Title: **SD-CFC/PAS 414**
Section: **ELIGIBILITY FOR SERVICES**
Subject: **High Risk Intake**
Reference: **ARM 37.40.1005 and 37.40.1114**
Supersedes: **SD-CFC/PAS 414 (April 2015)**

PURPOSE

➢The high-risk intake is utilized for members who need to receive Community First Choice/Personal Assistance Services (CFC/PAS) services immediately (within 48-hours) for the purpose of maintaining their health and safety.

PROCESS

1. Community First Choice/Personal Assistance Services (CFC/PAS) provider agency receives a referral where implementation of services is essential to:
   a. Prevent institutionalization,
   b. Facilitate a discharge from an institution, or
   c. Resolve a hazardous home situation that places the member at high risk.
2. Medicaid eligibility is validated by the provider agency.
3. ➢The CFC/PAS provider agency sets up an in-person home visit with the member and Personal Representative (PR), when applicable, to develop a temporary authorization, which is documented on the Service Plan (SLTC-175). The visit must take place in the member's home, unless they are discharging from the hospital or nursing home.
   a. The Plan Facilitator does not need to be present at this visit.
   b. ➢If the visit does not take place in the member's home, the provider agency must complete an in-home visit within 30 calendar days of delivering services.

4. The provider agency program oversight staff must document the scope (tasks and total time) and need for CFC/PAS services on the Service Plan (SLTC-175).
    a. The Service Plan should be marked to indicate, "High Risk," and "Temporary."
    b. ➢The Service Plan must include the Service Plan Schedule section with a detailed list of tasks, task frequency and comments to document how services will be delivered.
        i. ➢The provider agency can only authorize Activities of Daily Living (ADL), medical escort, shopping, household tasks, and laundry. The services must fall within the parameters of the CFC/PAS program. Community Integration, Correspondence Assistance, Yard Hazard Removal, and Personal Emergency Response System (PERS) may not be authorized on a high-risk intake.
    c. At the visit, the provider must also obtain a signed copy of the Member/PR Agreement (SLTC-159/166) and educate the member/PR about obtaining the Health Care Professional (HCP) Authorization form (SLTC-160).
    d. ➢The Comments and Special Instructions section must include member specific information about the member's medical and functional need for service and preference for receiving the service.
    e. ➢The Action Plan section must include the agency's plan to meet the member's need for high risk services.
    f. Attendant services may not begin until the Health Care Professional (HCP) Authorization form (SLTC-160) is completed and signed by the HCP.
    g. The provider agency must provide the member

with a copy of the Service Plan within 10 calendar days of completion.

h. The Service Plan acts as the authorizing document until MPQH has completed their intake process.

5. ➢The provider agency program oversight staff must complete the following additional requirements for an intake visit:

   a. SD-CFC/PAS program overview;

   b. Provider agency hiring policies;

   c. Member services and assistance;

   d. Voluntary attendant management training;

   e. Provider agency role and responsibilities;

   f. Member role, rights and responsibilities;

   g. Provider agency complaint procedure;

   h. Member responsibility to report serious occurrences, including reporting abuse, neglect and exploitation (Refer to CFC/PAS 709);

   i. Information on Medicaid fraud; and

   j. Information on the service delivery record; including when and how the record is completed and the implications if the record is not completed properly (Refer to CFC/PAS 718).

6. ➢The provider agency has 48 hours to implement services following the high-risk intake visit. If high risk services cannot be implemented in that time frame, the provider agency should document the reason why, the agency's attempts to meet the 48 hour guideline, and complete a risk assessment (Refer to CFC/PAS 914) to mitigate potential risks to the member until services can be implemented.

7. Once the provider agency completes the high risk intake, the provider agency must complete the Referral form (SLTC-154) and fax it to MPQH within 48 hours. The agency must indicate "High Risk" on

the form, provide the reason for the high risk intake, and complete the box on the bottom of the form documenting the date services were instituted, the number of days biweekly that services are provided, and the number of units of services that are provided biweekly. The information on the bottom of the form should correspond to the information on the member's High Risk Service Plan.

8. MPQH receives the referral and follows the process for initial admissions (Refer to SD-CFC/PAS 411) and sends the Overview and Service Profile (SLTC-154/155) or Pre-Screen to the provider and Plan Facilitator within 10 working days.

    a. ➢If the member does not meet capacity for directing their care MPQH will notify the agency. The member has 28 days from the date of denial to select a personal representative or transition to agency-based services before self-directed services are terminated.

        i. ➢The provider agency must issue a discharge letter no later than 10 days prior to the 28th day and indicate that the High Risk Temporary Service Authorization will end and they will be discharged if they cannot identify a Personal Representative by the 28th day.

9. ➢MPQH sends the Authorization letter (SLTC-151) to the member. The letter does not include the member's Service Profile.

10. ➢The provider agency must notify the member within 10 calendar days if the MPQH Service Profile differs from the provider agency's High Risk Service Plan, either in total time authorized or the type and/or frequency of tasks that are authorized. The provider agency program oversight staff must contact the member to discuss the change in authorization,

determine a plan to implement the change in authorization, and document the conversation in the member's case notes. It the MPQH authorization is for an amount that is less than the High Risk Temporary Authorization, the provider agency must implement the change no sooner than 10 calendar days from the date of the MPQH Service Profile. The provider agency must implement a change in authorization to the MPQH Service Profile no later than 20 calendar days from the date on the MPQH Service Profile.

a. ➢If the member elects to receive CFC/PAS services at the frequency identified on the amended/annual MPQH Service Profile, the provider agency program oversight staff must document the conversation with the member in the case notes and indicate "services delivered according to MPQH Service Profile" in the member's case notes.

b. ➢If the member elects to implement the flexibility parameters and receive CFC/PAS services at a frequency that is different from the MPQH Service Profile, the provider agency program oversight staff must complete a new Service Plan, mark the circumstance "Other", and work with the member to enter the following information:

   i. ➢Enter the current MPQH Services Profile date span, total bi-weekly profile units (bi-weekly total = two week total), total ADL units, Total IADL units, and total skill acquisition units.

   ii. ➢In the "Service Plan Section", list out all of the tasks that will be performed and their frequency, along with the frequency, and provide a comment.

   iii. ➢In the "Comments and Special Instructions section" document pertinent information to ensure member health and safety needs are addressed (refer

to CFC/PAS 717).

iv. ➢Upon completion of the Service Plan, the provider agency program oversight staff must sign and date the Service Plan.

v. ➢The provider agency must provide the member and Plan Facilitator with a copy of the "Other" Service Plan within 30 calendar days of completion.

11. ➢Provider agency will not be penalized when the amount of time on the Temporary Service Plan exceeds MPQH's authorization, so long as the authorized services comply with service scope parameters (Refer to CFC/PAS 403 and 404).

12. The Department will recover payment for services delivered and billed outside the scope of the CFC/PAS program for a high-risk intake.

PERSON CENTERED PLAN

1. ➢Once the provider agency submits the High Risk referral to MPQH and receives the MPQH Service Profile, the provider agency must determine who the member's Plan Facilitator is and complete (or receive) the PCP form. For more information regarding the role of the Plan Facilitator in a high-risk intake (Refer to CFC/PAS 1108).

2. ➢The member must have a PCP form (SLTC-200) completed within 10 working days of MPQH faxing the Service Profile to the provider agency.

3. ➢If the provider agency is the Plan Facilitator; the agency has 10 working days to schedule the person centered planning (PCP) meeting. The visit must be done in person.

   a. The Plan Facilitator must provide the member with a copy of the CFC/PAS Handbook prior to the PCP meeting.

b. ➢The PCP Form must be signed by the Plan Facilitator, provider agency representative and member at the time of the visit.

NOTE: The provider agency Plan Facilitator and provider agency program oversight staff may be the same person.

4. ➢If the case manager is the Plan Facilitator, the provider agency must contact the case manager to notify the case manager of the high risk referral, fax the High Risk Service Plan, and determine the month of the annual case manager meeting.

a. ➢The Case Manager Plan Facilitator has 10 working days upon receiving notification from the agency of the CFC/PAS high risk intake to complete the PCP form.

b. The provider agency and Plan Facilitator have two options for completing the CFC/PAS PCP process. The Case Manager Plan Facilitator should contact the member to discuss the options and obtain the member's preference.

NOTE: The provider agency and Plan Facilitator should document the member's preference for the option that is selected prior to implementing that option.

i. ➢Option 1: The member, provider agency program oversight staff, and Case Manager Plan Facilitator have the option of conducting a coordinated PCP visit within 10 working days of receiving the MPQH Service Profile to review the MPQH Service Profile, complete the PCP form and complete a new Service Plan (when necessary).

1. ➢During the visit, the PCP form must be signed by the provider agency program oversight staff, Plan Facilitator, and member.

2. ➢If a new Service Plan is completed at the visit, the new Service Plan must be completed and signed by the provider agency program oversight staff. The new Service Plan must be signed by the Plan Facilitator and member, as well.

3. ➢If the Service Plan that was completed for the high risk intake does not need to be changed, the Plan Facilitator must review and sign the original high risk Service Plan during the PCP coordinated visit.

i. ➢Option 2: The member, provider agency program oversight staff and Case Manager Plan Facilitator have the option of coordinating the CFC/PAS PCP process with the member over the phone. The Case Manager Plan Facilitator must complete the PCP form over the phone with the member within 10 working days of receiving the MPQH Service Overview and Profile. The Case Manager Plan Facilitator must obtain the member and provider agency signatures within 30 calendar days.

a. If the provider agency does not receive the PCP form within 30 calendar days the agency must follow-up with the Case Manager Plan Facilitator and document in case notes.

➢**NOTE**: If option 2 is selected, a coordinated meeting with the Plan Facilitator and provider agency must occur within six months of the member beginning CFC/PAS services. This can be done at the

member's next case management visit.