Medicaid Community Options

Course 10: Submitting a Plan of Services

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Presented to: New Supports Planner Training
June 20, 2019

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What Types of Plans of Service are There?

- Provisional
  - For new people to the program.
  - Allows for certain services to be approved before finalizing provider enrollment.
    - Very helpful for nursing facility applicants.
  - Provisional approval does not mean services can start.
- Initial
  - Initial plan approval must be made before enrollment.
  - All providers on plan must be final.
- Annual
  - Each year by the medical/technical date, an annual plan must be completed.
  - Same process and rules as an Initial.
- Revised
  - Mid-year changes to an initial or annual.
  - May be done at any time.

How is a Plan Developed?

- Determine which program the applicant/participant is eligible for
- Identify any other Medicaid programs in which the applicant is receiving services (BI/DDA/MDC Waiver/REM/Autism Waiver, etc.)
  - Any plan of service related to these programs must be uploaded to Client Attachments in LTSSMaryland
- Identify functional needs of the applicant when requesting program services
  - Cite the I/ADL need associated with the service request

Person-Centered Planning

- Before developing a plan of service, a face-to-face meeting with the applicant/participant should be conducted to:
  - Educate the person about self-directed options
  - Identify strengths, goals, and risks
  - Review the interRAI assessment and recommended POC
  - Assess any transition needs (if applicable)
  - Identify community resources to support the person (Medicaid and non-Medicaid)
  - Discuss with the applicant/participant
    - What is important *to* them and *for* them?
    - Who would they like to be involved in the process?
    - How will available services fit into their day and provide the most support?

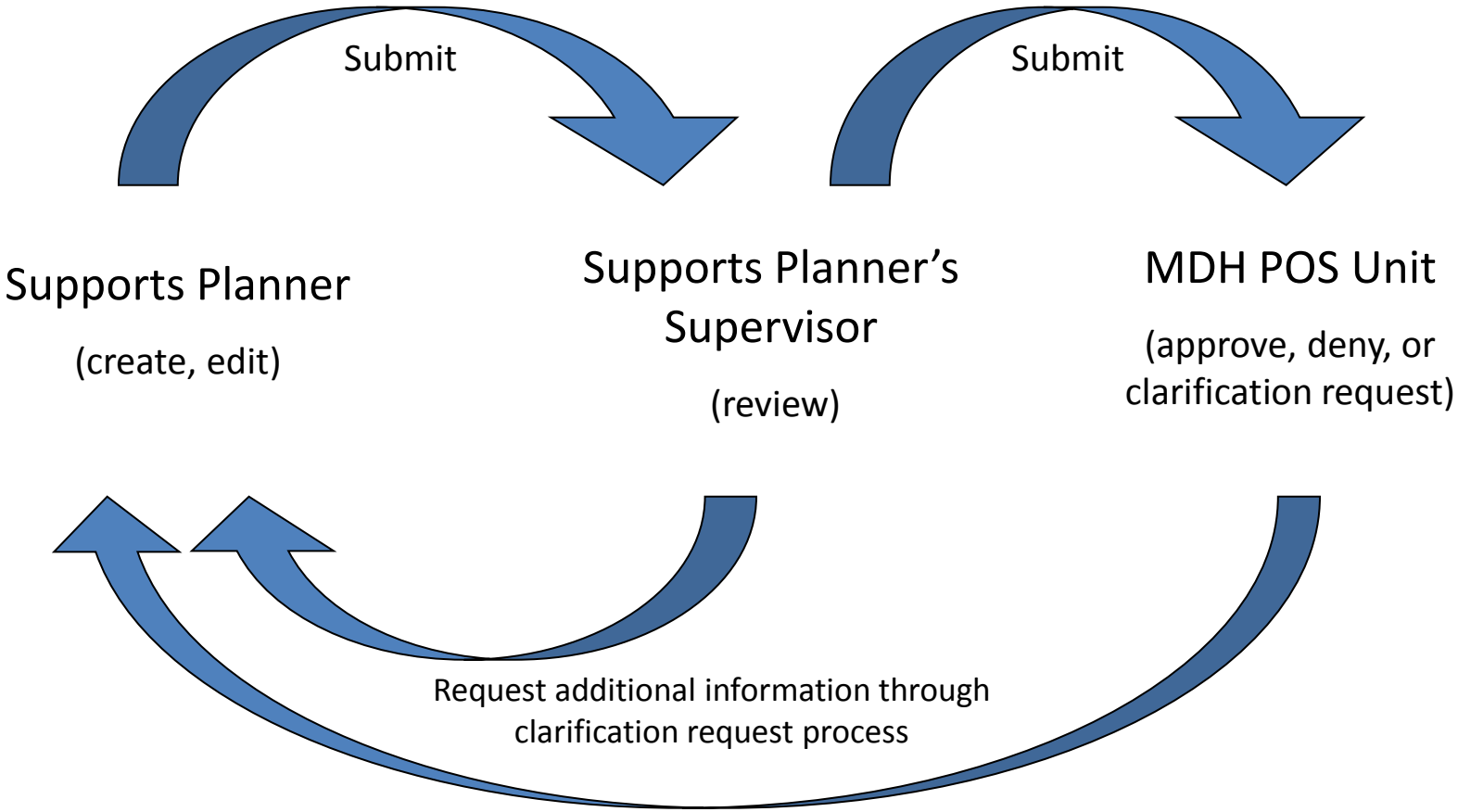
When is a Provisional or Initial Plan Ready to Submit?

- Is the person eligible to receive services?
  - For waiver participants applying from a NF, they must have LTC MA
  - For CFC and CPAS participants, they must have Community MA
- Are all required sections of the POS completed?
  - Overview (address to receive services not required for Provisional plans)
  - Strengths
  - Goals
  - Risks
  - Self-Direction
  - Emergency Backup Plan
  - Services (providers not required on Provisional plans)
  - Review
- If necessary, is the exceptions process completed?

When is an Annual or Revised Plan Ready to Submit?

- Is the person eligible to receive services?
  - Participants must have active Community MA
- Are all the providers identified on the plan?
- Are the required signatures collected?
  - Participant
  - Supports Planner
  - Emergency Back-up
  - Personal Assistance Agency (if applicable)
  - Nurse Monitor (if applicable)
  - Other signatures may be collected after a plan is approved
- The LTSSMaryland system will display many of the requirements and if they are completed.

What Happens After I Hit “Submit”?



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Review Process at the SPA

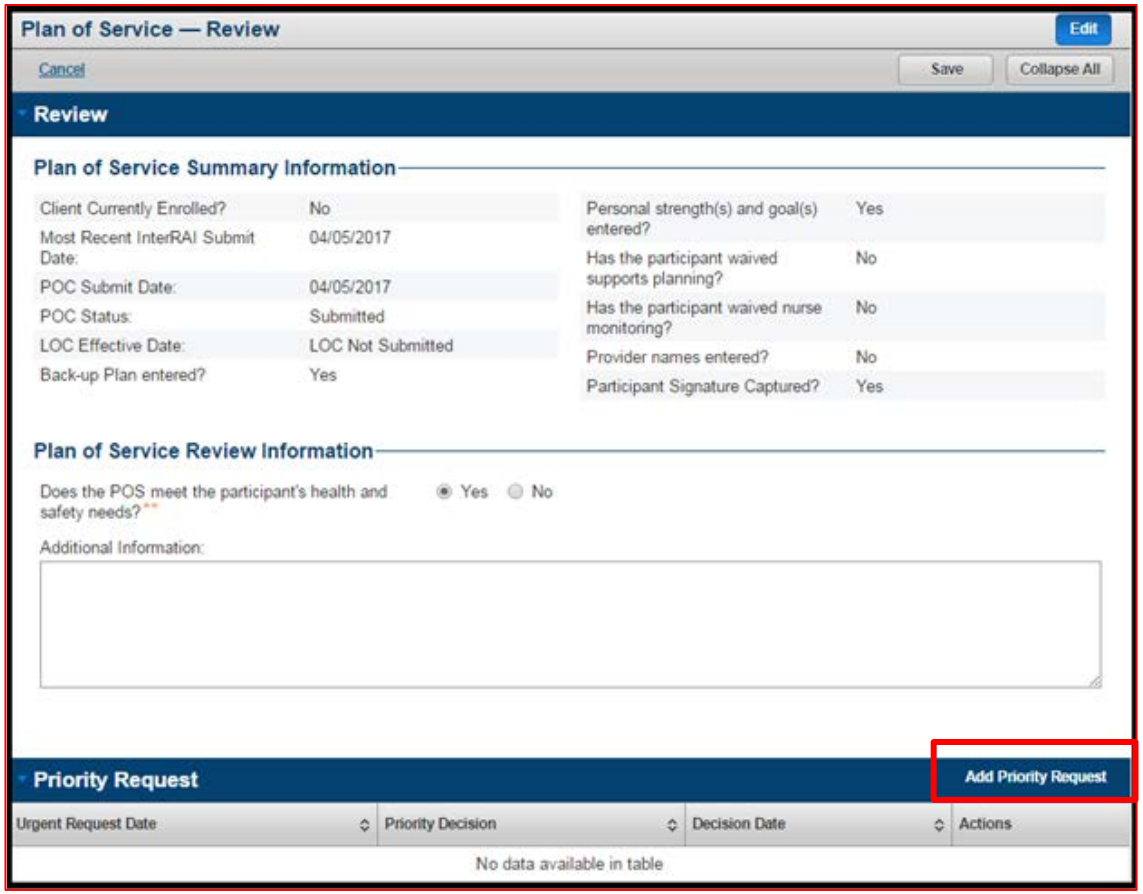
- After hitting submit, your supervisor reviews the plan
  - They may request additional information if they believe something needs clarification, or if something is missing
  - If it meets program and policy requirements, your supervisor then submits your plan to MDH Plan of Service (POS) Unit

Review Process at MDH

- The POS Reviewer reviews the following:
  - InterRAI, POC, and POS for completion
  - In depth review of InterRAI assessment
  - Recommended services on POC addressed in POS
  - Level of Care determination
  - Services provided by other Medicaid programs
  - Any denial of medical necessity for an item/service
  - Medicaid and non-Medicaid services to meet health and safety needs for the applicant/participant
  - Emergency backup plan is sufficient
  - Required signatures are obtained
  - Exceptions request and related documentation (if applicable)
  - Cost effectiveness of the plan
  - Any other relevant documentation (attachments, NM notes, RE's, etc.)

Urgent Requests

- Supports Planners have the ability to identify a plan of service as an urgent request in the “Review” section of the plan



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Urgent Requests

- When urgent review is requested, the supports planner is required to indicate the reason for an urgent review:
  - Immediate Jeopardy Reportable Event
  - Significant change in health status related to ADL/IADL needs
  - Involuntary discharge from an institution
  - Hospital discharge with change in service need
  - Provider issue with change in service need (provider was fired, was negligent, etc.)
  - Housing issue (eviction, safety issue)
  - Loss of informal supports (family member hospitalized)
  - Loss of NF LOC
  - Appeal disposition
  - Other

Urgent Requests

- The supports planner, or lead reviewer have the ability to edit, delete, or discard the Urgent Priority Request *prior* to submitting the plan to MDH
- If MDH does not agree with the Urgent Request the reviewer will change the priority back to normal, and the supports planner will receive an alert
- Examples that should not be sent as urgent:
  - Routine nursing facility discharges
  - Checking the status on a previously submitted plan
  - Plans not submitted timely

Getting Approved

- When a plan is approved you will be alerted in the LTSSMaryland system
- The supports planner should check the following:
  - Medical eligibility is met
  - Technical criteria are met
  - Financial criteria are met
- Any time a provisional POS is approved, it must be converted to an initial POS prior to final enrollment
- An ATP form should be submitted for program applicants
- ATP forms should not be submitted for approval of revised or annual plans

What are Some Potential Reasons for Denying a Plan?

- A participant may choose to request services that may not be allowed by the program
  - They have the right to submit the plan they want
  - There is a balance between guiding a participant to a person-centered but medically-based plan, and supporting them in their request
- A plan may be outside the scope of what the Department can determine medically necessary using documentation available
  - The plan may be requesting more services than other participants with similar needs, or
  - The services available in the programs are not enough to keep a person healthy and safe in their current setting

What Happens if a Plan is Denied?

- All participants are given appeal rights for a denial
  - Instructions on how to appeal are sent to the participant
    - Summary of Fair Hearings Procedures
  - The Office of Administrative Hearings will schedule a hearing to consider the request
  - If it is an annual plan, and the person does not have an active plan of service, services will stop 10 days from the date of the notice
    - The participant may appeal within those 10 days to continue services. However, if they lose the judgment, they may be held liable for the cost of those services
    - If they do not wish to appeal, the SP should create another plan with services indicated on the denial letter
      - Updated client signature is required

Do Not Initiate Services Prior to Enrollment

- Supports planning agencies are liable for services they initiate without following policies and procedures and failing to ensure participant and provider enrollment is complete and approved by MDH
- Starting services without verification of eligibility puts all involved at risk
  - The provider may not get paid
  - The participant may not be eligible and could lose eligibility status
  - Services may never be reimbursable if the participant never enrolls

Service Notification Form

- The Community Options Service Notification Form for personal assistance should be completed upon personal assistance service initiation, revision, or termination
- 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 plan of service 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

Community Options Service Notification Form

This form serves as a notification of a change in your participant's services. Please review all information and proceed accordingly based on the service action. Questions should be directed to the participant's Supports Planner listed below.

Participant Information

Date:	
Participant:	
MA#:	
Program:	---
Provider:	
Service Type:	

Description

Service Action:	---
Effective Date:	
Temporary Authorization:	
Temp. Auth. End Date:	
Plan of Service Attached:	
Comments:	

Support Planner Contact Information

Supports Planner:	
Supports Planning Agency:	
Telephone Number:	
Email:	

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Resources

- Plan of Service User Manual
- Plan of Service Development Manual
- Services by Program Type