HOME AND COMMUNITY-BASED SERVICES FOR OLDER PEOPLE AND YOUNGER ADULTS WITH PHYSICAL DISABILITIES IN MARYLAND

Final Report

Prepared for:
U.S. Department of Health and Human Services
Health Care Financing Administration

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INTRODUCTION

Maryland, a fairly small mid-Atlantic state with about five million people in 1999,[1] has 12 home and community services programs for older persons and adults with physical disabilities. Maryland's Medicaid program provided home and community services to approximately 5,100 beneficiaries through the optional personal care benefit and 4,600 beneficiaries through its optional medical day care program in fiscal year 1999. The state has one currently operating Medicaid waiver for older adults with 135 slots, which will be expanded to 1,135 slots in 2001. The state will implement another waiver in 2001 with 150 slots in the first year for non-elderly adults with physical disabilities. The state also has eight small, state-funded home and community services programs designed to serve adults who are not eligible for Medicaid. The state has a complex administrative structure for its home and community services programs, with several state and local agencies involved.

Maryland's home and community services programs have grown over the years. The state's new Medicaid waiver and the recently expanded waiver will result in increased coverage for community services. Maryland has some innovative programs, including a Program of All-Inclusive Care for the Elderly (PACE) site.

This paper addresses the home and community services system for older people and younger adults with physical disabilities in Maryland, focusing on the state administrative structure, eligibility and assessment, services covered by Medicaid and other programs, cost containment, and quality assurance. This report also summarizes government officials' and key stakeholders' opinions about how well the Medicaid and state-funded programs serving the aged and disabled work.

Information was obtained from public documents, state of Maryland web sites, and interviews with state officials, consumer representatives, and provider associations. Interviews were conducted in person in Washington, DC and Baltimore, Maryland, in

1 http://www.census.gov.

February and March 2000, respectively. One telephone interview was conducted in February 2000. Questions were asked using a structured, open-ended interview protocol. To encourage candor in their answers, respondents were told that they would not be quoted by name or identified by type of respondent within a state (e.g. home health industry representative in Maryland).

THE LONG-TERM CARE SYSTEM IN MARYLAND

Maryland has an average supply of nursing home beds -- 265 nursing facilities had 27,000 beds in 1998, a rate of 52.0 beds per 1,000 persons age 65 and over, compared with a national average of 52.5.[2] In the same year, about 66 percent of nursing home residents were Medicaid beneficiaries, in line with a national average of 68 percent.[3] In 1998, Maryland had a relatively high supply of nonmedical residential facilities —2,799 licensed residential facilities with a total of 21,858 beds, 36.9 beds per 1,000 persons age 65 and over compared to the national average of 25.5. State officials said that the state also had approximately 500 licensed assisted living facilities, 125 adult day care centers, 76 licensed home health agencies and approximately 2,000 Medicaid individual personal care providers in 1998.

Maryland's Medicaid long-term care expenditures (nursing facility, ICF/MR, home and community-based services waivers, personal care, medical day care, and home health) totaled $1.24 billion in fiscal year 1999, one-third of which were for home and community-based service.[4] Most stakeholders attributed the state's imbalanced financing and delivery system to state officials' fear of the "woodwork effect," the assumption that demand for long-term care services will increase dramatically and uncontrollably with the availability of such services.

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[2] Harrington C, Swan JH, Wellin V, Clemena W, Carrillo HM, 1998 State Date Book on Long-Term Care Program and Market Characteristics, University of California at San Francisco, January 2000.

[3] American Health Care Association (1998). Facts and Trends: The Nursing Facility Sourcebook. Washington, DC: American Health Care Association, Research and Information Services Group.

[4] DHMH, Office of Planning Development and Finance.

According to several stakeholders, the state legislature has historically taken an active role in shaping Maryland's health care policy, and long-term care is no exception. Three examples are that the legislature required the state to: 1) consolidate three separate regulatory structures for assisted living facilities, 2) apply for the new Medicaid waiver to serve physically disabled adults, and 3) expand the existing Medicaid waiver for older adults.

PROGRAMS AND ADMINISTRATIVE STRUCTURE

Maryland has two existing Medicaid programs and one currently operating Medicaid waiver to provide home and community services to the aged and disabled (See ***Chart 1***). The state will expand an existing Medicaid waiver and implement a new waiver during 2001 (See ***Chart 2***). These Medicaid waivers are jointly-administered by the Department of Health and Mental Hygiene (DHMH) with either the Department of Aging, or with the Department of Human Resources. The state also has one state-funded program in DHMH, three state-funded programs that serve older persons in the Department of Aging, and four state-funded programs in the Department of Human Resources that serve adults of all ages (See ***Charts 1 and 3***).

DHMH, which houses the Medicaid program, has varying roles in administering its home and community services programs. Medicaid directly administers its optional personal care benefit, which is the state's largest home and community services program with 5,084 unduplicated beneficiaries during fiscal year 1999. Under the personal care program, beneficiaries receive assistance with daily activities from agency or individual workers. Medicaid also directly administers its medical adult day care program, which served 4,598 unduplicated clients in fiscal year 1999. Both the personal care and medical day care programs are entitlements, providing all covered services to any individual who meets program financial and medical eligibility criteria.

In addition to the Medical Adult Day Care Program, DHMH administers an adult day care grant program that is financed with state-only funds. Grants to centers support adult day care services for low-income individuals age 55 and older who do not qualify for Medicaid, and lack the income to pay private rates. Eligible individuals are assessed

Chart 1: Established Maryland Medicaid Programs and Adult Day Care Programs in Department of Health and Mental Hygiene (DHMH)

	Maryland Medical Assistance Personal Care Program	Senior Housing Waiver
Year program started	1980	1993
Administrative responsibility	Department of Mental Health and Mental Hygiene (DHMH).	Department of Aging (DOA) and DHMH. Area Agencies on Aging do case management and monitor quality. DHMH enrolls beneficiaries and providers, and pays for services.
Functional eligibility	1+ ADLs. No standard assessment form and county health departments assign one of 3 levels of care.	Age 62+, must be Medicare eligible and meet nursing home level of care criteria. A DHMH contractor determines functional eligibility. Department of Human Resources (DHR) determines financial eligibility. DOA runs program.
Financial eligibility	Beneficiaries can be categorically eligible or medically needy.	Income – 200% of SSI, $2,000 in financial assets. Personal needs allowance of $60 a month.
Number of beneficiaries	FY99 - 5,084 unduplicated recipients	FY00 – 135 approved slots
Funding source	Medicaid.	Medicaid.
Expenditures	FY99 - $23.5 million	Est. FY00 budget - $1.02 million.
Covered services	Assistance with bathing, toileting, transferring, moving around in or out of doors, eating, meal preparation, dressing, medications, housekeeping, laundry, food shopping, transportation to medical appointments. Services are not available in registered or licensed homes with 4+ beds.	Assisted living facility (ALF) services, environmental assessments and modifications, medication administration, assistive equipment, and behavior consultation, and Senior Center Plus, which is adult day care for persons with cognitive impairment. ALFs must provide personal care, 24 hour on-site supervision, medication management, and a homelike setting. Only ALFs certified by the DOA can provide services under the Senior Assisted Housing Waiver.
Consumer-direction	Beneficiaries can receive services from agency workers or select individual workers, but case managers initiate hiring and firing of these workers on behalf of the beneficiary. Certain relatives cannot be paid workers including a spouse, child, parent or sibling. These exclusions include step and in-law relationships. There is no requirement that beneficiary sign the care plan.	
Cost containment mechanisms	No beneficiary cost sharing. There are three payment levels Level 1 - $10 a day is for beneficiaries who require minimal assistance with activities of daily living, provided in a single visit. Level 2 - $20 a day is for those who need extensive care which may be provided in one visit or two separate visits, but do not require full-time assistance. Level 3 - $50 a day for those who need constant supervision and assistance throughout the day and do not have access to other supportive resources. The three payment levels are per diem and do not vary by the number of hours worked or by employer.	ALFs cannot charge more than $1,400 a month for persons in the waiver. Waiver beneficiaries cannot receive more than $3,000 for environmental modifications during their lifetimes and $1,000 per client per year for assistive equipment. Behavior consultation fees are limited to $35 per hour and adult day care to $25 per day.
Quality assurance mechanisms	No licensure requirements for individual “personal care providers” but they must agree to a criminal background check if it is requested. Agencies must supervise workers in beneficiary’s home at least once a month. Case managers” must 1) ensure that workers are capable of providing required services, and 2) visit clients every four months to monitor provider performance. Individuals in group residences must be visited once every 6 months. State staff say that visits occur every 4 – 6 months. Caseload limit is 75. The number of beneficiaries a personal care provider serves per day varies according to the severity of needs.	ALF workers must pass the DOA’S Medication Management Training Course and be under nurse supervision. Providers must have one staff person per eight waiver residents during daytime. A DHMH nurse in the state's licensing unit monitors the ALF every 45 days.

Chart 1: Established Maryland Medicaid Programs and Adult Day Care, continued

	Maryland Medical Assistance Medical Day Care Program	Adult Day Care Home Services Grant
Year program started	1980	1975
Administrative responsibility	Department of Mental Health and Mental Hygiene (DHMH)	Department of Mental Health and Mental Hygiene (DHMH)
Functional eligibility	Participants must meet nursing facility level of care criteria.	Adults ages 55+ who have functional limitations that place them at risk for institutional care. Adult Evaluation and Review Services (AERS) unit at local health departments conducts the needs assessments.
Financial eligibility	Categorical eligibility.	For individuals who are not Medicaid-eligible. Participants must pay a co-pay based on a sliding fee schedule which takes family size and income into account.
Number of beneficiaries	FY99 – 4,598	FY99 - 750
Funding source	Medicaid	State-only Funds
Expenditures	FY99 - $47,083,013	FY 1999 - $2,778,682
Covered services	Medical services, nursing services, physical therapy services, occupational therapy services, personal care services, nutrition services, medical social services, activity program, transportation services.	Assistance with activities of daily living, nursing and social work services, personal care meals, transportation, activity programs, physician consultation, and counseling.
Consumer-direction	Beneficiaries select the center they wish to attend. Beneficiaries have on-going input into plan of care.	Beneficiaries select a medical day care center and have on-going input into plan of care.
Cost containment mechanisms	A flat rate is paid for a day of care. The flat rate is adjusted annually by a selected Consumer Price Index. The increase may not be greater than 5 percent.	Program receives an annual state fund appropriation. Grants do not cover the full cost of care; providers contribute to cost of care and recipients pay a co-payment.
Quality assurance mechanisms	All direct care staff required to have a criminal background check, except for staff with professional licenses such as nurses, social workers, therapists, etc. License is required for social workers, nurses, physicians and therapists. Nursing assistants must be certified. Medical day care centers are required to establish and maintain a quality assurance program. The Department's designee performs annual on-site reviews of all Medical funded centers to review compliance and quality of care. Licensure is required for all adult day care centers to operate in Maryland.	All direct care staff must have a criminal background check, except for staff with professional licenses. Social workers, nurses, therapists and physicians must be licensed. Nursing assistants and medicine aides must be certified.

Chart 2: New Maryland Medicaid Waivers

	Waiver for Adults with Physical Disabilities	Home and Community-Based Services Waiver for Older Adults
Year program started	Approved 3/00 Implementation Date: 4/01	Approved 3/00 Implementation Date: 1/01 An expansion of the Senior Assisted Housing Waiver
Administrative responsibility	DHMH and DHR jointly administer the waiver at the state level. DHR will contract with case management entities and fiscal intermediaries to conduct some administrative activities at the local level.	DOA and DHMH. DHMH sets policy and pays providers, DOA does day to day administration. AAAs are single point of entry and provide case management or contract w/ local Department of Social Services or Health provide case management services. DHMH's contractor, the Delmarva Foundation, conducts functional eligibility review.
Functional eligibility	Age 21 – 59, must meet nursing home level of care	Age 50+, must meet nursing home level of care
Financial eligibility	People can qualify if they are categorically eligible or medically needy, or have countable incomes at or below 300% of SSI. Assets cannot exceed $2,000 for categorically eligible persons and $2,500 for those who are medically needy.	People can qualify if they are categorically eligible or medically needy, or have countable incomes at or below 300% of SSI. Assets cannot exceed $2,000 for categorically eligible persons and $2,500 for those who are medically needy.
Number of beneficiaries	1st yr. – 150 slots, 2nd yr. - 300 slots, 3rd yr. – 400 slots	1,135 slots in 2001. Planned expansion to 5,135 slots over five year period.
Funding source	Medicaid.	Medicaid.
Expenditures	Not applicable.	Not applicable.
Covered Services	Attendant care, nursing supervision of attendants, case management, assistive technology, home modification, emergency response systems, occupational and speech therapy, family or consumer training, and extended supplies.	Assisted living services, environmental assessments, senior center plus, behavior consultation services, personal care (with higher payment rates than optional Medicaid personal care services, and allows family except spouse to be a worker), respite, environmental accessibility adaptations, family or consumer training, emergency response systems, home delivered meals, nutrition services, extended state plan services (home health, supplies and equipment, and transportation services that are more generous than regular Medicaid services.)
Consumer-direction	Consumers can hire and fire workers or use an agency. Family can be workers with the exception of spouses. A fiscal intermediary will be used to reimburse consumer-employed attendants.	Consumers can select their provider and switch to a different provider at any time. These changes are initiated for the recipient through the recipient's case manager.
Cost containment mechanisms	Hourly limits on personal care workers wages $11.75 an hour for individual workers; $15 an hour for agency workers.	Limits on ALF monthly charges, including room and board, ranging from $1,950 to $2,350. Hourly limits on personal care workers wages $9 - $11.75 for individual workers; $11.50 - $15 an hour for agency workers.
Quality assurance mechanisms	The state will conduct an annual review of a 10% sample of waiver recipients. Review process will include a medical record review, plan of care review and on-site visit. No licensing for attendant care workers. Workers must undergo a criminal background check. All nursing assistants and medicine aides must be certified. All aides are supervised by a nurse.	The state will conduct an annual review of a 10% sample of waiver recipients. Review process will include a medical record review, plan of care review and on-site visit. Assisted Living Providers: ♦ ALF workers must pass the DOA'S Medication Management Training Course and be under RN supervision. ♦ ALFs must have one staff person per eight waiver residents during daytime. Personal Care Providers: No licensing for attendant care workers. Workers must undergo a criminal background check. All nursing assistants and medicine aides must be certified. All aides are supervised by a nurse.

Chart 3: Maryland State-Only-Funded Programs in Department of Aging (DOA)

	Congregate Housing Services Program	Senior Assisted Living Group Home Subsidy Program	Senior Care Program
Year program started			Demonstration project in 1982, statewide in 1986
Administrative responsibilities	DOA at state level contracts with 17 agencies to provide services to older persons in group residential settings. Agencies can include local housing authorities, housing management companies, and non-profit organizations.	DOA at state level. 24 local governments designate a lead agency which can be local health (3), social services (2), or aging departments (19).	DOA at state level. 24 local governments designate a lead agency which can be local health (3), social services (2), or aging departments (19).
Functional eligibility	Age 62+ with physical or mental impairments who need help with housekeeping, meals, or daily activities. Person needs the level of care available in the setting. Spouses of participants also can receive services if they are age 55+ and meet other criteria.	Adults of all ages who are at risk of entering a nursing home.	Age 65+ and at risk of entering a nursing home.
Financial eligibility	Income cannot exceed 60% of state median income (as of 7/1/00, $1,857 monthly for one person), assets cannot exceed $27,375 for one person.	Income cannot exceed 60% of state median income (as of 7/1/00, $1,857 monthly for one person), assets cannot exceed $11,000 for one person.	Income cannot exceed 60% of state median income (as of 7/1/00, $1,857 monthly for one person), assets cannot exceed $11,000 for one person.
Number of beneficiaries	900 beneficiaries.	Subsidized beneficiaries – FY00 (est.) 463 and estimated waiting list is 433.	FY99 – 3,702.
Funding source	Federal, state, and providers.	Federal, state, local.	State, local.
Expenditures (FY00)	Total budget FY00 - $2.85 million.	FY00 (est.) - $3.368 million (includes waiver funding.	FY99 budget was $6,573,711. Monthly cost per gapfilling client was $148 a month in FY99.
Covered services	Meals, housekeeping and laundry, weekly personal care, care coordination, and supervision. Financial subsidies to residents of group residential settings to help participants pay the program cost, which is approximately $447 a month.	Financial subsidies to residents of ALFs to help residents pay their fees.	Case management, personal care, chore, adult day care, medications, medical supplies, respite, meals, assistive devices, emergency response systems, medical transportation, and other services such as dentures, glasses, and hearing aids.
Consumer-direction	18 month pilot project to give participants more choice over their services will begin 1/1/01.	Not applicable.	16 counties use independent workers. Amount of consumer-direction varies by locality.
Cost containment mechanisms	Subsidies are income-related and most sites have waiting lists.	Subsidies are income-related and capped. Number of subsidies is capped and a waiting list exists.	Some local jurisdictions maintain waiting lists for services and others do not. The waiting list had 3,831 persons in FY99. People remained on waiting list for an average of 7 months. 3 counties have income-related cost sharing and 6 counties have a per person cap on services. 13 counties impose limits on some services. State imposes a $500 monthly cap on an individual's services.
Quality assurance mechanisms	The DOA or AAAs monitor congregate homes at least once a year. The DOA reviews AAAs' monitoring reports and requires them to document how they followed up on any problems.	DHMH licenses ALFs. AAAs have a contract with DHMH to visit quarterly those homes where most residents are older. DHR has a similar contract with DHMH for ALFs where the majority of residents are younger adults with disabilities.	Case managers make home visits at least every 6 months and telephone calls at least every 6 months. Much local variation in both activities.

a co-payment for their adult day care services based on a sliding fee scale. Centers receiving grants also contribute to the cost of participants' care. This grant program served approximately 750 individuals in fiscal year 1999.

Within the waiver programs, Medicaid shares responsibility for enrolling beneficiaries and providers in the Medicaid Senior Assisted Housing Waiver with the Department of Aging and delegates many case management and quality monitoring activities to the Department of Aging. The current Senior Assisted Housing Waiver, which has 135 slots, covers assisted living services, Senior Center Plus (adult day care for people with cognitive impairment), environmental assessments and modifications, assistive equipment, medication administration, and behavioral consultation for people who meet the waiver's financial and medical eligibility criteria. In 2001, the existing Senior Assisted Housing waiver will be expanded and renamed the Waiver for Older Adults. The expanded waiver will have 1,135 slots devoted to assisted living and in-home services such as personal care for older persons. DHMH plans to expand the waiver to 5,135 slots over a five-year period.

In addition to expanding the existing waiver serving older adults, the state will implement a new Waiver for Adults with Physical Disabilities, with 150 slots for adults age 21- 59, by April 2001. This waiver will provide attendant care and other supportive services to beneficiaries who can use agency aides or hire individual workers. The state plans to expand this waiver to 300 and 400 slots in its second and third years of operation respectively. DHMH and the Department of Human Resources will administer this waiver jointly.

The Department of Aging houses three state-funded programs for older persons: the Senior Care Program, the Senior Assisted Living Group Home Subsidy Program, and the Congregate Housing Services Program (See ***Chart 3***). The Senior Care Program is the largest of the three with a fiscal year 1999 budget of $6.6 million and a total of 3,702 clients during the year. This program provides case management and "gapfilling" services to persons age 65 and over who have low incomes, are at risk of entering a nursing home, and have needs that cannot be met by other public or private programs. The two housing programs, which serve about 1400 participants, have similar structures in that they both provide subsidies to people with low or

moderate incomes who need long-term care and live in either assisted living or certain group residential settings.

The Department of Human Resources operates four state-funded programs for adults age 18 and over with disabilities. The Attendant Care program reimburses adults age 18 to 64 who are working, in school, or can be discharged from a nursing home for up to $8,450 in annual attendant care costs. In this program, beneficiaries hire, fire, and pay their own workers. The other programs—Social Services to Adults, Project Home, and In-Home Aide Services—provide funding for social services that help adults with disabilities remain in their homes or communities.

As at the state level, three parts of local government are involved in assessing eligibility, coordinating care and monitoring quality for the many home and community services programs. County departments of health perform these activities for the Medicaid personal care service, local Area Agencies on Aging do so for programs serving the older population, and local social services departments for state programs serving adults with disabilities.

With several agencies involved, the state and counties have had to develop mechanisms for coordinating the programs. The state relies on an Interagency Committee on Aging Services, comprised of the Secretaries of Aging, Health and Mental Hygiene, Human Resources, Housing and Community Development, Labor, Licensing and Regulation, Transportation, and the Governor's Office for Individuals with Disabilities, to help plan and coordinate services for older persons at the state level. There is no similar interagency coordinating committee for younger adults with physical disabilities at the state level. Each locality chooses how to coordinate services for the older population and some counties have consolidated agencies serving this population. One stakeholder contended that coordination at the state-level is ineffective, but that the local offices work together well in some jurisdictions. State officials say that the state Interagency Committee on Aging Services has been effective in building the Senior Care Programs and addressing other issues affecting the older population.

People who need home and community services must access the programs through their local Department of Health or Social Services, or through local Area Agencies on Aging. Having three local access points for varying types of services may result in confusion for

potential users of the system. When queried about this point, some observers said that if people call the local departments they might not be referred to the right program. State officials reported that people who call the Senior Information and Assistance Network will get referred to the appropriate agencies for services.

State home and community services programs have few outreach efforts designed to inform potential participants about relevant programs. However, as of October 2000, DHMH plans to conduct outreach to aged and disabled individuals in nursing homes, rehabilitation hospitals, and independent living centers to inform them about the new Medicaid waivers. For the Waiver for Adults with Physical Disabilities, the state is currently conducting focus groups in nursing facilities statewide to identify the best strategies to conduct outreach to potential waiver recipients. Facility staff and residents are participating in these focus groups. The state will develop its approach to outreach based on the research results.

ELIGIBILITY CRITERIA AND ASSESSMENT

Eligibility criteria differ by home and community services program. Within Medicaid, each waiver and state plan program has its own eligibility criteria. The Medicaid personal care program requires people to have limitations in one or more activities of daily living but does not require the county health departments to use a standard form when conducting assessments. Unlike the personal care program, individuals must meet the nursing home level of care to participate in the adult medical day care program. To receive services under the Medicaid home and community-based services waivers, beneficiaries must meet the nursing facility level of care.

According to most stakeholders, Maryland's nursing facility level of care criteria are too strict. Some stakeholders reported that the state's criteria require that participants need skilled services and are similar to criteria used by Medicare for the skilled nursing facility benefit. State officials however, indicate that the nursing home level of care determination process is an examination of an individual's total care needs, including functional and cognitive needs.

For example, stakeholders reported that when the Medicaid Senior Assisted Housing Waiver was first implemented in 1993, only three of 70 applications one AAA submitted were initially approved, although 14 applicants were approved upon appeal**.** According to state officials, denials that occurred during the waiver's start-up were largely due to inadequately

completed forms. In response, the state conducted education and training sessions and revised the level of care determination form. Currently, 98% of Senior Assisted Housing Waiver applicants are approved for nursing facility level of care. Even though nursing facility level of care approval rate is very high, some stakeholders feel that the public perception that the criteria are strict deters individuals from applying for programs that require nursing facility level of care.

The state reports that utilization of services that require a nursing facility level of care determination is comparable to the national average. In Maryland, 65 percent of the state's nursing facility services are financed by Medicaid, which is in line with the national average. In addition, the state served about 4,600 individuals who meet level of care criteria in the Medical Day Care Program. State staff feel that a restrictive level of care criteria is inconsistent with the observed use of relevant Medicaid services.

In an effort to broaden eligibility for waiver services without changing its nursing home level of care criteria, Maryland requested, in its application for the expanded waiver for older adults, that waiver services be available to people "at risk of institutionalization." The state's proposal would have enabled people who would meet the nursing home level of care requirement within 30 days to receive Medicaid waiver services. HCFA turned down Maryland's request because of inconsistency with federal Medicaid home and community services waiver requirements.

However, HCFA did approve a number of Maryland's requests including 1) reducing the minimum enrollment age from 62 to 50 years and older, and 2) eliminating the requirement that waiver beneficiaries be eligible for Medicare Part A and for a state housing subsidy.

Nationally and in Maryland, Medicaid's eligibility criteria for nursing facility coverage have an impact on the larger long-term care system. Some observers expressed concern that aged and disabled applicants who do not meet level-of-care criteria for nursing home or waiver services may end up in group homes, which may be unregulated and inappropriate. Reportedly, some homes do not have sufficient staff to meet residents' needs or may not even be wheelchair accessible, with the result that some people leave the homes only for medical appointments. In January 1999, the state implemented new licensing regulations for assisted living designed to

address these concerns. All licensed facilities must now meet requirements regarding minimum staff levels and accessibility standards.

Other barriers to use of waivers are reported to exist. Some waiver applicants experience difficulty getting physicians to sign the waiver application form, something that nurses do in some other states. The Senior Assisted Housing Waiver application process for potential beneficiaries was said to be "very long – six to nine months" and procedurally difficult. State officials reported that the time from application to enrollment now averages two months.

State-funded programs targeted to the older population generally require that beneficiaries need help with one or more daily activities or be at risk of entering a nursing home. The state-funded programs in the Department of Human Resources require that adults need help with daily activities, supervision, or general assistance to remain in the community.

Financial eligibility for Medicaid home and community services varies across programs. The personal care and medical day care programs allow people who are categorically eligible or medically needy to receive services if they also meet Medicaid's asset test. In the Senior Assisted Housing Waiver, the income standard is 200 percent of the federal Supplemental Security Income benefit level and beneficiaries have a personal needs allowance of $60 a month. As of January 2001, the Waiver for Older Adults, the expansion of the Senior Assisted Housing Waiver, will allow people with incomes up to 300 percent of the Supplemental Security Income level to be eligible. The new Waiver for Adults with Physical Disabilities will use identical income and asset eligibility criteria.

The state-funded Department of Aging programs are designed to serve people, who are not eligible for Medicaid, so they have somewhat higher financial eligibility standards. The programs' income eligibility standard are set at 60 percent of the state's median income or $1,857 a month for a single person in 2000 and beneficiaries can keep at least $11,000 in liquid assets. The Department of Human Resources programs are also means-tested.

CASE MANAGEMENT AND SERVICE PLANNING

The caseload and responsibilities of case managers vary among departments. Information on average caseloads of the local department of health case managers who handle

the Medicaid personal care benefit was unavailable, but individual caseloads are not to exceed 75 clients. These case managers are supposed to visit clients who live in their own homes in person every four months and clients in group residential settings every six months. Some health departments visit clients as often as every two months. Senior Care case managers in the Area Agencies on Aging have 45 – 50 clients on average. These case managers visit clients every three to six months, or sooner, if necessary. Case managers who work in the Department of Human Resources' programs targeted to younger adults with disabilities make in-home visits to clients every three months and reassess beneficiaries every six months.

SERVICES

Many stakeholders characterized the current home and community services programs as having too narrow an array of services. The Medicaid personal care program covers assistance with daily activities and instrumental activities of daily living for eligible recipients. Transportation only to medical appointments is available under the Medicaid transportation benefit, which does not cover transportation to work or to community activities, such as attending church. Under federal regulations applicable to this benefit, Medicaid can only cover medically necessary services. In addition, personal care cannot be delivered in licensed assisted living residential settings with four or more beds.

The state is using Medicaid waivers that will be implemented during 2001 to expand the range of home and community based services that Medicaid currently covers. The Waiver for Older Adults expands the benefits formerly available under its precursor, the Senior Assisted Housing Waiver, to include assisted living services provided in any licensed assisted living facility, respite care and personal care and other services provided in a beneficiary's home. The new Waiver for Adults with Physical Disabilities covers attendant care, case management, assistive technology, emergency response systems, family and consumer training and other services that the state cannot cover through a state plan option like the Personal Care Program.

Two programs cover services in adult day care centers. The Medicaid Medical Day Care Program provides medical, therapy, and nursing services in addition to personal care, activities, and transportation, among other services. The state-funded adult day care grant covers largely the same non-medically-related services as the Medicaid Medical Day Care Program.

Most of the state-funded programs cover a set of targeted services. The Congregate Housing Services Program and the Senior Assisted Living Group Home Subsidy Program within the Department of Aging provide supplemental payments and services to people residing in group residential settings or assisted living facilities. The state-funded Senior Care program provides reimbursement for the widest range of services. The four state-funded programs in the Department of Human Resources cover such services as case management, financial assistance, adult foster care, chore, and personal care.

Maryland's home and community services system funds assisted living via the Medicaid waivers and state-funded programs described above. Observers said that an advantage of residential care is that it enables people, particularly those in urban areas, to remain in the community because they would otherwise be homeless or have to enter a nursing facility. However, some stakeholders view assisted living facilities as negatively as they do nursing homes because they say both are institutions. Younger people with disabilities are said to want to avoid institutionalization all costs.

CONSUMER DIRECTION

Maryland's home and community services are provided by home care agencies, adult day health care centers, and individual providers. Under the Medicaid personal care program, at least 90 percent of beneficiaries have individual workers. In this program, beneficiaries can identify and are also free to choose individual workers but do not hire and fire the workers themselves. Rather, a case manager must initiate staff changes on beneficiaries' behalf.

Three other programs incorporate some consumer-direction principles; two of the programs are state-funded-only and are targeted to younger adults. Beneficiaries in the state-funded Attendant Care program in the Department of Human Resources receive cash reimbursement of their attendant care expenses. Senior Care has a small grant program for families that allows them to hire and fire workers or pay for other services or supplies. The new Medicaid Waiver for Adults with Physical Disabilities will permit beneficiaries to hire and fire their own workers but the new waiver targeted to older adults will not. Clients in both waivers have freedom of choice of providers, but stakeholder workgroups that participated in the

development of the Waiver for Adults with Physical Disabilities particularly emphasized consumer direction in that waiver's design.

Beneficiary family members can become providers in some Medicaid home and community based service programs. For the new and expanded waivers targeted to adults with physical disabilities and older adults, any family member other than a spouse can be a caregiver. However, in the Medicaid Personal Care Program, close family relatives cannot become paid workers. These exclusions include the spouse, a child, parent or sibling, and step and in-law relationships. A wider range of family members are allowed to become paid workers within the waiver programs.

State staff and stakeholders generally have a protective attitude toward beneficiaries, particularly those who are elderly and frail. State staff acknowledged that advocates want consumer-direction to foster consumer control and dignity and staff are exploring how to incorporate consumer choice into the Senior Care program. However, some state staff worried that consumers may want things that "are not in their best interests." Some observers do not think that elderly persons who need the nursing home level of care will be interested in consumer-direction because of their frailty. Other stakeholders said that people who are capable of and want to direct services should be able to do so, but some persons need the protection of an institutional environment and those with cognitive impairment need oversight. One group of stakeholders advocated consumer-direction through an independent living model where persons with disabilities have the ability to hire and fire workers and receive training and support with management tasks.

COST CONTAINMENT

Maryland has controlled expenditures by limiting appropriations for state programs, restricting reimbursement rates, limiting the number of waiver slots, and controlling nursing home level-of-care criteria. The state-funded programs serving older persons have waiting lists; the number of people on the Senior Care list was 1,553 at the end of fiscal year 1999. Although Senior Care has a $500 monthly cap on services to clients, the average annual expenditure per slot was $198 in fiscal year 2000. Most localities limit Senior Care program expenditures by requiring cost sharing, imposing their own monthly caps, or otherwise limiting services.

Medicaid personal care, by virtue of being an entitlement program, does not have a waiting list, but it does maintain tight control over provider payments. The program sets three daily rates for personal care based on the complexity of the beneficiary's needs and informal support system. Individual providers are paid $10 a day for Level 1 services, which include minimal assistance with activities of daily living provided in a single visit. Individuals requiring Level 2 services need extensive care, which may be provided in one visit or two separate visits, but do not require full-time assistance. Level 3 services are for individuals needing constant supervision and assistance throughout the day and who do not have access to other supportive resources. Reimbursement for Level 2 and Level 3 personal care services is $20 and $50 a day, respectively. Many stakeholders raised concerns about the concept of daily rates since workers have an incentive to work as few hours as possible because they are not reimbursed for each hour of service. The new Medicaid waivers will pay hourly rates to agencies or individual workers, rather than daily rates as in the Medicaid personal care program. Some observers raised concern about the new waivers' ability to contain cost increases because of these hourly rates and expressed fear that the waivers will drain the labor supply for the Medicaid personal care program.

Views of the adequacy of payment rates for other programs and providers depend upon the type of provider. Nursing home payment rates are thought to be adequate by some, but Medicaid Personal Care Program rates are not. Unlike other providers, adult day health care centers have an automatic inflation adjustment that has brought rates to $62 a day in 2000. No problems with centers' rates were mentioned during the site visit.

QUALITY ASSURANCE

Quality assurance systems vary by provider type and program. Medicaid personal care workers do not have to be licensed or certified but must agree to undergo a criminal background check if asked to do so. Agency workers must be supervised in a beneficiary's home once a month. Medicaid case managers visit personal care beneficiaries in their homes three times a year. Case managers in the Senior Care program visit beneficiaries' homes or have telephone contact with them every three to six months, but the frequency of these activities varies by client need and by Area Agency on Aging.

The state legislature recently consolidated the three assisted living facility regulatory systems and gave DHMH lead licensure responsibility. The new guidelines, requiring specific types of staff training, certain building standards, and other requirements that large facilities have little difficulty meeting. However, according to stakeholders, very small facilities are having greater difficulty in complying with the requirements.

The Departments of Health and Mental Hygiene, Human Resources, and Aging maintain toll free numbers that clients can use to ask questions and make comments about the home and community services programs. Both the Department of Aging and the Department of Human Resources will dedicate a toll-free line to their new and expanded waiver programs. When people do complain, the complaints are referred to the long-term care ombudsman, adult protective services, or the relevant local agencies to investigate.

In 1999, the Senior Care program conducted a consumer satisfaction survey by mail of a random sample of 598 recipients of Senior Care services.[5] The response rate was 44 percent. Eighty-six percent of respondents were completely or very satisfied with the quality of services; 75 percent had the same level of satisfaction with the quantity of services. Of the 22 percent who complained about services, the most frequent complaints were about late or missed services or the attitude of the worker.

Some observers said that fraud, such as providers billing for services that they did not deliver, is an issue in the Medicaid personal care service. For example, the Baltimore City Health Department initiated a telephone monitoring system requiring workers to call in and out as a way of monitoring hours of service. City staff found problems in about 200 of 1,500 cases.

Long-term care providers of all types are experiencing labor supply problems, which reportedly are affecting quality. State staff and stakeholders said that worker recruitment is difficult, particularly in rural areas with inadequate transportation. One stakeholder cited a number of problems with personal care workers, including failure to show up, a lack of back up

[5] Maryland Department on Aging, Consumer Satisfaction and Effectiveness of the Senior Care System in Maryland, November 1999.

when that occurs, and an unwillingness to do what consumers want them to do. Reportedly, some beneficiaries are afraid to complain because they fear a loss of scarce workers.

Stakeholders made several recommendations for dealing with the worker shortage. One stakeholder suggested that increasing provider payment rates would enable providers to pay higher wages and thus compete effectively for workers with other service industries. Another stakeholder said that reducing the paperwork burden would help alleviate the worker shortage; some nurses are leaving health care altogether because of paperwork. Another stakeholder said that a method of helping beneficiaries to recruit workers would be to maintain worker registries. The Senior Care program allows payments to members of a client's extended family and is exploring the possibility of allowing immediate family to receive payment.

FEDERALISM ISSUES

Many persons interviewed believe that while HCFA staff are very helpful in resolving problems, the waiver process itself is complex and time-consuming. Several problems were noted and recommendations for improvement made. Observers would like the ability to cover Medicaid home and community services by amending the state plan rather than having to obtain a waiver. The establishment of an appeals process for HCFA waiver decisions was also mentioned. State staff want the opportunity to learn more from other states and particularly appreciated the monthly telephone conference calls that HCFA sponsored in the past. HCFA was said by some to allow more flexibility than the state wanted to have. An example was that the state did not want the flexibility to allow children, parents and siblings to serve as caregivers in entitlement programs such as the Personal Care Program because of fears of the woodwork effect and its associated costs.

ISSUES FOR THE FUTURE

One of the major challenges that Maryland faces is the widely held perception that the younger adult population with disabilities is at a disadvantage compared to the older population. In the Medicaid personal care service, current reimbursement levels are not sufficient to encourage personal care providers to care for persons with heavy care needs such as quadriplegics. State officials assert that the Medical Day Care program provides adequate

support for individuals with severe disabilities. The older population's access to the flexible package of Senior Care Services with relatively generous financial eligibility through Department of Aging programs is cited as another inequity.

State staff mentioned that they are devoting more resources to younger adults with disabilities and are beginning to respond to the Supreme Court's Olmstead decision. The Governor has issued an Executive Order that created the Community Access Steering Committee and four task forces. The Steering Committee and task forces will make recommendations by June 2001 to the Governor to further facilitate the placement of persons with disabilities in more integrated community settings. Three of the four task forces will focus on needs for community-based services among Medicaid recipients, individuals with developmental disabilities, and individuals with mental illness. The fourth task force will address issues affecting all populations that may be served in the community. The Steering Committee and task forces include individuals with disabilities, and representatives from consumer advocacy groups, provider organizations, and state agencies.

Although state staff and various stakeholders pointed out innovations such as PACE and the nursing home discharge project supported by a HCFA planning grant, stakeholders consider the state's Medicaid program to be restrictive. Many observers cited the state's level of care criteria for nursing home and waiver services as making it difficult for beneficiaries to access services. The expanded waiver serving older adults, and the new waiver serving younger adults with physical disabilities that will be implemented in 2001 will expand opportunities for clients to be served outside of a nursing home. In addition, the state is conducting an evaluation of its nursing facility level of care criteria to respond to public concerns that the criteria are not sensitive enough to cognitive and functional impairments.

Another challenge for the state is that three departments at the state level and as many at the local level share responsibility for the state's numerous home and community services programs. This situation reportedly complicates coordination of services and programs but state officials say that there is a great deal of cooperation at the local level, particularly regarding access to Senior Care services. The state is trying to achieve more uniformity and collaboration among the departments with long-term care programs. The Departments of Health and Mental

Hygiene, Aging and Human Resources are collaborating in the implementation of the expanded older adults waiver, and the new waiver for physically disabled adults.

Stakeholders' views of the future varied, with some saying that Maryland's recent waiver expansions are a positive step and that over time the state's entire long-term care system could improve. Others said they did not believe that Maryland's system would change much over time.