OLDER ADULTS & AGING

RECOMMENDATIONS REPORT

2022

Prepared For:

Moore-Miller Unlocking Opportunities & Health Care Policy Committee

December 2022

PREPARED BY:

2023 PROJECT

BALTIMORE CITY HEALTH DEPARTMENT

ALZHEIMER'S® ASSOCIATION

Baltimore Jewish Council

An agency of The Associated

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We thank the Moore-Miller transition for considering these recommendations. For more details related to these ideas please contact: Regan Vaughan, Catholic Charities at rvaughan@cc-md.org.

INTRODUCTION

A coalition of Maryland stakeholders comprised of individuals who work in aging related services and who have policy expertise on issues affecting older adults developed recommendations and action steps to help Governor-elect Moore make Maryland an age-friendly state and position himself to serve as an informed advocate with and for older Marylanders. The group focused its recommendations on the roles of the Governor's office, the Department of Aging, and the Department of Health with a focus on positioning the Department of Aging as the advocate and coordinator for older Marylanders to ensure all state agencies serve the community. The types of participants in the workgroup sessions included representatives from service providers, national and state-based nonprofits, and local government offices focused on older adults and aging. Topics of discussion amongst these knowledgeable and passionate stakeholders included: strategies to end waiting lists for existing support programs; developing a masterplan for aging that involves community stakeholders and Area Agencies on Aging (AAAs); expanding the healthcare workforce and equipping state agencies with appropriate staffing levels and personnel who are knowledgeable, have expertise in aging, and reflect the communities they serve; prioritizing funding for community-based and state-level senior support services; and improving coordination amongst state state agencies.

KEY TAKEAWAYS

- There are more than 1.37 million older adults in the state of Maryland. Over the next twenty years, Maryland's 60+ population is projected to increase 27% to 1.79 million. **For the first time in history, there will be more older adults than children under the age of 18**. *(MDoA State Plan on Aging 2022-2025, Sept 2021)*

- The Department of Aging must refocus their vision on addressing the needs of the community by **serving as the voice, coordinator, and advocate for older Marylanders and ensure state regulatory agencies advance the vision for Maryland as an 'Age Friendly' state.**

- Funding to serve and support older Marylanders has not kept pace with the population growth. **Budgets communicate priorities. Older adults should not be left behind.**

- In addition to the Department of Aging, there are 19 Area Agencies on Aging (AAAs) who serve as the local infrastructure to provide robust federal programming as defined by the Older Americans Act and state programs. **The Department of Aging is the advocate, convener, funder, and regulator. It is a complex department and one that requires a leader with aging services expertise.**

- **Older adults are an economic driver, asset, and strength for the state, and shouldn't be viewed as a drain on state resources.**

- Coordination and collaboration among state agencies is essential to creating systemic change to **utilize resources effectively, leverage state funds, and provide quality services.**

- **"Age friendly", the framework that focuses on prevention and community-wide strategies, is essential to make progress and create a state that is forward-thinking and values older adults and their contributions to society.**

- Older adults were disproportionately impacted by the COVID-19 pandemic**. As the state continues to rebuild, funds need to be allocated and better used to plan for the growth of the older adult population.** Maryland must address the significant needs experienced by this population, including: social isolation, behavioral health, food insecurity, promoting healthy aging, serving older adults and caregivers, addressing extended waitlists for essential services, and enhancing and building infrastructure to support aging in place.

REPORT GUIDE

RECOMMENDATIONS

RECOMMENDATION #1: Enhance Maryland Department of Aging (MDoA) leadership and staffing

Context: According to the 2021, American Community Survey, older adults, aged 60 and over in Maryland account for 23% of the total population, a group similar in size to children under age 18 (22%). Yet, older Marylanders' needs have not been prioritized at the same level as the needs of children. The administration should take steps to recognize the importance of older Marylanders, their needs, and their contributions to the state. This must begin with action from the Department of Aging to appoint qualified leadership with demonstrated knowledge in aging policy, address Maryland's aging service infrastructure, and commit to transforming Maryland into an "Age Friendly State."

For too long, top MDoA leadership appointments have been designated for those who are politically connected rather than individuals with direct experience in Maryland's aging services (such as Area Agencies on Aging) or professional qualifications in aging. As a result, Maryland has missed opportunities for federal funding and cost savings related to Medicaid, and has consistently ranked (30th place in 2022) far below neighboring states such as Virginia (2nd), Delaware (4th), and even Pennsylvania (21st) of Best States to Retire.

A new administration provides the opportunity to renew our commitment to older Marylanders, reinvigorate the state's existing aging infrastructure, and capitalize on the state's amenities that make it a naturally desirable place to live to also make it a comfortable state in which to age in place.

Recommended Actions

First 100 Days • **Appoint a Secretary for the Maryland Department of Aging who:**

- ➔ Has professional qualifications and expertise in aging, including:
  - ◆ Meeting the qualifications established in SB511/HB430 from 2022;
  - ◆ Demonstrating prior experience working with local aging services, community organizations, and nonprofits; and
  - ◆ Expressing a commitment to the federal Older Americans Act.
- ➔ Believes MDoA should:
  - ◆ Be an inclusive, informed, diverse and responsive agency;
  - ◆ Be the statewide voice, coordinator, and advocate for older Marylanders to ensure state regulatory agencies serve and meet the needs of the aging community;
  - ◆ Be a champion for older adults as valuable contributors to our state and local communities;
  - ◆ Work in concert with the local Area Agencies of Aging to assess, plan and implement strategies that will improve statewide and local services to older adults and their caregivers; and
  - ◆ Collaborate with other senior serving organizations (AARP, Non-profits, corporate entities) to find common goals and opportunities to improve Maryland's age friendly approach.

- ➔ Preferred experience:
  - ◆ Strong leadership qualities that allow them to be the advocate for older adults; lead coordination with other secretaries; and conduct regulatory control over the programs that older adults depend on;
  - ◆ Experience with Maryland's Medicaid system; and
  - ◆ Good collaborator with a track record of success working with, and knowledge of AAAs, particularly if the Secretary comes from another state.

Sources & Support Resources

- ➔ Best & Worst States to Retire (WalletHub)
- ➔ MD Senate Bill 511 - Secretary of Aging Qualifications

RECOMMENDATION #2: Develop a master plan for aging to establish Maryland as an "Age Friendly State"

Context: "Age Friendly," an international movement first established by the World Health Organization in 2007 and led in the United States by AARP, helps communities prepare for the rapid aging population. Multiple local jurisdictions have joined the AARP Network of Age Friendly States and Communities, and University of Maryland Baltimore is designated as an Age-Friendly University supporting the well-being of older adults through education, research, and service. Utilizing the platform of Age Friendly, Maryland has the opportunity to demonstrate state-wide innovations; set strategic and coordinated priorities within state government; and leverage resources including community members and public and private organizations across sectors. This initiative is not about new work or increased funding but rather a new way of thinking, strategy, and collaboration to ensure Maryland remains a community where all members are connected to their community and a great place to live and age for all. The eight domains of livability: Housing, Transportation, Outdoor Spaces and Buildings, Social Participation, Respect and Social Inclusion, Civic Participation and Employment, Communication and Information, and Community and Health Services are areas that Maryland can improve upon to model a state that demonstrates older adults are valued and included, and as policy makers, recognize the important role to design and maintain a state where all members can participate fully.

Recommended Actions

First 100 Days **• The Governor should sign an Executive Order to establish a Governor's Council to pursue Maryland as an "Age Friendly State," and announce the Department of Aging will be developing a Master Plan for Aging, similar to the Blueprint for Education, to make Maryland a state for people of all ages, where older adults can thrive.** This should focus on the eight domains of livability for older Marylanders including but not limited to health, housing, transportation, and behavioral health.

- ➔ The Executive Order should require the Council to conduct a needs assessment; advise on best practices; and implement governmental policies that support and promote healthy aging in the State of Maryland. The Master Plan should:
  - ◆ Build on the success of programs across Departments already established in Maryland;
  - ◆ Consider the Aging Master Plan in the MDoA State Plan that was submitted to the federal Administration on Community Living (ACL) in 2021 (the ACL is the federal funder for many of the services administered by MDoA); and
  - ◆ Identify opportunities to make Maryland more age friendly across the state.
- ➔ MDoA should:
  - ◆ Reach out to AARP and other states for technical assistance, and join state cohorts that have engaged in similar processes; and
  - ◆ Lead the Council to develop the Plan and include representatives from: Maryland Association of Area Agencies on Aging (M4A); Maryland Association of Counties (MACo), Maryland Municipal League (MML), Area Agencies on Aging (AAAs), AARP, the Alzheimer's Association, the Maryland Hospital Association, Mental Health Association of Maryland, Catholic Charities of Baltimore, Jewish Community Services of Baltimore, Maryland Rural Health Association, labor representation for home health aides, and home healthcare providers, and representative or designee from all Departments.

First Year • In conjunction with the final Master Plan, MDoA should develop and launch an aging dashboard to measure the goals and tasks associated with the plan.

First Term • Following the development of the Master Plan, the administration should sponsor legislation to codify the recommendations before the end of the first term.

Sources & Supporting Resources

- ➔ AARP Age Friendly States and Communities
- ➔ How AARP Maryland Is Working to Provide More Livable Communities for All Ages
- ➔ Master Plan for Aging, EO for State of California
- ➔ CA Governors Master Plan for Aging 2021
- ➔ CA Governor's Task Force on Alzheimer's Prevention, Preparedness & Path Forward *(Task Force on Alzheimer's)*
- ➔ Governor's Council to Address Aging in Massachusetts
- ➔ UMB: An Age Friendly University

RECOMMENDATION #3: Increase and better allocate Department of Aging funding

Context: "The Maryland Department of Aging (MDOA) has the responsibility for administering community-based programs and services for older Marylanders, evaluating the services that they need, and determining the extent to which public and private programs meet those needs." According to the DLS Analysis of the FY 2023 Maryland Executive Budget, Department of Aging:

> "91% of MDOA's budget supports various aging services. Federal funding for aging programs totals $39.7 million and comprises 51% of the allowance. In addition to Older Americans Act (OAA) programs, other federal funding is received for the administration of the Veteran Directed Care Program ($1.6 million), the State Health Insurance Program ($569,843), and federal financial participation for Medicaid information and assistance ($5.8 million). A further $4.8 million State funds are also available to supplement federal funding in nutrition services, the Long-Term Care Ombudsman program, Public Guardianship, the Vulnerable Elderly Programs Initiative, and hold harmless funding that insulates AAAs from fluctuations due to formula-based allocations of federal funds. Other State-administered programs serving seniors comprise 33% of the allowance. In addition to the larger general funded programs, smaller State programs include the Community for Life (CFL) program, the Durable Medical Equipment (DME) Reuse Program, and the Senior Call Check program."

Federal funding, particularly through the American Rescue Plan Act (ARPA) and Build Back Better Act (BBBA) is available to support many of the programs provided by MDoA. BBBA funding includes direct care workforce (DCW) grants and grants for DCW pay. "From April 1, 2021 to March 31, 2024, states can use enhanced federal funding to: create financial incentives to recruit and retain DCWs; support training; increase rates to increase DCW compensation; offer leave benefits; and provide specialized payments, including hazard, overtime, and shift differential pay. States have already submitted initial spending plans but can modify their plan quarterly." Maryland should ensure it is utilizing all available federal resources, and that is expending all ARPA dollars. According to the DLS Analysis of the FY 2023 Maryland Executive Budget, Department of Aging "**After projected expenditures in fiscal 2023, $6.9 million federal stimulus funds from the American Rescue Plan Act (ARPA) remain available. The ARPA funds must be expended by September 30, 2024**."

Recommended Actions

First 100 Days **• Ensure MDoA is expending all ARPA funds by the deadline of September 30, 2024 and that these funds are being used to fund top priorities that benefit the most people.**

First 100 Days **• Increase funding for programs until waitlists are eliminated for state-funded programs (Senior Care, SALS, and Congregate Housing) and ensure funding is maintained to avoid the creation of waitlists in the future.**

First Year • **Assess and realign the Department of Aging's budget priorities, and provide transparency, accountability, and responsiveness in the budget process to ensure priorities reflect the needs of the community and the organizations it serves.**

- ➔ Funding should prioritize the highest needs and shift away from narrow scope initiatives. MDoA should collaborate with the programs it serves, such as AAAs, to identify funding needs and ensure funding is sufficient enough to cover day to day activities and expenses.
- ➔ Align funding with priorities for older adults, including: ending waitlists that allow people to age in place, subsidies for assisted living, congregate housing and meals, information and assistance, guardianship, caregiver assistance, aging in place villages, etc. with a focus on local distribution.
    - ◆ The Naturally Occurring Retirement Communities (NORC) budget hasn't increased in at least 10 years, creating many gaps in services and contributing to long waitlists.
    - ◆ State funding needs to address food insecurity among older adults and allow for flexibility in how older adults access high quality and nutrient-dense food. Older adults who have lower incomes, younger aging adults (ages 60-69), and those who are renters versus homeowners experience higher rates of food insecurity and are at risk for experiencing hunger. Food insecure older adults experience lower nutrient intake; poorer health outcomes; and mental health issues.
- ➔ The New Older Americans Act funding formula should be equitably distributed while maintaining sufficient funds for all jurisdictions (may require increasing funding); funding should not simply be reallocated (taken away) from one jurisdiction to provide for another.
- ➔ MDoA should advocate for more funding from the federal government and ensure that they are working with local jurisdictions to maximize federal funds for the state.
- ➔ Development of funding formulas should be transparent and inclusive.
- ➔ Distribution of funding for existing state funded programs should be released in a timely manner to prevent the need for AAAs to front funds for maintenance programs such as SALS and Senior Care without assurance that grant funds will be forthcoming.

First Year • **MDoA should have a greater focus on potential federal funding sources**, including but not limited to: ARPA Funding, CMS Health Care Innovation Awards, and CDC BOLD Funding. Many opportunities for funding were missed by the Department, especially during COVID.

First Term • **MDoA must recognize the distinct needs of specific populations including older BIPOC adults and older LGBTQ adults.**

- ➔ MDoA should provide culturally competent programming and provide diversity, equity, and inclusion training to all staff.
- ➔ MDoA should actively engage with stakeholders who represent historically excluded communities to better understand what their needs are, and prioritize funding and programming to meet their needs.
- ➔ This recommendation builds on the 2007 O'Malley transition report, which recommended that MDoA "develop diversity planning and cultural competency strategies through partnerships with offices of minority affairs and inclusion of minority stakeholder representation in all workgroups and committees designated to develop LTC program enhancements and geriatric workforce competency." Specific actions recommended:
    - ◆ "Partner with offices of minority affairs and include minority stakeholder representation in all workgroups and committees designated to develop LTC program enhancements and geriatric workforce competency."
    - ◆ "Provide diversity training to staff at Senior Information and Assistance offices."

First Term • **Review and implement relevant 2007 O'Malley transition workgroup budget-related recommendations for the Department of Aging:**

- ➔ Recommendation #2: "Assist and empower older adults to meet their needs at home and in their communities by expanding the older adult waiver for home and community-based services (HCBS), through research on successful HCBS in other states - continuing care at home, naturally occurring retirement communities, other home-based services programs, as well as continuing care retirement communities."
- ➔ Recommendation #5: "Design and apply critical measurements that will support the need/demand for expanded funding and resources to meet the growth in critical aging services and programs such as assisted living subsidy, older adults congregate housing, information & assistance, guardianship, family caregivers assistance, etc."
  Recommendation #7: "Review, agree upon, and implement a new Older Americans Act funding formula with priority given to establishing a base level grant for non-profit AAA's, consider new weights in the formula for 1) over 85 cohorts, and 2) people with disabilities. Also, consider a similar funding formula for state general fund allocations."
- ➔ Recommendation #9: "Fully fund MDOA budget, elevate the state's aging agenda and MDOA to ensure the requisite funding, leadership, research, information and support is in place for Maryland's increasingly aging and diverse population, and eliminate extensive waiting lists for essential and cost-effective services vital for aging in place."

Sources & Supporting Resources

- ➔ RAISE Act State Policy Roadmap for Family Caregivers, NASHP
- ➔ O'Malley Transition Team, Aging Workgroup Report, 2007
- ➔ DLS Analysis of the FY 2023 Maryland Executive Budget, Department of Aging
- ➔ Health Care Innovation Awards (CMS)
- ➔ BOLD Public Health Programs Award Recipients

RECOMMENDATION #4: End the waiting list for the Medicaid Community Choice Waiver

Context: Governor O'Malley's 2007 Aging transition team's top recommendation was to "fully fund the legislatively mandated 7,500 slots in the Medicaid waiver for older adults and the requisite administrative costs, and conduct a complete review of the viability of the community choice waiver".

The Community Choice Waiver has a waiting list of over 22,000 with wait times of several years. Recognizing the significant need to address this backlog, the Maryland General Assembly passed SB28 in 2022 to direct the Maryland Department of Health to take action to remove the cap of 7,500; create a plan to increase waiver participation; and to send applications to individuals on the waitlist, ultimately, this legislation was amended so the cap can be no fewer than 7,500, but the cap persists. In addition to a waitlist of several years, once Medicaid beneficiaries are enrolled in the waiver, the Maryland Department

of Health does not approve initial plans of care, annual reviews, and change requests timely leading to further delays to accessing much needed support. This backlog also negatively impacts waitlists for state funded programs such as Senior Care and Senior Assisted Living Subsidy when clients do not move off of these services into Medicaid funded services. This prevents others who may not be eligible for Medicaid services from accessing slots in the state funded services.

The Medicaid Home and Community-Based Services Options Waiver (HCBOW) permits the state to provide an array of home and community-based services that assist Medicaid beneficiaries who have disabling conditions and/or chronic illnesses to live in the community and avoid institutionalization. Long-term services and supports (LTSS) included in the HCBOW are designed to promote independence and provide supportive services such as assistance with bathing, dressing, meal preparation, medication reminders, and housekeeping along with options for assisted living, adult medical day care and social day programs. The program not only permits individuals to avoid nursing home placement but also provides significant cost savings with community based services costing much less than what Medicaid generally pays for nursing home placement (over $100,000 per year). The demand and need for the waiver, drastically exceeds the program cap of 7,500 participants and has resulted in an extensive waiting list. The individuals on the waiting list are forced to choose between going without services or entering a long-term care facility. The only way to bypass the waiting list is to enter institutionalized care first. Individuals enter into more costly institutional settings and/or die waiting for community-based Medicaid Waiver services.

While individuals are awaiting a slot on the waiver, most rely on three (3) state-funded programs administered by 19 (nineteen) Area Agencies on Aging (AAAs). These programs, Senior Care, Senior Assisted Living Subsidy (SALS), and Congregate Housing Program provide minimal, yet essential services such as home health, transportation, respite, and housing for individuals who require assistance with their activities of daily living. These state-funded programs also have extensive waitlists across jurisdictions. The governor-elect can designate these programs as priorities within the state budget to immediately address and alleviate the waitlists. Although MDoA receives regular updated waitlist numbers from the Area Agencies on Aging (AAAs), the reports from MDoA to Department of Legislative Services are consistently inaccurate, thus not accurately reflecting the depth and challenges of the long term care home and community-based service system.

Recommended Actions

First 100 Days **• Direct Maryland Department of Health (MDH) to implement HB 80/SB 28 as passed in 2022 by the General Assembly.**

- ➔ Requires the Home and Community Based Services Waiver Program to serve at least 7,500. At the time the legislation was introduced, only 4,500 people were being served, and the waiting list exceeded 20,000.
- ➔ MDH is also required to maintain a waiting list and send applications to those on the waiting list or registry every month if there are under 600 people on the list, or if there are more than 600 people, to send applications to at least 600 people.

First Year • **Direct MDH to establish a web-based system that:**

- ➔ Allows clients/caregivers to track where their waiver application is in the process, much like Social Security has for disability applications; and
- ➔ Regularly monitors data in a dashboard format to ensure that lists are accurate across agencies.

First Year • **Improve data collection and transparency**

- ➔ Aggregate current and accurate statistics, using a distinct age, in order to fully fund the state waiver waitlist; and
- ➔ Provide transparency regarding how the waitlists are created and monitored.

First Term • **Standardize the Medicaid process between levels of care and the waiver. An individual approved for Medicaid should be able to access all Medicaid services - healthcare, waiver, housing, long term care without additional applications or steps.**

Sources & Supporting Resources

- ➔ Supporting Testimony for SB28
- ➔ O'Malley Transition Team, Aging Workgroup Report, 2007
- ➔ Maryland Community Options Waiver / Home and Community Based Options Waiver (HCBOW), American Council on Aging

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RECOMMENDATION #5: Strengthen and improve the home care workforce to support Maryland's goal of aging in place

Context: The commitment of state leaders to a common goal is critical for making meaningful progress in strengthening the direct care workforce (DCW), which includes home care workers and workers at assisted living facilities, skilled nursing facilities, and medical adult day facilities. Ideally, state leaders from the Governor's office, the General Assembly, and the Departments of Labor, Health and Human Services, Medicaid, Aging, and Behavioral Health, would be aligned around a shared DCW goal. Importantly, the perspectives of DCWs and care recipients should also play a central role in setting state goals.

Home care workers are a crucial – and growing – part of the DCW. Their work allows many tens of thousands of older Marylanders and Marylanders with disabilities to remain independent in their homes and communities. As Maryland becomes an older state and more Marylanders choose to receive supportive services at home rather than in an institution, demand for these workers is growing faster than that of nearly every other occupation statewide. A 2018 study found that Maryland will need *40 percent more care workers* over the next ten years.

But the number of home care workers is not increasing. Residential Service Agencies (RSAs, the Health Code's term for home care agencies) report sky-high turnover. Workers are leaving for jobs at places like Wal-Mart or Royal Farms because of low wages and lack of benefits. The biggest reason for this is state

Medicaid policies. Medicaid funds about 60% of the state's home care. The Maryland Department of Health currently provides RSAs just $23 per hour of home care. There is no requirement that workers be paid anything other than minimum wage. The median wage for all the state's home health and personal care aides is just $13.51 – but it is *even less* for Medicaid-funded workers. Marylanders are already having extreme difficulty finding and keeping home care workers. If action is not taken soon, the shortage – and its consequences for those who rely on home care – will only worsen.

Home care job quality can – and must – be improved in a number of ways. First, Maryland should increase home care worker wages. One way to do this is to increase the hourly reimbursement rate Maryland Medicaid pays RSAs for in-home personal care while also mandating that workers be paid at least 25% more than minimum wage. Second, Maryland should ensure that all home care employees are properly classified as employees and not misclassified as independent contractors – a practice that strips workers of their rights and benefits and imposes on them costly obligations. Third, Maryland should reinstate the independent provider program, which can both improve job quality and give thousands of Marylanders who rely on home care services greater control over those services without an intermediary home care agency.

Recommended Actions

First 100 Days • **Identify immediate actions and long term goals to expand the home care workforce,** in conjunction with recommendation #2 to develop a Master Plan for Aging:

- ➔ Review wages and reimbursement across levels of care;
- ➔ Increase Medicaid reimbursement rates while including a requirement that home care workers be paid at least 25% more than Maryland's minimum wage;
- ➔ End the misclassification of home care employees as independent contractors;
- ➔ Address safety concerns for workers;
- ➔ Provide the tools necessary for a visiting healthcare provider to complete the necessary comprehensive home care; and
- ➔ Implement a program to collect state-wide data on how long term care personnel are paid, especially when paid using Medicaid reimbursement.

First Term • **Reinstate the independent provider home care program.** This would ensure that older adults and people with disabilities in Maryland have access to a variety of care options to meet their specific needs and allows participants to design their own plan of care in consultation with the state.

- ➔ MDH, working with DBM would need to allocate resources to pay aides for overtime as well as time spent traveling between clients when necessary.
- ➔ According to a 2017 analysis by the Maryland Center on Economic Policy, "the state's share of overtime and travel costs would total $3.3 million, or about 0.1 percent of current state Medicaid spending. This modest investment would promote better care options for Marylanders who rely on Medicaid-funded services to stay in their homes and better employment options for the aides who provide those services and supports."
- ➔ Example: California In-Home Supportive Services (IHSS) Program "operates programs, funded in part through the federal government, that provide domestic in-home services to the elderly and disabled. These homecare providers help with daily activities including housework, meal

preparation, and personal care. Since 1974, these services have been provided under California's In-Home Supportive Services (IHSS) plan. The program is administered partially by California counties."

Sources & Supporting Resources

- ➔ Four Ways to Strengthen the Direct Care Workforce (Center for Health Care Strategies)
- ➔ Expanding Home Care Options in Maryland *(MDCEP)*
- ➔ California manual for in home supportive services (IHSS) regulations
- ➔ Forging a Path Forward to Strengthen Michigan's Direct Care Workforce - Center for Healthcare Strategies
- ➔ The Direct Services Workforce in LTSS in MD and DC

RECOMMENDATION #6: Provide major investment in cognitive and behavioral health care for older adults

Context: In 2007, Governor O'Malley's Aging transition workgroup identified the need for significant "Attention To Dementia, Mental Illness, Polypharmacy And Substance Use Problems" as one of their top ten recommendations. Expanding on this recommendation, the need for major investments in behavioral health services cannot be understated.

The Commission to Study Mental and Behavioral Health in Maryland was formed in 2019 by an Executive Order from Governor Hogan. It is chaired by the Lt. Governor. According to its website, its purpose is "to study mental health in Maryland including access to mental health services and the link between mental health issues and substance use disorders." Currently the Commission is organized into 4 committees—(1) crisis system, (2) finance and funding, (3) public safety and the judicial system, and (4) youth and families. **None focus on older adults.** The Commission is active and regularly releases reports. Their most recent report was published at the end of 2021.

In addition, subject to Section 46 of the Joint Chairmen's Report – Operating Budget, April 2021- the Department of Health and Department of Aging jointly submitted a report on the Development of Cognitive Health Plan for Maryland's Aging Population, which included:
"(1) the current cognitive and behavioral health needs of Maryland's aging population;
(2) the challenges the State currently faces, and is expected to face over the next five years, in providing services that meet the cognitive and behavioral health needs of Maryland's aging population;
(3) information on the adequacy of State services to meet the cognitive and behavioral health needs of Maryland's aging population;
(4) a plan to coordinate MDOA and MDH Behavioral Health Administration services, specifically identifying programs that may benefit from interdepartmental collaboration, and a timeline, with specific goals to be achieved; and

(5) a plan to develop a multi-year strategy to meet the future cognitive and behavioral health needs of Maryland's aging population, including possible limitations in meeting these needs."

The Departments convened a committee of stakeholder which met just twice in July 2021. This plan should be revisited with a greater investment of time and a broader array of stakeholders to address this critical need.

Recommended Actions

First Year • **Implement HB166/SB 27, the Dementia Services Act of 2022.**

- ➔ MDH must hire a full time (40 hour) Director-level position whose responsibility is to focus on dementia, brain health and behavioral health for Maryland's older adults. This director must work across state agencies to prevent silo programming and to address systemic gaps in services. Position was posted for hiring in fall of 2022.
- ➔ Ensure appropriate funding is available to attract, hire and retain a highly qualified and skilled individual for this position. The legislation establishes minimum pay rates indexed for inflation, however, higher pay may be necessary to find the expertise needed to properly fill this position.

First Year • **Evaluate the mission and previous reports of the Commission to Study Mental and Behavioral Health in Maryland.**

- ➔ If the Governor chooses to continue the Commission, a new Executive Order should add a fifth subcommittee that focuses on older adults.
  - ◆ Several clauses should be added to the original mandate:
    - Change the "WHEREAS" clause related to co-occurring disorders to include co-occurring cognitive and behavioral disorders as well as co-occurring mental and substance use disorders;
    - Add "WHEREAS 25% or more of older adults suffer from cognitive and/or behavioral health disorders";
    - Add "WHEREAS there are extensive racial, ethnic, and socioeconomic cognitive and behavioral health disparities";
    - Add "WHEREAS there is incomplete data for planning purposes";
    - Add "WHEREAS older adults with serious mental illness and co-occurring serious physical illnesses or dementia cannot be served adequately in the current mental health system";
    - Add "WHEREAS older adults with behavioral health concerns are at greater risk of losing their independence through placement in public guardianship."
    - Add the Secretary of Aging to the list of members; and
    - Add a representative from Maryland Association of Area Agencies on Aging to the list of members: and
    - Section B (1)(N): Add italicized language "*...members representing all age groups including children, adults, and older adults; diverse racial, ethnic, and socioeconomic groups; and a range of experiences...* "

Sources & Supporting Resources

- ➔ Improving Cognitive and Behavioral Health Services For Older Adults in Maryland: Revising The Roles of Advisory Bodies, AD HOC GROUP OF EXPERTS ON COGNITIVE AND BEHAVIORAL HEALTH OF OLDER ADULTS IN MARYLAND
- ➔ Dementia Services Act of 2022 (HB 166/SB 27)
  - ◆ SB 27 Witness Testimony
- ➔ MD Governor - Executive Order: Commission to Study Mental & Behavioral Health in Maryland

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RECOMMENDATION #7: Improve coordination across state agencies and commissions

Context: In 2021 The State Department of Health and the Maryland Department on Aging made a report to the General Assembly that proposed that the existing Maryland Commissions and Councils related to health care and aging be reviewed with the goal of increasing attention to the cognitive and behavioral health needs of older people and to promote communication and coordination among the entities. The review of 10 relevant groups revealed no focus on cognitive and behavioral health needs of older people and no evidence that there is coordination or communication among the bodies. The existing commissions and councils give an indication that there are age related initiatives in different state agencies and departments but there is no identification and alignment with common priorities or goals across those state agencies or departments.
This siloed approach results in lost opportunity for greater effectiveness and innovation in planning, developing and implementation of programs, and services for older people in Maryland and their families.

Recommended Actions

First Year • **Provide communication and accountability**.

- ➔ The Governor's office or General Assembly should hold an annual meeting of the advisory groups described above that includes:
  - ◆ Presenting summaries of each entity's annual reports and recommendations;
  - ◆ Briefings from experts on matters of interest; and
  - ◆ Allowing for roundtable discussions regarding critical current and future needs.
- ➔ Use this group to facilitate the waitlist recommendations under #3;
- ➔ Create data dashboards as described under recommendation #3; and
- ➔ Establish a problem solving entity that can assist in implementing resolutions to issues discussed during each annual meeting.
- ➔ Initiate a framework for consistent performance management and data review across agencies and departments. Make real-time data accessible with a user-friendly dashboard.

First Year • **Per the recommendations in the** Memo: Improving Maryland's Advisory Groups**, all workgroups and councils involved in behavioral health for older adults need to be evaluated to ensure the committees, councils, and commissions are meeting the behavioral health needs of older adults; appropriately organized; and efficient.** *(Overall, a large number of these groups need better coordination to ensure efforts are streamlined, cohesive, and not duplicative.)*

- ➔ Evaluate the Interagency Committee on Aging Services to determine whether it should be activated or terminated.
  - ◆ If this committee becomes active, we recommend the following additions to the original mandate:
    - Add cognitive and behavioral health services to the list of elements of the required plan in section (a)(1); and
    - Change "mental health" to "behavioral and cognitive health" in section (c)(ii).
- ➔ With regard to the Maryland Behavioral Health Advisory Council, the Governor should: Mandate a review of the purposes and activities of the Council;
  - ◆ Rewrite the state of purposes of the Council to reflect concerns about equity and the need to overcome racial, economic, and generational disparities; and
    - Adjust the statement of purposes to address the broad range of needs of people with behavioral health challenges (both mental and substance use disorders) of all ages **including older adults**.
  - ◆ The MD Commission on Aging should review purposes and activities of the Commission:
    - Rewrite the authorizing legislation to provide more detail about the responsibilities of the Commission including:
      - Adding a fourth role to "address the unmet needs of older adults such as for expansion and improvement cognitive and/or behavioral health resources"; and
      - Amending section (b)(1)(iii) to read "Eleven [members] shall be selected to reflect the geographic diversity of the State and because of their interest and expertise in the needs of older adults including but not limited to cognitive and behavioral health."
      - Including representation from the Maryland Association of Area Agencies on Aging and local AAAs in the Commission's membership.
  - ◆ If the MD Commission on Caregiving is still active or re-activated, the Commission should review and develop recommendations regarding the cognitive and behavioral health needs of family caregivers.
  - ◆ In partnership with the MD Health Care Commission, the Governor should:
    - Nominate one Commissioner with a background in aging and behavioral health (Ex: a geriatric psychiatrist, geriatric clinical psychologist, geriatric clinical social worker, or geriatric psychiatric nurse.);
    - Update the Commission's Strategic Report to include planning to meet the needs of Maryland's rapidly growing population of older adults, including those with cognitive and/or behavioral health conditions, as a key priority;
    - Reactivate the Nursing Home and the Psychiatric Work Groups, and the findings and recommendations should be included in the Commission's Strategic Report; and
    - Address the unmet cognitive and behavioral health needs of the aging population.

- The Oversight Committee on Quality Care in Nursing Homes and Assisted Living should implement the following changes to the original mandate:
    - Amend (2) in section (d) to read " Standards for the identification of the presence or onset of dementia and Alzheimer's disease and/or behavioral health conditions";
    - Amend (2) in section (f) to read "Elements of the existing methodology that can be revised including operation and capital components";
    - Amend section (H) by changing "may" to "must" so that the Committee is required to review legislation that may affect nursing home or assisted living care and to make recommendations to the General Assembly; and
    - Amend section (I) by changing "may" to "must" so that the Committee is required to review proposed regulations that may affect nursing home or assisted living care and to make recommendations to the required departments.

First Year • Amendments should be made to the Behavioral Health Advisory Council by-laws **include the following:**

- ➔ Article I (4): Change from "collaboration for improved behavioral health services" to "collaboration to better meet the needs of people with mental and/or substance use conditions and their families";
- ➔ Article III (1): Add a representative of the Department of the Aging to the list of state agencies that are mandated members of the Council;
- ➔ Article III (3): Change to include family members of "older adults" as well as of "adults" and "children";
- ➔ Article III (4): Add "older adults" to the mandate that "adults who are currently or formerly involved in behavioral health services" be included on the Council;
- ➔ Article III (4) par. 2: Add "and of family caregivers of older adults with cognitive and/or behavioral disorders" to the requirement that "The ratio of family members or guardians of children with a serious emotional disorder should be sufficient...to provide adequate representation of children ... and [older adults with co-occurring mental and/or substance use disorders and cognitive impairment].";
- ➔ Article III(A 2) membership: Add AARP, the Maryland Psychiatric Society, NASW of Maryland, and Johns Hopkins Department of Geriatric Psychiatry to the list of organizations mandated to be members who are "representing behavioral health provider and consumer advocacy groups";
- ➔ Article III(A3): Add "family members of individuals with co-occurring dementia and behavioral health conditions" to the list of mandated categories of membership; and
- ➔ Article VI, Ad Hoc Committees:
    - Add a committee on older adults; and
    - Change the name of the "Cultural and Linguistic Competence Committee" to the "Equity Committee".

Sources & Supporting Resources

- ➔ MD Interagency Committee on Aging Services - Website
- ➔ MD Behavioral Health Advisory Council - Website
    - MD Behavioral Health Advisory Council By-Laws

- ➔ MD Commission on Aging - Website
- ➔ MD Commission on Caregiving - Website
- ➔ Oversight Committee on Quality of Care in Nursing Homes and Assisted Living Facilities Maryland Department of Aging - Website
- ➔ Improving Cognitive and Behavioral Health Services For Older Adults in Maryland: Revising The Roles of Advisory Bodies, AD HOC GROUP OF EXPERTS ON COGNITIVE AND BEHAVIORAL HEALTH OF OLDER ADULTS IN MARYLAND
- ➔ MD Code - Intragency of Aging Services - Duties

RECOMMENDATION #8: Provide better services for older adults with complex and co-occurring needs

Context: The demand for services for older adults with complex and co-occurring needs continues to grow. The O'Malley transition team identified this as a top priority, and recommended that the state "direct more attention to and support of dementia, mental illness, polypharmacy, and substance use disorder with older adults." The report specifically recommended:

- ➔ Conduct public education campaigns to destigmatize and increase awareness of late life mental health and substance use problems;
- ➔ Increase outreach to health and human service professionals with education on polypharmacy, dementia, mental illness, substance abuse and end of life care issues; and
- ➔ Support enhanced offerings of education, assessment and treatment on late life brain disorders and medication management in places where seniors congregate.

Maryland's unique all-payer rate system provides a valuable opportunity for the Health Services Cost Review Commission (HSCRC) to help address the complex needs of particular populations. The HSCRC is an independent regulatory agency that works outside of the state government. It was established in 2014 through an agreement between the State of Maryland and the Centers for Medicare & Medicaid Services (CMS). According to its website, its goal is "to modernize Maryland's unique all-payer rate-setting system for hospital services. As the State's hospital rate-setting authority, the HSCRC plays a vital role in the implementation of this innovative approach to health reform."

The HSCRC is mandated to:

- "Ensure that all Marylanders have access to quality health care by the nation's best health care providers in every corner of the state – whether rural or urban;
- Address the needs of our senior population, which is expected to increase by 40% over the next ten years; and
- Fight the opioid epidemic and [promote] other population health improvements such as diabetes prevention and other chronic conditions."

Recommended Actions

First Term • Utilize the HSCRC to provide more services for older adults with complex and co-occurring needs. The HSCRC should:

- ➔ Address the reality that co-occurring chronic mental, substance use, and physical disorders are the greatest driver of high healthcare costs;
- ➔ Focus on the complexity of serving people with dementia in hospitals;
- ➔ Cultivate better working relationships between hospitals and long-term care facilities; and
- ➔ Include at least one member on the Commission with expertise in cognitive and behavioral health.

First Term • Invest more resources in Adult Protective Services (APS) in order to address and prevent elder abuse and neglect, including self-neglect, by:

- ➔ Allocating funding under the Department of Human Services (DHS) to hire more APS staff for the state-wide abuse and neglect hotline with expertise in serving older adults. The hotline is primarily staffed by child welfare personnel;
- ➔ Ordering the DHS to increase funding to local DSS offices in order to provide 24/7 APS intervention in each County. This includes support for mobile crisis intervention teams to receive training to meet the needs of older adults (dementia behaviors, substance misuse, suicide, etc.);
- ➔ Establishing a better system of community-based mental capacity evaluations to avoid sending older adults who appear to lack mental capacity to a hospital emergency department;
- ➔ Requiring that DHS/Adult Protective Services disclose interventions and treatment plans for community-dwelling adults who are served by other community providers (e.g. AAAs);
- ➔ Exploring additional types of guardianship of the person appointees to address the increase in those who require or will require guardianship in the near future; and
- ➔ Expanding the Mobile Integrated Community Health Team pilot program to apply statewide under the Department of Health. These programs can have cost-savings benefits by helping people avoid hospital readmissions and reduce frequent 911 calls.
- ➔ MDoA's State Plan on Aging has a section on p.15 regarding the prevention of elder abuse and focusing on the Ombudsman program. Bottom line - **there needs to be more funding for elder justice issues**.

First Term • **Improve access to housing assistance for older Marylanders by:**

- ➔ Provide/broaden housing, shelter and alternative care arrangements for older adults who are not able to care for themselves independently, but do not meet nursing facility levels of care; and
- ➔ Intertwining funding between Housing and Aging to provide alternatives to institutionalization.
- ➔ Connecting older adults and caregivers to services that help them age independently, within their communities, and with maximum quality of life. Specifically, programs may include home modification and repair, which can also be used as a platform for delivery of a variety of services. (e.g. Housing Upgrades to Benefit Seniors (HUBS) in Baltimore City, Baltimore County Age-friendly Upgrades for Seniors (BCAUSE).
- ➔ Work to help older adults to access funds to avoid tax sale and mortgage foreclosure. (Homeowners Tax Credit, foreclosure prevention and mediation)
- ➔ Increase the supply of permanent supportive housing serving older adults.
- ➔ Improve utilization of Medicaid and HUD funds to create funding streams that allow Medicaid beneficiaries to access assisted living facilities similar to the District of Columbia Medicaid model.

Sources & Supporting Resources

- ➔ Maryland Health Services Cost Review Commission - Website
- ➔ HSCRC - Maryland's Total Cost of Care Model
- ➔ Mobile Integrated Community Health Team pilot
- ➔ O'Malley Transition Team, Aging Workgroup Report, 2007

OTHER KEY TAKEAWAYS

Staffing

- ➔ MDoA is understaffed after making regular staff reductions for the last 8 years;
- ➔ The Ombudsman program needs more volunteers and a marketing budget. There is not enough staff to carry out all the Ombudsman's functions; and
- ➔ The current Board of Nursing licensing technology is antiquated and has created **significant** delays in workforce growth.

State and Federal Funding

- ➔ Prioritize replenishing the MDoA budget to allow for increased staffing; program management; and innovation across the department for 2023 and the future of Maryland.
- ➔ Allocate resources to study and update the current budget models of MDH, MDoA, and MDoD for more effective programing and accountability.
- ➔ The current benchmarks under the Total Cost of Care for Medicare funding. There should be far more community based services coming from the savings to the acute care system.
    - ◆ Adapt current community based services to meet the acute care system benchmarks under the Total Cost of Care for Medicare funding plan.
    - ◆ Establish more comprehensive benchmarks under the Total Cost of Care for Medicare funding plan in order to increase community based services. Use the current savings from our acute care system to fund these services.
- ➔ Audit the use of all federal dollars to ensure these funds are allocated to the correct programs, including Older Americans Act funding and Centers for Medicare & Medicaid Services Innovation funds.

Data and Metrics

- ➔ Currently, AAAs are forced to individually purchase or maintain a paper manual or online assistance data-base. MDoA needs to establish uniform messaging and an online assistance database that is easily accessible to the public and can be utilized by AAAs. Data that is not currently collected and/or made publicly available and should be available on the web page includes:

- List of owners and operators of all of the nursing homes in Maryland;
- Number of people on waiting lists for care and how long individuals remain on the waiting list;
- How much long term care staff and personnel are paid, especially when using Medicaid reimbursement;
- Specific performance goals based on number of individuals served that is reviewed and used to inform strategies;
- Specific Medicaid encounter data based on recipient location in order to track the percentage of participants in long-term care vs. at home care; and
- Comparisons of cost of care by setting (i.e. long-term care facility, at home care, etc).

➔ Additional improvements can be made after the site is fully functioning, by:
- Measuring patient outcomes, particularly across time and for different demographics;
- Providing real-time data;
- Incorporating each AAA's year-end reports to MDoA (which in turn, is compiled and submitted by MDoA to ACL) on how OAA funding is utilized, numbers served, etc. MDoA should utilize the data to report annual services provided and people served; and identify where gaps exist in an effort to better inform state priorities and budget allocations;
- Requiring annual public reporting on data measured by the Maryland Health Care Commission in order to better inform the legislature for policy decisions (current data is from 2019);
- Requiring that the MD Department of Planning show their trend projections for the next ten years. (The new mdbre.gov website, which was legislatively mandated, is underutilized and lacks robust data collection. If properly updated, MDoA could be incorporating the state's data collections on aging.);
- Establishing a registry that identifies individuals who have been found to abuse or neglect older adults and individuals with disabilities(similar to the sex offender registry) to prevent future employment with service providers (nursing homes, assisted livings, community-based home health agencies, etc.);
- Reviewing and incorporating MD Think into the assistance database.