Maryland Department of Health
Community Options Advisory Council
5/4/18 Meeting Notes

1. Program Updates
    a. Staff Updates
        i. 9 vacancies
            1. Completed interviews for the new division chief and hope to have someone begin by June 1st.
            2. Two new clinical team members starting soon; a social worker and nurse
        ii. Internal promotions
            1. Mansi Shukla is the Participant Support unit supervisor
            2. Andrew Guy is the POS unit supervisor

    b. Program Enrollment Numbers
        i. Finally reversed the CO enrollment trend to the positive. Last summer slowly started increasing invites from registry. Still sending out 300 applications per month from the waiver registry (started in October at that level). Sending 300 invitations a month is sustainable for staff. In addition to sending the invites they conduct follow up, make phone calls, send second notices, and monitor enrollment progress.
        ii. Council members asked what the current response rate is for registry applicants, which is on the lower end. MDH is still inviting those added to the registry in 2011
        iii. Council members asked how many people total are on the registry and how MDH chooses the 300 people to be invited.
            1. There are about 22,000 individuals on the registry currently, and they are invited to apply based on date order.
        iv. Council members would like additional registry numbers to discuss at the next meeting.
        v. CPAS enrollment increased 44% between 2017 and 2018. MDH has not been able to find any trends explaining this, but is looking into level of care denials and the number of assessments.
        vi. CFC enrollment increased 10% in the past year.
        vii. CO enrollment – Number ALF residents decreased. More CO participants are living in independent housing—no reason identified.
            1. Council members asked if participants are having a hard time finding independent housing?
                a. MDH responded that housing is hard to find and in short supply. MFP efforts help, but there is still a lot of unmet need.
            2. Council members discussed characteristics of assisted living facilities vs. nursing facilities—services provided, number of beds, skilled tasks, etc. The different regulations for AFLs vs NF’s was mentioned. They expressed concern that finding an ALF isn’t hard, but finding a good one is (gave example of ALFs located in Baltimore County vs Baltimore City), and that ALFs are dropping from waiver due to Community Settings rule.
                a. MDH added that adding ALF as a CFC services will expand access, and rules and regulations will be needed, however the community settings visits need to be completed prior to moving forward.
                b. Lisa Toland (MDH) talked about her experience with ALFs and the community settings visits she has participated in. She noted that the expectation for wavier facilities has always been higher than non-waiver

sites, but in the last 5 or 6 years ALFs have had a higher standard than in past years.

c. Council members asked if there is a rating system for ALFs and how to know if one is wheelchair accessible.
    i. MDH responded that the Health Care Commission has a rating system. It was explained that individuals should call or visit potential AFLs to determine if the facility is accessible for them (ALFs are only required to be accessible for those living there).

c. Plan of Service Data Highlights
    i. Number of days that plans were with the SP vs the POS unit
        1. Mean and median days plans are with MDH was below 15 for most of 2017.
            a. Average 9.5 days with MDH; 6.4 days with SPA.
    ii. Plans that had a decision in less than 30 days by plan type
        1. Meaning of Plan Types
            a. Provisional: Developed prior to enrollment when not all providers are known, typically used for people who are transitioning from a NF but may not yet know where they will live or which provider they would like to use.
            b. Initial: Completed prior to enrollment, when all information about services and provider choices are known.
            c. Annual: Developed each year after a new medical assessment is completed.
            d. Revised: Completed when a change in services or providers is needed for an enrolled participant outside of their annual plan.
        2. 83% or above of plans approved within 30 days. The review process is the same regardless of plan type.
        3. Reviewed the number of plans approved in less than 30 days
            a. Council member inquired about auto-approval plans, and MDH clarified that not all plans auto-approve. In order to auto-approve certain fields cannot be changed. Rate changes affect overall cost of the plan and will prevent auto-approval
        4. Council members asked why some plans take so long to review and approve. MDH responded that circumstances change, people ask for more services than what seems appropriate (based on interRAI assessment and any other available documentation), life things happen that delay the applicant from submitting a plan, etc.
    iii. Plans that had a decision in less than 30 days, within budget vs over budget.
        1. 91% of plans under budget with decision in less than 30 days.
        2. 83% of plans over budget with decision in less than 30 days.
    iv. Denied plans
        1. 51% of the denied plans within budget had a decision rendered in less than 30 days.
        2. 57% of the denied plans over budget had a decision rendered in less than 30 days.
        3. Council suggested looking closer at the budgets due to the number of over budget plans that get approved. It was asked if the same groups can be kept, but just increase the budget amount of those groups.
            a. MDH responded that the Hilltop Institute has been reviewing budget data (and gathering information on other options on how to factor budgets)

and will be presenting his findings during a future meeting. MDH added that increased budget amounts could be implemented, but also want to make sure the groups are the best they can be and make the most sense.

4. Denials do take longer than approvals because MDH tries to gather more information to support an approval. More approved plans are in the higher days categories because we often are able to get needed information but it takes time.

v. Clarification Requests
   1. Average less than 2 clarification requests sent because we try to put everything in one request. There was not much difference between clarification requests sent for plans within budget (average 1.3 times) vs. over budget (average 1.4 times)
   2. Reasons for clarification requests could be that the supports planner didn't provide needed information or MDH asking questions to clarify the situation. The council asked if MDH tracks how many clarifications are for supports planner mistakes vs. clarity. MDH responded that it is difficult to do this, as the clarification request is free text in the LTSSMaryland tracking system
      a. A Council member asked about quality and integrity of the POS unit at MDH
      b. MDH continuously works on quality improvement related to Plans of Service. MDH has a formalized training process for POS reviewers and it includes partnering with experienced staff to review plans prior to being assigned their own plans to review. Reviewers also have clinical team consultations and weekly team meetings to ask questions and review decisions. The POS unit supervisor samples and reviews the decisions of staff to ensure they comply with regulations and policy.
      c. MDH also works with the provider network to improve the process and reduce decision timeframes. MDH routinely updates New Supports Planner Training which is required for all new supports planners, discusses areas of concern on monthly calls, and sends written guidance to SPAs as needed.
   3. Council member asked in revised plans get put back to the bottom of the list when returned to the POS unit. MDH clarified that plans are auto-assigned to reviewers based on the client's last name, not plan type, and mentioned that supports planners can request urgent review of a plan.

vi. Plans still pending as of 12/31/17—564 (plans pending a decision from MDH).

vii. The council decided that they would like MDH to send Plan of Service data out every 6 months, and discuss as needed at the next meeting. They would also like a further breakdown of days to approval, for example, how many were approved within 5 days, 6-11 days, etc.

d. Regulation Updates
   i. No new policies, but updates to the regulations are needed for rate increase, and to make chapters consistent with each other
      1. Updating CPAS to match the CFC regulations
      2. All regulations must be updated for rate increases. Could get a 1% or 3% rate increase. Current regulations limit the increase to 2.5% or CPI of last July, whichever is less, but 3% is greater than both.
   ii. ICS regulations have not been changed since program was implemented, and need lots of updates so that regulation package will be more comprehensive. MDH is moving to update it to match the HCBOW regulation. Large sections are being repealed and

language is being edited to match CO. Once drafted, MDH will share changes with the council. There are no substantive changes being made.

1. Council asked for clarity on ICS, and when someone is eligible to apply. MDH explained an individual could only be eligible to apply for ICS if that person is enrolled in Community Options wavier, and their income increases past the limit. If this happens EDD would send ICS information along with Community Options disenrollment letter.

e. Self-direction Amendments
   i. No date on when RFP will post, but could be soon, and then MDH communication and outreach will be top priorities.
   ii. The FMS (Fiscal Management Service) vendor could be up and running as early as December of 2018.
   i. Implementing self-direction will require a State Plan amendment and regulation updates.
   ii. MDH needs to revise the 1915k and apply for a new 1915j.
   iii. MDH and the Council will need to review all information and decisions from 201, to ensure the decisions are still supported.
   iv. Council member asked what percentage of current participants are expected to self-direct? MDH stated the estimate is 5-10%, but the CO programs are different because of the prior independent provider model. The responsibilities of self-direction are much more and could be intimidating to anyone who previously had an independent provider. People may not want that responsibility. Some Council members disagreed and suggested enrollment as high as 25%.
   v. Council asked if the self-direction vendor is working with both CFC and DDA? MDH confirmed that this is correct, the vendor will support both programs.

2. Consumer Training Service
   a. The goal of the review of the consumer training service is to make the service more meaningful and useful.
   b. The consumer training workgroup met in October and came to a consensus on several items.
   c. The full Council reviewed consumer training workgroup meeting notes and recommendations.
      i. Coverage
         1. Community Integration Activities needs further definition. How is this training rather than social or emotional support?
            a. Council suggested helping people learn public transit, getting to local church, etc.
         2. Anything missing from the list?
            a. Making sure it's person-centered, look at goal setting process
            b. How to perform ADL tasks?
               i. Difference between Personal Assistance and Consumer Training service
      ii. Limitations
         1. Council discussed how to measure capacity to learn a skill
            a. Who determines capability? Is a different assessment needed? Does the POS reviewer determine this?
            b. Discussion about capability to do the skill vs the capability to learn
               i. Just because someone wants to learn something, are they capable to progress and learn the skill?
               ii. Discussion of different disabilities and making reasonable goals

c. Discussion about mindset— council discussed how making people more independent could mean budget changes, resulting in fewer personal assistance hours. This may mean people will not utilize this service.
    i. Focus should be on the group of people who want to be more independent, and how to make the service successful. If people have success over time the mindset will change. The magnitude of change may not be enough to change budget.
d. Discussion on how to define and measure progress
    i. Council suggested to approve 90 days of service, then review progress and continue if appropriate

iii. Provider Qualifications
1. MDH asked for feedback on organizations other than CILs who could perform the service, and to define characteristics of those organizations. Will they be ethical? Will there be a need for different trainers for different skills? Couldn't find information from other states.
2. Should MDH submit 1915(b)(4) to limit provider selection (solicit for providers like SPAs)? Doing so will take longer, but may have better product. Could designate CILs and solicit for additional agencies.
3. Should there be an independent assessment or should it be something a supports planner can assist with? If a specialized person what qualification does that person need to do the assessment (specific certification(s) /training, certain education requirements, be certified or has access to an orientation and mobility specialist—disability specific).
    a. Independent trainer (same model as EA) agencies that have access to people with specialized training
4. Provider demonstrates progress, documents what happened, meaningful progress, etc.?

iv. Other
1. Assessment tool ideas, existing form(s) that could be useful:
    a. PT/OT forms
    b. Forms that the CIL uses
    c. Forms from nursing facilities
2. Person-centered thinking training forms
3. Would the same person doing assessment also complete the training portion?
    a. Council seemed to agree that they should be separate. Could be an unrelated third party or just someone else from the agency providing the training that meets criteria. Will need to set qualifications for the assessor (for example: person-centered thinking trainer and has so many years' experience). Try to ensure quality assurance within the agency.

i. Next Steps
1. Still need to determine wording for some of the coverage.
2. When decisions are made regulation changes will be needed and can be combined with other planned regulation packages.
3. Depending on the scope of changes, the CFC authority may need to be updated—it's pretty broad right now. MDH will review current language.
4. Communication plan on how do we get the word out to participants regarding this service is needed.

a. Mailings, adding information to the referral packets, provider training, adding information to New Supports Planner Training, training nurse monitors, etc.

3. Future meeting dates
   a. June 7th – Presentation for the Hilltop Institute on Registry Screening
   b. July 10th – Proposed new meeting from 1-3 pm
   c. July 31st – Self-direction
   d. September 13th - Proposed new meeting from 1-3 pm
   e. October 30th - Proposed new meeting from 1-3 pm

- There is a lot to talk about and it seems as if more meetings would be beneficial and allow the Department to get feedback from the Council before any changes are made to the programs
- The proposed dates try to avoid August as a vacation month and work around room/staff availability

4. Future Meeting Topics
   a. Self-direction
      i. It's been a long time since we discussed the details of the self-direction model. The proposed July meetings can be used to go over the basics of the model and decisions that were made in 2015. The 2015 discussions focused on the big picture and overall model for Maryland. We didn't get to all of the details because of the need for a vendor.
      ii. We should validate the decisions that were made then and identify any gaps/new decisions that need to be made.
      iii. Today's meeting will outline the plan for how we can move forward and get Council input on the process. Future meetings will be set aside specifically for policy discussions.
      iv. We'll do our best if we have time to review documents, request data or research, talk to others and get input, etc. before launching into decisions.
      i. Prior to our next meeting, we will send out materials to review so everyone can prepare and identify other voices, information, or data needed to inform discussions, etc.
      ii. MDH is researching topics and pulling together information for the next council meeting. Here are the topics we think need to be discussed. There are likely more topics to discuss, so please bring up any topics that aren't mentioned
         1. Policy Decisions
            a. Budget groupings
               i. Hilltop is working to analyze the budget groupings and look for any improvements to what we're currently doing. We asked them to start this work last year in preparation for self-direction
               ii. Data needed: Hilltop analysis
            b. Amount of flexibility within the budget
               i. DDA is using a 10% threshold. Other states have variance, or very broad variance. Need to decide on our model.
            c. Reasons that a person would be limited from self-direction (abuse, neglect, exploitation)
               i. Some states use risk agreements and screening tools to determine capacity to self-direct. We previously discussed and rejected both ideas. Should we go back over and confirm that decision?
            d. Self-direction consent/agreement

        i. Most states have a consent form or agreement for self-direction that outlines roles, responsibilities, and rights. We may want to consider one, particularly if we identify any reasons that we would take a person out of self-direction.

    e. Role of supports planners and nurse monitors
        i. Previously discussed that it would be the same in self-direction, in that people can waive the service down to minimum standards.
        ii. Do we need to revisit this topic?
    f. Delegated nursing
        i. Currently gathering information from DDA, and Maryland Board of Nursing (MBON). Some parameters are clear in the regulations, but some rules are up to the program.
        ii. Do we want any limitations on self-delegating nursing tasks? For example, do we use the existing definition of a representative and allow any representative to delegate for a participant? Do we limit to representatives with legal status?
    a. Develop and review materials for outreach, education of supports planners
        i. We will need to draft and get Council input on outreach and educational materials in the fall. We need materials for all groups, participants, direct service providers, supports planners, etc.

b. Quality Plan and Process
    i. The topic of quality has come up in several meetings and we want to start by discussing what MDH currently does related to quality oversight. That will inform discussion about how we can do better and what we're missing.
    ii. Reportable Events
        - All of our programs follow the Reportable Events policy. Our unit reviews critical incidents and responds to activate the network of resources to support individuals when things aren't going well. We're just starting to analyze trends and try to figure out what the data can tell us about our programs and what we can do better.
        - We will share charts on REs submitted and REs by agency prior to the next meeting.
    iii. Quality Measures
        - The CO programs follow the waiver quality measures approved by CMS for HCBOW. These include mostly process measures. We'll share our quarterly report with the Council and see how we can improve those measures.
        - After community settings visits to ALFs is complete, use the team to begin auditing and conducting site visits to residential service agencies.