons for reinstitutionalization, while promoting quality, timeliness, and accountability, it is not fully integrated with the existing waiver tracking systems. Plans are underway to incorporate all three existing tracking systems and expand functionality of a single long-term supports and services (LTSS) system. The modified system will expand to incorporate the new standardized assessment instrument, the State Plan personal care program, the TBI waiver, and the Quality of Care Review Team functions; link to the ISAS to automate billing and increase real-time quality monitoring; and streamline Reportable Events submission. It will also be built on a platform that can incorporate any changes to LTSS required for Community First Choice or the Balancing Incentives Payment Program, including linking to the Health Care Exchange.

MFP has also partnered with the MAP program to support the on-going development and maintenance of a statewide, web-based, searchable database that provides comprehensive, accurate, and user friendly information about long-term care planning, programs, and services. Launched on December 1, 2010, the site helps consumers, providers, and advocates quickly access information and connect with appropriate programs and providers. MFP may provide future support to enhance the system and integrate its client data into the LTSS tracking system.

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



community capacity, and providing comprehensive behavioral health supports to individuals receiving long-term care services in the community. One of the primary goals of this group was to develop recommendations for improving behavioral health services in the community for all individuals in need of those services.

The MFP Behavioral health workgroup met regularly through September of 2008 and developed a list of recommendations for the Department to better serve individuals with behavioral health needs (Appendix G). These recommendations were delivered to the advisory bodies for the LAH, OAW, and TBI waivers and the Aging in Place Task Force. These existing groups were charged with advocating for the implementation of these recommendations, but to date, none of the recommendations have been implemented.

The work group reconvened in July of 2009 and met through March of 2010, but once again efforts to implement recommendations stalled. In 2011, MFP successfully procured 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 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.

#### *New Efforts to Rebalance and Divert from Institutional Placement*

While not an MFP funded effort, advocating for the allocation of funding for waiver slots to divert people from institutions so they do not have to enter the NF before applying for a waiver would allow for targeted use of limited funding resources. This initiative would require budgetary authorization from the Maryland Department of Budget and Management (DBM) because of the ongoing state cost that cannot be covered by MFP. When they become available, a number of slots could be set aside for diversion, based on need as determined by the standardized assessment tool.

In order to truly rebalance the system, an increased and targeted effort needs to be initiated with institutions and the inconsistencies in reimbursement trends for institutional versus community providers must be eliminated. For example, Maryland will explore several options for reducing use of institutional services such as implementing equal rate cuts and/or increases to create payment parity between service providers; changes to institutional rate setting methodologies and policies allowing growth of institutional beds, voluntary bed closure incentives, and incentives for institutional providers to expand into HCBS. Financial incentives for bed closures will be used only if other efforts are unsuccessful and would be limited to short-term payments that results in the permanent closure of beds.

*Nursing Facility (NF) Expansion to HCBS.* The nursing facility provider community possesses many resources that could be successfully be re-invested to increase HCBS capacity. 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 institutional providers to shift their focus and ultimately change their business model is an important part of rebalancing efforts and crucial to meeting the goals of MFP. Maryland will explore options with the professional organizations representing facility providers including the Health Facilities Association of Maryland (HFAM) and LifeSpan, in addition to conducting outreach directly with providers. MFP will seek proposals for possible pilot projects. One example of a pilot proposed by a provider is to fund facilities at a capitated rate to provide transition services, assistive technology and electronic health monitoring, emergency response services, personal care, and nursing supervision to individuals who transition out of their facilities and into a community setting. Pilot models could include PACE-like models, financial incentives to NF providers who create MFP-qualified residences or assisted living facilities, and/or for providing traditional waiver services. Pilot projects will be awarded through a competitive procurement process in consultation with consumers.

### *Self Direction*

The five HCBS waivers that MFP participants will use to access community-based services offer a variety of self-direction opportunities that vary with each waiver. The Older Adults, Community Pathways, and Traumatic Brain Injury Waivers have the fewest opportunities for self-direction, incorporating the consumer in the care planning process but not offering additional self-direction options. The Living at Home Waiver offers participant centered planning, the consumer employed model of attendant care, and optional self-delegated care. The New Directions waiver offers the greatest number of options for self-direction, including support brokerage, supported employment, community supported living arrangements (personal supports), assistive technology, accessibility adaptations, and transportation. For additional information on these self direction options, please see section B.7.

MDoA, through a partnership with the Veterans Health Administration, is administering the Veteran Directed Home and Community Based Services Program which provides veterans with a flexible benefit that they self direct in order to purchase community-based long term supports and services. Implementation is set to start in Baltimore County in 2011, with additional counties to follow. The Community Living Program referenced above, also offers a flexible benefit that is self directed. Both programs use a cash and counseling model with a fiscal intermediary and support for consumers in managing their budget.

Self direction of personal care services is an option under Community First Choice (CFC) created by the Affordable Care Act. Maryland is exploring CFC with stakeholders and intends to form an Implementation Council to provide guidance on the development of a self-directed option through CFC. Should the Department implement CFC; rebalancing funds will be used to support the start-up administrative costs associated with the change such as supports for consumer participation in the Implementation Council, technology, training, and outreach.

### *Stakeholder Involvement in the LTC System*

Maryland's initial application for the MFP demonstration was based on stakeholder input. Once the grant was received, an announcement was posted on the DHMH website, and the State engaged in an extensive process to convene, listen to, and respond to stakeholder concerns, questions, and recommendations that continued throughout the planning process. Since the beginning of Maryland's MFP program, meeting schedules have ranged between biweekly and



quarterly. Generally the group meets monthly to discuss implementation issues, hear presentations on topics of interest, and provide input for future planning. In 2010 the group changed meeting locations in order to provide audio and video conferencing capabilities for stakeholders that are unable to attend meetings in person.

In addition to the MFP Stakeholder Group, there are stakeholders involved in the various Medicaid Waiver Advisory Committees, the MAP Advisory Board, and the Long Term Care Reform Work Group. For additional information on stakeholder involvement in the MFP demonstration, see section B.4.

#### *Description of the Demonstration's Administrative Structure*

The Department of Health and Mental Hygiene administers Maryland's Medicaid program. Within DHMH, MFP is housed within the Office of Health Services, in the Long Term Supports and Services Administration. There are thirteen dedicated positions for the MFP Demonstration that are paid for by the grant, the MFP Project Director, Associate Project Director, Data Specialist, Behavioral Health Specialist, Housing Supervisor, four Housing Specialists, Finance Specialist, Statewide (DDA) Transition Coordinator, and two Community Placement Specialists. All thirteen positions are full time positions in the Office of Health Services, Long Term Care and Community Support Services Administration and 100% of these positions are dedicated to the MFP Demonstration.

Collaboration with sister State Departments has been invaluable to the demonstration. Strong leadership from MDoA and MDOD has allowed for quick implementation of rebalancing initiatives and additional quality oversight and monitoring. DHMH will continue to work with both Departments, specifically with MDoA in order to provide options counseling and MDOD for peer supports. Stronger partnerships with the Departments of Human Resources and Housing and Community Development will also become a priority during the extension period.

State University systems have provided important support to the MFP demonstration. The Schaefer Center, a policy institute within the University of Baltimore, administers the Quality of Life Survey to MFP participants through a Memorandum of Understanding (MOU) with DHMH. The Hilltop Institute, a research institute housed within the University of Maryland, Baltimore County, developed and maintains the web-based MFP tracking system, as well as provides data analysis to assist in the decision making process. The Hilltop Institute activities are also funded through an MOU with DHMH.

#### **1. Benchmarks**

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

## 1.1 Required Benchmarks

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

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

| <b>Projections</b>         | <b>CY2012</b> | <b>CY2013</b> | <b>CY2014</b> | <b>CY2015</b> | <b>CY2016</b> | <b>TOTAL</b> |
|----------------------------|---------------|---------------|---------------|---------------|---------------|--------------|
| <i>Elderly</i>             | 220           | 264           | 317           | 381           | 457           | 1639         |
| <i>Physically Disabled</i> | 149           | 163           | 180           | 198           | 217           | 907          |
| <i>Other: Brain Injury</i> | 15            | 15            | 15            | 15            | 15            | 75           |
| <i>MR/DD</i>               | 20            | 20            | 20            | 20            | 20            | 100          |
| <b>Total Transitions</b>   | <b>404</b>    | <b>462</b>    | <b>532</b>    | <b>614</b>    | <b>709</b>    | <b>2721</b>  |

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

In the context of MFP, qualified expenditures are those waiver and State Plan services for which the State will seek an enhanced match. The table contains the projected costs of these services for all individuals in the given year. Should an application for the Balancing Incentive Payments Program be pursued, this benchmark will be expanded or supplemented to report *increased HCBS percentage of total Medicaid LTSS spending* required by BIP. The dollars and percentage data could include both totals and breakdowns between non-DD and DD spending as in Table A.2.3 to track accelerated rebalancing of spending toward HCBS in the non-DD LTSS systems

*Table A.2.2* Total Projected HCBS Expenditures by Calendar Year

| <b>CY 2012</b> | <b>CY 2013</b>  | <b>CY 2014</b>  | <b>CY 2015</b>  | <b>CY 2016</b>  | <b>TOTAL</b>    |
|----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| \$966,129,077  | \$1,019,259,852 | \$1,075,312,473 | \$1,134,447,621 | \$1,196,834,816 | \$5,391,983,839 |

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

## 1.2 Maryland's Benchmarks

*System-wide Rebalancing*

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



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

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

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

*Table A.2.3 Percent of Medicaid Long-term Care Service Days Provided in the Community*

|                                   | CY 2012      | CY 2013      | CY 2014      | CY 2015      | CY 2016      |
|-----------------------------------|--------------|--------------|--------------|--------------|--------------|
| <b>All HCBS Days / Total Days</b> | <b>65.77</b> | <b>68.81</b> | <b>71.84</b> | <b>74.87</b> | <b>77.90</b> |
| Without DD Waivers and SRCs       | 50.5         | 54.8         | 59.1         | 63.4         | 67.7         |
| Only DD Services and SRCs         | 99.0         | 99.0         | 99.0         | 99.0         | 99.0         |

This benchmark reflects Maryland's goal to increase the proportion of long-term care services provided in the community rather than in institutions. The State has already made considerable progress in rebalancing the system through which individuals with developmental disabilities receive services. While continuing to build on this progress, the State hopes to accelerate rebalancing in the other long-term care service delivery systems.

*Progress with Transitions*

**Benchmark 4: Number of nursing facility residents informed of their community care options through Options Counseling each year.**

This benchmark reflects the number of facility residents who receive Options Counseling in each year. The State will use its existing data tracking system to log referrals and service provision and require the contractor to document contacts with each resident.

*Table A.2.4 Number of nursing facility residents educated about HCBS through Options Counseling*

| CY 2012 | CY 2013 | CY 2014 | CY2015 | CY2016 |
|---------|---------|---------|--------|--------|
|---------|---------|---------|--------|--------|

|       |       |       |       |       |
|-------|-------|-------|-------|-------|
| 2,171 | 2,434 | 2,729 | 3,060 | 3,432 |
|-------|-------|-------|-------|-------|

Though this benchmark is more process oriented, the State believes that the central goal of the peer supports and options counseling is to provide information about options for receiving community services to as many potentially eligible individuals as possible. Based on the current number of program education referrals from peers and completed program education sessions, the State anticipates that contractors will document over 2,000 Options Counseling sessions with nursing facility residents next year.

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

This benchmark intends to measure the effectiveness of housing assistance provided through the demonstration. The measure reflects the number of individuals who secure housing with assistance from transition coordinators and MFP housing specialists in a given year. In an effort to measure overall rebalancing through MFP initiatives, individuals who are determined ineligible for MFP after receiving housing assistance will be counted in this benchmark (e.g., if an individual transitioned after less than 90 days in the institution or if they selected a non-qualified assisted living facility after receiving housing assistance). These numbers also reflect that not every individual who transitions will need or request housing assistance.

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

| CY 2012 | CY 2013 | CY 2014 | CY 2015 | CY 2016 | TOTAL |
|---------|---------|---------|---------|---------|-------|
| 148     | 169     | 194     | 223     | 256     | 990   |

These projections are based on data gained during the initial years of MFP implementation. It is estimated that 55% of LAH participants and 30% of OAW participants will access community housing with support from transition coordinators and/or MFP housing specialists.

**B. Demonstration Implementation Policies and Procedures**

In the first four years of Maryland's MFP demonstration, 1071 individuals transitioned from institutional settings to the community as MFP participants and hundreds more transitioned through parallel programs. The MFP demonstration will help the State further reduce barriers to receiving services in the community as well as target limited state resources to those most at risk of institutional placement. Specifically, the State intends to use lessons learned from the first four years of the demonstration and expand peer outreach, continue to improve the transition process, enhance community-based supports, create new initiatives to build community capacity, and focus on diversion from institutional placement. This section of the protocol outlines the State's policies and procedures as envisioned once the new initiatives and revisions are fully implemented. Individuals interested in pre-existing policies and procedures may request details by contacting [MFP@dohmh.state.md.us](mailto:MFP@dohmh.state.md.us).



## 1. Participant Recruitment and Enrollment

### 1.1 Eligibility for the Demonstration

The populations that will be transitioned through the demonstration are:

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

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

- One day prior Medicaid eligibility
- 90 days residence in a qualifying institutional setting (or settings), excluding rehab stays<sup>2</sup>

### 1.2 Qualified Institutions

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

### 1.3 Recruitment Efforts

#### *Minimum Data Set 3.0*

The Minimum Data Set (MDS) 3.0 is an assessment tool that is used with residents in all Medicare-licensed nursing facilities, regardless of payer source. Section Q of the MDS relates to goal setting and discharge planning. If a person wants to speak to someone about the possibility of returning to the community, a referral to the local contact agency (LCA) is indicated. In Maryland, MFP is the LCA. MFP has worked with the State’s CMS MDS liaison, the Office of Health Care Quality (OHCQ), in order to automate the MDS referral process. Currently, when a referral to the LCA is indicated, a referral to the local Area Agency on Aging is made through the MFP tracking system and program education is provided to the nursing facility resident, regardless of Medicaid eligibility status. This process will continue but Options Counseling will

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<sup>2</sup> While the least restrictive MFP eligibility will be used, in order to be eligible to apply for an HCBS waiver without accessing one of the registries, Maryland’s MFI act requires at least 30 days of the individual’s nursing facility stay are eligible to be paid for by the Program (Medicaid).



replace program education. Options counseling is described in detail below in 1.4 Enrollment in MFP from a Nursing Facility.

*Peer Outreach for NF Residents.* In addition to MDS referrals, the State will receive referrals through regional peer support contracts, procured through a Memorandum of Understanding with the Department of Disabilities. The previous iteration of peer outreach focused only on Medicaid-eligible residents and did not support an on-going relationship between peers and facility residents or staff. The new support model requires peers to establish relationships with nursing facility residents and staff as well as family and resident councils. The peers will have an on-going presence in the facilities in order to share personal experiences with community living and provide support to individuals and their guardians throughout the decision-making and transition process.

These peers will be persons with non-professional life experience with disability or long-term supports, in particular experience transitioning from an institutional setting, and/or in assisting others in transitioning.

In the facilities, peers will describe opportunities for community living, examples of others who have successfully transitioned to community living (including age and disability sensitive examples), how the basic process of transitioning works, and the community-based supports and services available. The peers will have access to written materials, including informational flyers about HCBS and video presentations about the transition process with examples of individuals living successfully in the community. The peers themselves can draw on their own experiences with transition and community living to provide additional information as appropriate. Peers will share this information with residents; guardians; family members and supporters of residents; and facility staff including social workers, nurses, direct support staff, and other medical professionals. Peers will also attend and educate participants of family and resident council meetings. The State and peer outreach contractors will help peers develop positive working relationships with facility staff. Peers will be expected to schedule their visits and to identify themselves when visiting a facility.

When an individual resident or guardian indicates an interest in further exploring HCBS options, the peer will make a referral via the MFP tracking system for options counseling. Options counseling is described in detail below in 1.4 Enrollment in MFP from a Nursing Facility

The Department of Disabilities and their peer supports contractors will be responsible for recruitment and training of peers, monitoring the work of the peers, and collecting and reporting data as required by the State. Training for peers will include information about MFP, basic information on Medicaid –funded home and community-based service options, and the State’s protections from abuse, neglect, and exploitation. The Department will also partner with the ombudsman program for training peers. The Department will approve all training material for the peers to ensure accuracy in presentation of the information and materials regarding community living options, protections against abuse or neglect, and exploitation and the process to report these experiences. The State will ensure availability of alternative formats for all MFP outreach materials and other MFP materials as requested, including audio recordings, captioning, large print, and electronic versions.



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

*SRC and Chronic Hospital Outreach*

A separate peer mentoring process and family mentoring effort was implemented for people with intellectual disabilities described below.

*Peer Mentoring for SRCs.* Maryland currently contracts with the Arc of Maryland's Self Advocacy Network (SAN) for peer mentoring. Community Connections is a peer mentoring initiative where individuals with developmental disabilities who live in the community (referred to as Community Connectors) are paired with individuals who live at the State Residential Centers. SAN staff matches the two individuals and helps them to get to know each other. The goal is for the person who lives in the community to share personal experiences about life in the community with the person living at the SRC. Referrals are received from SRCs, MFP Community Placement Specialists and day programs that SRC residents attend. The person living in the community is paid to make this connection. This effort was expanded in 2010 to provide opportunities for individuals to spend additional time with their Community Connector in the community, to increase the number of available peer mentors, to expand access to peers to all of the SRCs, to allow for peer mentoring opportunities for 6 months following transition to the community. In 2012, this effort will be reviewed and may be merged with the peer support and mentoring efforts for individuals in nursing facilities.

Opposition by family members and/or legal guardians is the most commonly identified barrier to community placement for SRC residents and thus a family-to-family peer mentoring program, called Friends and Family Ties, was deemed vital to the success of Maryland's MFP project for SRC residents. Family mentors address concerns that families share about their loved ones living and working in the community, such as the loss of health benefits and services, safety in the community, transportation, and assurances that medical needs will be met. To address these and similar fears, family-to-family peer mentoring will provide a forum to share fears openly with other families, a guided discussion on the benefits and effects of living in the community, which may not otherwise have been considered. Outcomes are being assessed as current contract ends February 2012.

*Chronic Hospital Outreach.* Maryland created a pilot resource coordination program in 2003 for individuals with acquired brain injuries to assist them with accessing services and supports that they need in the community, transitioning out of long term care facilities and/or diverting them from institutional care. Resource Coordinators assist individuals with accessing entitlements, finding housing, accessing clinical services, organizing their homes and finances, obtaining employment services and linking with other needed supports in the community so that the individuals can live as independently as possible in their own homes. Maryland's Traumatic Brain Injury Advisory Board, which reports to the Governor and Maryland's General Assembly, recommended expansion of the program statewide. MFP savings are being used to expand the Brain Injury Resource Coordination program to provide enhanced transitional case management



to individuals applying for the TBI waiver program. Resource Coordinators assist with outreach to residents in CARF accredited Chronic Hospitals and State owned and operated nursing facilities as well as to their family, guardians, and other supporters to provide education and support in making decisions about pursuing community living and offer application assistance for the TBI waiver.

*Access to Facilities and Residents.* MFP has worked to gather feedback from nursing facilities related to the new peer support model. Drafts of the proposed changes to the model of peer outreach were sent to both nursing facility industry groups and facility representatives were specifically invited to participate in the stakeholder discussions related to the new model. Prior to implementation in nursing facilities, a letter from DHMH will be sent to each Medicaid licensed facility to announce the changes to the demonstration, and its initiatives in Maryland, its goals and objectives, and the methods of communicating with facility residents. The letter will require that NFs allow peers to have access to residents in order to offer information about community-based living options. The letter will include assurances of the privacy of the residents' personal information and that no resident will be compelled or coerced to participate in any discussion or effort to transition to the community. The letter will also include a process for reporting concerns to DHMH about peers and their access to facilities. The peer support contractors will also receive this letter and have the ability to report concerns about access through the same reporting mechanism. Facility representatives currently on the stakeholder advisory group will have the opportunity to participate in reviewing the letter and to assist in disseminating information to their partners throughout the State. DHMH will continue to include the nursing home providers on its ongoing advisory committee, seek out their input, and ensure that the interests of the facilities are respected during the demonstration.

The Developmental Disabilities Administration (DDA) will send a similar letter to SRCs and their staff will be urged to work collaboratively with the expanded Community Connections peer mentoring program. Family members, guardians, and support staff of SRC residents is regularly receive newsletters which include information about the peer mentoring services, and serve to inform readers about the HCBS waiver programs, waiver quality standards, and benefits of community-based services.

*Targeting.* As the State plans to develop a comprehensive outreach program to reach NF residents through MDS 3.0 Section Q referrals, as well as peer support contracts as described above, the only targeting criterion used for this population will be residency in a Medicaid-licensed nursing facility.

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

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

*Transition Coordination.* The existing case management entities for each waiver are responsible for assisting individuals during the period of transition and will coordinate community services, assist the individual with securing providers for the approved waiver services, and administer



waiver transition funds and MFP flexible funds available for demonstration participants up to 60 days after the day of transition. The transition coordinators are highly knowledgeable about community living and resources, including but not limited to: housing options, home health providers, disability specific resources, assistive technology, medical equipment and supplies, and other local area resources, as well as Maryland Medicaid, including its programs, services, medical and financial eligibility criteria, complaint and fair hearing processes, and administrative processes. The transition coordinators will have access to the State-generated training and informational materials as well.

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

*Options Counseling.* Residents that want to explore the option to return to the community will be referred for options counseling. Options counseling will replace and merge the existing program education and application assistance services. The 19 local Area Agencies on Aging (AAAs) and their disability partner agencies will provide options counseling to nursing facility residents that indicate an interest in community living. Referrals for options counseling will come from the peer supports partners, the Minimum Data Set 3.0 (MDS 3.0) Section Q, ombudsman, waiver staff, nursing facility staff, information and assistance staff, family members, etc. Initially, 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 options counseling will provide further program information about each of the home- and community-based services (HCBS) waivers for which the individual may be eligible and assist the individual in understanding his or her options. The information can be shared with other interested people at the resident's request, such as family members, guardians, and other supporters.

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



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

*Housing Assistance.* As housing is one of the main barriers to community living, housing assistance may greatly increase the number of people that are able to make the transition. In 2009 and 2010, housing training was provided through the MFP demonstration to develop housing expertise among waiver case managers and MAP partners who will provide information about types of housing options, the availability of housing, and the housing subsidy systems. Due to the feedback that housing assistance should be provided by individuals with housing knowledge and expertise, 5 housing specialist positions were created within the MFP administration at DHMH specifically to work with consumers, family members or representatives, and case managers to assist individuals to access affordable, accessible housing. They provide intensive support to complete applications, acquire needed documentation, and secure housing. Housing assistance may also include opportunities for MFP participants to visit potential houses using their supplemental service funds (Section B.5.4). In addition to this individual assistance, the MFP housing team is responsible for monitoring and working to improve the housing situation for MFP demonstration participants. The MFP housing team will develop relationships with local housing authorities, developers, and other partners working on the same goals to increase housing opportunities and to more efficiently identify and access housing as it becomes available. This service will be vital to those seeking independent community housing.

*MFP Eligibility Determination.* Once an individual is determined eligible for the waiver, the transition coordinator will determine whether the individual is eligible for the MFP demonstration and its supplemental services. It is estimated that only a fraction of the individuals who apply for waiver services will meet the eligibility criteria for the demonstration. In order to verify that the individual has 90 days of residence in an institution or institutions, the transition coordinator will use data from current and former facilities of residence. This data can include admission and discharge dates. MFP participants may be eligible for additional services, but the State will in no way discourage MFP ineligible individuals who meet the waiver eligibility requirements from transitioning to the community.

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

*Relevant Legislation.* In July 2005, Maryland House Bill 794, entitled *Developmental Disability – Written plan of Habilitation – State Residential Centers*, was passed requiring independent resource coordinators to be part of the development of a Written Plan of Habilitation for all



individuals residing in State Residential Centers. The Written Plan of Habilitation (WPH) is developed by the individual, an independent resource coordinator, and a treating professional designated by the SRC facility Director on an annual basis or more frequently as requested. The plan includes recommendations from both the treating professional and the resource coordinator regarding the most integrated setting appropriate for the individual. As of June 2009, if no individual or family opposition to transition has been identified, a referral to the Regional Office is to be generated by the team.

The current WPH Information Form was modified in 2010 to reflect decision making for the person, his/her participation during the meeting, and how opposition was determined as recommended by the Advisory Committee. Training on the new WPH Information form was provided to treating professionals and resource coordinators in February 2011 and the new form was subsequently enacted.

As noted in the July 2011 WPH Report, 96% (115 of 120) of SRC residents were recommended for community residential services as the most integrated setting by both resource coordinators and treating professionals. These 115 people reside in Western Maryland (41) and on the Eastern Shore (79).

*Community Placement Teams.* For persons with developmental disabilities residing in SRCs, the Community Placement Teams will be utilized to assist in the process of moving into community-based services. Each Community Placement Team will include the SRC resident, an experienced Resource Coordinator (case manager), a community placement specialist, SRC staff, family, guardians, peer mentors from Community Connections, and others as identified by the individual. The Resource Coordinators are case managers who are knowledgeable about Developmental Disabilities Administration (DDA) processes, Medicaid HCBS and State Plan services, and community living options and resources. The Resource Coordinators will complete the application and eligibility process with the residents and their families. The community placement specialist will visit the SRCs, develop relationships with the residents, the center staff, the residents' families, and other interested parties in order to facilitate transition planning. This Specialist will be an essential member of the Community Placement Team who will identify barriers to transitioning for an individual and develop solutions. The DDA Regional Offices will continue to complete the eligibility process. DDA learned a great deal from the experience of closing several SRCs, including the importance of developing very close relationships with families who have concerns about moving their loved ones into the community. The community placement specialist will be a key figure in determining the root concerns of families and working to alleviate those concerns.

#### *Essential Lifestyle Planning*

Essential Lifestyle Planning is one of several person-centered planning processes that helps to identify, organize, and communicate what is important to an individual who needs support services. Essential Lifestyle Plans (ELPs) that are generated through this planning process incorporate the individual's priorities into the service plan.

As people transition out of SRCs and into home and community-based services, person-centered planning is crucial to determining high quality services in the most integrated setting of choice. In order to ensure each individual directs their service plan and that their values are respected, person centered plans will be completed with residents prior to the development of their service



plan for transition. Several staff involved in the closure of Rosewood (SRC) are now certified to complete ELPs and have received training and certification to do so. Additional people throughout the state have been trained to facilitate other nationally recognized person-centered planning systems (i.e. PATH, Circles of Support, etc.) These staff will be utilized to complete person-centered planning for other residents of Maryland SRCs as they plan their transition to the community.

### *Budget Allocations*

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

As part of MFP rebalancing, the DDA completed a pilot of the use of the SIS with an initial 100 transitioning SRC residents. This sample has been expanded to include an additional 900 individuals living in the community. DDA intends to further explore use of the tool to develop appropriate funding allocations based on people's support needs by working in concert with the American Association on Intellectual and Developmental Disabilities (AAIDD) and the Human Services Research Institute (HSRI) to develop a valid and reliable link between SIS scores and individualized budgets, and replace the Individual Indicator Rating Scale assessment with the SIS on a system-wide basis. On going analysis and algorithm development for individuals in SRCs and in community settings will form the basis for budget allocations that meet the needs of individuals with severe disabilities in the community.

### *Ask Me! Surveys*

Maryland MFP Stakeholder Advisory Group expressed many concerns about the national Quality of Life survey tool that is required as a part of the MFP demonstration; particularly that it was not an effective tool for assessing quality of life for people with significant intellectual disabilities. In Maryland, the Ask Me! Survey has been used annually since 2002 to collect information from people receiving community-based services through Developmental Disabilities Administration (DDA). The Ask Me! Survey measures people's perceptions of the quality of their lives and allows people with intellectual disabilities to define quality of life for themselves. People with intellectual disabilities helped develop the survey instrument and procedures, promote the survey, and conduct the interviews. The Ask Me! Project has demonstrated that people with intellectual disabilities elicit and provide data on quality of life that are valid, reliable, and useful for program enhancement. As Maryland has already been using an effective tool for measuring quality of life and has historical data on people receiving supports in the community, DDA chose to administer the Ask Me! survey to people who transitioned out of Rosewood through MFP. This survey was conducted in addition to the MFP Quality of Life survey. While this survey provided valuable information, the response rate and follow-up surveys for the Ask Me! were not as high as those achieved by the MFP QoL surveyors and the separate, second survey will not be implemented for future transitions.

## 1.6 Enrollment in the TBI Waiver



Resource Coordinators will assist with outreach to residents in CARF accredited Chronic Hospitals and State owned and operated nursing facilities as well as to their family, guardians, and other supporters to provide education and support in making decisions about pursuing community living, application assistance and coordination of needed community resources and supports for the individual, and enhanced transitional case management to ensure successful transitions to the community.

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

#### 1.7 Reenrollment and Reinstitutionalization Policies

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

If an individual completes 12-months of participation in the demonstration, and, for whatever reason, returns to a NF, chronic hospital, IMD, or SRC, the individual may return to the community as a demonstration participant if he or she meets the same initial demonstration requirements: 90 days of continuous residency in the institution, is Medicaid eligible on the day prior to participating, and returns to a qualifying residence.

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

#### 1.8 Ensuring Informed Choices about Care

Participants in the Maryland Money Follows the Person Demonstration will receive home- and community-based services through the existing and ongoing 1915(c) waivers that are currently in place. These waivers all require institutional level of care and participants are re-evaluated annually for medical eligibility. Therefore, an individual participating in a HCBS waiver remains eligible to receive their long-term care services in an institutional setting and can choose to



utilize institutional services rather than community-based services at any time. Maryland's HCBS waivers are voluntary and the participant is informed of their options for care by the waiver transition case manager during the enrollment process and indicates their preference for services on the informed consent form.

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

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

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

### **2.1 Informed Consent Procedures**

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

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

The State currently does not have a statutory or regulatory basis for determining who can and cannot provide informed consent without a formal adjudication process. Thus, in most instances,



informed consent is a process where there is agreement that the person involved is aware and is making an express choice to live in the community.

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

Consent Form for Money Follows the Person

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

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

In order to participate in the Money Follows the Person program, I have been informed that I must meet all of the eligibility requirements specific to the Money Follows the Person program, which include 90 days living in a qualified institution (excluding rehab stays), such as a nursing facility or State Residential Center, one (1) day of Medicaid eligibility prior to my date of transition to the community, and finally that I must choose to live in a qualified residence, defined as:

1. A home owned or leased by myself or a family member;
2. An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which myself or my family has domain and control.
3. A residence, in a community-based residential setting, in which no more than 3 other unrelated individuals reside.

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

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

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

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



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

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

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



to improve quality assurance and ensure that systems are in place for preventing the reoccurrence of incidents and complaints.

## 2.2 Guardianship under MFP

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

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

In all other cases, the resident of the institution will be the person providing the signature for the MFP consent form. However, other individuals who are representative payees or other legal representatives associated with the individual will be contacted by the transition coordinator or community placement specialist at the time of referral so that representatives can be involved in the process of planning for transition. Guardians and other interested parties identified by the individual will be an ongoing part of the transition planning process.

The State requires that the guardians have a known relationship with the person and that the person must interact with the individual. The law states that guardians "shall maintain appropriate records to document the care and maintenance services provided directly to the disabled person to receive any payment under this subsection" (Annotated Code of Maryland, Estates and Trusts Article § 13-708. Rights, duties and powers of guardians). The state does not have a specific visitation requirement for non-public guardians. However, non-public guardians are required to report on their activities at least annually to the court that appointed them. This current reporting practice will serve to fulfill any requests for information from CMS regarding MFP participants.

For most individuals residing in SRCs, family members act as guardians. However, on occasions where a family member is unavailable and some manner of guardianship is necessary, a public guardian is appointed. The Area Agencies on Aging (AAAs) and the Department of Human Resources (DHR) serve as public guardians for many people with disabilities, including some individuals currently living in nursing facilities and SRCs. The AAAs are required to visit those for whom they serve as guardians at least quarterly, and DHR is required to visit at least every six months. The AAAs and DHR maintain their own records of their contacts and will provide information on recent visits to the transition coordinator or community placement specialist at the time of application when the guardian signs the consent form for demonstration participation. Private guardians will be encouraged to visit individuals for whom they have been awarded



guardianship and to provide information on the frequency of their visits to the transition coordinator or community placement specialist at the time of application. The MFP project does not have the legal authority to compel private guardians to provide visitation data. It is the court's responsibility to ensure that guardians meet their obligations. If the project staff have reason to believe that a private guardian is not acting in the best interests of the demonstration participant, the State may seek redress to the court that appointed the guardian.

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

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

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

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

As described in targeting section B.1., to reach institutional residents and staff, the State will provide extensive outreach via peer support 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. These peers will use materials that are approved by the State. Outreach materials will consist primarily of a general informational flyer and handouts from the Maryland Medicaid Home and Community-Based Long Term Care Services booklet, or "blue book," of information distributed by the Department of Health and Mental Hygiene each year. Attached is the 2009-2010 informational booklet that will be used during the outreach and marketing of services to institutional residents (Appendix C). The general informational flyer will include information about the peer supports in facilities to inform residents of their community-based care options, the assistance available to assist with the transition, and contact information for additional questions or assistance. The materials will be provided to CMS upon completion. Additional information on peer outreach contracts is detailed in Section B.1.3.

Peers will work with institutional residents, family members, guardians, and facility staff. Outreach will be provided through marketing materials developed by the State and will be disseminated through letters to the institutional providers, educational articles in industry publications such as the Health Facilities Association of Maryland (HFAM) and LifeSpan Network newsletters, and through State-sponsored trainings for providers. The State will develop alternative formats for all MFP outreach materials and other MFP materials as requested, including audio recordings, captioning, large print, and electronic versions. . Individuals will also be able to access the outreach materials for MFP and the waiver programs through the MAP website. This site will serve as a web-based single point of entry for information about available



programs and services in Maryland. DHMH will partner with the MAP to ensure that MFP related materials are accessible through this site.

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

### 3.2 Training Professionals

Outreach will be expanded to hospitals in order to provide training for hospital discharge planners on available community options. Many people in nursing facilities came from a hospital stay and if there is more awareness about home and community based options, discharge planners can explore other options prior to institutional placement and educate individuals about options prior to a rehabilitation stay at a nursing facility so rehab stays are less likely to be prolonged.

Additional outreach and in-service training will be provided for MFP partners including discharge planners, MAP staff, peers, ombudsman, and others on topics related to MFP such as quality requirements, opportunities, and supports available in the community.

MFP will work to develop collaborative relationships with nursing facilities and their trade associations. Training and outreach will be provided to nursing facility owners, administrators, and staff to encourage their enrollment as providers in existing HCBS programs and promote the expansion of NFs into community-based personal care, nursing supervision, and other services.

Trainings relevant to MFP will be offered for health care providers and professionals working with persons with disabilities. Trainings will include information about MFP initiatives, affordable and accessible housing, and person-centered planning. The trainings will be extensively advertised through licensing and professional organizations such as the National Association of Social Workers (NASW) and the MFP stakeholder Advisory Group. The State will work with a local college to provide CEUs for attending the training program as an incentive for professionals to attend.

#### *Statewide Training for Staff at DDA Licensed Providers*

Quality training for direct support staff is a critical component in ensuring the availability of staff to provide supports to individuals with developmental disabilities in community settings. Quality training is based on core competencies and skill standards, and results in a more competent and effective workforce. DDA is looking for a recognized and validated training program with skill standards developed with input from direct support professionals, consumers, trainers, agency administrators, educators and others interested in the quality of services. The goals for implementing a new training system are to improve the quality of supports, as well as to improve retention of staff, job satisfaction, training satisfaction and to decrease provider costs associated with high staff turnover rates. DDA would like to utilize a training system that includes valuable management and human resource tools which assist states and licensed providers with tracking and recording all training and assessment activities.



The Developmental Disabilities Administration (DDA) will explore the purchase a state license for a new training system through MFP. A state license could ensure that the same high quality, competency-based training is available to all of the staff that supports the more than 22,000 individuals who receive direct support professional services funded by the DDA.

#### *Behavioral Health Provider Training*

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

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

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

However, due to budget constraints, advocacy efforts to add services were not successful. The MFP Behavioral Health Workgroup reconvened in July of 2009 and met through March of 2010, but once again efforts to implement recommendations stalled. In 2011, MFP procured 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 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 the Mental Hygiene Administration and the local mental health authorities.

#### **4. Stakeholder Involvement**

##### 4.1 Stakeholder Involvement in Demonstration Planning

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

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

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



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

Since the implementation of Maryland's MFP program, meeting schedules have ranged between biweekly and quarterly. Generally the group meets monthly to discuss implementation issues, present on topics of interest, and provide input for future planning.

The MFP Demonstration was extended through the passage of the Affordable Care Act of 2010 and Maryland began a series of discussions regarding revised MFP rebalancing initiatives and their inclusion in the operational protocol rewrite in July of 2010, when a time line and plan for completing the rewrite were presented to the Stakeholder Advisory Group. The topic has been on the agenda for the group every month since that time, and there have been at least 18 stakeholder meetings that addressed components of the operational protocol since. Each meeting offered a call-in option and the ability to view a video broadcast of the meeting via the internet. There were between 20 and 45 attendees, including at least 3 consumers, at each meeting.

In the fall of 2010, based on stakeholder input, Maryland developed a set of metrics with the Hilltop Institute in order to provide adequate information to the stakeholder group about the outcomes of our current rebalancing initiatives. The Hilltop Institute conducted research and presented the metrics to the stakeholder group five times over the course of four months between October, 2010 and January, 2011. Subsequent stakeholder meetings were used to discuss how existing initiatives could be modified or enhanced in the operational protocol re-write. In April, stakeholders were presented with a compilation of ideas and a list of proposed rebalancing initiatives. At the April 5, 2011 meeting, the stakeholders broke into small groups in order to discuss and gather feedback on rebalancing priorities. A survey on rebalancing priorities was developed and given to the group at that meeting. The survey was then put online and sent to the 200+ names on the MFP stakeholder email list, in order to gather feedback from a larger audience. This feedback was used by the Department to develop Maryland's proposed rebalancing initiatives, which reflects stakeholder ideas and includes the requested details of each proposed initiative.

Current consumer advisory group members will be encouraged to continue participating in the advisory group. Consumers and their families will continue to be welcomed to the advisory group to collaborate on the demonstration as it progresses. In January of 2012, the MFP Stakeholder Group will join with the newly formed BIPP sub-group and the expanded group will continue to work on rebalancing.

*MFP Project Director.* Following the departure of the initial Project Director, the State's 2011 search for the MFP Project Director culminated in the selection of Devon Snider who previously served as the MFP Associate Project Director. Ms. Snider brings her social work background and four years of Medicaid experience to the MFP demonstration project. She encourages all stakeholders to contact her directly by email or phone. Regular updates about the demonstration are sent by email to over 200 people who have asked to be notified.





likely to employ current consumers and their families in the role of peer mentors so that consumers and advocates will have a direct role in the outreach and marketing of Maryland's community-based care options and in the direct support of individuals who are seeking to transition. This will provide an avenue for consumers to directly influence the process and better inform the Advisory group of transition challenges and successes. Consumers will continue to be involved through the Advisory Group and may assist the process by including advertisements and articles in their publications regarding the MFP demonstration. These publications may help to educate consumers and families while promoting the goals of the demonstration.

#### 4.5 Specific Roles for Institutional Providers

Institutional providers are an essential element of the MFP demonstration. They will continue to provide care for their residents as well as play a role in the transition process for those individuals who pursue community living. Direct care staff at facilities often advise residents and inform nurses about elements of care that will be needed in the community. In addition, direct care staff of the SRCs may participate in trainings and be encouraged to pursue employment as community providers in order to continue supporting the individuals whom they serve as they move to a new setting. Nurses who develop institutional plans of care may be consulted in the process of developing the community plan of care. Social workers at the facilities will be providing direct assistance to the residents in the transition process by helping to secure needed documentation, such as prescriptions from doctors and copies of medical records, and will be helping to obtain durable medical equipment needed prior to and at the time of transitions. The cooperation of all staff working with residents at institutions will be required to facilitate a smooth transition and continuity of care between settings. Institutional administrators will need to understand and support the MFP demonstration so that they can assist in disseminating the information and encourage facility staff to fully participate in the process. The professional organizations that represent the staff at facilities may help support the project by allowing advertisements and articles about MFP in their newsletters and websites.

#### 4.6 List of MFP Stakeholder Organizations

- HCBS Consumers
- Baltimore City CARE Service (AAA)
- Baltimore County Office on Aging (AAA)
- The Brain Injury Association of Maryland (Advocacy Organization)
- The Coordinating Center (Non-profit Waiver Case Management Provider)
- Eastern Shore Center for Independent Living (CIL)
- Friends and Family Ties-Shared Supports (Non-profit Provider)
- The Freedom Center (CIL)
- Health Facilities Association of Maryland (Nursing Facility Provider Association)
- The Hilltop Institute (Research Center)
- Howard County Office on Aging (AAA)
- The Image Center (CIL)
- Independence Now (CIL)
- LifeSpan Network (Nursing Facility and Senior Care Provider Association)
- Maryland Disability Law Center (Protection and Advocacy Organization)
- The Mental Health Association of Maryland (Advocacy Organization)



- Millennium Health and Human Services (Community Based Outreach Organization)
- Montgomery County Aging and Disability Services (AAA)
- People on the Go (Statewide Self-Advocacy Organization)
- Prince George's County Administration on Aging (AAA)
- Resources for Independence (CIL)
- Southern Maryland Center for Independent Living (CIL)
- The Sunshine Folk (Advocacy Organization)
- Voices for Quality Care (Advocacy Organization)

#### 4.7 List of State Agency Partners

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

### 5. Benefits and Services

#### 5.1 Benefits of MFP for Demonstration Participants

The primary benefits associated with the MFP Demonstration are peer support and mentoring, options counseling, housing assistance, and one time only transition funds. These priorities were identified through the stakeholder process to assist individuals in transitioning into the community.

The peer supports program is designed to provide outreach and education about community living to institutionalized persons and their families in a comprehensive and accessible way. Peers will be able to reach out to individuals and share information about choices, opportunities, and challenges associated with leaving an institution in a personal and accessible format through sharing their own experiences. In addition, regionally based peer mentors will enhance the connection to the local community and the option of ongoing peer support will assist institutionalized individuals gain comfort, knowledge, and skills in accessing and navigating their communities while in the process of transitioning and throughout their year of MFP eligibility.

Peer support is available to residents of SRCs. Currently; peers spend time with SRC residents at the facilities and occasionally participate in community-based events with SRC residents and staff. There is little data to demonstrate that this effort is having an impact on the residents' comfort in the community and desire to transition and stakeholders have questioned its efficacy due to the structured facility-based events and limited amount of mentors available. The DDA intends to conduct an evaluation of the service in early 2012 and explore the option of merging

this effort with the peer supports available to individuals in nursing facilities. The NF peer efforts could be expanded to include all SRC residents and residents of nursing facilities with intellectual disabilities, and increase the focus on community activities, integration, and exploration of HCBS.

Family mentoring is currently provided to family members of SRC residents. Due to difficulty in developing one-to-one family mentoring partnerships in the first few years of the MFP demonstration, the initiative was refined to focus on family education and events. Families of former SRC residents who have been through the transition process are available to provide support to families of current SRC residents in the process of transition. Family mentoring will continue to be available through the end of the current contract and advertised to SRC families and staff, but the major focus of the initiative will remain on educational events and group support rather than individual mentoring.

TBI peer support is a new initiative that would build on the current peer support models and pilot peer support for TBI waiver applicants, participants, and their families. This model is carved out from the NF model because the TBI waiver includes chronic hospitals and requires a more narrow definition of a peer with specialized knowledge, training, and support.

Options counseling, as described above in the Project Introduction on page 11 and in section 1.4 *Enrollment in MFP from a Nursing Facility* on page 23, will aid individuals in learning more about community options and increase access to the current home- and community-based services.

As housing is one of the main barriers to community living, housing assistance may greatly increase the number of people that are able to make the transition. MFP housing specialists work with potential and enrolled MFP participants to provide information about types of housing options, the availability of housing, and the housing subsidy systems. They will provide intensive support to complete applications, acquire needed documentation.

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

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

These services will utilize different mechanisms for implementation and have varying timelines. The contract for peer supports will be managed by the Maryland Department of Disabilities and is set to begin January 1, 2012. Options counseling will begin on January 1, 2012 and will be provided through MAP sites via a collaborative effort between the local AAA and their disability partner.

For SRC residents, Community Placement Specialists and a Statewide Transition Coordinator will work to enhance community placement efforts. During the demonstration these positions



will be funded through the federal funds received through the demonstration and be billed as an administrative cost, not as a waiver service. The State proposes to transition 20 individuals with intellectual disabilities out of SRCs and nursing homes each year to further expand community-based services by the end of the demonstration period. As the system has less than 3% of consumers in institutional settings, there will no longer be a need for these positions after the demonstration and they will not continue. However, the knowledge and skills gained through the project will enhance the capacity of the DDA Regional Offices and Resource Coordinators to continue deinstitutionalization work for SRC residents.

The State added services to the waivers during the first years of the MFP demonstration. Home delivered meals, dietician and nutritionist services, and environmental assessments were added to the Living at Home waiver and transition services were added to the Older Adults Waiver. Some individuals remain institutionalized because they can not receive in-home personal support services for more than 12 hours per day within the cost neutrality of the waivers. Adding a roommate service, shared attendant care, a supervision rate, or daily rate to the waivers could offer options outside of the institution. *This initiative would require budgetary authorization from the Department of Budget and Management because of the ongoing state cost that can not be covered by MFP. However, MFP stakeholders and members of the MFP Behavioral Health Workgroup continue to advocate for the addition of these services with the legislature and budget officials.*

The clubhouse model of day program services will be added as a service to the TBI waiver during the extension.

In order to assist MFP participants to integrate successfully at home or in new housing, MFP may support pilots of evidence-based programs. Programs to be explored include, but are not limited to, the Living Well Program (Chronic Disease Self Management Program), PEARLS, and a modified bundle of existing services such as occupational therapy, environmental modifications, and assistive technology.

### 5.2 Continuous Case Management

The waiver case management services for demonstration participants will be the same as those that are currently offered to all waiver participants. For the Older Adults and Living at Home waivers that will be serving nursing facility residents who have transitioned, case managers are required to complete an annual review of the waiver plan of care/service. The Living at Home (LAH) case managers are required to have monthly contact and quarterly face-to-face visits with each participant. These case management services are provided through a single statewide provider. The Older Adults Waiver (OAW) participants receive case management services through the local Area Agencies on Aging who are required to have quarterly contact with participants. However, the case management for the Older Adults waiver will change from an administrative function to a waiver service beginning in 2012. A 1915 (b)(4) waiver to limit the providers to the local AAAs is currently under consideration at CMS and a 1915(c) waiver amendment is being completed. By July of 2012, the case management requirements for the OAW will match those of the LAH waiver, including lower caseload ratios and required monthly contacts.

For the Community Pathways and New Directions waivers that will be serving individuals discharged from the SRCs and individuals with intellectual disabilities leaving nursing facilities, the Resource Coordinators (case managers) are required to have contact a minimum of twice per year and complete new plans of care annually with the individual. The DDA provides Unified Funding Agreements with 13 local health departments and contracts with additional case management agencies to provide Resource Coordination services to participants of these waivers.

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

### 5.3 Receiving Services in the Community

Maryland has chosen to offer MFP demonstration participants services primarily through five existing HCBS waivers. On the day of transition to the community, an individual will use a slot in one of the waivers. As noted in the Project Introduction, Maryland's Money Follows the Individual policy and Waiting List Equity Fund assure that anyone transitioning from an institution who meets the eligibility criteria for a waiver will be able to access the waiver program, regardless of caps or waiting lists. As part of their enrollment in the waiver, individuals may access any of the approved waiver services as well as any services available through the State Plan. See B.5.4 for a list of services available through each waiver and the State Plan.

In some cases, individuals may meet the MFP eligibility criteria, but will receive their qualified home and community-based services through the State Plan. These specific State Plan services are detailed in *Table B.5.4 Qualified HCBS State Plan Services*.

Prior to their transition date, all MFP participants may access the supplemental services available only to demonstration participants; however, reimbursement to the providers will only be made after successful transition as an MFP participant. See sections B.5.1 and B.5.4 for a description of the supplemental services and their administration.

All demonstration participants will have access to acute care services through current Medicaid programs, but these acute care services will not be included as demonstration services in accordance with current CMS guidelines.

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

### 5.4 List of Waiver, State Plan, and MFP Services

*Service Category 1: Qualified Home and Community-Based Services*



Table B.5.4.1 Qualified Home and Community-Based Services

Waivers\*

| Service Type                      | Service  | OAW | LAH | CP | ND | TBI |
|-----------------------------------|--|-----|-----|----|----|-----|
| Home and Community Based Services | Assisted Living  | X   |     |    |    |     |
|                                   | Assistive Devices / Equipment / Technology                     | X   | X   | X  | X  |     |
|                                   | Attendant Care / Personal Care / Personal Supports/CSLA        | X   | X   | X  | X  |     |
|                                   | Behavior Consultation/Supports                                 | X   |     | X  | X  |     |
|                                   | Case Management / Service Coordination / Resource Coordination | X   | X   | X  | X  |     |
|                                   | Clubhouse Model of Day Supports                                |     |     |    |    | New |
|                                   | Day Habilitation   |     |     | X  | X  | X   |
|                                   | Dietitian / Nutritionist Services                              | X   | X   |    | X  |     |
|                                   | Environmental Accessibility Modifications                      | X   | X   | X  | X  |     |
|                                   | Environmental Assessments                                      | X   | X   | X  | X  |     |
|                                   | Family and Individual Support Services                         |     |     | X  | X  | X   |
|                                   | Family and/or Consumer Training                                | X   | X   |    | X  |     |
|                                   | Fiscal Intermediary  |     | X   |    | X  |     |
|                                   | Home-Delivered Meals   | X   | X   |    |    |     |
|                                   | Medical Day Care   | X   | X   | X  | X  |     |
|                                   | Nurse Monitoring for Personal Care Services                    | X   | X   | X  | X  |     |
|                                   | Personal Emergency Response System                             | X   | X   | X  | X  |     |
|                                   | Residential Habilitation                                       |     |     | X  |    | X   |
|                                   | Respite Care   | X   |     | X  | X  |     |
|                                   | Senior Center Plus   | X   |     |    |    |     |
| Supported Employment              |  |     |     | X  | X  |     |
| Supports Brokerage                |  |     |     |    | X  |     |
| Transition services               | X  | X   | X   | X  |    |     |
| Transportation                    |  |     |     | X  | X  |     |

\*Note: OAW – Older Adults Waiver, LAH – Living at Home waiver, CP – Community Pathways, TBI – Traumatic Brain Injury

*Table B.5.4.2 Qualified HCBS State Plan Services*

|   |
|---|
| <b>State Plan Service</b>                               |
| Medical Assistance Personal Care (MAPC) Program         |
| Disposable Medical Supplies / Durable Medical Equipment |
| Home Health   |
| Psychiatric Rehabilitation Program                      |

The qualified HCBS services offered under the demonstration will receive a 75% federal match for a period of one year for each MFP participant. This means instead of paying 50% of the costs, the State will only be responsible for 25%. The 25% that the State saves will be used to further the goals of the MFP demonstration.

During the initial phase of MFP, the State chose to add three additional qualified HCBS services as part of the MFP demonstration based on stakeholder feedback. Specifically, home delivered meals, dietician and nutritionist services, and environmental assessments were added to the Living at Home waiver and transition services were added to the Older Adults Waiver. The Mental Hygiene Administration would like to add services to the TBI waiver during the MFP extension period, pending budget allocations for the increased services. Proposed new services for the TBI waiver include the clubhouse model of day supports, and specialized occupational, cognitive and speech therapy services that are needed by individuals with brain injury to increase independence and quality of life. If these services are added directly to the waiver they will be available to all waiver participants, not just MFP participants. There is no cost to the demonstration to add the services as the increased service plan cost associated with the additional services would need to be authorized in the State's ongoing budget.

**Clubhouse Model of Day Services**

The TBI waiver currently offers day habilitation as a service to participants. While this model provides valuable supports, there is an alternative model of service that has shown to have positive outcomes for individuals with brain injury. This model is called the Clubhouse model and it provides a variety of comprehensive support services to individuals with brain injury including development of work skills and behaviors, exploration of vocational interests, development of compensatory strategies, social and recreational programs, and participation in a "work ordered day." The clubhouse model is a consumer driven model of care with support from staff. The State would like to offer this model of service to waiver participants to increase the choice of services and possibly improve the quality of life of participants who have access to this service.

However, the model is not currently available in Maryland and providers have indicated that training and start-up costs have been prohibitive. As incentive to bring the model to Maryland, provider incentives will be offered through MFP for costs associated with



efforts to replicate the model. These costs may include travel to other states to visit existing program sites, consultation, training for administrators, recruitment and training of direct support providers, and modifications to clubhouse sites. It is estimated that incentives will be offered to at least two providers to encourage the development of the model in Maryland and provide participants with choice of provider.

*Service Category 2: Demonstration Home and Community Based Services*

Peer mentoring for nursing facility residents was created at the beginning of Maryland’s MFP demonstration program as a demonstration service provided by the Centers for Independent Living. It was believed that offering this service through the demonstration would provide an evidence base for its efficacy and outcomes so that at the end of the demonstration, it would be added as a permanent waiver service with any willing provider. However, the service has had a very low utilization rate in the first few years of the demonstration, and there is not sufficient data about efficacy and outcomes to justify the budget initiative necessary to add the service to the waivers permanently. Peer mentoring will continue to be a demonstration service during the extension period in order to build the evidence-base. The service will be more extensively advertised through the revised peer supports and new options counseling models. A service description is attached in Appendix F.

Enhanced transitional case management was created as a demonstration service for applicants of the Older Adults waiver. The Living at Home waiver chose to add case management as a service during its renewal in the spring of 2009 and applicants to this waiver did not need to access the demonstration service. The Older Adults waiver funded case management administratively and did not offer comprehensive transitional support. In the initial phase of the demonstration, MFP offered enhanced transitional case management as an MFP demonstration service for OAW applicants to ensure transition supports. As noted in Section 5.2 *Continuous Case Management* above, the case management for the Older Adults waiver will change from an administrative function to a waiver service beginning in 2012, eliminating the need for MFP support. Starting January 1, 2012, enhanced transitional case management will no longer be an MFP service.

***Demonstration Services***

| <i>Demonstration Service</i> | <i>Provider</i>                | <i>Rate</i> | <i>Caps on utilization</i> |
|------------------------------|--------------------------------|-------------|----------------------------|
| Peer Mentoring               | Centers for Independent Living | \$7.78/unit | 48 hours per person        |

*Service Category 3: Supplemental Demonstration Services.*

Supplemental Demonstration Service:

- Up to \$700 in Flexible Funds
  - Initial groceries
  - Transportation
  - Other transition necessities

MFP participants will be able to access supplemental demonstration service as listed above. The service will be administered by waiver case managers with oversight from DHMH. After the demonstration, the service will not continue to be available unless the State chooses to fund it with 100% state funds. During the demonstration, the service will receive a 50% federal match. The State is aware that no MFP federal dollars may be expended until the date of transition to the community. If a prospective MFP participant uses supplemental services but does not transition under MFP, the State will not claim matching funds.

*Supplemental Services*

| <i>Service</i>     | <i>Provider</i>      | <i>Rate</i> | <i>Caps on utilization</i>               |
|--------------------|----------------------|-------------|--|
| MFP Flexible Funds | Waiver Case Managers | Varies      | Up to \$700 per participant <sup>1</sup> |

5.5 Funding Mechanisms for Peer Mentoring

The State will offer the peer mentoring services under the authority of the MFP demonstration. This initiative will receive funding as a demonstration service. Peer supports and options counseling will be funded as MFP administrative costs. As outreach activities that will reach many more individuals than those that will transition under MFP, these activities will be funded entirely through MFP rebalancing funds.

Demonstration services receive a 75% match through the demonstration. Supplemental services and administrative expenses both receive a 50% federal match under the demonstration. Supplemental and demonstration services may only be paid for individuals who become MFP participants, and administrative expenses are capped on a per participant basis.

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<sup>1</sup> For individuals that meet the MFP eligibility criteria, but transition and receive their qualified home and community-based services through the State Plan, up to \$3000 of flex funds may be expended.



## 6. Consumer Supports

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

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

### 6.1 Back-up systems

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

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

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

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

*Educational Materials*

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

### *Transportation*

There is currently not one universal back-up system for transportation available to waiver participants as local transportation options are varied. DHMH developed a comprehensive list of transportation options available to Medical Assistance enrollees. The list includes Medicaid transportation information including contact phone numbers, how to schedule transportation, and how to report complaints. It includes non-MA transportation information in local areas as well. This list will be made available to participants of all waivers through waiver case managers in the future so that demonstration participants will be assured access to this information.

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

### *Direct Service Workers*

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

### *Provider Registry*

The Maryland Personal Assistant Services Advisory Committee (PASAC), provider unions, waiver advisory committees, and various other stakeholder groups have advocated for an online, searchable database of providers of HCBS. This type of registry, similar to registries that already exist in other states, would allow participants to search for qualified, pre-screened providers and increase ease of access to support. The development of the provider registry will be pursued during the extension period of the MFP demonstration and may improve access to emergency back-up providers.



*Repair or replacement of durable medical and other equipment*

For the current HCBS waivers, persons in need of durable medical and other equipment are provided with information about their choices for providers in their area during the development of their plan of care or plan of service. This information is disseminated by the case manager during coordination efforts. The participant is given the contact information for the equipment provider and at least one alternate provider in their area. The case manager is responsible for assisting participants in locating and accessing repair to or replacement of medical equipment as needed. Again, lists of available providers may be given to the participant and case manager assistance in coordinating the repair may be provided.

*Access to medical care*

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

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

*Demonstration Support Services*

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

*Supplemental Support Services*

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

*New Emergency Back-up Systems*



The Department is currently pursuing other options for improving emergency back-up services and enhancing monitoring of emergency needs for waiver participants. A new Complaints and Surveillance Unit at the Department has been proposed to triage calls for emergency back-up. This proposed unit would consist of three staff, including one nurse. The staff would rotate on-call hours in order to be available 24 hours per day when the first and second emergency back-up options (a back-up provider on the plan of care and the case manager) fail to resolve the crisis. MFP will support the cost of some of the new staffing, phone lines, and associated technology needs. Some of the staffing for this unit will be funded through other State general funds.

Also proposed is a statewide contract for emergency personal care services. The Department proposes to procure a contractor that will be responsible for maintaining a pool of qualified personal service providers who will be available to waiver participants in emergency situations. The provider would be required to maintain plans for emergency situations such as severe weather and a sudden loss of provider. The contractor would be funded through an administrative contract to retain qualified providers, develop and maintain emergency procedures, and respond within 24 hours to requests for emergency assistance. The actual services rendered would be reimbursed through normal Medicaid service payments and only the administrative cost of maintaining a system of supports would be funded administratively using MFP rebalancing funds.

## 6.2 Complaint Resolution Process and Remediation

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

## **7. Self-Direction**

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

The Department is currently considering the new 1915(k) option of Community First Choice (CFC) for personal care, which offers a self-directed option. If implemented, CFC would offer additional self-direction options for MFP participants.

### *Living at Home*

The Living at Home waiver offers two levels of self-direction for attendant care. The first is the consumer-employed model in which the consumer hires and trains the attendant. COMAR 10.09.55.02 states that the 'Consumer-employed model' means the delivery of attendant care



services when: (a) A waiver participant chooses the attendant who will render services; (b) The attendant is a self-employed Medicaid provider; and (c) The participant utilizes services of a fiscal intermediary. This type of attendant has a nurse monitor that creates a plan of care and is responsible for training the attendant to provide appropriate care to the consumer.

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

For LAH participants choosing to self-delegate care, involuntary termination from self-delegation may be pursued by the service coordinator. If there is a concern that the participant's health is in jeopardy, a meeting will be held with the participant, service coordinator, LAH RN Clinical Supervisor, and provider to discuss concerns and options. If the strategies are determined not to meet the participant's health and safety needs, the service coordinator will inform the participant that the Living at Home Waiver Division will be notified. Once notified, the LAH Waiver Division will review the information provided by the service coordinator and, if necessary, complete the reduction/denial of services form to discontinue self-delegation of attendant care services. The form and appeal rights will be forwarded to the participant. The participant may appeal any decision regarding his/her ability to self-delegate attendant care services under the waiver. The Policy for Self-Delegated Care is attached as Appendix D.

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

### *DDA Waivers*

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

Any individual self-directing their services through the New Directions waiver can elect to change to provider-directed services through the Community Pathways waiver at any time. A participant of the New Directions waiver shall be disenrolled from self-directed services when either: the participant voluntarily elects to disenroll or the Developmental Disabilities Administration determines that: a) the individual no longer meets eligibility criteria for self-directed services through the New Directions waiver; b) the health and safety of the participant



may be threatened; c) a significant amount of the services outlined in the approved New Directions Individual Plan and Budget are not being provided to the individual; d) the Individual Plan and Budget is not being implemented as approved; e) the participant's expenditures or attempts to expend funds are inconsistent with the approved New Directions Individual Plan and Budget; f) there is mismanagement of funds; g) funds have been used fraudulently or for illegal purposes or; h) the individual has been without a certified Support Broker for more than 30 days.

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

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

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

MFP participants who decide to self-direct their services through the New Directions waiver will be provided with information and training about self-directed services, including information about the role of the FMS and available FMS providers. Information about FMS providers is also available at each DDA Regional office and on the DDA website. DDA recommends that individuals/families meet with each of the FMS providers to find the best "fit". It is then up to the individual/family, with any desired assistance from the Resource Coordinator and Support Broker, to make the choice. The individual/family will notify the FMS of their choice and plan for that expense during the development of the New Directions Individual Plan & Budget. Upon



receipt of that letter the FMS works with the individual/family to set up all the necessary paperwork, provide any necessary/desired education and begin managing funds on the participant's behalf. Each individual transitioning to community services, whether in traditional or self-directed services, is assigned a Resource Coordinator. The role of the Resource Coordinator includes: coordinating the planning and budgeting process, assisting the individual/family to interview & choose a support broker, assisting the individual/family to choose a Fiscal Management Service (FMS), if applicable, assisting in the development of the Individual Plan and ensuring that it includes all essential elements (i.e., services to ensure health and safety, emergency back-up plans), monitoring individual health, safety, and satisfaction, monitoring monthly budget statements, and monitoring Emergency Back-Up usage.

### *MFP*

Through the MFP demonstration, opportunities for self-direction will continue. Transitional case managers and Resource Coordinators will use person-centered planning as it is used to develop initial plans of care/service for the LAH, OAW, CP, and TBI waivers. The MFP demonstration has provided training on person-centered planning and continues to advocate that case managers utilize a person-centered service plan development process for all participants who receive transitional case management services. The participant or a chosen representative may direct the components of the Plan of Care, including the choice to reduce services to meet cost neutrality, as long as health and safety assurances are met. Transition coordinators will also apply principles of self-direction to the use of supplemental and waiver transition funds, allowing the participant to spend funds on qualified expenditures of their choosing. Additional person-centered planning training will be offered through the MFP demonstration as well as one-on-one consultation with transition teams to enhance the application of a person-centered philosophy to the waiver process.

## **8. Quality**

Maryland is offering MFP demonstration participants services through five existing HCBS waivers. On the day of transition to the community, an individual will use a slot in one of the existing waivers. Each waiver has a comprehensive quality management system which includes emergency back-up systems and incident reporting and management strategies. Maryland's Community Pathways and New Directions waivers recently revised their quality plans with technical assistance from CMS's contractor, Human Services Research Institute (HSRI), for submission with its recent waiver renewals that were submitted at the end of March 2008. Maryland's Living at Home waiver received technical assistance from Thomson Medstat for submission of its waiver renewal on April 1, 2009. The State assures that all MFP demonstration participants will receive the same level of quality assurance and improvement activities described in the existing 1915(c) HCBS waiver applications during the 12 month demonstration and throughout their participation in the waiver.

### 8.1 Existing Programs

Each of the 5 HCBS waivers that MFP participants may access for community-based care currently have comprehensive quality plans in place. These plans include the details of the quality assurances developed and implemented by the State, including the policy and process in place to ensure quality of individual plans of care and participant's health and welfare. The Older



Adults, Living at Home, Community Pathways, and New Directions waivers currently have a CMS approved 1915(c) Appendix H. For the waivers that will be utilized by MFP demonstration participants that do not have a new Appendix H approved by CMS, the quality assurances are described in more detail below.

#### *TBI Waiver*

To assure quality in care planning and assure the health and safety of participants of the TBI waiver, the case manager, waiver coordinator and the DWP work together. The case manager is responsible for developing the plan of care with the participant, monitoring its implementation, reviewing it for appropriateness on an ongoing basis, and revising the plan as needed but at least annually. The case manager is also responsible for conducting face to face visits with participants each quarter, following up on incidents and complaints. Participant Experience Surveys (PES) are completed with 100% of participants each year by an independent peer (individual with TBI) contractor. The Mental Hygiene Administration (MHA) Waiver Coordinator reviews participant's records and evaluates 100% of the plans of care on a semi-annual basis. The Waiver Coordinator writes plans of correction, as needed, based on their review. MHA's Chief of Long Term Care monitors the plans of correction to ensure resolution of any issues discovered, reviews the PES results, reviews critical incidents reports, reviews any grievances or complaints relating to the case manager, and initiates provider sanctions if needed. The Chief of Long Term Care also leads annual provider visits with the Waiver Coordinator and case manager to ensure that providers are in compliance with regulations, including maintaining appropriate staffing ratios.

#### *Quality Care Review (QCR) Team*

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

#### 8.2 MFP Quality Strategies

Additional quality assurances and improvement activities will be developed for peer mentoring and supplemental services as described below. The State is moving toward a more comprehensive quality management system across all HCBS programs using the CMS Quality Framework articulated in the revised Appendix H of the 1915(c) HCBS waiver application. This effort is designed to create a consistent and uniform strategy to measure and enhance performance across all community long-term care programs and services. The goals of this effort are to: (a) create a more evidenced-based quality management system, (b) improve the ability of the State and HCBS administering agencies and case managers to monitor service provision, (c) improve the capacity of the State to monitor and improve the quality of service from providers, (d) monitor the quality of care and life at the individual consumer level, (e) develop better



quantifiable indicators of quality, (f) improve infrastructure to collect and distribute data on quality indicators, and (g) create more comprehensive and standardized quality reports for improving program operations.

To that end, DHMH has reestablished the Waiver Quality Council with representatives from each waiver administering agency, the Office of Healthcare Quality, and Medicaid, who will work towards these goals over the next year. The Waiver Quality Council brings together these groups to discuss waiver quality management policies and procedures, the aggregate data analysis from the Division of Waiver Programs, and consumer experiences in an effort to develop recommendations for improving data collection and remediation processes. The council is currently working towards improving data collection across waivers to capture meaningful and uniform information on reports so that data analysis can be more efficient and useful to improving quality of care.

In order to enhance quality monitoring and oversight, rebalancing funds will be used to create an electronic system to monitor the provision of home and community-based services. This In-home Supports Assurance System (ISAS) is a way to increase the monitoring of services and remove the burden on consumers to monitor time sheets and report attendance issues of their providers. ISAS will require personal care providers to call-in to an automated system from the home of the participant when arriving and departing each day and to log some details of the services provided. The electronic system will include voice recognition and GPS technology to verify the identity and location of the provider. The system will match the provider's calls with the participant's approved plan of service to verify that the provider is qualified to provide that service and that the service duration and scope match the participant's needs in the plan of care. The system will then create electronic billing and eliminate the need for paper time sheets. Participants, providers, and case managers will have access to real-time reports on attendance via a website. Case managers will be required to use the attendance reports to identify quality issues and to review the reports with participants. The ISAS system will be phased-in, starting with personal care and nurse monitoring services in the Medical Assistance Personal Care program, Older Adults Waiver, and Living at Home Waiver. Other programs and additional in-home supports will be added each year after the initial system is established. Costs to be covered in the first two years include procuring a vendor, software, technology upgrades, and training to all key stakeholders (participants, providers, case managers, and administrators).

As noted above on page 50 in Section 6.1 *Back Up Systems*, in order to enhance the quality monitoring beyond what is currently in place for the existing HCBS waivers, a new Complaints and Surveillance Unit will be established to triage and respond to emergency backup calls. A statewide personal care back up agency will be a complementary initiative that the triaged calls for emergency backup could access. MFP will support the cost of the new staffing, phone lines, and associated technology needs.

As DDA works to rebalance its service delivery system to decrease institutional placements and increase community supports and services there is an increased focus on quality improvement in community-based services tied to the six HCBS waiver assurances required by the Centers for Medicare and Medicaid Services (CMS). As part of a comprehensive quality assurance system there is a need for an information and data system that is transparent to individuals, families, and providers that tracks activities related to quality of care and outcomes in community-based services. The availability of such a system will provide information to drive quality



improvement in community-based services and assist individuals and families in making choices about community-based care and supports. It may also increase the comfort level of those in institutions and their families that quality support systems in community-based services can address their health and safety needs in the most integrated setting.

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

As DDA develops its Strategic Plan to rebalance its service delivery systems, it is expected that consultant services may be required to address specific issues related to services for individuals dually diagnosed with developmental disabilities and mental illness, individual employment services, services for medically fragile individuals, services for aging individuals with developmental disabilities, developing community capacity, and enhancing self-direction for individuals with significant disabilities. The DDA projects to use consultants to assist it in its efforts to reform and rebalance its service systems and underlying infrastructure to improve quality.

The State may seek assistance from the MFP Quality Technical Assistance contractor in addressing improvement areas noted above. Any new quality assurances and improvement strategies will be implemented for all waiver participants, including MFP demonstration participants.

#### *MFP Demonstration Services*

*Peer Mentoring.* Peer mentoring quality assurances and improvement strategies will be tracked in the MFP Tracking System, described below. The identified providers will also be required to participate in quality activities as developed and required by CMS and the Quality Technical Assistance Contractor.

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

*MFP Tracking System.* As noted on page 11 in the Project Introduction, Maryland has developed a web-based tracking system in collaboration with the Hilltop Institute to assist in fulfilling CMS reporting requirements and evaluation. The current system tracks activities and performance of MAP partners, service providers, and contractors, including the number of peer outreach contacts, the number of referrals to program education, application assistance, transitional case management, and peer mentoring, as well as the services each potential participant receives. The Hilltop Institute will also continue its work toward a unified long-term care 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.

*MAP Information Technology.* The local MAP sites currently each use a unique system for tracking their efforts and incoming inquiries about long term supports and services. A single, statewide database is necessary to monitor inquiries about long-term supports and services and standardize data collection and reporting. Such a unified system could share data with the Medicaid long-term care tracking system, facilitating referrals for support and generating vital data on service demand. MFP will support the development and implementation of a statewide system that is compatible with the Medicaid LTSS tracking system by using MFP rebalancing funds for contractor and software costs, training for all users, and the connection to the Medicaid tracking system.

## **9. Housing**

### 9.1 Defining and Documenting Qualified Residences

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

1. A home owned or leased by the individual or the individual's family member;
2. An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control.
3. A residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.

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

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

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

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

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

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

"Group home" means a residence that:

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

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

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

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

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

Regulated by Department of Human Resources

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

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

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

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

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

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

Each of these types of residences as defined in the regulations has the potential to serve as a qualified residence for an MFP eligible individual provided that the residence serves no more than 4 unrelated individuals. For example, an assisted living facility that is licensed to serve 4 or fewer individuals may be chosen by an MFP participant and would meet the standards for a qualified residence. The transitional case managers and the community placement specialists will document the type of qualified residence where each MFP participant chooses to live. Staff will verify that homes or apartments meet the statutory definitions under MFP. Verifications may be based on a visit to the residence, a report of the consumer or representative, information obtained from the property manager or landlord, licensure information, or information from a local housing authority. For community-based settings serving four or fewer individuals, the transitional case manager will document the type of setting based on the definitions in the Code of Maryland Regulations. For assisted living facilities, this means verifying with the Office of Health Care Quality that the facility is licensed to serve four or fewer individuals. For Alternative Living Units, the staff need only verify the type of setting, since by definition this



residence serves 3 or fewer individuals. Maryland expects that few MFP participants will choose to live in a Group Home or Adult Foster Care Home. Information about the community residence chosen by each participant will be documented in the MFP tracking system and reported to the State in periodic required reports.

Due to difficulty in generating consolidated reports on housing type for MFP participants, the Department will work with the Hilltop Institute to add housing type as a data field in the LTSS system. This data field will then be required for all LTSS recipients and reports can be generated more easily to track when housing type changes and to compare non-MFP participants to MFP participants.

## 9.2 Strategies to Meet the Projected Housing Need

The lack of affordable and accessible housing is a major barrier to community transition. The MFP demonstration will employ a variety of strategies to address this barrier. These strategies coordinate to assure an adequate supply of quality housing for Marylanders.

*Housing Assistance.* One of the major components of transitional case management is the provision of housing assistance. Case managers provide information about types of housing options, the availability of housing, and the housing subsidy systems. They will also provide intensive support to complete applications, acquire needed documentation, and secure housing. It may also include opportunities for MFP participants to visit different housing options using their supplemental service funds (Section B.5.4). Housing assistance will be available to residents of SRCs who indicate a preference for independent community housing instead of an Alternative Living Unit and will be provided by their Service Coordinators. Through MFP, the Department maintains five (5) Housing Staff who accept referrals from transitional case managers and provided enhanced housing assistance when the case manager is unable to secure community housing. These staff are also tasked with participating in statewide housing policy development, establishing and maintaining relationships with local housing authorities to advocate for additional resources, and providing training to MFP partners.

### *Assisted Living Provider Incentives*

MFP allows congregate settings in the community if each individual has lockable access and their own private sleeping, bathing, and cooking areas. Maryland generally does not offer this type of congregate setting, forcing individuals who would like to live in assisted living to choose less independent options. Creating congregate settings with more independence could serve a group of individuals who remain institutionalized due to the lack of housing or due to lack of natural supports in the community. Start-up costs for providers to establish residences that meet the MFP criteria and newly proposed CMS definition of a community residence could increase options for people in need of long-term supports. Maryland's MFP demonstration will solicit proposals from providers to establish this type of residence and fund any proposals that meet the goals of the demonstration by increasing MFP-qualified community-based options. Proposals may include requests for funding for accessibility modifications, renovations to establish individual cooking, sleeping, and bathing areas or lockable egress and access, and funds for securing a new residence that meets these criteria.



As this model of smaller congregate setting with enhanced features and independence is not currently offered, the waiver rate structure for congregate settings may not adequately fund the support. If a new waiver or service is needed to adequately fund the supports, then State budget approval would be necessary as MFP could not cover the ongoing State cost. However, if a new service structure is identified, MFP could fund a pilot project or supplemental service to test its efficacy. If such a model is proposed, stakeholder input will be used to evaluate the model and develop a new MFP service.

#### *Behavioral Health Group Homes*

The MFP Behavioral Health Workgroup recommended the development of Behavioral health group homes that utilized current providers of assisted living and mental health residential rehab services to collaborate in small residential settings that meet the needs of individuals with significant behavioral health and somatic support needs. However, the collaboration has not yet been successful as most providers maintain larger group home sizes and are not willing to cross-license in both the behavioral and somatic service systems. In order to facilitate the development of these group homes, Maryland's MFP demonstration will solicit proposals from providers to establish this type of residence and fund proposals that meet the goals of the demonstration by increasing MFP-qualified community-based options for people with co-occurring somatic and behavioral health support needs. Proposals may include requests for funding for consultation services, accessibility modifications to existing group homes, renovations existing homes to meet MFP criteria, enhanced staff training, administrative staffing or consultation to develop a model, etc.

If a new waiver or service is needed to adequately fund the combined supports provided in the newly established residences, then this initiative could require budgetary authorization from the Department of Budget and Management because of the ongoing state cost that can not be covered by MFP.

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

DDA currently funds 20 Bridge Subsidies to support capacity for individuals moving out of institutions. Currently, all subsidies have been used and the ongoing annual funding supports a person already in a voucher slot. Only one of the DDA Bridge Subsidies went to a person moving out of an institution. The remaining subsidies created capacity in community living settings by allowing a person in a congregate setting to access these housing options. Continued funding of rental assistance through the Bridge Subsidy program for DDA MFP participants is



\$250,000 per year through FY2013. The DDA intends to continue the current level of funding through MFP rebalancing funds so that an additional 20 individuals can receive a voucher in the MFP extension period. Priority for new vouchers will be given to MFP participants transitioning out of institutions.

MHA proposes to fund 14 Bridge subsidies to support 14 individuals transitioning to the TBI waiver for the 5 year period that it takes to obtain a permanent housing choice voucher. Individuals transitioning from institutions will be prioritized for the Bridge Subsidy Program, to include chronic hospitals, nursing home facilities and state psychiatric facilities. Another priority group for the MFP Demonstration and funded with the Bridge Subsidy Program would be individuals moving from an Alternative Living Unit (ALU) or Residential Rehabilitation Program (RRP). These individuals would move into independent housing and create capacity in the congregate setting for an individual moving from an institution as most individuals transitioning to the TBI waiver choose a congregate setting as a step-down from institutional care.

The Office of Health Services proposes to fund 50 Bridge subsidies to support 50 individuals transitioning out of nursing facilities for the 5 year period that it takes to obtain a permanent housing choice voucher. Each of the 50 subsidies will be awarded to MFP participants leaving institutions.

While these MFP initiatives focus on maximizing available housing and subsidies, additional 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 BRAC realignment 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.

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

The State recognizes that working in partnership with housing professionals is essential to assuring a supply of accessible and affordable housing options. The Director of Multifamily Housing from the Department of Housing and Community Development (DHCD) and the President of the Maryland Association of Housing and Redevelopment Agencies (MAHRA) reaffirmed the importance of these partnerships at the 2008 MFP Housing Day. With leaders in the housing sector supportive of the MFP program, the next step is to target the local level. Building on the supportive efforts at the Federal level, the MFP program will work in partnership with the local MAP sites and stakeholders to promote MFP goals through changes in housing policy at the local level.

As noted in the Project Introduction on page 8, 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.

Also noted in the Project Introduction on page 10, Maryland was awarded 112 category II vouchers for non-elderly disabled individuals transitioning from institutions. The Coordinating Center, the case management provider for the Living at Home waiver that serves individuals under age 65, has taken the lead role in assisting eligible MFP applicants in accessing these vouchers. As of November of 2011, 75 vouchers had been awarded. These vouchers have been used successfully because of the partnerships between the MFP demonstration, local housing authorities, and the case management providers.

Maryland will continue to pursue any options created by the Federal partnerships between the Departments of Health and Human Services and Housing and Urban Development.

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

Participants in the Maryland Money Follows the Person Demonstration will receive home and community based services through the existing and ongoing 1915(c) waivers that are currently in place. Any additional services received through participation in the MFP Demonstration are one-time only and not ongoing services. Therefore, participants will continue to receive services without interruption or modification at the end of their participation in the demonstration via the HCBS waiver in which they are enrolled. Participants of the HCBS waivers are re-evaluated annually for medical, financial, and technical eligibility. Redeterminations for waiver services will likely coincide with expiration of MFP demonstration eligibility as the time periods are the same. MFP participation and eligibility will not affect the redetermination process.

As noted in the Project Introduction; MFP Rebalancing Initiatives on page 5, Maryland has developed a policy in accordance with the Money Follows the Individual Act. This policy allows any individual who has been an institutional resident, paid for by Medicaid, for at least 30 consecutive days to apply for the waiver programs even if those waivers are "closed".

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

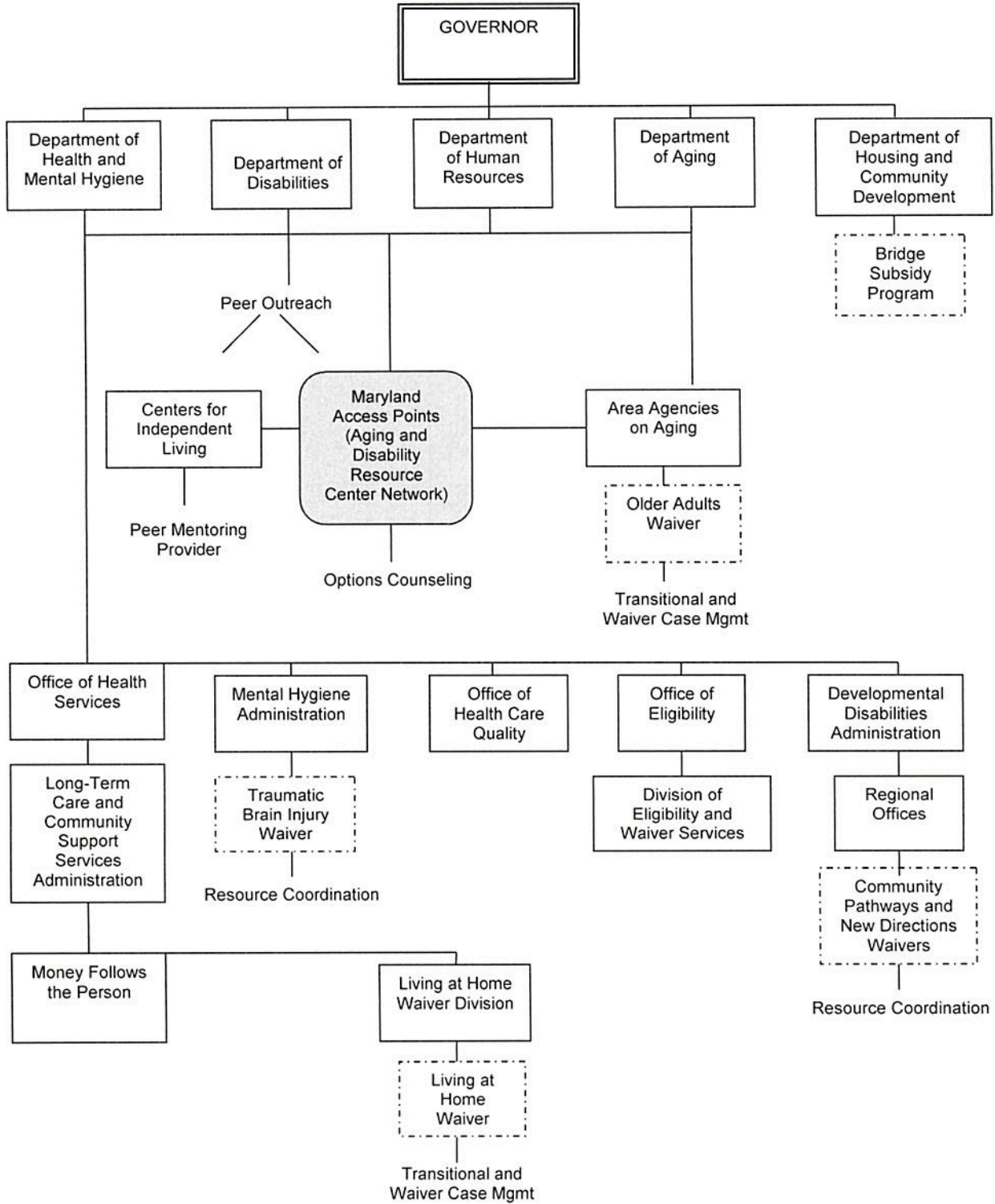
The central goal of the MFP program is to serve people in the community rather than in institutional settings. Recently, Maryland Medicaid recipients in nursing facilities were unable to transition to the community despite a strong desire to do so because their income was a few dollars over the 300% SSI income limit for our waiver programs. Maryland's MFP program allowed these individuals to transition to the community using the MFP demonstration authority. During the MFP demonstration year, the State pursued an amendment to its existing 1115 waiver to create a permanent authority to serve these individuals. This new option was approved by CMS in 2009 to serve 10 participants and was titled the Increased Community Services (ICS)



program. Since the initial approval, the 1115 was amended to allow 30 individuals to be served under this authority due to expanded interest.

**C Organization and Administration**

**Organizational Structure**





## 1. Staffing Plan

There are thirteen dedicated positions for the MFP Demonstration that are paid for by the grant, the MFP Project Director, MFP Associate Project Director, Data Specialist, Behavioral Health Specialist, Housing Supervisor, four Housing Specialists, Finance Specialist, Statewide (DDA) Transition Coordinator, and two Community Placement Specialists. They are full time positions in the Office of Health Services, Long Term Care and Community Support Services Administration. 100% of these positions are dedicated to the MFP Demonstration.

The primary role and responsibility of the Project Directors is to direct or assist the activities for Maryland's Money Follows the Person demonstration. This will include: reviewing and developing policies; serving as liaisons with interested groups, individuals, agencies, and the legislature concerning the demonstration; developing and implementing rules, regulations, standards, and controls for carrying out and completing the demonstration; preparing the budget for the assigned programs; completing required federal reporting; supervision of staff; and performing other related duties. The current Project Director was appointed as of 10/5/11. The Associate Project Director position is currently vacant.

The primary role of the Data Specialist is to assist the reporting and quality activities for the demonstration. This includes developing relationships with and gathering data from MFP partners, contractors, staff, and providers to monitor the efforts and outcomes in order to complete required State and Federal reporting. This position will also maintain accountability to the MFP stakeholders by generating monthly reports and responding to data requests.

The primary role of the Behavioral Health Specialist is to identify opportunities to improve Maryland's behavioral health support system; develop relationships with and gather input from behavioral health providers, advocates, and consumers; provide training and consultation to MFP contractors on coordinating behavioral health services and supports for MFP participants; and to provide direct support in coordinating these services as issues arise during the transition process.

The Housing Supervisor's main duties are to supervise four (4) housing specialists and direct policy development related to affordable and accessible housing for MFP participants. This includes direct training and support of the housing specialists and MFP partners such as staff of Maryland Access Point sites, Area Agencies on Aging, public housing authorities, and other stakeholders; clarifying policy and customer service issues, and identifying opportunities to increase collaboration and develop additional housing resources.

The primary role for the Housing Specialist positions is to provide direct housing assistance to MFP applicants including locating and securing community-based affordable housing and providing time-limited case management support as needed for NED category II voucher recipients that are not eligible for other case management services. The specialists will also provide training and support to MFP partners and case managers.

The Finance Specialist's role is to manage all of the finances for the demonstration. The finance specialist will monitor the accrual and expenditure of MFP service dollars and administrative funds; prepare the budget and grant funding requests; complete MFP adjustments & accruals, act as a liaison with the Budget and Management Office and General Accounting; compile rebalancing spreadsheets to account for total MFP funds; develop a report on the budget and rebalancing funds and present reports to the MFP Stakeholder Advisory Group; compile budget



reports and benchmark data for the required CMS Semi-annual Report; prepare and submit the quarterly MFP expenditure report to CMS; complete quarterly grant payment memos for the grantees; complete quarterly MBE reports on all contracts; review and adjust expenditure and revenue ledgers; monitor Federal grant award account for undrawn award balances; reconcile draws to Federal Fund share of Department-wide MFP expenditures; review and approve MFP-related invoices; respond to inquiries from contractors regarding payments; review and sign-off on MFP staff and partner requests for funds for conferences, training, and travel; and respond to legislative and CMS requests for MFP budget information.

The primary role of the Statewide DDA Transition Coordinator is to coordinate all aspects of the demonstration related to individuals with intellectual disabilities who qualify for funding from the DDA. The Transition Coordinator develops strategies for the smooth transition of individuals out of institutions, identifies individual candidates for transition to home and community-based services, monitors contracts and grants related to the MFP project, and supervises the work of the community placement specialists.

The primary role of the two Community Placement Specialist positions is to work with identified individuals in State Residential Centers and nursing facilities to assist in their transition to community-based services through MFP. Direct services include conducting outreach in nursing facilities including providing outreach to individuals with PASRR indicators for developmental or intellectual disabilities, providing consumer education and options counseling on community-based services options, assisting the transition teams in identifying and overcoming barriers to transition, utilizing the MFP web-based tracking system to document activities and consumer progress, documenting all transition-related activities and completing all required Federal and state reporting for the MFP demonstration acting as a liaison between DDA regional offices and the transition team.

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

Positions Providing In-Kind Support

| Name         | Title  | Roles and Responsibilities  |
|--------------|--|---|
| Tricia Roddy | Director of Planning   | Discuss program implementation activities, report and discuss evaluation data |
| Susan Tucker | Executive Director, Office of Health Services                            | Discuss program implementation activities, report and discuss evaluation data |
| Mark Leeds   | Director of Long Term Care and Community Support Services Administration | Discuss program implementation activities, report and discuss evaluation data |



|                 |  |  |
|-----------------|--|--|
| Sandra Brownell | Deputy Director of Nursing and Waiver Programs                           | Discuss program implementation activities, report and discuss evaluation data  |
| Susan Panek     | Deputy Director of Nursing Home and Community Long Term Care             | Discuss program implementation activities, discuss evaluation  |
| Lorraine Nawara | Deputy Director of Community Integration Programs                        | Directly supervise the MFP Project Director; ascertain relevant information about the impact of program, budget, and services on other programs and Medicaid in general; discuss implementation activities |
| Stephanie Hull  | Chief of Long-term Supports and Services, Maryland Department of Aging   | Ascertain information about impact of program, budget, and services on other programs; discuss and plan for implementation activities; liaison for the MAP initiative                                      |
| Kelli Cummings  | Director of Community Living Policy, Maryland Department of Disabilities | Ascertain information about impact of program, budget, and services on other programs; discuss and plan for implementation activities; liaison for the MAP initiative                                      |

*Staffing Time Line*

Most MFP staff and those that are providing in-kind support are currently in place. The newly identified positions and vacant positions are outlined in the chart below.

| Name  | Position                     | Created or Vacancy Date   |
|---|------------------------------|---|
| Devon Snider  | Project Director             |   |
| Vacant  | Associate Project Director   | Vacated on 10/15/11; actively recruiting replacement; anticipate hiring by March 2012               |
| Onika Constant                                      | Data Specialist              |   |
| Christin Whitaker                                   | Behavioral Health Specialist |   |
| Vacant  | Finance Specialist           | Newly created position, actively pursuing State permission to hire; anticipate hiring by April 2012 |
| Vacant  | Housing Supervisor           | Vacated July 2011; actively recruiting; anticipate hiring in January 2012                           |
| Michelle Haile<br>Adenike' Dobson<br>Jennifer Miles | Housing Specialists          | One position vacated 10/4/11; actively recruiting replacement – anticipate hiring in January 2012   |

|                                |  |  |
|--------------------------------|--|--|
| Vacant                         |  |  |
| Wayne Reed                     | DDA Statewide Housing and Transition Coordinator |  |
| Rick Mason<br>Catharine Dawson | DDA Community Placement Specialists              |  |

*Performance Assessment*

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

**2. Billing and Reimbursement**

*MFP Billing*

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

*Fraud Control Provisions and Monitoring*

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

The Office of Legislative Audits (OLA) is part of the Maryland General Assembly’s Department of Legislative Services. Their mission is to serve the General Assembly and the citizens of Maryland by providing independent, objective, and non-partisan audits and evaluations of State government agencies. OLA operates under the authority of the State Government Article, Sections 2-1217 through 2-1227 of the Annotated Code of Maryland and reports to the General Assembly’s Joint Audit Committee. OLA is responsible for performing fiscal compliance audits of State agencies to evaluate fiscal operations and determine compliance with laws and



regulations conducting performance audits to evaluate whether a State agency or program is operating in an economic, efficient and effective manner, operating a fraud hotline for reporting fraud, waste, and abuse of State resources, monitoring the financial reporting practices and financial condition of local governments, and conducting special reviews and investigations requested by the Joint Audit Committee.

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

## **D. Final Budget**

A considerable amount is included in the budget to enhance the transition process. Specifically, over the 5 year extension, we estimate more than \$17 million will be spent on peer supports and options counseling. These initiatives are designed to address two areas of particular concern for the stakeholder group. The details and specific duties of the peer support staff and options counselors may be found throughout the protocol.

A detailed description of the personnel and contractual costs follows. The total estimated administrative budget for CY12 is \$1,032,303. In addition to administrative costs, peer mentoring will incorporate MFP demonstration service dollars estimated at \$181,783 in CY12.

### *Personnel*

The total budget for salaries, fringe and indirect costs for the five year extension period is \$5,591,368. Full-time staff supporting the implementation of the demonstration include:

- *Project Director and Associate Project Director*– The Project Directors will oversee the day to day operation of the demonstration. The project director will be responsible for CMS reporting, MFP contract management, and overseeing the stakeholder process.
  - \* The total cost for CY 2012 is \$137,446.
  - \* The total cost over the 5 year extension period is \$744,452.
  
- *Housing Staff, Behavioral Health, Data, and Finance Specialists*-One housing supervisor and four housing specialists work directly with MFP applicants and advocate for affordable, accessible housing. The behavioral health specialist provides direct support to MFP participants and liaises on behalf of the MFP demonstration. The data specialist and finance specialist provide administrative support for the demonstration.
  - \* The total cost for CY 2012 is \$450,778.
  - \* The total cost over the 5 year extension period is \$2,441,559.
  
- *Developmental Disabilities Administration Transition Staff* – Three additional staff are necessary to work with families during the transition from State Residential Centers and nursing facilities to the community. One individual will work centrally to coordinate transitions. The other two staff will provide direct assistance to consumers during the transition process.
  - \* The total cost for CY 2012 is \$193,824.
  - \* The total cost over the 5 year extension period is \$1,049,893.
  
- The State has negotiated a 32 percent indirect cost rate for salaries.
  - \* The total cost for CY 2012 is \$250,255.
  - \* The total cost over the 5 year extension period is \$1,355,464.

### *Contracts*

#### *Memorandums of Understanding*



- *Bridge Subsidy Rental Assistance Program* – Additional funding to create availability of rental assistance through the Bridge Subsidy program for MFP participants.
  - \* The total cost over the life of 5 year extension period is \$5,300,000.
    - \$2,500,000 for 41 DDA participants,
    - \$300,000 for 5 TBI participants,
  - \* \$2,500,000 for 41 MFP participants transitioning from nursing facilities
  
- *State Residential Center Peer Support* – Additional funds will be provided to enhance the existing peer mentoring efforts for individuals residing in State Residential Centers. This support will expand the availability of peer supports to all SRC residents.
  - \* The total cost in CY 2012 is \$36,053.
  
- *The Hilltop Institute* – 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.
  - \* The total cost for CY 2012 is \$160,000.
  - \* The total cost over the 5 year extension period is \$800,000.

Set to begin during the extension period, 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 total cost for CY 2012 is \$186,000.

- *TBI Waiver Tracking System* – creation of a web-based tracking system to reduce delays in eligibility determination and increase quality monitoring abilities. This system will be integrated into the LTSS tracking system.
  - \* The total cost over the 5 year extension period is \$50,000
  
- *TBI Staff Development* – As MHA continues to expand the community based options available to support individuals with TBI, it is critical that TBI waiver staff that are involved with the MFP Demonstration have the opportunity to expand their knowledge of federal policies and funding opportunities, state programs and resources, and national best practices. MHA intends to use a portion of re-balancing funds to support MFP/ TBI waiver staff development through attendance at National and local meetings.
  - \* The total cost over the 5 year extension period is \$30,000

*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 ADRC development through CY2013. 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.

- \* The total cost for CY 2012 is \$4,768,841.
- \* The total cost over the 5 year extension period is \$15,768,841.
  
- *Maryland Department of Disabilities* – The Department will utilize an MOU with the Department of Disabilities to fund the peer support activities for nursing facility residents. The MOU includes funding for MDOD’s administrative costs related to the implementation of the peer supports program.
  - \* The total cost for CY 2012 is \$700,000
  - \* The total cost estimated cost over the 5 year extension period is \$4,025,517.
  
- *Maryland Department of Disabilities*- The Department will utilize an MOU with the Department of Disabilities to fund housing development. 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.
  - \* The total cost for CY 2012 is \$215,228
  - \* The total cost over the 5 year extension period is \$1,076,140.
  
- *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 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 provide relevant data to the State regarding survey results and follow-up needs.
  - \* The total cost for CY 2012 is \$363,097.
  - \* The total cost over the 5 year extension period is \$2,448,125.
  
- *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.
  - \* The total cost for CY 2012 is \$230,000.
  - \* The total cost over the 5 year extension period is \$1,245,753.

*Contracts – Requests for Proposals*

- *Aging and Disability Resource Center Liaison* – The liaison assesses existing MAP sites for their capacity to integrate MFP services and identify structural, staffing, and funding barriers. They will develop action plans for MAP sites to facilitate the incorporation of MFP services and overcome identified barriers and will develop a State-level action plan.
  - \* The total cost for CY 2012 is \$218,724
  
- *Behavioral Health Consultant* – The consultant has reconvened the MFP Behavioral Health workgroup and will create action plans for various administrations within DHMH



for the purpose of improving behavioral health supports to individuals with co-occurring somatic and behavioral health support needs.

- \* The total cost for CY 2012 is \$69,478
- *SRC Family Mentoring* – families of former SRC residents who have been through the transition process will provide mentoring to families of current SRC residents in the process of transition.
- Family Peer Support – monthly payments will be made to the contractor to provide support to families of SRC residents throughout the transition process.
  - \* The total estimated cost for CY 2012 is \$115,000.
- *Provider Training* – this contractor will host trainings 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.
  - \* The total estimated cost for CY 2012 is \$125,000
  - \* The total estimated cost over the 5 year extension period is \$625,000
- *Partner Training* – this 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 total estimated cost for CY 2012 is \$125,000
  - \* The total estimated cost over the 5 year extension period is \$625,000
- *Training for Direct Support Staff* – Cost to purchase the license and training support for direct support staff in the DDA service system.
  - \* The total cost over the 5 year extension period is \$1,482,000
- *Rebalancing Budget Allocations* – DDA pilot of the Supports Intensity Scale with SRC residents to develop individualized budgets.
  - \* The total cost over the 5 year extension period is \$750,000.
- *Person Centered Planning* – intensive person-centered planning process for SRC residents transitioning to the community through MFP.
  - \* The total cost over the 5 year extension period is \$750,000
- *DDA Data Management* – improved information technology systems to increase quality monitoring capabilities and drive quality improvement activities. Any new system will be integrated with the LTSS tracking system.
  - \* The total cost over the 5 year extension period is \$300,000
- *TBI Provider Incentives* – to increase the availability of providers for the TBI waiver and increase choice of providers for participants.
  - \* The total cost over the 5 year extension period is \$200,000

- *TBI Resource Coordination* – outreach, application assistance, and transitional case management for chronic hospital and TBI waiver eligible nursing facility residents.
  - \* The total cost over the 5 year extension period is \$750,000
- *TBI Waiver Clubhouse Model* – establish a consumer-driven alternative to day programs for TBI waiver participants.
  - \* The total cost over the 5 year extension period is \$100,000
- *Single Standardized Assessment* – cost of the instrument, software, technology, and initial training for the users.
  - \* The total cost for CY2012 is \$2,000,000
  - \* The total cost over the 5 year extension period is \$3,000,000
- *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.
  - \* The total cost for CY2012 is \$1,000,000
  - \* The total cost over the 5 year extension period is \$3,000,000
- *Personal Care Back-up Agency* – cost of procuring a vendor, and paying a retainer fee, this agency would respond to emergency back up calls from the Complaints and Surveillance unit.
  - \* The total cost for CY2012 is \$200,000
  - \* The total cost over the 5 year extension period is \$1,000,000
- *MAP Information Technology* – The local MAP sites currently each use a unique system for tracking their efforts and incoming inquiries about long term supports and services. A single, statewide database is necessary to monitor inquiries about long-term supports and services and standardize data collection and reporting. Such a unified system could 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
  - \* The total cost over the 5 year extension period is \$1,250,000
- *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
  - \* The total cost for CY2012 is \$75,000
- *Maryland Hospital Diversion Model* – After an evaluation of current diversion efforts and national models, Maryland could create its own model of nursing home diversion that could be implemented statewide. A unique program would allow Maryland to continue



and expand the efforts at lower costs in order to be viable after the MFP demonstration period.

- \* The total cost for CY2012 is \$75,000
- \* The total cost over the 5 year extension period is \$175,000
- *Hospital Outreach* – An expansion of the NF peer outreach model to hospitals in order to provide training for hospital discharge planners on available community options.
  - \* The total cost for CY2012 is \$200,000
  - \* The total cost over the 5 year extension period is \$1,000,000
- *Prioritize the Waiver Registries* – Assess all individuals on the Living at Home and Older Adults waiver registries using the new evidence-based standardized assessment instrument and prioritize based on need rather than date of application.
  - \* The total cost over the 5 year extension period is \$4,000,000
- *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.
  - \* The total cost over the 5 year extension period is \$500,000
- *Community First Choice Implementation* – If the state pursues this ACA option, MFP would fund the start-up administrative costs such as staffing, technology, training, and outreach.
  - \* The total cost over the 5 year extension period is \$2,000,000
- *Assisted Living Provider Incentives* – Start-up costs for providers to establish residences that meet the MFP qualified residence and newly proposed CMS definition of a community residence
  - \* The total cost over the life of the 5 year extension period is \$1,000,000
- *Behavioral Health Group Homes*– Incentivize current providers of assisted living and mental health residential rehab services to collaborate on the development of small residential settings that can meet the needs of individuals with significant behavioral health and somatic support needs.
  - \* The total cost over the life of the 5 year extension period is \$200,000
- *Pilot HCBS Services*–Programs to be explored include, but are not limited to, the Living Well Program (Chronic Disease Self Management Program), PEARLS, and a modified bundle of existing services such as occupational therapy, environmental modifications, and assistive technology.
  - \* The total cost over the 5 year extension period is \$1,000,000

- *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
  - \* The total cost over the 5 year extension period is \$2,000,000
  
- *Bed Closure Incentives* – Provide incentive payments to nursing facilities for the permanent, voluntary closure of unused beds.
  - \* The total cost over the 5 year extension period is \$1,000,000



## Consent Form for Waiver Services

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

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

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

- I choose to receive services in a nursing facility.

- I choose neither of these service options. Explanation:

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

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

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

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

**Participant Consent Form**

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

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

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

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

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

Individual

or

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

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



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

**Consent Form for TBI Waiver Services**

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

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

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

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

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

**or**

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

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

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

INTERPRETIVE INTERVIEW: COMMUNITY PATHWAYS WAIVER

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

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

Check only one of the boxes and complete:

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

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

|   |      |                            |      |
|---|------|----------------------------|------|
| Guardian/Parent of<br>under 18 Yr. Old Individual | Date | Witness to Guardian/Parent | Date |
|---|------|----------------------------|------|

I was present

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

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

Relationship \_\_\_\_\_

I was present

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

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

|   |      |                    |      |
|---|------|--------------------|------|
| Resource/Service Coordinator/Case Manager | Date | Other/Relationship | Date |
|---|------|--------------------|------|



Appendix B-1: DHMH Reportable Events Policy

See attached PDF file:

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

Also Available:

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

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

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

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### **BACKGROUND AND INTENT**

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



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

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

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

### GENERAL REQUIREMENTS

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

#### a. SERIOUS REPORTABLE INCIDENTS

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



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

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

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

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

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

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

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

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

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

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

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

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

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

(e) The findings and conclusions of the investigation.

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

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

### b. INTERNALLY INVESTIGATED INCIDENTS



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

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



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

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

### c. INTERNALLY REVIEWED INCIDENTS

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

### IRREGULAR SITUATIONS

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



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

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

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

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

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

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

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



Appendix C: Blue Book – Outreach Materials

See attached PDF file:

[Appendix C Blue Book.pdf](#)

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

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

#### Process:

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



## Appendix D: LAH Participant Delegation Policy

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

## Appendix E: Guardianship Resources

### **Guardianship Resources**

The Guardianship Handbook

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

Code of Maryland Regulations (COMAR)

07.02.16.11 Guardianship Procedures

<http://www.dsd.state.md.us/comar/getfile.aspx?file=07.02.16.11.htm>

Annotated Code of Maryland

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

Maryland Rules of Procedure

Title 10 Guardians and Other Fiduciaries



## Appendix G: Behavioral Health Workgroup Recommendations

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

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

The goals of the program are to:

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

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

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

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

## Appendix G: Behavioral Health Workgroup Recommendations

### To the Aging in Place Task Force

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

### To the Brain Injury Advisory Board

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



## Appendix G: Behavioral Health Workgroup Recommendations

Expand eligibility for the TBI waiver to include all brain injury and all institutional settings

*If the waiver is expanded consider the following:*

*Add financial management or rep payee service*

*Add peer support service*

*Add in-home respite care*

*Add specialized training for consumer-directed attendants*

*Move to aggregate cost neutrality*

### To the Living at Home Advisory Committee

Behavioral Consultation Services

Residential or Supportive Housing Option

Enhanced attendant care rates for attendants with specialized behavioral health training

Short-term intensive support by a behavioral health professional

Financial representatives to assist with money management

Peer support services

Increase availability of behavioral health training for attendant care providers

Enhance access to assistive technology

Collect data on LAH applicants with a history of brain injury

Move to aggregate cost neutrality

### To the Older Adult Advisory Committee

Enhanced rates for assisted living providers with specialized behavioral health training

Enhanced attendant care rates for attendants with specialized behavioral health training

Short-term intensive support by a behavioral health professional

Financial representatives to assist with money management

Peer support services

Increase availability of behavioral health training for attendant care providers

Enhance access to assistive technology

## Appendix G: Behavioral Health Workgroup Recommendations

Collect data on OAW applicants with a history of brain injury

Move to aggregate cost neutrality