Community Options (CO) Advisory Council Charter

Established February 17, 2026

1. Purpose of the Council

1.1 Background

The Community Options (CO) Advisory Council was established in 2013 in accordance with 42 CFR § 441.575, which requires a Development and Implementation Council for the Home and Community-Based Attendant Services and Supports State Plan Option (Community First Choice (CFC) program).

While the State is required to consult and collaborate with the Council when developing State Plan amendments, Maryland expands the role of the Council to represent not only CFC participants, but also the Community Options Waiver (COW), Community Personal Assistance Services (CPAS), and Increased Community Services (ICS) participants in discussions on policy changes, proposed regulations, waiver amendments, and waiver renewals.

To ensure that the majority of the Council consists of "individuals with disabilities, elderly individuals, and their representatives," the Maryland Department of Health ("the Department") has prioritized building a diverse Council.[1]

1.2 Mission

The Council's mission is to enhance the quality of CFC, CPAS, COW, and ICS programs and improve the experience of their beneficiaries through transparent communication between the Department and the stakeholders.

1.3 Purpose

The Council's purpose is to identify common issues and barriers to quality service delivery, develop solutions, and recommend policy changes and program improvements to the Department.

[1] Home and Community-Based Attendant Services and Supports State Plan Option (Community First Choice) 42 C.F.R. § 441.575 (2012). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-K/section-441.575

2. Oversight

2.1 The Council is overseen by the Director of the Office of Long Term Services and Supports, along with the Assistant Director of Nursing and Waiver Services. Meetings are prepared and led by leadership from the Division of Clinical Support, the Division of Participant Enrollment and Service Review, and the Division of Provider Integrity, Claims, and Compliance.

3. Organization of Council

3.1 Membership

(1) The Council shall consist of no less than 10 and no more than 25 members. A vacancy shall not prevent the Council from conducting business.
(2) The majority of the Council (50 percent) must be individuals with disabilities, elderly individuals, and their representatives. In other words, they are participants or representatives of participants of CFC, CPAS, COW, or ICS programs.
(3) Other members are stakeholders involved in the work for individuals with disabilities or elderly individuals in Maryland.

3.2 Recruitment

(1) Anyone interested in joining the Council must submit a nomination form. Nominees will be considered potential members based on the following criteria:
    (a) Alignment between the Council's goals and the nominee's interests.
    (b) Commitment and availability to attend and actively participate in meetings.
    (c) Contribution to the diversity and composition requirements of the Council.
(2) Nomination process includes:
    (a) Interested individuals complete the online nomination form.
    (b) Department staff will verify the nominee's program enrollment status or credentials.
    (c) Department staff will contact the nominee to provide a copy of the Council charter for review.
    (d) The nominee attends the first meeting and provides consent, by signing the Council charter, to the Department staff to formally join the Council.
(3) Anyone who does not meet the criteria may still attend meetings as a stakeholder.

3.3 Requirements

(1) Arrive at each meeting on time.
(2) Review documents in advance of each meeting and be prepared for discussion.
(3) All members of the Council shall serve on a voluntary basis without compensation.

(4) Council members shall serve a term of two (2) years. Membership shall be reviewed on an annual basis. There shall be no limit to the number of terms a member may serve.
(5) Members who do not attend at least two (2) meetings during the year without a reasonable excuse presented in written form and accepted by the Department staff will be removed from the Council at the annual membership review.
(6) Council members may designate a proxy to attend Council meetings on their behalf; however, the proxy must represent the same constituency or hold a comparable role as the member. Members must notify the Department staff at least 24 hours in advance and provide the name and role of the designated proxy.
(7) Council members may identify issues, discuss options, and draft recommendations as needed, in alignment with Section 1.3 Purpose. Any recommendation proposed by the Council must be approved by a vote of the members, in accordance with Section 5. Voting and Decision Making, before it is formally submitted to MDH.

3.4 Positions
Chair positions will be filled by leadership from the Division of Clinical Support, the Division of Participant Enrollment and Service Review, and the Division of Provider Integrity, Claims, and Compliance, or their designees.

4. Meetings

4.1 A quorum for a full Council meeting shall consist of at least five (5) Council members.

4.2 Council meetings shall be conducted in a hybrid format, permitting both in-person and virtual participation.

4.3 Council meetings shall be held at least quarterly.

4.4 Email or written notice of the time, date, location, and meeting materials shall be sent to Council members at least seven (7) calendar days in advance. The same information will be shared with stakeholders via the designated email listserv.

4.5 A designated time shall be reserved for public comments. Stakeholders may provide comments only during this period.

4.6 Comments should remain general to protect the privacy of individuals and avoid disclosing personal medical information. Questions or concerns regarding a specific person should be directed to the Department staff outside of the meeting.

4.7 Meeting summaries shall be reviewed and approved at the subsequent meeting and posted on the CO Advisory Council webpage within 10 business days of the meeting's conclusion.

5. Voting and Decision Making

5.1 If consensus cannot be reached, the Council shall proceed to a vote. Each member is entitled to one (1) vote per decision. A decision requires a two-thirds (2/3) majority to pass.

5.2 Council members may not vote on behalf of another member, and voting must occur only during the meeting. However, a member's designated proxy is permitted to vote on their behalf.

5.3 Stakeholders do not have voting rights.

5.4 The Council is primarily advisory, and its decision-making authority is limited to voting on advice to the Department. Advisory initiatives advanced by the Council shall be reviewed by the Medicaid Administration, which shall approve or deny each recommendation. Decisions shall be communicated to the Council at a subsequent meeting. Council members will work expeditiously and avoid revisiting decisions once they are made.

6. Guiding Principles

6.1 The Council's decisions shall be data-driven, evidence-based, and informed by the knowledge and experience of individuals.

6.2 The Council shall facilitate processes that are transparent and inclusive.

6.3 The Council shall encourage engagement from a diverse range of stakeholders.

6.4 The Council shall prioritize learning and continuous improvement over judgment and blame.