May 14, 2012

DHMH Task Force on Regulatory Efficiency, Final Report

Regulatory Proposals Declined by DHMH

Area	Proposal #	Proposal	Reason for Declination
Long Term Care	3	Make the role of the Director of Nursing optional.	The role of the Director of Nursing is a pivotal role at a nursing facility, and his/her duties need to be clearly spelled out in regulation. In addition, regulations also allow the Director of Nursing to delegate certain duties, where appropriate.
Long Term Care	6	Enable nursing homes to increase bed capacity in times of an emergency without getting prior approval from the Department.	The Office of Health Care Quality now has an emergency response team available 24/7 to address these requests. The Department and Maryland Institute for Emergency Medical Services Systems must be able to maintain information about facilities exceeding bed capacity to provide a complete picture of the impact of an emergency situation, and so that the Department can monitor conditions when a facility exceeds capacity.
Long Term Care	8	Combine patient transport and resident relocation policies into a single regulation.	Patient transport and resident relocation policies serve different purposes. Patient transport relates to an individual resident's transport to a hospital in the event his or her care needs can no longer be met at a nursing home. The purpose of a Resident Relocation Plan is to relocate multiple residents in the event of an emergency situation.
Long Term Care	10	Simplify requirements for emergency power generation.	The requirement that fuel be available on-site is an essential requirement. If there is a widespread emergency there is likely to be limited access to fuel, and residents' health will be at risk.
Long Term Care	13	Relax standards for the physical requirements for dayroom and dining areas.	Maintaining physical standards for the dayroom and dining area is important for overall resident experience and quality of life.
Long Term Care	14	Permit changes to existing kitchens and dietetic service areas.	Maintaining standards regarding the physical space of kitchens and dining areas is important for overall resident experience and quality of life.
Assisted Living	23	Waive requirement that employees of assisted living facilities submit a physician's statement that an employee is free from certain "impairment."	It is important to ensure the ability of employees of assisted living facilities to perform their duties, which will promote overall resident safety.
Assisted Living	25	Reduce from weekly to monthly the required resident care note.	Weekly care notes are the appropriate minimal requirement in the assisted living environment, where observations by direct care staff regarding a resident's status and any change of condition are relied on by clinicians who may only visit periodically.
Adult Medical Day Care	27	Remove the requirement that quality assurance plans include health care audit and utilization reviews.	A provider is in the best position to review the quality and utilization of its own services; moreover, such review is a federal requirement for payment for services. In addition to extrinsic review of utilization by the Department and its contractors, federal law requires the Department to provide for methods to safeguard against unnecessary utilization of care and services and to assure that payments are consistent with efficiency, economy, and quality of care. In addition, federal approval of medical day care services under a home and community-based services waiver is contingent upon extensive quality assurance requirements and is subject to a federal audit. The Department's regulation accomplishes this by ensuring that providers who seek reimbursement for services track the appropriateness and utilization of services and monitor and improve the quality of services.

Page Two- DHMH Task Force on Regulatory Efficiency

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Adult Medical Day Care	27	Remove the requirement that quality assurance plans include health care audit and utilization reviews.	A provider is in the best position to review the quality and utilization of its own services; moreover, such review is a federal requirement for payment for services. In addition to extrinsic review of utilization by the Department and its contractors, federal law requires the Department to provide for methods to safeguard against unnecessary utilization of care and services and to assure that payments are consistent with efficiency, economy, and quality of care. In addition, federal approval of medical day care services under a home and community-based services waiver is contingent upon extensive quality assurance requirements and is subject to a federal audit. The Department's regulation accomplishes this by ensuring that providers who seek reimbursement for services track the appropriateness and utilization of services and monitor and improve the quality of services.
Adult Medical Day Care	29	Remove the requirement that adult medical day care centers have a medical director.	It is important to ensure that every resident has access to a primary care provider. It is possible that the medical director of the center may be the primary care provider for several residents.
Mental Health	30	Eliminate the requirement that therapeutic group homes collaborate with local Core Service Agencies.	Collaboration between the therapeutic group home and the local Core Service Agencies is key to ensuring the group home continues to meet the needs of the local jurisdiction.
Mental Health	33	Permit therapeutic group homes to serve nine children rather than the current limit of eight.	Maintaining a therapeutic milieu with a group of severely disturbed adolescents is critical. Emotional stability of the youth may vary, so the group size should be limited with close monitoring, ongoing assessment, observation, crisis intervention, and regular revision of treatment plans.
Mental Health	35	Extend the period of time for an initial assessment of the child at therapeutic group home.	It is important that a child being placed in a therapeutic group home undergoes the initial assessment within the first seven days of placement. This is a clinical program and there is a need to understand the clinical needs of the child before the child is placed in the therapeutic milieu.
Mental Health	36	Eliminate the requirement that therapeutic group homes collaborate with a child's primary care physician.	The child's primary care provider may have information and input on health that is critically important to the well-being of the child. It is critical that the therapeutic group home establish and maintain contact with the child's primary care provider and the educational system.
Mental Health	43	Replace the term "Case Coordinator" with the term "Program Coordinator" in regulations for therapeutic group homes (TGH).	Regulations allow a Case Coordinator position to be filled either by a licensed mental health professional or Residential Care Specialist with a high school diploma who is supervised by a licensed mental health professional. The term, "Program Coordinator" would be inappropriate for Residential Care Specialists/Care Coordinators, and suggests a supervisory or managerial function that is not in fact delegated to the Case Coordinator in such TGH programs.
Mental Health	44	Clarify that the ultimate responsibility for identifying staff training needs and providing inservice training rests with the Chief Executive Officer, and the CEO should not be required to collaborate with the clinical coordinator and program staff in order to fulfill these responsibilities.	Collaboration with clinical staff is appropriate in determining staff training needs in a therapeutic group home.

Page Three- DHMH Task Force on Regulatory Efficiency

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Mental Health	46	Clarify that the responsibility for ensuring appropriate supervision of staff rests with the Chief Executive Officer, not Clinical Coordinator.	The current requirement is collaboration, when appropriate, and not direct management or supervision by clinical staff.
Mental Health	47	Remove the requirement that clinical coordinators be responsible for establishing protocols for medical and psychiatric emergencies.	Clinical input is essential in establishing these protocols.
Mental Health	49	Waive the requirement that a psychiatrist participate in the screening, assessment, admission, and discharge process at therapeutic group homes.	Therapeutic group homes offer intensive mental health services, usually involving medication. It is appropriate for a psychiatrist to be involved in processes relating to the administration of medication to children in these settings.
Mental Health	51	Allow community mental health programs to use one Medicaid number for multiple sites.	The assignment of individual Medicaid numbers for each site enables the Department to monitor utilization and need for services. Moreover, sites are licensed and equipped to provide different services and there are varying payments according to provider types for services rendered.
Mental Health	54	Streamline the eligibility determinations for non-Medicaid consumers of the public mental health system.	Maintaining access to timely and accurate eligibility determinations and reimbursement claims data is integral to the integrity of the system. Providers have unique access to information on individual patients. Reviewing organizations are not in the same position to follow up with individual patients.
Mental Health	55	Adjust regulations that require community mental health providers to inform consumers about mental health advance directives.	Advanced directives should be encouraged and providers should be available to discuss these issues with the consumers.
Mental Health	57	Eliminate or adjust required staffing ratios for mobile treatment services.	Mobile treatment services are a clinical service, and the licensing and staffing requirements in regulations are important to ensuring good clinical care.
Mental Health	59	Eliminate the multi-site staffing requirements of outpatient mental health clinics.	By definition, an outpatient mental health clinic involves an interdisciplinary team, which supports the higher Medicaid reimbursement rate. The existing regulations allow the Department to grant variances from the staffing requirements on a case-by-case basis. The Department will continue this process, rather than changing the regulations.
Mental Health	60	Eliminate the requirement that a licensed mental health professional must refer consumers to psychiatric rehabilitation programs as a condition of consumer eligibility.	Referral from a mental health professional to psychiatric rehabilitation programs is critical for care coordination. In addition, the Department must be able to document care coordination as a part of federal waiver requirements.
Mental Health	61	Adjust authorization periods for Medicaid-eligible and uninsured psychiatric rehabilitation program recipients.	This proposal is in conflict with federal Centers for Medicare and Medicaid Services requirements. The implementation of health reform will require the Department to be able to continue to demonstrate aggressive review of psychiatric rehabilitation program services to ensure that active treatment services are being provided, that medical necessity review criteria are being met, and that the services being provided are needed by the consumer.

Page Four- DHMH Task Force on Regulatory Efficiency

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Mental Health	62	Eliminate the requirement that psychiatric rehabilitation programs must have a 24/7 emergency response plan in place for children and adolescents when the psychiatric rehabilitation program is not open.	Regulations simply require the provider to have a 24/7 emergency response plan in place for when the psychiatric rehabilitation program is not open, not be open 24/7. This plan, which may simply be a referral to another source of services, is necessary for adequate after hours clinical care while decreasing unnecessary reliance upon hospital emergency rooms.
Mental Health	63	Eliminate the requirement that psychiatric rehabilitation program direct care staff must have 60 hours of on-the-job direct psychiatric rehabilitation program supervision before providing services to minors served by the program without supervision.	Providers should be responsible for ensuring that direct care staff are credentialed, receive appropriate training and orientation, and receive appropriate supervision before providing direct care psychiatric rehabilitation program services.
Developmental Disabilities	65	Adjust the regulatory requirement when Individual Plans are updated, from annually to at least every three years.	Based on person-centered services, the individual must have a voice in any decisions made about their life or services and their needs and preferences must be discussed in the individual plan meeting.
Developmental Disabilities	67	Remove the requirement that providers complete annual wage and benefits surveys and require the surveys every two years.	Accurate and timely wage and benefits surveys are essential to the work of the Community Services Reimbursement Rate Commission.
Developmental Disabilities	69	Waive requirements to maintain individual records for five years and instead update these records on a quarterly basis.	Maryland law requires a 5-year retention of medical records, and the Centers for Medicare and Medicaid Services has similar record retention requirements for federal waiver programs.