MEETING INFORMATION

Title: Community First Choice Implementation Council Meeting
Host: Maryland Department of Health and Mental Hygiene
Day/Time: Wednesday, October 23, 2013 2pm-4pm
Location: Department of Health and Mental Hygiene, Rm L3

INTRODUCTIONS

- Welcome
- Attendance
- Guest speaker Deputy Secretary Chuck Milligan

DISCUSSION

1. Rate Discussion
    a. Document 1: New Budget Proposal
        i. General RUGS information –
            1. Takes assessment data where people have different needs and abilities and coming up with assessment scores that put individuals on the same scale to find people with overall comparable needs.
            2. Is a relative comparison across groups. A mechanism to give budgets, resources, and services. Compares based on a validated assessment process
            3. This is not a medical model – not the one used in NFs.
            4. A method of comparing disparate needs on one assessment. We will be using this methodology.
        ii. Changes
            1. We will still be using RUGS, but changed to 7 groups
                a. MAPC – using the uniform, valid instrument, most MAPC participants are in group 1 or 2.
                b. OAW & LAH waiver participants have significant participation in groups 1 & 2, but also many in group 4 (over 1000).
            2. We put significantly more funding in the budget – $181M in personal budgets rather than $153.9M.
                a. This is new BIP money that was invested in the CFC budget based on consumer recommendation
                b. We can't raise the budget in one group alone – the groups are interrelated. So, the more money in the program, the budget for each group is increased.
            3. We did not change the range to minimum and maximum rates for individual providers but we did for agencies. Main reason: Colorado – higher hourly rate payments resulted in exploitation amongst family and friend providers. Led to fewer hours of service to the consumer.
            4. We are making a change to allow consumers to pay for training new personal assistance providers.

b. Document 2: financial modeling
    i. 76% for personal budgets.
    ii. Enhanced match results in $24M. This will provide additional services to MAPC roughly $6M, and $17.7M for new participants.
    iii. Individual participant budgets $181M. $27M set aside for exceptions process to give people bigger budgets (including getting people to the level of service they receive today).
    iv. There are several other services that are financed through CFC but to not come out of the budget. These total almost $44M.
    v. Total budget - $252M – includes old budget + new money we gave to the CFC budget.
    vi. If there was more money in the program, each of the personal budgets could grow (relatively). If people think there are not enough hours for people, this is a feature of budget limitations, not because of the RUGs score. The problem is not the RUGs, the problem (if that is the point of view) is the overall funding for the budget. Request: focus less on RUGs and more on budget. We are proposing to bring in a significant amount of new money, but we cannot change the appropriation for this year. This would require advocacy to the legislature.
c. Questions:
    i. Is there a part of the budget that reflects negotiations with AFSCME? Or those negotiations ongoing?
        1. The budget for FY14 is set. There is a process that requires negotiation re: independent provider rates. There are ongoing conversations. AFSCME negotiations will not take us beyond the budget that we are working with.
    ii. Group 7: If there were 15 people in group 7, would that be the exceptions budget?
        1. The exceptions process is tailored to the needs of an individual – not to move them into different RUGs. We have not modeled where the exceptions budget will go, or to which people, but we have modeled it to be sufficient for the people moving into the program.
    iii. Does the enhanced match sunset?
        1. It is not time limited. BIP is time limited, but CFC is not.
        2. BIP funding is time limited. It is a grant that ends Sept 30, 2015 (unless extended). One challenge is to determine how much BIP money should be built into our base, since it will go away. Here, we have decided to build BIP funds into our base.
    iv. What if more people fall into a group than are projected? Will the money to cover them come from the exceptions budget?
        1. Yes
    v. What if the BIP money goes away? Is the state promising state general funds to make up the difference?
        1. We are proposing that this will be the starting point and we will still have BIP funding in 2015. This is not a short term funding plan.

vi. Can we get an idea about the distinctions between the RUG groups and the kinds of individuals who will land in each group?
    1. We could send to stake holders some examples (hypothetical case studies) with more details.

vii. There could be variation within RUG groups
    1. There will be people in groups who have higher needs than their groups will provide, and we have an exception process. The issue is the overall budget. People in MAPC have not gotten very many services to date. Also, we don't pay well in MAPC so providers provide fewer hours each day due to the fixed rate. We have an exceptions budget, likely for people mostly in group 1 and group 2, to increase the services their budget allows.

viii. Valarie is happy that she will have more useful personal care, but she is very concerned that other people will not get the services that they need. Worried that people transitioning will not get what they need to have their full lives. The exceptions process should be renamed because it isn't exceptional. What about exceptions for things that you need in real life – help going to a meeting, help eating, etc. Is the exception process based on the assumption that people won't ask for more?
    1. Leading a fulfilled life: One part is that the state has been able to manage a budget for HCBS by managing participation in waivers. States are able to contain budget exposure by limiting waiver slots, etc. When we move these services to the state plan entitlement model, the state's ability to control the budget is much more limited because they cannot control participation. We want to do this, despite the inability to control budget exposure, and we are trying to by bringing in BIP money. We are increasing participation – most of this budget is for people who are getting 0 services today.
    2. We are assuming that some people will get a budget and will not need to ask for more because what is offered meets their needs. We are not assuming that each person who has one less hour will ask for an exception. If it was the case, it would not be an exception and it would not be a uniform assessment. We are trying to standardize which is where the feds want us to go.

ix. In defense of MAPC – many people have been sustained in the community with support services on MAPC. We should take the program, and add to it which is what we are doing with CFC.
    1. Not a criticism, but a comment that it is under financed.

x. To what extent does the budget reflect that people getting waiver services will get a reduction?
    1. Several people in waiver services whose InterRAI puts them in 1 or 2, will have fewer hours. Those who are put in group 4 or 5 will get comparable levels of services. The exceptions process will likely be used for those people.

xi. Question about RUGs for nursing homes.
    1. Our InterRAI takes into account IADLs which are not included in the NF RUG groupings. The core has overlap, but the CFC RUGS has additional components that are absent from the NF assessment.

xii. If collective bargaining will not accept the rates presented at the low & high end, will that skew the hours available? This seems to be possible since we are still in negotiation.
    1. We are confident that we will land either at or very close to what is presented. If there is a change that will alter what we have presented we can talk about it again. We cannot commit that this is final, but can commit that this is close and we will know soon. If it changes, we can have another meeting or conference call.

2. Exceptions Process
    a. This form is a draft.
    b. After a person sees their score and their budget to tell us what other factors should be considered for this person:
        i. Services provided under their current service budget
        ii. Demonstrated needs – needs that wouldn't be met with the budget
        iii. Health, safety, independence
        iv. Change in circumstances
    c. We are interested in your comments about it, please send them in.
    d. Likely this is a document that will be changed over time
    e. Questions:
        i. Who is expected to fill this out? Language seems high level, should be more user friendly.
            1. Intended to be filled out in conjunction with the supports planner as part of the plan of service.
        ii. New requested budget – what does this mean?
            1. Personal budget, not overall budget. Whatever is over what is already granted. We will clarify these fields, but this is not supposed to represent the entire plan of service – only those services that are beyond.
        iii. Would the Dept be willing to commit to a process that brings (redacted) exceptions to the council as this process develops? It seems that the council would want to know that the process would be working. Increase accountability.
            1. We can commit to a reporting process, but cannot now commit to what it will look like at this time. Nervous about a redacted version – PHI makes it much trickier. We need the exceptions process managed by people who understand how to make these decisions.
        iv. Is there an appeal process for the exceptions?
            1. Yes, the appeals process will be the same as it is currently for plans of care/plans of service. It will be the next step after the exception form.
        v. How often can an individual ask to go through the exceptions process?

1. Could be requested based on change in circumstance at any time. Otherwise it would be in the normal course of annual reviews of plans of service.

vi. Will the appeals process be written on this form?
vii. Will there be a timeframe for approval or denial?
1. Both of these comments are good and useful as we develop this form.

3. Training Plan
   a. LHDs – talk about CFC and make sure they are clear on their roles
   b. MAP/CIL/AAA – will be trained through the first 2 weeks of November (regional)
   c. Providers – drafting materials to send to them. Will be sent next month
   d. Supports Planning Agencies – once they are identified, we will target train them through December
   e. Participants – we will send info to them as well, but also use their current support people.
      i. Please send us suggestions about what you would like this information to contain. Will contain information about changes in services, etc. Information on consumer training.
      ii. Will there be a CFC eligibility fact sheet? Yes – we can put something together.
      iii. If you would like us to come to trainings, please contact the CFC mailbox. Please give us as much time as possible.
4. Next Steps
   a. Our next council meeting will be in early December. That will be our last meeting with this version of the council.
   b. Between now and then, we will send nomination forms for the new council that will also have waiver advisory committee members.
   c. Follow up on AFSCME - If you don't hear from us, assume everything that we have presented today is final. If you do hear, we will organize a call between now and the next meeting.
5. Public Comment
   a. Adah's InterRAI – she would like to know what her RUG group is. She wants to use CFC to expand services.
      i. We don't know what group she is in. We got it, but there hasn't been analysis. It was hand written and has to be programmed into the system. Our target to get it to her is next week.
   b. When will the council have a chance to explore the exceptions process in more detail?
      i. Please send comments by Nov 1. Then we can make changes and send out drafts prior to the next meeting.
   c. For people who are leaving a rehab hospital, how will they apply for CFC?
      i. First point of contact is department, then they will be referred to AYERS for an assessment.
   d. Is the exception temporary or permanent
      i. Depends on the situation. In a change of circumstances, a person may get a new InterRAI and possibly not need an exception.
   e. Regulation chart – would like an opportunity to see that changes that were made or not made. Rebecca will send out the version that was submitted.