To: Division of Participant Enrollment and Service Review
Division of Clinical Support

From: Chief, Division of Clinical Support, Office of Long Term Services and Supports

Date: March 4, 2024

Re: Standard Operating Procedure – Personal Support Services and Personal Assistance

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PURPOSE:

The purpose of this communication is to 1) standardize policy and procedures for the Office of Long Term Services and Supports (OLTSS) when reviewing plans of service (POS) for participants enrolled in the Community Personal Assistance Services (CPAS), Community First Choice (CFC), Home and Community-Based Options Waiver (HCBOW) and Increased Community Services (ICS) programs, 2) assist in determining when personal assistance services (PAS) through CFC may be duplicative of personal support services (PSS) and 3) outline the criteria for determining when a participant has significant behavioral needs and the corresponding implications for the receipt of PAS through CFC.

BACKGROUND:

Robust utilization review not only ensures that there is no overlap or duplication of Medicaid home and community-based services, but it 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.

PAS is a service provided through two Medicaid State Plan programs - CPAS and CFC. HCBOW and ICS participants may also receive PAS through CFC, if residing in a qualifying setting.[1] Similarly, participants enrolled in other Medicaid waivers may also receive services through the CFC program if meeting the technical eligibility requirements.

As defined in Code of Maryland Regulations (COMAR) 10.09.84.14, PAS includes the following when provided by a personal assistance provider:

(1) Assistance with activities of daily living (ADL);

(2) Delegated nursing functions if this assistance is:

(a) Specified in the participant's plan of service; and

(b) Rendered in accordance with the Maryland Nurse Practice Act, COMAR 10.27.11, and other requirements of the Maryland Board of Nursing;

(3) Assistance with tasks requiring judgment to protect a participant from harm or neglect;

[1]HCBOW and ICS participants residing in an assisted living facility (ALF) are ineligible to receive PAS as it is duplicative of the assistance provided in the ALF.

(4) Assistance with or completion of instrumental activities of daily living (IADL), provided in conjunction with the services covered under §B(1)—(3) of this regulation; and
(5) Assistance with the participant's self-administration of medications, or administration of medications or other remedies, when ordered by a physician.

PSS are provided through the three 1915(c) Medicaid waivers operated by the Developmental Disabilities Administration (DDA) - Community Pathways Waiver, Community Supports Waiver and Family Supports Waiver. As defined in the approved 1915(c) waiver application for Community Pathways,[2] and mirrored in the other two waivers, personal supports are *"individualized supports, delivered in a personalized manner, to support independence in an individual's own home and community..."* and provide *"habilitative services and overnight supports to assist individuals who live in their own or family homes with acquiring, building, or maintaining the skills necessary to maximize their personal independence."* PSS includes in-home skills development, community integration and engagement skills development and overnight supports. Although PSS is distinct from PAS provided through CFC, personal assistance may be provided in combination with, and incidental to, the provision of habilitation services through PSS.

Behavioral support services are also provided through the three 1915(c) Medicaid waivers operated by DDA. As defined in the approved 1915(c) waiver application for Community Pathways (see footnote 1), and mirrored in the other two waivers, behavioral support services are *"an array of services to assist participants who, without such supports, are experiencing or are likely to experience difficulty at home or in the community as a result of behavioral, psychological, social, or emotional issues."* Behavioral support services include behavioral assessment, behavioral consultation and brief support implementation services.

ELIGIBILITY:

Personal Assistance

To receive PAS, a participant must meet the respective medical, technical and financial eligibility requirements for CPAS or CFC, or the applicable waiver through which eligibility for services under the Medicaid State Plan is achieved. PAS must be pre-authorized in a participant's POS in response to an assessed need and determined to be medically necessary and necessary to prevent institutionalization. PAS must not duplicate or overlap with other services intended to support ADL or IADL needs, or which assist with ADLs and IADLs when incidental to the service being provided. This includes, but is not limited to home-delivered meals, medical day care services, personal support services and private duty nursing.

Personal Support Services and Behavioral Support Services

To receive PSS and behavioral support services, a participant must meet the respective medical, technical and financial eligibility requirements for the Community Pathways Waiver, Community Supports Waiver or Family Supports Waiver. PSS and behavioral support services must be pre-authorized in a participant's PCP in response to an assessed need and determined to be

[2] https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81941

medically necessary.

PROCEDURE:

1. During the first level of POS review, the reviewer must identify whether the individual is also enrolled in one of the three Medicaid waivers operated by DDA by looking for the applicable special program codes in LTSS*Maryland.*
    a. Special program codes are listed under "Eligibility Information" in the *Client Summary* section (accessible via the left navigation panel under *Client Profile*) and in the "Special Program Codes" section within "Overview Information" in the POS.
        i. Participants enrolled in one of the three Medicaid waivers operated by DDA will have one of the following special program codes:
            1. Community Pathways Waiver (DRW, DRM, NRM, NRW)
            2. Community Supports Waiver (CSW, CSM)
            3. Family Supports Waiver (FSW, FSM)
2. If the applicant/participant is enrolled in one of the three Medicaid waivers operated by DDA, the reviewer must determine what services the applicant/participant is receiving by reviewing the below sections of LTSS*Maryland*:
    a. *Current Services* (accessible via the left navigation panel under *Programs*) pulls information from the active, approved Person-Centered Plan (PCP)[3]
    b. *POS/PCP/SP/POC* (accessible via the left navigation panel under *Programs*) includes active, approved PCPs, as well as those that were previously active (and are now inactive), pending review or discarded
        i. The reviewer should review the active, approved PCP as well as PCPs pending review by DDA
        ii. Each service under the "Service Authorization" section is listed by the number of units received per month, over a 12-month period.[4] For PSS and certain other services, one unit of service equates to 15 minutes[5]
3. After reviewing the active, approved PCP, as well as any PCPs pending review by the DDA, the reviewer must determine if any services overlap with the requested services through CFC. 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. If the reviewer determines that there is possible overlap, the reviewer should:
    a. Return the POS to the applicant/participant's assigned Supports Planner via a clarification request and request submission of a task schedule, or

[3]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).
[4]Generally, a PCP covers a 12-month period; however, specific services may be approved for a shorter length of time. A high number of service units generally equate to a significant budget, both of which are indicators of possible duplication with CFC services.
[5]https://health.maryland.gov/mmcp/provider/Documents/Transmittals_FY2024/PT%2041-24%20Fiscal%20Year%202024%20Rates%20for%20Medicaid%20Waiver%20Programs%20Operated%20by%20the%20Developmental%20Disabilities%20Administration%20(DDA).pdf

b. If a task schedule was already provided, offer the applicant/participant an opportunity to provide additional information that substantiates that no overlap is occurring. If the task schedule provided preceded approval of services by DDA, the reviewer should request that the SP revise the task schedule to reflect all current services.

4. If after review of the provided task schedule and/or additional information, the reviewer determines that overlap is definitively occurring, the reviewer should:
    a. Return the POS to the applicant/participant's assigned SP via a clarification request and request that the SP, Coordinator of Community Services (DDA's case manager) and the applicant/participant meet to discuss changes to the CFC POS and/or DDA PCP to ensure there is no overlap. The reviewer should refer the SP and CCS to the "quick guide" for concurrent enrollment as a resource.
    b. If upon return of the POS, overlap is still occurring, the reviewer should convene a coordination meeting with the SP and CCS to provide regulatory guidance and technical assistance to aid in the creation of a POS without overlap.
    c. Following the coordination meeting and re-submission of the CFC POS, if overlap is still occurring, the reviewer should deny the POS.
5. If the reviewer determines there is no overlap of services, the reviewer must then determine there is also no duplication. Determining duplication requires a more detailed review of the PCP, specifically the ways in which PSS are utilized. The reviewer should review the entire PCP, including:
    a. Service Implementation Plans, which provide additional information detailing the use of DDA-approved services,
    b. The most recent Health Risk Screening Tool, which is used by the DDA to detect health risks and destabilization,
    c. Task schedule (if provided),
    d. Behavioral Assessment (if applicable), and
    e. Behavioral Support Plan (if applicable).
6. Duplication occurs when PSS and PAS are supporting the same assessed needs related to ADLs, IADLs and/or delegated nursing functions. **If the participant's ADL, IADL and delegated nursing needs are addressed by the PSS approved on the DDA PCP, approving PAS through CFC duplicates an existing Medicaid service.** If the reviewer determines that there is possible duplication, the reviewer should:
    a. Return the POS to the applicant/participant's assigned SP via a clarification request and offer the applicant/participant an opportunity to provide additional information that substantiates that no duplication is occurring.
7. If after review of the additional information, the reviewer determines that duplication is definitively occurring, the reviewer should:
    a. Return the POS to the applicant/participant's assigned SP via a clarification request and request that the SP, CCS and the applicant/participant meet to discuss changes to the CFC POS and/or DDA PCP to ensure there is no duplication. The reviewer should refer the SP and CCS to the "quick guide" for concurrent enrollment as a resource.

b. If upon return of the POS, duplication is still occurring, the reviewer should convene a coordination meeting with the SP and CCS to provide regulatory guidance and technical assistance to aid in the creation of a POS without duplication.
c. Following the coordination meeting and re-submission of the CFC POS, if duplication is still occurring, the reviewer should deny the POS.
    i. When ALL of an applicant/participant's ADL, IADL and delegated nursing needs are met by DDA-approved PSS, the reviewer must deny the request for PAS and approve zero hours
    ii. If some duplication exists, but the applicant/participant still has unmet ADL, IADL and delegated nursing needs, the reviewer may deny the requested hours, but approve *some* hours of PAS
        1. If an applicant/participant is receiving PSS for overnight supports only, it may be appropriate to provide PAS through CFC during the day in response to an assessed need
        2. If an applicant/participant is receiving PSS for community integration only, it may be appropriate to provide PAS through CFC in response to an assessed need

8. Finally, if the reviewer has determined that the requested CFC services are not overlapping or duplicative of DDA-approved services, the reviewer must determine if the applicant/participant has significant behavioral needs that may be outside the scope of PAS due to the training and skills required by staff to appropriately, and safely, support participants. If the "Service Authorization" section of the PCP includes behavioral support services, the reviewer should review the applicant/participant's behavioral assessment and behavioral support plan to determine if the behaviors for which the individual is supported occur "in home." If the reviewer determines that the applicant/participant has significant behavioral needs occurring "in home," the reviewer should:
    a. Return the POS to the applicant/participant's assigned SP via a clarification request and offer the applicant/participant an opportunity to provide additional information that substantiates how PAS can be safely delivered.
    b. If after review of the additional information, the reviewer determines that the applicant/participant's needs are too behaviorally complex for PAS, the reviewer should deny the request for PAS and approve zero hours as a result of behavioral complexity.