



Benefits Utilization System

Long Term Care Service Plan Instructions

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INSTRUCTIONS FOR THE LONG TERM CARE SERVICE PLAN

The Case Management Agency (CMA), which includes Single Entry Point Agencies, Community Centered Boards (CCB), and private case management agencies, shall utilize the Long Term Care Service Plan form to develop a client centered plan. This form replaces the Long Term Care Plan issued in 2003 and any other previously used service plan.

The Plan shall be developed in collaboration with the client and/or client's representative. The case manager shall gather all of the assessment information to establish services needed for the client to function effectively in the community and prevent the need for institutionalization. The Plan shall address client needs in a way that reflects the individual's preferences and decisions. For each authorized service, the case manager shall enter the provider information, and frequency, specific function, and goal of the service. Service plan revisions shall be documented on the form.

The Plan shall be completed in its entirety and signed by the client or client's representative each certification period and when services are revised. The signature page is documentation of the client's participation in the planning process and acceptance of services.

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IDENTIFYING INFORMATION

The first section of the form asks for *Identifying Information*. Provide the following:

Client Name: Enter the client's name (Last, First, MI)

Staffing Date: Enter the date that the Case Manager met with the client and their representative, if applicable, to develop the Service Plan.

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Service Authorization Dates: The Service Authorization dates are used to indicate that the client is authorized to receive Home and Community Based waiver services and the provider can be reimbursed. In order for services to be authorized, the following criteria must be met:

- **Functional Eligibility**
 - **Authorized ULTC 100.2**
- **Signed Service Plan**
- **Financial Eligibility**
- **Disability Eligibility**
- **Enrollment Date**

The beginning authorization date will be the latter of the above criteria depending on the client's specific situation. The ending authorization date is the end of the LTC Certification Span. The LTC Certification Span is used by the counties to determine the Medicaid Eligibility Span. On an enrollment these date spans may differ, however, shall align at the continued stay review.

3 Program(s): Check the program for which the client is authorized to receive services.

4 Legal Guardian (s) Name: Indicate all legal guardians.

5 Additional Health Insurance: Check all the sources that apply and enter the name of the insurance agency.

6 **AREAS OF CONCERN IDENTIFIED BY THE ASSESSMENT**

The *Areas of Concern Identified by the Assessment* section records problem areas identified during the functional needs assessment (ULTC 100.2), assessment for Instrumental Activities of Daily Living (IADL), and the Supports Intensity Scale (SIS). The assessments are not electronically linked to the Service Plan. Thus, the case manager is expected to mark all applicable areas from the assessments that have been completed for that client.

While each plan will not be monitored on an ongoing basis to ensure continuity between this section, the assessments upon which it is based, and the services to be provided, the State does expect Case Management Agencies to follow a logical line of consistency. When the State conducts a formal monitoring of the Service Plan, the expectation is there will be continuity between the various sources of information. For example, if a client is scored a 3 on the Supervision/Behavioral section of the ULTC 100.2, the case manager should also mark a behavioral concern in this section as well as illustrate how that need is being met either through State Plan Benefits, Non-Medicaid Supportive Services, or Long Term Care Services (waiver services).

SERVICE PLAN

The *Service Plan* section features services the client may need. Complete only parts of this section that are applicable to the particular client; do not complete the sections that are not applicable. The form has been designed to minimize unnecessary repetitive text. Always consider cost effectiveness, including services provided at no cost from family, friends, neighbors and volunteers. Secondly, consider services as provided by a third-party, including third-party insurers. If those services and providers are not appropriate or available, then proceed to the services offered within the Medicaid funded long-term care programs.

Services are divided into the following five categories:

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State Plan Benefits provided in the Medicaid State Plan as both mandated benefits and optional services. The intent is to illustrate that State Plan Benefits are being accessed and used appropriately. Additionally, this information provides oversight for monitoring of duplication of services. Always remember the Payment Hierarchy: 1st Third Party Resources including natural supports, private insurance, and Medicare, 2nd Medicaid State Plan, and 3rd Medicaid Long Term Care Services (waiver services.)

Definitions for the State Plan Benefits are found in Volume 8: State Medicaid Rules. This is available on-line at:

<http://www.chcpf.state.co.us/HCPF/StateRules/newToc2.asp>

In addition, the HCPF website offers resources through the Billing Manuals and regularly posted Provider Bulletins. This information is available on-line at:

http://www.chcpf.state.co.us/ACS/Provider_Services/provider_services.asp

Case managers are expected to be familiar with and be able to access these resources to determine whether or not the service is a covered benefit.

Program/Services – check the appropriate box

- Acute Medical: Rule 8.190 and 8.200 (physician services)
 - Dental Billing Manual:
 - http://www.chcpf.state.co.us/ACS/Pdf_Bin/Dental_Billing_Manual_021907.pdf
- Early & Periodic Screening Diagnosis & Treatment (EPSDT): Rule 8.280
- Hospice: Rule 8.550
- Medical Equipment/Medical Supplies: Rules 8.580 and 8.590.
 - Please note that each January a Provider Bulletin is issued with list of equipment and supplies offered through the State Plan.
 - If it is not found there, verify the Rules to ensure that the particular item in question does not meet the criteria for a State Plan benefit prior to requesting it through the waiver.
 - If you have additional questions contact HCPF - DME Request Hotline at:
 - 303-866-5571.
- Medical Transportation: Rule 8.014
- Mental Health: Rule 8.212
- Private Duty Nursing: Rule 8.540
- Professional Therapies: Provider Billing Manual: CO 1500 pages 83-97
- Targeted Case Management: Rule 8.760

Please Note: Case Managers are required to access Medicaid State Plan Benefits prior to requesting services through the HCBS Long Term Care Services.

Provider/Frequency: Enter the type of provider and indicate how often the client needs the service.

- Provider Type indicates the types of provider. If the provider is known the case manager may indicate that as well. However, the case manager is not expected to update the provider name each time a new provider is selected as long as the provider type is indicated.
- Frequency includes amount, scope and duration of the service being provided.
 - Example: A client sees a community mental health therapist (provider type) for 1 hour a week for the plan's year (amount, scope, duration).

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Non-Medicaid Supportive Services that a person may receive from a variety of programs and funding sources outside the long term care programs. The intent here is to illustrate that all of the client's needs are being addressed and not solely those identified within the Long Term Care Services (waiver) section. These services should be considered **first** in planning for the client's care. (Remember: Payment Hierarchy)

Program/Services – check the appropriate box

- **Child/Adult Protective Services:** Protective Service programs protect at risk adults and children.
- **Dental Care:** Dental services the client may be receiving through private insurance, private pay, or other third party resources.
- **Food Stamps:** The Colorado State Food Stamps Program assists low-income individuals and families who need assistance purchasing food.
- **LEAP (Low Income Energy Assistance Program):** Federally funded program administered by the Colorado Department of Human Services and is designed to **help** with your winter heating costs.
- **Legal Services:** Services the client may be receiving through a personal attorney or Legal Aid.
- **Meals:** Food assistance services through natural or charitable resources such as Meals on Wheels.
- **Money Management:** Services received through natural or private resources, such as family, financial planning services, or charitable organizations.

- **Optical Services:** Vision services the client may be receiving through private insurance, private pay, or other third party resources.
- **Senior Companion:** Services provided typically through non-profit and charitable organizations, which offer companionship, assistance with independent living, transportation, and friendship to at risk adults (elderly, disabled, isolated, etc).
- **Subsidized Housing:** Programs which provide rental/mortgage assistance to low income individuals, such as Section 8. Typically such programs are found through Department of Housing and Urban Development (HUD), but may be available through natural, third party, or charitable organizations as well.
- **Other:** Any other services that the client may be receiving that contribute to increased independence in their home and community.

Provider/Frequency may include a range of possible providers, including relatives, spouse, non-relative provider agencies, and third-party payers. Some providers are inherently understood by the type of program or service as with Food Stamps and LEAP. However, if there is a provider or provider type that must be noted. Provider and Frequency will vary depending on the type of service and must be noted accordingly.

- Examples:
 - Food stamps are always provided monthly (frequency only)
 - LEAP may be used monthly November through March (frequency only)
 - Meals are brought 3 times per week by Meals on Wheels. (provider and frequency)

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Home Health Benefits that an individual may receive from more than one funding source. The funding source must be identified as either Medicare or Medicaid. If an individual is receiving Home Health through a third party payer (ex. private insurance) indicate this in the "Other" box in the Non-Medicaid Supportive Services section.

Please Note: A hard copy of the 60-day Home Health Plan of Care issued by the Home Health agency shall be maintained in the client record for services funded by Medicaid. All rules and regulations pertaining to the Medicaid Home Health program apply to these services.

Home Health Rule: 8.520

10**Medicaid Funded Services**

- Provider: Check the appropriate service box. Note some services have age restrictions.
- Frequency: Indicate how often the client needs the service. Note that responses vary depending on the type of service.
- Revisions: Address all changes to a service in the corresponding revision box.
- Record the reason for the change and date of the change.
- Frequency: In the second frequency box address changes recorded in the revision box. Indicate how often the client needs the service. Note that responses vary depending on the type of service.

11**Medicare Funded Services**

Please note that in order for a client to receive Home Health Services through Medicare they must meet the Homebound Criteria, which includes:

- A normal inability to leave home and therefore leaving home requires a considerable and taxing effort.
- A beneficiary may leave home to receive therapeutic, psychosocial or medical treatment in an adult day-care program that is licensed or certified by the state.
- Occasional absences from the home for non-medical reasons such as attendance at a family reunion, funeral, graduation or other infrequent or unique events are acceptable when the absences are of short duration, and do not indicate the beneficiary has the ability to obtain healthcare services in a setting other than the home.

More information on Medicare and Home Health Services the following resources are available on-line:

www.medicare.gov , and,

[https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/hh_coverage.pdf#search='homebound criteria'](https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/hh_coverage.pdf#search='homebound%20criteria')

- Provider: Check the appropriate service box.
- Frequency: Indicate how often the client needs the service. Note that responses vary depending on the type of service.

12 Other State Programs

- Adult Foster Care
 - Provider: Enter the name of provider.
 - Frequency Information: Indicate how many days of the dates covered on the Service Plan the client needs the service and the actual start and end dates for services.

- Home Care Allowance

Provider(s): Check the appropriate provider type box, and if applicable, the same household box.

- Frequency Information: Indicate how many visits per week and hours per visit the client needs the service.

13 Long Term Care Services (HCBS) available through the long term care waivers administrated by the CMA. Many of these services are available on a fee-for-service basis for private pay clients.

Complete the information by going across the form left to right. The headings include:

- ### 14
- Services: The system will automatically designate services by waiver type when the case manager selects the corresponding waiver in the Identifying Information section of the Service Plan.
 - Check the appropriate service box.
 - Enter the type of provider agency administering the service.
 - Clients in the HCBS-DD, SLS, and CES waivers must include the name of the provider as well. If the provider is not known at the time of Service Plan staffing, a provider type may be added until the provider is identified. At that time the case manager will enter the information into the Service Plan.
 - If the service box indicates to specify type, either check the box or enter information on the attached line.

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- Frequency: The Service Plan offers several options to identify frequency depending on the type of service provided.

- Indicate how often the client needs the service on the appropriate lines.
- If travel time is listed for the service, enter the amount on the attached line.
- Indicate the total number of units authorized for the dates covered on the Service Plan.
- For services requiring a date of service, such as Dental or Vision, indicate the date of service, if known. If the exact date of service is not known at the time of the Service Plan staffing, indicate the start date of the Service Plan.

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- Revisions: Address all services changes to a service in the corresponding revision box.
 - Record the reason for the change, type of provider and date of the change.

17

- Frequency: The additional Frequency box is to indicate changes associated with the Revision. The aforementioned guidelines will be followed.

18

- Service Goals: Because the Long Term Care Services are 3rd on the Payment Hierarchy, it is particularly important to provide substantial detail in the service goal to ensure that the service provided is appropriate for waiver funding. In other words, the intent of the service goal is to justify the purpose of the service being provided.
 - Main Components of a Service Goal
 - What/Why? Briefly state the need or purpose of the needed service
 - How? Explain if the goal is supportive or habilitative in nature.
 - Results! Describe the intended outcome or the desired results.

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CONTINGENCY PLAN

The new waiver application is requesting that a contingency plan be addressed with each client as these individuals are at the NF/institutional level of care and without HCBS would be institutionalized.

In the corresponding box, develop a Contingency Plan that identifies a back-up plan to address contingencies such as “emergencies” that put a participant’s health and welfare at risk. Emergencies include the failure of a family member, support worker, or caregiver to appear when scheduled to provide necessary services when the absence of the services presents a risk to the participant. Contingency Plans are individualized to the specific client’s needs.

20**CLIENT GOAL**

This section documents how the client or guardian plans to address the client's remaining needs that are not covered benefits of the waiver or those that have not been addressed through additional resources identified in the Service Plan.

Additionally, this is an opportunity for the client to truly express their personal goal for the upcoming service plan year. It may include any personal wishes, dreams, ambitions, etc.

21**ROLES AND RESPONSIBILITIES**

The Roles and Responsibility section assigns specific roles and responsibilities to the client and case manager. This provides the case manager an opportunity to clearly communicate that both the case manager and the client have responsibilities as a result of participating in a wavier. It is a good time to answer questions in terms of expectations and case management roles.

22**Contact Information**

Agency contact information must be provided to the client. The intent is to provide the client with not only the case manager's information, but to provide a chain of command in the event that the case manager is unavailable. Depending on the size of that agency, the "Administrator" role can be defined by the agency, but must be consistent with the organizational structure and hierarchy.

23**Appeal Rights**

These are listed for the client's convenience. However, it does provide an opportunity for the case manager to review this information with the client and provide a copy to the client.

24**STATEMENT OF AGREEMENT**

In the Statement of Agreement section, check the appropriate program box and review the statement with the client.

- Have the client or client's representative read the statement or read it to him/her before obtaining a signature.
- If the legal guardian is not present at the Service Plan staffing, the client or their representative can sign in order for services to be initiated.
- However, the case manager must send the Service Plan to the legal guardian for signature.

If the guardian fails to respond, the case manager must document in the log notes that good faith efforts have been made to obtain the signature.

CHOICE OF QUALIFIED PROVIDERS

Resource of qualified providers given: The annual service plan is an opportunity to review the client's choice of providers while providing them a resource of available qualified providers in the event they are unsatisfied with current services or wish to add a service. Checking this box would indicate that the case manager has provided a resource of all qualified providers to the individual or guardian. Please note: A client may change providers at any time and is responsible for contacting his/her case manager to make this request during the plan year. Case managers will provide the resource of qualified providers upon request during the plan year.

Request for New Provider: This box should be checked when the individual or guardian wants to select a new provider and requests a referral be sent to a specific service provider(s). The case manager should check this box if a specific referral is needed and select the applicable service type as indicated in the pull-down menu.

Referral Given: The case manager will check this box if the client has chosen a qualified provider and actions are being taken to refer this client to the selected provider. Clients must be informed that a provider has the right to deny services. The client will be informed that a provider has the right to accept or deny a request for services.

Other Action Taken: This box should be checked when an individual or guardian expresses an interest in selecting a new provider but an action other than the other two is taken. For example, the individual or guardian may state an interest in selecting a new provider but may want to wait for a period of time before they begin the selection process. This box should be checked and a brief description of the action should be included in the text box as applicable.

Client Advised of Potential Conflict of Interest, if applicable: There are times when the selected provider may pose a potential conflict of interest for the client. For example, the case management agency is also the provider agency. Prior to beginning services, the client must be informed of this potential conflict of interest. Checking this box, the case manager ensures that the client has made an informed decision.

SERVICE PLAN REVISIONS

Service Plan Revisions are generally completed at the 6-month review to document any changes made to plan that will affect the remaining authorization period. The purpose of the 6-month review is to monitor the care and progress of the client as

well as review the effectiveness of the current services and make changes as needed. Changes may include:

- New Service(s)
- Termination of Service(s)
- Increase Frequency/Units
- Decrease Frequency/Units

The case manager uses the information obtained through the 6-month review process to adjust units on the PAR based on current and expected utilization.

Revisions shall also be made outside of the 6-month review process if the revision requires an immediate change to the existing PAR, such as a new service being added or the client has experienced a significant life event that clearly alters the plan year. In addition, a revision must be completed if the action is considered to be an adverse action and requires the LTC 803 Notice of Action form, such as a reduction in a service.

Review with the client or client representative the statement attesting to all revisions made. Check the appropriate box and have the client or client representative sign the document. The case manager may mail the Service Plan to the client for their signature. The case manager shall document the mail date in a BUS log note. If the Service Plan is not returned 30 calendar days from the mail date the Case Manager shall document in a BUS log note the form was not returned, as well as, any additional attempts that may have been made during that time period.

A revision copy is not needed to add or change the provider name. If the Service Plan was entered into the BUS and authorized then a Supervisor may remove the unauthorized status to allow the Provider information to be added or changed. All changes shall be documented in a BUS log note reflecting the effective date of the change.

Please Note: If there are no changes being made to the Service Plan at the 6-month Review, a Service Plan Revision is not necessary. The case manager will document in a log note that the review was completed and no changes were noted.