

## *Plan of Care & Attendant Care Worksheet*

### **F-1 What should be included in the forms**

#### a. Plan of Care

An individual written Plan of Care (POC) will be developed by a qualified ILC and will describe medical and other services to be furnished, their frequency, and the type of provider who will provide each service (regardless of funding). The POC for a PD waiver consumer will contain those services needed to maintain health and safety in their living environment as well as those that can assist the individual in realizing reasonable personal goals.

- i. Informal supports should always be listed on the paper POC. If there are no informal supports, that information should be stated on the documents as well.
- ii. The cost of the entire POC must be equal or greater than the client obligation or the consumer does not meet eligibility requirements (see KEESM 8240).
- iii. AMM staff must prior authorize Plans of Care that include spousal exceptions for self-directed care. The ILC should submit the required documentation to the CIL director for first approval. Prior to POC approval, a note should be sent to the AMM staff via the MMIS information screen advising of the request for a spousal exception. All documentation regarding a spousal exception (*see Section B-3, a., K.A.R. 30-5-307*) should be sent to the AMM staff for review prior to the request for the POC approval. Existing POCs that have not been approved by the AMM staff should comply with this policy by June 30, 2002.

#### b. Attendant Care Worksheet

An assessment is completed on the basis of the activities that occur in a “typical day” for the individual consumer. The Plan of Care (POC) and Attendant Care Worksheet (ACW) should be completed based on the “typical day” information. Estimated times to perform tasks are included on the ACW to serve as guidelines for the ILC. Any variance from these estimated times should be explained in the comment section.

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### c. Client obligation

- i. The client obligation will be recorded on both the electronic and paper POC. The ILC should review the POC with the consumer and identify to which service provider the client obligation is to be applied to. A new consumer signature is not required for a POC change that is solely due to a change in the client obligation. The following criteria should be used:
  - (1) Whenever possible, the entire client obligation should be applied to a single service provider.
  - (2) To the greatest extent possible, PCA services should be used to meet the client obligation. If these services do not fully meet the client obligation, then another waiver service may be used in conjunction with PCA services to meet the client obligation.
- ii. Only the SRS EES Specialist can adjust the monthly client obligation amount. If the EES Specialist makes any changes to the monthly client obligation, it is their responsibility to notify the ILC using the ES-3161 form. *(This form can be found in Section Q.)*
- iii. Using a NOA, the ILC shall notify the consumer to which service provider the client obligation will be paid.
- iv. The ILC shall notify the service providers of any client obligation or adjusted obligation that is to be applied toward their service in writing using the same NOA indicated above in (3). The service providers are responsible for collecting the client obligation directly from the consumer.
- v. Client obligations cannot be prorated on the POC.
- vi. The MMIS PA system must accurately reflect the amount of the client obligation and must accurately document to which provider the obligation is applied.
- vii. The ILC should report the cost of the POC to the EES Specialist using the ES-3160 & ES-3161 forms to ensure that the cost is enough to cover the client obligation. *(See Section C-2 for the usage instructions of these forms. Samples of these forms can be found in Section Q.)*
- viii. The ILC cannot open a HCBS/PD waiver case if the client obligation exceeds the

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cost of the POC.

### **F-2 Prorating**

A POC beginning in the middle of the month must be prorated.

Example: A consumer receives 23 PCA hours per week. For service beginning in mid-month, such as on January 15, the ILC would divide 23 by 7 to conclude there are approximately 3.3 hours used per day. This number is then multiplied by the remaining days in the month (in this case 16), resulting in a total of 52.8 hours.

$$23 \div 7 = 3.3 \times 16 = 52.8$$

### **F-3 Updating**

A Plan of Care should be changed as is necessary when the individual's needs have increased or decreased. An increase of hours must be justified by a change in the consumers health and safety needs, medical condition or informal supports.

If a change in a POC is due to a change in informal supports, environmental conditions, etc., anything other than a change in the consumer's condition, the ILC needs to document this in the logging and update the ACW and POC to reflect the change in need and services. The ILC should send this information to the AMM staff for approval via the MMIS system.

### **F-4 Development of the Plan of Care for Assisted Living Facilities, Residential Care and Homes Plus**

When a consumer chooses HCBS/PD and lives in an Assisted Living Facilities (ALF), Residential Care Facility (RCF) and Homes Plus (HP), the ILC, in addition to the steps outlined in Section F-1, should:

- a. Encourage the consumer to negotiate the room and board costs with the facility staff, with the ILC advocating on behalf of the customer as needed;
- b. Review the negotiated service agreement to identify the tasks the facility will provide within the room and board charge;
- c. Request time studies from the facility staff for tasks that are completed for a number of consumers at the same time (e.g., meal preparation and laundry) to support the ACW and POC hours;

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- d. Develop the POC with the consumer and the facility staff based on needs identified using the UAI and ACW; after completion of the POC and negotiated service agreement, all parties are required to sign as needed.

### **F-5 Closing a case file**

- a. The reasons for case closure may include the following:
  - i. Loss of Medicaid eligibility.
  - ii. Consumer no longer meets HCBS/PD functional eligibility criteria. If the consumer no longer meets the LTC Services Threshold, HCBS/PD eligibility ends. All HCBS/PD consumers are reviewed annually by the ILC to ascertain their current functional eligibility.
  - iii. Lack of cooperation to the point that the consumer and/or family substantially interfere with the provider's ability to provide services, (e.g., refusing providers, inability to get along with providers, or inappropriate consumer and/or family behaviors). All other options (i.e. training, counseling, etc.) must be explored prior to termination of services.
  - iv. Change in medical condition where health and welfare needs cannot be met with HCBS/PD waiver services.
  - v. Consumer fails or refuses to pay the monthly client obligation as per agreement and the provider is unwilling to continue services and no other provider can be found. It is the responsibility of the ILC to identify and locate service providers and/or community resources.
  - vi. Consumer fails or refuses to sign or abide by the POC or the ACW.
  - vii. Providers of critical services are no longer available or the consumer refuses critical service(s).
  - viii. Consumer is determined to be no longer safe in his or her own home, as determined jointly by the consumer, APS, and the ILC.
  - ix. Consumer chooses to terminate services.
  - x. Consumer moves out of state. If they should move within the state, but out of the IL

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Counseling agency's service area, the consumer's POC is closed, but the consumer's HCBS/PD case remains open and the case file should be transferred to the CIL of their choice which operates in the area to which the consumer has moved.

- xi. Consumer's whereabouts are unknown (e.g. post office returns agency mail to the consumer indicating no forwarding address).
- xii. If the consumer's planned brief stay in a nursing facility or hospital is over-extended. (A planned brief stay is a temporary institutional placement in a nursing home, hospital, rehabilitation unit, etc. The short term stay shall include the month of admission and the month following admission.)
- xiii. Consumer enters a nursing facility and is not expected to return to the community.
- ix. Consumer dies.
- b. The ILC should complete all case file closures with the appropriate documentation and send the SRS EES Specialist the ES-3161 form as needed. The ILC should send a copy of the case closure NOA to all providers listed on the POC. The NOA should be sent in order to give the consumer and providers 10 clear days before the actual closure date. (See section I-2).

### **F-6 Medicaid Management Information System Prior Authorization**

The POC should be submitted for authorization to the Medicaid claim processing (fiscal) agent via the Medicaid Management Information System (MMIS) computer program. The MMIS Prior Authorization (PA) system is a provider payment system that is used to enter HCBS/PD POCs and is accessed through the fiscal agent. Because this system is linked to the Medicaid claim processing system, the PA system can automatically pull information from the MMIS to add to the POC. Information that automatically comes from the MMIS includes beneficiary name and eligibility, client obligation, provider information, provider specialty codes and allowed amounts. In addition, the PA system tracks information for the state.

- a. All POCs must be submitted to the appropriate AMM staff member for authorization. Their primary function is to review all POCs submitted by the ILCs and ensure that the information on the computerized POC is consistent to allow authorization for Medicaid payment to providers listed on the plan. POCs are reviewed against an established protocol for the following:

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- i. Accuracy of information (e.g. eligibility codes, dates, and client obligation);
  - ii. Completeness of fields within the document;
  - iii. Consumer and provider eligibility;
  - iv. Correct mathematical calculations for frequency of monthly services including correctly prorating the cost of services;
  - v. Total costs are within allowable cost caps.
- b. Any time the POC changes, a system POC must be re-authorized. POC changes may include, but are not limited to a change in service, client obligation amount, the ILC or a provider's services end. POCs that do not begin on the first day of the month will have to be prorated for Medicaid eligibility requirements. The fiscal agent's Prior Authorization Handbook outlines how to input and update the POC.
- c. All MMIS POCs (that are not CCAP) should be authorized within 48 hours of receipt provided there are no concerns identified that require additional time for resolution.
- a. All cost cap requests should be authorized within ten working days of receipt of the completed documentation.
- e. Concerns identified on the MMIS POC will be referred back to the ILC.