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Introduction to Home and Community-Based Services (HCBS)

Maryland Medicaid offers eight 1915(c) waivers, two waiver-like State Plan programs, an 1115 demonstration waiver and numerous State Plan services, all of which are considered home and community-based services (HCBS) as they offer an alternative to institutional supports**.** The Maryland Department of Health's (MDH) Office of Long Term Services and Supports (OLTSS) operates the following:

- Community First Choice (CFC)
- Community Personal Assistance Services (CPAS)
- Home and Community-Based Options Waiver ("CO Waiver")
- Increased Community Services (ICS)
- Medical Day Care (MDC) Services Waiver
- Model Waiver for Fragile Children ("Model Waiver")
- Disposable Medical Supplies/Durable Medical Equipment (DMS/DME)
- Non-Emergency Medical Transportation (NEMT)
- Home Health
- Program of All Inclusive Care for the Elderly (PACE)

Other HCBS programs under the authority of Maryland Medicaid include:

- Rare and Expensive Case Management (REM), operated by the Office of Medical Benefits Management
- Community Pathways Waiver, operated by the Developmental Disabilities Administration (DDA)
- Community Supports Waiver, operated by DDA
- Family Supports Waiver, operated by DDA
- Waiver for Individuals with Brain Injury ("Brain Injury Waiver"), operated by the Behavioral Health Administration (BHA)
- Waiver for Children with Autism Spectrum Disorder ("Autism Waiver"), operated by the Maryland State Department of Education (MSDE)

A waiver allows states to waive certain federal requirements for Medicaid programs to target specific populations, offer additional services, and/or expand eligibility criteria. Participants must meet certain financial, medical, and technical criteria, and the services must be cost-neutral (compared to the cost of institutional services).

CPAS, CFC, and REM are optional State Plan programs, and while they are not waivers, they are considered "waiver-like" because they target specific populations and require an individual to meet additional medical and technical criteria. One key difference between the HCBS waivers and the optional

State Plan programs is that the State Plan programs do not limit enrollment. All HCBS programs are designed to assist individuals with remaining in their communities through services such as supports planning (i.e., case management), personal assistance, personal supports, home-delivered meals (HDM), adaptive equipment, and private duty nursing (PDN).

Program Information

The CPAS, CFC, CO Waiver, and ICS programs support participants who require assistance with activities of daily living (ADLs). Each program has certain financial, medical, and technical requirements; however, each uses the Plan of Service to identify an individual's request for services.

CFC participants must meet an institutional level of care (LOC). This is typically a nursing facility (NF) LOC determined by MDH's Utilization Control Agent (UCA) based on a standardized assessment. Occasionally a participant may have another institutional LOC, such as Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) (required for the Medicaid waivers operated by DDA) or Chronic Hospital (used by the Model Waiver and Brain Injury Waiver). Participants must qualify for Medicaid under the State Plan, and while they may be of any age, they must reside in a community setting.

CPAS participants do not meet an institutional LOC; however, they require hands-on assistance with at least one ADL or supervision for performance of one ADL in conjunction with other criteria (thereby meeting the CPAS LOC). Participants must qualify for Medicaid under the State Plan, and while they may be of any age, they must reside in a community setting. CPAS offers a smaller array of services as compared to the CFC program.

CO Waiver participants must meet a NF LOC determined by MDH's UCA based on a standardized assessment. Participants may not have incomes above 300 percent of Supplemental Security Income (SSI) or assets that exceed $2,000 or $2,500, depending on eligibility category. Participants must also be at least 18 years of age. Individuals must be invited to apply to the CO Waiver from the registry or reside in a qualifying institution with Long Term Care Medicaid. An individual may not be enrolled in more than one waiver at a time, but a waiver participant may simultaneously receive services through the Medicaid State Plan.

ICS participants must meet the medical and technical requirements for the CO Waiver; however, the financial requirements are different. Only institutional residents who have applied for the CO Waiver and been denied due to overscale income may apply to ICS, and if deemed eligible, must contribute a monthly premium. ICS is limited to 100 participants, and as with the CO Waiver, an individual may not be enrolled in more than one waiver at a time but may receive State Plan services simultaneously.

What is the Plan of Service (POS)?

The POS is a request for CPAS, CFC, CO Waiver, or ICS services that includes a detailed picture of all services the individual is currently receiving or has requested. The POS also details the supports, activities, and resources required for the individual to achieve their personal and health goals. The POS is submitted and managed via LTSS*Maryland*, MDH's data management system.

There are four different types of POS:

- Provisional[1] – This plan type is for applicants, as it allows services to be approved prior to the final selection of providers and does not require a start date. This type of POS is particularly useful for applicants waiting to discharge from a NF, as it allows for planning to occur without knowing the exact discharge date. A Provisional POS will eventually be converted to an Initial POS. Approval of a Provisional POS *does not* mean that services may start.
- Initial – This plan type is also for applicants; however, an Initial POS must be approved with a specific start date and all providers prior to enrollment in the program. Once an Initial POS is approved and the applicant is enrolled, services may begin.
- Annual – This plan type is for enrolled participants and should be completed each year by the annual medical/technical date identified in LTSS*Maryland*. An Annual POS is considered routine in nature and offers an opportunity to re-evaluate services in relation to currently approved and requested services through all Medicaid HCBS.
- Revised – This plan type is for enrolled participants and may be used to request a change to services, including provider changes, before the Annual POS is due. A Revised POS is also the appropriate plan type for participants requesting urgent changes to their POS.

Supports Planner Role

The supports planner (SP) is employed by a Supports Planning Agency (SPA), which is designated, or selected through a competitive solicitation, by OLTSS to provide case management services. The SP's role is to provide comprehensive case management services to individuals applying for, or enrolled in, the CPAS, CFC, CO Waiver, or ICS programs. The SP helps the participant understand the results of the interRAI assessment and recommended Plan of Care (POC) as part of developing a person-centered POS. Then, the SP assists in securing appropriate services and monitoring the rendering of those services as it relates to the participant's health and welfare in the community.

The SP is responsible for creating and revising all POS in conjunction with the participant and working with OLTSS to ensure plans are approved; hence, the SP is the main point of contact for the POS reviewer. The participant's assigned SP is listed under **Current Assignments** on the **Client Summary** page

[1]CFC and CPAS applicants do not require a Provisional POS, and if all providers have been selected, an Initial POS is likely more appropriate.

in LTSS*Maryland*. A POS reviewer should direct all questions and clarifications regarding the POS to the participant's currently assigned SP.

Program Referrals

When an individual is referred to the CPAS, CFC, CO Waiver, or ICS program (through a Maryland Access Point (MAP) site, by contacting OLTSS directly, or by invitation from the CO Waiver registry), OLTSS staff send the applicant program materials, including information on available SPAs in their area. Applicants can choose their SPA; if they do not choose a SPA within 21 days of referral, one is automatically assigned. The SPA immediately assigns one of its SPs to the applicant, who contacts the individual to start the enrollment process.

The program referral includes triggering a request for an interRAI assessment in LTSS*Maryland*. The interRAI assessment and recommended POC must be completed by the applicable Local Health Department (LHD) or when assigned, MDH's UCA, prior to the SP's creation of the POS (see pages 37-41 for more detail).

Level of Care (LOC)

The UCA uses the interRAI assessment to determine whether an individual meets the required LOC if both LOC are not auto approved. The UCA is alerted via LTSS*Maryland* when review is needed, and a Registered Nurse (RN) and/or a physician reviews the results and approves or denies the requested LOC. An approved LOC is valid for one year and must be redetermined annually. The LOC will determine the program(s) for which the individual is medically eligible, and an approved LOC is an indication to the SP that they may begin working with the individual to develop a POS.

The NF LOC criteria is defined in the Code of Federal Regulations; however, Maryland Medicaid has determined the outputs from its standardized assessment that correlate to those criteria and established the criteria for the CPAS LOC. Various combinations of dependencies associated with ADLs, IADLs, skilled nursing needs, and cognition determine LOC eligibility.

If an individual does not meet a NF LOC, they may still qualify for a CPAS LOC; however, an individual who only meets a CPAS LOC and no other type of institutional LOC may only enroll in the CPAS program. It is possible for an individual to meet an institutional LOC, but not meet the specific criteria for a NF LOC as NF is only one type of institution.[2] If an individual meets an institutional LOC by virtue of their participation in another Medicaid HCBS program, this will be indicated by a special program code, which is visible in LTSS*Maryland*.[3] An institutional LOC from another waiver is valid for the purpose of

[2]Even if an individual is eligible for CFC by virtue of their participation in another waiver program, an interRAI assessment is still required prior to enrollment.
[3]REM does not require an institutional LOC; therefore, the REM special program code is not an indicator that an individual has meet an institutional LOC.

enrollment in CFC as long as the participant remains enrolled in that waiver. However, if the institutional LOC has expired, a new POS may not be approved until that level of care is redetermined.

For more details regarding NF and CPAS LOC requirements, please refer to *Personal Care Services Transmittal 53* and *Nursing Facility Transmittal 213* and *Transmittal 237*, provided as attachments to this manual.

Recommended Budget

Each participant is given a recommended flexible budget based on their needs, which are identified primarily through the interRAI assessment, to ensure that all participants are given an equitable allocation of the programs' services budget. The interRAI assessment, which is completed prior to the development of the POS, generates a Resource Utilization Group (RUG). OLTSS has assigned each RUG to one of four groups and has developed a budget for each group based on a scale of needs. The recommended flexible budget amount is displayed on the POS, but it does not establish a minimum or maximum for services. The following chart is the current RUG structure with associated budgets.

Budgets by Group

	RUG	Grouper Description	Budget
Group 1	PA1	Physical Function – Low ADL	$15,600
	BA1	Behavioral – Low ADL	$15,600
	CA1	Clin. Complex – Low ADL	$15,600
	IA1	Cognitive Impairment – Low ADL	$15,600
Group 2	PA2	Physical Function – Low ADL, Low to High IADL	$20,800
	RA1	Rehabilitation - Low ADL	$20,800
	BA2	Behavioral – Low ADL, High IADL	$20,800
	CA2	Clin. Complex – Low ADL, High IADL	$20,800
	IA2	Cognitive Impairment – Low ADL, Low to High IADL	$20,800
Group 3	PB0	Physical Function – Low to Medium ADL	$29,120
	CB0	Clin. Complex – Low to Medium ADL	$29,120
	RA2	Rehabilitation Low – Low ADL, High IADL	$29,120
	PC0	Physical Function – Medium to High ADL	$29,120
	SSA	Special Care – Low to High ADL	$29,120
	IB0	Cognitive Impairment – Medium ADL	$29,120
	BB0	Behavioral – Medium ADL	$29,120
Group 4	PD0	Physical Function – High ADL	$43,680
	CC0	Clin. Complex – High ADL	$43,680
	SE1	Extensive Services 1 – Medium to High ADL	$43,680
	RB0	Rehabilitation High – High ADL	$43,680
	SSB	Special Care – Very High ADL	$43,680
	SE2	Extensive Services 2 – Medium to High ADL	$43,680
	SE3	Extensive Services 3 – Medium to High ADL	$43,680

Within the plan, services are divided into flexible and non-flexible services. The recommended flexible budget applies only to flexible services, which are personal assistance services (PAS), HDM, and "other

items" that substitute for human assistance. The recommended flexible budget is designed to give participants with similar needs a starting point for requesting flexible services; however, participants may request flexible services which exceed the recommended budget through the exceptions process (see page 23 for more detail).

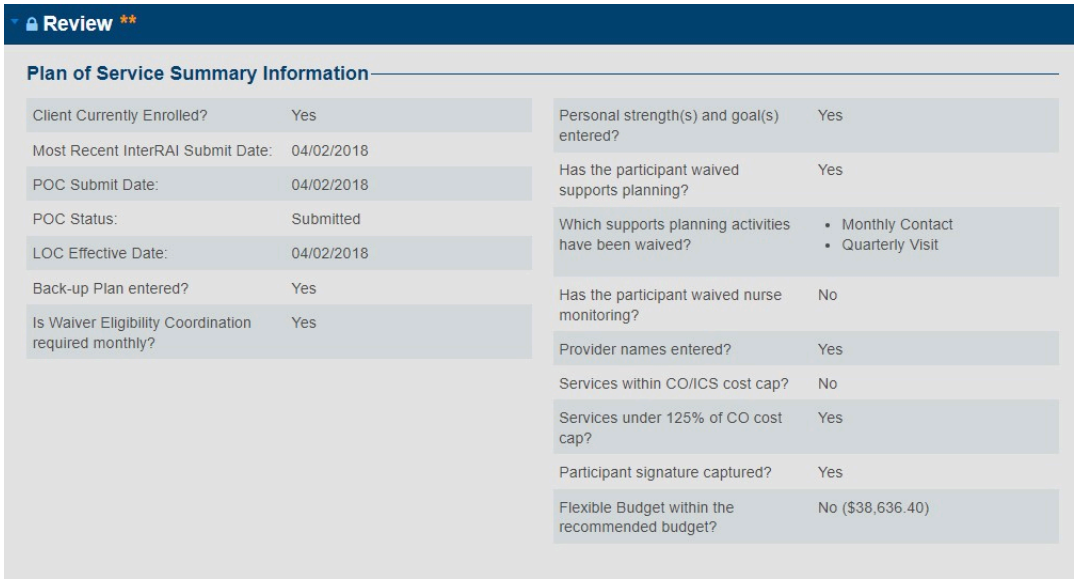
Cost Neutrality

Cost neutrality means that the annual cost of all Medicaid services (waiver and non-waiver) for a waiver participant may not exceed the annual cost to the State of a NF stay. Plans for the CO Waiver and ICS program are subject to cost neutrality and LTSS*Maryland* includes functionality that identifies when the total cost of the plan, which includes flexible and non-flexible program services, as well as other State Plan services such as PDN, dialysis, and DME/DMS, exceeds cost neutrality. The SP must indicate the costs associated with all other State Plan services that are not pre-populated on the POS.

If the POS is over the cost neutrality parameter, LTSS*Maryland* provides an alert to the POS reviewer, but *will not* prohibit approval of the plan. In these instances, the reviewer must alert the SP via a clarification request (CR), so the SP can work with the participant to make changes to the plan that will render it cost-neutral.

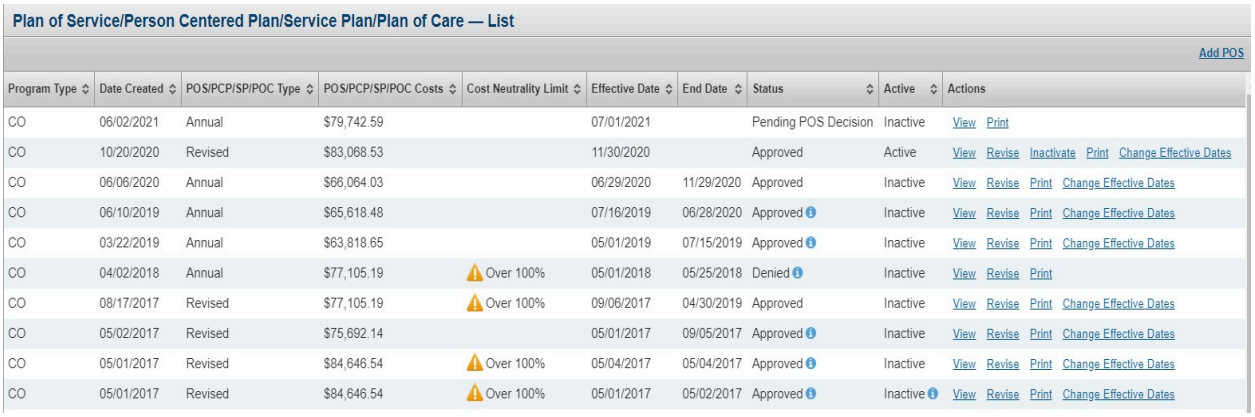
CO Waiver Cost Neutrality

For the CO Waiver, a participant's POS may not exceed 125 percent of the cost neutrality figure. This figure is calculated annually and programmed into LTSS*Maryland*. There are two places where the reviewer can identify whether the plan is cost-neutral. The first is the **Review** section of the POS.



In the screenshot above, the plan is not within the cost cap (100% cost neutrality), but *is* under 125 percent of the cost cap. In this case, if the services are medically necessary and meet all other requirements, the POS may be approved.

The other place where cost neutrality is displayed is the **Plan of Service List**. All previous and current plans, as well as plans associated with other Medicaid HCBS in which the participant is enrolled or to which they are applying, are displayed on the list page. In the screenshot below, several previous plans were flagged for being "Over 100%." If a plan is over 125 percent of cost neutrality, the triangle is red with the warning "Over 125%."



Plan of Service/Person Centered Plan/Service Plan/Plan of Care — List

Add POS

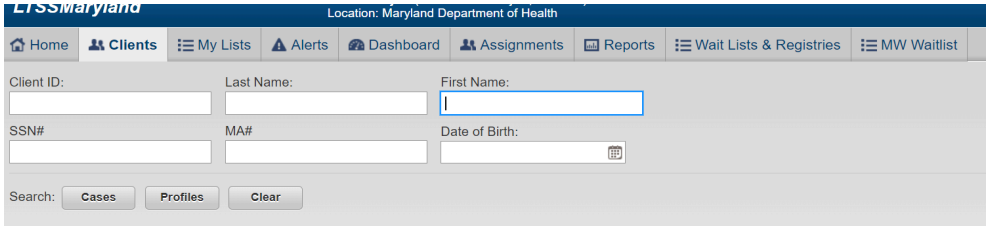
Program Type	Date Created	POS/PCP/SP/POC Type	POS/PCP/SP/POC Costs	Cost Neutrality Limit	Effective Date	End Date	Status	Active	Actions
CO	06/02/2021	Annual	$79,742.59		07/01/2021		Pending POS Decision	Inactive	View Print
CO	10/20/2020	Revised	$83,068.53		11/30/2020		Approved	Active	View Revise Inactivate Print Change Effective Dates
CO	06/06/2020	Annual	$66,064.03		06/29/2020	11/29/2020	Approved	Inactive	View Revise Print Change Effective Dates
CO	06/10/2019	Annual	$65,618.48		07/16/2019	06/28/2020	Approved	Inactive	View Revise Print Change Effective Dates
CO	03/22/2019	Annual	$63,818.65		05/01/2019	07/15/2019	Approved	Inactive	View Revise Print Change Effective Dates
CO	04/02/2018	Annual	$77,105.19	Over 100%	05/01/2018	05/25/2018	Denied	Inactive	View Revise Print
CO	08/17/2017	Revised	$77,105.19	Over 100%	09/06/2017	04/30/2019	Approved	Inactive	View Revise Print Change Effective Dates
CO	05/02/2017	Revised	$75,692.14		05/01/2017	09/05/2017	Approved	Inactive	View Revise Print Change Effective Dates
CO	05/01/2017	Revised	$84,646.54	Over 100%	05/04/2017	05/04/2017	Approved	Inactive	View Revise Print Change Effective Dates
CO	05/01/2017	Revised	$84,646.54	Over 100%	05/01/2017	05/02/2017	Approved	Inactive	View Revise Print Change Effective Dates

ICS Cost Neutrality

The cost neutrality parameters for ICS are different. ICS cost neutrality figures are individualized, meaning all Medicaid services received by the participant may not exceed 100 percent of the costs to the State to provide nursing facility services to that individual. For ICS participants, the **Individual Cost Neutrality** figure is located under the **Programs** section on the left navigation bar in LTSS*Maryland*. If there is no cost neutrality figure entered for an ICS participant, the reviewer should contact OLTSS.

Logging into LTSS*Maryland* and Searching for a POS

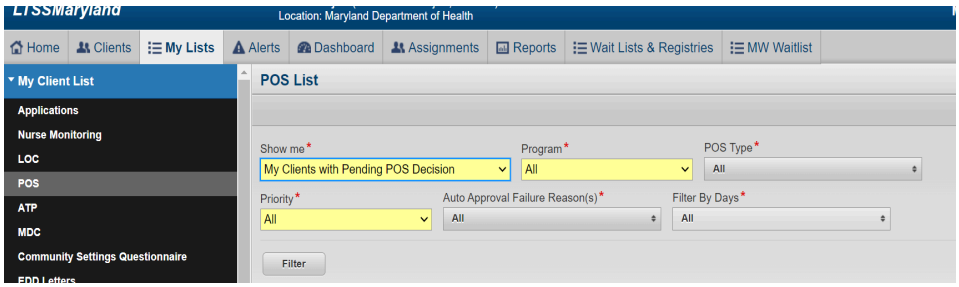
After logging into *LTSSMaryland*, a user can search for a POS by going into the **Clients** section and using one unique identifier, such as the Client Identification Number (Client ID), Medicaid Number (MA#), or Social Security Number (SSN#). If a user does not know one of these unique identifiers, a combination of date of birth and first name and last name may be used.



All plans are accessible via **POS/PCP/SP/POC** under the **Programs** section on the left navigation bar in LTSS*Maryland*.

Using My Lists

My Lists displays all POS assigned to a reviewer and can be filtered according to certain criteria such as POS type, number of days pending, and urgent requests. A user can select the **POS My List** from all available **My Lists** and filter the data as displayed in the screenshot below.



The **POS My List** assists the reviewer in prioritizing plans for review. Generally, the length of time a plan has been pending review (days since entering the workflow status “Pending POS Decision”) determines the order in which the plan is reviewed, meaning plans are reviewed from oldest to newest; however, plan type, urgency, and the program for which the individual is applying must also be considered. More specifically, Provisional and Initial POS should be prioritized over Revised and Annual POS. Similarly, plans submitted as an urgent request and deemed truly urgent by a reviewer should be prioritized over POS that were not submitted as, or not deemed, urgent. Lastly, Provisional and Initial POS for CO Waiver applicants may need to be prioritized over other Provisional and Initial POS given the timeframe in which a waiver application is considered active.

POS Components

The POS is comprised of the following sections:

I. Overview Information

A. General Information

Includes the individual’s name, address, phone number, age, date of birth, guardian (if

applicable), Medicaid number, and assigned SPA

B. POS Information

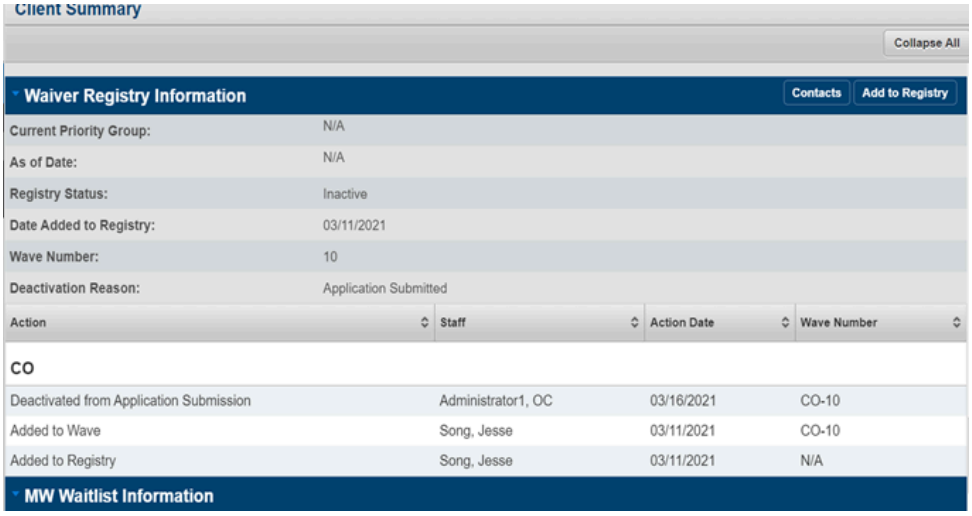
Includes more specific Medicaid information such as the Medicaid coverage group, Medicaid start and end dates, program for which the plan is being submitted, current program type and enrollment date (if applicable), medical/technical redetermination status and due date (if applicable), appeal status, and whether the plan meets health and safety requirements

One of the first steps in the utilization review (UR) process is to determine whether the individual is eligible for the program to which they are applying, or to continue receiving services in the program in which they are currently enrolled. Except for applicants to the CO Waiver or ICS program, an individual must have an active Community Medicaid coverage group. For CPAS and CFC, an individual must also be in a qualifying Community Medicaid coverage group. An eligibility span ending with the year “9999” indicates that the individual has open-ended eligibility. If an individual does not have active Medicaid or their coverage group is ineligible for participation, the reviewer should send the POS back to the SP through a CR.

There are two ways an individual may apply to the CO Waiver – as a community applicant or as an institutional applicant. Community applicants must be invited to apply to the CO Waiver from the registry. Institutional applicants who have been in a qualifying institution for at least 30 days and have active Long Term Care Medicaid may apply to the CO Waiver without being invited from the registry. Typically, a community applicant to the CO Waiver will not have active Community Medicaid. Individuals in the community are placed on the registry by MAP sites, who also complete a Level 1 Screen. The Level 1 Screen is used to prioritize individuals for waiver services based on their risk of institutionalization as compared to others on the registry.

Both community and institutional applicants must submit a CO Waiver application. Unlike CPAS and CFC participants, whose financial eligibility for Medicaid is determined by the Local Departments of Social Services (LDSS), the Eligibility Determination Division (EDD) within the Medicaid Office of Eligibility Services determines whether an individual is financially eligible for the CO Waiver. Waiver enrollment must occur by the last day of the sixth month from the month in which the application was submitted.

A reviewer can identify a community applicant invited to apply to the CO Waiver from the registry in LTSS*Maryland* under **Client > Client Summary > Waiver Registry Information**. If there is an entry that states "Added to Wave," this means that the individual received an invitation to apply to the waiver (see page 33 for more detail).



Individuals applying to the CO Waiver from an institution will have active Long Term Care Medicaid and may have a NF listed as their current address.

For both community and institutional applicants, EDD enters the overall decision regarding eligibility and sends the enrollment letter to the applicant. A reviewer can view the status in LTSS*Maryland* under **Programs > Financial & Overall Decision > Overall Decision.**

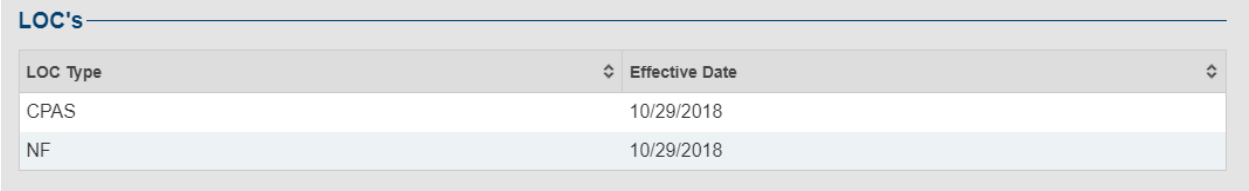
The medical/technical redetermination date is established based on the participant's first LOC effective date. Once an Annual POS is approved, the medical/technical redetermination date will advance by one year from the first LOC effective date.[4]

If a participant is actively appealing a medical, technical, or financial (for CO or ICS only) denial, this information will also be included in **POS Information**.

[4]If an annual POS is not submitted or approved, the medical/technical redetermination date will not advance and the reviewer may need to triangulate other data elements to determine the appropriate plan type.

C. LOC's

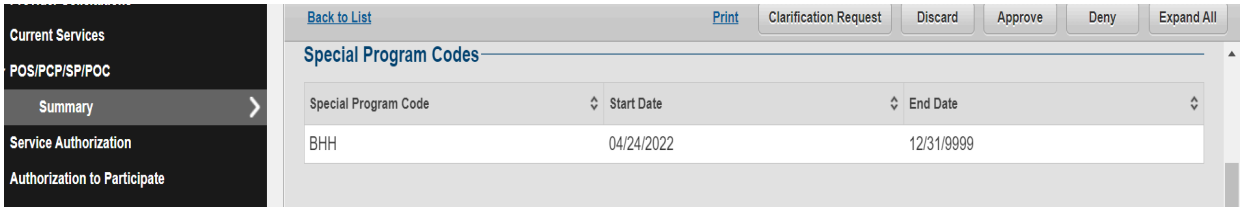
The most recent CPAS and NF LOC along with its effective date, will be displayed in this section. The LOC is one factor in determining the program(s) for which a participant is eligible as each program has a specific LOC requirement (see page 9 for more detail). NF LOC and CPAS LOC are considered active up to one year after the effective date. The reviewer must verify that the participant has an active LOC before taking any action on the POS. If the LOC is expired, "under review," "in progress," or if the field is blank, the reviewer should send the plan back to the SP through a CR.



The details of a LOC decision are in LTSS*Maryland* under **Programs > Level of Care > NF Level of Care or CPAS Level of Care List > View**. If the LOC was not auto approved and the UCA made the LOC decision, selecting the view option will display the rationale for the decision.

D. Special Program Codes

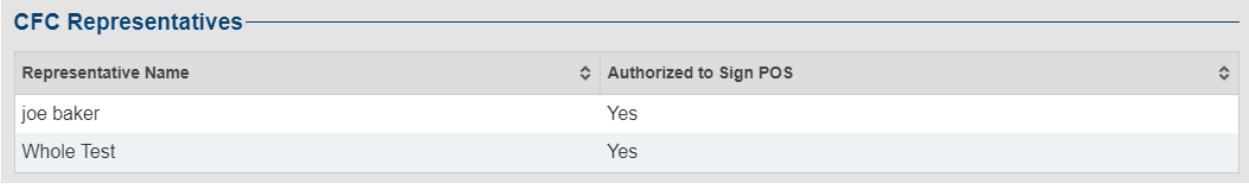
Any Medicaid HCBS programs (that have special program codes) in which a participant is enrolled are listed in this section. These programs include, but are not limited to: REM, the three Medicaid waivers operated by DDA, Model Waiver, MDC Services Waiver, Brain Injury Waiver, and Autism Waiver. CPAS and CFC do not have special program codes. If a participant has an active special program code and is receiving services through one or more Medicaid HCBS programs, those services should be clearly indicated on the plan (see page 68 for more detail).



E. CFC Representatives

A participant may choose to have someone else act as their representative for the purpose of making decisions about program participation, including the POS. If the participant has a legal guardian, whether that is a parent of a minor child or a court-appointed individual for an adult, that guardian is by default the representative. If

a participant has a guardian, the name of that individual will be listed at the top of the POS and does not need to be re-entered in this section.



CFC Representatives

Representative Name	Authorized to Sign POS
joe baker	Yes
Whole Test	Yes

Per Code of Maryland Regulations (COMAR) 10.09.84.02B(31), a representative is defined as:

1. "The person authorized by the individual to serve as a representative in connection with the provision of Community First Choice services and supports;
2. The individual signing the Plan of Service on a participant's behalf;
3. A legal guardian of the participant;
4. The parent or foster parent of a dependent minor child;
5. Any individual who makes decisions on behalf of the person related to the participant's plan of service."

A Residential Service Agency (RSA) may not assign an individual's representative or guardian to provide PAS (COMAR 10.09.84.06C). If it is clear to the reviewer that a participant's representative or legal guardian is the paid provider, they should contact OLTSS for further guidance.

F. Overview

This section contains the program type (i.e., CPAS, CFC, CO, or ICS), POS type (i.e., Provisional, Initial, Revised, or Annual), POS created date (i.e., date that the SP created the POS), POS effective date (i.e., date that services on the POS will take effect), and the POS end date (if applicable).

A Provisional POS is not required to have an effective date since services may not begin until the Provisional POS is converted to an Initial POS. As such, this field may be left blank on a Provisional POS. For all other plan types, see page 86-87 for further guidance regarding POS effective dates.

The **Overview** section also includes the narrative. The narrative should be current, accurate, and align with the POS request. The SP should include important information that is not listed anywhere else on the POS, including, but not limited to:

- The reason for a Revised POS
- All services recommended in the POC that the participant declined
- DME already owned by the participant
- Additional supports received that are not covered by Medicaid, including the presence of informal supports

G. Address to Receive Services

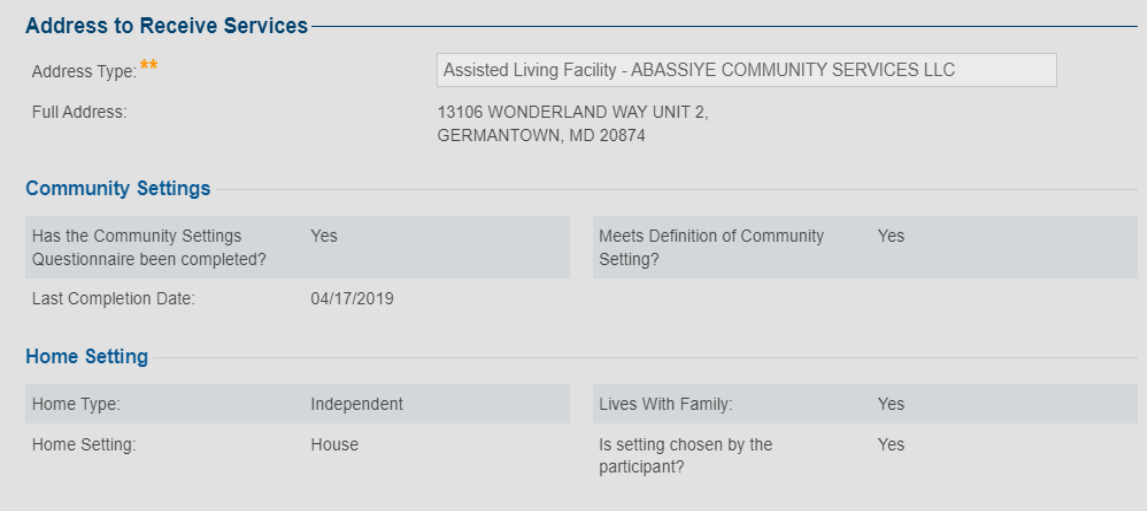
The current address listed in the **General Information** section of the POS and **Client > Profile > Address** section should match that which is listed in the **Address to Receive Services** field. If the addresses do not match, the reviewer should send the plan back to the SP through a CR.

A community address must be listed for Initial, Revised, and Annual POS. A NF or other institutional address should never be listed as the address to receive services. If an applicant is in a NF and submitting a Provisional POS in preparation for discharge, but housing is yet to be determined, the **Address to Receive Services** field may be left blank. Once the Provisional POS is converted to an Initial POS, the address must be updated to reflect the community setting in which the participant will receive services.

1. Community Settings and Home Settings

These are subcomponents of the **Address to Receive Services** section and provide a snapshot of the results of the Community Settings Questionnaire (CSQ).

All participants must reside in a setting that meets the federal definition of a community setting. The SP must complete a CSQ with the applicant before enrollment, annually thereafter, and each time the participant's address changes. See page 34-35 for further guidance on how to view and interpret a CSQ.



Address to Receive Services

Address Type: **	Assisted Living Facility - ABASSIYE COMMUNITY SERVICES LLC
Full Address:	13106 WONDERLAND WAY UNIT 2, GERMANTOWN, MD 20874

Community Settings

Has the Community Settings Questionnaire been completed?	Yes	Meets Definition of Community Setting?	Yes
Last Completion Date:	04/17/2019		

Home Setting

Home Type:	Independent	Lives With Family:	Yes
Home Setting:	House	Is setting chosen by the participant?	Yes

II. Strengths and Goals

This section must include at least one strength and one goal shared by the participant and should be updated annually. Given the person-centered nature of the POS, this section should reflect what is important to the participant, rather than what others may perceive as strengths or goals of the participant. If a participant is unable, or unwilling, to communicate their strengths

and goals, the SP should indicate this in the narrative section and ensure that the text that is included is not attributed to the participant. If the strengths and goals are carried over from the previous POS and the participant chooses not to provide updated ones, the SP should also indicate that in the narrative and state that there are no changes to the strengths/goals.

III. Risks

Risks are auto populated in this section based on Clinical Assessment Protocols generated from the interRAI assessment. The SP reviews these risks with the participant and may revise them as appropriate; however, there must always be at least one risk listed on the POS. If this field is blank, the reviewer should send the plan back to the SP through a CR.

IV. Self-Direction

Upon implementation of the self-directed model, a participant may choose to self-direct the services in their flexible budget. For PAS, this means hiring, training, and supervising one or more employees to provide personal assistance. Currently, all selections should be “No” in this section, and the reviewer should return the plan to the SP through a CR if corrections are needed. Once the self-directed model is implemented, a participant choosing to self-direct should indicate “Yes” to all selections in this section.

V. Services

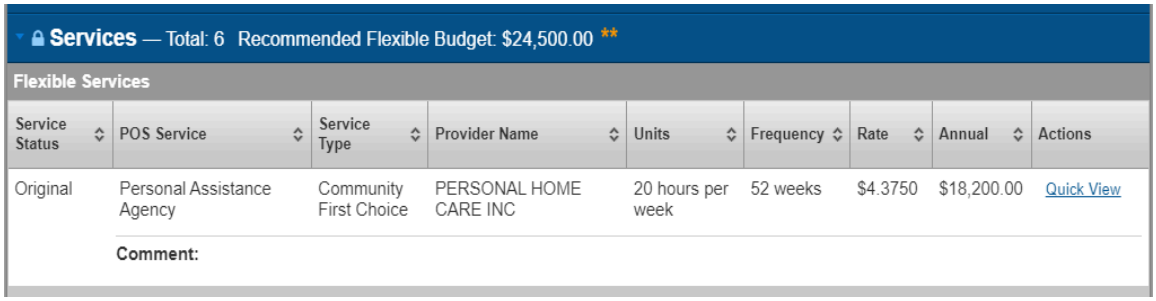
Services are categorized as “flexible” or “non-flexible.” Flexible services translate to the recommended flexible budget (see page 10 for more detail) and consist of PAS, home-delivered meals, and “other items” that substitute for human assistance (e.g., assistive technology not otherwise captured in the assistive technology categories under the non-flex services).

Non-flexible services include all other services the participant is requesting through the program, as well as a description of additional services the participant receives through other Medicaid or non-Medicaid programs (see page 66-80 for more detail). The other services that may be requested through the programs include:

- Supports Planning
- Nurse Monitoring
- Environmental Assessment
- Accessibility Adaptations
- Assistive Technology
- Personal Emergency Response System
- Consumer Training
- Transition Services
- Flexible Funds

- Assisted Living Facility
- Medical Day Care
- Senior Center Plus
- Family Training
- Behavioral Consultation
- Dietitian and Nutritionist Services
- Respite

All flexible and non-flexible services must include the number of units and frequency, which in combination with the current rate of reimbursement, translate to an annualized cost. If any of this information is missing, the reviewer should send the plan back to the SP through a CR. A service provider must be included for Initial, Revised, and Annual POS. A provisional POS does not require selection of a provider.



Services — Total: 6 Recommended Flexible Budget: $24,500.00 **

Flexible Services

Service Status	POS Service	Service Type	Provider Name	Units	Frequency	Rate	Annual	Actions
Original	Personal Assistance Agency	Community First Choice	PERSONAL HOME CARE INC	20 hours per week	52 weeks	$4.3750	$18,200.00	Quick View

Comment:

Services being provided outside of the CPAS, CFC, CO Waiver, or ICS programs do not require an associated cost *unless* the service is provided through another Medicaid waiver or State Plan program and the participant is applying to, or enrolled in, the CO Waiver or ICS. *All* state-funded service costs must be included on CO Waiver and ICS plans so that cost neutrality can be determined.[5]

All POS should be developed based on a full year of service, regardless of a participant's redetermination date; for example, if the plan effective date is February 1, all services should be planned from February 1 through January 31 of the following year (52 weeks). Developing a POS for less than a one year period negates OLTSS' ability to analyze whether the plan is cost effective over time. Services required on a temporary basis should be submitted accordingly (see page 63 for more detail).

For items or services that are not continuous; for example, an accessibility adaptation, the item or service should remain on the POS until it is purchased/completed. Once it has been provided, then it

[5]The responsibility for determining cost neutrality for other Medicaid waivers, which includes the cost of CFC services (if applicable), lies with the operating entity.

should be removed from the subsequent plan. This ensures that the date of service for the item or service falls within the date range of an approved POS and allows claims to be processed successfully.

No service may be provided prior to both the approval of the POS and the effective date of program enrollment, which certifies program eligibility. Providers are at risk of non-payment if the POS is not approved, or enrollment is not attained on the date services were delivered.

The chart below lists all services and the programs in which they are offered:

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

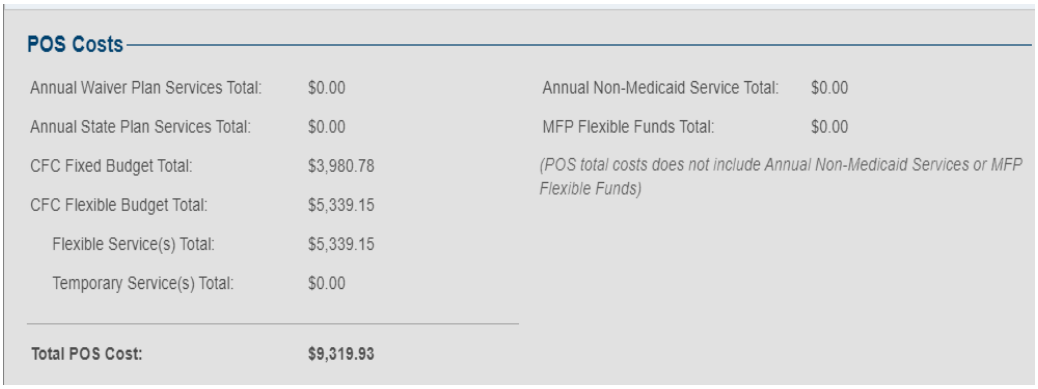
* These services are allowable in an Assisted Living Facility. All other services are not.

** CO Waiver and ICS participants access CFC services by virtue of their enrollment in those waivers.

A. POS Costs

This subsection of **Services** provides a breakdown of the costs associated with the POS. Each service is categorized as waiver, State Plan, or "Other". All flexible services are categorized as CFC services. CO Waiver and ICS participants can access CFC services by virtue of their enrollment in these waivers, but the CFC services are part of the State Plan, not the respective waivers. Services that are available only to CO Waiver and ICS participants are categorized as waiver services.

- **Annual Waiver Plan Services Total** = The total cost of waiver services identified on a CO Waiver or ICS plan.
- **Annual State Plan Services Total** = The total cost of non-CFC State Plan services such as DMS/DME, home health, primary care, and specialty services.
- **CFC Fixed Budget Total** = The total cost of non-flexible CFC services.
- **CFC Flexible Budget Total** = The total cost of all CFC flexible services. This is broken down further to identify any costs associated with temporary services.
- **Annual Non-Medicaid Service Total** = The total cost of community or privately provided services; for example, PDN obtained through private insurance.
- **MFP Flexible Funds Total** = The total cost of flexible funds for Money Follows the Person (MFP)-eligible participants.



POS Costs

Annual Waiver Plan Services Total:	$0.00	Annual Non-Medicaid Service Total:	$0.00
Annual State Plan Services Total:	$0.00	MFP Flexible Funds Total:	$0.00
CFC Fixed Budget Total:	$3,980.78	*(POS total costs does not include Annual Non-Medicaid Services or MFP Flexible Funds)*	
CFC Flexible Budget Total:	$5,339.15		
Flexible Service(s) Total:	$5,339.15		
Temporary Service(s) Total:	$0.00		
Total POS Cost:	**$9,319.93**		

VI. Emergency Back-up Plans

At least one back-up provider must be listed on the POS. This may be the same RSA that is the primary provider of PAS, a different RSA, or informal supports, such as family or friends, that agree to serve as back-up if an RSA is unavailable. A family member or friend who is the paid provider of PAS cannot serve as the back-up provider. Upon implementation of the self-directed model, a participant choosing to self-direct their services may also select an RSA as a back-up provider.

The reviewer should verify that one back-up is selected as primary, meaning “Yes” is selected for that provider under the primary column in the **Emergency Back-Up** section. OLTSS recommends that SP assist participants in identifying more than one back-up provider, especially if the participant has skilled needs, or is self-directing their services, but a plan can be approved with just one. The reviewer should ensure that appropriate phone numbers are listed for all back-up providers. A non-working phone number (i.e. 000-000-0000 or 999-999-9999) is not appropriate and if identified, the reviewer should send the plan back to the SP through a CR.

VII. Exception Request

If a participant is requesting services that exceed the recommended flexible budget, the plan is subject to the exceptions process, which is built into the POS module in LTSS*Maryland.* The reason for the request and supporting documentation must be included in this section. If the SP fails to complete the section when the cost of the POS exceeds the flexible budget, LTSS*Maryland* alerts the SP and prohibits submission of the plan until rectified.

The exceptions process is only required for CPAS and CFC participants, as the CO Waiver and ICS are subject to cost neutrality requirements, which serve the same cost containment function. The exceptions process may also be used to request items or services that are not directly supported by available information. Medical documentation such as treatment plans, progress notes, discharge summaries, or notes from an Occupational or Physical Therapist may help a reviewer understand a request for services that is not supported solely by the interRAI assessment.[6] A letter requesting a specific number of hours from a health care provider, absent any other documentation, is not sufficient. If no supporting documentation is available or obtainable, the SP should note that in the narrative section of the POS so that the reviewer is aware and can review the POS "as is."

VIII. Signatures

The participant, or legal guardian or representative as applicable, and all service providers must sign the POS. The providers' signatures indicate their agreement to provide services, and for all providers apart from SPAs and LHDs, to provide services in the specific amount, scope, frequency, and duration delineated on the participant's POS. If the participant does not agree with the services as delineated on the POS, then they should not sign the POS. **Unless otherwise specified below, all plans require a valid signature from all parties.**

Participants under the age of 18 and adults who have a legal guardian may not sign their plans as their legal guardian is required to sign the POS on their behalf. Conversely, if a participant has identified a representative, that individual may sign the POS, but is not required to do so.

Minimum signatures required for provisional approval:

- Participant (Legal Guardian or Representative, as applicable)
- Supports Planner
- Supports Planning Agency
- Nurse Monitor (only if PAS is requested)
- Personal Assistance Agency (if included)
- Assisted Living Facility Provider (if included)

[6]A letter from a health care provider simply stating that a participant needs a specified number of PAS hours, absent any other documentation, is not sufficient.

Minimum signatures required for Revised POS:

- Participant (Legal Guardian or Representative, as applicable)
- Supports Planner
- Supports Planning Agency
- Service providers for whom the revision is relevant (i.e., new service provider)

Legal Guardian Signatures:

- A guardian is appointed by a court to make decisions on an individual's behalf because that individual is deemed by the court to be unable to make decisions. In some instances, an individual's guardian may be a state entity, such as the Department of Human Services.
- For minors (individuals under age 18), the minor's parent is assumed to be the guardian unless there is a court order specifically naming another adult as the guardian. For a minor in Foster Care, the LDSS is the guardian.
- If one exists, a guardian is legally required to sign the POS. If a reviewer identifies that the participant's guardian did not sign the plan, the reviewer should send the plan back to the SP through a CR.
- A court-appointed guardian or parent of a minor child must be listed in the participant's record in LTSS*Maryland* under **Client > Profile > Representatives**.
    - Documentation of guardianship, other than the parent of a minor child, must also be uploaded to attachments under **Client > Profile > Representatives**.

Representative Signatures:

- A participant may designate a representative for the purpose of making decisions about program participation by completing a representative form. This form is not required for the parent of a minor child or a legal guardian.[7]
- Any representative designated by the participant must be listed in the participant's record in LTSS*Maryland* under **Client > Profile > Representatives** with a corresponding representative form, which is uploaded to the same section.
    - If a representative is selected, the participant must designate that individual annually by providing an updated authorized representative form.
    - If an individual is no longer designated as a representative, the SP should inactivate that individual in the **Representatives** section.
- Any individual who signs the POS for a participant is automatically indicated as a representative, and may not serve as the participant's paid provider of PAS.

IX. Review

The **Review** section is divided into the **Plan of Service Summary Information** section, the **Plan of Service Review Information** section, and the **Priority Request** section.

[7]If a participant has not designated a representative and does not have a legal guardian identified but may be unable to make decisions regarding program participation, the reviewer should contact OLTSS for further guidance.

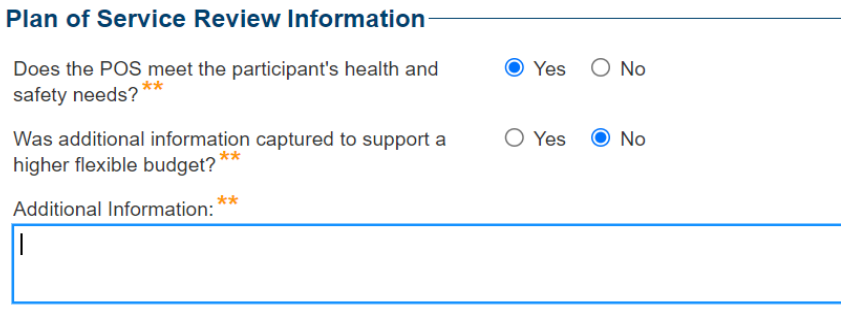
A. Plan of Service Summary Information

This section highlights all the important technical components of the plan and is an indicator to the reviewer of areas to "double check" before acting on the POS.

B. Plan of Service Review Information

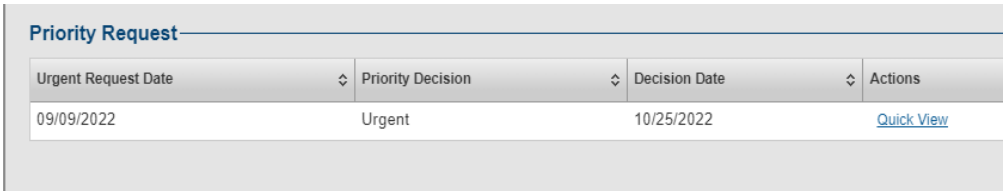
All plans must meet the health and safety needs of the participant to be approved. If "No" is indicated in response to this question, the reviewer should send the plan back to the SP through a CR. A reviewer is unable to approve a plan that does not meet a participant's health and safety needs and an error message will appear in LTSS*Maryland* that prevents further action. If "Yes" is indicated, but the reviewer has concerns about the participant's health and welfare that are not addressed by the plan, the reviewer should request consultation with a clinician within their agency and/or send the plan back to the SP through a CR to obtain additional information.

This section also captures whether the SP has provided additional information to support a request for services that exceeds the flexible budget.



C. Priority Request

An SP may request that the review of the POS be expedited via this section. This field will only appear on the POS if a priority request is made. The SP must select a reason for the urgency when submitting the plan and the reviewer will determine whether the plan is deemed truly urgent based on established criteria.



A SP should submit a POS as a priority request if the participant's health and welfare could be adversely impacted if no action is taken. Examples of urgent situations include, but are not limited to:

- Immediate Jeopardy reportable event (see page 35 for more detail)
- Significant change in health related to ADL/IADL needs supported by medical documentation
- Appeal outcomes
- Involuntary discharge from an institution
- Critical provider issue requiring a change in services
- Housing issue
- Loss of informal supports
- Loss of NF LOC

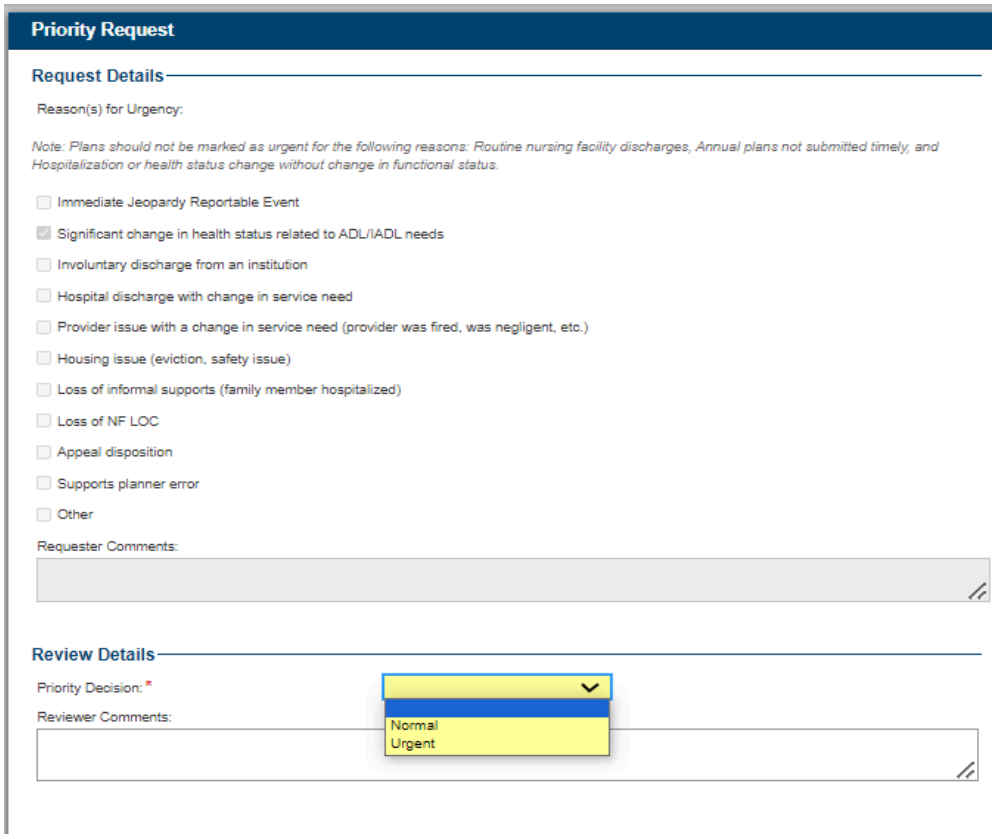
The reviewer must decide whether the request is truly urgent and indicate whether the priority decision is "urgent" or "normal" before taking any action on the plan. If the reviewer determines the request to be "normal," the reviewer should include the rationale in the **Reviewer Comments** field, select **Save** and exit out of **Edit**. The plan then remains in the queue to be reviewed using the standard guidance.

If the reviewer determines the request to be "urgent," the reviewer should include the rationale in the **Reviewer Comments** field, and select the appropriate reason from the dropdown box, which may be different than the reason provided by the SP. Then, the reviewer should select **Save** and exit out of **Edit**.

If the SP has not provided an explanation for the priority request or additional information to support it, the reviewer should select "normal" and send the plan back to the SP through a CR requesting a detailed explanation and/or relevant documentation.[8] The SP may then resubmit the plan as a priority request with the applicable information.

The details of the priority request in the POS are under **Review** > **Edit** > **Priority Request** > **Review** > **Review Details**.

[8]LTSS*Maryland* will not allow a user to send the plan back to the SP through a CR until the urgency is determined.



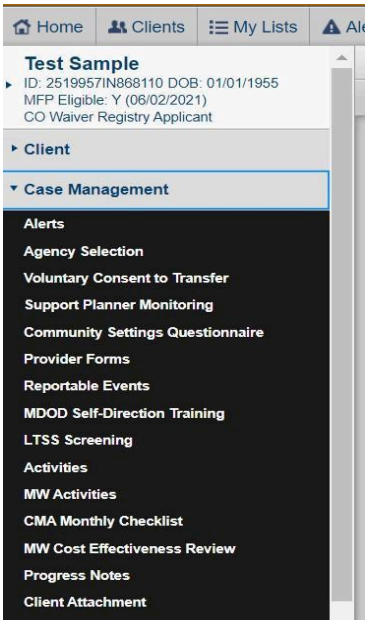
X. Attachments

There are two locations in LTSS*Maryland* where a SP can add attachments in relation to the POS. The **Attachments** section of the POS is the preferred section, although documents attached here do not carry over from one POS to another.

Attachments

Created Date	Created By	Description	Filename
12/20/2023	Clark, Shaune	Participant PT notes	PT Assessment and Notes.docx
12/20/2023	Clark, Shaune	Participant task schedule 12/20/23	Task Schedule.docx

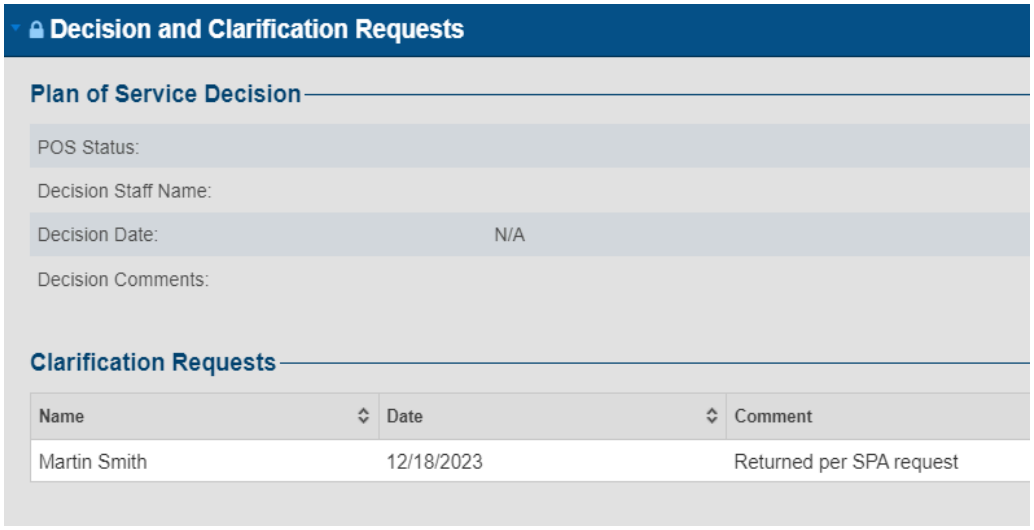
The other location is **Client Attachment**, which is accessible via the left navigation panel under **Case Management**.



Documents placed in **Client Attachment** are linked to the participant's profile and can be accessed when reviewing any POS. Typically, documents related to waiver enrollment, financial documentation, supports planning services, appeal hearing outcomes, and environmental assessments are uploaded here. The reviewer should always check this location if task schedules or other information specific to the plan are not included in the **Attachments** section of the POS.

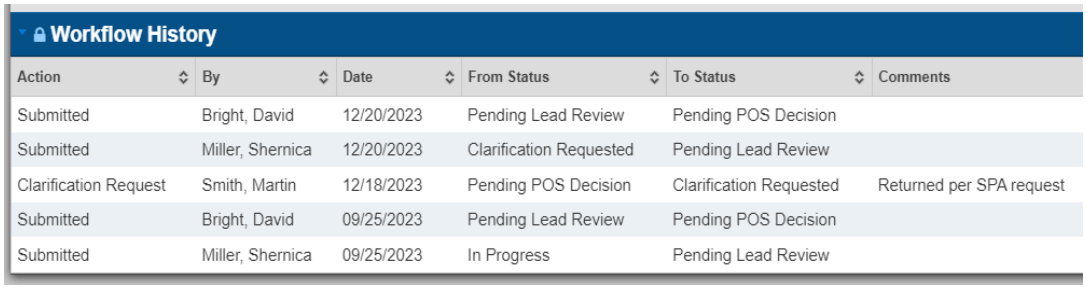
XI. Decision and Clarification Requests

All CRs submitted in relation to the plan are included in this section. The reviewer should review all previous CRs before initiating a broader review of the plan (see page 85 for more detail). Once a reviewer makes a final determination regarding a plan, the **POS Status** field will populate with "Approved" or "Denied." The name of the reviewer and decision date will auto populate.



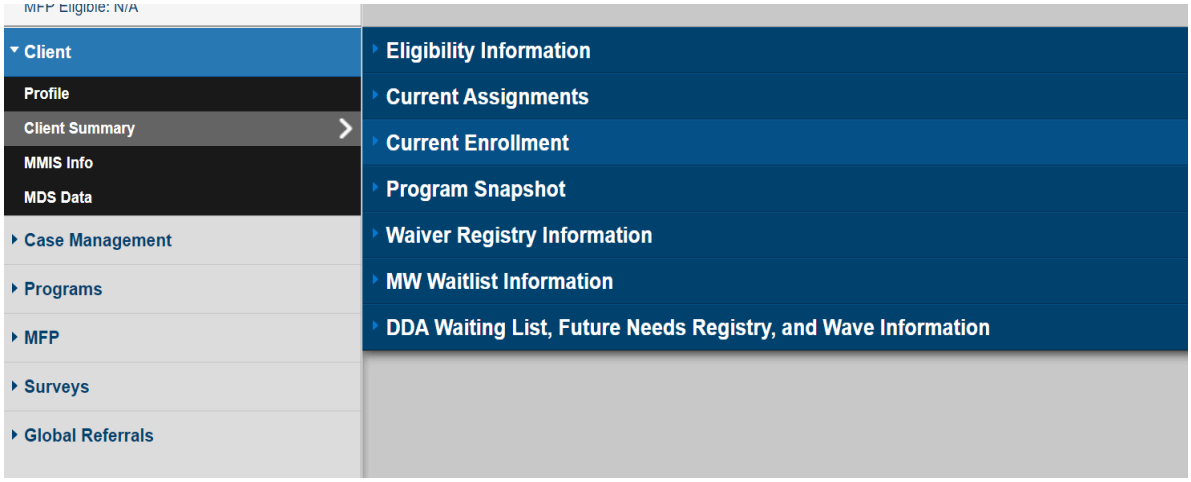
XII. Workflow History

The last section of the plan shows the workflow history, specifically who had possession of the plan, when, and what actions were taken. Under the **To Status** column, "In Progress," "Pending Lead Review," and "Clarification Requested" all indicate that the SP is in possession of the POS. The status "Pending POS Decision" means that the plan is pending a decision by the agency responsible for plan determinations, which historically has been OLTSS.



Information Accessible from the Left Navigation Panel

When a user searches for an individual in LTSS*Maryland* (see page 12 for more detail) and selects **Profile,** the below screenshot is the first screen displayed. A user chooses from several options on the left navigation panel to search the participant's record further.

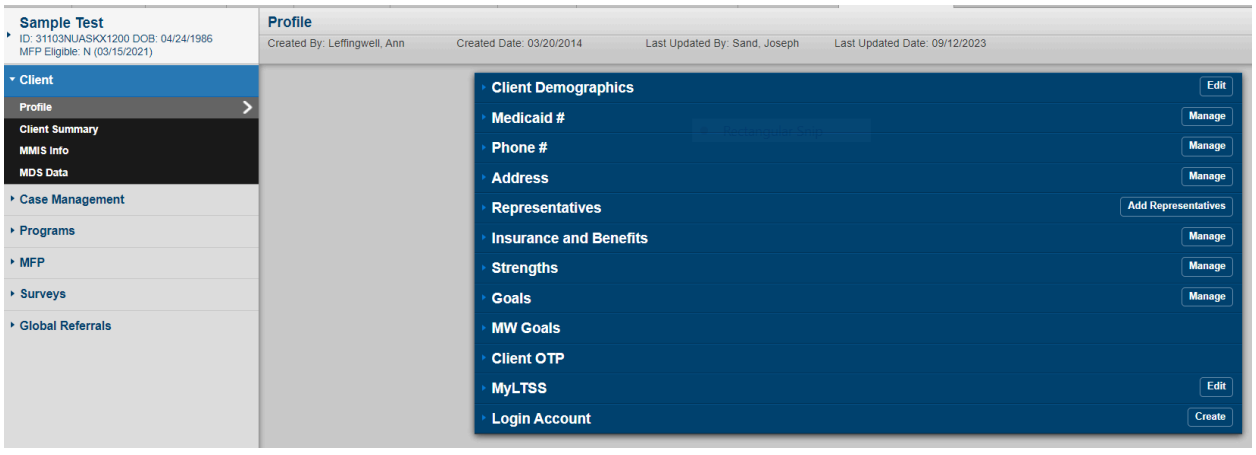


I. Client

The reviewer may review key sections of the participant's profile under the **Client** section, including **Profile**, **Client Summary**, and **MDS Data**.

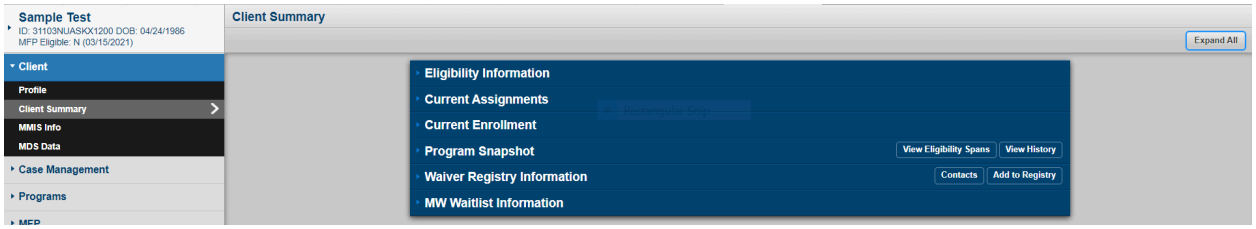
A. Profile

- The **Profile** section includes a participant's demographic information, Medicaid number, phone number, address, and representatives (if applicable). The **Representative** section must include the representative form or documentation of guardianship, if applicable. The reviewer must verify information in this section before providing information about the participant to anyone other than the participant or their assigned SP.



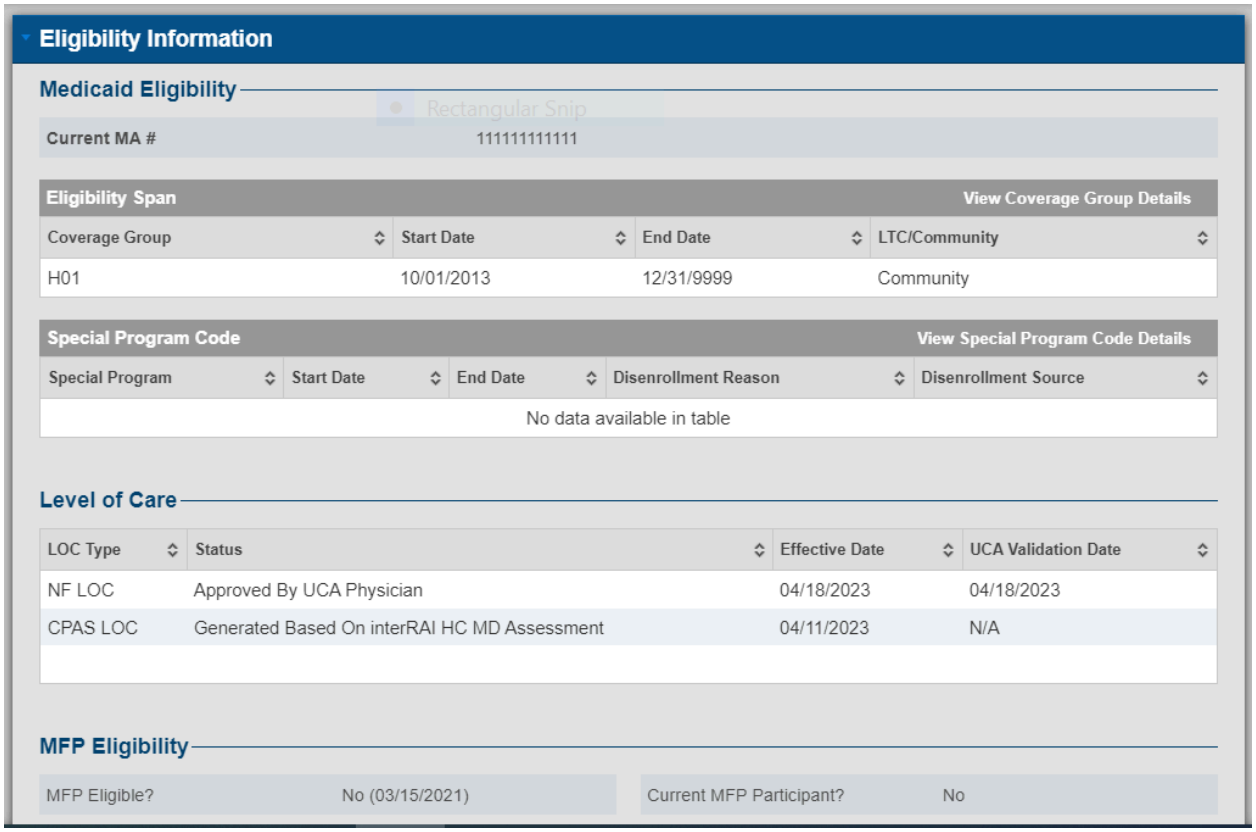
B. Client Summary

This section includes much useful information related to the participant's eligibility, enrollment, and waiver registry status, as well as the names and contact information of assigned SP, LHD assessors, LHD nurse monitors (if applicable), and EDD case workers (if applicable).



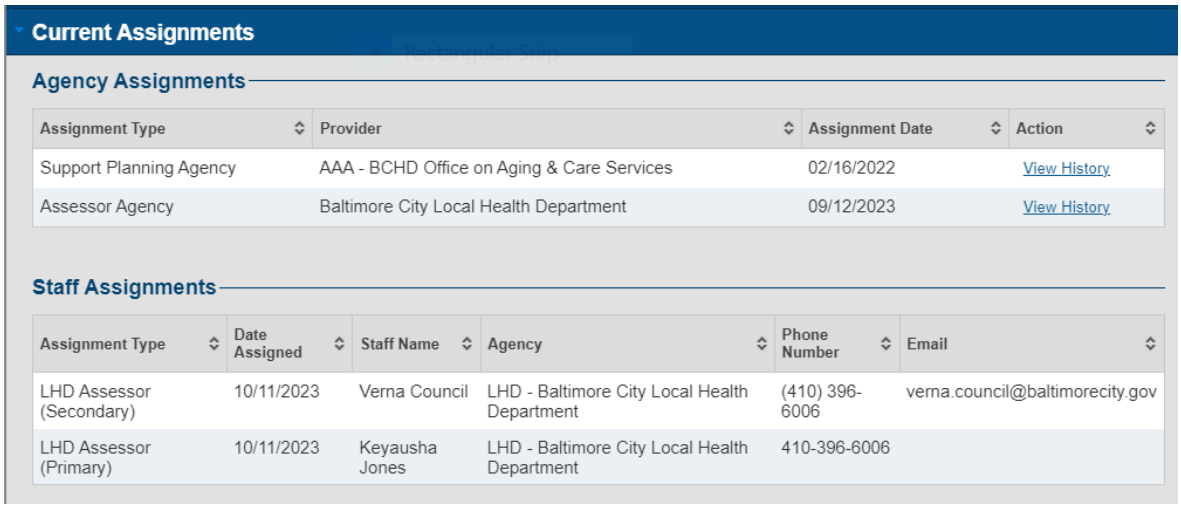
1. Eligibility Information

This section contains the participant's Medicaid number, Medicaid coverage group, special program codes (if applicable), LOC (CPAS, NF, Chronic, and DDA), and MFP eligibility and participation. Occasionally, eligibility information on the POS may not be populated, or it may seem questionable. In these instances, the reviewer should check this section to confirm eligibility status. If the LOC is more than 60 days expired, the field will be blank.



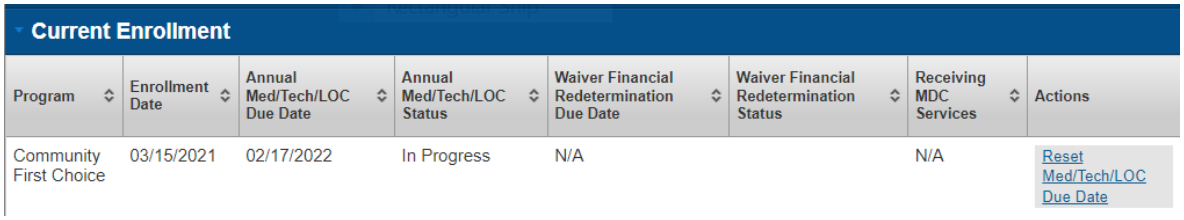
2. *Current Assignments*

This section provides names and contact information for individuals assigned to work with the participant, including the POS reviewer, once assigned.



3. *Current Enrollment*

This section details programs in which the participant is currently enrolled or in which enrollment is pending, as well as the annual medical/technical due date.

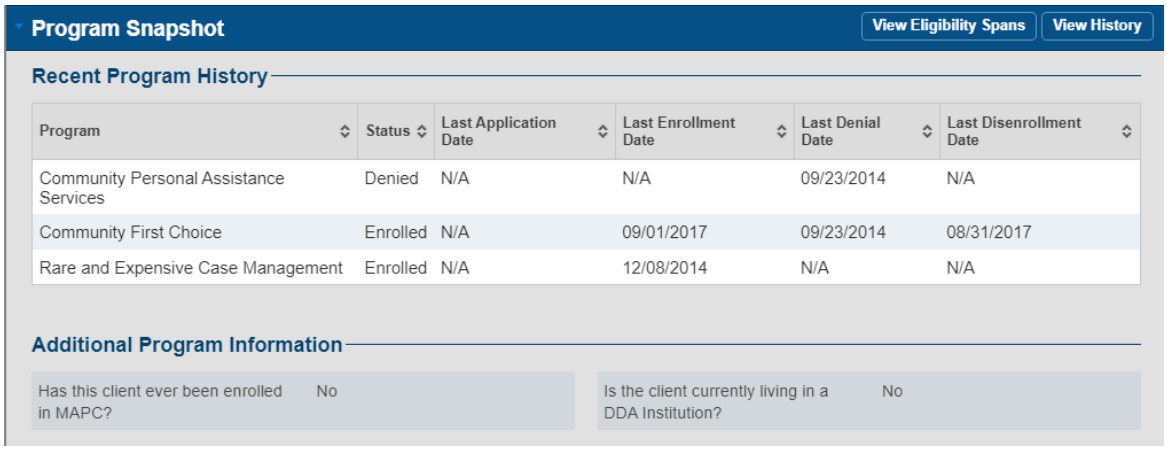


Current Enrollment

Program	Enrollment Date	Annual Med/Tech/LOC Due Date	Annual Med/Tech/LOC Status	Waiver Financial Redetermination Due Date	Waiver Financial Redetermination Status	Receiving MDC Services	Actions
Community First Choice	03/15/2021	02/17/2022	In Progress	N/A		N/A	Reset Med/Tech/LOC Due Date

4. Program Snapshot

This section provides a full enrollment history for all programs, including enrollment and disenrollment dates (if applicable).



Program Snapshot View Eligibility Spans | View History

Recent Program History

Program	Status	Last Application Date	Last Enrollment Date	Last Denial Date	Last Disenrollment Date
Community Personal Assistance Services	Denied	N/A	N/A	09/23/2014	N/A
Community First Choice	Enrolled	N/A	09/01/2017	09/23/2014	08/31/2017
Rare and Expensive Case Management	Enrolled	N/A	12/08/2014	N/A	N/A

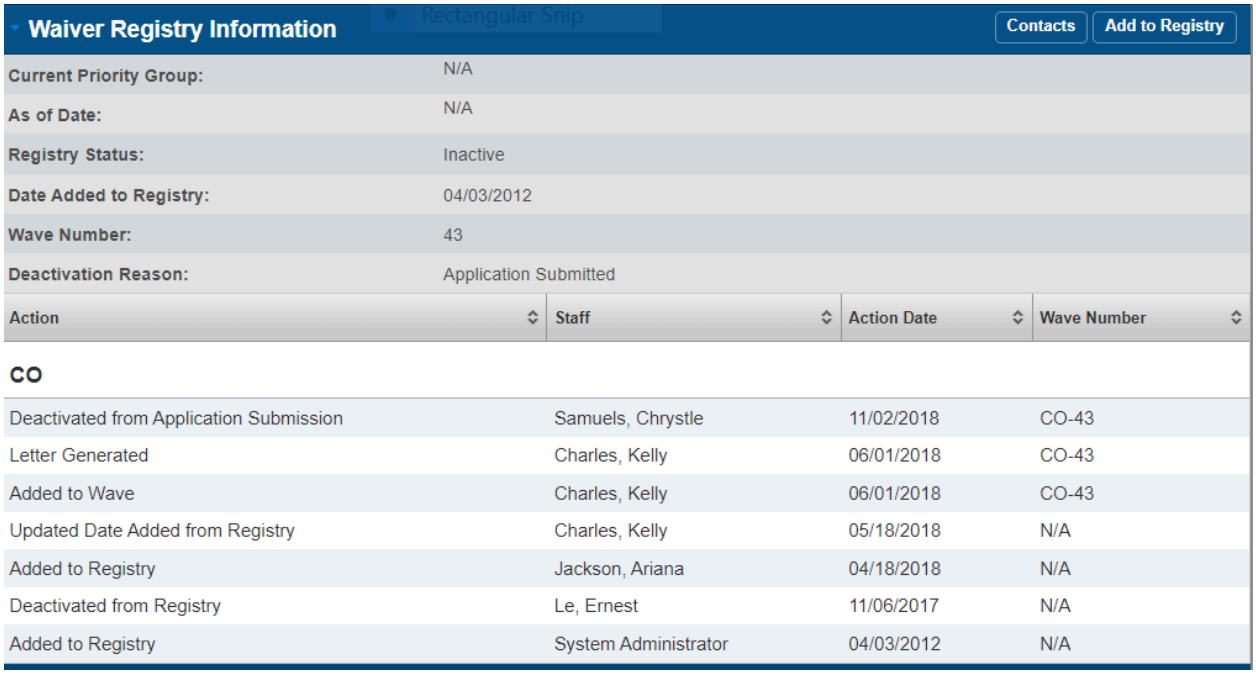
Additional Program Information

Has this client ever been enrolled in MAPC? No

Is the client currently living in a DDA Institution? No

5. Waiver Registry Information

This section provides information about whether an individual is currently on the CO Waiver registry and has been invited to apply to the waiver. As evidenced by the screenshot below, a user can see the date an individual was added to the registry (2012), deactivated from the registry (2017), added to the registry again (2018), and "Added to the Wave" of individuals who were sent invitations to apply to the waiver in June 2018. The individual was then deactivated from the registry in November 2018 after OLTSS received their waiver application.



Waiver Registry Information — Contacts | Add to Registry

Current Priority Group:	N/A
As of Date:	N/A
Registry Status:	Inactive
Date Added to Registry:	04/03/2012
Wave Number:	43
Deactivation Reason:	Application Submitted

Action	Staff	Action Date	Wave Number
CO			
Deactivated from Application Submission	Samuels, Chrystle	11/02/2018	CO-43
Letter Generated	Charles, Kelly	06/01/2018	CO-43
Added to Wave	Charles, Kelly	06/01/2018	CO-43
Updated Date Added from Registry	Charles, Kelly	05/18/2018	N/A
Added to Registry	Jackson, Ariana	04/18/2018	N/A
Deactivated from Registry	Le, Ernest	11/06/2017	N/A
Added to Registry	System Administrator	04/03/2012	N/A

C. MDS Data

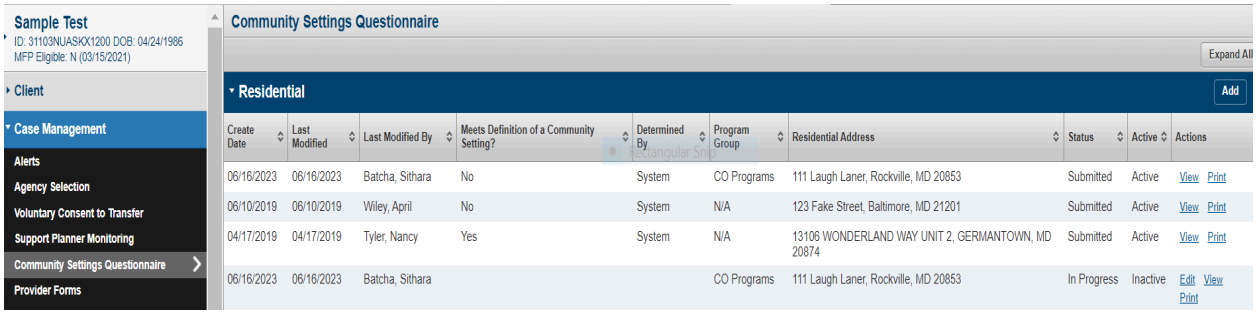
An individual in a NF is required to have an assessment called the Minimum Data Set (MDS). If a participant has been in a NF as a Medicaid recipient, this section will contain MDS information generated while in the NF. On occasion, when the results of the interRAI assessment do not support a participant's service request, a reviewer may use the MDS as an additional source of information regarding the participant's functional status. The reviewer should balance the information found in the MDS with that of the interRAI and other supporting documentation, with the understanding that MDS results may be skewed in the interest of the NF.

II. Case Management

As the name suggests, this section is primarily focused on activities completed by the SP. The following should be reviewed by the reviewer in concert with the POS:

A. Community Settings Questionnaire

This section contains all completed and in progress CSQs for both residential and day settings (e.g., Medical Day Care).



If a reviewer has questions about the CSQ summary information included in the POS, the full CSQ is accessible via this section. To receive services through CPAS or CFC, the participant must live in a community setting as defined by COMAR 10.09.84.02B(9) and COMAR 10.09.84.02B(13). As of March 2023, all CO Waiver and ICS participants that reside in an ALF, must reside in a facility that also meets the definition of a community setting.

If a CSQ looks inaccurate; for example, the CSQ reports the residence is a private home, but the address is listed as an ALF or appears to be a provider-controlled setting, the reviewer should stop their review and contact OLTSS for further guidance.

B. Reportable Events

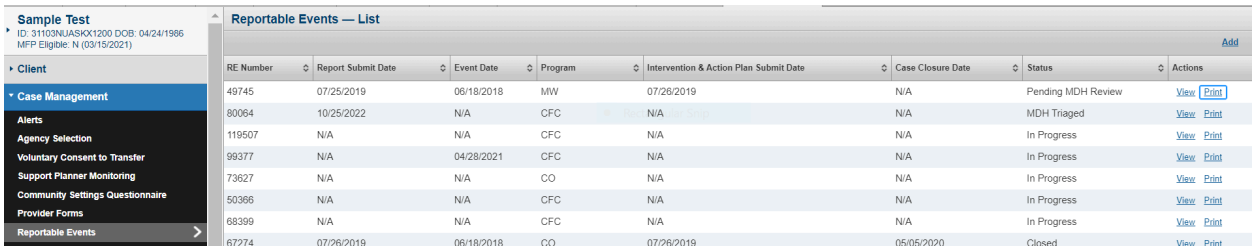
This section contains all reportable events (RE) submitted for a participant. An RE is an allegation or actual occurrence of an incident that adversely affects or has the potential to adversely affect the health and welfare of a program participant. Complaints by participants related to their participation in the program, including services and providers, should also be reported as an RE.

Incidents that should be reported as an RE include, but are not limited to:

- Hospitalization
- Falls
- Death
- Wounds
- Suicide/Suicide attempt
- Abuse, neglect and exploitation
- Medication errors
- Fraud
- Poor quality of services

SPs and LHD nurse monitors are responsible for submitting REs for any eligible occurrences. If the reviewer believes an RE should be submitted based on information in the POS, but does not see a corresponding RE in LTSS*Maryland*, the reviewer should contact OLTSS. REs may also give a reviewer additional context to help support or counter a participant's request for services as they provide another source of information for triangulation.

An RE is best viewed in the **Print** format. The RE includes the **Event Report** provided by the submitter, the **Intervention and Action Plan** to address the root cause(s) of the incident or complaint, and follow-up completed by OLTSS staff documented in the **Progress Notes** section of the RE.



C. Activities

The **Activities** section is intended as the mechanism through which SP and Nurse Monitors (as well as other Medicaid programs' case managers) submit activities and supporting documentation for the purpose of reimbursement. Activities translate to submitted claims, which are processed via the Medicaid Management Information System (MMIS). Despite its intended use, conventionally it is used by SP to document interaction with the participant. The reviewer may find it useful to view detailed activity notes entered by the SP, particularly when a reviewer has questions about what the SP communicated to the participant regarding the POS or recent interactions between the SP and the participant.

Access to **Activities** is limited to certain user roles; for example, while reviewers can see the full details of SP activities, LHD assessors and nurse monitors are unable to view these details.

D. Progress Notes

The Progress Notes section is intended as the area in which all individuals working to support the participant document their interactions with the participant and provide relevant updates; however, as noted above, SPs complete most of their documentation in the **Activities** section.

E. Client Attachment

As noted on page 27, a user can upload documentation that is not categorized elsewhere in LTSS*Maryland* under **Client Attachment**. There are many subcategories such as Application, Financial Documents, Medical Documentation, Environmental Assessment, Guardian of Person, and Other.

While task schedules and medical documentation specific to a POS are often included in the **Attachments** section within the POS, they may be uploaded in this section instead. The reviewer should check both locations when searching for documents.

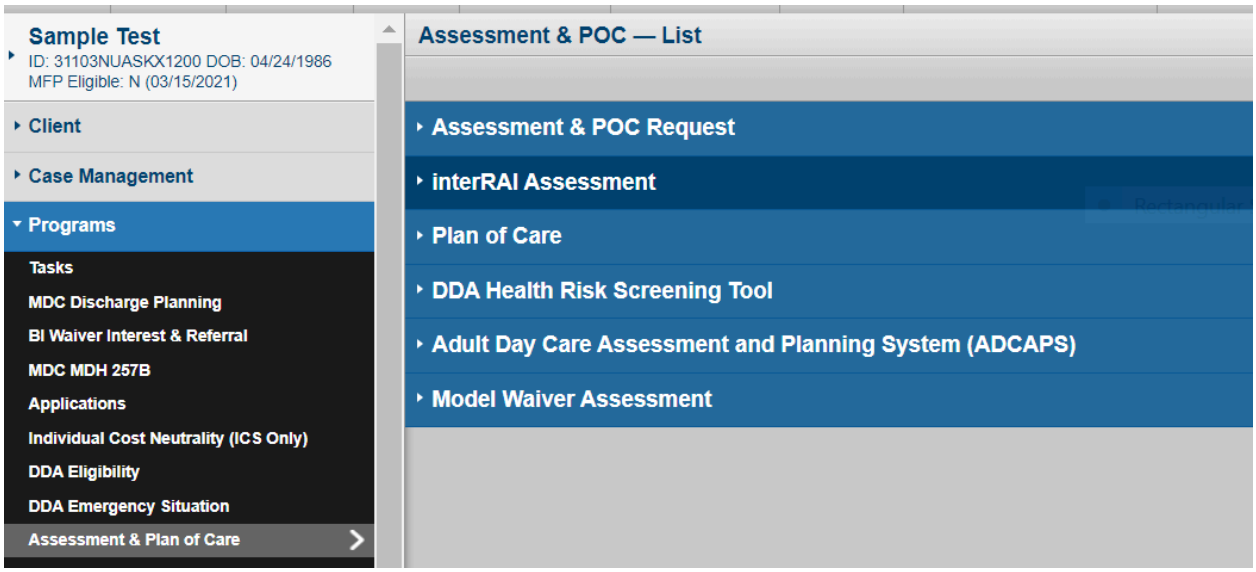
III. Programs

A. Individual Cost Neutrality (ICS Only)

This section will only appear for ICS participants. If the cost neutrality figure is missing for an ICS participant, the reviewer should contact OLTSS to request that the ICS cost neutrality amount be entered so that the review may continue (see page 12 for more detail).

B. Assessment & Plan of Care

This section contains all interRAI assessment requests, completed and in progress interRAI assessments, completed and in progress POC, as well as assessments for some other Medicaid HCBS programs, such as the Health Risk Screening Tool utilized by DDA.



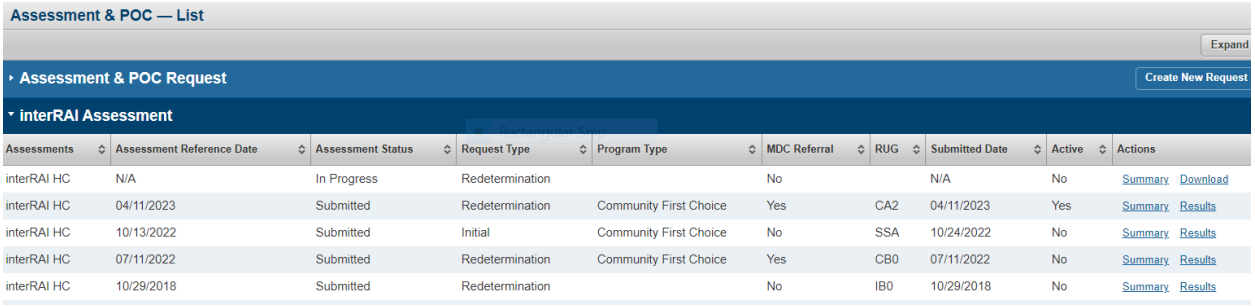
1. Assessment & POC Request

The **Assessment and POC Request** contains all active and inactive interRAI assessment requests, including the original request date, assessor agency assigned, due date, completion date (if applicable), and deactivation date (if applicable). If a reviewer has questions about the status of an assessment request, they can see additional detail about **Attempts to Contact**, **Justification for Delay, and/or Deactivation Details** (for inactive requests) by selecting **View** for the respective request.

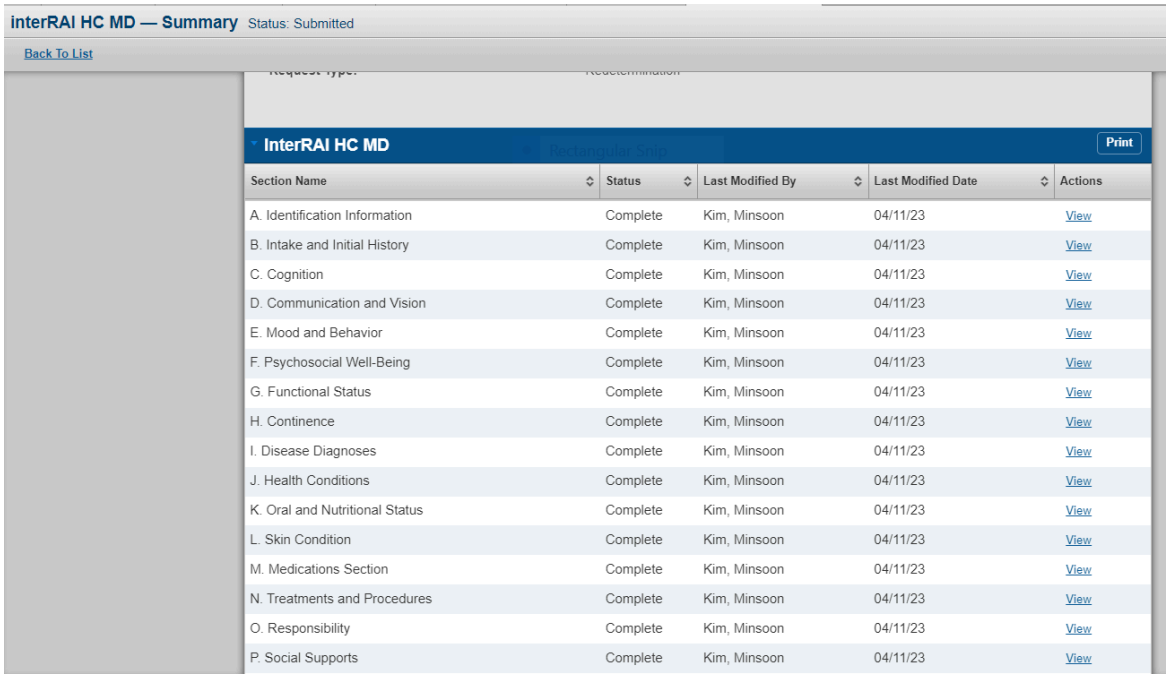
Original Request Date	Requested By	Requested By Agency	Request Type	Agency Assigned	Assigned Staff	Triage Date	Due Date	Request Completion Date	Deactivation Date	Status	Actions
05/15/2023	Kim, Minsoon	LHD	Redetermination	Baltimore City Local Health Department	Keyausha Jones	09/12/2023	9/27/2023	N/A	N/A	Active	View
04/13/2023	Kim, Minsoon	LHD	Initial	Montgomery Local Health Department	Minsoon Kim	N/A	4/28/2023	N/A	05/15/2023	Inactive	View
01/18/2023	Goodman, Carrie	DHMH	Redetermination	Montgomery Local Health Department	Evelyn Mba	N/A	2/2/2023	N/A	01/18/2023	Inactive	View
10/12/2022	Powell, Tonia	LHD	Initial	Montgomery Local Health	Evelyn Mba	N/A	10/27/2022	10/25/2022	N/A	Inactive	View

2. *interRAI Assessment*

This section contains all in progress and submitted interRAI assessments. In addition to being a critical component of determining medical eligibility, the interRAI assessment is the primary supporting document for a participant's POS requests. A reviewer can read the full interRAI assessment by selecting **Summary** for the applicable assessment or review key components of the assessment through the *Personal Health Summary* by selecting **Results**. The full assessment is best viewed in its entirety by selecting **Print** in the right-hand corner after choosing the assessment of interest.



Assessments	Assessment Reference Date	Assessment Status	Request Type	Program Type	MDC Referral	RUG	Submitted Date	Active	Actions
interRAI HC	N/A	In Progress	Redetermination		No		N/A	No	Summary Download
interRAI HC	04/11/2023	Submitted	Redetermination	Community First Choice	Yes	CA2	04/11/2023	Yes	Summary Results
interRAI HC	10/13/2022	Submitted	Initial	Community First Choice	No	SSA	10/24/2022	No	Summary Results
interRAI HC	07/11/2022	Submitted	Redetermination	Community First Choice	Yes	CB0	07/11/2022	No	Summary Results
interRAI HC	10/29/2018	Submitted	Redetermination		No	IB0	10/29/2018	No	Summary Results



interRAI HC MD — Summary Status: Submitted

Back To List

InterRAI HC MD

Print

Section Name	Status	Last Modified By	Last Modified Date	Actions
A. Identification Information	Complete	Kim, Minsoon	04/11/23	View
B. Intake and Initial History	Complete	Kim, Minsoon	04/11/23	View
C. Cognition	Complete	Kim, Minsoon	04/11/23	View
D. Communication and Vision	Complete	Kim, Minsoon	04/11/23	View
E. Mood and Behavior	Complete	Kim, Minsoon	04/11/23	View
F. Psychosocial Well-Being	Complete	Kim, Minsoon	04/11/23	View
G. Functional Status	Complete	Kim, Minsoon	04/11/23	View
H. Continence	Complete	Kim, Minsoon	04/11/23	View
I. Disease Diagnoses	Complete	Kim, Minsoon	04/11/23	View
J. Health Conditions	Complete	Kim, Minsoon	04/11/23	View
K. Oral and Nutritional Status	Complete	Kim, Minsoon	04/11/23	View
L. Skin Condition	Complete	Kim, Minsoon	04/11/23	View
M. Medications Section	Complete	Kim, Minsoon	04/11/23	View
N. Treatments and Procedures	Complete	Kim, Minsoon	04/11/23	View
O. Responsibility	Complete	Kim, Minsoon	04/11/23	View
P. Social Supports	Complete	Kim, Minsoon	04/11/23	View

Although the primary entity completing interRAI assessments are the LHDs, the UCA and MDC providers also complete assessments. **For purposes of participation in the CPAS, CFC, CO Waiver and ICS programs, only assessments completed by either an LHD or the UCA are valid.** If the SP submits a POS in which the active LOC was determined by an assessment completed by an MDC provider, the reviewer should send the plan back through a CR indicating that a new assessment must be completed by the LHD. Section T of the interRAI contains information about who completed the assessment, the method by which it was completed,[9] and how long it took to complete the assessment. While an interRAI assessment completed by an MDC provider is not valid for CPAS, CFC, CO Waiver and ICS program participation, the annual assessment that MDC providers complete (called the ADCAPS) may be a useful source of supplemental information and is often reviewed in the context of plan review.

SECTION T. Assessment Information

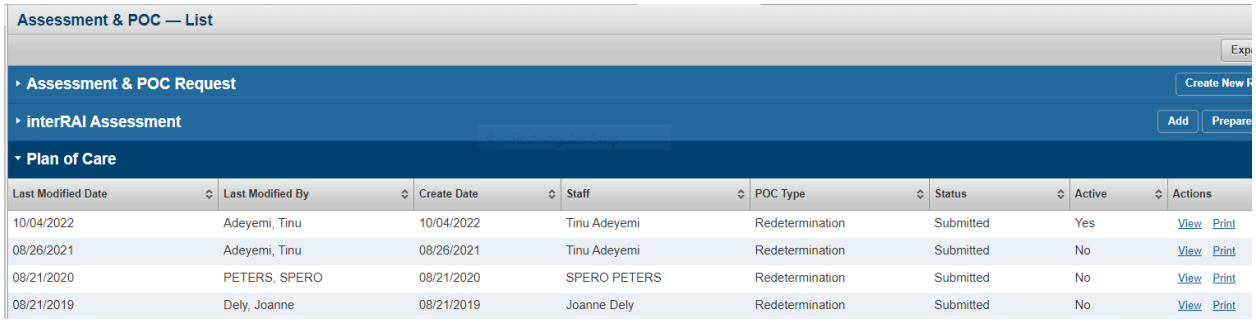
Question	Answer
Person Coordinating / Completing the Assessment	
1. Assessor:	Purnell, Rochelle
2. Assessor Agency:	Baltimore City Local Health Department
3. Date assessment completed:	3/21/2023
3.a. How was this assessment completed? Please select all options that apply.	In-Person
4. How long did this assessment take to complete?	
In person	2 hours 0 minutes
Additional	0 hours 15 minutes
Section T. Comments:	

[9]Effective July 1, 2023, all interRAI assessments must be completed in person. If a reviewer determines that an assessment was not completed in person, they should contact OLTSS for further guidance.

OLTSS uses two versions of the interRAI – the interRAI Home Care (HC), which is intended for individuals ages 18 and up, and the interRAI Pediatric HC (PEDS HC), which while intended for individuals ages four to 17, is used by OLTSS for any participants under the age of 18 (see pages 48-57 for more details about the interRAI assessment and using it in the context of UR).

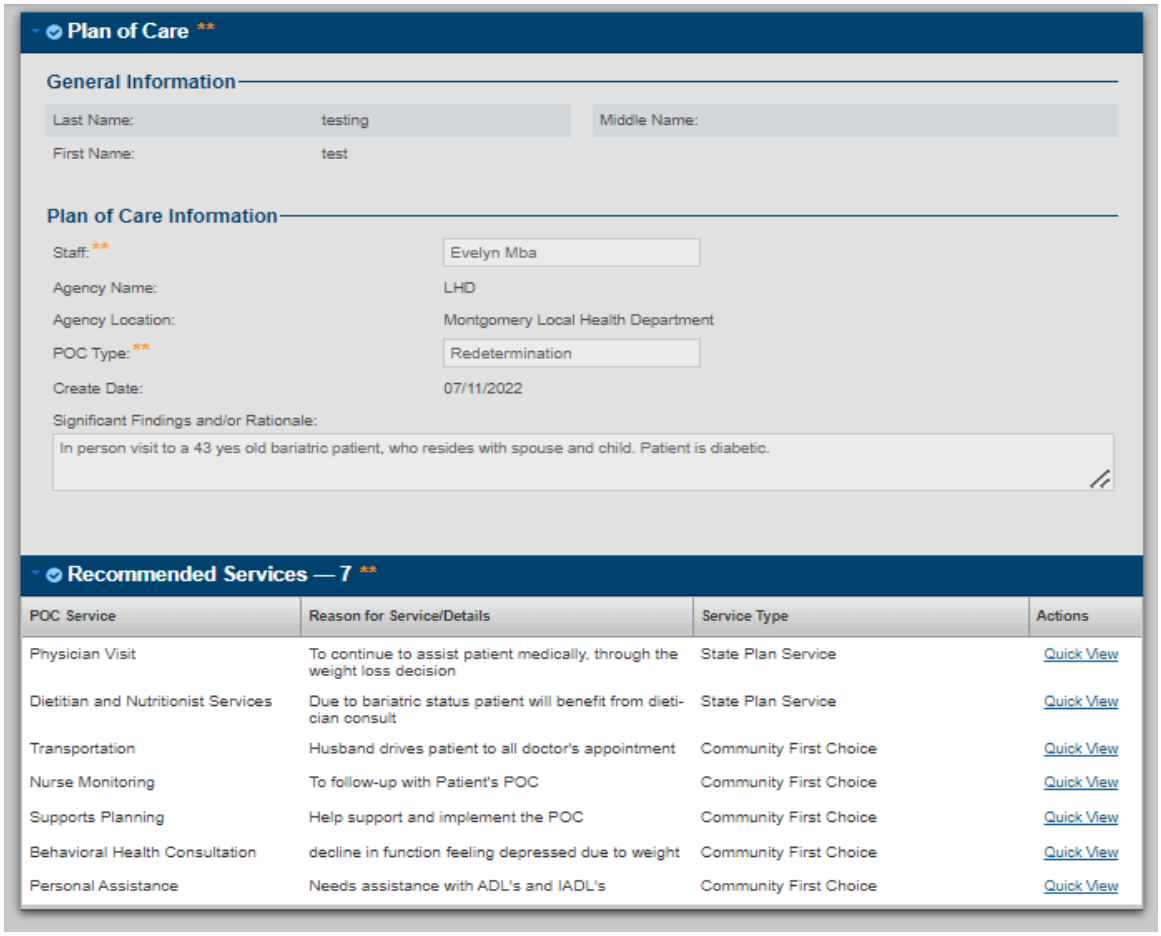
3. *Plan of Care*

Each interRAI assessment must be accompanied by a POC, which the assessor uses to recommend services that are needed to support the participant's health and welfare in the community. Ideally, the POC is holistic in nature, meaning it does not simply include CPAS, CFC, CO Waiver or ICS program services that are recommended, but other Medicaid, as well as non-Medicaid services from which the participant would benefit. A reviewer can select either **View** or **Print** to read the POC.



Last Modified Date	Last Modified By	Create Date	Staff	POC Type	Status	Active	Actions
10/04/2022	Adeyemi, Tinu	10/04/2022	Tinu Adeyemi	Redetermination	Submitted	Yes	View Print
08/26/2021	Adeyemi, Tinu	08/26/2021	Tinu Adeyemi	Redetermination	Submitted	No	View Print
08/21/2020	PETERS, SPERO	08/21/2020	SPERO PETERS	Redetermination	Submitted	No	View Print
08/21/2019	Dely, Joanne	08/21/2019	Joanne Dely	Redetermination	Submitted	No	View Print

The reviewer should check to see that all recommended services from the POC are addressed in the POS as the POC correlates to the interRAI assessment in suggesting services and supports in response to the participant's assessed needs. If the recommended service is not listed under either the flexible or non-flexible services, and there is no indication in the narrative that the participant is refusing the recommended service, the reviewer should send the plan back to the SP through a CR. **If the service is necessary to support the participant's health and welfare in the community, the SP must address how the need will be met without the recommended service.** For example, if a PERS is recommended by the assessor, but declined by the participant because they have substantial informal supports (which were ostensibly not shared by the participant during the assessment), the SP should provide this context in the narrative section of the POS.



Plan of Care **

General Information

Last Name:	testing	Middle Name:	
First Name:	test		

Plan of Care Information

Staff: **	Evelyn Mba
Agency Name:	LHD
Agency Location:	Montgomery Local Health Department
POC Type: **	Redetermination
Create Date:	07/11/2022

Significant Findings and/or Rationale:

In person visit to a 43 yes old bariatric patient, who resides with spouse and child. Patient is diabetic.

Recommended Services — 7 **

POC Service	Reason for Service/Details	Service Type	Actions
Physician Visit	To continue to assist patient medically, through the weight loss decision	State Plan Service	Quick View
Dietitian and Nutritionist Services	Due to bariatric status patient will benefit from dietician consult	State Plan Service	Quick View
Transportation	Husband drives patient to all doctor's appointment	Community First Choice	Quick View
Nurse Monitoring	To follow-up with Patient's POC	Community First Choice	Quick View
Supports Planning	Help support and implement the POC	Community First Choice	Quick View
Behavioral Health Consultation	decline in function feeling depressed due to weight	Community First Choice	Quick View
Personal Assistance	Needs assistance with ADL's and IADL's	Community First Choice	Quick View

4. ADCAPS

The Adult Day Care Assessment and Planning System (ADCAPS) is used by MDC providers to assess the needs of their participants annually. As mentioned above, it can also serve as another source of information during the UR process, especially if the service request is not supported by the interRAI. As with MDS data, the reviewer should balance the information found in the ADCAPS with that of the interRAI and other supporting documentation, with the understanding that ADCAPS may be skewed in the interest of the MDC provider.

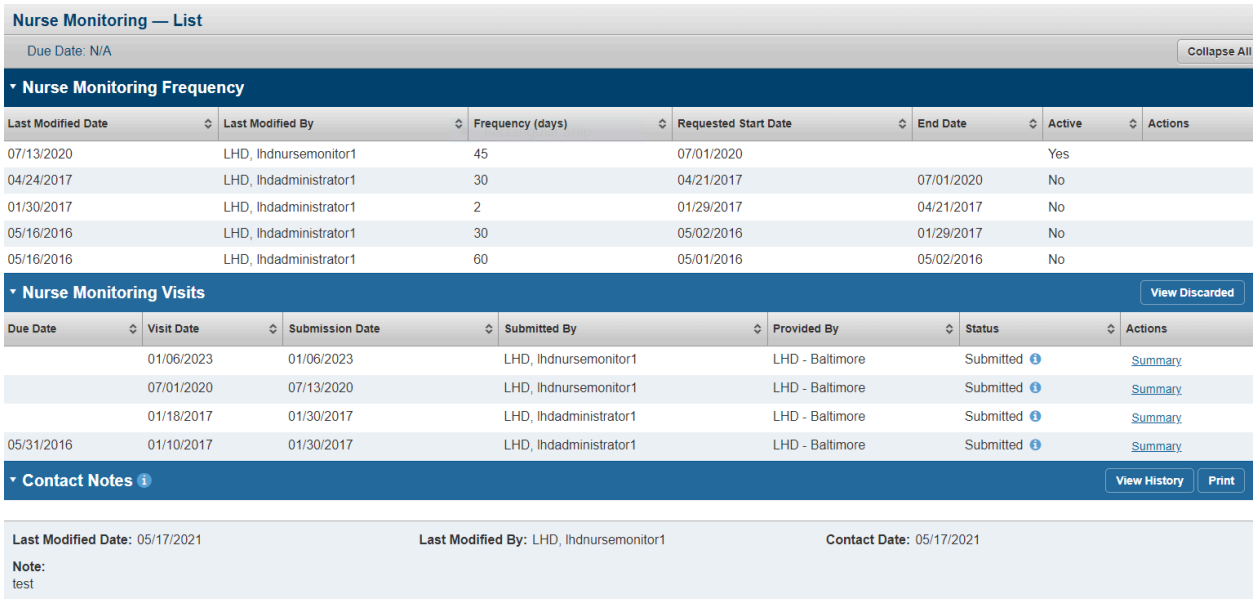
B. Nurse Monitoring

Nurse monitoring is a service provided by the LHDs to participants who receive PAS. All participants actively receiving PAS, must also receive nurse monitoring as the purpose of the service is to evaluate the quality of PAS. At minimum, nurse monitoring must be delivered twice annually, with at least one of the two visits conducted in person. Unless waived by the participant to the minimum, the LHD nurse monitor and the participant

will agree upon a frequency of visits, which are established in LTSS*Maryland*.[10] The SP must obtain an updated waiver form each year, during the development of the Annual POS if the participant wishes to continue waiving the service of nurse monitoring.

A reviewer can view whether a participant has waived nurse monitoring to the minimum in LTSS*Maryland* under **Case Management > Provider Forms > Nurse Monitoring Waiver**. The accompanying waiver form should be uploaded to **Client Attachments**.

Nurse Monitoring Frequency displays all current and previous frequencies. The current frequency is indicated by "Yes" under **Active**. **Nurse Monitoring Visits** provides summary information about the due date, visit date, submission date, and status of nurse monitoring visits. Nurse monitors use three different tools in the context of their visits – the **Nurse Monitoring Participant Assessment**, the **RSA Checklist** and the **Visit Note**. Completing any one of the three activities constitutes a visit. Data collected by nurse monitors can be an invaluable source of information for the UR process, as they constitute observations of a participant's health and functional status in direct relationship to PAS. At minimum, a reviewer should review data from the most recent nurse monitoring visit if the participant is actively receiving PAS and the interRAI and other submitted documentation do not support the service request. A reviewer can view the specific activities conducted during a visit by selecting **Summary**. **Contact Notes** function much like **Progress Notes**, but offer the nurse monitor a place to provide more detailed status updates.

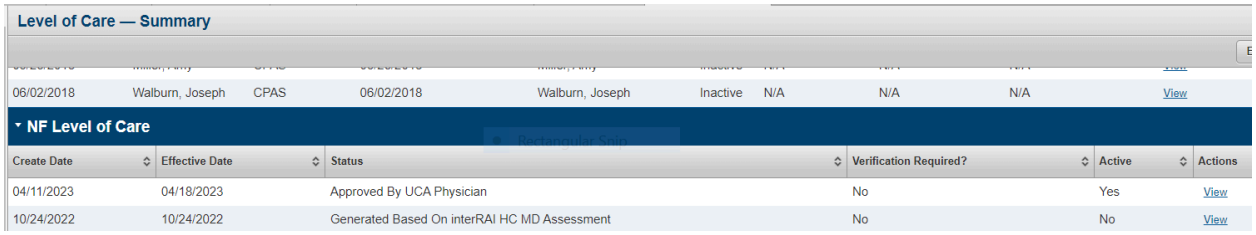


[10] The nurse monitor does have the discretion to increase the frequency of visits, even if the participant has waived the service to the minimum, if there are documented health and welfare concerns related to PAS.

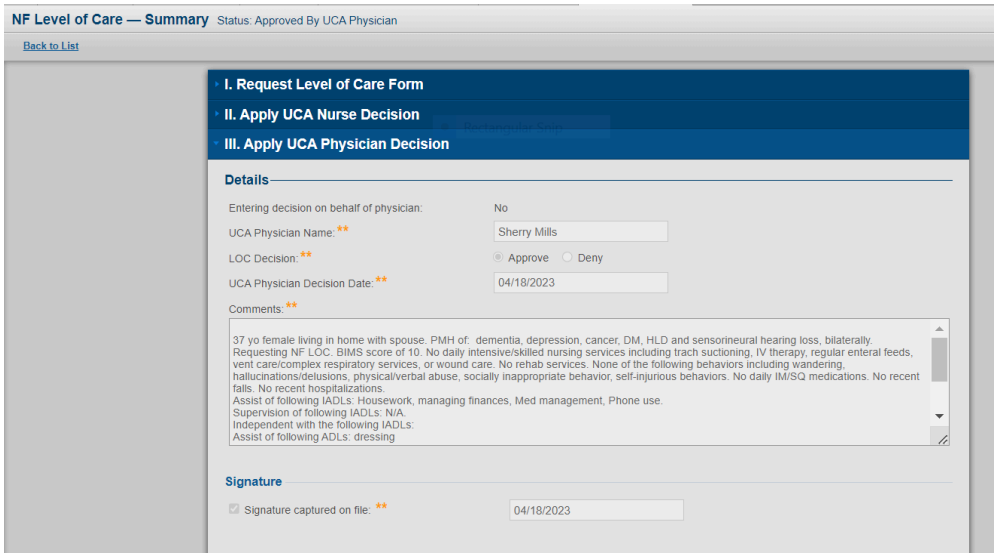
C. Level of Care

This section contains all LOC history, except for DDA LOC, for all Medicaid HCBS programs utilizing LTSS*Maryland*. The **LOC Summary** is divided into the **LOC Request** (type, date received, date completed, and who completed it) and LOC outcomes (NF, CPAS, Chronic, and MW LOCs). A user can select any LOC outcome to see additional details about that specific LOC.

In the below screenshot, there are two NF LOC decisions displayed. The request created on 10/24/2022 was auto approved upon submission of the interRAI assessment. The request created on 4/11/2023 was not auto approved; thus, the request was sent to the UCA for review and LOC determination.



A user can view the rationale for the UCA's decision, by selecting **View > Apply UCA Physician Decision**.



D. Current Services

This section provides a synopsis of the services provided to a participant enrolled in any of the listed programs. The following terms are used by the respective programs to refer to their plans:

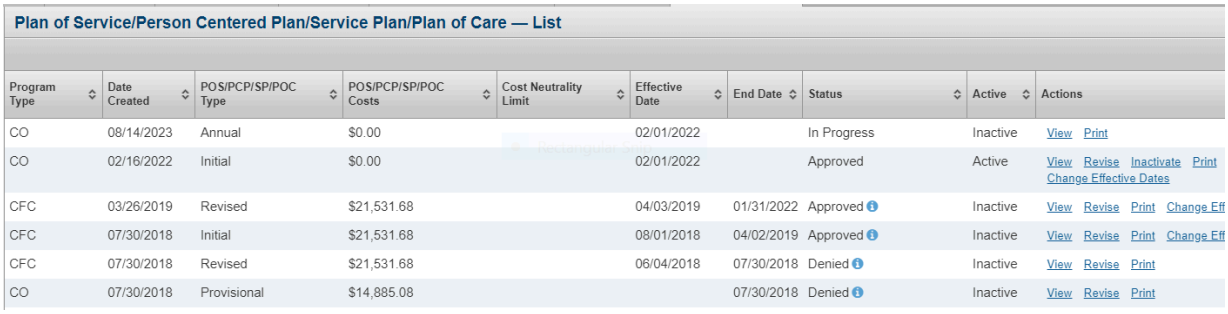
- Plan of Service (POS) – CFC, CPAS, CO Waiver, ICS
- Person Centered Plan (PCP) – Community Pathways Waiver, Community Supports Waiver, Family Supports Waiver
- MDC Service Plan (SP) – MDC Services Waiver
- Service Authorization (SA) – Used to authorize PDN for REM and MW
- Plan of Care (POC) - Model Waiver and Autism Waiver[11]

The synopsis will not provide enough information about how concurrently enrolled participants use the services provided in the other programs, so the reviewer must also review the detailed plans under the **POS/PCP/SP/POC** section.

E. POS/PCP/SP/POC

This section contains all POS history, including other programs' plans (to the extent a user has the appropriate permissions to view them). At minimum, a reviewer should review the active, approved POS (if applicable) to understand what services the participant is already receiving, as well as any previously denied POS. A user can select **View** to see plan details.

[11] As of the date of publication, information from Autism Waiver POC was not yet reflected in LTSS*Maryland*, but slated for a future enhancement.



Plan of Service/Person Centered Plan/Service Plan/Plan of Care — List

Program Type	Date Created	POS/PCP/SP/POC Type	POS/PCP/SP/POC Costs	Cost Neutrality Limit	Effective Date	End Date	Status	Active	Actions
CO	08/14/2023	Annual	$0.00		02/01/2022		In Progress	Inactive	View Print
CO	02/16/2022	Initial	$0.00		02/01/2022		Approved	Active	View Revise Inactivate Print Change Effective Dates
CFC	03/26/2019	Revised	$21,531.68		04/03/2019	01/31/2022	Approved	Inactive	View Revise Print Change Eff
CFC	07/30/2018	Initial	$21,531.68		08/01/2018	04/02/2019	Approved	Inactive	View Revise Print Change Eff
CFC	07/30/2018	Revised	$21,531.68		06/04/2018	07/30/2018	Denied	Inactive	View Revise Print
CO	07/30/2018	Provisional	$14,885.08			07/30/2018	Denied	Inactive	View Revise Print

If a participant is concurrently enrolled, the reviewer must review the plan(s) for the other programs (see pages 82-85 for more detail on the UR process for concurrent enrollment).

F. Authorization to Participate

One of the last steps in the enrollment process is the submission of the "Authorization to Participate" (ATP), although enrollment is not finalized until OLTSS or EDD (for the CO Waiver and ICS) enters an **Overall Decision** of "approve." The ATP is auto-generated in LTSS*Maryland* after approval of an initial POS. For CPAS and CFC, OLTSS reviews and submits the ATP, enters an **Overall Decision** of "approve," and issues the enrollment letter. For the CO Waiver and ICS, OLTSS reviews and submits the ATP to EDD, who is responsible for entering an **Overall Decision** of "approve" and issuing the enrollment letter.

ATPs are also used by OLTSS to indicate other actions such as denial or disenrollment. All ATPs are detailed in this section, and a user can select **View** to see ATP details.

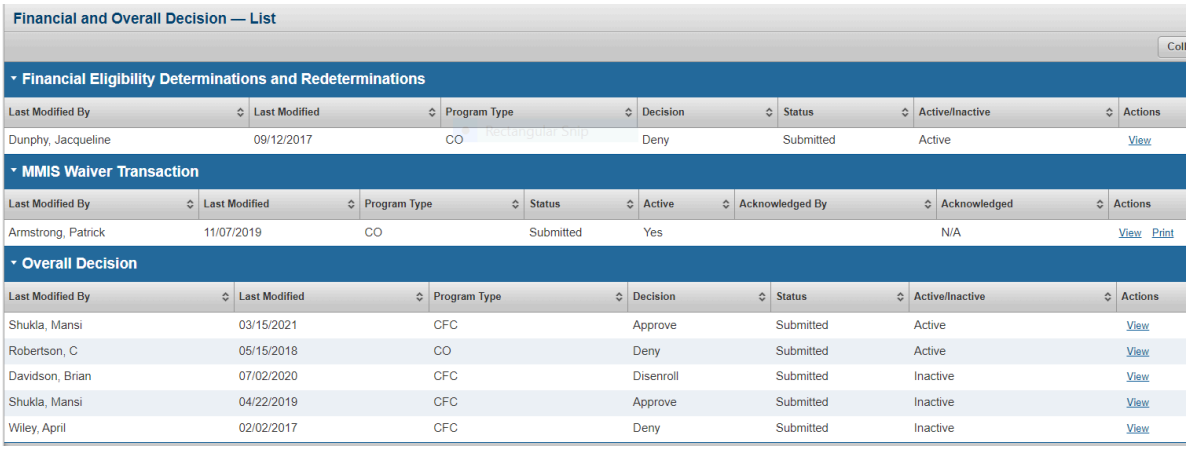
Authorization to Participate

ATP Questionnaires

Program Type	ATP Type	Last Modified Date	Last Modified By	Status	Active/Inactive	Actions
CFC	Authorization	03/15/2021	Shukla, Mansi	Submitted	Active	View Print
CFC	Authorization	04/22/2019	Shukla, Mansi	Submitted	Inactive	View Print
CFC	Disenrollment	02/02/2017	Wiley, April	Submitted	Inactive	View Print

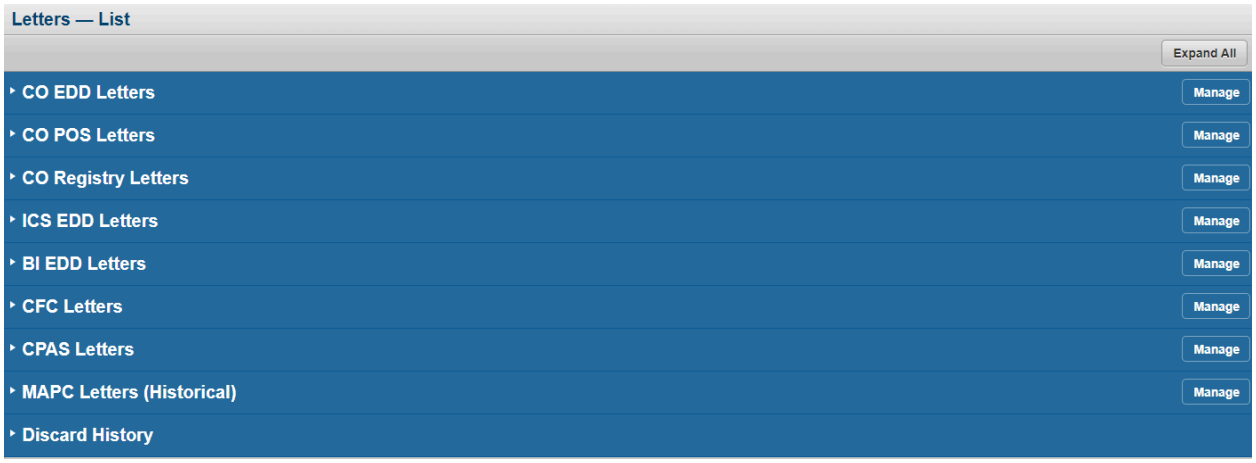
G. Financial and Overall Decision

The **Financial and Overall Decision** section provides information regarding financial eligibility for the CO Waiver and ICS program, as well as each program's overall decision as it relates to enrollment. EDD is responsible for entering the **Overall Decision** for the CO Waiver and ICS, while OLTSS staff are responsible for entering this information for CPAS and CFC. A reviewer may need to review this section to understand the status of a CO Waiver applicant, as it relates to prioritizing a Provisional POS.



H. Letters

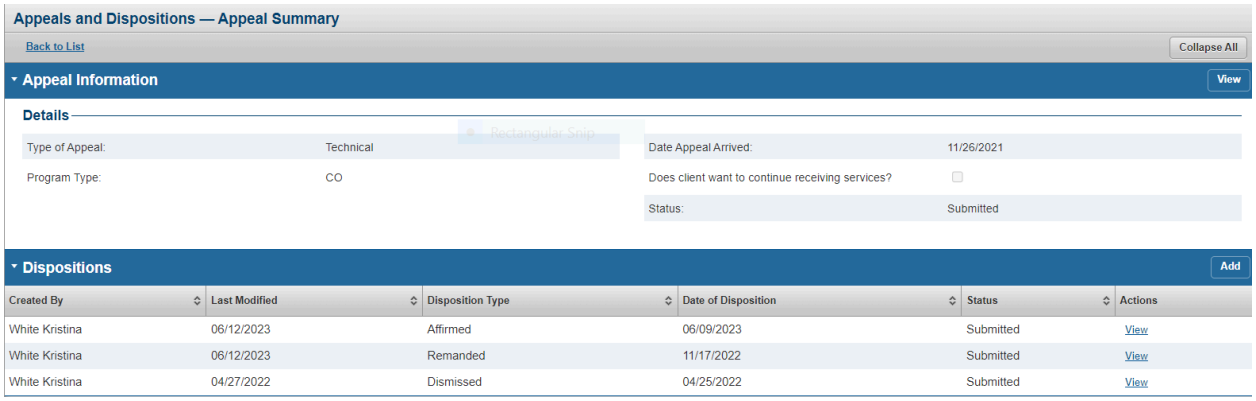
Most communications to the participant generated by OLTSS or EDD staff are housed in this section, including enrollment, disenrollment, and denial letters. POS denial letters for CO Waiver participants are included in **CO POS Letters**, while POS denial letters for CPAS participants are included with all other program communications under **CPAS Letters** and POS denial letters for CFC and ICS participants are included in **CFC Letters** (see pages 89-90 for more detail about creating POS denial letters).



I. Appeals and Dispositions

When a participant appeals a medical, technical, or financial (for CO Waiver and ICS only) denial, information about that denial and appeal is recorded in this section. The summary page lists all adverse decisions that the participant has appealed, and a user can see the details of each appeal by selecting **View**. In the **View** screen, the type of denial and the date MDH received the appeal are included. If the participant is currently receiving services and appealed timely, they are eligible to continue to receive those services pending the outcome of the hearing. In this situation, “Does the client want to continue receiving services?” will be checked. The outcome of the appeal, called a

disposition, is also recorded in this section (see page 92-93 for more detail about how appeals interact with the UR process).



J REM PDN Assessment

If a participant is concurrently enrolled in REM and receiving PDN, they will have one or more PDN assessments in this section. The assessment provides information about the participant's skilled nursing needs, how many hours of PDN are recommended or currently being received, and when. A reviewer must review this assessment when conducting UR for a participant concurrently enrolled in, or applying to, REM and CFC, CO Waiver, or ICS (see page 82-85 and the standard operating procedure (SOP) on participants receiving PDN provided as an attachment to this manual).

K Transition Funds

Transition services is a CFC service available to CFC, CO Waiver, and ICS participants moving from a qualifying institution to the community, or from an ALF to a private residence. Transition services must be approved on a participant's POS and may only be used for up to 60 days following the qualifying transition. The participant's SP should enter information regarding the use of transition funds in this section but given that the current functionality of this section is still relatively new, the reviewer should also review previous POS to see if transition funds were approved to ensure that the maximum amount per transition is not exceeded (see page 72 for more detail).

IV. MFP

MFP is a Medicaid program that helps eligible participants move from certain types of institutions to a home or community-based setting. MFP offers a service called flexible funds to eligible participants, which may be used after transition funds are exhausted to support a qualifying transition. The **MFP Questionnaires** and details regarding the utilization of **Flexible Funds** are in this section. As with transition services, the reviewer should also review previous POS to see if MFP flexible funds were approved to ensure that the maximum amount per transition is not exceeded (see page 73 for more detail).

Understanding the interRAI

The interRAI HC and interRAI PEDS HC are comprehensive assessments that evaluate the needs, strengths, and preferences of individuals in home and community-based settings. The assessments focus on individuals' functioning and quality of life and can be used to inform and guide comprehensive planning of care and services. Maryland utilizes the interRAI HC and interRAI PEDS HC to determine whether an applicant or participant meets the medical eligibility requirements for the CPAS, CFC, CO Waiver, and ICS programs.

The interRAI assessment manuals provide detailed instructions on performing and coding the assessments, including providing definitions and intent for most questions. This section is intended to provide reviewers with a basic overview of key sections, including how to interpret coding and other outputs from the assessment (see https://interrai.org/instrument-category/comprehensive-assessment-instruments/ to purchase the interRAI HC and interRAI PEDS HC manuals).

Section C: Cognition

The purpose of this section is to record a participant's *actual* performance in making everyday decisions rather than recording what the participant's family or provider believes to be the participant's capacity. If a participant chooses not to participate in this section, or a family member responds for the participant because they are unable to participate, then the assessor documents this as impaired performance. If a participant has impaired decision-making skills, it would be appropriate for the reviewer to consider the need for cues or reminders in performing their ADLs and/or IADLs. The functional status section should be triangulated with this section in determining how service requests correlate to assessed needs.

Coding for Decision Making

0 - Independent: The participant's decisions in organizing daily routines and making decisions are consistent, reasonable, and safe. There are no issues.

1 - Modified independence: The participant's decisions in organizing daily routines and making decisions are safe in familiar situations, but the participant experiences some difficulty when faced with new tasks or situations.

2 - Minimally impaired: In specific recurring situations, the participant's decisions are poor or unsafe, which requires cueing or supervision during those situations (e.g., needing assistance in one area, such as medication management).

3 - Moderately impaired: The participant's decisions are consistently poor or unsafe, requiring cueing or supervision at all times to plan, organize, and conduct daily routines (e.g., needing assistance in multiple areas, such as medication administration and weather appropriate dressing).

4 - Severely impaired: The participant rarely or never makes decisions. An example is someone that never decides or blinks or shakes their head to answer, "yes" or "no."

5 - No discernible consciousness: The participant is unresponsive (e.g., coma).

Section G: Functional Status

ADLs are defined as fundamental skills required to independently care for oneself. The interRAI assessment only evaluates the *performance* of ADLs. IADLs are defined as complex activities related to the ability to live independently in the community. The interRAI HC assesses both *performance* and *capacity* for each IADL, while the interRAI PEDS HC assesses *performance* and *effect*. Effect helps determine if performance of a task is related to age as opposed to medical condition. The assessment evaluates the core ADLs and IADLs that a participant needs to safely remain in the community and for which the risk of being hospitalized or institutionalized increases if these activities are not performed. The assessor evaluates a participant by their performance or capacity, as applicable, over a specified period of time.

In the context of the interRAI, *performance* measures what a participant **actually** did within each category in the last three days (for the interRAI HC) and the last seven days (for the interRAI PEDS HC), while *capacity* is based on the participant's presumed ability to carry out the activity.

Weight bearing is defined as requiring physical assistance to complete a task, such as taking the weight of a participant's arm or holding the participant under their arm to assist them with putting on a shirt. Another example of assistance which is weight bearing is a participant leaning on the provider while transferring or walking.

Guiding movements is defined as minimal physical contact or contact guarding (e.g., hand on a participant's back while they are walking) that is not weight bearing.

The functional status section is generally the most determinative for the reviewer's decision regarding a participant's request for services in the POS.

Coding for Functional Status for interRAI HC[12] (same for performance and capacity)

0 - Independent: No help, setup or supervision needed.

1 - Setup help only: Article or device provided or placed within reach, no physical assistance or supervision needed.

[12] Coding for performance and effect for the interRAI PEDS HC is not included given the small percentage of overall participants that are under the age of 18; however, coding does not differ substantially and can be provided upon request.

Example 1: Placing meal ingredients within the participant's reach, but the participant is able to make the meal

Example 2: Placing the walker next to the participant, but the participant independently uses the walker to get to the bathroom

2 - Supervision: Oversight/cueing required.

Example 1: Participant is able to make a meal, but needs cues or reminders to complete the steps

Example 2: Participant is able to eat food independently, but needs reminders to continue eating

3 - Limited assistance: Help required on some occasions; physical guidance without weight bearing.

Example 1: Participant is able to create a shopping list, retrieve items, pay for items, and put items away, but is unable to lift bulk items when occasionally purchased

Example 2: Holding a participant's jacket as the participant places their arm in the sleeve

4 - Extensive assistance: Help required throughout the task, but participant performs 50% or more of the task; weight bearing support (including lifting limbs) by one helper.

Example 1: Participant is able to keep track of finances, but needs assistance with writing checks

Example 2: Physically assisting the participant in and out of the tub, but the participant is able to independently bathe

5 - Maximal assistance: Help required throughout the task and participant performs less than 50% of the task on their own; weight bearing support (including lifting limbs by two or more helpers) for more than 50% of subtasks.

Example 1: Participant is able to clean clutter on bedside table, but unable to do any other housework

Example 2: Participant needs support to place their arms into the shirt, but is able to button their shirt once it is on

6 - Total dependence: Full performance of activity by others during the entire period; no participation from the participant, meaning the task is completely done by another person(s).

8 - Did not occur: Activity did not occur during the entire period.

Section H: Continence

Bladder incontinence is defined as any level of dribbling or wetting of urine. It does not include a participant's ability to get to or from the toilet. *Bowel incontinence* refers to a participant's control of their bowel movements and also does not include their ability to get to or from the toilet. Understanding

a participant's ability to control their bladder or bowel movements can help a reviewer understand the amount of assistance that might be required for toilet use.

Coding for Continence

0 - Continent: Complete control, including control achieved by cueing, supervision, habit training, or reminders. This does not include participants who use a catheter, any urinary collection device, or ostomy.

1 - Control with catheter or ostomy: Control with the use of a catheter, ostomy, or any collection device, including self or intermittent catheterization (see page 81 for more detail regarding catheter types).

2 - Infrequently incontinent: Not incontinent within the specified time period, but does have incontinent episodes. This is an indicator that there is not complete control.

3 - Occasionally incontinent: Incontinent less than daily, such as incontinence once or twice within the specified time period.

4 - Frequently incontinent: Incontinent daily, but some control is present; for example, continent during the day, but incontinent at night.

5 - Incontinent: No control of bladder and/or bowel. Multiple episodes daily or almost all the time.

8 - Did not occur: No urine output or no bowel movement within the specified time period; for example, no urine due to being on dialysis or does not have a bowel movement frequently.

Section I: Disease Diagnosis

This section should include a list of diagnoses that are relevant to a participant's current health and functional status, including the participant's ability to perform ADLs, cognition, mood or behavior, medical treatments, skilled nursing needs, or risk of institutionalization or death. Not all diagnoses impact current functional status, as a participant may have recovered or received rehabilitation thus improving their functional status.

A reviewer should look for the assessor's comments throughout the assessment to assist in describing the functional ability of a participant as it relates to specific diagnoses. Diagnoses may help the reviewer understand why assistance with a task is requested; for example, if the participant has a diagnosis of diabetes, then it would be logical to include a request for assistance with checking the participant's blood glucose level if the participant was not independent with this task. This section should be triangulated with the functional status section in determining how service requests correlate to assessed needs as disease processes may impact one participant differently from another.

Section J: Health Conditions

This section includes a participant's physical and/or mental health symptoms that relate to their functional status. Below are the most commonly included health conditions:

Falls: Any unintentional change in position where the person ends up on the floor, ground, or a lower level. A fall while being assisted by another person should also be included. Understanding if a participant has experienced recent falls, and if so, how many, what was occurring at the time of a fall, whether the participant has an unsteady gait, and the presence of symptoms impairing balance and thought processes may help a reviewer decide about a participant's request for assistance with transfers and mobility. For example, if a participant was assessed as being independent with locomotion, but had multiple recent falls and a shuffling gait, a request for assistance with transfers or mobility may be supported.

Psychiatric: Abnormal thought processes. When the participant is observed, there is an apparent abnormality in how they are expressing their thoughts. This should correlate with a participant's cognitive status, possibly lending support for a request for reminders or supervision of multiple ADLs and IADLs.

Dyspnea: A report or observation that a participant appears breathless or "short of breath." Dyspnea can impact any ADL that involves movement, which can correlate with impaired functional status. Specifically, a code of 2 or 3 can impact how a participant is able to perform an ADL or IADL and a reviewer should consider the impact of this condition when reviewing service requests on the POS.

Coding for Dyspnea

0 - Absence of symptom
1 - Absent at rest, but present when performing moderate activities (includes exercise)
2 - Absent at rest, but present when performing day-to-day activities (includes ADLs)
3 - Present at rest (i.e., present without performing an activity)

Fatigue: An overwhelming or steady sense of exhaustion, resulting in a decreased ability to perform physical or mental tasks, including ADLs and IADLs. Fatigue is associated with many chronic or end-stage diseases and can result in functional impairment for multiple ADLs and IADLs. A reviewer should consider the impact of fatigue in reviewing service requests on the POS.

Pain: The physical, mental, or emotional suffering or discomfort usually associated with an illness or injury. It can be highly subjective, as everyone perceives pain differently, and self-reports of pain should be considered reliable. Pain can impact a participant's ability to want to participate in or complete ADLs and IADLs. Many diagnoses have pain as a symptom and a reviewer should consider the impact of pain in reviewing service requests on the POS.

Coding for Pain Control

0 - No issue of pain
1 - Pain intensity is acceptable to participant, no treatment or change in treatment is required
2 - Controlled adequately by therapeutic regimen
3 - Controlled when therapeutic regimen followed, but not always followed as ordered
4 - Therapeutic regimen followed, but pain control not adequate
5 - No therapeutic regimen being followed, pain not adequately controlled

Section K: Oral and Nutrition Status

Height and weight: Understanding a participant's height and weight can provide insight into their completion of, or need for assistance with, ADLs and IADLs. Obesity may impact mobility, which can be associated with pain in the lower extremities, inability to move to and from bed, and difficulty with cleaning after toileting or during bathing. The reviewer should consider the participant's body size in reviewing service requests on the POS.

Mode of nutritional intake: Many health conditions affect a participant's ability to swallow safely, which can impact the length of time it takes to prepare a meal or assist a participant with eating. Swallowing difficulties may require alterations to foods and fluids to provide nutritional support safely. Understanding a participant's ability or inability to swallow and the consistency of a participant's diet may assist a reviewer in determining the appropriateness of requests for assistance with meal preparation and eating. If a participant requires assistance with nutritional support through a feeding tube, this is considered a skilled nursing task and may not be covered.

Coding for Swallowing

0 - Normal: Participant swallows all types of food.

1 - Modified independent: Liquids are sipped, or a participant takes limited solid food; modification is unknown.

2 - Requires diet modification to swallow solid food: For example, a mechanical diet (e.g., pureed, minced) to safely ingest foods.

3 - Requires modification to swallow liquids: For example, adding a thickening agent to liquids.

4 - Can swallow only pureed solids and thickened liquids.

5 - Combined oral and parenteral or tube feeding: If the participant is receiving both oral and tube feeding, determine if the oral feeding is to assist in the nutritional support of the participant or is only for pleasure.

6 - Nasogastric tube feeding only: A tube that is inserted through the nares (nostrils) and advanced into the stomach.

7 - Abdominal feeding tube: Nutrition that is provided through a tube into the stomach or intestine (g-tube, j-tube, g/j tube) inserted through the abdominal wall.

8 - Parenteral feeding only: Nutrition that is administered intravenously; for example, total parenteral nutrition (TPN).

9 - Did not occur: No food or fluid intake within the specified time period.

Section L: Skin Condition

A pressure ulcer is an injury that breaks down the skin and the underlying tissues. Pressure ulcers occur when pressure reduces the blood flow to the area, causing injury. Common areas for pressure ulcers to develop are the buttocks and bony prominences (e.g., hip, lower spine, heels), or areas where moisture (e.g., incontinence) or traction occurs (e.g., pulling or stretching of the skin, including sliding down the bed). Wounds can impact a participant's ability to move or create a need for frequent repositioning, which can increase the amount of time needed for a task. Depending on the condition of a participant's skin, assistance may require delegation by a licensed RN.

Coding for Stages of Pressure Ulcers

0 - No pressure ulcer

1 - Stage 1: Any area of persistent skin redness - The area looks red and feels warm to the touch. The reddened area does not disappear with repositioning. The skin is intact. Treatment is to monitor, keep clean, and provide repositioning intermittently to relieve pressure for the area.

2 - Stage 2: Partial loss of skin layers - The area has an opening of the skin (e.g., open sore, scrape, blister). Treatment is to monitor, keep clean, provide repositioning intermittently, and apply medicated ointments or a simple dressing.

3 - Stage 3: Full loss of skin layers, deep craters in the skin - Damage is below the skin's surface, exposing subcutaneous tissue. Treatment is monitoring (likely by a wound specialist), repositioning, specialty pressure mattress and complex dressings. Requires delegation by a licensed RN and inclusion of wound care in the delegating RN's care plan.

4 - Stage 4: Full loss of skin layers, deep craters in the skin - Damage is below the skin's surface, possibly exposing muscle or bone. Treatment is a wound care regimen under the direction of a specialist, repositioning, specialty pressure mattress and complex dressings. Requires delegation by a licensed RN and inclusion of wound care in the delegating RN's care plan.

5 - Not codable/Unstageable: Base of the wound is covered by dead tissue (necrotic eschar), which does not provide visual access to the wound. The stage of the wound is unclear and/or unable to determine if tissue injury is present under the eschar. Requires delegation by a licensed RN and inclusion of wound care in the delegating RN's care plan.

Section M: Medications

Medication can assist or inhibit a participant's functional status. Medications may also impact the frequency with which a covered task is performed. Having a general understanding of certain medications may assist a reviewer in determining the appropriateness of a request for assistance. The

following is a list of medication types that may impact a participant's ability to perform ADLs and IADLs or alter the standard of care for a particular task.

Diuretics are medications that increase urine flow. These medications reduce the amount of fluid in the body and are used to treat conditions such as edema, heart failure, and high blood pressure. Possible side effects that can impact functionality include increased urination (specifically in the first few hours after administration), dizziness, and low blood pressure. Common diuretics include Lasix (furosemide), Bumex (bumetanide), HCTZ (hydrochlorothiazide), and Aldactone (spironolactone).

Sedatives are medications that may cause drowsiness, dizziness, or lethargy. Sedatives slow down the brain's activity, which can alter a participant's reaction time, way of thinking, and perception. Possible side effects that can impact functionality include dizziness, slower movements, and the inability to focus on tasks. Common sedatives include benzodiazepines: Valium (diazepam), Ativan (lorazepam), and Xanax (alprazolam); hypnotics: Ambien (zolpidem) and Lunesta (eszopiclone); barbiturates: phenobarbital; and others including melatonin and opioids - MS Contin (morphine), Percocet and OxyContin (oxycodone), and Vicodin (hydrocodone).

Psychotropics are medications that affect the mind, emotions, and behavior. Each type of medication has its own use and side effects that can impact functionality including drowsiness, tremors, nausea, appetite changes, confusion, and fatigue. Common psychotropics include antidepressants: Prozac (fluoxetine), Zoloft (sertraline), Effexor XR (venlafaxine), and Trazodone; anti-anxiety benzodiazepines (see sedatives); antipsychotics: Abilify (aripiprazole), Risperdal (risperidone), and Haldol (haloperidol); and mood stabilizers: lithium, Depakote, Neurontin (gabapentin), and Topamax.

Anticoagulants/Antiplatelets (blood thinners) are medications that slow down the body's way of clotting. Even though this may not impact a participant's functionality, adverse effects can severely impact a participant, specifically if prone to falls. Common anticoagulants include Xarelto (rivaroxaban), Eliquis (apixaban), Coumadin (warfarin), and Pradaxa (dabigatran). Common antiplatelets include Aspirin and Plavix (clopidogrel).

Antidiabetics are medications that assist in blood glucose control or manage diabetes. Most oral antidiabetics help with increasing the production of insulin (hormone produced by the pancreas to assist with glucose (sugar) in the body), which in return decreases the overall glucose level. When oral antidiabetic medication is not enough or the body no longer produces insulin, then an insulin medication is used to assist with glucose control. Possible side effects that can impact functionality include nausea, dehydration, weight gain or loss, edema, and low blood sugar (dizziness, shaking, sweating, tiredness, weakness). If a participant has poor sugar control leading to frequent fluctuations of glucose levels, this may impact mobility. Common antidiabetics include Humulin (insulin), Aspart (insulin), Lantus/Toujeo (insulin glargine), Basaglar (insulin glargine), Novolog, Glucotrol (glipizide), Amaryl (glimepiride), Diabeta/Glynase (glyburide), Metformin (glucophage), Ozempic (semaglutide), Trulicity (dulaglutide), and Jardiance (empagliflozin).

Section N: Treatments and Procedures

This section provides a list of services that a participant currently utilizes or utilized previously to maintain their health (prevention and maintenance). Below are the most commonly included treatments and procedures:

Treatment and Programs Received/Scheduled: Treatments included in this section may help a reviewer understand a participant's request for services, including whether their needs and subsequent tasks required to meet those needs are outside the scope of PAS. If a participant is utilizing any of the below services, the reviewer should also review the assessor's comments, which may offer additional information.

1. **Chemotherapy:** May indicate the need for additional time in relation to transportation, as well as additional time for tasks as a result of common side effects such as fatigue, nausea, and vomiting.
2. **Dialysis**: May indicate the need for additional time in relation to transportation, as well as additional time for tasks as a result of common side effects such as fatigue. Assessor comments may include the type of transportation needed or if treatments are provided in the participant's home. If treatments are provided in the participant's home, assistance with this task is outside the scope of PAS as it is a skilled nursing task.
3. **IV medication:** Indicates that a participant has a skilled nursing need, as IV medication administration is not a delegated task, and that more information is needed to determine whether the need is continuous (see the SOP on continuous skilled nursing needs provided as an attachment to this manual).
4. **Oxygen therapy:** May indicate the need for additional assistance with adjusting tubing, or due to the participant's shortness of breath and lack of endurance.
5. **Radiation:** May indicate the need for additional time in relation to transportation.
6. **Suctioning**: Includes any type of suctioning (oral, nasal, pharyngeal, tracheal) and may indicate that a participant has a skilled nursing need.
7. **Tracheostomy care**: Includes removal of cannula and cleaning tracheostomy site and surrounding skin with appropriate products. Indicates that a participant has a skilled nursing need and that associated skilled tasks may be outside the scope of PAS.
8. **Ventilator or respirator**: Includes an electrical or pneumatically powered device such as BiPap or CPap. Some devices require skilled nursing and may be outside the scope of PAS.
9. **Wound care**: Includes bandages, dressings, wound irrigation, application of ointments/medications, and suture removal. May indicate the need for additional time in relation to transportation or repositioning. Some wound care requires delegation, and some types are not able to be delegated and therefore outside the scope of PAS.

Formal Care: Direct services to support a participant's ADL and IADL needs, care management, or therapeutic care (e.g., physical therapy, occupational therapy, speech therapy) by any agency or service provider that is paid. The most commonly included services are home health, personal care, nursing services, meals, and therapies. If services are provided by other Medicaid or non-Medicaid programs, services through CPAS, CFC, CO Waiver, or ICS may be duplicative (see page 82 for more detail about overlap and duplication).

Hospital Use, Emergency Use: Recent hospitalizations or emergency room visits reported in this section should prompt the reviewer to look for additional information in the **Reportable Events** section of LTSS*Maryland* and along with additional medical documentation, may support a participant's request for additional services due to a change in functional status.

Section O: Responsibility

Legal guardian: The information in this section should align with guardianship reported elsewhere in LTSS*Maryland*. If the assessment specifies that a participant has a legal guardian, but that individual is not listed in LTSS*Maryland* and has not signed the POS, the reviewer should send the plan back to the SP through a CR. If the legal guardian is acting as the paid provider, the reviewer should contact OLTSS for further guidance.

Flexible Services

There are three CFC services under this category:

- Personal Assistance Services
- Home-Delivered Meals
- "Other items" that substitute for human assistance

The cost of these services is applied to the recommended flexible budget.

Personal Assistance Services (PAS)
COMAR 10.09.84.02B, 10.09.84.14, and 10.09.84.23 (CFC)
10.09.20.01B, 10.09.20.09, and 10.09.20.13 (CPAS)

PAS is offered through the CFC and CPAS programs, but CO Waiver and ICS participants are eligible to receive PAS by virtue of their waiver participation unless residing in an ALF. A reviewer considers the number of PAS hours requested in connection with the recommended flexible budget, the participant's assessed needs identified by the interRAI assessment, the recommended POC, and any available supporting documentation.

PAS is reimbursed in 15-minute increments, called units; however, requests for PAS are reviewed in relation to discrete tasks that correlate to a participant's ADL, IADL, and delegated nursing needs. The total number of PAS hours approved is based on the aggregation of the time estimated to complete each covered task. A participant must receive assistance with at least one ADL (or medication management) to also receive assistance with IADLs.

PAS may not exceed 12 hours per day or 84 hours per week. If a participant requires more than 12 hours of PAS per day, the participant must request Daily Personal Assistance Services (DPAS). If the request is for more than 12 hours per day and the POS does not reflect DPAS, the reviewer should send the plan back to the SP through a CR (see page 61 for more detail).

Personal Assistance Hours Breakdown

The request for PAS hours can be entered using the daily chart or as a weekly total. If the cost of flexible services exceeds the recommended flexible budget, the SP must use the daily chart and provide additional information to support the exceptions request (see page 23 for more detail about the exceptions process).

Covered and Non-Covered Tasks

Activities of Daily Living	Instrumental Activities of Daily Living
• **Bathing or showering** • **Personal hygiene** • **Dressing or changing clothes** • **Eating** • **Toileting** (bladder/bowel requirements; routines associated with the achievement or maintenance of continence; incontinence care) • **Mobility** (transferring from a bed, chair, or other structure; moving, turning, and positioning the body while in bed or in a wheelchair; moving around indoors and outdoors)	• **Preparing meals** • **Performing light chores** that are incidental to covered tasks • **Shopping for groceries** • **Nutritional planning** • **Transportation** • **Managing finances/handling money** • **Using the phone** or other means of communication to make appointments • **Reading** in conjunction with covered tasks • **Planning and making decisions**

Personal assistance is defined as assistance specific to the functional needs of a participant with a chronic illness, medical condition, or disability. The program covers the following when provided by a personal assistance provider:

- Assistance with ADLs,
- Assistance with IADLs, provided in conjunction with ADLs or delegated nursing functions,

- Delegated nursing functions if this assistance is specified in the participant's POS and rendered in accordance with the Maryland Nurse Practice Act (COMAR 10.27.11) and other requirements of the Maryland Board of Nursing (MBON) (see page 80 for more detail about delegated tasks), and
- Assistance with the self-administration of medications or administration of medication or other remedies when ordered by a physician.

PAS may not include:

- Skilled nursing services, including tasks that cannot be delegated,
- Services rendered to anyone other than the participant or for the benefit of anyone other than the participant,
- The cost of food or meals prepared in or delivered to the home or otherwise in the community,
- Housekeeping services, other than those incidental to covered tasks, and
- Observation or supervision of the participant when unrelated to an ADL or IADL.

Assistance means another individual:

- Physically performs the activity for the participant,
- Physically helps the participant to perform the activity,
- Monitors the participant's performance of the activity to ensure health and safety, or
- Cues or encourages the participant to perform the activity.

Tasks are covered when tied to an ADL or IADL (incidental to an ADL or delegated nursing function) and <u>an action is occurring</u>; for example, providing hands-on assistance or supervising or cueing a participant during performance of an ADL or IADL. General supervision of a participant, in other words, "watching and waiting" is not covered. Similarly, if no ADL, IADL, or delegated nursing function is occurring, the task is not covered (e.g., assisting a participant in walking their dog).

The ADL or IADL must also be medically necessary and necessary to prevent institutionalization (e.g., Reading is an IADL, but reading a magazine is not medically necessary and therefore not a covered task). Transportation to a medical appointment is medically necessary and necessary to prevent institutionalization, but traveling to religious services or social outings is not and therefore is not a covered task. Going for a walk is an activity related to maintaining one's health, but unless it is part of a very specific treatment protocol, it is not considered medically necessary or necessary to prevent institutionalization and therefore is not a covered task (see the SOP on covered tasks and determining PAS hours provided as an attachment to this manual).

Schedules

Schedules are an assistive tool for a reviewer so they can better understand a participant's "ask," meaning the specific tasks for which assistance is requested, the type of assistance requested, and when it is being requested. In some scenarios, OLTSS requires the submission of a task schedule to accompany the POS including, but not limited to: when a participant is concurrently enrolled, the costs of requested

flexible services exceed the recommended flexible budget or a participant is requesting DPAS or shared PAS hours. If a task schedule is required or the reviewer feels it would be helpful and the SP has not provided a task schedule along with the POS, the reviewer should send the plan back to the SP through a CR. A task schedule may be daily or weekly, depending on the complexity of the request, but must account for all periods of time in which a participant is requesting assistance. The creation of a schedule, like the development of a POS, should be a collaboration between the participant, their representative(s) (if applicable), and their assigned SP, which is indicated by the participant's signature (or that of their representative) on the schedule.

Schedules help to support the UR process by providing the following information:

- The action occurring and when it is occurring for each individual participant (particularly useful in requests for shared PAS hours)
- Whether the tasks for which assistance is requested adhere to applicable federal and state regulations, including helping to identify overlap or duplication with other services (e.g., MDC, PDN, school-based services, personal support services)
- The need for additional services when the request exceeds the recommended flexible budget or is greater than what is generally expected for a participant with similar assessed needs
- Insight into the participant's day-to-day experience as part of the person-centered planning process

In reviewing a schedule, the reviewer should consider the following:

- Whether critical tasks are missing; for example, activities that are medically necessary (e.g., eating, toileting) or specific to a participant's current health and functional status (e.g., wound care)
- Whether the schedule requests more or less time than the total number of PAS hours requested daily or weekly
- Whether the schedule is the most current request, as a participant who has been enrolled for several years may have multiple task schedules in **Client Attachment**
- If the participant is requesting HDMs as well as PAS, whether the schedule includes a request for meal preparation and/or cleanup during the time that HDMs are supposedly utilized as these services may not overlap
- If the participant is concurrently enrolled, whether the schedule accurately reflects the receipt of other services

The following are the most common reasons a reviewer might send a plan back to the SP through a CR in relation to the submitted schedule:

- It is simply unclear what the participant is requesting, when services are being requested, or when other services are being received
- There are no durations or frequencies for any tasks
- It is no longer valid because the services the participant is receiving have changed since the original submission

- The total hours requested based on the schedule do not equal the number of PAS hours requested on the POS

If a reviewer determines that the schedule does not indicate sufficient support for the health and welfare of the participant, they should send the plan back to the SP through a CR to determine if informal supports are present that were not detailed in the POS. If a participant does not want to submit and/or make changes to a schedule based on the reviewer's request, the SP should indicate in the narrative section of the plan that the POS should be reviewed "as is."

Daily Personal Assistance Services (DPAS)
COMAR 10.09.84.24

If a participant requires more than 12 hours per day of PAS, they may be eligible to receive DPAS, which consists of a daily rate for services. A participant may request DPAS for certain days and hourly PAS for the remainder of the week. If DPAS is requested for seven days per week, then hourly PAS should not also be included on the plan. Additionally, if a personal assistance provider agrees to render DPAS, they must be aware that they may be asked to provide PAS up to 24 hours per day.

As with hourly PAS, the need for DPAS must be deemed medically necessary and the scope of personal assistance, meaning covered tasks, is the same regardless of whether a participant is receiving hourly PAS or DPAS.

Given the nature of DPAS, the reviewer must ensure that the following technical requirements are met:

- DPAS must be provided by a single agency within a 24-hour period, meaning only one agency can be paid for DPAS per day,
- DPAS can only be used on the days for which it is approved; for example, if DPAS is requested and approved for Friday, it cannot be used on Saturday instead, unless DPAS is also requested and approved for Saturday,
- A request for DPAS must include the submission of a task schedule,
- DPAS must be approved by OLTSS (or its designee) through the POS process. The Medicaid Provider Billing Support Office cannot approve DPAS even on a temporary basis in the event of an emergency, and
- A clinical reviewer should confirm the decision on the plan if either a new request for DPAS is going to be approved (someone who has not been previously approved for DPAS) or if an Annual POS for someone who currently receives DPAS is going to be denied.

Shared PAS Hours

Shared PAS hours, including shared DPAS, are available to participants who reside in the same location, share one or more paid providers of PAS, and both require and request assistance with at least one

ADL or medication management. Shared hours allow a provider to support multiple participants in the same residence at the same time without having to log time worked for each participant individually. Providers are paid two-thirds of the rate of reimbursement per unit of PAS for each participant. Shared hours may be used for both individual ADLs, such as bathing and toileting, and shared IADLs such as meal preparation, grocery shopping, and laundry; however, they may only be used when both participants are present and actively receiving services.

Ideally, the plans for participants requesting shared hours are reviewed by the same reviewer at the same time so that the reviewer can more easily identify discrepancies between the plans. For example, if the number of shared hours per week on the participants' plans do not align, or the provider is not the same, a reviewer who is responsible for both POS can more easily identify this issue. If plans with shared hours are assigned to different reviewers, the reviewers must coordinate their reviews to ensure appropriate UR.

Given the nature of shared hours, the reviewer must ensure that the following technical requirements are met:

- Each participant should have at least one week of non-shared hourly PAS or non-shared DPAS listed on their POS to enable the shared provider to be reimbursed for non-shared services if an emergent need arises. For example, if Participant A and Participant B are sharing personal assistance for 45 hours per week, both participants must have "Personal Assistance - Shared Attendant" for 45 hours per week for 51 weeks, and then a second service line with "Personal Assistance Agency" for 45 hours per week for one week on their POS.

Flexible Services

Service Status	POS Service	Associated Temp Service	Service Type	Provider Name	Units	Frequency	Rate	Annual	Actions
New	Personal Assistance Agency	No	Community First Choice	ABSOLUTE SUPREME COMPANIONS IN-HOME CARE &	45 hours per week	1 week	$4.5075	$811.35	Quick View
	Comment: For use in the event spouse hospitalized and can't use shared hours.								
New	Personal Assistance — Shared Attendant	No	Community First Choice	ABSOLUTE SUPREME COMPANIONS IN-HOME CARE &	45 hours per week	52 weeks	$3.005	$28,126.80	Quick View
	Comment: Sharing hours with spouse. For assistance with bathing, dressing, meal prep								

If a participant receives additional non-shared PAS hours, then those hours must be listed on a third service line with the applicable number of hours for 52 weeks.

Flexible Services

Service Status	POS Service	Associated Temp Service	Service Type	Provider Name	Units	Frequency	Rate	Annual	Actions
New	Personal Assistance Agency	No	Community First Choice	ABSOLUTE SUPREME COMPANIONS IN-HOME CARE &	45 hours per week	1 week	$4.5075	$811.35	Quick View
	Comment: For use in the event spouse hospitalized and can't use shared hours.								
New	Personal Assistance — Shared Attendant	No	Community First Choice	ABSOLUTE SUPREME COMPANIONS IN-HOME CARE &	45 hours per week	52 weeks	$3.005	$28,126.80	Quick View
	Comment: Sharing hours with spouse. For assistance with bathing, dressing, meal prep								
New	Personal Assistance Agency	No	Community First Choice	ABSOLUTE SUPREME COMPANIONS IN-HOME CARE &	9 hours per week	52 weeks	$4.5075	$8,438.04	Quick View
	Comment: For assistance with dialysis appointments								

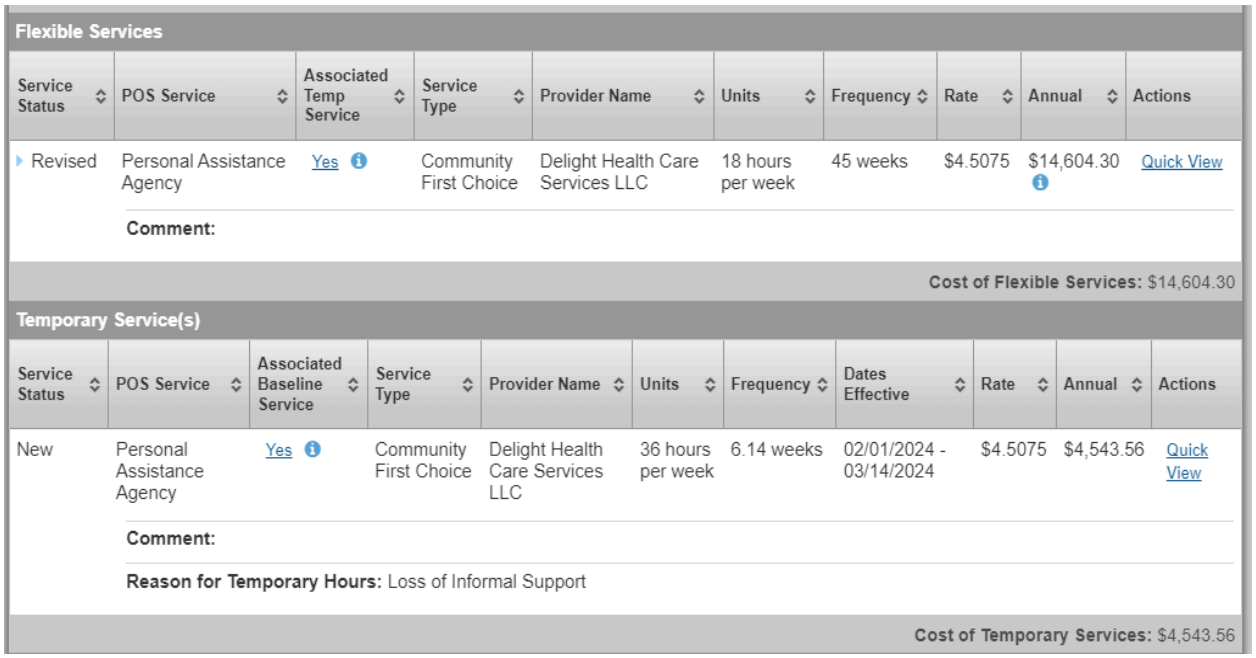
- The participants' schedules must align with the requests in the plans, meaning they must indicate that the participants are utilizing the same provider at the same time.
- Each participant's interRAI assessment must be compared to the requests on the schedules and associated plans to determine if the requests are supported by the participants' assessed needs.
    - The reviewer should consider each participant's functional status. Because schedules are person-centered, the reviewer will have to ensure that the shared hours do not exceed twice the recommended time established for assistance with ADLs, IADLs, and delegated nursing functions (see the SOP on determining PAS hours provided as an attachment to this manual).
        - Total shared PAS hours = time for Participant A's individual ADL and IADL tasks + time for Participant B's individual ADL and IADL tasks + time for shared IADL tasks

Temporary Services

A participant may also request PAS or HDM on a temporary basis. In the context of the POS, *temporary* is defined as less than a year in duration and must have a clear start and end date. The most requested temporary service is PAS, which is usually requested in a greater amount following an injury, hospitalization, or loss of informal supports. The rationale for the temporary request must be included in the **Comments** in relation to the service requested or the narrative section of the POS. The reviewer should consider the service type, units, and duration in conjunction with the rationale provided for the temporary request.

- When requesting a temporary increase in hours, the SP should submit the Revised POS as follows:
    - Enter the temporary hours request under the Temporary Service section
    - The specific dates of the request need to be identified

- The *total* number of hours needed, not just the additional hours are to be listed. Example: If a participant currently has 18 hours of PAS per week, but needs 36 hours of PAS per week for 6.14 weeks (does not equal six because a week is associated with a claims cycle), 36 temporary hours should be entered
- The frequency of the current hours should be reduced to the appropriate number of weeks (in the above example, 18 hours of PAS per week for 45 weeks)



Flexible Services

Service Status	POS Service	Associated Temp Service	Service Type	Provider Name	Units	Frequency	Rate	Annual	Actions
Revised	Personal Assistance Agency	Yes	Community First Choice	Delight Health Care Services LLC	18 hours per week	45 weeks	$4.5075	$14,604.30	Quick View

Comment:

Cost of Flexible Services: $14,604.30

Temporary Service(s)

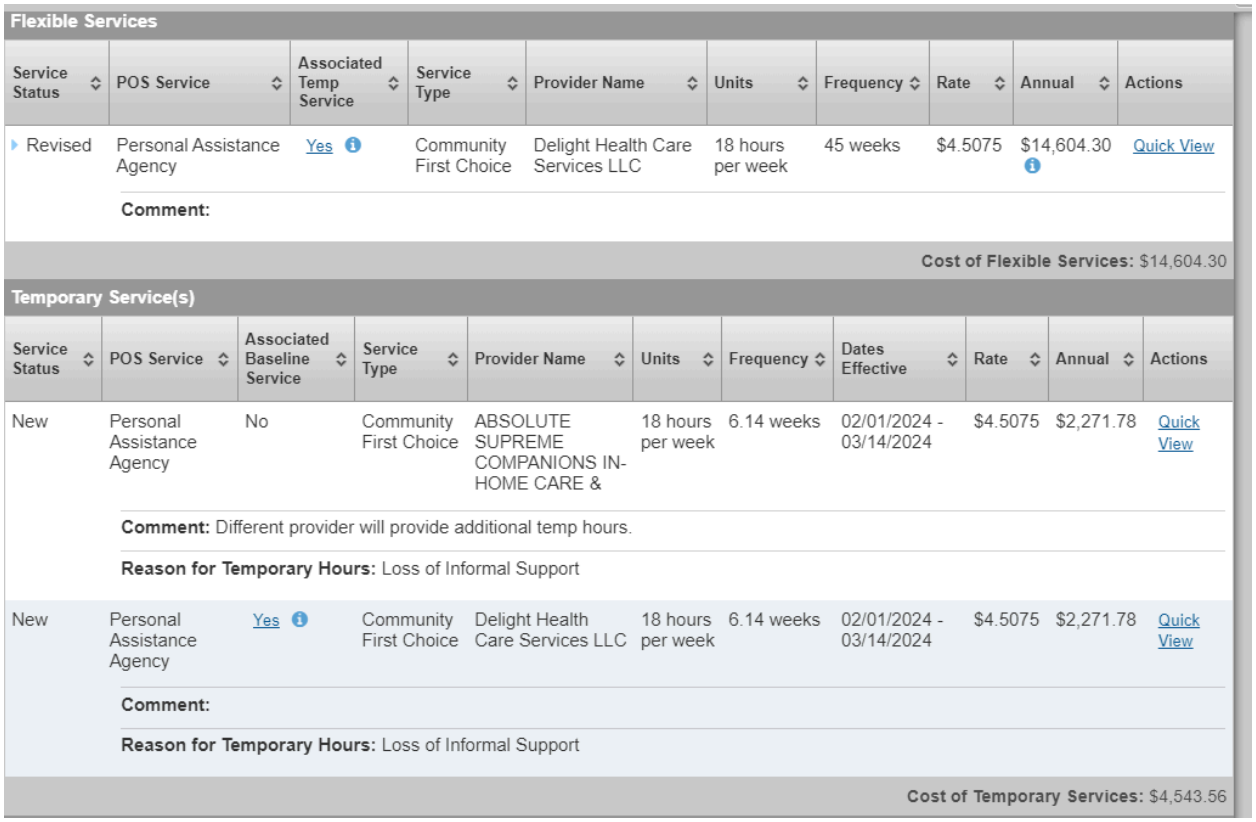
Service Status	POS Service	Associated Baseline Service	Service Type	Provider Name	Units	Frequency	Dates Effective	Rate	Annual	Actions
New	Personal Assistance Agency	Yes	Community First Choice	Delight Health Care Services LLC	36 hours per week	6.14 weeks	02/01/2024 - 03/14/2024	$4.5075	$4,543.56	Quick View

Comment:

Reason for Temporary Hours: Loss of Informal Support

Cost of Temporary Services: $4,543.56

- If the provider of temporary PAS hours is different from the baseline provider, there should be two entries under the Temporary Services section, one for each provider. Example: 18 hours of PAS per week from Provider A for 45 weeks (current service) and 18 hours of PAS per week for 6.14 weeks from Provider A and Provider B, respectively, totaling 36 hours (temporary service)



Flexible Services

Service Status	POS Service	Associated Temp Service	Service Type	Provider Name	Units	Frequency	Rate	Annual	Actions
Revised	Personal Assistance Agency	Yes	Community First Choice	Delight Health Care Services LLC	18 hours per week	45 weeks	$4.5075	$14,604.30	Quick View
	Comment:								

Cost of Flexible Services: $14,604.30

Temporary Service(s)

Service Status	POS Service	Associated Baseline Service	Service Type	Provider Name	Units	Frequency	Dates Effective	Rate	Annual	Actions
New	Personal Assistance Agency	No	Community First Choice	ABSOLUTE SUPREME COMPANIONS IN-HOME CARE &	18 hours per week	6.14 weeks	02/01/2024 - 03/14/2024	$4.5075	$2,271.78	Quick View
	Comment: Different provider will provide additional temp hours.									
	Reason for Temporary Hours: Loss of Informal Support									
New	Personal Assistance Agency	Yes	Community First Choice	Delight Health Care Services LLC	18 hours per week	6.14 weeks	02/01/2024 - 03/14/2024	$4.5075	$2,271.78	Quick View
	Comment:									
	Reason for Temporary Hours: Loss of Informal Support									

Cost of Temporary Services: $4,543.56

A participant may temporarily increase their PAS up to 12 hours a day for no more than seven consecutive days without approval by OLTSS (or its designee) in the event of an emergency. The participant's SP should complete and submit the applicable form to the Medicaid Provider Billing Support Office to allow claims for services to be successfully processed.

Home-Delivered Meals (HDM)
COMAR 10.09.84.18

HDM is offered through the CFC program, but CO Waiver and ICS participants are eligible to receive HDM by virtue of their waiver participation unless residing in an ALF. CFC covers items that increase a participant's independence and substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance. Home-delivered meals are considered "items that substitute for human assistance" and may be provided during meal periods when PAS is not provided. The meals must be delivered to the participant's home and consumed by the participant in the home. HDM must be nutritionally adequate for the participant's age as designated by the Food and Nutrition Board of the National Research Council and menus for HDM must be certified in writing by a physician, nutritionist, or dietician to contain at least one-third of the Recommended Daily Allowance or Dietary Reference Intakes (DRI).

HDM may be used in place of PAS, but due to the requirement that HDM increase a participant's independence and substitute for human assistance, HDM is not appropriate for participants who require assistance warming up a meal, eating, or cleaning up after the meal. The participant must be able to retrieve, heat, eat, and clean up after the meal independently. If a participant requests HDM, the reviewer should review the interRAI assessment to determine if the request is appropriate for the participant based on their cognition and functional status. As a substitution for human assistance, HDM is also not intended to supplement a participant's grocery budget and cannot replace the purchase of groceries.

A participant may receive HDM and PAS, but not at the same time. If a participant receives both HDM and PAS, meals may not be consumed in the presence of the PAS provider as this creates overlap and duplication of Medicaid services. Participants residing in an ALF are also not eligible to receive HDM as it is duplicative of services provided by the ALF.

The number of approved HDM may not exceed two meals per day, for a maximum of 14 meals per week. As with all CFC services, HDM may not be provided primarily for the comfort or convenience of someone other than the participant.

In addition to ensuring that the request for HDM aligns with all program requirements, the reviewer must ensure that the SP has uploaded a menu from the HDM provider, signed by a physician, nutritionist, or dietitian to **Client Attachment** in LTSS*Maryland*.

Non-Flexible Services (For all Programs)

Supports Planning
COMAR 10.09.84.15 (CFC)
COMAR 10.09.20.10 (CPAS)

Supports planning services are offered through the CPAS, CFC, CO Waiver, and ICS programs. For CO Waiver and ICS participants, this service is referred to as case management, but the service is materially the same with the exception of providing support for the initial application and waiver redetermination process, which are unique to the CO Waiver and ICS. Supports planning is intended to assist a participant in securing appropriate services and monitor the rendering of those services as it relates to the participant's health and welfare in the community.

Based on discussions with the participant, the SP estimates the units of service based on the degree of involvement with the participant. While this will likely fluctuate throughout the year, OLTSS recommends:

- Six hours per month for applicants (i.e., an individual who is not yet enrolled) (288 units)
- Three hours per month for participants (144 units)
- 20 hours per year for participants in an ALF (80 units)

If the hours requested exceed the above recommendations, the SP should provide a rationale in **Comments** in relation to the service requested or the narrative section of the POS. If a participant chooses to waive supports planning to the minimum, thereby forgoing monthly and quarterly contacts, the participant must complete a waiver form. The SP must obtain an updated waiver form each year, during the development of the Annual POS, if the participant wishes to continue waiving the service.

A reviewer can view whether a participant has waived supports planning to the minimum in LTSS*Maryland* under **Case Management > Provider Forms > Supports Planning Waiver**. The accompanying waiver form should be uploaded to **Client Attachment**.

Supports planning cannot be the only service received by a CFC participant. If a POS contains only supports planning, the reviewer should send the plan back to the SP through a CR.

Nurse Monitoring
COMAR 10.09.84.20 (CFC)
COMAR 10.09.20.11 (CPAS)

Nurse monitoring is offered through the CPAS and CFC programs, but CO Waiver and ICS participants are eligible to receive nurse monitoring by virtue of their waiver participation unless residing in an ALF. Nurse monitoring is provided by the LHDs to participants receiving PAS. All participants actively receiving PAS, must also receive nurse monitoring as the purpose of the service is to evaluate the quality of PAS. At minimum, nurse monitoring must be delivered twice annually, with at least one of the two visits conducted in person. Unless waived by the participant to the minimum, the LHD nurse monitor and the participant will agree upon a frequency of visits, which are established in LTSS*Maryland*. The SP must obtain an updated waiver form each year, during the development of the Annual POS if the participant wishes to continue waiving the service of nurse monitoring. If waived, the SP should list four hours per year (16 units) for nurse monitoring on the POS.

A reviewer can view whether a participant has waived nurse monitoring to the minimum in LTSS*Maryland* under **Case Management > Provider Forms > Nurse Monitoring Waiver**. The accompanying waiver form should be uploaded to **Client Attachment**.

Nurse monitoring does not include the provision of nursing services (i.e., PDN), and should not be confused with the responsibilities of the RSA RN within the RSA. The RSA RN is responsible for training, supervising, and evaluating the delivery of PAS by a Certified Nursing Assistant (CNA), Certified Medication Technician (CMT), or an individual with no certification. As such, the RSA RN assumes responsibility for those individuals who work under their nursing license and to whom they have delegated authority. By contrast, nurse monitors evaluate the quality of PAS provided by the RSA, including the responsibilities attributable to the RSA RN. Nurse monitors do not train, supervise, or delegate to individuals providing PAS. Upon implementation of the self-directed model, nurse monitors

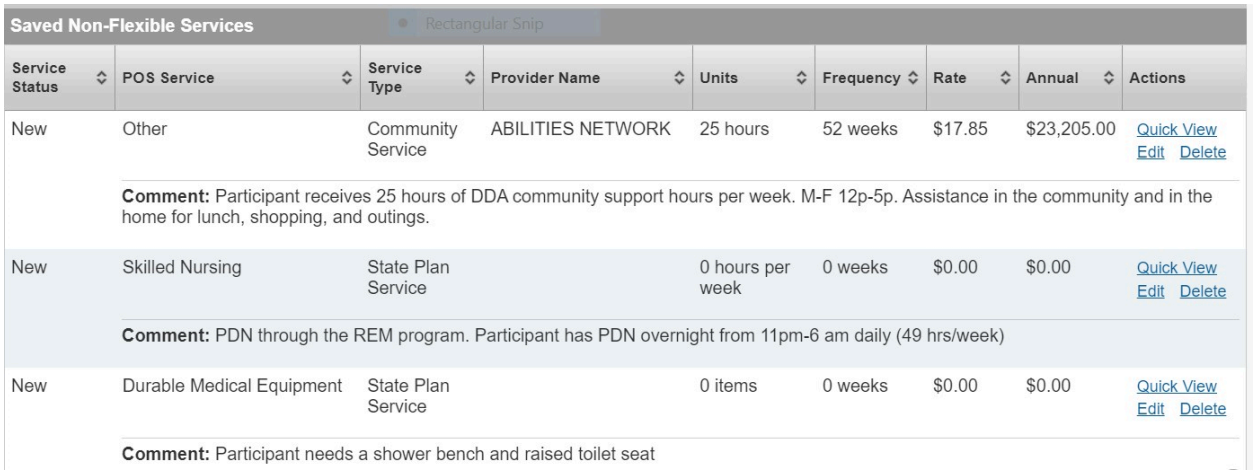
will also evaluate the quality of PAS provided by individuals employed by a participant in the self-directed model.

State Plan and Other Services

Each service that may be included in this section has its own eligibility criteria. For example, for DMS/DME, the SP should follow the established procedures for obtaining authorization, where applicable, and securing a health care provider's order for DMS/DME where prior authorization is not required. Provider signatures for services included in this section are not required, but inclusion of these services on the POS is paramount to holistic service planning and robust UR. The most commonly included programs are:

- MDC Services Waiver (for CFC participants)
- Community Pathways Waiver, Community Supports Waiver, or Family Supports Waiver
- Autism Waiver
- Model Waiver
- Brain Injury Waiver
- REM
- Therapeutic Foster Care (see the SOP provided as an attachment to this manual)
- Home health (can be used for wound care)
- Skilled nursing services (can be used to describe PDN or home health services)
- Behavioral health
- Dialysis
- DMS/DME
- Veterans' Affairs
- Feeding program through Kennedy Krieger Institute
- Psychiatric Rehabilitation Program

All Medicaid State Plan services received by the participant or services through another program in which the participant is concurrently enrolled must be listed in the non-flexible services section, even if the program only provides case management (e.g., REM participants who are not receiving PDN and only receive case management). If the participant is enrolled in the CO Waiver or ICS, the costs for any other state-funded services *must* be included to determine whether the plan meets the cost neutrality requirements. If a reviewer determines that a participant is receiving services that are not included on the POS, they should send the plan back to the SP through a CR (see page 82 for more detail on concurrently enrolled participants). The reviewer is not responsible for the approval or denial of any services appropriately listed in this section, and an approved POS for CPAS, CFC, CO Waiver, or ICS does not equate to approval of any services in this section.



Saved Non-Flexible Services

Service Status	POS Service	Service Type	Provider Name	Units	Frequency	Rate	Annual	Actions
New	Other	Community Service	ABILITIES NETWORK	25 hours	52 weeks	$17.85	$23,205.00	Quick View Edit Delete
	Comment: Participant receives 25 hours of DDA community support hours per week. M-F 12p-5p. Assistance in the community and in the home for lunch, shopping, and outings.							
New	Skilled Nursing	State Plan Service		0 hours per week	0 weeks	$0.00	$0.00	Quick View Edit Delete
	Comment: PDN through the REM program. Participant has PDN overnight from 11pm-6 am daily (49 hrs/week)							
New	Durable Medical Equipment	State Plan Service		0 items	0 weeks	$0.00	$0.00	Quick View Edit Delete
	Comment: Participant needs a shower bench and raised toilet seat							

Non-Flexible Services (For CFC, CO, and ICS Programs)

Personal Emergency Response Systems (PERS)
COMAR 10.09.84.17 and 10.09.84.23

Personal Emergency Response Systems (PERS) are offered through the CFC program, but CO Waiver and ICS participants are eligible to receive PERS by virtue of their waiver participation unless residing in an ALF. A PERS 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 a participant's phone, which is 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 a participant to be mobile); or
- A motion detector.

PERS are appropriate for participants who live alone or have no formal or informal supports for extended periods of time and would otherwise require extensive supervision to ensure the participant's health and welfare. Given the nature of PERS, it is not appropriate for participants under the age of 18 who generally require the supervision of a parent or legal guardian. PERS are also not appropriate for concurrently enrolled participants who receive extensive services through other Medicaid HCBS programs and thus are not without human assistance for extended periods.

The program covers the purchase, installation, and monthly monitoring of PERS, which includes maintenance and repair, as needed. The cost for the PERS device should not exceed the usual and customary charge to the public as required by COMAR 10.09.84.24D(2)(a). MDH has established a maximum allowable amount for purchase and installation ($547.04 as of date of publication). The PERS device type and cost should correspond to a participant's assessed needs and the SP and requested PERS provider should not default to the maximum allowable amount. If the maximum allowable amount is

requested, the reviewer should send the plan back to the SP through a CR requesting product specifications and manufacturer information to support the cost.

In addition to the guidance above, if a participant requests a PERS on the POS, the reviewer must determine:

- Is this the first PERS requested by the participant? (*see guidance below regarding replacements for previously purchased PERS*)
- If the participant does not live alone or is not alone for extended periods of time, does the participant have access to, and use of, a reliable phone?
- If the participant lives with others, do they have a history of falls, cognitive impairment, or wandering where they would "otherwise require extensive supervision to ensure their health and safety"?
- If the device requires user interaction, does the participant have the cognitive and physical capacity to use the PERS independently? A PERS may not be approved to enable a family member to request help on behalf of the participant.
- Did the assessor recommend a PERS on the POC even though the participant lives with others? If the assessor recommended a PERS despite the fact that the participant does not live alone, the reviewer should review the interRAI assessment to determine the assessor's rationale, which may support the participant's request.

If a participant requests a replacement PERS, the reviewer must determine:

- What responsibility does the PERS provider have, if any, with regard to a replacement? The provider is responsible for installation, monitoring, maintenance, and repair of the device. The provider is also responsible for training the participant on the use and maintenance of the device at the time of the installation and the manufacturer's warranty. If there is an issue with the PERS device within the first year of purchase, the SP should contact the PERS provider to determine if the issue is covered under the manufacturer's warranty and if so, work with the PERS provider to get the device replaced.
- If the issue is not covered by the warranty or the warranty period has expired, OLTSS may replace the device if three or more years have elapsed since the last PERS device was purchased. The reviewer should contact OLTSS to confirm the date of purchase using MMIS.

Environmental Assessments
COMAR 10.09.84.19

Environmental assessments (EA) are offered through the CFC program, but CO Waiver and ICS participants are eligible to receive an EA by virtue of their waiver participation unless residing in an ALF. An EA is an evaluation of a participant's home by an occupational therapist (OT), who helps identify ways to change the home to make it work better for the participant and increase the participant's independence. An EA must be completed before a participant requests accessibility adaptations.

The assessor must evaluate all areas of the home where the participant performs, or receives help to perform ADLs and IADLs, and the assessor's recommendations must relate to ADLs and IADLs and increase a participant's independence. More specifically, the EA is intended to provide the reviewer with information regarding a participant's functional status, including challenges to completing ADLs and IADLs, and information regarding the most appropriate and cost effective accessibility adaptations. The assessor may not recommend changes that will only help people other than the participant.

The EA must include:

1. An evaluation of the participant's condition,
2. Environmental factors in the home,
3. Participant's ability to perform ADLs,
4. Participant's strength, range of motion (ROM) and endurance, and
5. Participant's need for assistive devices and equipment.

Although there are no limitations to the number of residences for which an EA can be performed, multiple assessments for the same residence that are not a result of changes in the participant's functional status are not appropriate. OLTSS also requires additional information for recommendations in which the most acceptable and standard approach is NOT the one recommended; for example, the recommendation of a walk-in shower versus a walk-in tub or building new bathrooms versus modifying existing ones (see the SOP provided as an attachment to this manual for more detail).

Accessibility Adaptations
COMAR 10.09.84.19 and 10.09.84.23

Accessibility adaptations, or environmental adaptations, are offered through the CFC program, but CO Waiver and ICS participants are eligible to receive adaptations by virtue of their waiver participation unless residing in an ALF. Accessibility adaptations are changes to a participant's home that assist with ADLs and IADLs and take the place of human assistance. As such, adaptations are considered "items that substitute" (like HDM and assistive technology) and must increase a participant's independence. Adaptations to a participant's home must relate directly to the participant's ADL and/or IADL needs and represent the most appropriate and cost effective intervention without sacrificing quality.

Adaptations do not include:

1. General repairs to a participant's home, like carpeting, roofing, air conditioning or heating;
2. Making a participant's home bigger;
3. Changing things on the outside of a participant's home, unless they relate to getting in and out of the home;
4. Modifications that are not of direct medical or remedial benefit to the participant; or
5. Installation of accessibility items for a home that is under construction or not yet built.

Accessibility adaptations may not be requested before the completion of an EA, and requests must include at least two quotes from Medicaid-enrolled contractors for adaptations over $1,000, unless the request is for repair to a stair glide with associated costs at or below $1,500, in which case one quote is acceptable. The combined costs for adaptations and assistive technology cannot exceed $15,780 over a three-year period, and the full cost of the adaptation must be covered by a participant's available funds, as opposed to cost sharing across two Medicaid HCBS programs that include accessibility adaptations or cost sharing between two participants in the same program who live together (see the SOP on determining PAS hours provided as an attachment to this manual). If the participant lives in a rented property, a signed letter from the landlord or property manager approving the installation of the specific adaptation items must be provided.

Assistive Technology
COMAR 10.09.84.18

Assistive technology is offered through the CFC program, but CO Waiver and ICS participants are eligible to receive technology by virtue of their waiver participation unless residing in an ALF. Assistive technology is non-experimental devices and equipment that help a participant with ADLs and IADLs and take the place of human assistance. As such, assistive technology is also considered an "item that substitutes" and must increase a participant's independence. Many devices and equipment are covered by the DMS/DME program through the Medicaid State Plan. If a device or equipment is covered by DMS/DME, it cannot be covered as technology. Items determined not medically necessary by DMS/DME also cannot be covered as technology. The combined costs for accessibility adaptations and assistive technology cannot exceed $15,780 over a three-year period, and the full cost of the adaptation must be covered by a participant's available funds, as opposed to cost sharing across two Medicaid HCBS programs that include accessibility adaptations or cost sharing between two participants in the same program who live together (see the SOP provided as an attachment to this manual for more detail).

Assistive technology items over $300 must be recommended on either the EA or assessor's recommended POC. Items costing $300 or less may be considered by the reviewer without one of these recommendations.

Transition Services
COMAR 10.09.84.21

Transition services are offered through the CFC program, but CO Waiver and ICS participants are eligible to receive the service, which is available for a participant transitioning from a qualifying institution to the community. This service provides a participant with up to $3,000 per transition for essential goods and services and must be expended within 60 days of the participant's transition date. Participants transitioning from an ALF to a private residence are also eligible for transition services, but participants transitioning from a NF to an ALF are not.

Transition services may include funds for:

- Security deposit for housing
- Setting up essential utilities (e.g., deposits or installation fees for gas and electricity)
- Basic furniture
- Small appliances (e.g., microwave, coffee maker, air conditioning unit)
- Essential personal or household items
    - Personal items such as soap, deodorant, razors, and toilet paper
    - Household items such as sheets, towels, dishes, cookware, and cleaning supplies
    - Basic clothing

Transition services may not pay for:

- Food
- Rent
- Recreational items such as home décor, televisions, gaming/entertainment systems, cable television, internet access, and cell phones
- Items that are covered as assistive technology or by another Medicaid program (e.g., DMS/DME)

When a participant is requesting transition services, the SP should list the name, quantity, and cost of each item, as well as any shipping and assembly costs. This can be listed in the **Comments** in relation to the requested service, uploaded as a separate document in the **Attachments** section of the POS, or uploaded in **Client Attachment**. Prior to approving transition services, the reviewer should also review the **Transition Funds** section under **Programs** as well as previous POS to ensure that the maximum amount per transition is not exceeded (see page 47 for more detail).

Flexible Funds

Flexible funds are offered through the MFP program and currently administered by OLTSS. Flexible funds provide up to $700 to MFP-eligible participants to pay for items that could not otherwise be funded by Medicaid to support a participant's transition from a qualifying institution to the community. While the funds are designed to cover a wide array of essential goods and services, they are primarily requested to pay for groceries. The following is a list of items for which flexible funds may be expended:

- Accessibility or rehabilitative equipment
- Companion animal and accompanying pet supplies
- Groceries
- Home repairs
- Non-medical transport for community integration
- Non-medical transport to secure housing
- Nutritional supplements
- Over the counter (OTC) medication

- Cost of obtaining a birth certificate from the Division of Vital Records to secure housing
- Pest eradication

Flexible funds cannot be used for items covered by transition funds even if the transition funds have been exhausted. Additionally, flexible funds must be expended within 60 days of the participant's transition. The funds may only be used for items for the participant's consumption or use and may not include items for other household members.

When a participant is requesting flexible funds, the SP should list the name, quantity, and cost of each item, as well as any shipping and assembly costs. This can be listed in the **Comments** in relation to the requested service, uploaded as a separate document in the **Attachments** section of the POS, or uploaded in **Client Attachment**. Prior to approving flexible funds, the reviewer should also review the **Transition Funds** section under **Programs** and the **Flexible Funds** section under **MFP,** as well as previous POS to ensure that the maximum amount per transition is not exceeded (see page 47 for more detail).

Consumer Training
10.09.84.16

Consumer training is offered through the CFC program, but CO Waiver and ICS participants are eligible to receive consumer training by virtue of their waiver participation unless residing in an ALF. Consumer training is designed to train a participant on the acquisition, maintenance, and enhancement of skills necessary to perform ADLs, IADLs, and delegated nursing functions. The topics covered by consumer training may include, but are not limited to:

- Money management and budgeting
- Independent living
- Meal planning

The focus of consumer training must be targeted to the individualized needs of the participant receiving the training and sensitive to the educational background, culture, and general environment of the participant receiving the training. It is not intended to train family members or others providing informal supports (see page 78 for information about family training) or PAS providers.

If a participant requests consumer training on the POS, the reviewer must determine:

- Is the training duplicative of other Medicaid services the participant is receiving? Consumer training is not intended to supplant PAS or prescribed occupational, physical, or rehabilitative therapies.
- Is the proposed training appropriate for the participant's cognitive and functional status and relevant to the participant's goals identified in the POS?
- Is the training time limited? There is no limit to the period of time in which consumer training may be approved, but the service is by definition, time-bound in its achievement of specific,

measurable goals. Sequential requests for consumer training may indicate that the service is being used inappropriately.

- Is the request accompanied by a detailed plan outlining S.M.A.R.T[13] goals, how progress will be evaluated, and expected outcomes?

Non-Flexible Services (For CO Waiver and ICS Only)

Medical Day Care (MDC)
COMAR 10.09.54.10 and 10.09.07

MDC is a service offered through the CO Waiver and ICS programs, but CFC participants who meet a NF LOC may also access MDC services through enrollment in the MDC Services Waiver. MDC provides meals, therapies, medication management, and group activities to assist a participant with their ADLs, IADLs, and delegated nursing functions. For CFC participants, concurrent enrollment in the MDC Services Waiver is indicated by the applicable special program code under **Eligibility Information** in the **Client Summary** and the SP should list MDC under non-flexible services as "Other" and include information on the days per week and hours per day that the participant attends MDC. Approval of a POS that includes MDC for a CFC participant does not equate to eligibility for that service without subsequent enrollment in the MDC Services Waiver.

Saved Non-Flexible Services

Service Status	POS Service	Service Type	Provider Name	Units	Frequency	Rate	Annual	Actions
New	Other	Community Service	Test MDC Provider	3 days	52 weeks	$0.00	$0.00	Quick View Edit Delete
	Comment: Attends MDC 3 days/week (M,W,F) from 8a-1p							

For CO Waiver and ICS participants, the SP should list MDC as a waiver service under non-flexible services with the specified units and frequency, which in combination with the current rate of reimbursement, translate to an annualized cost.

Saved Non-Flexible Services

Service Status	POS Service	Service Type	Provider Name	Units	Frequency	Rate	Annual	Actions
New	Medical Day Care	Waiver Service	Chinese Culture Comm Svc Ctr Inc dab CCACC Residential Svc Agency	5 days per week	52 weeks	$82.24	$21,382.40	Quick View Edit Delete
	Comment:							

[13]Specific, Measurable, Achievable, Realistic, and Time-bound

Participants attending MDC must do so for a minimum of four hours per day, not including transportation, for the service to be reimbursed. **MDC may not overlap with PAS, HDM, or any other day service (e.g., day habilitation, Senior Center Plus).** If a participant is receiving any combination of these services, particularly on the same day, the plan (and if applicable, schedule) must clearly describe when the participant is receiving each service. If the reviewer is unable to determine whether the services overlap, they should send the plan back to the SP through a CR. Please see the following section for guidance on the interaction between MDC and ALF services.

Assisted Living

COMAR 10.09.54.13

Assisted living is a service offered through the CO Waiver and ICS programs and serves as an alternative to PAS. These two services should not be included on the same POS unless PAS is being provided temporarily to support a participant's transition to or from an ALF. The facility determines the level of services (2 or 3) a participant needs based on the facility's assessment of the participant. A participant residing in an ALF may also attend MDC. The rate of reimbursement to the ALF depends on the level of services (2 or 3) and whether the participant attends MDC.

The POS for a participant residing in an ALF must indicate assisted living services for all seven days of the week. If a participant is requesting MDC and assisted living services, the SP must select "Assisted Living Level 2 w/ AMDC" or "Assisted Living Level 3 w/ AMDC," as applicable, and also include MDC on a separate service line. More specifically:

- The number of days a participant is attending MDC must equal the number of days for which "Assisted Living w/ AMDC" has been selected.[14]
- If a participant is not attending MDC every day, the days on which they do not attend should be listed as "Assisted Living w/o AMDC." For example, if a participant attends MDC three days per week, their POS should reflect:
    - Assisted Living with AMDC: 3 days per week,
    - MDC: 3 days per week, and
    - Assisted Living without AMDC: 4 days per week.

[14]If a participant is receiving assisted living services and attending MDC and Senior Center Plus, the total number of combined days for MDC and Senior Center Plus must be equivalent to the number of days for which "Assisted Living w/ AMDC" is selected.

Original	Medical Day Care	Waiver Service	WINTER GROWTH INC (MDC) HOWARD CO	3 days per week	52 weeks	$104.8100	$16,350.36	Quick View
	Comment: MADC for oversight of multiple health conditions and socialization, as well as physical therapy and speech therapy. Current days are M/W/F.							
Original	Assisted Living Level 3 w/o AMDC	Waiver Service	PEARLS OF WISDOM ASSISTED	4 days per week	52 weeks	$102.9400	$21,411.52	Quick View
	Comment: Client requires assistance with multiple ADLs/IADLs.							
Original	Assisted Living Level 3 w/ AMDC	Waiver Service	PEARLS OF WISDOM ASSISTED	3 days per week	52 weeks	$77.1800	$12,040.08	Quick View
	Comment: Client requires assistance with multiple ADLs/IADLs.							

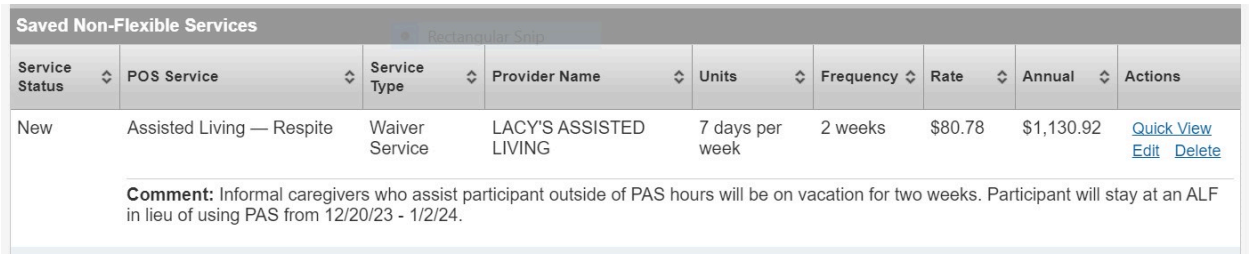
If the reviewer determines that the requests for ALF and MDC do not align, they should send the plan back to the SP through a CR.

CO Waiver and ICS participants residing in an ALF are only eligible to receive MDC, Senior Center Plus, and behavioral consultation in conjunction with assisted living services and may not receive any of the following as they are duplicative:

- PAS
- Nurse monitoring
- HDM
- Environmental assessments
- Accessibility adaptations
- Assistive technology
- PERS
- Dietitian and nutritionist services
- Consumer training
- Family training

Temporary Respite
COMAR 10.09.54.18-01

Temporary respite is a service offered through the CO Waiver and ICS and may be provided by an ALF or NF up to 14 days in a 12-month period. The SP should list respite as a waiver service under non-flexible services, specifying the provider, units, and frequency. Regardless of whether the service is being provided in an ALF or NF, the service type will be “Assisted Living - Respite.” The SP should include rationale for the request as well as the specific days respite is requested in **Comments**. The reviewer should review all plans approved within the last 12 months to ensure the maximum number of respite days has not been exceeded.



Saved Non-Flexible Services

Service Status	POS Service	Service Type	Provider Name	Units	Frequency	Rate	Annual	Actions
New	Assisted Living — Respite	Waiver Service	LACY'S ASSISTED LIVING	7 days per week	2 weeks	$80.78	$1,130.92	Quick View Edit Delete

Comment: Informal caregivers who assist participant outside of PAS hours will be on vacation for two weeks. Participant will stay at an ALF in lieu of using PAS from 12/20/23 - 1/2/24.

Dietitian and Nutritionist Services
COMAR 10.09.54.17

Dietitian and nutritionist services are offered through the CO Waiver and ICS programs and include nutrition care planning, nutrition assessment, and dietetic instruction. This service may be appropriate for a participant whose medical condition requires the judgment, knowledge, and skills of a licensed nutritionist or licensed dietitian and whose cognitive and functional status enables the individual to be an active participant in the service. As with consumer training, this service must be targeted to the individualized needs of the participant receiving the service and sensitive to their educational background, culture, religion, and eating habits.

This service is not intended to be ongoing. If sequential requests for the service are made, the reviewer should send the plan back to the SP through a CR and request a detailed plan from the clinician providing the service, which outlines the medical necessity for continuation.

Family Training
COMAR 10.09.54.16

Family training is a service offered through the CO Waiver and ICS programs that provides training and counseling to a participant's family members, with the intention of providing the family with skills and strategies to better support the participant (and perhaps themselves as "informal supports"). For the purpose of this service, "family" is defined as the people who reside with, or provide consistent informal support to, the participant. In this context, "family" does not include individuals who are paid providers of PAS, whether through the agency or self-directed model.[15] CO Waiver and ICS participants residing in an ALF are not eligible for this service.

Family training is provided on a one-on-one basis with qualifying family members and must be targeted to the individualized needs of the family member as it relates to the participant, rather than providing information that is of general interest. Family training may include, but is not limited to: instruction on treatment regimens and dementia or use of equipment specified in the participant's POS.

[15]As of the date of publication, the self-directed model has not yet been implemented.

Family training, like consumer training and dietitian and nutritionist services, is not intended to be on-going. If a participant requests family training on the POS, the reviewer must determine:

- Is the training time limited? There is no limit to the period of time in which family training may be approved, but the service is by definition, time-bound in its achievement of specific, measurable goals. Sequential requests for family training, particularly for the same family member, may indicate that the service is being used inappropriately.
- Is the request accompanied by a detailed plan outlining S.M.A.R.T goals (see footnote 11), how progress will be evaluated, and expected outcomes?

Behavioral Consultation
COMAR 10.09.54.14

Behavioral consultation is a service offered through the CO Waiver and ICS programs. This service may be appropriate for a participant when their behavior is:

- Potentially dangerous to themselves or others, or
- Places them at risk of institutionalization or hospitalization.

Behavioral consultation includes a visit to the participant's home by an individual qualified to:

- Evaluate a participant's behavior,
- Assess the broader situation in which the behavior is occurring,
- Determine the contributing factors, and
- Recommend interventions and treatments.

The behavioral consultation provider generates a report with the results of their assessment and their recommendations, which is reviewed with the participant, their representative (if applicable), and the participant's SP. If a participant is residing in an ALF, the report is also shared with that provider.

This service is for consultation only and is not meant as a substitute for ongoing behavioral health services available through the State Plan, which may also be recommended on the POC. Sequential requests for behavioral consultation may indicate that the service is being utilized inappropriately and the reviewer should send the plan back to the SP with the recommendation to discuss ongoing behavioral health services with the participant.

Senior Center Plus
COMAR 10.09.54.15

Senior Center Plus[16] is offered through the CO Waiver and ICS programs, and while similar to MDC in some ways, is distinct in others. Unlike MDC, which is available to all individuals aged 16 and older,

[16]Senior Center Plus is not associated with Senior Care, a non-Medicaid program operated by the Maryland Department of Aging, or community senior centers. If a participant is receiving Senior Care or other senior center services, these should be included as "Other" under non-flexible services.

Senior Center Plus providers often have a higher minimum age. In general, Senior Center Plus is also intended for individuals with lower functional needs. Like MDC, Senior Center Plus provides meals, therapies, medication management, and group activities to assist a participant with their ADLs, IADLs, and delegated nursing functions.

Participants attending Senior Center Plus must do so for a minimum of four hours per day, not including transportation, for the service to be reimbursed. **Senior Center Plus may not overlap with PAS, HDM, MDC, or any other non-Medicaid day-based programs.** If a participant is receiving any combination of these services, particularly on the same day, the plan (and if applicable, schedule) must clearly describe when the participant is receiving each service. If the reviewer is unable to determine whether the services overlap, they should send the plan back to the SP through a CR. Please see page 75 for guidance on the interaction between MDC and ALF services, which is also applicable to Senior Center Plus.

Delegation and Skilled Nursing Tasks

Delegation is the act of authorizing an unlicensed individual, CMT, or CNA to perform acts of registered nursing or licensed practical nursing while the delegating RN retains accountability for the tasks. The delegating RN must assess whether the conditions are conducive for delegation to occur, including stability of the individual to whom services are rendered, the task being delegated, training received by the individual to whom the task is delegated, and that individual's ability to perform the delegated task in a safe manner.

Agency Model: Delegation

The regulations for CPAS and CFC allow the performance of delegated nursing tasks as part of PAS if rendered in accordance with the Maryland Nurse Practice Act, COMAR 10.27.11, and other requirements of the Maryland Board of Nursing (see COMAR 10.09.84.14B). A participant's POS must document the intent of delegation (in the case of a Provisional or Initial POS) or an actual occurrence of delegation by an RSA RN (in the case of a Revised or Annual POS) as not all skilled nursing tasks can be delegated. Documentation to support delegation includes:

- A letter from the RSA RN delegating certain skilled task(s),
- The most recent nursing assessment and care plan, or
- A recent RSA Checklist or visit note completed by the LHD nurse monitor noting current delegation with listed task(s).

For more details, please see the SOP on delegation provided as an attachment to this manual.

Agency Model: Self-Administration of Medication

The Maryland Nurse Practice Act (COMAR 10.27.11) allows unlicensed providers to assist an individual with self-administration of medication or other remedies when prescribed by a physician, which is also considered within the scope of PAS. A participant's POS must document (in one of the methods described above) the intent of self-administration or the actual occurrence of self-administration in conjunction with documentation that the RSA RN is providing on-site supervision of staff that assist the participant with self-administration of medications. Per COMAR 10.07.05.12E(2)(b), "the registered nurse shall provide periodic, on-site supervision of care at least every three months if the staff assists the client with self-administration of medications."

Self-Directed Model: Delegation and Self-Administration

Upon implementation of the self-directed model, a participant who elects to self-direct their services will employ one or more individuals as their PAS providers. For these participants, there will be no RSA involvement; thus, no delegating RN. The self-directed model will also allow a participant's representative to "self-direct" services on their behalf. Per COMAR 10.27.11.01, "a cognitively capable adult that employs an unlicensed caregiver to assist with treatments of routine nature and self-administration of medication is excluded from delegation regulations." **A participant in the self-directed model may receive assistance with skilled nursing tasks only if the same skilled task would be considered delegable under the agency model.** Upon implementation of the self-directed model, a participant with skilled needs who elects to self-direct their services will need to complete a form indicating the acceptance of all liability associated with the "delegation" of allowable tasks to their employee, which will be included with the POS.

For more details, please see the SOP on delegation provided as an attachment to this manual.

Delegation of Urinary Catheters

The following is a description of the most commonly utilized urinary catheters, whether assistance with that type of catheter is delegable, and if so, to what extent. A reviewer should consult with a clinical reviewer, preferably an RN, in determining whether a participant's request for assistance with a urinary catheter is within the scope of PAS (see the SOP on delegation provided as an attachment to this manual).

Indwelling "Foley" catheter: A urinary drainage system in which a tube is inserted into the urethra, which goes to the bladder and stays in the bladder with a balloon-like mechanism.

- Non-skilled tasks (i.e., no delegation required)
    - Empty or change collection container
    - Perform peri-care (i.e., washing/cleaning the tubing that is external to the participant's body and therefore considered non-invasive)

- Skilled nursing tasks, which require delegation (see the SOP on delegation provided as an attachment to this manual)
    - Inserting the tube/catheter
    - Flushing fluid into the tube/catheter

Condom catheter: A urinary collection system in which a condom is applied to the penis to control urinary incontinence.

- Non-skilled tasks (i.e., no delegation required)
    - Empty drainage container
    - Apply or remove

Intermittent catheter: A urinary drainage system in which a tube is inserted into the urethra and advanced to the bladder and is removed once the urine is drained.

- Skilled nursing tasks, which require delegation (see the SOP on delegation provided as an attachment to this manual)
    - Setup and cleanup
    - Inserting the tube/catheter

Suprapubic catheter: A urinary drainage system in which a tube is inserted into a surgically made opening in the abdomen advancing to the bladder. With delegation, a PAS provider may empty or change the collection container, but insertion of the tube or flushing the tube is non-delegable.

Concurrent Enrollment

A participant may only be enrolled in one Medicaid waiver, but can receive services through multiple State Plan programs in conjunction with waiver services (see pages 16 and 68 for more detail). A robust UR process not only ensures that there is no overlap or duplication of Medicaid HCBS, but also determines the programs and services, in amount, scope, frequency and duration, that best meet the assessed needs of a participant. This process is, by definition, participatory, and requires the involvement of the participant, authorized representatives of the participant (as applicable), case managers from multiple programs, and a multidisciplinary plan review.

Identifying Concurrent Enrollment & Current Services

Identifying whether a participant is enrolled in more than one Medicaid HCBS program is the first step for concurrent enrollees. With the exception of the Autism Waiver, all Medicaid waiver and waiver-like State Plan programs utilize LTSS*Maryland* as their system of record. There are multiple indicators of concurrent enrollment in LTSS*Maryland*:

- **Client Summary** includes:
    - **Eligibility Information** lists the special program codes.

        - Special program codes are three-digit alphabetical codes that identify the waiver (and in some cases the State Plan) program in which a participant is enrolled
    - **Current Enrollment** lists the Medicaid HCBS program(s) in which a participant is currently enrolled.
    - **Program Snapshot** lists past and present Medicaid HCBS program enrollment.

Although less clearly defined, information entered by a participant's assigned SP or another program's case manager within the **Progress Notes** section may provide more detail on a participant's concurrent enrollment or other Medicaid HCBS programs to which the participant is applying.

Each Medicaid HCBS has an array of services and understanding whether a participant is concurrently enrolled is only the first step. Once a reviewer determines the programs in which a participant is currently enrolled, the next step is to determine what services are being received through that program, when they're being received, and what each service entails. There are multiple indicators of current services in LTSS*Maryland*, although unlike the clearly defined distinction of enrolled versus not enrolled, current services can be challenging to decipher:

- **Current Services** (accessible via the left navigation panel under **Programs**) pulls information from the active, approved plan for all Medicaid HCBS that utilize LTSS*Maryland*, although this information alone does not equate to an accurate indication of what a participant is actually receiving at the time of UR.[17]
- **POS/PCP/SP/POC** (accessible via the left navigation panel under **Programs**) includes active, approved plans, as well as those that were previously active (and are now inactive), pending review, or discarded. Each program uses different terminology for their plan, but they serve the same purpose - to request program services and supports, which require approval by Maryland Medicaid, or the Operating State Agency (OSA). A reviewer may not be able to see all details associated with a participant's plan for another program, but the core components needed for UR should be visible. If additional information or clarification is needed, the reviewer should reach out to the participant's assigned case manager for the applicable program.

Determining Overlap, Duplication, and Other Service Limitations

Determining whether the requested program services and supports overlap with, or are duplicative of, other Medicaid HCBS requires an understanding of what each programs' services entail. More detailed information about Maryland Medicaid's eight 1915(c) waivers, two waiver-like State Plan programs, and its 1115 demonstration waiver can be found here.

This manual is focused on the most common sources of overlap and duplication for participants in CPAS, CFC, CO Waiver, and ICS, including services among the four programs that are duplicative and therefore, may not overlap. For the purposes of UR, a reviewer must determine if overlap of Medicaid

[17]As of the date of publication, other State Plan services such as DMS/DME, NEMT, and PACE also do not utilize LTSS*Maryland*.

services is occurring, and if the overlap is prohibited. Overlap is defined as the occurrence of more than one Medicaid service at the same time or, in some cases, another specified period of time; for example, within the same day. Overlap is prohibited in situations where the core components of the services, or their intended goals, are duplicative. For example, MDC and Senior Center Plus both consist of a program of structured group activities to support socialization, while also assisting with ADLs, IADLs, and delegated nursing functions; as such, they cannot be provided to a participant on the same day. Similarly, HDM and PAS may not be delivered at the same time as HDM take the place of the human assistance otherwise provided for meal preparation. In both examples above, the delivery of these services at different times does not constitute overlap (or by extension, duplication), but their delivery at the same time, or same specified period of time, does.

To determine duplication, a reviewer must look beyond the timeframe in which various Medicaid services are occurring to determine if the core components of the services, or their intended goals, are duplicative. For example, regardless of whether PAS and personal support services (PSS), a service provided through the three 1915(c) Medicaid waivers operated by DDA, are occurring at the same time, there is potential for duplication.

As it relates to other Medicaid HCBS programs, the most common sources of overlap and duplication for participants in CPAS, CFC, CO Waiver, and ICS are PDN and PSS; however, other services such as MDC, day habilitation and individual support services also include the potential for overlap or duplication. In addition to determining overlap and duplication, a reviewer must also ensure that there are no specified limitations on the receipt of specific CPAS, CFC, CO Waiver, and ICS services based on a participant's assessed needs.

Private Duty Nursing and Continuous Skilled Nursing Needs

Private duty nursing is provided to participants under the age of 21 through the Medicaid State Plan, specifically the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. PDN is provided to participants over the age of 21 through the 1915(c) Model Waiver for Medically Fragile Children ("Model Waiver") or the Medicaid State Plan, specifically the Rare and Expensive Case Management (REM) program. Nursing services are defined as more individual and continuous than home health services; thus, services are provided by a Licensed Practical Nurse (LPN) or a licensed RN.

If a participant is receiving PDN through the Model Waiver, it may also be appropriate for the participant to receive PAS through the CFC program. Similarly, if a participant is receiving PDN through the REM program, they may be concurrently enrolled in the CO Waiver. The degree to which PDN and PAS may appropriately coexist is a function of 1) whether there is an overlap in services, 2) the degree to which PAS is duplicative of assistance with ADLs, IADLs, and delegated nursing functions provided by the nursing services, and 3) whether a participant has a continuous skilled nursing need.

In some instances, a participant may not be eligible for PDN through any Medicaid program but has continuous skilled nursing needs. If such needs exist, regardless of whether the participant is receiving PDN, the participant has needs that exceed the scope of personal assistance.

For more details, please see the SOP on continuous skilled nursing needs provided as an attachment to this manual.

Personal Support Services

PSS is provided to participants ages 18 and older through the 1915(c) Community Pathways Waiver or the 1915(c) Community Supports Waiver, both of which are operated by DDA. PSS is provided to participants up to age 21 through the 1915(c) Family Supports Waiver, which is also operated by DDA. PSS includes community integration, habilitative services, and overnight supports, and may include personal assistance when incidental to community integration and habilitation. If a participant is receiving PSS through one of the three Medicaid waivers operated by DDA, it may also be appropriate for the participant to receive PAS through the CFC program. The degree to which PSS and PAS may appropriately coexist is a function of 1) whether there is an overlap in services, 2) the degree to which PAS is duplicative of assistance with ADLs, IADLs, and delegated nursing functions provided through PSS, and 3) whether a participant has significant behavioral needs.

For more details, please see the SOP on PSS and PAS provided as an attachment to this manual.

Taking an Action on a POS

Clarification Requests (CR)

Clarification requests are used as a communication tool by the reviewer to request additional information, seek clarification about a service request, or to ask for the completion or correction of any technical aspect of the POS. A CR is part of the participant's POS record in LTSS*Maryland* and should reflect a professional, respectful tone and clear, concise, unbiased, and fact-oriented language as these records may be reviewed by other parties, including Administrative Law Judges, attorneys, and anyone else who requests and is allowed access to a participant's medical records.

Clarification Request Do's:

- Note ALL needed changes and be specific
    - Ensure the request is comprehensive to reduce the need to send future CRs
- State the number of PAS hours or HDMs being requested
    - LTSS*Maryland* does not keep a historical record of all POS changes during the review process. In some instances, if details about the original request are not recorded in the CR, the reviewer will not know what changes were made after the CR was sent.
- State the relevant COMAR, if applicable

- If needed, provide a general description of covered services
- Give the SP an opportunity to provide additional information or clarification
    - In general, a CR should be initiated before issuing a denial
- Be as concise as possible as the number of allowable characters is limited
    - While not ideal, it is permissible to put a CR in a Word document and upload it to **Attachments** within the POS. The reviewer must then direct the SP to this document in the text of the CR.

Clarification Request Don'ts:

- Do not make specific PAS hours recommendations or state that participants cannot receive a service for which they are otherwise eligible
    - This is considered a negotiation technique or a "denial" without appeal rights. Instead, word the request as a query; for example, *"It is not clear how 20 hours of PAS is medically necessary or necessary to prevent institutionalization. Please clarify and submit any available medical documentation to support the request."*
- Do not state the number of PAS hours the current evidence does support because this is also considered negotiation
- Do not make service recommendations unless those services are absolutely necessary to ensure the plan meets a participant's health and safety needs
- Do not communicate with the SP about the POS by email, unless a copy of the email is included in the **Attachments** within the POS

If there is a possible benefit to calling the SP; for example, a faster review process, ease of getting clarity on complex information, or to provide technical assistance to the SP, then calling is appropriate. If a reviewer calls a SP to discuss a POS, the same guidance for written communication applies to oral communication. After the call, if a correction or change is still needed, the reviewer should send the plan back to the SP through a CR with a short synopsis of the phone discussion.

Generally, a reviewer should make a final determination on a POS after no more than two CRs. If the SP has not addressed everything in one of the previous two CRs, the reviewer should make one additional attempt with the instruction that if the participant does not wish to change the POS or provide additional information, then the SP should state in the narrative that the plan should be reviewed "as is" and resubmit. It may also be helpful for the reviewer to reach out to the SP via phone to request clarification before making a final determination on the plan.

Approvals

A reviewer may approve a POS once the reviewer verifies the participant's eligibility, ensures all technical plan requirements are met, and determines that the requested services are appropriate. Once a reviewer has determined an approval is appropriate, they must ensure the effective date of the plan aligns with the following guidance:

	CPAS	CFC	CO/ICS (from NF)	CO/ICS (from community)
Provisional [18]	Not required; **OR** 1st or 15th of the month (whichever date comes first)	Not required; **OR** 1st or 15th of the month (whichever date comes first)	Not required; **OR** the discharge date on the 257 form	Not required; **OR** current date; **OR** date in the future
Initial	1st or 15th of the month (whichever date comes first) [19]	1st or 15th of the month (whichever date comes first) [19]	The discharge date on the 257 form (will most likely be a date in the past)	Current date; **OR** date in the future
Revised[20]	Current date; **OR** date in the future	Current date; **OR** date in the future	N/A	Current date; **OR** date in the future
Annual[20]	Current date; **OR** date in the future	Current date; **OR** date in the future	N/A	Current date; **OR** date in the future

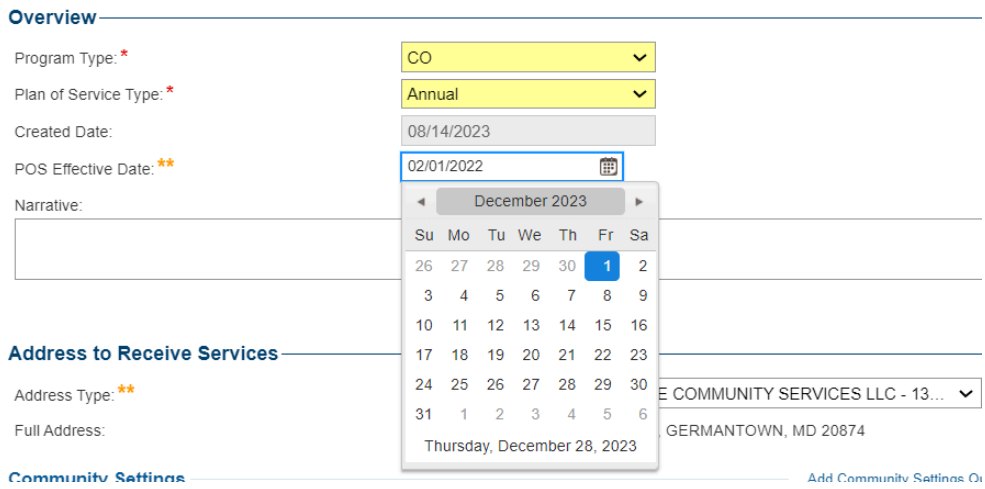
With the exception of an Initial POS for an applicant enrolling in the CO Waiver or ICS from a NF, any requests by a SP to backdate a plan must be approved by a supervisor as approval of a backdated plan may affect a participant's enrollment status and provider payments.

To change the effective date of a POS, the review should select **Edit** in the top right corner of the **Overview** section and scroll down to the "POS Effective Date" to open the date drop-down. Once the correct date is entered, select **Save** in the top right corner.

[18] Services cannot start with approval of a provisional plan; as such, a start date is not required. If the provisional plan is submitted with a start date and that date has not passed, the start date does not need to be updated. If a start date is included and has passed at the time of review, the reviewer should delete the date and leave it blank.

[19] **If a participant is changing from CFC to CPAS (due to a loss of NF LOC), or from CO/ICS to CFC or CPAS (either due to loss of NF LOC or voluntary disenrollment from CO/ICS), an initial POS is required for the new program.** Although there will be a lapse in services between disenrollment from one program and enrollment in another, the start date of the initial POS should be the 1st or 15th of the month.

[20] If the start date entered on the plan has not passed at the time of review, the start date does not need to be updated; otherwise, the date should be updated to the current date unless the plan has a provider change. In this instance, the start date should be the next business day. This will allow the SP enough time to complete the necessary forms to switch providers and prevent a lapse in services.



Denials

General Information about Denials

Once the UR process is complete and a reviewer has determined that some or all of the requested service(s) do not meet regulatory or other program requirements, the reviewer issues a denial, which consists of denying the plan in LTSS*Maryland*, creating a denial summary, and issuing a denial letter to the participant. The denial letter communicates the regulatory basis for each denied service and informs the participant of their appeal rights associated with the denial (see page 92 for more detail on appeals). If a requested service is appropriate, but in a different amount, frequency, or duration than the participant requested, the denial letter will specify this as well.

A reviewer may not deny previously approved services in conjunction with a Revised POS unless the participant is receiving new or additional services through another Medicaid or non-Medicaid program, or the reviewer identifies the participant as having a continuous skilled nursing need or significant behavioral needs. For example:

<u>Scenario 1</u>

- Participant is currently receiving 20 hours of PAS
- Revised POS is requesting 25 hours
- The reviewer identifies no new services, continuous skilled nursing need or significant behavioral needs
- The reviewer *may not* deny the plan for fewer than 20 hours, even if the 20 hours are deemed not medically necessary

<u>Scenario 2</u>

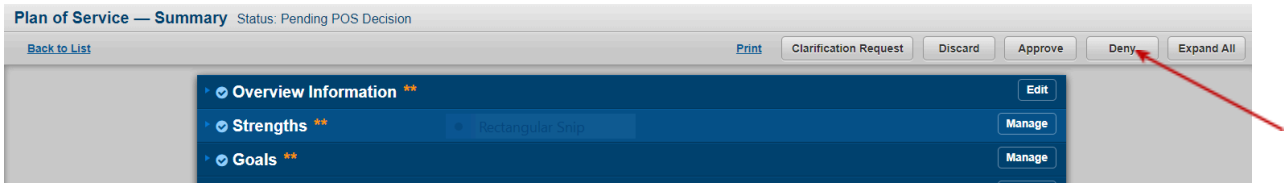
- Participant is currently receiving 20 hours of PAS
- Revised POS is requesting 25 hours

- The reviewer discovers that the participant is now receiving additional services through another program that are either new or were not disclosed at the time the current plan was approved
- The reviewer *may* deny the plan for fewer than 20 hours

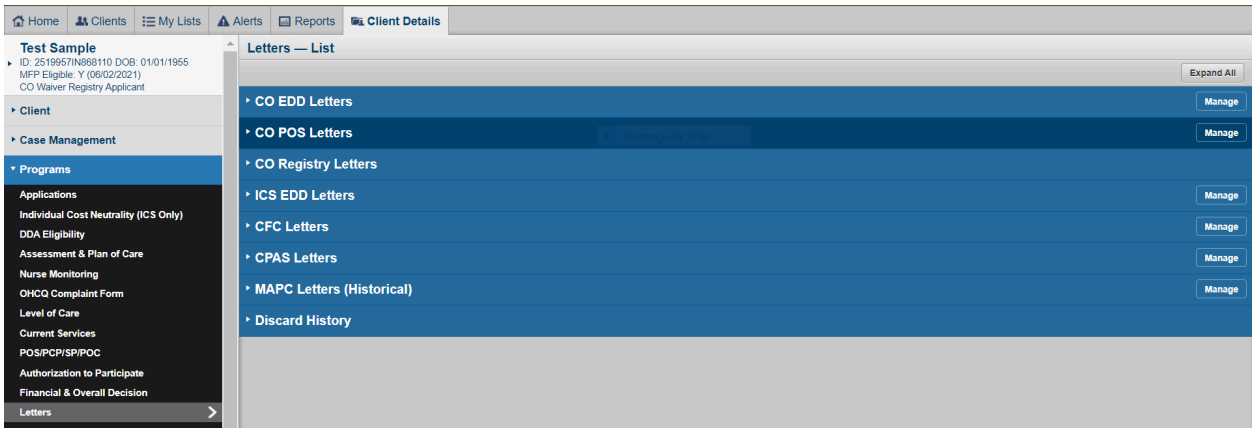
There are no reconsiderations of POS denials. If a participant disagrees with a denial, they may appeal the decision in accordance with the Medicaid fair hearings regulations (COMAR 10.01.04).

Creating a Denial

1. Select **Deny** in the top right corner, then enter "POS is denied" in the reason section. If a custom denial letter is needed, meaning one created outside of LTSS*Maryland*, enter "POS is denied, please see denial letter in Client Attachment." **The POS must be denied before creating a denial letter!**

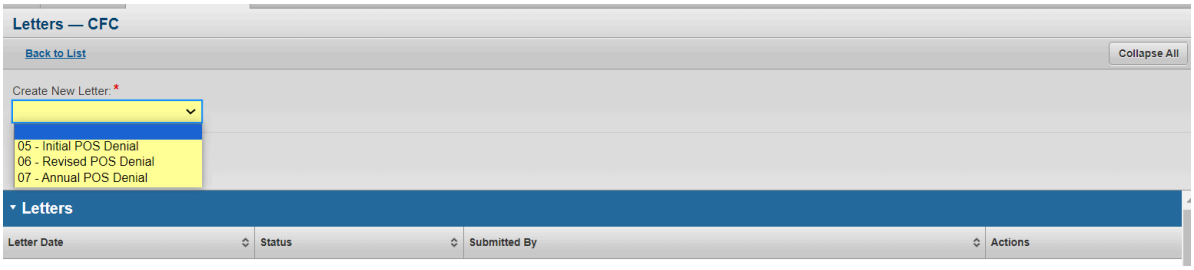


2. Select **Letters** under **Programs** on the left navigation panel.



3. Select the applicable program section (CO POS Letters, CFC Letters,[21] CPAS Letters).
4. Select **Manage** to choose the specific denial letter.
5. In the middle of the screen there is a drop-down (highlighted yellow), labeled "Create New Letter." Select the appropriate letter based on the plan type[22] (Initial POS Denial, Revised POS Denial, Annual POS Denial), then "Create."

[21]Use CFC Letters for ICS POS denials.
[22]Use "Initial POS Denial" for a denied provisional plan.



6. The denial letter includes fillable areas that are auto populated (e.g., name, address, Medicaid number). Confirm that this information matches what is in LTSS*Maryland*.
7. In the top right corner of the denial letter, there is a drop-down labeled "Client." Open the list and select "Authorized Representative" to determine if there is a need to mail a denial letter to a representative as well. *This is particularly important if a participant has a legal guardian or their representative resides in a different location than the participant.*
8. Select the statement "Services you requested are not supported by documents submitted to the Department…," then select all services being denied (e.g., PAS, items that substitute for human assistance). **With the exception of denials for exceeding cost neutrality and those that require a custom letter, this is the template for all denials.**
9. Populate all highlighted areas with applicable information concerning the denial using the exact language used in the POS.
10. Once the information is entered, select **Submit** in the top right corner.
11. From the **Letters** list page, review the denial letter and verify it was filled out correctly. If so, print and mail the denial to the participant and if applicable, the representative, within one calendar day of generating the letter.

Creating a Custom Denial Letter

When the rationale for a denial is not included in the template in LTSS*Maryland* or additional information is needed, a custom denial letter is warranted. If the denial is related to a continuous skilled nursing need, duplication of services through the DDA, or significant behavioral needs, the applicable custom denial letter template must be used. If a new custom denial letter is needed, please contact OLTSS for further guidance.

1. Direct the SP to **Client Attachment** to view the custom denial letter (see step 1 on page 89).
2. Populate all highlighted areas of the custom denial letter with applicable information concerning the denial using the exact language used in the POS.
3. Attach the supplemental information (i.e., appeal rights, authorized representative form, notice of non-discrimination) to the denial letter, creating one document that contains all required information.
4. Upload the custom denial letter (that now includes the supplemental information) to **Client Attachment**.

5. Print and mail the custom denial letter to the participant and if applicable, the representative, within one calendar day of generating the letter.

Creating a Denial Summary

A participant has up to 90 days from the date of the denial or disenrollment notice to file an appeal. Having a summary of a reviewer's rationale for a denial assists the OLTSS in defending the decision should the participant appeal. The following should be included in a denial summary:

1. Identifying information for participant and reviewer:
    a. Client ID number,
    b. Date of denial,
    c. Program type,
    d. Plan type, and
    e. Reviewer's name;
2. Requested services, current services, and approved services;
3. Flexible budget and RUG - *Have these changed since the last POS review?;*
4. Other services currently received:
    a. Medicaid programs (e.g., Community Pathways Waiver, REM, Model Waiver, MDC Services Waiver, Autism Waiver)
    b. Private/public programs (e.g., PDN through private insurance, school-based services, Psychiatric Rehabilitation Program (PRP))
    c. Other reoccurring treatments (e.g., dialysis, physical therapy, occupational therapy, speech therapy, behavioral health, feeding clinic at Kennedy Krieger);
5. Reason for the denial - Provide a brief narrative and list the specific reasons for the denial; for example:
    a. Excessive times for tasks,
    b. Non-covered tasks,
    c. Duplication with other services,
    d. Outside the scope of the program,
    e. Does not increase independence and substitute for human assistance, or
    f. Over the maximum allowable covered amount;
6. Supporting documentation (including dates) - Include only documentation used in determining the decision; for example:
    a. interRAI assessment and POC,
    b. DDA PCP,
    c. PDN assessment,
    d. Nurse monitoring visits,
    e. RSA documentation (e.g., RSA RN assessment and care plan),
    f. Medical documentation (e.g., physical therapy notes, physician progress notes), or
    g. Assessments completed by an MDC provider;
7. Calculation of PAS hours (if applicable), including the reviewer's calculations and rationale associated with their determination on the task schedule;

8. A timeline of all services (if concurrent enrollment); and
9. Key regulations supporting the decision.

Creating a Denial Folder

Upon completion of the denial summary, the reviewer should go to the UCA SharePoint site and find the folder labeled "Plan of Service Review." Then, create a folder, label it with the participant's Client ID number from LTSS*Maryland*, and save it under the appropriate denial month. The folder should contain the denial summary as well as the task schedule if the reviewer made comments or entered calculations on it.

Appealing a Denied POS

Timeframe to Submit an Appeal

A participant has up to 90 days from the date of the denial or disenrollment notice to file an appeal. If the participant wants to maintain the amount, scope, and frequency of the denied services while awaiting the outcome of the appeal, then MDH must receive the written appeal request within 10 days of the date of the denial or disenrollment notice (referred to as "pending benefits").

All appeal requests must be submitted to MDH in writing via mail, fax, or email. The SP may support this process by assisting the participant in transcribing the letter and sending the appeal request to OLTSS.[23] The Medicaid Appeals Coordinator receives the appeal, transmits it to the Office of Administrative Hearings (OAH), and enters it in LTSS*Maryland* under **Appeals and Dispositions** (see page 46 for more detail).

Pending Benefits and Changes During the Appeals Process

If a participant is eligible to continue services, appeals timely, and elects "pending benefits," they may continue services in the same amount, scope, and frequency as indicated on their last approved plan. **While a participant is "pending benefits" the only service change that may be made is to a provider on a Revised POS.**

If a participant is not eligible to continue services, does not appeal timely, or does not elect "pending benefits," their SP must submit a new POS that aligns with the approved services listed in the denial letter. For example, if a reviewer denies a participant's Initial POS requesting 30 hours of PAS, but approves 20 hours, the SP should submit a new Initial POS reflecting 20 hours of PAS. The SP should indicate that the POS is being submitted to accept the approved service; however, the reviewer should

[23] The SP may not author an appeal letter on behalf of the participant/representative. They may only transcribe the letter in the participant/representative's own words and then have them sign it.

compare the denied POS and denial letter to the new POS to make sure no additional services are included on the new plan that were not previously requested. Once that plan is approved, the SP may submit another POS with the participant's request for new or additional services.[24]

Updating a POS after an Appeal Hearing

Once an appeal is resolved by a withdrawal (by the participant), rescind (by MDH), settlement, or a decision rendered by the Administrative Law Judge (ALJ), additional action may be required by the SP in relation to the plan. In all instances except when a hearing goes forward and the ALJ is responsible for rendering a disposition, the expert witness representing MDH is responsible for communicating the outcome to the SP and requesting any subsequent action related to a plan. The witness enters a progress note in LTSS*Maryland* apprising all parties of the outcome of the hearing.

An ALJ has 30 days from the date of the hearing to issue a disposition. Once available, the disposition is shared with MDH's attorneys and the Medicaid Appeals Coordinator, who enters the disposition in LTSS*Maryland* under **Appeals and Dispositions**. The SP is responsible for monitoring the participant's record and submitting a plan, as necessary, to actualize the ALJ's disposition. For example, if the ALJ affirms MDH's denial and the participant is "pending benefits," the SP must submit a new plan (generally of the same type) that reflects MDH's original denial. A SP should submit a plan in conjunction with an appeal outcome as a Priority Request, which is reflected in the current criteria (see page 26 for more detail). If a reviewer is uncertain as to whether the plan aligns with the disposition, they should contact OLTSS for further guidance.

[24] If the denial is for a Revised POS and the approvable service is the same amount, scope, frequency, and duration as a service on the active, approved POS, a new POS is not required.