Plan of Service Development and Review Manual

The following guidance should be used during the development, submission, and approval of all plans of service for the Community Options (CO) Waiver, Community First Choice (CFC), Increased Community Services (ICS), and Community Personal Assistance (CPAS) programs.

Contents

Program Information

The Community Options Waiver, Community First Choice, Increased Community Services, and Community Personal Assistance Services programs each serve participants in need of support of activities of daily living. Certain requirements apply to each program; however, they each use the same Plan of Service to identify services. This Plan of Service should capture all services that will be provided to the participant (under these programs or through other Medicaid or non-Medicaid programs).

Community Options (CO) Waiver participants must meet a nursing facility level of care as determined by the Department based on its standardized assessment. In addition, these participants must meet certain financial eligibility criteria and complete an annual application. Participants in the waiver must be 18 years or above. This waiver has reached its enrollment cap. Only individuals invited to apply from the waiver registry or who have Long-Term Care Medicaid and are living in an institution are eligible to apply for this program. Community residents may not apply directly to this program without the registry invitation.

Increased Community Service (ICS) participants must meet all of the requirements of the Community Options Waiver and may also receive all of the service offered under that program. However, the application for enrolling in these services has different financial requirements than the CO waiver. Only institutional residents who have applied for the CO waiver and been denied due to over scale income may apply to ICS. Institutional residents must have a CO denial letter prior to applying to ICS. This program is limited to 100 participants.

Community First Choice (CFC) participants must meet an institutional level of care, which includes nursing facility level of care. Participants may be of any age and must reside in a community setting.

Community Personal Assistance Services (CPAS) program participants do not meet the nursing facility level of care standard, however do have needs related to activities of daily living and meet the CPAS level of care. In addition to other State Plan services, participants in the CPAS program may only receive personal assistance, supports planning and nurse monitoring. Participants may be of any age but must reside in the community.

Developing a Plan of Service

Services Being Provided in Other Programs

The supports planner should identify all other Medicaid programs in which the person is receiving services. These programs may include:

- Brain Injury Waiver
- Community Pathways Waiver or other DDA-funded services
- Medical Day Care Waiver
- Model Waiver

- Autism Waiver
- Rare and Expensive Case Management Program (REM)
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Nursing
- Other Medicaid programs

Enrollment in other waiver programs and REM are indicated in the client profile in the Eligibility section of the LTSSMaryland system. On the left navigation bar, select Client Summary, then Eligibility Information. Data under the Special Program Code section indicates current or prior enrollment in a waiver program, hospice, or REM. Supports planners should review the eligibility to determine if other programs are available and work with the applicant/participant and any other case manager/service coordinator assigned.

Any Plan of Service related to these programs must be included as an upload to the LTSSMaryland system prior to submission of a Plan of Service for any program (CO, ICS, CFC, and CPAS). This will help provide supporting documentation for the need of each service and avoid duplication of services which may cause non-payment or take back.

Functional Needs

Plans of service should be developed in association with the need for support in activities of daily living (ADLs) and instrumental activities of daily living (IADLs). When describing the service being requested, citing the ADL or IADL need will assist the reviewer when approving a Plan of Service.

Please note that as per the CFC regulations, IADL assistance is only covered when provided in conjunction with ADL assistance, delegated nursing functions, and/or assistance with tasks requiring judgment to protect a participant from harm or neglect.

Activities of Daily Living (ADLs)	Instrumental Activities of Daily Living (IADLs)
- Bathing/completing personal hygiene routines - Dressing/changing clothes - Eating - Mobility - Transferring from a bed, chair, or other structure - Moving, turning, and positioning the body while in bed or in a wheelchair - Moving about indoors or outdoors - Toileting - Bladder/bowel requirements - Routines associated with the achievement or maintenance of continence - Incontinence care	- Preparing meals - Performing light chores that are incidental to the personal assistance services provided to the participant - Shopping for groceries - Nutritional planning - Traveling as needed - Managing finances/handling money - Using the telephone or other appropriate means of communication - Reading - Planning and making decisions

Person-Centered Planning

Medicaid's HCBS programs are based on a philosophy of self-direction, where program participants are empowered to make choices that work best for them regardless of the nature or extent of their disability. Self-direction means the opportunity for participants to exercise choice and control over the budget, planning, and purchase of personal assistance services, including the amount, duration, scope, provider, and location of service provision.

Person-Centered Planning gives people choice, direction, and control of their lives. It allows participants to have a significant role in the delivery of their specific care, including exercising as much control as desired to select, train, schedule, determine duties, and dismiss the personal assistance worker in their homes.

Each supports planning agency has identified a person-centered planning process to be used by their staff. The person-centered strategy is designed to encourage self-direction and offer the participant choice and control over the process and resulting plan. Examples of person-centered planning strategies include Essential Lifestyle Planning, Planning Alternative Tomorrows with Hope (PATH), and Life Maps.

Before developing a plan of service, a face-to-face meeting with the applicant should be conducted to:
- Engage in a person-centered planning process
- Educate the applicant about self-directed options
- Identify the applicant's strengths, goals, and risks
- Review the medical assessment with the applicant
- If applicable, assess the applicant's transition needs from a nursing facility such as the need for household items, furniture, etc.
- Identify various resources to support the applicant in the community, Medicaid and non-Medicaid

Things to think about during Plan of Service Development
- What is important to the participant? (e.g., sleeping late)
- What is important for the participant? (e.g., taking medication as prescribed)
- Who the participant would like to be involved in the process? (e.g., their spouse)
- How will available services fit into the individuals' day and provide the most support?

Plan of Service

There are nine (9) sections in the LTSSMaryland system to be completed and reviewed prior to submission of a Plan of Service. These sections include:

- Overview Information
- Strengths
- Goals
- Risks
- Self-Direction

- Emergency Backup Plans
- Services
- Signatures
- Review

All sections must be completed prior to submission to the Department. There are two levels of submission at the Supports Planning Agency level: supports planner to team lead/supervisor and team lead/supervisor to DHMH. At either of these steps, a clarification request may be sent to acquire additional information or clarify a request for services. All plans should be thoroughly reviewed to make sure it adheres to all regulations, policies, procedures, and contains all supporting documentation prior to submission to the Department.

Overview Information

This section is largely populated by the client profile demographic information and will pull all of the information noted as "primary" such as phone number and address.

Program Type

By selecting a program type on the Plan of Service, a different set of allowable services will be listed based on program limitations. For instance, participants in the CO waiver will have access to all services while participants enrolled in CPAS will only have access to personal assistance, nurse monitoring, and supports planning.

It is critical that the correct program type be selected for the plan of service to avoid delays in the enrollment process. Supports planners must read the eligibility and level of care information in the LTSS before doing a POS to determine which plan type to enter.

For New Applicants

In the Client Summary, select Expand All to view all eligibility information. If there is an active waiver application, the program of application will be listed under Program Snapshot and the POS type should match the waiver application, either CO or ICS.

If there is no waiver application pending, then the person is either a CFC or CPAS applicant.

Both CFC and CPAS applicants must have a qualifying Coverage Group. Please see Appendix A for Coverage Group details.

Eligibility Span				View Coverage Group Details
Coverage Group	Start Date	End Date:	LTC/Community	
S02	12/01/1971	12/31/9999	Community	

If the person has a qualifying coverage group, the program type will be determined by the Level of Care (LOC). If the person meets an institutional level of care, this will be indicated by either of the following; a special program code indicating participation in another waiver program (see Appendix B) or a nursing facility LOC.

Special Program Code				View Special Program Code Details	
Special Program	Start Date	End Date	Disenrollment Reason	Disenrollment Source	
MDC	08/01/2014	06/17/2015	0AA	3	
MDC	12/21/2015	11/30/2016	0AA	3	
MDC	12/01/2016	11/30/2017	0AA	3	

Please note that REM is not a waiver and the REM special program codes do not indicate an institutional level of care.

If a person is participating in another waiver program or meets NF LOC, then they are eligible for CFC. If they do not meet this criterion, then they may still be eligible for CPAS.

In order to be eligible for CPAS, the CPAS LOC status must be generated based on the assessment or approved by the UCA in the Level of Care section of the Client Summary Page.

▾ CPAS Level of Care List					Add
Create Date	Effective Date	Status	Verification Required?	Active	Actions
09/12/2016	09/12/2016	Generated Based On interRAI HC MD Assessment	No	Yes	View

For Enrolled Participants

The program of enrollment will be indicated in the Program Snapshot section of the Client Summary. However, the eligibility information above should be reviewed to ensure correct enrollment and determine any change in eligibility status at the annual redetermination.

Please see the spreadsheet below for a list of all services offered and the programs that offer them:

	CPAS	CFC	CO Waiver and ICS Program *
Personal Assistance Services	X	X	
Case Management/Supports Planning	X	X	
Nurse Monitoring	X	X	
Home Delivered Meals		X	
Environmental Assessments		X	
Environmental Adaptations		X	
Technology		X	
Personal Emergency Response Systems		X	
Consumer Training		X	
Transition Services		X	
Family Training			X
Nutritionist/Dietician			X
Assisted Living			X
Medical Day Care **			X
Behavioral Consultation **			X
Senior Center Plus **			X

* All CO waiver and ICS program participants are eligible for CFC services.

** These services are allowable in an Assisted Living Facility. All other services are not.

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Plan of Service Type

Pending Applicants

Prior to enrollment, supports planners should create an Initial plan of service for applicants from all programs (CO, ICS, CFC and CPAS). An initial plan is completed when all information about services and provider choices are known. Initial plans of service are completed for new community participants, registry applicants, and when a person leaves an institution.

A provisional Plan of Service is normally developed while a person is planning to leave an institution and not all information is known prior to discharge – specifically certain provider information. The Department may approve a provisional Plan of Service if all other requirements are met. A provisional plan is not required for a person living in the community if all information is known.

Once this provider information is known, the supports planner must convert the Plan of Service by editing the approved provisional Plan of Service and changing the Plan of Service type. An initial Plan of Service is completed when services are ready to begin and all information required in the Plan of Service is known.

Enrolled Participants

An annual Plan of Service must be completed at redetermination for all programs (CO, ICS, CFC and CPAS).

All previously approved plans of service (initial or annual) may be "revised" for future planned changes. This allows a certain amount of information to be pre-populated and edited which ensures consistency over time. Revisions are required when services or providers change or when a participant has a significant social or health change.

- Revised plans of service should include all services to be provided throughout the duration of the Plan of Service (from effective date through 52 weeks)
  - o If a one-time or short-term service has been approved on a POS, but not provided before a revised plan is needed (e.g., technology was approved but not purchased yet) that service should remain on the Plan of Service until completed
  - o If a one-time or short-term service has been approved on a POS and has been provided, the supports planner should remove it from the POS when submitting a revision or annual POS

Plan of Service Effective Date

Enter the proposed date that the Plan of Service is requested to be effective. When adding this date, ensure that there is enough time for the POS to be reviewed, clarification received, and then approved.

The following is recommended when requesting a date:

- For an annual POS, effective date should be set at the medical/technical redetermination date
- For an initial POS, set the effective date for date of discharge (if known, if not please estimate)
- For a revised POS, effective date should be set at the time services should take effect

o This date should be at least 2 weeks in the future at time of submission to ensure plan approval prior to service initiation

The effective date should be in the future unless otherwise directed by the Department. <u>A service should be not provided until it is listed on an approved Plan of Service and the participant has an active eligibility span to be in the program.</u>

It is the supports planner's responsibility to ensure that the POS is up to date and submitted timely. Any gaps in plans of service based on the SPA failure to submit timely will force a Corrective Action Plan and recoupment of funds. A support planner must not initiate services for a participant until after the Plan of Service has been approved by the Department and the participant is actively enrolled through an approved Authorization to Participate form. Please submit plans at least 2 weeks in advance of the requested effective date and communicate to the participant time frames for approval prior to service changes being implemented.

An urgent request for a Plan of Service approval may be submitted to the Department through the Urgent Priority Request in the Review section of the plan—please see page 35 for more information on this process. DO NOT instruct providers to call or email the POS Unit to check on the status of a plan. The Department is not authorized to release any participant information to a provider and is unable to update them. It is the supports planner's responsibility to monitor the status, communicate with the Department, and communicate with others.

Narrative
The narrative should include information relevant to the POS request that is not captured within another section of the plan of service. Do not copy and paste from other forms in the system as the duplication is unnecessary.

Recommended items to address:
- The reason for the submission of a revised plan
- Any services recommended on the Plan of Care that the applicant or participant has declined
- Durable Medical Equipment already owned by the applicant or participant
- Any informal supports that are involved and contributing to ADL, IADL, or health related needs
- The contact information for case managers from other programs
- Other factors relevant to the individual's health and safety needs

Address to Receive Services
When adding the address to receive services, choose the correct address type from the drop down box. The address and address type import from the information in the Address section of the Client Profile. If a Community Settings Questionnaire has not been completed for the chosen address to receive services, one can be completed by choosing "Add Community Settings Questionnaire" or by completing the questionnaire within the Community Settings Questionnaire section of the client's profile. A Community Settings Questionnaire should always be completed upon application, annually, and upon a change in residence.

If an applicant is currently residing in a Nursing Facility, the address to receive services should be a community address, not the address of the Nursing Facility. Provisional plans of service do not require an address to receive services.

Strengths

The purpose of this section is for the supports planner and participant to list the strengths identified during the person-centered planning process. Each supports planning agency will have a different way of working with participants to ensure services are self-directed and are meeting the needs of the participant.

Strengths should be unique and individualized for the participant. Supports planning agencies should not have prescribed or predetermined strengths for participants. Strengths should consider the entire person and their life outside of the Medicaid system. Areas to explore and consider with participants while identifying strengths include the following:

- Friendships
- Faith Communities
- Addictions or Recovery communities
- Employment
- Hobbies
- Arts and Talents
- Education
- Family Relationships

Examples of strengths include maintaining sobriety, mentoring youth, staying out of the hospital, being a good friend/singer/artist/parent, etc.

Again, strengths should be individualized and discovered through the person-centered planning process. Representatives and other supporters may help identify strengths and should be included in person-centered planning.

No standardized, non-specific strengths should be placed on plans. A single, unique strength related to the person is required but there is no limit on the number that may be included on the plan.

Goals

This section should include any short term and long term goals that the participant would like to achieve. After submitting a Plan of Service, these goals can be managed in the client profile so they can be kept up to date. Goals will pre-populate from the POS to the client profile; and vice versa when creating a revised or annual POS.

Each supports planner and participant should select a goal category they feel best fits the desired outcome. The following options are available when selecting a goal category:

- Education
- Family/Personal Life
- Social/Recreational

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- Health
- Employment
- Housing
- Other

When a goal has been achieved or discontinued it will no longer populate on the Plan of Service.

Risks

There are two ways risks will become part of a Plan of Service: through the assessment or through discussions with the participant and their representatives. These may be cited under each service requested, in the description section, as a rationale for why the service request (e.g., item, frequency, duration, etc.) is necessary.

The assessment automatically reviews parts of the assessment and identifies areas that may require additional follow-up or planning. These are called Clinical Assessment Protocols (CAPs) and are pre-populated on the Plan of Service (from the most recent assessment). Each CAP can be used to help interpret some of the information that has been collected through the assessment.

- Note that any risks that the participant disagrees with may be deleted from the Plan of Service.
- Each CAP that is triggered has a brief description on the Plan of Service.
- Additional information for each CAP is available under the Assessment Results page
  - Click the link for each CAP and a printable description of the problem, goals of service, and approach to working with a participant with the issue identified.

Any additional risks may be added, or deleted, as necessary.

Self-Direction

There are many levels of self-direction and the extent to which a participant "self-directs" varies. The CFC program regulations require that personal assistance provider agencies and their workers accept instruction from the participant or their representative and "Allow participants to have a significant role in the delivery of their specific care including: (a) Directing the services and supports identified in their plan of service; and (b) Exercising as much control as desired to select, train, schedule, determine duties, and dismiss the personal assistance worker in their home."

The Department collects information on how many participants have an active role in designing their service package as well as whether they are involved in the selection and training of their personal assistant provider. Supports planners should discuss with participants the opportunity for them to have a significant role in the delivery of their services and record their preferences in this section. Supports planners should also discuss the participant's expressed preferences for self-direction when communicating with providers.

Emergency Backup Plans

Each participant must have access to an alternate provider(s) in case of an emergency. At least one backup provider is required. Accurate contact information is vital.

Alternate personal assistance providers who do not have regularly scheduled hours of service with a participant may be placed in the emergency back-up section so that they may bill through ISAS, if and when called upon by the participant to provide services. Any enrolled provider who may provide personal assistance services to a participant must be listed on the approved plan of service in order to bill through ISAS

- If an agency is the sole provider of personal assistance, they may also be the primary backup
- Additional backups are recommended in case of long-term emergency needs.
- A Plan of Service modification is not required when a backup is used; only if the change is long term (greater than one week)
- Family members or other unpaid supports may be listed as the emergency backup (primary or alternate)
- Emergency backup providers should not be available via telephone only and should be available to respond in-person in case of an emergency situation
- Backups may be enrolled Medicaid providers
  - If so, they must bill for services using the ISAS call-in system. All Medicaid personal assistance providers should be aware of ISAS protocol when calling in
  - The provider may not bill for more than 12 hours of consecutive service except for participants who are pre-approved to receive the Daily Rate for Personal Assistance
- A Plan of Service will not be approved without at least one primary backup listed
- The primary backup's signature must be on the Plan of Service.

Services

This section is meant to collect a list of all services necessary to meet the needs of the participant. Note that only certain service types are available under the Medicaid programs and there may be limitations on these services per State and federal regulations. Please see each service, beginning on page 16, for general guidance and recommendations when selecting services.

All services should correspond to a functional need (ADL, IADL, or other diagnosis or condition) that is noted in the assessment or other supporting documentation.

Note that all services listed under the State Plan service category are approved and denied by other programs outside of the Department's Plan of Service Unit. The approval of a Plan of Service does not override the decision of the program responsible for providing that service.

* Note that all descriptions outlined in this manual are superseded by the Code of Maryland Regulations (COMAR).

Frequency Options

Each individual service has associated Frequency Types available. For example, service frequency types include Daily, Weekly, Monthly and Annual. The selection of a specific Frequency Type will drive the additional fields within the section as well as the maximum values allowable for each field. For example, if nurse monitoring was selected weekly, the user must specify the following: Days per week (max value is 7), How many weeks (max value is 52) and Rate (pre-populated based on current Medicaid rate). By inputting each individual component the LTSSMaryland system will calculate the Annual Cost field for that service.

Another unique feature related to Frequency Type for specific services is the ability to use the Daily Chart. When available, by clicking the checkbox for Use Daily Chart as seen in the figure below, the user will be able to enter the number of hours and minutes they plan to provide for each specific day in the week and LTSSMaryland will calculate the Hours per week for that service by taking the sum of all the hours for each individual day in the Daily Chart. Once again, there will be default and maximum values allowable based on the Frequency Type selected for the service.

Flexible Budget

Each participant is given a recommended flexible budget based on the needs identified through the assessment. The purpose of this process is to ensure that all participants are given an equitable allocation based on what is known about their ADL and IADL needs.

This assessment is completed prior to the development of the Plan of Service and generates a Resource Utilization Group (RUG) score. This RUG score is used to assign a recommended flexible budget based on need. The assessment uses statistically validated algorithms to assign clients to 1 of 23 resource utilization groups (RUGs). DHMH has assigned each RUG to one of seven groups and has developed a budget for each group based on a scale of needs. The recommended budget amount displays on the plan of service.

This recommended flexible budget is designed to give participants with similar needs a starting point for requesting the following services:

- Personal Assistance
- Home-Delivered Meals
- *Other* Items that Substitute for Human Assistance

Only the above services are included in the flexible budget. All other services are not included in the recommended flexible budget and should be completed based on guidance within this document. The cost of other services is calculated separately.

Any Plan of Service submitted above the flexible budget must include a completed exceptions request with an explanation to substantiate the need for services above the flexible budget.

The supports planner should gather documentation to support the exception request. Former level of service alone is not sufficient to justify additional hours of personal assistance. If there is no supporting documentation available or obtainable, note that in the overview so that the reviewer knows that there will not be any supporting documents obtained and why.

Examples of appropriate supporting documentation include assessment results, progress notes, rehabilitation notes, physical therapy progress notes, occupational therapy progress notes, speech therapy progress notes, nursing facility discharge summary, hospital discharge summary, rehabilitation stay discharge summary, or documentation of diagnosis not listed on the assessment. A letter from a physician indicating an individual needs a specified number of hours is not sufficient to demonstrate medical necessity.

Any supporting documentation must be uploaded into Client Attachments section of the LTSSMaryland tracking system.

Please note that the assessment and nurse monitoring visit documentation do not need to be uploaded or copied but can be referenced in the exceptions request.

Personal Assistance
Personal assistance services are offered under the CFC and CPAS programs. CO waiver and ICS participants are eligible for CFC personal assistance services if they are not residing in an assisted living facility. Personal assistance services include assistance with Activities of Daily Living, Instrumental Activities of Daily Living, delegated nursing tasks, tasks requiring judgment to protect an individual from harm, and/or the self-administration of treatments or remedies. Personal assistance services do not include assistance with skilled nursing tasks or non-delegated nursing tasks. The Department will review hours requested based on the recommended budget, the needs identified in the assessment and recommendations from the Local Health Department or assessor agency.

The number of personal assistance hours requested should correspond to functional needs (ADL, IADL, or other diagnosis or condition) that are noted in the assessment or submitted medical documentation.

Personal Assistance Hours Breakdown
Personal assistance hours can be entered using the daily chart or a weekly total of hours per provider.

If the plan is above the flexible budget, the daily chart should be used and additional information should be provided. Please see the Exceptions Request section below. .

Duration of a Plan of Service
All plans of service should be developed based on a full year of service, regardless of when redetermination dates are set.
- For example, if a Plan of Service will be effective February 1, all services should be planned from February 1 through January 31 of the following year (52 weeks).
  - An item or service should remain on the Plan of Service until it is purchased or completed. Once it has been provided, then it may be removed from the Plan of Service. This ensures that the date of service falls within an approved Plan of Service and all billing/claims should be processed accordingly.
- No service should be provided prior to both the approval of the Plan of Service and the effective date of program eligibility.
  - Providers are at risk of non-payment if the Plan of Service is not approved or eligibility is not attained on the date services were delivered.
- Cost neutrality for waiver participants is based on an annualized cost to the program.
- Developing a Plan of Service for a shorter term based on the redetermination date negates the Department's ability to analyze whether a Plan of Service is cost effective over time. Short term services should show limited frequency. For instance, a temporary increase in personal assistance should be shown as:
  - 60 hours of personal assistance for 8 weeks;
  - 40 hours of personal assistance for 44 weeks.

Previously approved hours, retrospective changes, or other shorter term changes should not be submitted as Plan of Service modifications. It is the responsibility of the supports planner to monitor

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usage of services (specifically personal assistance via the ISAS) to ensure services are received in accordance with the approved plan of service.

- Only a long term (greater than one week in duration and expected to continue) change should prompt a revised Plan of Service to request additional services.
- Temporary emergency situations (e.g., weather, temporary loss of provider) do not require a Plan of Service modification.
- Additional personal assistance hours may be used as respite, with the approval of the Department on a plan of service. Any temporary increase in hours for the purposes of respite or a planned absence of informal supports should be reflected on a revised plan of service.

Shared Personal Assistance

Shared personal assistance may be utilized when two participants are living together and choose to have the same independent personal assistance provider. This personal assistance provider will be paid 2/3 the rate for each person. This service allows a provider to clock-in and clock out just once with ISAS when serving two people in the same residence during the same hours.

- Each participant must have the same provider on their Plan of Service listed as a shared personal assistant provider.
- The duration and frequency must match on each Plan of Service.
- The shared rate can only be billed when both participants are present.

Each participant should also have the provider listed on the plans of service as an individual personal assistance provider for one week. This enables the shared provider to bill for non-shared services if needed.

For example, if John and Mary are sharing personal assistance for 40 hours per week, both John and Mary must have the shared provider on their POS for 40 hours per week for 51 weeks and then a second service line on each POS for personal assistance service (not shared) for 40 hours per week for 1 week.

POS Service	Service Type	Provider Name	Units	Frequency	Rate	Annual	Actions
Personal Assistance Agency	Community First Choice		16 hours per week	1 week	$4.2475	$271.84	Quick View
Comment:							
Personal Assistance — Shared Attendant	Community First Choice		16 hours per week	51 weeks	$2.8325	$9,245.28	Quick View
Comment:							

If John receives additional hours per week that are not shared, then those hours must be listed on a third service line separately on the plan for 52 weeks.

POS Service	Service Type	Provider Name	Units	Frequency	Rate	Annual	Actions
Personal Assistance Agency	Community First Choice		7 hours per week	52 weeks	$4.2475	$6,184.36	Quick View
Comment:							
Personal Assistance Agency	Community First Choice		16 hours per week	1 week	$4.2475	$271.84	Quick View
Comment:							
Personal Assistance — Shared Attendant	Community First Choice		16 hours per week	51 weeks	$2.8325	$9,245.28	Quick View
Comment:							

Daily Personal Assistance Service

If a participant has needs that require more than 12 hours per day of personal assistance the Department will pay a flat rate for each pre-authorized day of personal assistance over 12 hours. This service option is called Daily Personal Assistance and is available within the POS Service drop down.

The Daily Personal Assistance service will only be approved if it is medically necessary for an individual to receive more than 12 hours of personal assistance services on a specific day of the week. The plan should not specify a specific number of hours over 12 hours per day. The definition and scope of personal assistance tasks are not changed from hourly personal assistance, only the way it is reimbursed.

- The Daily Personal Assistance rate cannot be split between two different agencies on the same day. Only one agency can be approved and paid per day.
- Task schedules must be submitted to support the request for the Daily Personal Assistance Service.
- Daily Personal Assistance services must be preauthorized by the POS Unit—ISAS cannot approve Daily Personal Assistance hours even for temporary emergency situations.

Personal Assistance Services Emergency Policy

Plan of service revisions are not required for short term emergency needs of less than 7 days. Supports planners may request authorization for additional personal assistance services up to 12 hours per day by emailing mdh.ISAShelp@maryland.gov. The email should identify the reason for the emergency hours, along with the dates and total number of hours for the identified time period.

A revised plan of service must be submitted if the additional services are needed for longer than 1 week or if the Daily Personal Assistance Service rate is being requested. Requests for the Daily Personal Assistance Service must be requested in advance and can only be authorized by the POS Unit. The Urgent Priority request process can be used for emergency POS revisions.

Home-Delivered Meals

Home –delivered meals are a covered service under CFC as an item that substitutes for human assistance and are not intended to supplement a participant's grocery budget. Each meal is delivered to the participant's home, which includes the cost of the food, food preparation, and delivery. This service may not constitute the participant's full nutritional regimen of three meals per day and cannot replace the purchase of groceries.

A home-delivered meal should not overlap with personal assistance. Personal assistance services include assistance with IADLS, which by definition include meal preparation. 10.09.84.02.B (18) "Instrumental activities of daily living (IADLs)" means tasks or activities that include, but are not limited to: (a) Preparing meals; "

As such, an individual should only have one of these services at any given time. In some circumstances, these may both occur in the same day. For instance, if the personal assistant works from 8am – 10am, a home delivered meal may be needed for lunch and/or dinner, when no personal assistance provider is available.

- The supports planner and participant should take into consideration meals that may require additional preparation beyond the ability of the participant (such as the use of an oven/microwave). While these types of meals may be appropriate for certain participants, others may require alternative cold meals.
- Participants with limited mobility may utilize items that substitute for human assistance (technology or adaptations) to ensure delivery of meals.
  - o Items such as lockboxes so a provider may access a key to enter, keypads for a door lock, or intercom with automatic door locks may be covered based on the needs of the participant.

Additional guidance:

- Home-delivered meals may not exceed 2 meals per day, 7 days per week.
- Each meal is intended for consumption at home.
- The participant should be able to consume the meal.

This service is not available to CPAS participants or CO waiver and ICS participants who are not eligible for CFC, i.e. are assisted living residents.

Other Items that Substitute for Human Assistance

The Community First Choice program covers items that substitute for human assistance and reduces a participant's dependence on another person for complete of covered ADL or IASL tasks. Certain items that substitute for human assistance have been pre-authorized by CMS and are included in their own service categories for the purpose of the Plan of Service. These items are home-delivered meals, environmental assessments, environmental adaptations, and technology. This category of "other items that substitute for human assistance" should include only items that are <u>not</u> covered under those other categories.

Potential items that substitute for human assistance, that are not covered under another service definition, will be considered on a case-by-case basis in conjunction with the full Plan of Service. Potential items that substitute for human assistance are service animal, delivery services, or other non-medical in-home services.

Other items that substitute for human assistance *do not* include:

- Items that were determined not medically necessary under another coverage category.
- For example, it does not include durable medical equipment determined not necessary by the DME program. Items may not be for recreational items such as televisions, gaming systems, DVD players, cable television access, or other luxury items outside of the basic essentials.

These services are not available to CPAS participants.

Community First Choice Services

Personal Assistance
See flexible budget section.

Home-Delivered Meals
See flexible budget section.

Consumer Training
Consumer training is designed to offer training to the participant on the acquisition, maintenance and enhancement of skills necessary to perform ADLs, IADLs, and Health Related Tasks. The topics covered by consumer training may include, but are not limited to:

- Money management and budgeting,

- Independent living, and
- Meal planning.

These activities are to be targeted to the individualized needs of the participant receiving the training; and sensitive of the educational background, culture, and general environment of the participant receiving the training. Consumer training will be provided by an approved Medicaid provider. These services are not intended to duplicate or supplement personal assistance hours or prescribed occupational, physical, or rehabilitative therapies. Consumer training to should relate to the person's identified goals. Progress milestones and expected outcomes should be included in the service detail on the plan.

This service is not available to CPAS participants or assisted living residents.

Environmental Assessment

An assessment of the person's home may be completed upon request to identify improvements to make the house functional and safe for the participant.

The assessment may be necessary to:

- Ensure the health and safety of a participant; and
- Obtain additional professional advice from an occupational therapist about the:
    - Physical structure of a participant's home or residence;
    - Functional abilities of a participant and barriers in the home environment; and
    - Recommendations for adaptive equipment or structural modifications needed for the participant to achieve the desired level of independence.

Recommendations and findings should be uploaded to the client attachment portion of the LTSSMaryland system. Additionally, pictures should be uploaded to further support the recommendations.

This service may not be provided prior to the effective date of the participant's eligibility for services.

This service is not available to CPAS participants or assisted living residents.

Environmental Adaptations

Prior to submitting a request for an environmental adaptation, an environmental assessment should be performed by an Occupational Therapist. Multiple quotes/bids are required for any purchase exceeding $1,000. There is a combined limit for this service of $15,000 over three years when combined with technology. There are no limitations on the number of homes in which adaptations may be received per participant.

If the adaptation is for a rental property, the request must be accompanied by a signed letter from the landlord that states that the adaptation is allowed in the residence and the participant may live there for at least one year. Please note that there is no Medicaid-funded resource to pay for the removal of adaptations or equipment after a renter leaves. Letters from landlords that include a requirement to

remove them should be discussed carefully with the participant as there is no financial assistance available for the removal or storage of adaptive equipment.

Adaptations should be itemized with a description and should include, when applicable, the model number, item number, and manufacturer as well as any size or measurements that may be pertinent. Documentation should be uploaded to the Other section of the Client Attachment portion of the LTSSMaryland system.

These items may include:

- Automatic door opener
- Grab bar
- Ramp
- Stair glide or lift
- Widening Doorways
- Internal railing
- Roll-under sink
- No-step shower entry

Adaptations may not include adaptations that:

- Are of general maintenance, such as carpeting, roof repair, and central air conditioning
- Are not of direct medical or remedial benefit to the participant;
- Add to the home's total square footage
- Modify the exterior of the home, other than the items specified in regulation

This service is not available to CPAS participants or assisted living residents.

Technology

Technology includes non-experimental technology or adaptive equipment, excluding service animals, which enables a participant to live in the community and to participate in community activities. This service is not covered under the CPAS program.

Many items that are medically necessary and require a physician's order, otherwise considered technology, may be covered under Medicaid's DMS/DME program. Items not listed under the DMS/DME formulary may be covered under the CFC program if it substitutes for human assistance and is supported by program regulations.

However, items that have been determined not medically necessary by the DMS/DME program are not allowable as technology. Additionally, any repair to an item covered under DMS/DME must be submitted to that program (whether purchased by the Department or another program). Supports planners must check the DMS/DME coverage list to determine if the item is covered under another program prior to submitting a request for technology. The list can be found here. https://mmcp.dhmh.maryland.gov/communitysupport/SitePages/approvedlist.aspx. The list is also available in the Supports Planning Resource Guide online.

All technology should be itemized with a description and should include, when applicable, the model number, item number and manufacturer as well as any size or measurements that may be pertinent. Documentation should be uploaded to the client attachment portion of the LTSSMaryland system.

Options within the LTSS system include, but are not limited to:

- Audio Devices for the Blind
- Communication Devices
- Over the bed table
- Reacher
- Security Feature (lockbox/keypad)
- Software
- Water Temperature Gauge
- Other

Technology must:

- Prevent the participant's institutionalization;
- Ensure the participant's health, safety, and independence; and
- Specifically relate to ADLs or IADLs within the approved Plan of Service;

Some examples of technology:

- A specialized talking locked pill box that issues medication reminders during non-staffed hours. The machine can be set to assist when supports are not available.
- A lockbox or keypad on the front door enables a provider (e.g., personal assistant, home-delivered meals, etc.) to enter the residence without requiring someone to open the door.
  - This eliminates the need for formal/informal supports to be available at all times when services are being delivered or when a provider is going to arrive.

Supporting documentation or references to the assessment, or recommended Plan of Care completed by the Local Health Department, may be necessary to support the approval of technology. A reason or rationale why other DMS/DME is not being requested may be appropriate depending on the item.

Finally, multiple quotes/bids are required for any purchase exceeding $1,000. There is a joint limit for this service of $15,000 over three years when combined with accessibility adaptations.

An additional resource available to participants is the Maryland Department of Disabilities Technology Assistance Program (MDTAP). More information about how technology can support participants in their homes can be found at:

http://www.mdod.maryland.gov/mdtap/Pages/MDTAP-Home.aspx

Nutritional supplements, gloves and wipes are not an allowable expenditure under technology and must be requested under DMS/DME.

This service is not available to CPAS participants or assisted living facility residents.

Nurse Monitoring

Nurse monitoring is a service associated with the quality oversight of personal assistance services. Only participants receiving personal assistance receive nurse monitoring services. All plans that include personal assistance services must include Nurse Monitoring in order to be approved. The frequency of visits should be based on recommendations from the Local Health Department nurse. Only local health departments (LHDs) may provide nurse monitoring services under CFC.

Nurse monitoring may be waived by the participant down to two visits per year. Monthly visits are not required by the program. If nurse monitoring is waived, the LHD will remain on the Plan of Service however contact should occur every six (6) months: one nurse monitoring visit and one annual evaluation.

- Within the description of the service, please note the service was waived and upload the appropriate signed waiver form to the client attachment section of the LTSSMaryland system.
- When waived, Nurse Monitoring should be entered on the plan of service with 6 hours projected annually.

A participant residing in an assisted living facility is not eligible for nurse monitoring. A participant living in the community but not receiving personal assistance services is also not eligible for Nurse Monitoring. Nurse monitoring does not include skilled nursing tasks. If skilled nursing services are required, they must be provided by another program.

Personal Emergency Response Systems (PERS) Purchase and Monitoring

The initial purchase and installation of PERS is available to participants who live alone or may be alone for extended periods of time and do not have the reliable use of a cell phone.

A personal emergency response system is an electronic device or system which enables a participant to secure help in an emergency and may include, but is not limited to:

- A device connected to the participant's telephone or other device and programmed to signal, upon activation of a help button, a response center with properly trained staff on duty 24 hours a day, 7 days a week;
- A portable help button to allow for the participant's mobility; and
- A motion detector when necessary for the participant's safety.

CFC regulations limit the use of the PERS as follows in COMAR 10.09.84.23 Limitations.
A. Reimbursement for Personal Emergency Response System is limited to participants who:
(1) Live alone; or
(2) Have no regular caregiver for extended parts of the day and would otherwise require extensive routine supervision to ensure the participant's health and safety.

Extended parts of the day will be considered on a case by case basis during the POS review process. How the participant meets the criteria for this service should be noted in the details of the service on the POS.

This service is not available to CPAS participants or assisted living residents.

Supports Planning

Supports planning services are offered to all participants in the Community Options, CFC, ICS, and CPAS programs. Based on discussions with the participant, the supports planner should estimate the amount of time and frequency they will need to be involved with the participant. This will generally fluctuate throughout the year based on individual circumstances (e.g., transition, redetermination, provider changes, etc.).

Note that one monthly contact and one quarterly visit must be completed for all participants.

While participant needs may differ, the Department recommends:

- 20 hours per year for participants currently enrolled and living in an assisted living (80 units).
- 3 hours per month for currently enrolled participants (144 units).
- 6 hours per month for pending applicants (288 units).

If hours requested are expected to exceed those recommended above, a description of the need should be provided. If the supports planner consistently exceeds the number of hours recommended by the Department, a modification to the Plan of Service must be submitted with justification for the additional hours of service.

Supports planning cannot be the only CFC service received by a participant. A plan of service with only supports planning listed will not be approved.

A participant may waive supports planning, however, it is important that individuals enrolled in the waiver, but who receive all of their services through the CFC program, must have at least one waiver service per month in order to maintain CFC eligibility.

If supports planning is waived, the supports planner will remain on the Plan of Service. However contact will not be necessary except for program redetermination and eligibility checks.

- Within the description of the service, please note the service was waived and upload the appropriate signed waiver form to the client attachment section of the LTSSMaryland system.
- The supports planner must complete one activity monthly for each waiver participant (i.e., provide at least one Waiver Eligibility activity).
  - This is not required for CFC or CPAS participants.

Transition Services

Transition services are available for a participant when they are moving from an institution to the community or from an Assisted Living facility to a private residence. These services cover goods and services essential to transition. Transition services can be spent up to 60 days post transition.

Transition services may be used for participants discharging from a nursing facility to a home or residence or from an assisted living facility to a home or residence. Funds may not be used for participants who are moving from a nursing facility to an assisted living.

When requesting transitions funds on the plan, the name and quantity of the items along with a total estimated cost should be listed.

Transition services may include funds to/for:

- Obtain Housing (e.g., security deposit)
- Secure essential utilities (e.g., installation/setup fees)
- Basic furniture
- Small appliances or other approved appliances (e.g., a microwave)
- Essential personal or household items
    - Personal items such as soap, toilet paper, etc.
    - Household items such as sheets, dishes, towels, etc.
- Transition-related transportation

Transition services may not pay for:

- Food,
- Rent, or
- Recreational items such as televisions, gaming systems, DVD players, cable television access, or other luxury items outside of the basic essentials.

Over the bed tables, reachers, ramps and other items that substitute for human assistance should be listed under the appropriate Technology or Environmental Adaptation sub-headings.

This service is not available to CPAS participants.

Flexible Funds
Flexible funds are offered through the MFP demonstration and administered by transitional supports planners to further address barriers to transition. This MFP supplemental service includes funds for groceries, transportation, and other needed items that could not otherwise be funded by Medicaid. While the funds are designed to cover a wide array of goods and services needed at the time of transition, they have primarily been used to pay for groceries.

This service includes up to $700 in flexible funds to pay for an initial supply of groceries when they transition, for transportation that will allow an individual to attend housing interviews and run errands related to the transition and to allow provision of needed goods or services that are not otherwise available.

This service is only available to MFP participants. If the request is for items that are allowable under transition funds (such as security deposit, utility hook-up, etc.), flex funds cannot be used unless transition funds have been exhausted. Flex funds must be expended within 60 days of transition.

Community Options Waiver and ICS Program Services

The following services are only offered to participants enrolled in the CO Waiver or ICS program. These participants are also eligible for certain CFC and State Plan services.

Assisted Living

Assisted living is a service offered instead of personal assistance. These two services may never occur on the same day and will rarely be on the same Plan of Service unless the participant is moving. The assisted living facility determines the level of services they will provide based on a medical assessment (level 2 or 3). The participant and the assisted living must agree whether the participant will attend Adult Medical Day Care as part of their Plan of Service.

- If Assisted Living with Adult Medical Day Care (AMDC) is selected, you must also add Medical Day Care in the Plan of Service and indicate the number of days AMDC will be attended.
    - o The number of days attending Medical Day Care should equal the number of days of Assisted Living with AMDC.
    - o For days in which the person will not attend Medical Day Care should be listed as Assisted Living without AMDC.
    - o For instance, if the person lives in an assisted living seven days per week and attends Medical Day Care five days per week, the Plan of Service should list:
        - ▪ 5 days per week Assisted Living with AMDC,
        - ▪ 5 days per week Medical Day Care, and
        - ▪ 2 days per week Assisted Living without Adult Medical Day Care.
- Services offered outside of the bundled rate include allowable for participants residing in an assisted living are:
    - o Medical Day Care
    - o Behavioral Health Consultation
    - o Senior Center Plus

Since assisted living facilities are paid a bundled rate, many services are *not offered* individually at the time the participant is living in the assisted living (they will be duplicative). The services not offered include:

- Nurse monitoring,
- Personal assistance services,
- Home-delivered meals,
- Environmental assessment and adaptations,
- Technology,
- PERS installation and/or monitoring,
- Dietitian and nutritionist services,
- Consumer Training, and
- Family Training.

This service is only available to those participants enrolled in the CO Waiver or ICS program.

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Temporary Respite (Assisted Living and Nursing Facility)

Temporary respite may be provided by an assisted living facility and/or nursing facility (up to 14 days annually). Please follow these instructions when adding this service:

- Under the services drop down, select "Other."
- Under Item Description state "Assisted Living – Respite"
- Choose frequency type "monthly" and include number of days, 1 month and rate ($72.05).
- Select the appropriate Medicaid Assisted Living Facility under the provider search.
- Under the description, add why the temporary move is planned as well as the dates in which the person will reside in that facility.

Note that these settings are only allowable for participants in the CO Waiver or ICS program. CFC and CPAS participants are not eligible for this service.

Behavioral Health Consultation

These services are mainly offered when behavior is:

- Potentially dangerous to the participant's or another person's health and functioning; or
- Placing the participant at risk of institutionalization due to health and safety concerns.

The service includes a:

- Home visit by an individual qualified to render services to:
  - Evaluate a participant's behavior;
  - Assess the situation;
  - Determine the contributing factors; and
  - Recommend interventions and treatments;
- Written report with the results of the provider's assessment and recommendations to be reviewed by the participant, the participant's representative and family when applicable, and the participant's case manager and caregivers, which may include an assisted living provider; and
- Verbal review of the report with the participant, the participant's representative and family when applicable, and the participant's case manager and caregivers, which may include an assisted living provider, to discuss:
  - The report's findings and recommendations; and
  - A course of action, including any related needed medical interventions.

This service is only available to those participants enrolled in the CO Waiver or ICS program.

Dietitian and Nutritionist Services

The service includes nutrition care planning, nutrition assessment, and dietetic instruction. The service is approved when:

- The participant's medical condition requires the judgment, knowledge, and skills of a licensed nutritionist or licensed dietitian;
- Targeted to the individualized needs of the participant, rather than being of general interest;
- Specified in the participant's Plan of Service as necessary to:
  - Ensure the participant's health and safety; and
  - Prevent the participant's institutionalization or hospitalization.

The service is not provided to participants residing in an assisted living facility.

This service is only available to those participants enrolled in the CO Waiver or ICS program.

Family Training

Training and counseling services are available as needed for family members. For this service, "family" is defined as the person/s who lives with or provides support to a waiver participant, and may include a parent, spouse, children, relatives, foster family, in-laws, or other unpaid caregivers. Family does not include individuals who are paid to serve the participant. This service is provided on a one-on-one basis with the family member. The training targets the individualized needs of the participant, rather than providing information that is of general interest.

Family training may include:
- Instruction on treatment regimens and dementia;
- Use of equipment specified in the Plan of Service;
- Other issues; or
- Follow-up training as authorized.

This training may not be provided to participants residing in an assisted living facility.

This service is only available to those participants enrolled in the CO Waiver or ICS program.

Medical Day Care

This service is only available to those participants enrolled in the CO Waiver, ICS program, or the Medical Day Care (MDC) Waiver. It is not available to CFC only participants unless they are also enrolled in the MDC waiver.

If a CFC or CPAS participant wants to attend a Medical Day Care facility, they must apply to and enroll in the Medical Day Care Waiver separately. It is the supports planner's responsibility to ensure enrollment in the MDC waiver. The special program code will be displayed in the eligibility information section. If the person does not have an active/open MDC span and the person is not enrolled in CO or ICS, then the person is not eligible for the service. Placing MDC on the POS, even if approved, will not equate to eligibility for the participant without the proper application and special program codes.

This service may not overlap with personal assistance hours. If these services are combined, a description of days of the week with expected attendance should be included. The daily frequency chart may be helpful to easily display when each service is being provided. Additional information may be included in the comments or detailed in a task schedule.

Please see the guidance under assisted living for when a person will attend Medical Day Care while in the assisted living facility.

Senior Center Plus

This service may not overlap Medical Day Care on the same day. If these services are combined, a description of days of the week with expected attendance should be included.

There is a minimum age limit on this service that varies by provider. Supports planners should check with providers regarding their age requirements and availability prior to listing them on the participant's Plan of Service.

One day of attendance means at least 4 hours of service, not including transportation to and from the center. The services provided include a program of structured group recreational activities, supervised care, assistance with activities of daily living and instrumental activities of daily living, and enhanced socialization provided in an out-of-home, outpatient setting. Social and recreational activities designed for elderly, disabled individuals, as well as one nutritious meal shall be available within the center's confines.

As this service includes the provision of a meal, home-delivered meals may not be provided for the meal during which the person is at the Senior Center Plus program. Any co-occurrence of home-delivered meals and Senior Center Plus should be explained in comments or reflected in the daily service chart to assure that there is no duplication of services.

Please note that this service is not associated with Senior Care or a regular Senior Center. This is a specific Medicaid service paid for under the waiver. Information regarding similar programs may be listed under the "other" service and should note days/times the person regularly attends.

This service is only available to those participants enrolled in the CO Waiver or ICS program.

State Plan and Other Services

Each service listed under this section has its own eligibility criteria and the appropriate program within the Department should be contacted. For example, for durable medical equipment, the DMS/DME unit should be contacted directly. Signatures for these services are not required because they are not covered under the CO, ICS, CFC or CPAS programs. These services are included in the plan to provide a holistic view of the services a participant receives, regardless of funding source, to ensure coordination of services, and to estimate cost neutrality when applicable.

The Department's Plan of Service Unit is not responsible for the approval or denial of any of the services listed in this section. An approved plan of service does not equate to an entitlement to or Departmental approval of these services.

Dentist Visit

This is a service that may be offered through a participant's managed care organizations (if applicable) and should include a general estimate of the frequency in which it will occur. Rate and provider may be

left blank unless otherwise known. If a person is not eligible for managed care, alternate resources such as a dental clinic or dental school program may be included to demonstrate that the need is met.

Dialysis

This is a State Plan service and should include a general estimate of the frequency in which it will occur. Rate and provider may be left blank unless otherwise known.

Disposable Medical Supplies and Durable Medical Equipment (DMS/DME)

These are State Plan services that are offered by a different program under the Department's Division of Community Support Services (DMS/DME unit). Please review the list of DMS/DME allowable at: https://mmcp.dhmh.maryland.gov/communitysupport/SitePages/approvedlist.aspx

While these items should be included in the Plan of Service, approval of an item is contingent on the Medicaid's DMS/DME unit. Certain limitations may exist based on the approved list of covered items. Additional items will not be covered in excess of the DMS/DME approval.

Since this service is not approved by the CO, ICS, CFC or CPAS programs, a provider name is not required on the Plan of Service, however any known costs for items should be included. These costs do count towards cost neutrality for waiver participants.

If an item is determined by the DMS/DME unit to be not medically necessary, or not coverable due to service limitations, the item will not be covered under the CFC program. As part of the POS Unit review, staff will review denials made by the DMS/DME unit based on medical necessity. The POS unit will also verify that needed DMS/DME items are listed on the plan as required to demonstrate that a participant's health and safety needs are met.

The Department's Plan of Service Unit will review items not covered under the formulary separately.

Mental Health Services

This is a State Plan service and should include a description of the service and a general estimate of the frequency in which it will occur. Rate and provider may be left blank unless otherwise known. For additional resources, please contact the local Core Service Agency. If these services are recommended on a Plan of Care, but declined by the applicant or participant, this should be noted in the narrative on the plan.

Occupational Therapy

This is a State Plan service and should include a general estimate of the frequency in which it will occur. Rate and provider may be left blank unless otherwise known. This service is covered only for children under the State Plan and through REM. Certain exceptions apply for those participants in a hospital or in the Home Health program.

Other

Any service not covered by the waiver, ICS, CFC or CPAS may be listed here. Provider name, rate and frequency may be left blank. This is mainly used for informational purposes but should include pertinent services that will help encompass the entirety of services being provided to the participant.

Please see the Temporary Respite section for instructions on how to add this particular service in the "other" category.

Physical Therapy

This is a State Plan service and should include a general estimate of the frequency in which it will occur. Rate and provider may be left blank unless otherwise known.

Physician Visit

This is a State Plan service and should include a general estimate of the frequency in which it will occur. Rate and provider may be left blank unless otherwise known.

Skilled Nursing

This is a State Plan service available for certain participants and should include the frequency in which it will occur. Rate and provider may be left blank unless otherwise known. Since this is a high cost service, please include a description of the service as it may affect a waiver participant's cost neutrality.

This is a limited benefit offered under EPSDT for children and for adults in REM or Model Waiver. It is also offered through the Home Health benefit, which is a short term, post-acute service. This is not a covered service under the CO waiver, CFC, CPAS, and ICS program.

This service should be described in as much detail as possible, including a daily schedule, as it should not overlap with personal assistance services. These services must be carefully coordinated to ensure needs are met but that services and hours are not duplicated. Coordination with other coordinators will be required and documentation about these services should be uploaded under Medical Documentation in the Client Attachments section. Nursing Care Plans, task schedules, and other service information should be included as applicable. Any denial of skilled nursing should also be included.

Speech Therapy

This is a State Plan service and should include a general estimate of the frequency in which it will occur. Rate and provider may be left blank unless otherwise known. This service is covered only for children under the State Plan and through REM. Certain exceptions apply for those participants in a hospital or in the Home Health program.

Substance Use Disorder Services

Any Substance Use Disorder (SUD) services and/or supports such as peer support groups like AA or NA should be listed here. SUD services are a State Plan service and should include a general estimate of the frequency in which it will occur. Rate and provider may be left blank unless otherwise known. If these services are recommended on a Plan of Care, but declined by the applicant or participant, this should be noted on the plan.

Transportation

Non-emergency medical transportation is a State Plan service that covers transportation to approved medical services and should include a general estimate of the frequency in which it will occur. Rate and provider may be left blank unless otherwise known.

Medicaid does not pay for transportation to non-medical, recreational activities.

Exceptions Request

If services are requested above the flexible budget, the exceptions request section of the Plan of Service must be completed. The exceptions request should clearly identify the service requested, if the request is temporary, why these services are being requested, and identify any supporting documentation provided. The Supports Planner should gather and upload documentation to support the request for services over the flexible budget. Medical documentation provided should be objective and related to the participant's functional status or chronic health needs.

Examples of supporting documentation include:

- Task schedules
- Clinical progress notes
- Rehabilitation notes
- Physical, Occupational or Speech therapy progress notes
- Nursing facility or rehabilitation discharge summary
- Hospital stay progress notes
- Documentation of a diagnosis not listed on the assessment
- Physician notes documenting an upcoming procedure requiring a temporary increase in services

Supporting documentation does not include the assessment, Local Health Department notes or other documentation already collected within the LTSSMaryland tracking system. This information is considered as part of the plan of service review process and should not be copied into the Exceptions Request.

If there is no supporting documentation available or obtainable, the supports planner should note this on the plan in the Exceptions Request.

A letter from a physician indicating an individual needs a specified number of hours per day is not sufficient to prove medical necessity for program services. Medical documentation should specifically describe the participant's functional status or chronic health needs.

Task Schedules

If the plan is above the flexible budget, or if the participant is regularly involved in other Medicaid funded programs or community services, the supports planner should submit a schedule including the tasks that the personal assistance services provider will perform. This schedule should include all regularly scheduled services and activities.

Task schedules should identify the ADL, delegated nursing task, or IADL tasks that the personal assistance services are intended to provide and the duration for each task. Please include a reference to any service or support (formal or informal) that may be occurring in conjunction with the personal assistance services.

Task schedules should be submitted in the form of a weekly schedule, Sunday through Saturday, and are required in the following situations:

- When the applicant/participant is attending school
- When the applicant/participant is attending Medical Day Care
- When the applicant/participant is receiving services from multiple Medicaid funded programs, i.e. Medical Day Care Waiver, REM, Community Pathways Waiver, Autism Waiver, physical therapy, occupational therapy, dialysis, etc.
- At the request of the POS reviewer

Signatures

The participant and all providers responsible for implementing the Plan of Service must sign the Plan of Service according to the Federal CFC regulation. This confirms the agreement that services will be provided in the approved frequencies. These signatures should be captured on paper and kept on file by the supports planning agency. Audits will be conducted to ensure signatures have actually been captured.

At a minimum, the following signatures are required by the Department when approving a provisional Plan of Service:

- Participant
- Supports Planner
- LHD Nurse Monitor

At a minimum, the following signatures are required by the Department when approving an initial or annual Plan of Service:

- Participant
- Supports Planner
- Personal Assistance provider(s)
- LHD Nurse Monitor

Please note the following:

- The participant's signature on the plan of service indicates their agreement with the plan. If they don't agree, they should not sign.
- Participants under the age of 18 should not sign their plan of service. Their legal guardian must sign on their behalf.
- Participants with a legal guardian of the person usually need the guardian to sign the plan. Supports planners should inquire about the guardianship court order to determine specific guardian responsibilities. More information on guardianship and Maryland law can be found here. http://digitalcommons.law.umaryland.edu/cgi/viewcontent.cgi?article=2162&context=fac_pubs
- Signatures from provider agencies must list the name of the individual signing on the agency's behalf.

- While not required at the time of approval, it is highly recommended that the signature of the emergency backup provider and any agency-based nurse monitor are included in the Plan of Service.
- If signature of personal assistance provider has not yet been collected, e-mail verification between the Department and the supports planner may suffice that contact and agreement has been made with the personal assistant provider. However, signature must be gathered as soon as possible.
- If nurse monitoring will be conducted by the Local Health Department, a signature will be required.
- Signatures for State Plan services are not required.

Participant Signature

The participant's signature on the plan of service indicates their agreement with the plan. If they do not agree, they should not sign. DO NOT coerce a participant into signing a plan of service with which they do not agree. Forcing a participant to sign a plan that they do not accept denies them their appeal rights. The Department cannot process appeals for approved plans of service as the Department did not deny any service.

Refusing to sign any plan of service could result in a technical denial.

Review

This section and all supporting documentation should be reviewed prior to submission. The section auto-populates certain answers but requires the supports planner, and their lead, to check to ensure that the plan of service meets the participant's health and safety needs and all other requirements.

Once the supports planner submits a Plan of Service, the Lead at that supports planning agency should repeat the review. The lead/supervisor may use the "request clarification" button to enable editing by the original supports planner and correct any errors or issues with the plan prior to submission to the Department. Otherwise, they may submit to the Department.

Urgent Priority Request

If a plan is in need of an urgent decision, the supports planner can request an urgent priority review within the Review section of the Plan of Service. By selecting the "Add Priority Request" button, a box will appear where the supports planner should identify the reason for the urgent priority request. Once the plan of service is submitted to the Department the assigned Plan of Service Unit staff will review the plan within 2 business days. Once reviewed, the Plan of Service Unit staff will set the priority as either urgent or normal. If the request is determined to be urgent the review of the plan will be expedited. All supporting documentation related to the request must be submitted at the time of the request.

Examples of urgent reasons include:

- A change in provider based on a Reportable Event (provider quit, was fired, was negligent, etc.)
- Involuntary discharge from an institution
- Hospital discharge

- Enrollment into CPAS after losing NF LOC.

Examples that are not considered urgent:

- Routine nursing facility discharges
- Checking the status on a previously submitted plan
- Plans not submitted timely
- Provider changes that do not impact health and safety.

Plan of Service Unit Staff

Plan of Service staff will receive an alert in the LTSSMaryland system when a Plan of Service is submitted. When an alert is received, the participant record will also be listed in their My List.

Review Steps

Initially, Plan of Service Unit staff will review the assessment, recommended plan of care, and the Plan of Service for completion.

All plans of service are reviewed to assure the Plan of Service includes appropriate waiver, State Plan, community and other services to meet the participant's needs. The following information is reviewed:

- Assessment.
- Recommended plan of care.
- Level of care (LOC) required for the program.
- Services provided by other Medicaid programs.
- Any denial of medical necessity for a particular item/service (e.g., DMS/DME)
- Services requested and justification.
- Both Medicaid and non-Medicaid services meet health and safety requirements for the participant.
- Emergency backup section is complete.
- Signatures for the participant and all required providers are captured.
- Exception request (if applicable) is completed with rationale and documentation.
- Cost effectiveness of the Plan of Service.
  - Cost neutrality figures are not exceeded; the following symbols will appear when cost neutrality is not met: Over 100% or Over 125% .

Department Plan of Service Clarifications and Decisions

The Department may not have enough information to make a determination of the Plan of Service without additional documentation or information from the supports planner. The POS Unit Staff may contact the supports planner or "request clarification" within the LTSSMaryland system. By doing so, a comment will be sent to the supports planner to answer additional questions or provide more documentation. This will also allow the supports planner to upload additional documentation, answer specific questions, provide insight or information, and edit the Plan of Service prior to re-submitting.

The Department may deny a Plan of Service.

Appeal rights are given to all participants if their Plan of Service is denied. All denials may be appealed within 10 days in order for current service levels to remain in place; however appeals will be accepted until 90 days after denial.

Plan of Service Approval

Any time that a provisional POS is approved, the plan must be converted to an initial POS prior to enrollment in the CO waiver, ICS, CFC, or CPAS.

When a provisional POS is approved for a CO waiver or ICS applicant, the Advisory Authorization to Participate (ATP) form should be completed. When an initial POS is approved for a CO waiver or ICS applicant who has transitioned into the community, an Authorization ATP form should be submitted.

After the approval of a CFC or CPAS initial POS, the CFC or CPAS Authorization ATP form should be completed. Services may not begin until the approval of the Authorization ATP form and the assignment of an enrollment date by the Department.

ATP forms should not be submitted upon the approval of revised or initial plans. Services for enrolled participants approved on a revised or annual POS should begin on the POS effective date.

Service Notification Form

The Community Options Service Notification Form for personal assistance must be completed upon personal assistance service initiation, revision or termination. This form should be completed for CO waiver, ICS, CFC, and CPAS participants. The form should be completed by the assigned Supports Planner and sent to the personal assistance provider agency affected by the change in the participant's services.

The date that the form is sent to the personal assistance provider agency should be listed on the form, along with the date that the service initiation, revision or termination should take place. If the form is to notify the personal assistance provider agency of an initiation or a revision of services, a copy of the approved POS should be attached. If the form is to notify the personal assistance provider of a temporary revision of services, this should be noted on the form along with the date those temporary services should end.

The Service Notification form should be uploaded into the client attachments section of the client profile.

Appendix A – Coverage Groups

Adults

♦A02 Adults up to 65, no Medicare; up to 138% FPL
♦A03 Parents and Caretaker Relatives who meet Adult standard (<65, no Medicare); 124%--138% FPL
♦A04 Disabled adults, no Medicare, up to 77% FPL (not newly eligible)

No spend-down for newly eligible adults.

Parents & Primary Caretakers

♦F05 Parents/Primary Caretakers, any age, Medicare permitted, up to 123% FPL

F99 Medically Needy with Spend-down: Parents & Primary Caretakers or Children.

Children

♦P06 Newborns of Eligible Mothers and children under 1 year old
♦P07 Children 1 up to 19
   1 up to 6 years old, 143% FPL
   6 up to 19 years old, 138% FPL
♦F98 Children 19 & 20 years old, up to 123% FPL
♦P13 Title XXI MCHP, Child 1 up to 19 years old, up to 189% FPL
♦P14 Title XXI MCHP, Child under 19 years old, 190 – 211% FPL

Transitional Medical Assistance

♦†F02 Post-TCA parents/children: earnings
♦†F03 Post-TCA parents/children: alimony

Maryland Children's Health Program (MCHP) Premium

♦D02 MCHP Premium, 212 - 264% FPL
♦D04 MCHP Premium, 265 - 322% FPL

Pregnant Women

♦P02 Pregnant Women up to 189% FPL
♦P11 Pregnant Women 190% – 264% FPL
#P10 Family Planning Program services only

Hospital Presumptive Eligibility (HPE)

#C13M MAGI groups (excluding Pregnant Women)
#C13P Pregnant Women

Foster Care & Subsidized Adoptions

♦†E01 IV-E or SSI, Foster Care or Subsidized Adoptions
♦†E02 Non-IV-e, Foster Care or Special Needs Subsidized Adoption & Subsidized Guardianship
†E03 State Funded Foster Care
†E04 State Funded Subsidized Adoptions & Subsidized Guardianship
♦E05 Former Foster Care up to 26 years old

Revised June 2017

Home & Community Based Waivers & PACE

♦†H01 HCBS Waiver and PACE participants

Refugees

♦†G01 Refugee Medical Assistance
♦†G02 Post RCA Extension – Earnings
♦†G98 Refugee Medical Assistance
†G99 Refugee Medical Assistance, Spend-down

Aged, Blind or Disabled (ABD)

♦†S01 Public Assistance to Adults (PAA)
♦†S02 SSI Recipients
†□S03 Qualified Medicare Beneficiaries(QMB)
♦†S04 Pickle Amendment
♦†S05 Section 5103
†S06 Qualified Disabled Working Individuals(QDWI)
†□S07 Specified Low Income Medicare Beneficiaries I (SLMB I)
#S13D Employed Individuals With Disabilities (EID)
#□S14 Qualifying Individuals (QI) [also called SLMB II]
♦#S16 Increased Community Services Program (ICS)
♦†S98 ABD – Medically Needy
†S99 ABD – Medically Needy With Spend-down

Children Long Term Care

†T02 P-track and Other Children in Long Term Care
†T03 Child Under 1 in LTC (P06 Standards)
†T04 Child Under 6 in LTC (P07 Standards)
†T05 Child Under 19 in LTC (P07 Standards)
†T99 Child in LTC With Spend-down

Aged, Blind or Disabled Long Term Care

†L01 SSI Recipient in LTC
†L98 ABD Long Term Care
†L99 ABD Long Term Care With Spend-down

Women's Breast and Cervical Cancer Health Program

#W01 WBCCHP (No new applications accepted after 12/31/13; Grandfathered program)

Aliens

†X02 MAGI & Non-MAGI Undocumented or Ineligible Aliens (Emergency medical services only)

Meaning of symbols in front of coverage groups

♦ **HealthChoice Eligible unless:**
   √ On Medicare
   √ Living in an Institution
   √ Living Out of State
   √ Waiver Code of MOD or MWD for Model Waiver
\# **On MMIS Only**
† **Eligibility Determined in CARES**
□ **Medicare Savings Program**

No Shading – Financially eligible for CFC/CPAS
Dark Grey – Not eligible for CFC/CPAS

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Appendix B – Special Program Codes

Program	Special Program Code	Key
Model Waiver	MOD	Model Waiver-Deinstitutionalized
	MWD	Model Waiver-Diverted
Autism Waiver	AUT	Autism Waiver
Community Pathways (Waiver)	MRW	Intellectual Disability, deinstitutionalized
	DRW	Intellectual Disability, diverted
	NRX	Developmentally disabled, diverted
	DRM	MFP - Intellectual Disability, diverted
	NRM	MFP - Developmentally disabled, deinstitutionalized
New Directions (Waiver)	NRW	Developmentally disabled, deinstitutionalized
	MRM	MFP Intellectual Disability, deinstitutionalized
Brain Injury Waiver	TBW	Brain Injury Waiver
	TBM	MFP-Brain Injury Waiver
Living at Home Waiver	ACD	Living at Home-Deinstitutionalized
No Longer in Use	ACI	Living at Home-Diverted
	ACM	MFP-Living at Home
Residential Treatment Center Waiver	RTC	RTC Waiver
Community Options	OAA	Community Options Waiver-Assisted Living
	OAH	Community Options Waiver-Private residence
	OHM	MFP - Community Options Waiver-Private residence
	OAM	MFP - Community Options Waiver-Assisted Living
Rare and Expensive Medicine	APD	Asymptomatic Pediatric Disease
	BLD	Blood Disease
	CON	Congenital Anomalies
	DEG	Degenerative Disease
	IID	Infant with Inconclusive Disease
	MET	Metabolic
	PSA	Pediatric Symptomatic Disease
	VDP	Ventilator Dependent Person
	OTH	Other
Hospice	HOS	Hospice
Medical Day Care	MDC	Medical Day Care
Increased Community Services	ICS	Increased Community Services
	ICM	MFP-Increased Community Services
Behavioral Health Homes	BHH	Behavioral Health Homes
Money Follows the Person	MFP	State-plan only MFP, no waiver services

In order for waiver claims to pay, the appropriate special program code must be listed on screen 8 of the participant subsystem in MMIS. EDD updates the Special Program Code upon enrollment and disenrollment.

There is no Special Program Code for CFC or MAPC because they are State Plan Services