Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

June 7, 2024

The Honorable Guy Guzzone, Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Ben Barnes, Chair
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

RE: 2023 Joint Chairmen's Report (p. 129-130) - Report on Home- and Community-Based Options (Community Options) Waiver Care Plan Backlog - July 2023 Report

Dear Chair Guzzone and Chair Barnes:

Pursuant to the requirements of the 2023 Joint Chairmen's Report (p. 129-130), the Maryland Department of Health (Department) submits this report on the Community Options waiver care plan backlog. Specifically, the report addresses the impacts of this backlog on waiver applicants, participants and home- and community-based services (HCBS) providers, such as delays in accessing HCBS and increased risk of hospitalization.

The committees requested the Department submit monthly reports beginning July 1, 2023, on the progress in addressing the outstanding plan of service backlog. This report covers the first month requested.

This report discusses current efforts underway as of June 2023 and recommendations to address the backlog, including the feasibility of allowing medical adult day care centers (MDCs) and other HCBS nurses to temporarily review and make determinations on plans. In addition, the report details the following information by county:

- the average number of days to approve a plan;
- the total number of pending plans at the beginning of each month;
- the number of new plans received in the prior month; and
- the number of plans approved by the end of the prior month.

If you have any comments or questions about this subject, please contact Sarah Case-Herron, Director of Governmental Affairs, at sarah.case-herron@maryland.gov.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary

Cc: Marie Grant, JD, Assistant Secretary for Health Policy
Ryan Moran, DrPH, Deputy Secretary, Health Care Financing and Medicaid
Sarah Case-Herron, JD, Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies)

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Background

The Department's Medicaid Office of Long Term Services and Supports (OLTSS) operates and/or oversees several home- and community-based services (HCBS) programs. Of importance for this Joint Chairmen's Report (JCR) is the Home and Community-Based Options Waiver (HCBOW or "Community Options Waiver"), Community First Choice (CFC), Community Personal Assistance Services (CPAS), and Increased Community Services (ICS). The four (4) aforementioned programs are impacted by the Plan of Service (POS) backlog reported during the 2023 legislative session.

Program Information

The HCBOW, CFC, CPAS, and ICS programs offer a unique array of services and supports that enable individuals to live in their homes or in other community settings instead of an institution. Individuals must meet specific technical, financial, and medical eligibility criteria to qualify for each of the four (4) programs.

Community First Choice (CFC)

The CFC program is a 1915(k) State Plan option authorized by Section 2401 of the Affordable Care Act of 2010 (ACA) and Section 1915(k) of the Social Security Act[1] that allows states to expand access and availability of long term services and supports. The CFC program offers a variety of services and supports to children and adults who are elderly or have disabilities and require assistance with activities of daily living and instrumental activities of daily living.[2] The intent of this program is to prevent or delay institutionalization by allowing participants to receive services in a community setting while providing a cost savings to the State. The following services and supports are offered through the CFC program: accessibility adaptations; assistive technology; consumer training; environmental assessments; home-delivered meals; nurse monitoring; personal assistance services; personal emergency response systems; supports planning (i.e., case management); and transition services.

In order to qualify for the CFC program, applicants must meet an institutional level of care[3] and certain financial eligibility requirements; specifically, an individual must be enrolled in an eligibility category covered under the Medicaid State Plan. As part of the Medicaid State Plan, the CFC program is considered an entitlement benefit and individuals who meet the technical, medical, and financial eligibility criteria are enrolled in the program. A person-centered planning process is employed to empower applicants/participants and their families to assist the Department's agents (i.e., supports planners) with developing a POS that will safely address the

[1] https://www.medicaid.gov/sites/default/files/2019-12/md-cfc-spa-matrix.pdf

[2] https://health.maryland.gov/mmcp/longtermcare/Resource%20Guide/03.%20Program%20Fact%20Sheets/Fact%20Sheet%20-%20CFC%20March%202018.pdf

[3] An institutional level of care means an individual has a higher medical acuity that would qualify them to receive care in an institutional setting, such as nursing facilities, chronic hospitals, and/or intermediate care facility for individuals with intellectual disabilities.

applicant's/participant's health and welfare needs. OLTSS reviews an applicant's/participant's request for services through the person-centered POS and makes a determination based on program requirements, including but not limited to medical necessity and necessity to prevent institutionalization.

Community Personal Assistance Services (CPAS)

Like CFC, CPAS is an optional Medicaid State Plan program that provides personal assistance services to children and adults who are elderly or have disabilities and require assistance with activities of daily living or instrumental activities of daily living.[4] The intent of this program is also to prevent or delay institutionalization by allowing participants to receive services in a community setting while providing a cost savings to the State. The following services and supports are offered through the CPAS program: personal assistance services; supports planning (i.e., case management); and nurse monitoring.

In order to qualify for the CPAS program, applicants must meet the CPAS level of care, which requires assistance with at least one (1) activity of daily living. Additionally, individuals must meet certain financial eligibility requirements; specifically, an individual must be enrolled in an eligibility category covered under the Medicaid State Plan. As part of the Medicaid State Plan, the CPAS program is considered an entitlement benefit and individuals who meet the technical, medical, and financial eligibility criteria are enrolled in the program. A person-centered planning process is employed to empower applicants/participants and their families to assist the Department's agents (i.e., supports planners) with developing a POS that will safely address the applicant's/participant's health and welfare needs. OLTSS reviews an applicant's/participant's request for services through the person-centered plan and makes a determination based on program requirements, including but not limited to medical necessity and necessity to prevent institutionalization.

Home and Community-Based Options Waiver (HCBOW)/Community Options

Community Options is a 1915(c) Medicaid waiver program authorized by Section 1915 of the Social Security Act that allows states to provide certain services to target specific populations. Maryland's HCBOW provides community services and supports to enable older adults and people with physical disabilities to live in their own homes.[5] In January 2014, the Living at Home (LAH) Waiver and the Waiver for Older Adults (WOA) were consolidated to create the Community Options waiver program. The following services and supports are offered through Community Options: assisted living services; behavioral consultation; case management; dietitian and nutritionist services; family training; medical day care; and senior center plus.

To qualify for the Community Options waiver program, individuals must meet the technical, medical, and financial requirements of the program, including a level of care required to receive services in a nursing facility. The Department gives first priority to individuals who can be

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[4] https://health.maryland.gov/mmcp/longtermcare/Resource%20Guide/03.%20Program%20Fact%20Sheets/Fact%20Sheet%20-%20CPAS%20March%202018.pdf

[5] https://health.maryland.gov/mmcp/longtermcare/Resource%20Guide/03.%20Program%20Fact%20Sheets/Fact%20Sheet%20-%20CO%20Waiver%20March%202018.pdf

discharged from a nursing facility upon receipt of waiver services. Interested individuals may contact the Office of Long Term Services and Supports (OLTSS) for a referral to Options Counseling, which provides information to individuals in a nursing facility to help them understand their discharge options and programs that may support them in the community. For individuals already residing in the community who are interested in waiver services, OLTSS maintains a registry. Individuals can place their name on the registry by calling a Maryland Access Point (MAP) office (sites are located in jurisdictions around the state of Maryland) and completing a Level One Screen. Based on the results of the screen, individuals are placed in one of Medicaid's priority groups. Individuals are invited to apply to the HCBOW from the registry on a monthly basis.

Increased Community Services (ICS)

The ICS program supports individuals residing in institutions with incomes above 300% of Supplemental Security Income (SSI) to transition into the community while also permitting them to keep income up to 300% of SSI[6]. The ICS program is covered under Maryland Medicaid's 1115 Waiver and is currently capped at 100 individuals. It is operated and managed almost identical to Community Options. Individuals must be at least 18 years of age and reside (and have resided for a period of not less than 90 consecutive days) in a nursing facility. However, unlike the Community Options waiver program, an individual participating in the ICS program must contribute income in excess of 300% of SSI to the cost of care in the community (i.e., meet financial eligibility criteria), in addition to meeting technical eligibility criteria. In order to qualify for the ICS program, applicants must meet a level of care required to receive services in a nursing facility.

The ICS population receives Medicaid State Plan benefits and HCBS identical to those provided in the HCBOW. An individual's services in the community may not cost the Medicaid Program more than the individual's services in the nursing facility and an individual must not be eligible for an existing Medicaid 1915(c) waiver program.

Person-Centered Planning, Review and Determination Processes

Each of the aforementioned programs requires a person-centered plan, approved by OLTSS, for the enrolled participant to begin receiving services and supports. This process is essential to assure that the applicant's or participant's personal strengths, goals, risks, and preferences are incorporated into service planning and reflected on the POS. Case management entities, referred to and hereafter known as Support Planning Agencies (SPA), develop the POS in conjunction with each applicant/participant and/or the applicant/participant's authorized representative using a standardized assessment of need and recommended plan of care to inform the development of the POS. Currently, the Department utilizes the interRAI Home Care (HC) and interRAI Pediatric HC for the purpose of the standardized assessment of need. The interRAI is a comprehensive assessment that also uses a person-centered approach to gather clinical and social information to evaluate an individual's needs, strengths, and preferences. The interRAI assessment is also used to determine whether an applicant/participant meets the required level of care for the respective program. The interRAI assessment is administered by licensed registered

[6] https://health.maryland.gov/mmcp/longtermcare/Resource%20Guide/03.%20Program%20Fact%20Sheets/Fact%20Sheet%20-%20ICS%20March%202018.pdf

nurses and licensed social workers within the 24 Local Health Departments (LHDs) or the Department's Utilization Control Agent (UCA) as needed.

Once the interRAI assessment is completed, the assessor develops a recommended plan of care based on the applicant/participant's assessed needs. The Supports Planner (SP) utilizes the interRAI, the recommended plan of care, and the engagement with the applicant/participant and/or the applicant/participant's authorized representative to develop the POS. SPs are required to engage individuals in a person-centered planning process designed to encourage self-direction and offer the individual choice and control over the process and resulting plan. The POS should include all Medicaid and non-Medicaid services and supports that address an applicant/participant's medical, social, educational, employment/vocational, and behavioral health needs.

For an applicant, the SP submits an initial or provisional POS to OLTSS for review and determination prior to enrollment. For an individual who is already enrolled, OLTSS must review and approve the participant's request for services at least annually. As such, SPs must meet with the participant and/or the participant's authorized representative to develop and submit an annual POS to OLTSS. If a participant experiences a change requiring a change in services, the SP develops and submits a revised POS to OLTSS for review and determination.

Upon review, OLTSS will deny, approve, or request additional information (i.e., clarification request). Plans requiring additional information are sent back to the SP for clarification, which may include supplemental information that supports the requested services and supports. Multiple clarification requests may be necessary in order to obtain the necessary information for OLTSS to render a decision on the POS. POS reviewers, which include clinical and non-clinical staff, render POS determinations; however, non-clinical reviewers have readily available access to licensed registered nurses and licensed clinical social workers for consultation and support for medically and/or behaviorally complex applicants/participants, including participants who are concurrently enrolled in more than one Medicaid HCBS program.

The SP is notified when OLTSS renders a POS determination and when the determination is a denial, the applicant/participant also receives written notification. The SP assists the applicant/participant with the next steps based on the POS decision. If OLTSS requests additional information through a clarification request, the SP assists the applicant/participant and/or the applicant/participant's authorized representative in responding to the request, including gathering additional information. If OLTSS denies the POS, the SP assists the applicant/participant and/or the applicant/participant's authorized representative with appealing the decision, should the individual want to proceed in that manner. If OLTSS approves the POS, the SP assists the applicant/participant with initiating services and supports as approved in the plan.

Plan of Service Staff

The Department, specifically the OLTSS, reviews and renders decisions on the four (4) types of POS (e.g. initial, provisional, revised, and annual) for the four (4) aforementioned programs: HCBOW, CFC, CPAS, and ICS. Clinical and non-clinical reviewers conduct POS reviews, in addition to other administrative functions that support the POS review process. In addition to

reviewing and making POS determinations, the clinical reviewers provide consultation and support to the non-clinical reviewers for medically and/or behaviorally complex applicants/participants, including individuals who are concurrently enrolled in more than one Medicaid HCBS program. The clinical reviewers are also responsible for representing the Department in POS appeal hearings, which means primary plan review is a fraction of their scope of work.

There are four (4) non-clinical and four (4) clinical POS reviewers, which includes two (2) supervisory staff for whom primary plan review is only part of their scope of work. On average, a full-time POS reviewer can review 10 POS per day, while staff who are not engaged in plan review as a sole responsibility can review four (4) POS per day. With the current staffing model, OLTSS is able to review an average of 56 POS per day. Currently, OLTSS receives an average of 80 POS per day, each of which may require multiple reviews before a final determination can be made.

As a point of reference, in 2018, the number of non-clinical reviewers was more than twice the number of current non-clinical reviewers. Since that time, the number of non-clinical reviewers has steadily declined, despite an increase in the overall number of merit and contractual positions. Additionally, program enrollment across the four (4) programs increased by 10 percent from 2019 to 2023, resulting in a subsequent increase in the total volume of plans. Thus, the current backlog is attributable not only to the current disparity between the number of plans reviewed per day as compared to the number of plans received, but also the trends associated with program enrollment and staff attrition.

Plan of Service Metrics

As requested by the committee, the average number of days to approve a plan, total number of pending plans at the beginning of each month, and the number of plans that received a decision within 30 days (one (1) month) are reported below for January 2023 through April 2023. At this time, we are unable to provide data points by jurisdiction as we do not receive the data at this granularity from our contractor. We are reviewing options to add this to our product requests. The metrics report below are inclusive of initial, provisional, revised, and annual POS for applicants and participants in the HCBOW, CFC, CPAS, and ICS programs.

Month/Year	Average # of days to approve a plan	Total # of pending plans at the beginning of the month	# of plans receiving a decision in less than 30 days
January 2023	122	12,567	445
February 2023	144	12,886	347
March 2023	187	12,914	390
April 2023	137	13,394	265

Recommendations

The Department recognized the unsustainability of the current structure for plan review several years ago and began developing short-, intermediate-, and long-term strategies to address the backlog. Short- and intermediate-term strategies employed have included requests for additional merit and contractual positions, engaging other OLTSS staff as supplemental reviewers for low complexity plans, and leveraging OLTSS' data management system to determine annual plans which met specified criteria and could go through an expedited approval process. Unfortunately, several rounds of recruitment efforts did not produce any candidates for OLTSS to consider and the use of supplemental reviewers did not prove sustainable. While the initial utilization of data for expedited review did result in approval of over 1,000 annual POS, the human resources required to extract and analyze the data, as well as to manually approve the plans identified as meeting the criteria were substantial.

In an effort to assist OLTSS with the backlog, several stakeholders have offered recommendations for improvement, most significantly, whether current providers, including SPs, LHDs, and MDCs could help ameliorate the backlog by temporarily reviewing and making determinations on POS. Due to the conflict of interest requirements for federal HCBS programs, Medicaid providers of HCBS are unable to authorize services as it creates a conflict for the provider of services requested in the plan to make the determination about the services. Furthermore, the entity that completes the standardized assessment of need and the entity that creates the person-centered plan, must be distinct from each other, and the entity making the POS determination.

As an effort to implement an immediate short-term strategy, while continuing to actively recruit for vacant positions via several social media platforms (e.g., LinkedIn, Handshake) and various stakeholder networks, OLTSS has drafted an expedited RFP to solicit a temporary contractor to review and render determinations on the backlogged POS. It is anticipated that this RFP will be posted to eMaryland MarketPlace in September/October 2023 with vendor selection occurring in early winter 2024. This temporary vendor will be responsible for the backlogged plans, while the UCA will assume responsibility for newly submitted plans beginning in January 2024.

By way of a long-term strategy, OLTSS decided to include the POS review and determination process in the Department's Utilization Control Agent (UCA) contract. The contract was awarded to Maryland's incumbent, Telligen, on June 8, 2023 with an expected implementation date of January 1, 2024. Medicaid has begun to hold business requirements meetings with the UCA to prepare for the implementation of the contract.

OLTSS continues to collaborate with other offices within the Department, including Medicaid Provider Services (MPS) and the Eligibility Determination Division (EDD), on other efforts that will continue to increase the efficiency and timeliness of the POS decision process. Recently, OLTSS began efforts to enhance its data management system to allow auto-approval (i.e., no manual review required) of annual plans meeting specified criteria, which builds on OLTSS' earlier efforts mentioned above, but improves its execution. The auto-approval of annual plans is expected to be implemented in the Department's data management system in spring 2024. Additionally, OLTSS is working with the EDD to develop a report that will analyze pending POS and the age of an HCBOW application in order to prioritize plans for those individuals whose

application is nearing the end of its six-month life cycle. This report is expected to be available in fall 2023.

Conclusion

The Department is confident that the short, intermediate, and long-term strategies, once fully implemented, will address the backlog of POS reviews. As required, the Department will submit a monthly report with the POS metrics and provide a monthly update on the implementation schedule for the strategies outlined in the recommendations section of this report.