NASDDDS
National Association of State Directors of Developmental Disabilities Services

Report and Recommendations: Targeted Case Management/Coordination of Community Services in Maryland

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This report was prepared pursuant to a contract between the Developmental Disabilities Administration (DDA) and the National Association of State Directors of Developmental Disabilities Services (NASDDDS). Contributing staff from NASDDDS include Nancy Thaler, Robin Cooper, Mary Sowers and Jeanine Zlockie.

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Introduction

Maryland Developmental Disabilities Administration (DDA) contracted with the National Association of State Directors of Developmental Disabilities Services (NASDDDS) to conduct a review of the functions and processes of Targeted Case Management, known as Coordination of Community Services (CCS) in Maryland, and to make recommendations for improvements. This report on CCS in Maryland summarizes the findings and observations that resulted from the review as well as recommendations for improvements.

CCS in Maryland[1], as in all states, is the cornerstone of the community service system. The role of CCS is to assist people with disabilities and their families to learn about and gain access to resources in their community, to plan for their future, and to access needed services and supports. The CCS role is also to assure that people and their families receive the supports and services that are in their plan, that the person's needs are met, their preferences are honored and that as people's needs change, their individual plan and services change. Ultimately, it is the CCS who must discover what matters most to the person and their family in order for them to have a good life.

CCS is an important service for individuals and families. Equally as important, it is the means by which the state fulfills its obligation to oversee the program, ensure people are receiving high quality services, and that their health and welfare is assured.

CCS providers play a pivotal role in supporting people and their families and also in acting as a resource to the state.

Methodology

The NASDDDS team conducted the review of DDAs CCS system through individual listening sessions, and reviewing a wide range of documents. During the past two years, Maryland's system for CCS has undergone significant change. The state moved CCS (then called Resource Coordination) from a service provided under the 1915(c) waivers to Targeted Case Management provided under the Medicaid state plan. This chang resulted in new and/or different providers of CCS within the state, and also shifted the method that the state paid for the services. DDA initiated this review of CCS, as currently delivered, to ensure that it is meeting the needs of individuals and families throughout the state.

[1] While currently called Resource Coordination in Maryland, proposed regulations seek to change the name to Coordination of Community Services (CCS). PROPOSAL Maryland Register Issue Date: February 6, 2015; Volume 42 • Issue 3 • Pages 354—359

The NASDDDS team met with self-advocates, families, CCS agencies, and DDA leadership.

DDA also contracted with NASDDDS to review the Community Pathways waiver, and relevant information collected during that review informed this report.

The range of review activities include:

- Fifteen listening sessions with self-advocates, families and providers;
- Two, two-hour meetings with the agencies that provide CCS;
- Review of the Title 10 Department of Health and Mental Hygiene's Targeted Case Management for People with Intellectual and Developmental Disabilities Regulations;
- Review of regulations specific to DDA's individualized planning and service requirements;
- CMS-approved TCM state plan amendments;
- A detailed demonstration and walk-through of the CCS fields within the PCIS2 Information System;
- Review of the Community Pathways waiver;
- Research related to a multitude of process documents focused on the delivery of the CCS service; and,
- Consultation with People on the Go.

In addition to the meetings with the RCC, the RCC provided significant useful information through a number of reports and recommendations. Many of these reports and recommendations are included in appendices in this report.

Description of Current Programs

The goals of DDA for people with developmental disabilities are to:

- Direct their lives;
- Have viable support options; and,
- Have information to make decisions.

In adhering to these goals, DDA Leadership identified a number of priority areas to focus attention for the delivery of services to individuals with intellectual and

developmental disabilities I/DD. These identified priorities are critical to the work of CCSs:

- Fostering self-determination;
- Supporting families;
- Facilitating individualized services and supports;
- Developing accessible housing; and,
- Promoting Employment First.

There has been significant change in Maryland's service delivery system over the past two years. As noted above, Maryland moved the coverage of CCS from the waiver program to the Medicaid state plan. This move resulted in changes to the providers of CCS, the financing of the service, as well as the requirements for the delivery of services.

Maryland DDA merged its two Section 1915(c) Home and Community Based Services (HCBS) Waivers (Community Pathways and New Directions) into one comprehensive program, approved on March 26, 2014, with a retroactive effective date of July 1, 2013. CMS approved a period of transition to the fully merged waiver over the course of 18 months from the approval date.

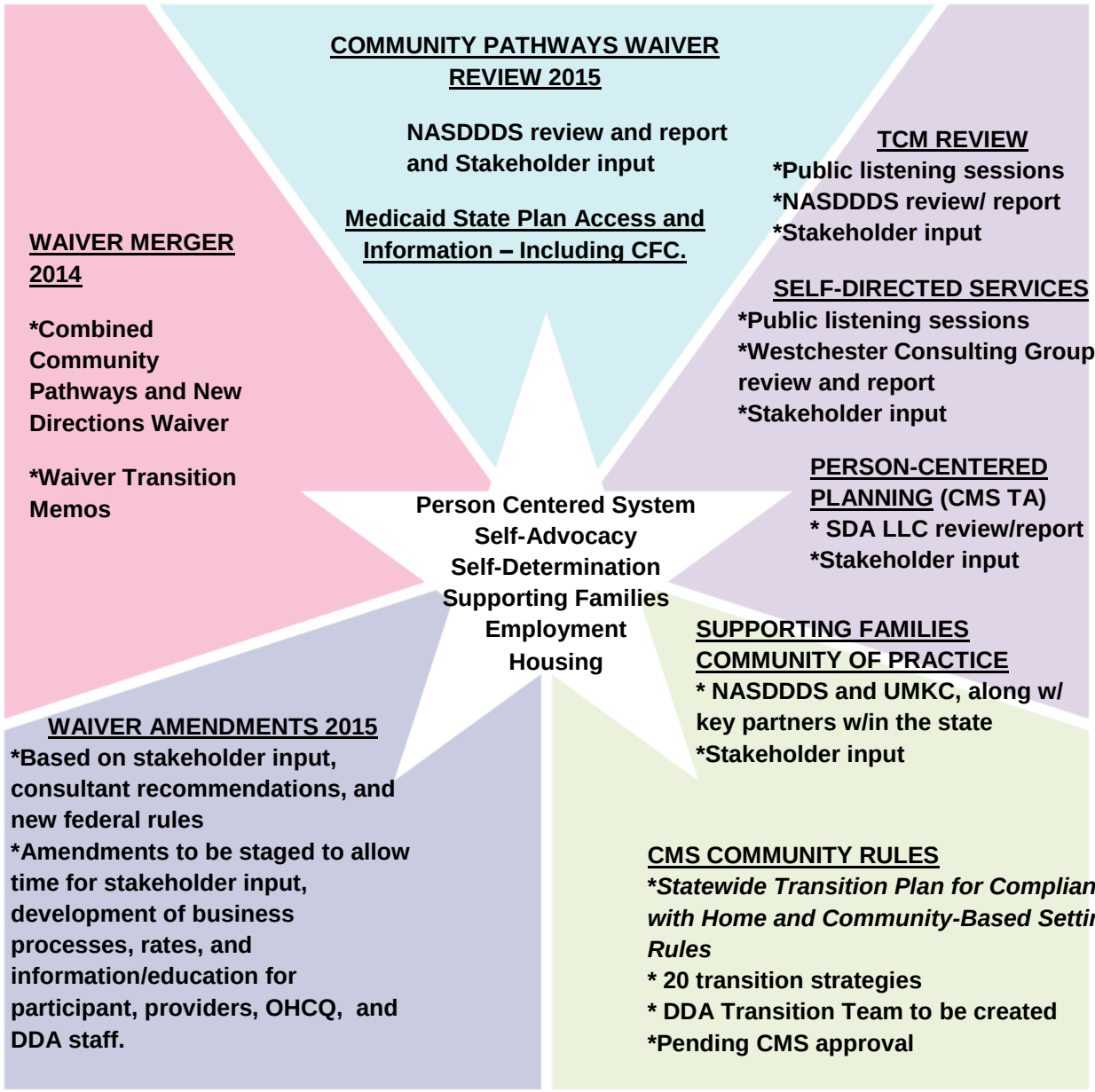
In addition to managing the transition to the newly combined waiver program, DDA worked with Medicaid to develop a statewide transition strategy to ensure compliance with the settings requirements of the final HCBS rule promulgated by CMS[2]. The effective date of the rule is March 17, 2014, and statewide transition plans were due to CMS no later than March 17, 2015. Maryland's statewide transition plan was submitted to CMS on March 12, 2015.

In addition to these developments, Maryland Medicaid has also gained approval to operate the Community First Choice (CFC) State Plan option under 1915(k) within Medicaid. Individuals with I/DD, among other individuals, meeting institutional level of care requirements are eligible for this benefit.

With these system changes occurring at a rapid pace, it is critical for DDA to continue active dialogue with individuals with disabilities, families, CCS's, service providers, other state operating agencies, and other external partners/stakeholders.

[2] 42 CFR 441.301(c)(4)

The graphic below illustrates the program areas that DDA is focusing on to achieve its goals. CCS is critical to each of these initiatives.



Overview of Coordination of Community Services in Maryland

There are eighteen CCS provider agencies within the state, covering four regions and supporting over 24,000 people.

Individual CCS must meet the following criteria:

- Bachelor's degree in a human services field; except for CCS employed for a minimum of one (1) year by January 1, 2014 with an existing DDA licensed CCS agency, can be grandfathered as a qualified CCS in lieu of education requirements.
- Uses all communication methodologies, strategies, devices and techniques necessary, including sign language, assistive technology, or language interpreter services, to facilitate the involvement of the participant in the assessment, development, and monitoring of services and supports;
- Ensures that each individual receives an Individual Plan (IP) that is designed to meet the individual's needs and in the most cost effective manner.

Maryland has three State Plan Amendments (SPAs) that provide authorization for Federal Financial Participation (FFP) for specific target groups of people with limits on annual units of service. Each target group is authorized for CCS based on their category of service or waiting list priority as follows:

- **CCS for Waiting list Coordination** (#062120134051) – Provided for individuals on the DDA waiting list in the following categories and limitations of units:
    - Crisis resolution (168 units) - minimum monthly contacts for first ninety (90) days and then quarterly until priority category changes, unless additional contacts otherwise authorized by DDA; or services offered;
    - Crisis prevention (112 Units) - minimum quarterly contacts until priority category changes, unless additional contacts otherwise authorized by the DDA, or services offered;
    - Current request (60 Units) - minimum annual contact until priority contact changes, unless additional contacts otherwise authorized by DDA, or services authorized. Those that have priority and people residing in a State Residential Center (SRC) who do not attend a DDA day program off campus and are not transitioning to the community (60 units).

- **CCS for Community Coordination** (#662820134010) – Provided for individuals receiving on-going funding for services (i.e. day, residential, Supported Employment, etc.) and people residing in an

SRC who attend a day program off campus (212 units per fiscal year unless authorized for additional units).

- **CCS for Transition Coordination** (#062120134052) – Provided for individuals transitioning from an institution to the community including people residing in an SRC that do not attend an off campus day program, people in nursing facilities, and people in a Secure Evaluation and Therapeutic Treatment (SETT) (208 units).

CCS functions are consistent between the three State plan amendments and include services furnished to assist individuals, eligible for Medicaid, in gaining access to needed medical, social, educational and other services.

Some of the CCS functions include:

- Coordinating and facilitating meetings to develop and make revisions to the IP based on the individual's person-centered planning methodology preference;
- Completing monitoring and follow up to ensure services are provided as specified in the IP, and that progress is being made. Monitoring and follow-up also includes requests for service change, priority category recommendations and identification of new medical needs; and,
- Sharing information about relevant resources, and making referrals on behalf of the person they are supporting.

CCS providers also complete a one-time Comprehensive Assessment for each individual applying for DDA eligibility. Information about needed supports is captured on a Critical Needs List Recommendation (CLNR) form and submitted to the referring DDA regional office within 45 days of the initial request. A flat rate of $450.00 is paid to the CCS provider for the assessment.

Findings and Recommendations

The findings and recommendations in this report are organized under five themes:

1. *Focusing on a person-centered system*
2. *Building Infrastructure to Support Effective CCS Services*
3. *Develop a Training Program to Strengthen CCS Knowledge and Competencies*
4. *Reduce Administrative Complexity, and;*
5. *Rate structure and units of service maximum.*

Theme 1: Focusing on a Person-Centered System

One of the most significant issues identified by stakeholders during the review is that the system has lost its **"person-centered focus"**. The factors that interfere with person centered practices include: burdensome time recording requirements; overly complicated billing requirements; service unit limitations; onerous processes to request exceptions and changes to service plans; and an information system that is heavily focused on administrative requirements and has no capacity to record the elements of person centered planning.

The PCIS2 information system is used by CCSs to support documentation of services, activities and billing. CCS providers use two modules within the system, the CCS module and the IP module that includes ten components. During our review, concerns were expressed by CCS entities that the PCIS2 data collection system and the IP as constructed within the system are not structured to capture fundamental information from the person centered planning process. For instance, there are no data fields to capture what is what is important to and important for a person. It was also reported that a full IP was required for all people on the DDA waiting list. The challenge raised with this expectation was the level of required personal information dictated by PCIS2, and a concern that a full, comprehensive IP may be burdensome for individuals who are not likely to access paid supports soon. This may also set up expectations from individuals and families that cannot be readily addressed due to the waiting list.

Although the current data system requirements are necessary information for DDA to track against waiver assurances to CMS, this should not, and cannot take the place of person centered planning on behalf of every individual supported.

Recommendations:

1. From the results of the Support Development Associates (SDA) review of person centered planning and practices and the IP workgroup; identify and prioritize actions to improve person centered planning. (See Attachment 1 for IP work group recommendations).

2. Involve CCS in the Community of Practice for supporting families to strengthen their capacity to be family and person centered.

3. Build the requirements of PCP from the CMS regulations into the roles, responsibilities and IP development process of CCS. These include: ensuring IP development includes people chosen by the person, the plan is directed by the person to the maximum extent possible, the meeting is timely and occurs at times and locations of convenience to the person, the

process reflects cultural considerations, strategies for solving conflict or disagreement, and a process for plan updates that are initiated by the person.

4. Make improvements to the PCIS2 to improve facilitation of person centered planning**.** Evaluate the PCIS2 system to assess the extent to which the technology supports the work of CCSs in the areas of person-centered planning. If the Department plans to replace PCIS2, a new system should support person centered planning.

5. Re-evaluate the need for a full IP for people on the waiting list. Consider the development of an abbreviated plan. (See Attachment 2 for Waiting list work group draft recommendations).

Recommendations related to person centered practices in this report may also fall under other themes and will be referenced in those recommendations

Theme 2: Building Infrastructure to Support Effective Coordination of Community Services

During the information collection process, communication was identified as a challenge. There is concern regarding the clarity of information from DDA, which contributes to inconsistency in interpretation and application across the state. There was also concern that DDA does not regularly seek key stakeholder input and advice on policy changes.

The current CCS guidelines focus primarily on administrative requirements and processes and are not all collected under one document. Little guidance is provided on the CCS responsibilities that affect the persons' quality of life such as identifying strengths, preferences, needs and desired outcomes, connecting individuals to appropriate services (paid and unpaid), and ensuring health and welfare.

CCS entities report that they do not feel their work has the support of the DDA because problems identified by CCS are often not acted on.

CCS reported that, in the past, DDA held regular meetings with them to exchange information and discuss issues, problems and potential solutions. CCS saw these meetings as useful, because they kept CCS informed and current in DDA policy and provided an essential opportunity to build relationships between the CCS organizations and DDA.

Achieving clear communication and effective supervision and support in a large system is dependent on an administrative structure with clear roles and responsibilities

including responsibilities for information dissemination and responsibilities to make decisions and carry out policies.

Recommendations:

1. Establish a tiered organizational structure within DDA that establishes a CCS lead in each of the regional offices to provide support, communication and supervision to CCS entities within each region. Establish a CCS Director in Central Office to coordinate and supervise the work of the Regional Office leads.

2. Establish regular methods **of communication with CCS entities.** DDA should establish methods of sharing information on a statewide and regional basis to ensure a common understanding of the many activities afoot in the state.

3. Establish a CCS-specific resource page on the DDA website so that all information covered and conveyed during meetings are available for CCS in a comprehensive and consistent fashion.

4. Define the role of the CCS in the administration of the CFC benefit. Linkage and coordination with this new benefit will be critical for people and their families served by and/or awaiting services from DDA.

5. Develop a CCS operations manual. In cooperation with the CCS entities, develop a comprehensive CCS operations manual. This manual should include operational practices and detailed administrative responsibilities. It should be structured simply so self-advocates and their families understand the responsibilities they can expect from the services of a CCS. An example of a strong manual would be the Missouri Individual Support Plan Guidelines. (These can be found in Attachment 3 of this report).

6. Clarify and affirm the role of the CCS as acting on behalf of the DDA. The role of the CCS must be made clear to all stakeholders, including individuals, family members, providers, and DDA staff. Service providers must understand the responsibility of CCS to assure that services are of good quality, and that the person is healthy and safe.

Theme 3: Develop a Training Program to Strengthen CCS Knowledge and Competencies

CCS are required to participate in mandatory training topics that are mostly limited to general skill development and do not include person centered practices, self-direction, employment, supporting families or other program related topics. DDA requires evidence of training in the topic, but does not prescribe the content of the training, nor the competencies expected to be acquired through the training.

The following represents the current mandatory training topics for CCS:

- Person-directed supports focusing on outcomes as required by DDA;
- Data collection, analysis and reporting;
- Coaching, mentoring, and feedback skills;
- Creative problem solving and conflict resolution; and,
- Re-training as required by the DDA.

While training topics are mandatory, there are also no apparent mechanisms for CCS to be reimbursed for time spent attending training.

CCS entities have not received adequate guidance on the administration of services under the merged New Directions and Community Pathways waivers as well as the newly approved 1915 (k) benefit.

A number of CCS entities have moved or are moving toward virtual workspaces. This business model offers great flexibility and encourages strong community interactions, but must be coupled with training, mentoring and adequate technological support to ensure that the quality of the CCS service remains high.

A well-developed training curriculum for CCS that focuses on DDAs priority areas will improve the capacity of CCS to achieve the Department's desired outcomes. This curriculum must be designed and delivered by individuals skilled in the specific topic area, utilizing existing strongly designed courses where available.

Recommendations:

1. In consultation with the Resource Coordination Coalition (RCC) training workgroup, develop a training strategy that includes basic orientation and training for new employees specific to their roles and responsibilities and person-centered practices. Training may include a web-based training platform, but must include some face-to-face instruction. Utilize the recommendations of the CCS training workgroup as a strong foundation (These recommendations can be found in Attachment 4).

2. Identify core knowledge and competencies of CCS and develop a core curriculum that is provided for both orientation and on-going staff development. Key areas to consider:

- Person-centered practices – Develop training that incorporates the results of the work of SDA, the IP workgroup and that comports with the CMS HCBS regulations.
- Supporting families – Develop training informed by information collected through the Community of Practice for supporting families.
- Employment First (and school to adult transition) - Develop training on employment that assist the CCS in understanding the value of employment. The training should include information on: individual integrated employment, supported employment, customized employment, and self-employment. The state of Kentucky has some very good materials on both informing families about employment and training case managers regarding the value of employment. (These resources are attached and can be found in Attachment 5). In addition, the State employment Leadership Network (SELN), of which Maryland is a member state, has excellent materials on training case managers and working with families found on the SELN member site at: http://www.selnmembers.org/events/casemanagement
- Self-direction of services – Develop training that considers the work completed by Sue Flanagan, a noted expert on self-direction (including how to collaborate with the FMS entities and support brokers). Connecticut, Oregon and New Mexico have done considerable development in self-directed options, including strategies to engage case management in providing information to individuals about the options available. The following links contain information that may be of assistance/interest:
    - Connecticut http://www.ct.gov/dds/cwp/view.asp?a=2050&q=391098
    - Oregon http://www.oregon.gov/DHS/spd/provtools/dd/rate_manual/intro.pdf
    - New Mexico http://archive.mivianm.org/
- CMS HCBS regulations - Develop training that includes person centered planning, settings requirements and expectations for community inclusion.

- Housing – Develop Training focused on assisting individuals to access housing separate from services so individuals have maximum control over their lives.
- Medicaid State Plan services - Develop training and information in cooperation with Maryland Medicaid on the availability of Medicaid State Plan services.
- The merging of the New Directions with the Community Pathways waiver.
- Virtual workspaces or Mobile CCS – Provide training to individuals providing CCS related to the transition to a mobile work environment; including training on the technology and supports available to them to enable them to meet the needs of the individuals they serve.

Theme 4: Reduce Administrative Complexity

Many stakeholders, including CCS individuals and entities, note there is great complexity within the system, and that the system overall may benefit from greater clarity and simplicity whenever that can be achieved. CCS must complete a self-assessment, remediate, monitor, report, identify system improvement strategies, and follow all quality and compliance actions.

Some of the areas identified as being particularly complex are:

- Billing requirements.
- The PCIS2 system is inefficient and cumbersome and does not support the work flow of the work of CCS:
- Data and alerts from the system contain errors;
- Information from the system does not interface with CCS systems allowing for data transfers;
- Data is only available for one particular person at time;
- The system lacks the capacity to make updates to the annual IP after a planning meeting, so an entire new plan must be generated; and,
- System audits prevent supervisors or anyone else to assist in an emergency as it only allows for one CCS to bill per day, even if it is at different times.
- The Quality Assurance measures:
    - Do not reflect a person's experiences;
    - Retrieval from PCIS2 and provider information systems is time-consuming;
    - The data source for the measures from PCIS2 and provider information systems do not fully support the measures; and,

    - The data extracts from DDA are unreliable and inaccurate.
- Lag times in DDA review and response to requests for Individual Plan changes.
- Lag times in DDA's review and response to requests for additional units of RC services.

Recommendations:

1. Evaluate the requirement for CCSs to track and record activities in 15-minute increments.

2. Evaluate Provider Consumer Information System (PCIS2) as a tool to support the work of CCS in the areas of person-centered planning, case notes, monitoring health and safety, incident management, and monitoring against the plan and waiver assurances. Make adjustments where possible to improve this functionality. NOTE: The timeline to transitioning to the new IT platform (LTSS) platform will be a determining factor in how to prioritize changes to the PCIS2 system).

3. Engage CCSs as key business partners in the planning to transition to the new LTSS including designing the requirements for modifications to ensure the new platform supports the work and requirements of CCS.

4. Evaluate the Quality Assurance (QA) Measures

    a. Working with CCSs, conduct a detailed analysis of current QA reporting requirements to determine if the activities can be streamlined, simplified or eliminated to reduce administrative burden wherever possible.

    b. Assess the need to hold CCS providers to a 100% performance rate. CMS has set an 85% threshold on many measures which may be more appropriate for some of the measures being collected. Determine a new basis for triggering improvement plans, and whether measures that require a compliance standard can be reduced.

    c. Ensure consistent strategies for quality oversight by the state of CCS providers.

    d. Working with CCSs, review the required measures to identify those most useful and relevant to CCSs to measure quality in terms of the person's experiences.

5. Streamline DDA review and response for requests to change plans, requests for additional units of CCS services and to facilitate transfers between CCS entities.

    a. Review actions that necessitate DDA approval.

    b. Review the limits on CCS units of services to establish the number of units that would be adequate to meet the needs of the majority of people supported, and to narrow the exception process to truly exceptional situations.

    c. Review the work flow from submission to DDA action to identify inefficiencies and improve time limits.

    d. Identify more seamless approaches to transfers between CCS entities. (See Attachment 7 CCS Recommendations on Transfers)

Theme 5: Rate structure and units of service maximum

CCS providers have undergone significant changes during the past two years; including a change from a type of per member payment to a fee-for-service payment utilizing fifteen-minute units that became effective on July 1, 2013.

During the review, providers expressed concerns about managing in a fee-for-service environment and the fiscal solvency of their agencies. From the CCS perspective, this change in the fee structure has administrative billing now driving the delivery of the CCS service. Some providers lost 50% of staff through the transition, relationships were broken, there was lack of communication and direction regarding the impact of the changes, and providers were not part of the design and development.

DDA authorizes the specific number of units of CCS services for each participant based on their service category. The volume of requests for additional units of service has created an administrative burden for CCSs and DDA as well as delays in service delivery.

Recommendations:

1. As noted in theme 4, recommendation #1, evaluate the requirement for CCSs to track and record activities in 15-minute increments.

2. Establish a method of assigning the number of people each individual CCS supports through a weighted process based on the level of need of the persons being supported. Some states have chosen to assign caseloads based on an FTE-to- person served ratio while others have set specific caps. The ratio approach allows supervisors to assign caseloads by intensity of support need, and allows for flexibility in managing caseloads. Another approach is to permit CCS to determine the best way to meet individual needs. Whatever approach is used, caseload size clearly affects capacity and the ability to perform the CCS job. (Attachment 6).

3. As noted in theme 4, recommendation #5 (b), review the limits on CCS units of services to establish the number of units that would be adequate to meet the needs of the majority of people supported, and to narrow the exception process to truly exceptional situations.

4. Consider review of and redefinition of activities eligible for billing, building more of the documentation elements into the indirect portion of the rate to incentivize greater individual interaction or work directly on behalf of the individual.

5. Continue to support CCS providers to do business in a fee for service environment through training and individual technical assistance. The move from block funding to fee-for-service has challenged many CCS agencies. Training requirements should be built into the indirect portion of the CCS rate. DDA should also identify technical assistance resources to assist organizations through this transition and should institute methods to ensure the ongoing health and stability of these providers.

Summary and Conclusions

CCS has many strengths and has providers strongly committed to actively supporting individuals to lead fully inclusive lives in the community. Consistency of communication and information sharing by CCSs to individuals and their families is the foundation for building a person centered system, so they must be supported in this effort by consistent and timely guidance and information from DDA.

There are 4.7 million people with I/DD in the US and 89% of those people are being supported by family. This fact should guide DDA in building the capacity of CCSs to partner with individuals and their families so they are supported in ways that maximize their potential, strengths and unique abilities.

DDA should continue efforts to improve the system of CCS within the state to further develop a more person centered process. This improvement effort should recognize the need for ongoing feedback and dialogue with the individuals and entities providing this essential service. Thoughtful approaches and sequencing of these improvements will be very important in building and maintaining a strong CCS workforce.

DDA efforts in this area will allow CCS to focus on the most important part of their role, which is to support individuals and their families in an interactive and person centered way.

Attachments

Attachment 1: IP Workgroup Report

Attachment 2: CCS Report on Waiting List Coordination

Attachment 3: Missouri ISP Guidelines

Attachment 4: CCS Training Report

Attachment 5: Kentucky Materials on informing families about employment

Attachment 6: CCS Report on Unit Recommendations

Attachments 7 and 8: CCS Report on Transfers