Maryland Commission on Aging
North Laurel Community Center, Laurel, Maryland
April 12, 2017
10:00 AM—12:30 PM
Minutes

Members Present: Rose Maria Li, Chair; John Haaga; Hon. Jordan Harding; Joy Hatchette; Dot Principe; Carmel Roques; Mary Ellen Thomsen

Members Absent: Hon. Barbara Frush; Helen Kimble; George Rebok; Sharonlee Vogel

Staff Present: Rona E. Kramer, Secretary of Aging; Rosanne B. Hanratty, Maryland Department of Aging (MDoA), Staff to the Commission

Other: Lorraine Nawara, Department of Health and Mental Hygiene (DHMH), Long Term Services and Supports Administration (LTSS); Carolyn Thompson, *Velocity of Books* program

Greetings--Rose Maria Li, Chair:
Dr. Li welcomed attendees. She distributed the publication *The Health and Retirement Study (HRS): Aging in the 21st Century, Challenges and Opportunities for Americans*. She explained that the HRS was initiated in 1990 to provide longitudinal data for research on health, retirement and other aspects of the aging population. Study data are compiled biennially and include both recurring and experimental modules. Dr. Li said that the HRS is funded, in part, by the National Institute on Aging (NIA), Division of Behavioral and Social Research of which Commission member, Dr. John Haaga, is Director.

Secretary's Remarks—Rona E. Kramer, Secretary of Aging:
Secretary Kramer noted that the 2017 legislative session had concluded and that she had spent a significant amount of time in Annapolis because of legislative and budgetary issues. She expressed appreciation for the efforts of Department staff during the session, especially Andrew Ross, the Director of Government Affairs and Administration, and Ms. Hanratty who assisted with legislative tracking, analysis, and research.

The Secretary reported that all of the five proposed Department bills had passed and would be signed by Governor Hogan. One Department bill codifies the Commodity Supplemental Food Program, a federally-funded nutritional program through which boxes of food are distributed monthly to low-income older adults. In addition, it clarifies the Secretary's authority to implement programs and, as a result, will facilitate the adoption of new approaches to serving older adults.

Another Department bill establishes the Healthy Aging program to be administered by MDoA. It authorizes the Department to accept money provided by public and private sources to implement the Healthy Aging program and to develop innovative strategies and programs to

respond to issues facing Maryland and its older adult population--which is rapidly increasing in size and as a percentage of the population. Secretary Kramer noted that the growth in the number of Maryland older adults has outpaced that of the school-aged population and that in thirteen years the proportion of Maryland's population that is aged 60 or over will progress from its present 18% to approximately 26%.

Secretary Kramer also informed the Commission that a bill, which had failed during the 2016 legislative session, establishing the Senior Call Check program had passed during the 2017 legislative session and that MDoA is charged with implementing the program. The costs of the program will be funded through the Universal Services Trust Fund, financed through a surcharge on phone bills not to exceed $.05 monthly.

Secretary Kramer said that the Governor's budget reflected full funding of MDoA's submission and that an additional $1.2 million in program funds had been included by the Governor and was retained in the final budget. The Governor's budget, as introduced, had retained the Department's then-current permanent full-time staffing level [PINs]. However, while the Senate Budget and Taxation Committee had retained the staff level as proposed, the House Health and Human Services Subcommittee had reduced the number of PINs by three, and this reduction was upheld in Conference. Secretary Kramer said that the Department had had some vacancies which had not been filled because she had held these open until the budget deficiencies carried over from the previous administration had been resolved, and that the legislature's reduction in the number of PINs would prevent her from filling some vacancies.

Secretary Kramer observed that public funding allotted to programs to address the needs of older adults is not keeping pace with the rate of growth of the older adult population. In addition, she noted that the reduction in the number of Department positions would be challenging but that Department's staff is being utilized effectively and efficiently. The Department also has some flexibility in the number of contractual employees that it has authority to hire. Secretary Kramer also said that, while state salary levels may present challenges in recruiting personnel, one strategy she has been pursuing is to hire professionals with extensive work histories who are interested in contributing to the efforts of the public sector later in their careers.

Several Commissioners expressed concerns about the Department's staffing level and loss of positions. Mayor Harding emphasized the need to address these issues with state legislators and Secretary Kramer acknowledged the importance of Commissioners as individuals and other members of the public to inform legislators of their concerns. Dr. Li also encouraged Commissioners, as individuals, to address their concerns to General Assembly members for their home districts as well as members of the budget committees.

Secretary Kramer informed the Commission that the Department, in conjunction with the Maryland Association of Area Agencies on Aging (M4A), had sponsored a workshop on developments in, and innovative models of, health care financing in Maryland. She said that such developments provide opportunities for partnership development between Area Agencies

on Aging (AAAs) and various sectors in the health care system. These partnerships may facilitate innovative strategies to maintain older adults in the community while enabling components of the health care system to successfully fulfill the goals of statutorily-mandated financing models, such as reducing the rate and number of readmissions to acute care hospitals. Such partnerships may present opportunities for AAAs to be reimbursed by hospitals for services that the AAAs provide to the hospital's discharged patients. Secretary Kramer also noted that the leadership of the National Association of Area Agencies on Aging (n4a) had observed that the work that MDoA, as the state unit on aging in Maryland, is undertaking in this area provides a model for other state units on aging.

Presentation: *Velocity of Books Program*—Carolyn Thompson, founder:
Ms. Thompson is the founder of a real estate firm and has a professional and personal interest in facilitating adults' ability to age in place. She was invited by Commissioner Harding to share information with the Commission about the *Velocity of Books*, a program she founded and administers to collect and distribute books to promote literacy and reverse cognitive decline. Ms. Thompson In her introductory remarks, she observed that there is a dearth of housing stock, which is purpose-built or has been modified, to facilitate safe aging in place. She also said that Maryland is one of only five states having no provision for awarding continuing education units for realtors to become senior adult housing specialists. She believes that realtors should have conversations with buyers of all ages about buyers' plans for aging in the residence they are considering for purchase. She noted that areas like the District of Columbia are in the process of becoming "silver collar" communities, a term that the National Association of Realtors has coined to describe cities which are experiencing population growth both as a result of their populations aging in place, as well as from people relocating to the cities because urban areas facilitate aging in place.

In presenting the *Velocity of Books* program, she explained that books may be distributed in many settings, including in senior centers, "villages," and nursing homes. Her goal is to eliminate what she terms "book deserts." The beneficiaries of the program also include children, younger to middle-aged adults and seniors. She hopes to facilitate distribution of 1 million books by 2018. Ms. Thompson said that she uses flexible models to obtain, distribute, replenish, and "re-freshen" books. For example, the supply and selection of books in informal libraries at nursing homes and rehabilitation centers often become stagnant and she aims to encourage periodic purging and refilling book supplies by teaching strategies to residents and staff to maintain book programs that are self-sustaining. She would like senior centers to establish book swap programs. Senior center clients are generally community-dwelling and are often able to readily resupply the reading material. She is working with a variety of partners, including for-profits, and she is presently in conversation with Discovery Communications about a possible partnership.

Dr. Haaga inquired about the role of public libraries. Ms. Thompson, while noting that public libraries are good sources of audio books for readers who need or want them, informed attendees that Montgomery County's public library alone pulps approximately a quarter of a million books a year, including audio books. She also observed that public libraries have

reading initiatives targeted to pre-schoolers and school-aged children but generally do not have similar programs for older adults. She said that such older-adult-targeted programs would be beneficial both for the clients who would utilize them and for other library patrons, such as children, who would observe older adults modeling reading. Ms. Thompson indicated that she believes that libraries must rethink their service paradigms, and retool their services to reflect the most current demographic profiles of clients and those clients' needs.

Presentation: Medicaid LTSS and the *Level 1 Screen* **[Power Point Slides appended]--**
Lorraine Nawara, DHMH, LTSS Administration:
Ms. Nawara provided an overview of the Medicaid program generally, the Medicaid LTSS program, comparisons of LTSS programs' eligibility criteria, LTSS community services, LTSS reform, and the *Level 1 Screen*. She said that Medicaid--a state-federal partnership--encompasses services and beneficiary eligibility categories. Some of these services are mandatory for all states, some are optional and some of which are "exceptional." "Exceptional" services require additional authorities and/or waivers of Medicaid rules. Medicaid beneficiaries are required to meet certain medical, technical, and financial criteria that vary by Medicaid program and service. The State Plan is the agreement between a state and the federal government about how that state's Medicaid program will be structured and administered.
[*Retrieved at Medicaid.gov:* Information about benefits that are mandatory under and optional benefits that states may choose to cover:
https://www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html]

Ms. Nawara explained that Medicaid LTSS are a set of services to assist people in the performance of activities of daily living (ADLs)—for example, bathing, dressing, eating--or instrumental activities of daily living (IADLs)—for example, meal preparation and management of finances. Medicaid covers LTSS both in institutions and in the community. Medicaid LTSS institutional [nursing facility services for persons aged 21 or older] coverage is mandatory under the Social Security Act (the Act). Medicaid LTSS community-based-services may be either optional or exceptional. LTSS State Plan optional services are entitlements and may not be capped by number of participants (enrollment) nor targeted by group. States manage the budgets for such LTSS optional services through limitations on services covered rather than enrollment caps. LTSS exceptional services are authorized under Medicaid statutory waiver authority in Section 1915 (c) the Act, or research and demonstration waiver authority in Section 1115 of the Act. These authorities permit states to waive provisions of the Act. Under such waivers, states may set enrollment limits. Services under such waivers may also be targeted to specific groups, such as to older adults.

Ms. Nawara said that to be eligible for Medicaid nursing facility benefits (a mandatory Medicaid service), an individual must require nursing home level of care, actually reside in a facility, and meet certain financial requirements. For the Community Options waiver program, she said that an individual must meet the threshold for nursing facility level of care, be aged 18 or over, reside in a community residence as defined under federal regulations, and meet certain financial requirements. For entitlement to the Community First Choice (CFC) program (a

statutory benefit authorized under the Affordable Care Act), an individual must meet the threshold for institutional level of care (nursing home, chronic care hospitals, Intermediate care facilities/IID and psychiatric hospitals), reside in a community residence as defined under federal regulations, and meet certain financial requirements. There is no age restriction under CFC. For Community Personal Assistance Services (CPAS), individuals must require assistance with one ADL and meet certain financial requirements.

Ms. Nawara noted that Medicaid LTSS reforms have been focused on fulfilling the Medicaid program's obligations under the Supreme Court Olmstead decision and on rebalancing Medicaid services to increase access to non-institutional LTSS, as well as improving Medicaid program consistency. [Information on the Olmstead decision may be found at: https://www.ada.gov/olmstead/olmstead_about.htm] The Balancing Incentive Program (BIP), established under the Affordable Care Act, provided financial incentives to states to increase access to non-institutional LTSS. One requirement under the BIP is that states utilize "core standardized assessment" tools to streamline access to LTSS. The core assessment tool unilized by Maryland is the interRAI—Home Care (HC) assessment, selected because of its standardization, wide use, and existing tests for validity that had been conducted by the interRAI group. Ms. Nawara stated that this assessment is completed for beneficiaries of Medicaid home-and-community based services. She said that an interRAI phone screen is completed for those who would like to access LTSS, whether or not they will be covered by Medicaid. Also termed the Level 1 screen, this phone screen was piloted in 2013 in Maryland and has been in routine used since 2014.

Ms. Nawara stated that the Level 1 phone screen takes approximately 30 minutes while the full in- person interRAI HC assessment takes approximately 90 minutes to two hours, with additional follow-up time required. Presently only local health departments and DHMH contractors are able to complete this assessment at a cost of $422 per assessment.
Ms. Nawara explained that the Level 1 phone screen, which is designed to identify an individual's functional needs (both in ADLs and in IADLs), is completed by staff of the local Maryland Access Point (MAP) sites, who then counsel potential clients and identify resources for which the client is potentially eligible (such as Senior Care or food or energy assistance).

Ms. Nawara also explained that the Level 1 phone screen had originally yielded a score based on risk categories but that a score is not currently being generated pending review by the Hilltop Institute at the University of Maryland Baltimore County (UMBC) of significant predictors of nursing home admission. Two such predictors (recent hospitalization and self-reported health status) were added to the screening tool in 2016. As part of the Hilltop review, the screening tool and risk algorithms are being studied to ascertain how well they reflect population needs and to analyze the impact of prioritization based on risk of admission to an institution. CY 2018 is the target date for implementation of a revised risk algorithm and scoring mechanism.

Dr. Haaga observed that optimal screening algorithms, designed to be predictive of risk for nursing home placement, are of importance in administration of the Senior Care program--

which provides services designed to minimize risk of actual nursing home placement for clients who have been assessed to be at risk of such placement. Ms. Nawara stated that the original algorithm for the screening tool was designed to identify a need for nursing home care, but that the revised algorithm will be designed to better identify the level of need for such care. Dr. Haaga also observed that completing the interRAI-HC, the in-person assessment described by Ms. Nawara, is very resource-intensive. He said there is ongoing research on use of item-response-theory utilizing computer-aided statistical models that are designed to reduce the number of follow-up questions based on the predictive level of responses to initial questions. Secretary Kramer said that it is important that screening and assessment instruments be both predictive of need and resource-efficient. She noted that the $422 average cost of conducting an interRAI- HC is not always Medicaid-reimbursable.

Dr. Li said that screening and assessment tools will be considered as part of the Commission's review of the Senior Care program. She briefed attendees on the status of, and timeline for, the first deliverable under the review—evaluation of Senior Care wait list practices. She stated that Dr. Rebok had agreed to chair the Subcommittee for the Senior Care Review and has been joined on the Subcommittee by Dr. Haaga. Ms. Roques and Ms. Hatchette offered to also serve on the Subcommittee. Dr. Li said that she is also serving on the Subcommittee and that MDoA will provide data-gathering and other staff and research assistance to the Subcommittee. Secretary Kramer thanked the Commission for undertaking the review. She requested that Ms. Hanratty and Andrew Ross be utilized as liaisons with other MDoA staff and the AAAs to facilitate efficiency and information accuracy and to minimize burden on local jurisdictions and other staff.

Other:
Mayor Harding said that he would defer a proposal, until the June Commission meeting, to develop a strategy to enhance the visibility of the Department and the Commission. He stated that his experience in public affairs had reinforced for him the importance of spotlighting the effectiveness of MDoA programs and the efficiency with which it administers them.

Approval of February 8, 2017 Minutes:
The February 8, 2017 minutes were approved, without changes.

Adjournment:
The meeting was adjourned at 12:35 PM.

Minutes prepared by Rosanne B. Hanratty