SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

COMMUNITY FIRST CHOICE Policy Manual	Section: SERVICE REQUIREMENTS
	Subject: Home and Community Based Waiver Program

PURPOSE

This policy describes the Home and Community Based Services (HCBS) program and the procedure to make a referral and authorize services.

Some members applying for or receiving personal assistance services may also be eligible for the Home and Community Based Services (HCBS) Program.

ELIGIBILITY

To be eligible for the HCBS Program, members must be Medicaid eligible, require the level of care of a nursing facility, and be physically disabled or over 65 years of age. An individual's total HCBS plan of care costs may not exceed a cost limit set by the Department.

SERVICE DELIVERY

Home and Community Based Services are individually prescribed and arranged according to the individual needs of the member. The Department contracts with case management teams to develop an individual plan of care in conjunction with the member and attending physician, when necessary.

COVERED SERVICES

Services as defined and provided under the HCBS Program are not available under the regular Medicaid program.

Personal assistance services under the HCBS program can include supervision for health and safety reasons, socialization, escort and transportation for non-medical reasons, specially trained attendants for members with extensive needs, or standard personal assistance services which continually exceed State Plan limit. Personal assistance services that are an extension of CFC/PAS services may be self-directed by the member. However, other services under HCBS, including specially trained attendants, cannot be self-directed.

CASE MANAGEMENT RELATIONSHIP TO CFC/PAS

The HCBS Case Manager performs the function as the member's CFC/PAS plan facilitator. This function includes the coordination of a person centered planning (PCP) process, including coordinating the annual visits, and completion of the PCP form (SLTC-200).

It is the HCBS Case Management Team's (CMT) responsibility to develop and monitor HCBS service plans of care for all members enrolled in the HCBS Program. The HCBS plan of care does not include CFC/PAS as defined and offered under the State Plan Program. However, the Case Manager Plan Facilitator is responsible for overseeing the delivery of CFC/PAS services as they relate to the overall PCP process.

HCBS REFERRAL PROCEDURE

Many CFC/PAS providers are also enrolled as HCBS providers. A CMT may make a HCBS waiver service referral to a HCBS provider to provide services such as socialization, supervision, specially trained attendants, homemaker, or respite care. The CMT is responsible for providing a written referral for HCBSA waiver services to the CFC/PAS provider. The provider implements these services based on the referral and at the wishes of the member. The CMT must notify the provider in writing when the referral for services is amended or terminated. The CMT will complete this task using their forms and processes.

SERVICE AUTHORIZATION

The CMT authorizes HCBS personal assistance services using their HCBS forms. Authorization for HCBS services does not require any action by Mountain Pacific Quality Health (MPQH). Members who do not receive state plan self-directed services require a capacity assessment completed by Mountain Pacific Quality Health when they plan to self-direct their waiver services. The case management team is responsible for referring a member to MPQH for a capacity screen (refer to HCBS 722).

EMERGENCY REFERRALS

If the CMT contacts the provider agency with an emergency referral, the provider agency will coordinate with the member and the CMT to implement services as soon as possible. Emergency requests will be limited to members who are at immediate risk of institutionalization or in a hazardous home situation.

REASSESSMENTS

The CMT will keep the provider agency informed of all changes affecting the member's need for HCBS related personal assistance.