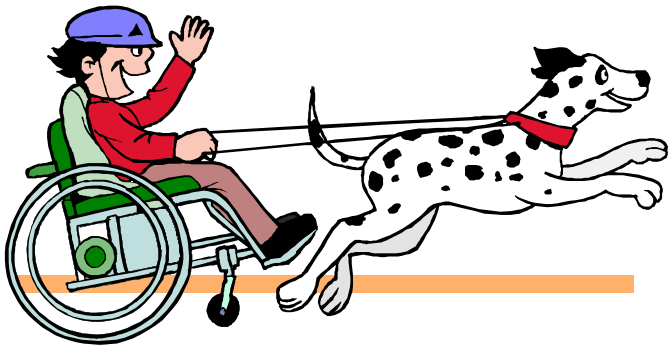
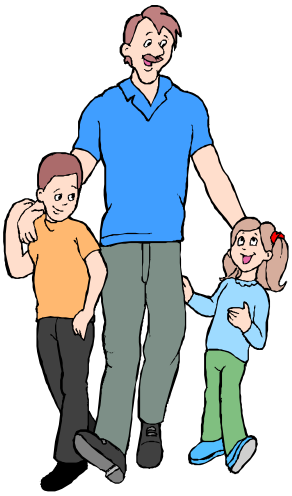


Children's Extensive Support Waiver

July 2002



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Note: At the end of most Sections are "Frequently Asked Questions"

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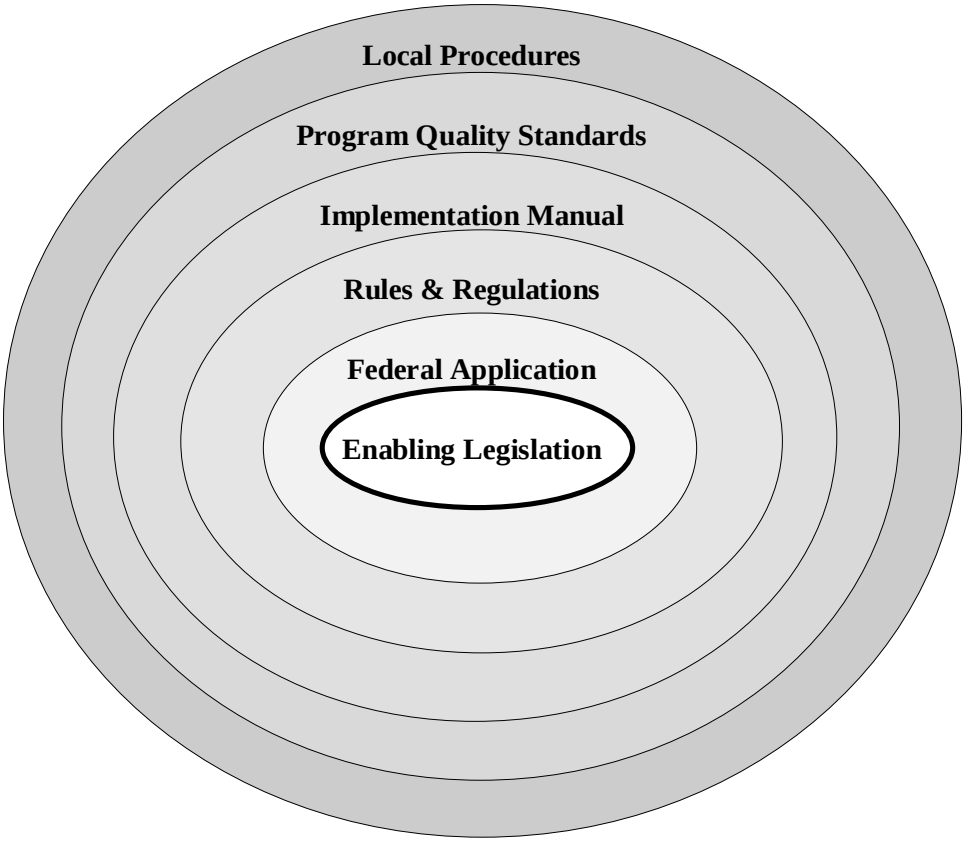
Appendix

Overviews of Supporting Documents

(Reference C.R.S. 27-10.5-404 (3) (b), C.R.S. 26-4-621, federal application, HCPF rules 8.503 – 8.503.210)

What You Will Find
- Overviews of Supporting Documents
- Making Changes to CES

Implementation of the Children's Extensive Support (CES) waiver is based on several documents which establish the intent and parameters for the program; Enabling Legislation, Federal Application, Rules & Regulations, Implementation Manual, Program Quality Standards, and local procedures. Each document plays an important and interlocking role in understanding the CES program. In order to have a complete understanding of how to implement the CES program, all of the documents must be taken in context and considered as a part of the whole program. Each document builds upon the previous one and supports the following documents. The support begins with the Enabling Legislation as illustrated below.



Enabling Legislation

Title 27, Article 10.5, Colorado Revised Statutes (C.R.S.), as amended, is the enabling legislation (law) which articulates Colorado's public policy regarding Care and Treatment of Developmentally Disabled in Colorado. These statutes are the cornerstones of programs offered by Children's Health and Rehabilitation Services (CHRS) and Developmental Disabilities Services (DDS). See Appendix F for a copy of Title 27, Article 10.5.

Federal Application

Funding for the Children's Extensive Support program is provided by federal Medicaid funds. Under authority of section 1915 (c) of the Social Security Act, the federal Center for Medicaid Service (CMS) has approved Colorado's waiver application to receive Title XIX Medicaid reimbursement when providing CES services to Medicaid eligible children with developmental disabilities. As stipulated in the federal application, CES provides community-based services as an alternative to receiving services in an institutional setting [i.e. Intermediate Care Facility for the Mentally Retarded (ICF-MR)].

Rules & Regulations

As prescribed in Statute, Rules & Regulations must be promulgated (established) in order to further define the requirements and procedures necessary to implement the Children's Extensive Support program. All State Rules & Regulations are developed through statewide input and represent due process procedures. Developmental Disabilities Services (DDS) Rules & Regulations apply to all programs funded by CHRS and DDS, including the CES program. In addition, the CES program is administered by the Department of Human Services (DHS), Children's Health and Rehabilitation (CHRS) and Developmental Disabilities Services (DDS) under agreement with the Colorado Department of Health Care Policy and Financing (HCPF). HCPF is the single State Medicaid agency for Colorado and acts as the liaison with the federal Center for Medicaid Services (CMS) for Medicaid funding. The CES program is implemented in accordance with HCPF Medicaid Manual, Sections 8.503 – 8.503.210 which provides the minimum requirements on how CES is to be implemented by local Community Centered Boards (CCBs). In the event a direct conflict arises between the Rules & Regulations of HCPF and DDS regarding the implementation of CES, the rules of HCPF, as the single State Medicaid agency with overall authority for all Medicaid funded services, would take precedence. See Appendix G for a copy of pertinent HCPF and DDS Rules & Regulations for CES.

Implementation Manual

Many times language in Rules & Regulations must adhere to a strict format which makes it difficult to fully convey the intent or values guiding the program and how the program should be implemented. An Implementation Manual provides additional direction about intended outcomes, examples and information about procedural requirements, such as reporting & billing procedures, and recommendations for best practices.

The document which follows provides these additional directives and recommendations for the Children's Extensive Support program.

Program Quality Standards

As prescribed in Statute CHRS/DDS is responsible to monitor the implementation of the Children's Extensive Support program. As part of this process, DDS develops a set of Standards by which it monitors and evaluates programs. These Standards are based on Statute, Rules & Regulations, and best practices. On-site surveys of programs are conducted regularly to determine compliance with the Standards. See Appendix H for a copy of DDS Program Quality Standards for the Children's Extensive Support program.

Local Procedures

The above documents are used to establish the State parameters under which the Children's Extensive Support program is to be implemented. Each local agency (CCB) is responsible to develop its own internal procedures which provide the specific directions for how the agency will implement services. Contact the person responsible for local implementation of the Children's Extensive Support program for a copy of any pertinent local procedures.

Making Changes to CES

The following manual identifies the State parameters for the CES program, as well as provides guidance to local service areas regarding decision-making for those areas of CES which are impacted by the individualized planning process. This manual (inclusive of Statute, Rules & Regulations, etc.) is to be used as the first source of reference for questions regarding the CES program. If an answer cannot be ascertained from the information provided, and local processes have also been unsuccessful, please contact CHRS. The continuing improvement of the Children's Extensive Support program is important and CHRS invites your comments, and suggestions for revision. Please contact:

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Introduction

What You Will Find
- Introduction
- Mission Statement
- Purpose
- Program Goals
- Guiding Principles
- Organizational Structures
- Balancing Choice and Responsibility
- Frequently Asked Questions

Families who have a child with a developmental disability face many challenges in helping the child reach maximum potential as he or she grows and develops. Children's Health and Rehabilitation Services (CHRS) provides three programs that are targeted to help meet specific needs experienced by families. These programs are:

1. Early Intervention (EI) services for early childhood development – ages birth through two years;
2. The Family Support Services Program (FSSP) to assist families who provide care for a family member with a developmental disability at home; ages birth through primarily age seventeen (but can extend throughout adulthood in some circumstances); and
3. The Children's Extensive Support (CES) Program – ages birth through 17 - which provides regular State Plan Medicaid benefits ***and*** additional targeted services and supports to those children with developmental disabilities/delays who are most in need because of the severity of the disability.

It is important to note that CES does have different implementation guidelines and stricter parameters than the State General-funded FSSP.

Mission Statement

The Children's Health and Rehabilitation Services' mission statement outlines the purpose of CHRS and works in support of CES goals and objectives

Children's Health and Rehabilitation:

Mission:

We ensure that the well being of children, youth and their families is a priority.

Guiding Principles

- *The lives of diverse families are enhanced when they are successful in maintaining their everyday lives and relationships*
- *All children and youth should belong, be welcomed and participate fully in typical places and activities of their communities.*
- *New opportunities for program initiatives and resources are developed with a focus on integration and collaboration of substance abuse, mental health, and developmental disabilities.*
- *Opportunities for leadership are offered in an environment that respects, values, and recognizes the contributions of colleagues and other partners.*

Purpose

The Children's Extensive Support (CES) program provides Medicaid benefits to eligible children under the regular State Plan (i.e. those Medicaid services which are available to all Medicaid recipients) in addition to specific targeted services and supports. Because CES is a Medicaid-funded program services are directed toward the eligible Medicaid recipient (the child), however, family members may benefit secondarily. For example; the provision of childcare services would provide a break for the parent(s); or, trainings provided to the parents, such as medical or behavioral interventions, would bolster the parent's confidence in and ability to support their child's needs. Services and supports provided through CES should increase the family's ability to maintain their child in the family home and prevent out-of-home placement. Without such services and supports, the long-term stability of the family setting would be jeopardized, potentially resulting in out-of-home placement for the child.

Although the CES program can provide a variety of services and supports which can be tailored to individual family situations, **CES is not designed to provide full 24-hour services with CES as the only (funding) source.** The services and supports provided through CES address identified and specific needs which utilize services and supports to help meet those needs; this does not mean all needs are met by the CES program.

The CES program does NOT replace the family's responsibilities to provide for the basic needs of the eligible child and family. CES can and does enhance the family's ability to care for the child in the home, however, there must be a basic level of support provided by the family/community to meet the full range of needs that a child may have. For example: regular supervision of the child is provided by the parent(s)/guardian and CES can provide temporary relief, but it is still the responsibility of the parent to provide the majority of care. Services through CES may provide necessary modifications to a home, due to the child's disability, but the family is responsible for the general living environment and building structure. **There may also be some portion of support, which is available from sources other than CES or the family, such as generic community services, public school districts, or private insurance.** This manual provides information about how to use Medicaid funding through the CES program to compliment other services and supports available to the child.

CES is targeted to a small group of children who cannot possibly be funded or supported through FSSP because of the extensive level of behavioral and/or medical needs they have. Along with the higher level of support and funding available through CES, there is a higher level of oversight and scrutiny as to how funds are used to support the child in the family home.

CCB staff should be very thorough when describing to families, the intent and service options available within CES, so as not to mislead families that CES and FSSP operate within the same structure – they do not.

Program Goals

1. To provide necessary services/supports to a child with a developmental disability so the child may remain in the family home/community and to prevent or delay unwanted out-of-home placement.

2. To promote individual family choice through the individualized planning process and the tailoring of services and supports to address unmet needs.

3. To supplement existing or newly developed natural supports and generic community resources with targeted and cost effective CES services and supports.

Guiding Principles

The Children's Extensive Support program encourages the least amount of systems intrusion necessary to assist the child to remain in the family home and community. The following principles act as implementation guidelines:

Facilitating Self-Determination

(Reference C.R.S. 27-10.5-101 & 401)

Families are the final decision makers in selecting which services and supports will be utilized for their child. Their selections must take into account whether or not the service is allowed through CES, availability of the service, qualifications of the provider, and if adequate funds are available. Professionals and service providers are in a unique position to be a resource to the child and family and not supervisors of families. Families make informed decisions concerning prioritization of needs and services for their child and work in partnership with the CCB. Through this partnership, a plan is developed to best meet the child's identified needs.

Adhering to Individualization

(Reference C.R.S. 27-10.5-101 & 401)

Families vary in their emotional, physical, and financial capacities and in the severity of impact that a developmental disability may have on their child and family. Communities also vary in potential for social supports. Therefore, by developing an individual plan of care the uniqueness of each family and community is recognized.

Creating Options / Choices

(Reference C.R.S. 27-10.5-101 & 401)

Often there is more than one way to meet a need for a child. **Support options should come from many different sources in a community and should not focus on just financial funding through CES.** Families, communities, CCB's and others should work together to encourage creative and individualized responses for identified needs. A *combination* of generic community resources,

natural supports, and other types of supports help offer flexibility and choices, which are not solely reliant on a long-term system of paid support for the child. By utilizing a wide array of community-based support options, the family, CCB and the community can address the immediate and future needs of the child. This may reduce or avoid more costly supports later.

Focusing on Inclusive Communities

(Reference C.R.S. 27-10.5-101 & 401)

CES is a holistic approach, which supports all aspects of the child in typical family and community life. Flexible and individualized services and supports assist children to access and participate in typical activities and functions of community life, such as; family, social relationships, school, community activities, etc. The flexibility of CES to address the unique needs of children is best achieved through local community collaboration and implementation. **CES not only builds upon existing natural supports and generic community services, but also encourages and assists the family to access these supports and services.**

CES should not be the sole source, which supports children in the family home. To be "supportive" of the child (and family) is to encourage broad community involvement and help the family avoid developing unnecessary dependence on a single program. CES should interface with other local resources in a complimentary manner. This will increase the family's ability to utilize existing social networks, natural supports and local community resources effectively. Sometimes a little community awareness and encouragement can open a lot of doors and opportunities for meaningful inclusion. CES is not an answer in itself. CES is more of a catalyst, which is most successful when it involves community support. **The needs of the child should drive the plan, not the funding.**

Respecting the Family

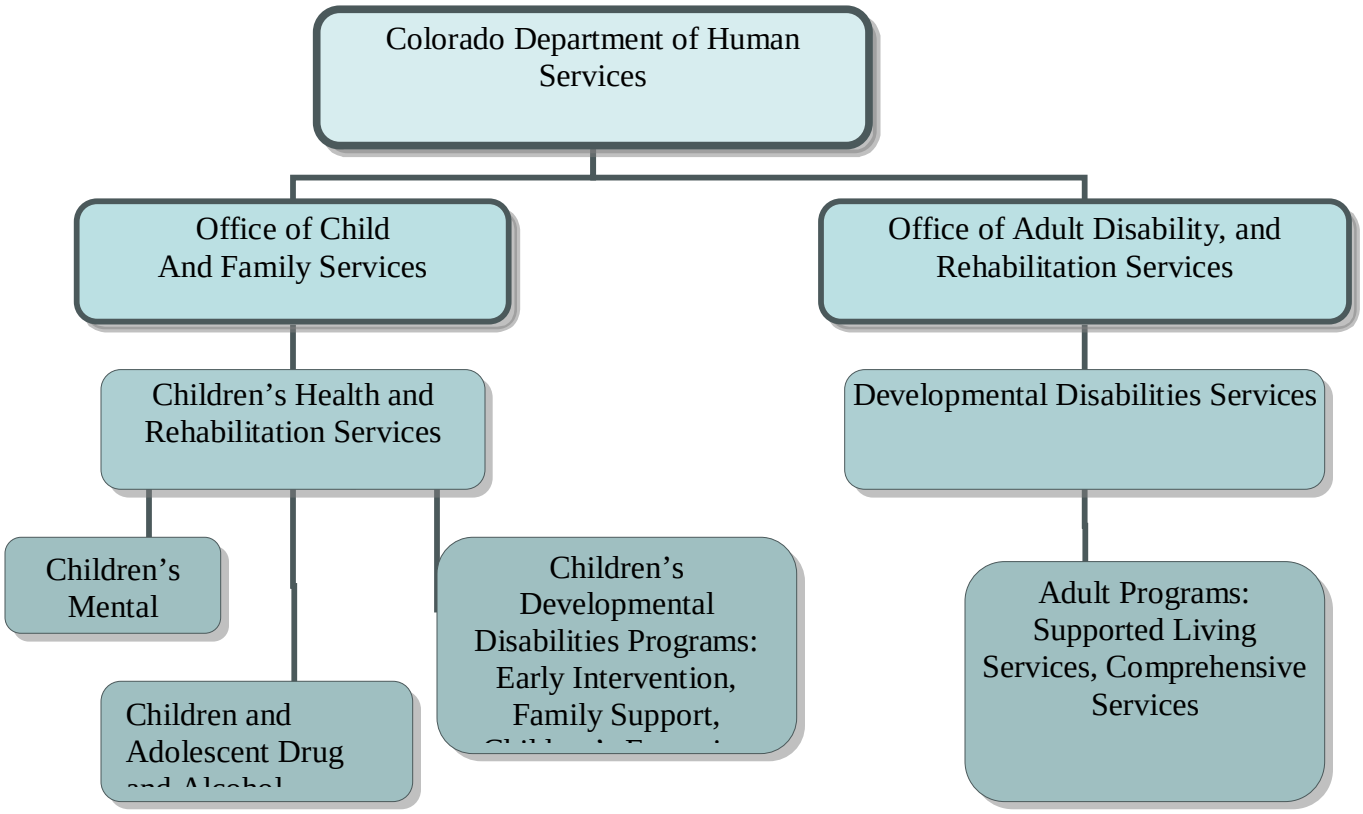
(Reference C.R.S. 27-10.5-101 & 401)

All families should be treated with dignity and respect to make choices about their lives. The CES program is a partnership between the family and the CCB. It is where the family can expect support in their decision-making process and not fear that outside control will take over. The need for accountability, paperwork, documentation, and so forth must be carefully balanced with the need to be flexible in responding to a child's needs. Since the families are responsible for their child, intrusion into the family's life should be minimized and focused only on the needs identified and prioritize through the individualized planning process.

Organizational Structures

Children's Health and Rehabilitation Services work in conjunction with Developmental Disabilities Services to provide the CES program statewide. Program management is under CHRS while the Waiver Administration and Medicaid/Billing continue to be provided by DDS.

On page 11 is a simplistic organizational view of the Department of Human Services with regards to the relationship between CHRS and DDS.



Balancing Choice and Responsibility

The Children's Extensive Support Program is one of many services offered for individuals with developmental disabilities in Colorado. Children's Health and Rehabilitation (CHRS) and Developmental Disabilities Services offer services, which cover the lifespan. Each program is designed to balance the amount of responsibility an individual/family has with the amount of responsibility the State has, in meeting identified needs. The following chart illustrates how the locus of responsibility shifts from one source to another depending on the degree to which State support and public funds are used. (Children's programs reflect the family's degree of independence from "systems".)

Independent	Interdependent	Dependent	ILD
Family Support (CHRS)	Supported Living Services (DDS)	IRSS*- - - - - - - - GRSS*	Regional Centers
Early Intervention (CHRS)	Supported Employment (DDS)	Sheltered Workshops (DDS)	
	Integrated Day Services (DDS)	Non-integrated Day Services (DDS)	
	Children's Extensive Support (CHRS)		

- Independent-Independence is achieved when an individual is able to meet his or her own needs without assistance from others. There is maximum freedom to make choices in all areas of daily living. Without the involvement of public funds, how a need is met is entirely up to the individual/family.

- Interdependent-The point at which outside assistance is requested (no matter how great or small). When an individual is interdependent, a relationship begins to evolve regarding the locus of responsibility and expectations of action. What responsibility will the individual/family have and what responsibility will others have (in this case, the State or community)? How will adjustments in the relationship be made over time if/when circumstances change? Key determinants for the State include who is responsible for daily living expenses (room and board), as well as the health, safety and welfare (including supervision) of the eligible person.

The Children's Extensive Support program is interdependent. This means a partnership exists between the family and the CCB to help meet the needs of the eligible child. Due to the extensive needs of the child, the CES program is designed to provide services and supports beyond those typically provided through Family Support Services Program or regular State Medicaid Program. Because CES is a Medicaid program, the level of State involvement is more intense than with FSSP. Since the child must be living with his or her biological or adoptive family to qualify for CES, the family is the primary caregiver who holds ultimate responsibility for the child. The family has flexibility in determining, on a service-by-service basis, use of providers and location of services/supports. This flexibility is limited only by the program guidelines and funding limits.

- Dependent-There are circumstances in which the level of need an individual has is so great and the individual has not family or other community supports to provide the necessary support. In circumstances such as this, the State, within available appropriations, provides comprehensive (24-hour) services to ensure the health and safety of the person. At this point, the locus of responsibility is predominantly upon the State to provide the primary source of support. The types of services and supports are still negotiated with the individual/family or guardian, but there is greater reliance on standards of care and professional oversight. This level of State responsibility and supervision is part of the Comprehensive Services Block under the Systems Change Project.

- Imposition of Legal Disability (ILD)-An emancipated adult is presumed to have all the same rights and responsibilities as all other citizens unless a court of law specifically removes an individual's right(s). In the developmental disabilities system, an Imposition of Legal Disability (ILD) is required for long-term placement into a State operated Regional Center. This process takes away the individual's right to determine his or her place of abode and may also include programmatic restrictions.

* IRSS = Individual Residential Services and Supports (three or fewer persons)
GRSS = Group Residential Services and Supports (4-8 persons)

Frequently Asked Questions

07/02

1) **Can the family choose anything they want; as long as they say it addresses their child's needs to remain in the family home and community or to address what they consider to be quality of life?**

While the Children's Extensive Support program does provide a great deal of flexibility in how the needs of the child are met, there are not unlimited choices available. Section 7 outlines allowable services and supports. The availability of resources, as well as issues of health and safety may also influence decisions which are made at the local level.

Eligibility Determination

What You Will Find
- ♦ Eligibility Determination
  - Determination of a Developmental Disability
  - Eligibility Criteria for CES
- ♦ Frequently Asked questions

There are two stages of eligibility determination the child must complete in order to enroll in the CES program.

- **First,** the child must be determined through a CCB to have a developmental disability or a developmental delay if younger than age five; and found eligible to receive services or programs funded through Children's Health and Rehabilitation Services. No services are available until after a determination of a developmental disability/delay is made, even though individuals or families may initially inquire about a specific service or program.
- **Second,** the child must be found eligible for the CES program.

Determination of a Developmental Disability

(Reference C.R.S. 27-10.5-106, DDS rule 16.420)

A referral for developmental disabilities services may come from any person or agency. Referrals are to be directed to the CCB in the local service area where the person resides (pursuant to DDS Rules & Regulations, see rule for exceptions). The eligibility determination process should be streamlined, timely and in compliance with DDS rules.

Ä **Note: There is a very distinct difference between the amount of information necessary for the determination of a developmental disability and the additional information, which may be required for enrollment into a specific program.**

Eligibility Criteria for CES

(Reference DDS rule 16.600, HCPF rules 8.503.30)

Once it has been determined that a child has a developmental disability/delay, then if appropriate, a referral can be made to the Children's Extensive Support program or other community services or programs. In the case of the CES program, as with all CHRS/DDS programs, this is done through developing the Individualized Plan (IP) (see Section 5 for more information). During the IP planning process the family and the CCB support person (a.k.a. Case Manager, Service Coordinator, or Resource Coordinator) should discuss the full array of service options and generic community supports, which could meet their child's needs, including a comprehensive discussion of the benefits and alternatives of each. The CCB support person plays a critical role in assisting the family to gain a reasonable understanding of services, supports and/or resources available so they can make an informed decision.

Eligible children must meet ALL of the following requirements:
(See Appendix A for a copy of CES Application Packet)

1. The child has not reached his/her 18th birthday; and

2. The child is living at home with his/her biological, adoptive parent(s) or guardian, or is in an out-of-home placement including an ICF/MR, hospital or nursing facility and can be returned home with the provisions of CES services; and
3. The child, if age five or older, has a developmental disability; or if less than five years of age, has a developmental delay, as determined by a Community Centered Board (CCB); and
4. The Child meets SSI criteria for a disability as determined by Disability Determination Services; and
5. The quality and quantity of medical services and supports identified in the Individualized Plan (IP) are provided pursuant to a physician's order to meet the needs of the child in the home setting; and
6. The income of the child shall not exceed 300% of the current maximum SSI allowance; and
7. The resources of the child shall not exceed the maximum SSI allowance; and
8. Enrollment of a child in CES shall result in an overall savings when compared to the ICF/MR cost as determined by the State; and
9. The Utilization Review Contractor (URC) certifies that the child meets the Level of Care for ICF/MR placement; and
10. Through a review of the CES application the child meets the following targeting criteria:

    The child demonstrates a behavior or has a medical condition that requires direct human intervention, more intense than a verbal reminder, re-direction or brief observation of medical status, at least once every two hours during the day and on a weekly average of once every three hours during the night. The behavior or medical condition must be considered beyond what is typically age appropriate and due to one or more of the following conditions:

    A. A significant pattern of self-endangering behavior(s) or medical condition which, without intervention will result in a life threatening condition/situation. Significant Pattern is defined as a behavior or medical condition that is harmful to self or others, is evidenced by actual events, and the events occurred within the past six months; or

    B. A significant pattern of serious aggressive behaviors toward self, others or property. Significant Pattern is defined as a behavior or medical condition that is harmful to self or others, is evidenced by actual events, and the events occurred within the past six months; or

    C. Constant vocalizations such as screaming, crying, laughing, or verbal threats, which cause emotional distress to family caregivers. "Constant" is defined as an occurrence on average of fifteen (15) minutes of each waking hour.

11. The above conditions shall be evidenced by parent statement/data that is corroborated by written evidence that:

    A. The child's behavior(s) or medical need(s) have been demonstrated; or

    B. In the instance of an annual reassessment, it can be established that in the absence of the existing interventions or preventions provided through the CES waiver that the intensity and frequency of the behavior or medical need would resume to a level that would meet the criteria listed above.

    C. Examples of acceptable evidences shall include but not be limited to any of the following: medical records, professional evaluations and assessments, educational records, insurance claims, Behavior Pharmacology Clinic reports, police reports, social services reports, or observation by a third party on a regular basis

12. The eligible child must receive a waiver service once per month as per Health Care Policy and Finance Rule, 8.059. Children will be exempted under the following conditions.

    A. Individuals newly enrolled in the CES waiver (60 days or less); and

    B. Individuals enrolled in any waiver program where the billing was rejected by the Community Contract Management System (CCMS).

Frequently Asked Questions

07/02

1. Is anyone who lives in the household eligible for CES, (e.g. siblings, parent(s), relatives, etc.) since the CES program is a support model?

No, CES only provides services and supports, which are specific to the eligible child. There may be some instances where the primary caregiver may secondarily benefit. For example, a CES participant may require supervision when the primary caregiver (i.e. family) is not available. This may give the caregiver a needed break, but it is still a direct service needed by and provided to the CES participant. Another example is training for parents. The training is provided directly to the parents; however, the purpose of the training is to benefit the child.

2. Is it possible for a child to be Medicaid eligible under section 1619 (b) and be eligible for the (Medicaid) CES waiver?

Yes, although rare, a child who retains their Medicaid benefits under section 1619 (b) is considered to be Supplemental Security Income (SSI) eligible, even though no SSI payment is made, therefore he or she could be eligible for the CES waiver.

CCB Responsibilities

(Reference HCFP rules, 8.503.63)

This Section will explain the Enrollment process from beginning to end. It will also cover the Continued Stay (Annual) Review process.

The application process is a joint effort between the family and the CCB. To allow for better program management the Utilization Review Contractor (URC) can only accept applications that come directly from the CCB. (See Appendix A for a copy of the CES Application Packet.)

What You Will Find

Upon receipt of a referral, the CCB is responsible to provide the following services:

1. Arrange for a case manager to be assigned; and
2. Inform the parent(s) or guardian of the purpose of the CES Program, the eligibility process, the minimum documentation required and the necessary agencies to contact; and
3. Begin assessment activities within ten (10) calendar days of receipt of the referral;
4. Arrange for and complete at least one (1) face-to-face contact with the child, or document reason(s) why such contact was not possible, within thirty (30) calendar days of receipt of the referral; and
5. Refer the child, as needed, to the County Department of Social/Human Services to determine eligibility for Medicaid or other services and benefits as appropriate, the Early and Periodic Screening, and Diagnostic Treatment (EPSDT) Program, and deliver services in coordination with the County Department; and
6. Ensure that the child has been determined to meet the eligibility criteria for developmental disabilities services;
7. If necessary, ensure the family has obtained a denial letter for SSI benefits; and
8. If there is no resource available for CES and the child must be placed on the wait list the CCB shall follow the waiting list protocol. (See "Managing the Statewide Waiting List", page 19)
9. If there is a resource available for CES the CCB shall assist the parent(s) or guardian in completing the CES Application Packet and submit the completed CES Application Packet, and all necessary paperwork to the

Utilization Review Contractor for Level of Care determination and CES targeting criteria. (See; "Enrollment Procedures", page 20).

Managing the Statewide Waiting List

(Reference, HCPF rule 8.503.40)

In the event that the demand for the Children's Extensive Support program is greater than available resources, the CES state program manager will maintain a single statewide waiting list of children who are requesting the CES program. The waiting list will be generated from CCMS and will rely entirely on information entered by the CCB. Children will be placed on a statewide waiting list in the order in which the information was entered into CCMS by the CCB.

Waiting List Protocol

(Reference HCPF rule 8.503.40)

1. Applications for the CES Program shall be completed by the CCB with participation of the family. The supporting documentation shall be reviewed promptly by the CCB and submitted to the URC for approval. The case management agency shall provide advice and assistance to the family regarding any additional information, i.e. data, assessments, evaluations, etc. that may be necessary to meet targeting criteria.
2. Once the URC has determined the child is eligible for the CES waiver the Community Centered Board shall enter all applications for the CES waiting list into the CCMS system. Order of placement on the statewide waiting list shall be determined by the date and time the child's application was received by the URC.
3. At the time of application the CCB is to refer the family to the County Department of Services Social Services for Medicaid financial eligibility and determination of SSI disability by Disability Determination.
4. Exceptions to the waiting list priority may be made if a child is residing in an ICF/MR, nursing facility, Residential Treatment Center, treatment center for persons with behavioral issues, or foster care and could be moved to their family home with an available resource. Contact the CES state program manager in the event an exception needs to be made.
5. If a family chooses not to enroll in CES when offered a resource, the family may request to remain on the waiting list and retain the child's original date of eligibility. This will occur only at the family's request; otherwise the child's name will be removed when the resource is turned down. It will be the responsibility of the CCB to notify the family and the State CES program manager of this option.

Enrollment Procedures

Enrollment Procedures are outlined in Step One and Step Two on the following pages. First, paperwork must be submitted to the Utilization Review Contractor (URC). When the child is approved for CES the CCB will receive the Certified 100 from the URC. Then the CCB must submit the necessary paperwork to DDS Medicaid Section. Once DDS Medicaid Section receives al necessary paperwork the child is officially enrolled in CES.

Step One: Paperwork to be submitted to the URC

1. The CES state program manager will notify the CCB, via phone call/voice mail and letter when an opening is available in CES.
2. The CCB has 30 days from date of notification from the state CES program manager to submit a recently completed ULTC-100 (first page only), LTC-102, and the CES Application Packet to the Utilization Review Contractor for the ICF/MR Level of Care determination and the review of the CES targeting criteria. (See Appendix A for copies of forms). *(Reference HCPF rule 8.503.40)* **These documents must be submitted together as one packet.**

    a) ULTC-100: The first step in the process to determine eligibility for CES begins with the ULTC-100. Since the CES program is an alternative to an ICF/MR, it must be demonstrated that the child has a need for the level of care that would be given in an ICF/MR. The ULTC-100 is the supporting documentation that shows the medical diagnosis and demonstrates the child needs long-term level of care. Upon initial application the CCB sends the first page of the ULTC-100 along with other required documents to the URC. The full ULTC-100 form contains both a physician's section (page 1) and a functional assessment section (pages 2-8). **Only page 1 needs to be completed for CES**

    b) **LTC-102**: The LTC-102 form replaces the functional assessment section (pages 2-8) of the ULTC-100 form and is specific to assessment areas for the developmental disabilities population. Children who are eligible for CES must meet the level of care identified on the backside of the LTC-102 form under the Intensive Medical/Psychosocial Section.

    c) **CES Application Packet**: The CES program targets services to those children who are considered to be most in need. The CES application packet provides the necessary detailed information about the child in order to determine if a child meets this threshold. The Utilization Review Contractor (URC) makes this determination. This form consists of fourteen pages. The first eight pages are to be completed for the Initial application and Continued Stay (Annual) Review (CSR). Pages nine through twelve are to be completed only for CSRs and only if the child is not demonstrating behaviors that would re-qualify him/her for the waiver due to services and supports provided through the waiver. Page thirteen lists all the documents the family and CCB relied upon to provide information in the application packet. Page fourteen is the signature page and also includes a checklist forms to be submitted with the application packet.

3. Once the Utilization Review Contractor (URC) has received all necessary paperwork the information will be reviewed within 10 days and the URC will notify the CCB of the determination of eligibility.
4. If the URC determines that the child meets the level of care (ULTC-100 and LTC-102) and the CES targeting criteria (CES Application), the URC shall send an approved and date Certified ULTC-100 form to the CCB. This is not to be confused with the ULTC-100 that the CCB originally submitted to the URC. The form the URC will return is often referred to as the "Certified ULTC-100". The Certified ULTC-100 will have a Certification Start and End date.
5. Once the URC notifies the CCB that the application has been approved the CCB shall contact the parent(s) or guardian. The CCB must arrange for the development of the Individualized Plan (IP) within thirty (30) calendar days of the Certification start date on the Certified ULTC-100.

If the child is found not eligible:

1. If the URC determines that the child does not meet the level of care and/or the CES targeting criteria, the URC shall notify the CCB, CES state program manager and the family in writing of the decision and include the reasons for the denial. The CCB shall contact the parent(s) or guardian within ten (10) calendar days of the denial and explain their appeal rights in accordance with HCPF rule 8.503.190 rule.
2. If the child is not Medicaid eligible, in his or her own right, and/or does not meet the level of care criteria, the case manager shall refer the child to the county department of Social Services or other community agencies for possible services, as appropriate, within ten (10) working days of notification of denial.

Ä **Note: Children who apply for the CES program who are not currently Medicaid eligible due to parental income should also apply for the Children's HCBS programs. This will be helpful in the event the child becomes ineligible for CES but still needs access to Medicaid benefits available through the other program.**

Checklist for paperwork to be submitted to URC for Initial Enrollment

Document Needed	Pages	Submit to Whom	By When	Where Can I find a copy?
ULTC-100	First Page	Utilization Review Contractor	Within 30 days of notification from state CES program manager of opening	Appendix A
LTC-102	Two Pages	Utilization Review Contractor	Within 30 days of notification from state CES program manager of opening	Appendix A
Application Packet	Pages 1-8, 13 and 14	Utilization Review Contractor	Within 30 days of notification from state CES program manager of opening	Appendix A

Step Two: Paperwork to be submitted to DDS Medicaid Section

It is important to remember that CES is a Medicaid Waiver funded program so **all** of the following steps are **required** in order to properly enroll an eligible child into CES and access CES/Medicaid funds.

Once the Utilization Review Contractor has returned the Certified ULTC-100 to the CCB, the CCB shall notify the parent(s) or guardian and arrange for the development of the Individualized Plan (IP) within 30 calendar days of the Certification start date given on the Certified ULTC-100. *(Reference HCPF rule 8.503.63)*

The CCB must submit all the following information to Developmental Disabilities Services Medicaid Section within thirty (30) calendar days of the receipt of the Certified ULTC-100. *(Reference HCPF rule 8.503.81)* (See Appendix A for copies of all forms). **The following documents and information must be submitted together as one packet.**

1. **ULTC-100**: The URC will return a Certified ULTC-100 to the CCB. This is the form that must be submitted to DDS Medicaid Section.
2. **LTC-102:** The LTC-102 form replaces the functional assessment section (pages 2-8) of the ULTC-100 form and is specific to assessment areas for the developmental disabilities population. For this reason it is used as part of the ULTC-100 and must be included in the child's file with DDS Medicaid Section.
3. **CES Application Packet:** The CES program targets services to those children who are considered to be most in need. The CES application form provides the necessary detailed information about the child in order to determine if a child meets this threshold. The Utilization Review Contractor (URC) makes this determination. **Copies of the CES Application form must be submitted to DDS Medicaid Section for initial enrollment**.

Ä **Note: Approval of the ICF-MR Level of Care Screen by the URC does not guarantee the availability of services or supports, and there may be additional requirements for a particular service as described in Section 7.**

4. **Individual Choice Statement:** CES is a Medicaid funded, Home and Community-Based Services waiver, which provides an alternative to placement in an Intermediate Care Facility for the Mentally Retarded (ICF-MR). There is a federal requirement that each parent/guardian applying for CES on behalf of their child be provided the opportunity to choose between the waiver and institutional placement. With assistance from the person's CCB support person, and others as appropriate, the family must be provided with information about CES and a determination made as to whether the CES program is appropriate to meet the child's needs. In addition, the individual must be informed that by selecting to enroll in CES, he or she is also choosing to receive Targeted Case Management services. This information may be provided as part of the Individualized Plan (IP) development process**. A signed and dated copy of the Individual Choice Statement must be obtained prior to the provision of any CES**

services or Targeted Case Management services. This form is to be maintained in the child's file and a **copy must be sent to DDS for initial enrollment**. The Individual Choice Statement only needs to be completed upon initial enrollment for CES or Targeted Case Management. The form does not have to be reviewed or re-done annually. Authorization for continuation in CES and TCM is part of the annual IP process. The Individual Choice Statement is also used to notify CHRS/DDS of termination from CES as well as TCM. (See "Termination", page 33).

5. **Individualized Plan:** The parent(s)/guardian, CCB support person, and others as appropriate, must develop an Individualized Plan (IP) prior to receipt of any CES services. However, there is no standard number of needs or services, which must be identified in the IP in order for it to be considered a "full" IP. The IP may contain as little as one service for initial enrollment, and additional services may be added or deleted over time. **For initial enrollment into CES, the CCB must submit the complete IP to DDS**. (See Section 5 for more detailed information). Depending on CCB procedures, an Individual Support Plan (ISP) may also be developed. If there is an ISP, it does not have to be submitted to DDS, providing the IP contains sufficient information (i.e. needs, services, dates, etc.) to support enrollment into CES.
6. **IP Cover Sheet:** The IP cover sheet must be completed based on information contained in the IP document itself. **DDS Medicaid Section requires that the *original* IP cover sheet (not a copy or fax) be completed and submitted to DDS prior to authorization of payment. The Support Block IP Cover sheet is to be used for CES.**
7. ~~**IP Summary sheet**: This identifies the needs of the child and the supporting documentation for how the need was identified.~~
8. **SSI Denial Letter:** All children applying for the CES program must have verification from the Social Security Administration (SSA) of SSI eligibility or ineligibility. If a child is SSI eligible, the benefit amount must be reported to the County DSS as part of the County Notification. If a child is not SSI eligible in his or her own right, and the child is obtaining Medicaid waiver eligibility under the 300% rule, then **a copy of the SSI denial letter must be submitted to DDS and the County DSS for initial enrollment.**
9. **County Notification Form:** Enrollment for Medicaid funded long-term care includes notification to the County Department of Social Services (DSS), a.k.a. Options for Long-term Care Agencies (note: not all OLTC agencies are the County DSS). The County DSS (or OLTC) is responsible to ensure Medicaid financial eligibility for long-term care. CCBs have a case management responsibility to ensure all necessary paperwork for enrollment is completed and should assist (directly or indirectly) the family to ensure that accurate and complete financial information is provided upon initial enrollment, as well as any updates to changes in financial status on an ongoing basis. Remember that financial eligibility includes the monthly income of the child only, as well as accumulated assets of the child. Failure to maintain current financial information at the County DSS (OLTC) could result in recovery of CES payments back to the point of financial ineligibility. **The County Notification form must be completed with the appropriate financial information and submitted to the County**

DSS (OLTC) and a copy sent to DDS Medicaid Section as part of a complete enrollment process for CES.

10. **Medicaid ID number:** The Medicaid ID number **MUST** be included on all relevant documents or the application will not be processed by DDS Medicaid Section and will be returned to the CCB.
11. **Disability Determination Services:** CCBs should work with the family to ensure that the appropriate application for Disability Determination Services is completed with the County DSS (OLTC). Do not assume all Medicaid recipients have completed this application process. Individuals who have been receiving Medicaid under SSI may not have completed this type of application for Disability Determination Services prior to enrolling into CES.
12. **PETI Assessments** *(Reference HCPF rule 8.503.210):* Post Eligibility Treatment of Income (PETI) assessments must be completed on all CES participants who are not Supplemental Security Income (SSI) eligible, even though no actual payment may be required as a result of the PETI assessment. If the child is SSI eligible, for whatever reason [e.g. regular eligibility or special qualifications found under Section 1619 (b)] PETI assessments are not required. **CCBs are required to notify the DDS Medicaid Section through a check box on the IP cover sheet, at the time of enrollment into the CES program, if the child is qualifying under the 300% rule**. CCBs are required to perform PETI Assessments each month and maintain this information for State and Federal review. Should a child have a PETI obligation, the CCB must immediately send the PETI Assessment form to the Medicaid Section at DDS. Failure to maintain current financial information could result in recovery of CES payments back to the point of financial ineligibility, which can be devastating for some families.

Ä **Note: The effective date/enrollment date can be no earlier than the start date on the URC approved ULTC-100 form. An approved ULTC-100 form does not constitute Program Enrollment. No services may be authorized prior to the date of enrollment.**

Once DDS Medicaid Section has received and approved all necessary paperwork, the DDS Medicaid Section will determine the Medicaid approved date of enrollment based on the latest signature date on all paperwork submitted. CES providers may receive reimbursement for CES services provided after the Medicaid approved date of enrollment.
All of the following information must be submitted as one packet.

Checklist for paperwork to be submitted to DDS Medicaid Section for Initial Enrollment

Document Needed	Pages	Submit to Whom	By When	Where Can I find a copy?
1. Certified ULTC-100	First Page	DDS Medicaid Section	Within 30 calendar days of receiving the Cert.ULTC-100.	Received from URC
2. Approved LTC-102	Two Pages	DDS Medicaid Section	Within 30 calendar days of receiving the Cert.ULTC-100.	Appendix A
3. CES	Pages 1-	DDS Medicaid	Within 30 calendar days	Appendix A

Application Packet	8, 13 and 14	Section	of receiving the Cert.ULTC-100.	
4. Individual Choice Statement	One Page	DDS Medicaid Section	Within 30 calendar days of receiving the Cert.ULTC-100.	Appendix A
5.Individualized Plan		DDS Medicaid Section	Within 30 calendar days of receiving the Cert.ULTC-100.	Agency Document
6. IP Cover Sheet	One Page	DDS Medicaid Section	Within 30 calendar days of receiving the Cert.ULTC-100.	Appendix A
~~7. IP Summary Sheet~~	~~One Page~~	~~DDS Medicaid Section~~	~~Within 30 calendar days of receiving the Cert.ULTC-100.~~	~~Appendix A~~
8. SSI Denial Letter	One Page	DDS Medicaid Section	Within 30 calendar days of receiving the Cert.ULTC-100.	From Disability Determination Services
9. County Notification Form	One Page	DDS Medicaid Section	Within 30 calendar days of receiving the Cert.ULTC-100.	Appendix A
10. Medicaid ID Number, to be added to documents.	NA	DDS Medicaid Section	Within 30 calendar days of receiving the Cert.ULTC-100.	From DSS

Continued Stay (Annual) Review Requirements

(Reference HCPF rule 8.503.120)

Eligibility for each child must be re-determined on an annual basis. **All necessary paperwork must be submitted to the URC, approved, and submitted to DDS Medicaid section before the EXPIRATION DATE of the current Certified ULTC-100. IN ORDER TO ACCOMPLISH THIS THE CCB MUST PLAN AHEAD.**

Step One: Paperwork to be submitted to the URC

Approximately thirty days prior to the expiration date of the current Certified 100 the CCB should **submit the following documents to the URC for Continued Stay Review (CSR). *(Reference HCPF rule 8.503.120)***

1. **LTC-102:** When the LTC-102 form is received by the URC, and the URC approves the child for continuation of CES, the URC will generate Certified ULTC-100 for the child and will indicate that the LTC-102 is certified and the new authorization dates. The timing for the completion and submission of the annual LTC-102 must comply with the

existing submission requirements for the ULTC-100 and LTC-102 forms. It is recommended that completion of these forms be coordinated with the development of the annual Individualized Plan

2. **CES Application Packet: All children enrolled in the CES program must submit a new CES Application Packet ANNUALLY to URC, as part of the CES program eligibility re-determination process.** When the CES Application form is received by URC, they will utilize this form to update the certification dates. It is recommended that completion of these forms be coordinated with the development of the annual Individualized Plan. **A copy of the CES Application form must be sent to DDS along with the approved LTC-102 form from URC**. (See Appendix A for a copy)

The ULTC-100 is not typically required for annual review; once a child is has been determined to meet the ICF/MR level of care, the ULTC-100 form will remain in effect indefinitely. If one of the following situations exists, then a new ULTC-100 must be completed.

- **a.** A child terminates from CES, and then returns after the LTC-102 annual certification has expired. For example, if a child terminates from the waiver on 2/1 and the LTC-102 expires on 9/1 and he/she returns to the waiver on 8/1, a new ULTC-100 is not required. However, if the child returns on 10/1, a new ULTC-100 will be required.
- **b.** A new annual LTC-102 is not submitted timely and the URC certification date has passed. Remember: The annual LTC-102 may be submitted to the URC up to 90 calendar days before the expiration of the current LTC-102.
- **c.** When the URC conditionally certifies a child for the ICF/MR level of care, a new ULTC-100 must be submitted prior to the expiration of each conditional certification until URC removes the condition.
- **d.** When the long-term medical condition of the child changes significantly and the original ULTC-100 no longer is accurate.
- **e.** If one of the above situations occurs, the case management agency (CMA) is responsible for the completion and submission of a new ULTC-100 and LTC-102 to URC. If the case management agency fails to fulfill this obligation, a break in Medicaid payment authorization for waiver services will result. Should this occur, the same level of service **must** be provided to the child and payment for those services **shall be the sole financial responsibility of the Case Management Agency.**

Checklist for paperwork submitted to URC for Continued Stay Review

Document Needed	Pages	Submit to Whom	By When	Where Can I find a copy?
LTC-102	Two Pages	Utilization Review Contractor	30 days prior to expiration date of current Certified ULTC-100	Appendix A
Application Packet	Pages 1-8, 9-12 may need to be completed, 13 & 14.	Utilization Review Contractor	30 days prior to expiration date of current Certified ULTC-100	Appendix A

May be needed: ULTC-100	First Page	Utilization Review Contractor	30 days prior to expiration date of current Certified ULTC-100	Appendix A

Step Two: Paperwork to be submitted to DDS Medicaid Section

The CCB is responsible to submit paperwork to DDS Medicaid section for continued certification and for the annual Individualized Plan update. These are two separate processes that occur annually. Often CCB's work in conjunction with the URC to coordinate the two processes so all paperwork can be submitted to DDS Medicaid Section at once.

For Continued Certification

If the child continues to be eligible for CES services following the Continued Stay Review (CSR), the URC will send a Certified ULTC-100 to the CCB. (If the URC notifies the CCB that the child is found to be ineligible the CCB notify will notify the family of their appeal rights.) Upon re-determination of eligibility the CCB then must submit the necessary paperwork to DDS Medicaid section in a timely manner to prevent any lapse in payment for CES services. **The following documents must be submitted to DDS no later than fifteen (15) working days prior to the expiration of the previous/current ULTC-100 form:** *(Reference HCPF rule 8.503.120, B. 2.)*

1. **Certified ULTC-100: This must be sent to DDS**. This is the document that the CCB receives from the URC. If the case management agency (CMA) fails to fulfill this obligation, a new ULTC-100 and LTC-102 is required. This would also cause a break in Medicaid payment authorization for waiver services. Should this occur, the same level of service must be provided to the child and payment for those services shall be the sole financial responsibility of the CMA.
2. **LTC-102**
3. **CES Application Packet**

For Annual IP update

The following documents must be submitted annually to DDS Medicaid section. It may be beneficial for the CCB to maintain a schedule similar to the Continued Stay Review for submission of these documents.

4. **The IP Cover Sheet (not a copy or fax) must be submitted annually to DDS at the time the complete IP is reviewed.** Annual updates to the IP do not have to be submitted to DDS, only the IP cover sheet. If there are amendments to the IP during the year, which identify a new service to be provided, only an amended IP cover sheet must be submitted to DDS.
5. ~~**IP Summary Sheet:** Identifies the needs of the child and the supporting documentation for how the needs were identified.~~

Checklist for paperwork to be submitted to DDS Medicaid Section for CSR and Annual Update

Document Needed	Pages	Submit to Whom	By When	Where Can I find a copy?
1. Certified ULTC-100	One Page	DDS Medicaid Section	Fifteen (15) days prior to the expiration of ULTC-100	Received from URC
2. LTC-102	Two Pages	DDS Medicaid Section	Fifteen (15) days prior to the expiration of ULTC-100	Appendix A
3. CES Application Packet	Pages 1-8, 13 and 14	DDS Medicaid Section	Fifteen (15) days prior to the expiration of ULTC-100	Appendix A
4. IP Cover Sheet	One Page	DDS Medicaid Section	Annually	Appendix A
~~5. IP Summary Sheet~~	~~One Page~~	~~DDS Medicaid Section~~	~~Annually~~	~~Appendix A~~

There are several factors which impact eligibility for the Children's Extensive Support program. The CCB is responsible for monitoring eligibility for the CES program, and assuring that each child is reviewed based on his or her situation. There are also circumstances in which a child may no longer meet the definition of a developmental disability or delay. In such a case, the child would no longer be eligible for the CES program and services funded under CES would be terminated. The interdisciplinary team and the CCB support person (i.e. case manager) are responsible to monitor the eligibility status of each child.

Records Maintenance

(Reference HCPF rules 8.503.110)

Referrals

The CCB must maintain a confidential record of each child referred to the CES program. The record must include the initial assessment materials, documentation of all contacts by the case manager, copies of the home health agency plan of care, if applicable, and documentation of the disposition of the referral.

Enrollments

For each CES child enrolled, the case manager must create and maintain a case record including:

1. Identifying information, name, address, phone, DOB, emergency contact;
2. Documentation that eligibility for Medicaid has been determined by the county department of social services;

3. Documentation of the URC's level of care determination; the child's initial assessment materials including a copy of the CES Application Packet, the Individual Choice Statement;
4. Documentation of the disposition of the referral, Individualized Plan; SSI denial letter, if applicable; and verification of eligibility for developmental disabilities services; and
5. Documentation of case management.

Community Contract and Management System

(Reference DDS rule 1.3.6, 2.1, 8.4.1.1, 15.2.1)

The enrollment information must be entered into the DDS Community Contract and Management System (CCMS), computerized data system, per the CCMS manual.

Frequently Asked Questions

07/02

1) **Why does the County DSS need to be notified of the child enrolling CES?**
It is the County DSS responsibility to authorize monthly issuance of the Medicaid Authorization Card (MAC) and to verify financial eligibility for Medicaid funded Long-term Care. CES is a 1915 (c) Waiver for Long-term Care and the child's income and assets must be verified for initial enrollment and monitored on a monthly basis for Medicaid eligibility. If the County DSS does not know that the person may be eligible under the 300% rule, they may inadvertently terminate him or her from Medicaid.

2) **If someone is already Medicaid eligible, does the County DSS still need to be notified about a CES enrollment?**
Yes, the County DSS is responsible for financial eligibility for Medicaid long-term care. This is a separate eligibility process from regular State Plan benefits.

3) **Why is the Post Eligibility Treatment of Income (PETI) assessed for CES when no payment will be required?**
Federal regulations require that programs receiving Medicaid Waiver funding, such as CES, determine if Medicaid recipients, who are <u>not</u> SSI eligible, are able to share in the cost of their care. This waiver has the personal needs allowance at the maximum amount (300% of SSI), which effectively nullifies any payment requirement, but we cannot forego the actual assessment process. The assessment must be applied on an ongoing basis to ensure that the child's income has not changed to the point where it could affect his or her eligibility for CES.

4) **Since CES is not a "slot" program, at what point is a child considered enrolled?**
Once any level of service funded under CES has begun, the child is considered enrolled. There is no standard level of service in CES. For example, if someone has ten identified needs and CES can accommodate five of the prioritized needs, only one or two may initially begin and then others added later as funds are available, providers are located or circumstances allow for expansion.

5) **Can a child receive Home Care Allowance through the County DSS and be enrolled in the CES program?**
The CES program does not prohibit this type of situation. Check with the County DSS (a.k.a. Options for Long-term Care Agencies) to determine any limitations they may have. If, however, a child is receiving a Home Care Allowance, then the CES program cannot pay a family member for providing personal supports for which the child (family) has already been paid. The CCB and County DSS must carefully specify what service is being purchased and by whom. If Home Care Allowance through the County DSS is unwilling or unable to provide this type of detailed information, then CES cannot be used to pay a family member for personal supports.

Frequently Asked Questions

07/02

6) **Is there a minimum level of service (e.g. monthly) required in order to remain "enrolled" in the CES program?**

No, however, CES is an alternative to placement in an ICF-MR for children who are considered to be the most in need in the state which would seem to indicate a level of need for services on a regular basis for most participants. At the same time, due to the individualized nature of the services and supports provided through the CES program, there may be situations in which a CES participant does not receive a CES service on a monthly basis and would still be considered appropriate to be enrolled in the program.

If someone only needs a one-time or short-term service, such as home modification, or an assistive technology device, the CCB should first consider if CES is the most appropriate means to meet that need, and if so, once the need is met, the child should not remain in the CES waiver past that month of service. Remember that services from the federal perspective must be necessary in order to prevent institutionalization.

7) **Can CES services be provided to a CES participant while he or she is in a hospital, nursing facility or ICF-MR, or foster care?**

Reimbursement <u>cannot</u> be made under the CES program while a child is in a hospital, nursing facility, ICF-MR, or foster care... While a Medicaid recipient is in these facilities, the facilities are claiming Medicaid reimbursement for the child's total care. The CCB should contact the state CES program manager (CHRS) about how to procedurally manage this time period.

Movement between Local Service Areas

What You Will Find

- Movement between Service Areas
- Termination
- Frequently Asked Questions

There are occasions when a family with a child receiving CES services may wish to move from one part of the state to another. **CES allocations are child specific and the resource will automatically transfer with the child**.

Case Management Agency Procedures

(Reference HCPF rule 8.503.130)

When a parent/guardian expresses a desire to move and have the CES resource transferred, it will become the responsibility of the originating CCB to manage the transfer. The originating CCB should work with the family and the receiving CCB, to facilitate and coordinate the transition for continuation of services in the new service area. **The effective date of termination from the transferring agency shall be the 14th or the last day of the month, whichever date follows the actual moving date of the family.**

The **originating Case Management Agency (CMA**) shall complete the following procedures to transfer a child to another CMA:

1. Inform the family of the process, anticipated timelines, services/supports available in the area the family is moving to, and possible barriers, if any.
2. Initiate contact with the receiving CCB, via telephone, to give notification that the child is planning to transfer, negotiate an appropriate transfer date and provide information.
3. If it is an inter-county transfer, notify the income maintenance technician that the individual is transferring; and
4. Forward copies of pertinent records and forms to the receiving CMA within five working days of the child's transfer date; and
5. Notify the Utilization Review Contractor (URC), the CES state program manager, and the Developmental Disabilities Services Medicaid Section within five working days of the transfer, using the choice statement form.

The **receiving CMA** shall complete the following:

1. Conduct a face-to-face visit with the child within ten working days of the child's transfer date; and
2. Review and if necessary revise the Individualized Plan and change or coordinate services and providers as necessary.
3. Work with the family to identify appropriate services for the child within the CCB's service area.

Transfer of Funds

When a child moves from one CCB service area to another, the CES funds are transferred with the child. Upon notification of the transfer the state will do a contract amendment to transfer the funds with the child. The amount transferred will be 1/12th of the standard annual amount multiplied by the number of months remaining in the current fiscal year (or for the remainder of the IP should an IP end prior to the end of the fiscal year). This amount would include a pro-rated 15% management fee. At the beginning of the next fiscal year, July 1, the base contract of both CCBs, the sending and receiving, would be adjusted to reflect the transfer of the full standard annual allocation amount for CES. Targeted Case Management (TCM) will also be transferred on a pro-rated FPE basis (annualized the following fiscal year).

Termination

(Reference, HCPF rule 8.503.140)

When to terminate

The child must be terminated from the CES Program when one of the following occurs:

- The child no longer meets eligibility criteria;
- The cost of services and supports provided in the home or community exceed the cost effectiveness of the program;
- The parent/guardian chooses ICF/MR rather than the CES program;
- The family chooses to discontinue the CES program (e.g., moves out of state, no longer needs the Medicaid coverage);
- The child enrolls into another HCBS waiver program or is admitted for a long-term stay in an institution (e.g. Hospital or Nursing Facility); or
- The child expires; or
- The family or guardian fails to cooperate in the determination of financial eligibility. Failure to cooperate will be considered failure to respond within thirty (30) days of a request for necessary information by the case management agency and service providers agreed to in the IP. This includes prompt reporting of changes in income or resources.
- When the child has not use a waiver service in the past 30 days (see Section 2, page 16 for exemptions)

How to terminate

(Reference HCPF rule 8.503.140)

A CES participant may terminate from the CES program at any time. CCBs must complete the following steps:

1) **Inform** the child's parent(s) or guardian in writing on a form provided by the State of the termination from the CES Program, ten (10) calendar days before the effective date of the termination; and inform the child's parent(s) or guardian of his or her appeal rights in accordance with HCPF rule 8.503.190.
2) **Notify** all providers listed in the Individualized Plan within ten (10) working days prior to the effective date of termination; and notify the Utilization Review Contractor, the State CES Program Manager and the Developmental Disabilities Services Medicaid Section at DHS within five (5) working days from the termination date on a State-designed form (Individualized Choice Statement).
3) **Provide** appropriate referrals to other community agencies if the child needs continued assistance to remain in the community, including the County Department of Social/Human Services. This must be within five (5) working days.
4) **Complete** a new County Notification Form indicating termination and submit it to the County DSS/OLTC.
(See Appendix A for a copy)
5) **Document** in the child's case record the reasons for termination and all agency referrals.
6) **Update** the DDS Community Contract and Management System (CCMS), computerized data system, per the CCMS manual.

Frequently Asked Questions

07/02

1) **Can a CES participant move to a new service area and retain their old CCB?**

There are circumstances under which it may be practical for the original CCB to continue to act as the CES agency for a child. Usually, this would involve short distances between service areas, such as in the Denver metro area, where literally you cross into a new area by crossing the street. The CCB would still be responsible for all aspects of the program including monitoring, which is why this type of arrangement would not be practical across long distances. CCB should also consider the length of time such an arrangement would be in place.

Section 5 Individualized Planning Process

What You Will Find

- Purpose of an Individualized Plan (IP)
- Minimum Requirements for the IP
- Developing the IP
- Required Assessments
- Relationship to Other Service Plans
- Relationship to Other Sources of Funding
- Review & Amendments
- Frequently Asked Questions

Purpose of the Individualized Plan

(Reference C.R.S. 27-10.5-113), DDS rule 16.440, HCPF rule 8.503.70, federal application)

The purpose of the Individualized Plan (IP) is to capture, at a given point in time, the need(s) and goal(s) of a child (parent(s)/guardian); to document the necessary services, supports and resources to meet the needs; and to identify responsibility and accountability for follow through. The IP identifies the agreement and obligation between the parent(s)/guardian and the CCB for a specified period of time.

The IP is also part of a dynamic process and should not be considered a one-time end product. Each CCB must determine if the IP format used in the CCB is able to accommodate the types of detailed information necessary for documenting multiple discrete services and providers that are often found in CES. An appendix to the IP, such as an Individual Support Plan (ISP), might be needed. **The form and format of the IP are at the discretion of the CCB, as long as the minimum information required below is included**.

The guiding principles, Creating Options/Choices and Focusing on Inclusive Communities, from Section One state:

- Support options should come from many different sources in a community and should not focus on just financial funding through CES; and
- CES not only builds upon existing natural supports and generic community services but also should encourage and assist the family in use of these resources; therefore CES should not be the sole source which supports children in the family home.

Both informal and formal services and supports should be explored with the parent(s)/guardian and identified on the IP, as appropriate. *Federal requirements stipulate that the IP contain information about "all" needed services, including non-Medicaid funded services.* Parent(s)/guardian need to be encouraged to utilize, develop or be assisted to develop natural support networks, such as community activities, groups, committees, and other friendships. Examples of possible services and supports not funded under CES might be parents encouraging parents (PEP), Early Intervention Services or Part C funding, child care, Title 8 HUD services, Food Stamps, Energy Assistance programs, such as LIEAP, mental health services, public education, civic organizations and groups, recreation groups, youth groups, etc.

Minimum Requirements for the IP

(Reference DDS rule 16.440, HCPF 8.503.72)

The Individualized Plan (IP) shall include information about why the child requires services and supports. All services and supports required to meet the needs in the community/home shall be listed. The purpose and the expected outcome of the services shall be included in the IP.

The IP shall consist of a Child's Needs Section, a Plan Section and a Purpose Section.

- Child's Needs Section shall identify and list specific (medical and/or behavioral) conditions and/or other areas in which services and supports are required to maintain the child in the community/home setting. The areas of need shall include, but not be limited to:
  - Medical needs; and
  - Functional needs; and
  - Home/environmental needs
- Plan Section shall identify and quantify all services and supports required to meet the needs of the child, including case management services. The service listing shall identify the payment sources (i.e. family or informal supports, parental out-of-pocket expenditures, private insurance, CES etc.)
- Purpose Section shall be a statement of a measurable goal that the case manager, child's parent(s)/guardian and service providers expect to obtain during the period covered by the Individualized Plan.

Standard information the IP **must** contain:

- Child's name
- Child's Social Security
- Date of birth
- Date the IP was developed or revised;
- The specific type of service or support and the committed time period;
- An explanation of the desired results;
- The projected timelines for obtaining the services or supports, and as appropriate, the frequency of the services and supports;
- The needs, including health and safety assessments, requiring support as identified and prioritized by the parent(s)/guardian, as well the child's strengths, abilities, preferences, and desires;
- Provide an assessment of non-CES services and natural supports that assist the child to continue to live in the family home;
- A statement of agreement with the Plan; and,
- The signatures of the parent(s)/guardian and an authorized CCB representative.

Completion of the IP document should facilitate the child receiving services and supports and not become the goal itself. The IP should be directly related to the needs of the child and the complexity of the services and supports provided.

Ä **Note: No services or supports may be provided under the CES program unless an IP has been developed and implemented. The IP must include sufficient documentation of the needs of the child to support the types and frequency of services provided**.

Developing the IP

The CES program encourages the least amount of system intrusion necessary to assist the child and family. The challenge is to balance the family's desire for privacy and the CCB's need for adequate information to satisfy funding requirements; however, good planning requires a thorough review of the child's situation and needs. It is for this reason that it is key that the parent(s)/guardian are supported to express their child's strengths and needs during the IP development to assure that the IP fits their own circumstances and needs. The CCB representative should assure that the parents have an understanding of the IP process; including, but not limited to:

- The parent(s)/guardian may choose any individual to be a member of their child's support team and participate in the IP development;
- The IP captures the family's creative thoughts regarding how their child can best be supported in the home and community;
- The IP is to be used as a tool to guide parents and provider(s) as to how services are to be delivered; and
- As needs change over time, the IP will be amended to continually reflect child and his or her needs.
- The CCB representative should also assure that parent(s)/guardian understand service and support options and funding amounts available, before making decisions.

It is important to adhere to the concept of an "individualized" plan and recognize that each child's situation is unique. The IP planning process can be approached from the perspective that, while each family has the "opportunity" to access all of the elements of the service system, they may not necessarily need or want to do so (i.e. don't treat all children like they should have ten services when they may only need or prioritize one). The CCB support person (i.e. generally the case manager, resource coordinator) is in a position to assist the parent(s)/guardian to consider immediate and ongoing needs, as well as intermittent or future needs. For example, a need may not be present all the time (e.g. assistance/support should the primary caregiver take a vacation or environmental adaptations during the cold winter months). Current services or supports may change tomorrow. It is recommended that the Inter-Disciplinary Team (IDT), which includes the

parent(s)/guardian, avoid a short-range planning focus and become familiar with all of the service and support options in order to know where to draw from to fill a gap in services or supports.

(See DDS rule 16.440 for specific IP requirements)

Required Assessments

(Reference C.R.S. 27-10.5-102), DDS rule 5.4.3, HCPF rule 8.503.20)

There are certain types of assessments, which are reasonable and necessary prior to the use of public funds for long-term care. Required assessments must include, but not be limited to, the following:

1. **Medical and nutritional needs;**
2. **Functional needs; and,**
3. **Home/environmental needs**

The CES program covers such a wide range of family situations and programmatic needs (e.g. someone may only need/request child care services, while other have extensive daily support needs); CCBs have some latitude to exercise judgment about the extent of additional assessments, which need to be completed based on individual circumstances. When making a determination about additional assessments, CCBs should remember that the program is <u>not</u> intended to be overly intrusive into a child/family's life where no assistance or support is needed or requested (i.e. services are directed to prioritized areas of need of the child). At the same time there is a practical reality that in order to understand a child's needs and to help the parent(s)/guardian make informed decisions, there must be sufficient information gathered about the child. The CCB and the parent(s)/guardian should determine the extent and type of additional assessment needed. The CES eligibility application should contain a substantial amount of information (i.e. medical and behavioral needs).

The Plan Section must identify and quantify all services and supports, which will be acquired to meet the needs of the child, including case management services. The service listing must identify the payment sources (i.e., family or informal supports, parental out-of-pocket expenditures, private insurance).

Although the parent(s)/guardian has the right to make choices, if there are concerns about the impact on the child's health and safety, the CES agency must assess and monitor the child's vulnerability to abuse, neglect, mistreatment or exploitation. Should the CES agency (CCB) have concerns, the County DSS must be notified pursuant to C.R.S. 19-3-304.

<u>The agency must document any such efforts</u>. The frequency and manner of the documentation (e.g. case notes, incident reports, monitoring activities) may be determined by the CCB based on the individual circumstance and level of potential risk to the child.

Relationship to Other Service Plans

(Reference C.R.S. 27-10.5-102 (20) (c), DDS rule 5.4, HCPF rule 8.503.78)

Depending upon the circumstances of the child with a developmental disability, there may be other Plans [e.g. Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP), and Mental Health Treatment Plan], which have been developed for the child. If other Plans are in place, then the services and supports provided through the CES program must be integrated with those other services or supports for the person. While there is no need or requirement to develop an entirely separate (IP) document in order to meet State requirements, whatever format is used it must meet the minimum IP requirements as outlined in this section. The emphasis is on content, not necessarily format. *Examples* of other types of plans include:

- **Individual Support Plan** (*optional, used at agency discretion*) depending on the child's circumstance and the agency's internal policies and procedures, a more detailed support plan (e.g. Individual Support Plan - ISP) may be required. Such a document may be used to specify details, such as who, what, when, where, how, and how often. The IP may have many similar features to an ISP, i.e. evaluation and assessment of needs, description of services, etc. When appropriate, the IP can reference information included in the ISP, and visa versa, in order to reduce duplication of efforts. The Individualized Plan (IP) is the overall coordinating service plan for child with developmental disabilities who are receiving services or on waiting lists for services through the CCB.

- **Individual Service and Support Plan** (*optional for CES, used as needed*) Although CES is a support model, there may be situations, which require organized training or support by a paid staff person. If a child enrolled in CES requires a plan of intervention or instruction that directly addresses the needs identified in the child's Individualized Plan and which provides specific direction and methodology to staff providing direct service to a child, then an Individual Service and Support Plan (ISSP) might need to be developed. An ISSP is a useful tool, which can be helpful when, for example, a child wants/needs to learn a specific task in order to become more independent, such as dressing, bathing, or learning appropriate behavior. The support model does not mean that everything is done for the child. An ISSP may also be useful for coordination between multiple staff or service providers for complex support services (e.g. a range of motion program, particular dietary regimen). Even though a service may be purely support for the child (i.e. there is no expectation that the child will learn the task or change his or her behavior), consistency of how the support is provided may be necessary and formal documentation is provided through an ISSP. An ISSP is not "required" for CES participants but common sense may indicate the usefulness of an ISSP. The IP planning process should determine the need for an ISSP.

- **Safety Plans** (*optional*) *(Reference DDS rule 11.9)* A Safety Plan is not required for CES participants. However, it may be advisable and it is CHRS/DDS's expectation that the CCBs review, with families, the need and/or benefit for such a plan. For example, outside staff may

come into the home to provide services so a safety plan may be useful. If used, the plan should be kept current, address how emergencies, such as fire, intruders, etc., will be handled and provide for twenty-four hour emergency assistance. Safety plans should be reviewed or practiced regularly with the child/family to ensure persons are knowledgeable about the plans and capable of performing them.

- **Monitoring Plans** (*optional*) Often information on how services will be monitored can be included in the IP document. In some situations, it may make sense to develop a formal plan for how services and supports will be monitored. Monitoring plans are at the discretion of the CCB and on a person-by-person basis as necessitated by factors, such as the complexity of the services and supports provided, the vulnerability of the child or a pattern of problems or incident reports.

Relationship to Other Sources of Funding

(Reference C.R.S. 27-10.5-401 (q), DDS rule 2.1.1.4)

The CES program is to be utilized in conjunction with a variety of other generic community services, supports and resources to meet the child's needs. The Individualized Plan is to clearly identify the services and supports needed by the child and the funding source for each in order to avoid any confusion. **Duplication of public funding across specific programs must be avoided.** The funding available through CES is to be used to provide services or supports which are considered necessary to maintain the child in his or her family home and community, and avoid out-of-home placement services or more costly 24-hour comprehensive services.

The area with which CHRS/DDS is most concerned is the potential overlap between the CES program and the Family Support Services Program (FSSP). For example, a child enrolled in Children's Extensive Support (CES) can only access FSSP funding when that service is not allowable under CES. FSSP funding cannot be used for a child enrolled in CES in situations when the service is allowable under CES, but was not paid for by CES because the service was a lower priority for that family (i.e. funds available under CES were used to address other priorities). Also, when FSSP funds can be used in addition to CES funds for service available, this does not automatically mean they should be used. There are very legitimate concerns about having some children/families receiving a greater share of available resources from multiple programs while other children are on waiting lists receiving no services at all.

At this time, there are no absolute limitations on the use of CES funds in conjunction with FSSP State General Funded programs. However, due to the large numbers of children on wait lists, who are receiving no services, it is expected that CCB's are prudent managers of their limited funds available for children's programs. CCB's must balance the use of FSSP funds for children on CES with the needs of children on the wait lists. There are Federal restrictions, which prohibit a child

from being enrolled simultaneously in other Medicaid waiver programs, such Children's HCBS waiver, or the CHRP waiver. **Each child may only be enrolled in one Medicaid waiver at a time.**

Review & Amendments

(Reference DDS rule 5.4.6, HCPF rule 8.503.73, federal application)

CCBs must document whether and how the services provided are meeting the child's needs, as defined in the Individualized Plan. They must also ensure that the child continues to meet the cost containment criteria. As a dynamic document, the Individualized Plan must be reviewed and amended as often as is necessary to ensure that it is reflective of the needs of the child and the services and supports being received. **At a minimum, the IP must be reviewed at least annually with the parent(s)/guardian**. It is recommended that the frequency and extent of the review take into account the degree to which a child's situation has changed.

If the necessary changes are outside the scope of the IP, as originally developed, then a more extensive review and update must take place. The CCB support person (i.e. case manager, resource coordinator) should work with the parent(s)/guardian and service providers to determine the appropriate method of review.

Since the parent(s)/guardian are key figures in the IP process, the degree to which others need to be involved in changes should be determined by the parent(s)/guardian and by the nature of the change(s). It is recommended that the IP be developed in such a way that adjustments can be made throughout the year without requiring extensive revisions. Only the case management agency (CCB) is authorized to approve changes in the IP, others may be involved as requested in the development/revision of the IP.

Changes in the IP do not require the CCB to re-submit the IP to DDS Medicaid Section, only an IP cover sheet (see Section 5).

Frequently Asked Questions

07/02

1) **If a parent(s)/guardian only identifies one area of need (e.g. childcare), would DDS Program Quality consider this to be a complete Individualized Plan?**

   Yes, however, the CCB should work with the parent(s)/guardian to ensure that they have adequate information available to them from which to make good decisions. For example, a parent(s)/guardian may not have even considered a particular service or service option simply because they did not understand it could be a consideration, or they may have been so focused on one area that others went un-noticed.

2) **Does the Individualized Plan have to specify the amount of funds provided to a child?**

   Not necessarily, it depends on the commitment made in the Individualized Plan. Generally, the commitment is for a service to be provided (e.g. 10 hours a week of personal care) rather than a dollar amount. Federal requirements do stipulate that the IP contain information about "all" needed services, including non-Medicaid funded services.

3) **Can a CCB restrict how often changes are made to a plan or in the provider selected?**

   CCBs do have a responsibility to ensure choice for families and are expected to provide ***reasonable*** *efforts to accommodate needed changes in a timely manner. At the same time, DDS recognizes that excessive and unwarranted changes in plans or service delivery are not the intent of choice. CCBs already have a great deal of flexibility to address most problems in this area. For example, a CCB can include in contracts or service agreements with providers that a service change can only occur with advance notice, such as 30, 60 or 90 days. This notice could be on the part of the provider, as well as the family.*

Resource Assignment

(Reference C.R.S. 27-10.5-104, DDS rule 16.241)

What You Will Find
- Resource Assignment
- Parameters for Resource Assignment
- Cost Effectiveness and Efficiency
- Frequently Asked Questions

When a CES opening becomes available for a child the state CES program manager will notify the CCB there is an opening. A resource will be allocated specifically for that child. This resource, also know as an "allocation", is for a set and finite amount of money. When a resource first becomes available for an eligible child the resource will be based on a specific number of months available. Children who terminate from CES typically have a specific number of months left in their annual resource. The remaining months go to the next child to enroll in CES. It is for this reason that the first year a child is in CES the resource is typically not a full year resource. The resource will annualize at the beginning of the next fiscal year, which begins July 1. Allocations are child specific and the child/family has the right to access the full amount of their resource. If the child/family does not need to utilize the full amount of their resource, the CCB has the latitude to manage the remaining amount in a pool of CES funds. This allows greater flexibility to assist children who have more intensive levels of need. (i.e., some children may need less than a full allocated resource amount allowing for other children in CES, who have higher needs, to access more of the funds within the CCB pool of CES funds).

Funds are provided to each service area (CCB) within the available appropriations each fiscal year, which include funds for direct services (85%) and management fee (15%). It is the responsibility of each local service area to establish the criteria and procedures for assigning resources based on Individualized Plans which address the identified needs of CES participants, CCBs are also responsible to meet the contract control point requirements in Exhibit C of the CHRS/CCB contract (see Appendix D for a sample), and to remain within the cost effectiveness average for its service area for CES funds. (Note: See Transfer of Funds, page 33)

Parameters for Resource Assignment

Resource Assignment is the process by which a determination is made regarding the level of services and supports to be delivered to a child.

The purposes of State guidelines for individual resource assignment are:

- To promote consistency and fairness in decision-making across CCBs.
- To ensure that all stakeholders in each service area can know and understand how resource assignment decisions are made.
- To provide an approach which will minimize disputes and appeals.

- To assign resources in a manner that is reflective of the individual needs of the child. Thus, children with greater needs would receive a higher resource assignment level than would children with lower needs, this would include existing supports.

There is no recognized instrument or assessment tool to utilize when assigning individual resources. Consideration must be given to prioritized needs, professional judgment, and family desire when assigning resources. By working within the partnership between family and CCB, there is an enhanced ability to develop a well-rounded support package, which blends natural supports, generic community resources and CES resources. This process will frequently require give and take on both sides and will be more successful if all parties approach this process in a spirit of collaboration. While there are a variety of local strategies to be used, there are some guiding principles for resource assignment that apply to all service areas. Below are the minimum requirements. (A Decision Making Guide is provided in Appendix B to assist with resource assignment.)

Resource Assignment Criteria

Each CCB must develop resource assignment criteria that will minimally have the following elements. The criteria:

- Is based on needs which are identified in the Individualized Plan and prioritized by the parent(s)/guardian.
- Considers options of providing needed services and supports other than through the CES program.
- Assures the service or support needed is allowable. (See Section 7 for more information)
- Promotes cost containment.
- Assures there are available resources within the CCB Children's Extensive Support pool of resources.
-

Resource Assignment Process

Each CCB must develop a written process for resource assignment and make it available upon request to interested parties. It must contain at least the following elements:

- The criteria to be considered when assigning resources.
- That the criteria are applied uniformly and consistently to all individuals.
- Specifies who, within the agency, has what level of decision-making authority regarding resource assignment.
- Specifies what documentation will be required to support the decisions that are made.
- Addresses under what circumstances a plan of services (IP) is reviewed and adjustments made in funding levels for needed services. Decisions must be reviewed at least annually.

Cost Effectiveness & Efficiency

(Reference HCPF rule 8.503.80, federal application)

The flexibility of the CES program allows many opportunities to meet the needs of an eligible child in unique and individualized ways. When addressing the issue of resource assignment, cost effectiveness is one of the critical factors, which must be considered along with the overall determination of whether or not a service or support is allowed. The CES program is designed to **Meet the Basic Need in a Cost Effective and Efficient Manner**. In particular, this is an underlying principle in the use of all Medicaid funds, which prescribes, that "needs" be addressed and not "wishes or hopes". For the reality is that there are other children on waiting lists receiving no services, and others who may be in *need* of additional services beyond what they are currently receiving. For this reason, there is less flexibility in use of CES (Medicaid) resources than there is in Family Support Services (State) funds.

The cost containment function of the case manager is to ensure, on an individual child basis, the cost of providing CES services is a cost effective alternative to ICF/MR institutional level of care placement. The case manager must identify costs as part of each Individualized Plan. The CCB is responsible for ensuring that, on average, each plan is within the cost effectiveness average for its service area.

The term, **Cost Effective and Efficient** means that the least expensive and appropriate alternative is to be used to reasonably meet the needs of the child at a basic level (See Section 7, Process to determine if a Service is Allowed, page 61). It is good public policy to maximize use of limited government resources. It is the responsibility of the CCB to have a reasonable decision-making process determine how to adequately and cost effectively meet prioritized need(s) at a basic level.

Frequently Asked Questions

07/02

1) **Can a parent(s)/guardian appeal resource assignment decisions?**

The grounds for an appeal are set out in statute (C.R.S. 27-10.5) and include decisions involving eligibility determinations and modification or reduction of services or supports set forth in the Individualized Plan (IP). Thus, depending on the impact of the resource assignment, there may be grounds for appeal as the decision affects service provision. However, it is important to understand that statute requires that any provision of services and supports be within available appropriations and subject to the existence of appropriate services and supports with available resources. What this means is that there would likely be a strong defense to an appeal based upon the resource allocation decision.

Just as the Systems Change Project does not affect the statutory basis and procedure for DHS appeals, it also does not affect the basis and procedure for appeals through the single state Medicaid agency.

2) **Can parent(s)/guardian change their minds about how they want to use funds authorized for their child's services?**

Funds must be used for services and supports authorized in the IP unless the plan is changed. Parent(s)/guardian should be allowed the opportunity to adjust their child's Individualized Plan as their child's needs change over time. However, a change in the agreed upon Individualized Plan will also necessitate a reassessment of resource assignment and other factors, which could influence the continued availability of, previously committed funds (i.e. local service area cost effectiveness).

3) **Can parent(s)/guardian use CES funds for new needs that were not identified on the current IP?**

Funds may be utilized for new needs only after the IP has been revised to accurately reflect the child's needs. This could mean a decrease in other services to provide funds to address the newly identified need. If a new service is added to an IP, a new IP cover sheet (the original, not a copy or fax) must be updated and submitted to DDS Medicaid Section

4) **What obligation does the CCB have to adjust plans prior to the end of the twelve-month period?**

Within its cost effectiveness average, CCBs are obligated to make necessary adjustments during the course of the fiscal year. The flexibility of the CES program is intended to provide a fluid means for adjustments as needed. If all CES funds have been committed and increased funding is still needed, the necessary adjustments would be made based on local discretion and other non-CES resources available.

Frequently Asked Questions

07/02

5) **Who should decide if it makes sense to provide access to Family Support Services Program (FSSP) funding or other State funded programs in addition to CES funds?**

At this time, it is the responsibility of the local service area to make this decision. These types of decisions should be considered only under very unique circumstances.
(See Section 5 for further information about this issue)

6) **If a CES participant has an emergency, is the CCB required to address this need by providing more CES funds?**

If the CCB has not encumbered all of its CES funds for the fiscal year, and it is below its cost effectiveness average, the CCB would need to review the child's needs through its local allocation process and proceed accordingly. Any adjustments for an emergency situation must still meet the allowed criteria, the same as any CES service or support. If the CCB has committed all of its CES funds and it is at its cost effectiveness average, then the CCB does not have a responsibility to increase CES funding for services. However, depending on the gravity of the situation, an agency may likely be directed by common sense to develop an alternative means to address a need, which clearly places the CES participant at risk of harm.

General Service Categories

(Reference C.R.S. 27-10.5, HCPF rule 8.503.100, federal application)

What You Will Find
- General Service Categories
- Personal Assistance Services
- Environmental Engineering
- Specialized Medical Equipment and Supplies
- Professional Services
- Community Connections
- Process to Determine Whether a Service is Allowed
- Frequently Asked Questions

The CES program is provided to assist an eligible child remain in their family home and community and avoid out-of-home placement or more costly comprehensive services. This is accomplished by providing services and supports which address needs of the child due to his or her disabilities. Listed to the right are the service categories identified in the Community Contract and Management System (sometimes referred to as encounter data). Some of the main service categories are inclusive of more than one sub-category, such as personal assistance services which includes child care services, personal supports and household services. Each service category specifies what services can be billed to each particular category. These categories provide for a consistent reporting format on a statewide basis. CCBs **must** bill all services and supports provided to individuals under the CES program within these categories. (See Section 9 for more information about billing procedures).

It is important to remember that any service or support provided through CES must be identified in the IP. The service and support reporting categories listed below are available under the CES program. A service or support under CES can only be provided when it is not available under the regular Medicaid State Plan, including EPSDT or third party source. Within each service category below are *SAMPLE* descriptions of needs which may be met by providing the related service. **This is not an exhaustive list**. The main service categories must be used when billing or reporting through CCMS.

PERSONAL ASSISTANCE SERVICES

Personal Assistance services provide necessary personnel and supports to meet activities of daily living for a child with a developmental disability. These services and supports, including evaluation and assessment, are provided to ensure adequate functioning in the child's family home or for accessing and/or participating in the community. Personal Assistance services may include assistance or training with a wide range of activities necessary to meet the needs of the child. There are three sub-sets which are all reported under Personal Assistance services: Child Care, Personal Supports, and Household Services. **Monthly billing category: Personal Assistance Services**

CHILD CARE SERVICES

Child care services means the temporary care of a child necessary to keep a child in the home and avoid institutionalization. The key consideration is how the disability creates a need above and beyond that of typical child rearing costs for any family.

EXAMPLES **of areas of need for child care services include:**

supervision	Examples: parents may need to attend sibling functions or other family activities that normally would not require a child-sitter in order to leave an older child at home alone (e.g. while not a hard and fast threshold, generally children over the age of twelve could be left alone where a CES eligible child could not.) *If a child is truly CES eligible, there should be no time during which the child could be safely left unattended. Typical before and after school care or during regular working hours for a parent are not covered unless there are additional costs due to the disability of the child.*
respite care	Examples: the parent(s) need time away from the daily demands of caring for a child with a disability.
siblings	Examples: parents often must take a child with a disability to medical appointments or therapy sessions and require child care for siblings in the home in order to maximize the benefit of the service to the child with a disability. *Generally, this would be considered above and beyond typical family expenses.*

PERSONAL SUPPORTS

Person supports means the direct involvement of another person to ensure that the physical care of a CES participant is met. Please see the General Limitations, page 52 for information pertaining to family members as providers for personal supports.

EXAMPLES include:

eating/ drinking	Examples: cutting food into bite-size morsels, chewing, hand-over-hand use of utensils, and gastrostomy feeding (if done by non-medical personnel). *Assistance with nutritional diets which require skilled medical care, such as intravenous feedings, is covered under health monitoring.*
dressing	Examples: putting on or taking off clothing. May also include appropriateness of dress for weather conditions. *Does not include purchasing of clothes, mending, or suggested style of dress (i.e. formal, informal, color selection - considered to be decision-making).*
bathing	Example: washing and drying of one's body and hair. This can be done in either a shower or bathtub, and does not matter if the child is ambulatory. *Does not include areas not related to "cleaning" the body, such as skin care for dryness which is covered under personal hygiene.*
personal hygiene	Examples: oral hygiene, hair grooming, application of cosmetics, use of deodorant, nail care, shaving, menstrual care, or skin care. *Bathing, dressing, and toileting are covered above.*
Bowel and bladder care	Examples: physically accompanying the child to the restroom, physical assistance removing clothing, ensuring use of toilet tissue, or washing hands. Also includes use of urinal, diapering and maintenance of a colostomy bag. *Does not include medical intervention for bladder infection, constipation or other*

	procedures which are normally considered outside of routine daily bowel and bladder activity.
medications	Examples: medication administration by a person(s) who is legally authorized to administration medications. (may be over-the-counter or prescription medication)
health monitoring	Examples: assure that activities of daily health needs are carried out, such as special diet requirements, asthma or allergy treatments, following physician's orders or blood pressure monitoring. Basic first aid may be provided, as well as operating and maintaining medical equipment for a child who cannot perform these functions alone due to the disability or medical condition.
positioning / transferring	Examples: positioning to prevent skin breakdowns, contractures, or to assist with comfort for a child who cannot position himself or herself. Also includes physical transfers for toileting, getting in or out of bed or a wheelchair for children who cannot transfer themselves without physical assistance. Transfers can range from full human assistance (one or two person lifts) to mechanical devices (i.e. Hoyer lift, grab bars which are cover under Home Modification or Assistive Technology). *Does not include any equipment or purchases which are covered under Home Modification or Assistive Technology.*

HOUSEHOLD SERVICES

Household Services shall include assistance in performing housekeeping tasks which, due to the needs of the child with a developmental disability, are above and beyond the tasks generally required in a home and/or increase the parent(s) ability to provide care needed to the child with a developmental disability.

***EXAMPLES* include:**

chores	Examples: routine household tasks, such as cleaning, dusting, vacuuming, making beds, etc. which if performed for the family would allow needed time to be spent with the child a disability, as well as reduce stresses on the family.
laundry	Examples: excessive clothing care due to the child's disability, such as bowel and bladder incontinence, frequent vomiting, certain medical conditions which cause abnormal soiling of clothes, bed linens, or towels. *Laundry is only available to the extent needed by the child with a disability. Regular family laundry costs and products are not allowable.*

General Exclusions for Personal Assistance Services

- Personal Assistance services provided under CES must not be available under the regular Medicaid State Plan, ESPDT *(HCPF rule 8.280),* or third party source.
- Under no circumstance can the parent(s)/guardian be reimbursed for the provision of CES services.

General Limitations for Personal Assistance Services

- Family members over the age of eighteen **(parent(s)/guardian are excluded**) who live in the same household as the child with a developmental disability may, on an exception basis when no other qualified providers are available or it is clearly demonstrated to be the most cost effective and efficient means to provide the service, **be reimbursed for only personal supports and only up to a maximum of $6,000 per fiscal year**. Family members who live in the same household as the child with a disability cannot be paid to provide household services or child care. Adult family members who live outside of the home may be used the same as any other qualified provider but must meet all criteria as a qualified provider as determined by the CCB.

Environmental Engineering

This includes Home Modification, Assistive Technology Services and adaptive Recreational equipment.

Home Modification

Home modification covers physical adaptations which are directly related to the child's disability and identified in the IP to help ensure the child's safety, security and accessibility in the home and community. Modifications must be above and beyond those which would be considered part of regular home maintenance or modification needed by all homeowners. Such adaptations minimize or eliminate the need for ongoing human assistance and must be a cost effective and efficient means to meet the identified needs. **Monthly billing category: Home modification**

EXAMPLES **include:**

accessibility	Examples: adaptations to living quarters including showers, toilets, control switches for the home, kitchen equipment for the preparation of special diets and accessibility, such as ramps, railings, lifts, widened door frames, and retro-fitting bathrooms for accessibility.
safety	Examples: safety-enhancing supports, such as security or emergency response systems. These items must be related to the child's disability and not just something the average citizen might want. For example, door alarms because the child wanders; an intercom system or lifeline system for medical emergencies, or fencing for the child's protection.
home use	Examples: wall light switches, motion detectors, micro-switches, sound-activated switches, or automatic door openers.
repairs and maintenance	Examples: normal wear and tear incurred on modifications, and repairs to the home structure or furnishings due to for damage which is beyond normal wear and tear and caused by the family member with a developmental disability who has destructive behaviors. Coverage can include the cost of actual repairs, as well as purchased maintenance contracts.
assessment	Examples: assessing the need for, arranging for, providing and maintaining home modifications.

ASSISTIVE TECHNOLOGY

Assistive Technology services may include the evaluation of the child's need for assistive technology related to the disability; helping to select and obtain appropriate devices; designing, fitting and customizing those devices; purchasing, repairing or replacing the devices; and training the child and/or family to use the devices effectively.

Assistive technology services include devices and services that will help a child with a developmental disability and the child's family to overcome barriers related to the disability that they face in their daily lives. This may include the use of devices to help the child move around such as wheelchairs, wheelchair adaptations, and adaptations for vans (e.g., lifts for vans or roof storage for wheelchairs), devices that help the child communicate such as electronic communication devices **(excluding cell phones, pagers, and internet access unless prior authorized by the State CES Program Manager);** devices that make learning easier such as adapted games, adaptive recreational equipment, toys or computers; and devices that control the environment such as switches. **Monthly Billing category: Assistive Technology**

***EXAMPLES* include:**

communication	Examples: expressive and receptive communication augmentation including electronic communication boards, hearing aids and adapted computers.
safety	Examples: safety enhancing supports, such as electronic monitoring monitors for the house, intercom system, safety covers or cabinet locks, customized shoes for stability, an organizer/reminder for medications, or a telephone with programmable numbers for emergencies, if the cost is above and beyond that of normal daily living expenses also incurred by children without disabilities.
skill acquisition	Examples: skill acquisition devices which are proven to be a cost effective and efficient means to meet the need and which make learning easier, such as adapted computers, computer learning software, or educational games, related to the child's disability.
mobility devices	Examples: mobility devices to help children move around, such as wheelchairs, wheelchair adaptations, and adaptations for vans (e.g., lifts for vans or roof storage for wheelchairs) to enable access by the child with a developmental disability. *Must not be available under State Plan or EPSDT.*
repairs and maintenance	Examples: normal wear and tear incurred on assistive technology devices. Coverage can include the cost of actual repairs and replacement, as well as purchased maintenance contracts.
assessment	Examples: assessing the need for, arranging for, designing, fitting and customizing those devices, and maintaining such devices.
training	Examples: training the child and/or family to use the devices effectively.

Recreational Equipment

Recreational Equipment is to be used for recreational adaptive equipment and devices which are needed for the child to participate in recreational activities. The equipment must be necessary due to the child's disability and be adapted to the disability. CES will not pay for typical sports

equipment such balls, bats, bicycles, shoes, uniforms, tennis racquets, etc. These are considered typical expenses for children with or without disabilities.

Examples **include**:

recreational equipment

Examples: items related directly to supporting the child to engage in recreational activities which are necessary due to the child's disabilities, whether in their home or in their community, are identified in the IP and are above and beyond costs normally incurred by a family with a child without a disability, such as various types of balls with internal auditory devices, adaptations for positioning in order to participate in the activity like a floatation collar for swimming or a bowling ramp, adaptation to existing equipment like special grips for a bat or a three-wheeled bicycle for stability, and other types of equipment.

General Exclusions for Environmental Engineering

- Devices and services must not be available under the regular Medicaid State Plan *(HCPF rule 8.590)*, EPSDT *(HCPF rule 8.280)*, third party source, or other State or Federal funded programs. Many, if not most items, are covered under EPSDT. It is highly recommended that CCBs get a WRITTEN denial from Medicaid prior to use of CES funds.
- Excluded items and services include those adaptations or devices for the child's environment which are not associated with a direct medical or remedial need of the child, such as carpeting, roof repair, central air conditioning, regular clothing, etc., as well as adding square footage to a residence.
- Normal operating expenses for vehicles, such as vehicle repairs, maintenance, and car insurance, are not allowable costs. These types of costs are inherent with ownership of any vehicle.
  (*Note: reasonable associated vehicle modifications at the time of initial installation to accommodate a device, such as a lift, are allowable (e.g. heavier shocks due to the weight of the lift). Ongoing maintenance of the specific device, such as the lift itself, is also allowable*.)
- Vitamins, food supplements, any food items (including organic foods) are excluded.
- Medicines (FDA and Non-FDA approved, prescription and over-the-counter) are excluded.
- Touch Therapy is not an allowable CES service.
- Cell phones, pagers, and internet access are excluded unless prior authorization is received from the State CES Program Manager.

General Limitations for Environmental Engineering

- A combined total of Home Modification and Assistive Technology (which includes recreational equipment) are limited to a maximum of $10,000 per child within a five year period beginning July 1, 1998, and again July 1, 2003, except that on a case-by-case basis the State (DDS) may prior authorize additional funds for a child. Exceptions to this

limitation will only be considered if it can be demonstrated that the excess costs will substantially reduce the ongoing need for human assistance (i.e. the amount of paid staff time is reduced long-term).

- CCBs must use reasonable and prudent practice for the purchase of all items (e.g. Home Modification and Assistive Technology). When appropriate, multiple bids should be obtained to ensure that a reasonable value for the item is considered. The child's file should contain adequate documentation for decisions made.
- DDS is recommending that CCBs use a $3,000 benchmark for computers and therapeutic (hot) tubs. Although documentation of need is always required, if the cost for such items exceeds a $3,000 benchmark, there should be heightened scrutiny on the part of the CCB to ensure that the item is cost effective and that no other reasonable alternatives are available which could meet the need.
- All devices and adaptations must be provided in accordance with applicable State or local building codes and/or applicable standards of manufacturing, design and installation.

Specialized Medical Equipment and Supplies

Specialized medical equipment and supplies means:

- devices or items related directly to supporting the child in their home or community,
- are necessary due to a child's disabilities,
- identified in the IP and,
- are above and beyond costs normally incurred by a family with a child without a disability.

The need for such items should be age adjusted for the child and what would be considered necessary due to a disability and not the age of the child (e.g. children under the age of 3 normally use diapers whereas a twelve year old would not). **Monthly billing category: Specialized Equipment**

Ä **<u>Note</u>: There have been changes in the regular Medicaid State Plan over the recent years which make most of these items covered under the State Plan. CCBs are strongly encouraged to research with the County DSS or State Medicaid Office as to whether or not any of these items are allowed under the State Plan. (Written documentation is preferred)**

<u>EXAMPLES</u> include:

medical equipment	<u>Examples</u>: specialized medical equipment which is available only through a medical supply company, such as respiratory or heart monitors for sleep apnea, or equipment for sterilization (<u>these are examples only</u>).

	Items available under the Medicaid State Plan, EPSDT or third party source are excluded.
non-medical equipment	Examples: equipment which may be generically available to anyone but the need for such devices are directly the result of caring for the child with a disability, such as a specific kitchen appliance for the preparation of specialized diets if this results in a cost saving over prepared foods, and portable humidifier or air-filter devices for respiratory problems. *Items available under the Medicaid State Plan, EPSDT or third party source are excluded.*
general care items	Examples: products which are directly applied to the body or absorbed by the body, such as non-prescription body lotions, lubricants and ointments, etc. All such items must be required by a child with a developmental disability due to his or her disability or medical condition, and are documented as being above and beyond typical costs incurred by families with child without disabilities. *It must be first considered whether these types of items are available under the Medicaid State Plan in the form of a prescription from a physician. See exclusions below.*
supplies	Example: supplies (disposable or durable) used by the caregiver when caring for the child, including supplies related to the operation or maintenance of medical equipment, such as distilled water for saline solutions, adaptive eating utensils for use by the child or specialty utensils necessary to feed a child, baby wipes for chronic rashes in older children with incontinence, gum swabs for dental care, disposable gloves, cleaning or sterilization materials for medical equipment etc. *It must first be considered whether these types of items are available under the Medicaid State Plan in the form of a prescription from a physician.*
specialized clothing	Example: specially designed or adapted clothing necessary as a result of the child's disability and the cost is over and above the costs generally incurred for a child's clothing, such as Velcro to adapt existing or regular "off-the-rack" clothes, personal clothing made for a specific child's need. *The cost of the actual "off-the-rack" store bought clothing is not an allowable expense, only the cost of the modification. Specialized clothing does not include any heavy wear-and-tear replacement or the purchase of heavier duty clothing available to all customers, such as heavy-duty jeans.*
repairs and maintenance	Example: normal wear and tear incurred on specialized equipment. Coverage can include the cost of actual repairs and replacement, as well as purchased maintenance contracts.
assessment	Example: assessing the need for, arranging for, designing, fitting and customizing those devices, and maintaining such devices.

General Exclusions for Specialized Medical Equipment and Supplies

- Devices and services must not be available under the regular Medicaid State Plan *(HCPF rule 8.590)*, EPSDT *(HCPF rule 8.280)*, third party source, or other State or Federal

funded programs. Many, if not most items, are covered under EPSDT. It is highly recommended that CCBs get a WRITTEN denial from Medicaid prior to use of CES funds.

- Excluded items and services include those adaptations or devices for the child's environment which are not associated with a direct medical or remedial need of the child, such as carpeting, roof repair, central air conditioning, regular clothing, etc., as well as adding square footage to a residence.
- Normal operating expenses for vehicles, such as vehicle repairs, maintenance, and car insurance, are not allowable costs. These types of costs are inherent with ownership of any vehicle.
  (*Note: reasonable associated vehicle modifications at the time of initial installation to accommodate a device, such as a lift, are allowable (e.g. heavier shocks due to the weight of the lift). Ongoing maintenance of the specific device, such as the lift itself, is also allowable*.)
- Vitamins, food supplements, any food items (including organic foods) are excluded.
- Medicines (FDA and Non-FDA approved, prescription and over-the-counter) are excluded.
- Touch Therapy is not an allowable CES service.
- Cell phones, pagers, and internet access are excluded unless prior authorization is received from the State CES Program Manager.

General Limitations for Specialized Medical Equipment and Supplies

- A combined total of Home Modification and Assistive Technology (which includes recreational equipment) are limited to a maximum of $10,000 per child within a five year period beginning July 1, 1998, and again July 1, 2003, except that on a case-by-case basis the State (DDS) may prior authorize additional funds for a child. Exceptions to this limitation will only be considered if it can be demonstrated that the excess costs will substantially reduce the ongoing need for human assistance (i.e. the amount of paid staff time is reduced long-term).
- CCBs must use reasonable and prudent practice for the purchase of all items (e.g. Home Modification and Assistive Technology). When appropriate, multiple bids should be obtained to ensure that a reasonable value for the item is considered. The child's file should contain adequate documentation for decisions made.
- DDS is recommending that CCBs use a $3,000 benchmark for computers and therapeutic (hot) tubs. Although documentation of need is always required, if the cost for such items exceeds a $3,000 benchmark, there should be heightened scrutiny on the part of the CCB to ensure that the item is cost effective and that no other reasonable alternatives are available which could meet the need.
- All devices and adaptations must be provided in accordance with applicable State or local building codes and/or applicable standards of manufacturing, design and installation.

PROFESSIONAL SERVICES

Professional services, **when not covered under the regular Medicaid State Plan, EPSDT *(HCPF rule 8.503.100)*, or third party source** include: evaluation and assessment that requires the service provider to be licensed or certified in a particular occupational skill area. Also included are personal care functions (including the operation of medical equipment) requiring professional care by an RN, LPN, Physician's Assistant or other such licensed or certified medical personnel. The key factor for determining if a service is a professional service is: Does the person need to be licensed or certified to perform the service? (i.e. Occupational Therapy, Physical Therapy, Communication Services (Speech Therapy), and PC Licensed Medical Care. **Monthly billing category: Professional Services**

EXAMPLES include:

expressive/ receptive communication	Examples: visual, auditory, verbal and gestural means to convey one's thoughts, needs or wants or understand those of others. *Examples of interventions include speech language therapy and sign language. Services are performed by a person. Needed devices are covered under Assistive Technology.*
wheelchair mobility	Example: independent use of a manual or motorized wheelchair in the person's home or community. *Examples of interventions include occupational therapy and mobility training.*
range of motion	Examples: significant limitation of movement of joints or muscles due to problems, such as contractures, hyper-tonic muscles, hypo-tonic muscles, medical conditions which require regular movement, stretching or therapeutic intervention to prevent deterioration. *Examples of interventions include occupational and physical therapy, as well as consultation for programs implemented by others.*
arm use	Examples: significant impairment of gross motor skills, such as lifting, reaching, carrying, use of elbow or wrist. *Examples of interventions include occupational and physical therapy.*
hand use	Examples: significant impairment of fine motor skills, such as pincer grasp, object manipulation, eye-hand coordination, general grasping, or rotation. *Examples of interventions include occupational therapy.*
ambulation	Examples: gross motor skills involving use of legs, such as walking, crawling, climbing stairs, jumping, and balance. *Examples of interventions include physical therapy and occupational therapy.*
medical	Examples: personal care functions and physical ailments which require the attention a medically trained personnel. *Examples of interventions include a registered nurse, licensed practical nurse, physician's assistant or other such licensed or certified medical personnel which is not covered under the regular State Plan. This may also include operating medical equipment.*
training	Examples: consultation and direct service costs for parent(s)/guardian, family members, or other care providers for training associated with providing unique support services to a child, such as sign language training for a volunteer, techniques for caring for the child, and behavioral intervention training. This type of training is child and need specific.

	Includes acquisition of information for family members of children with developmental disabilities from support organizations and special resource materials (e.g., publications designed for parents of children with developmental disabilities). *This service is not meant to replace or fund an agency's responsibilities for staff training or independent contractors who should already possess the skills to perform the functions. It also does not include generalized training or employment requirements, such as CPR, rights protections, or agency policies and procedures which would be required of all personnel.*
evaluation & assessment	Examples: diagnostic, evaluation and testing services necessary to determine the child's health and mental status and the related social, psychological and cognitive needs and strengths, including genetic counseling and family planning.

General Exclusions for Professional Services

- Professional services must not be available under the regular Medicaid State Plan, EPSDT *(HCPF rule 8.503.100)*, third party source.
- Examples of services which must not be reported under professional services but may require licensing or certification include plumbing services, carpentry, and money management.
- Home health services are provided by a home health agency and are characterized as either supportive care or personal care.

General Limitations for Professional Services

- Medical services must be provided by appropriately qualified personnel. For example, therapies must be prescribed by a physician or licensed/certified therapist (e.g. Occupational, Physical, or Speech/Language Therapy) and may include related support activities which are recommended as part of the therapy (e.g. exercise passes, Para-professional used to carry-out maintenance type therapy).
- If the intervention is provided by someone other than the core professional service which completed the initial evaluation and referral (i.e. music therapist, chiropractor), the service is still reported under the service category of professional services and provisions must be made for the periodic re-evaluation by the appropriate core service professional to determine if the intervention is achieving the expected outcome. Related support activities which are part of the intervention activity (e.g. music therapy, chiropractor) are NOT allowable costs. For example, supplemental vitamins or herbal supplements recommended by a doctor of naturopathic medicine are not allowable, but a consultation from the naturopathic doctor, if recommended by a medical physician and supported by the child's needs, is allowable.

BEHAVIORAL SERVICES

Behavioral services are provided for a child with a developmental disability when challenging behaviors interfere with activities of daily living, social interaction, or other similar situations. Such

behaviors would be beyond those typical experienced in child development for a child of similar age without disabilities. **Monthly billing category: Behavioral Services**

EXAMPLES include:

intervention	Examples: a wide range of behaviors, such as self-abuse, aggression toward others, destruction of property, repetitive self-stimulation, pica, screaming, etc. *Examples of interventions include counseling services, such as individual and/or group counseling, behavioral interventions related to the child's disability, needed to sustain the overall functioning of the child with a developmental disability.*
consultation	Examples: diagnostic evaluations, and consultations with family members or other professional providing services, setting up behavior plans to be implemented by others.

General Exclusions for Behavioral Services

- Behavioral services must not be available under the regular Medicaid State Plan, EPSDT *(HCPF rule 8.503.100)*, or third party source.

General Limitations for Behavioral Services

- Assessment to determine behavioral needs must be provided by appropriately qualified personnel with expertise in behavioral services.
- If the intervention is provided by someone other than a behavioral specialist, licensed psychologist or psychiatrist who completed the initial evaluation and referral (e.g. music therapist), the service is to be reported under the behavioral services category and a behavioral professional must provide for a periodic re-evaluation to determine if the intervention is achieving the expected outcome.

COMMUNITY CONNECTION SERVICES

Community Connections services explore community services appropriate to the child in the community, natural supports available to the child, match and monitor community connections to enhance socialization and community access capability. ***Monthly billing category: Community Connection Services***

EXAMPLES include:

recreation & leisure activities	Examples: financial assistance for fees to participate in recreational or community activities due to physical or mental impairments, or needing behavioral support, recreational programs that will allow the child with a developmental disability to experience typical community leisure time activities, increase their ability to participate in these activities and develop appropriate physical and psychological-social skills. *These are for the child with a developmental disability (**Limited to $500 per year).** Specifically excluded are tickets for movie, theater, concerts and professional and minor league sporting events.*
community connector	Examples: exploring community services appropriate to the child in their community, natural supports available to the child match and monitor community connections to enhance socialization and community access capability.

General Exclusions for Community Connections

- Family members who live in the same household as the child receiving services may not be paid for any other services other than personal supports (e.g. NOT community connectors, household services, child care services, etc.).
- Uses of CES for community activities which are of an entertainment nature are excluded. For example: the cost of admission to professional or minor league sporting events (e.g. football, baseball games), movie, theater or concert tickets. This exclusion pertains to the cost of entrance for the child with a developmental disability. If that child needs supervision or assistance from a paid staff person in order to attend, the cost of admission for the staff person may be included as a CES expense in the child's IP. CCBs should monitor use of this carefully to ensure that the need is legitimate, it is identified in the child's IP and is not overused or misused to the benefit of a paid staff person. No family member (i.e. parent, sibling, extended blood relative, etc.) may have the cost of admission paid.
- The cost of meals or any food items for the child with a developmental disability or others, as well as for staff are excluded. It does not matter whether the community activity lends itself to the availability of food, such as community training for appropriate behavior or ordering meals in a restaurant. The staff time can be covered but <u>not</u> the expense of the food items.
- Recreation and Leisure activities are limited to $500.00 per year.

General Limitations for Community Connections

- Unlike the case manager, a community connector is an optional service and each child's plan may be built to include the cost of this service to the degree that the child needs this type of service.
- Only the actual hours of service provision may be counted toward reimbursement and are considered allowable encounter data to be reported in CCMS.
- Recreation and leisure needs must be directly related to the child's disability, <u>or</u> to the direct enhancement of social or community inclusion for the child with a developmental disability, and must be identified in the IP as a need. CES is intended to "assist" the child to be able to engage in activities typically enjoyed by all citizens by helping to offset any barriers or extra burdens caused by a disability or which are habilitative in nature. Reasonable judgment needs to be exercised when considering what is meant by "community inclusion" (i.e. Durango is not "community" for someone who lives in Denver).

Process to Determine if a Service is Allowed

The previous list of reporting categories included several examples. Although the list is comprehensive, it is not exhaustive. Because of the flexibility of the CES program, unique

situations or circumstances come up that need to be addressed. The CCB has the ability to make decisions about how their CES funds are spent and the responsibility to ensure proper use of CES funds*****. The "Process to Determine if a Service is Allowed" has been developed to be utilized in the decision making process.

There are several reasons why it is important to utilize the "Process to Determine if a Service is Allowed" when making decisions about services and supports:

- CES funds are public funds and while flexibility is important, so is accountability to the public for efficient use of limited resources.
- In order to effectively balance individual tailoring and maintain a level of accountability, the following "Process to Determine Eligibility" has been developed to be used at the local level.
- This process should provide for statewide consistency in application of how services and supports are allowed statewide, as well as provide flexibility for individual situations.
- Ultimately, the CCB must be able to logically and rationally support the decision-making process and be able to justify or defend its use of CES funds.
- This process contains some key determinants which provide guidance in the decision-making process and which lead to more sound judgments, as well as adherence to the intended use of CES funds.
- CCBs are charged with the responsibility for prudent management of limited resources available and it is a responsibility that will require appropriate staff training and support in making good decisions.

***** For example, the use of CES funds to purchase services, equipment, or supplies available through the regular Medicaid State Plan, ESPDT or Third Party Source would put the CCB at risk for loss of Federal Financial Participation (FFP). While CCBs have pointed out extenuating circumstances under which a reasonable person would consider making an exception (e.g. having to drive from Grand Junction to Denver to find a Medicaid provider), <u>any exceptions made to the requirement to utilize State Plan benefits, EPSDT or Third Party Source for CES will be taken at the CCB's own financial risk and the cost of this may be recovered by the State</u>

It is strongly recommended that documentation be kept in the child's record for any services or supports, provided <u>or</u> denied, which would or could be considered controversial or outside usual and customary services. The flexible nature of allowable services and supports places a great deal of responsibility on local agency/staff to make rationale decisions with criteria that can be consistently applied to a wide variety of individual situations. This type of formal documentation will be helpful to the family and the agency in understanding how a decision was made to approve or deny a service or support.

The "Process to determine if a Service is allowed" is divided into two stages, consideration of Primary Factors, and then consideration of Secondary Factors.

All <u>Primary Factors</u> must be met. If all Primary Factors are not met the service/support will not be allowed. Once all the Primary Factors are met, the Secondary Factors are to be considered.

The <u>Secondary Factors</u> provide the more interpretive element of the decision-making process and influences how an approval or denial is supported. Questions to consider are; "What are the

mitigating circumstances?" and "What impact does this have on the child/family?" It is important to note that the **CCBs must remember to separate the identification of a "need" from the availability of a "service".** A CES service should **NOT** be provided just because it is available under the program or because the parent(s)/guardian wants it. A need must first be identified on the IP, and all options for meeting the need examined. (See Appendix B for *SAMPLE* Decision-making Guide which can be used to document the answers to the questions identified below.)

Ä **Note: Determining the whether or not a proposed service or support is allowed is an important step but it does not guarantee that CES funds would be used to provide the service. Even if a service or support is allowable, it may not be available due to provider availability, service may be currently available through another source, available funding or other issues**.

Primary Factors

Primary factors must be answered as indicated below for each item. A brief description may be required to confirm or support how the answer was concluded.

A) The services and supports are not specifically excluded by the State. (NO)

Exclusions are described within each service category listed in this section. CHRS/DDS has an ongoing responsibility to monitor the types of services and supports provided at the local level through CES to determine whether or not the overall purpose and intent of CES is being met. There may be occasions when factors, such as the potential for misuse, public perception, cost effectiveness, etc. will require that a service or support be added to the list of excluded items in order to preserve the overall integrity of the program even though a single child may have benefited.

B) The needs, goods, and/or services are related to the child's disability. (YES)

For example, sunglasses could be an allowable expense for a child with autism to reduce excessive light which may trigger disruptive behavior, but not allowable for a child who does not have a disability which is impacted by excessive light. Making a connection to how a disability creates a need should be readily apparent when explained to a reasonable person. The greater the amount of convincing or stretching needed to justify the connection, the greater the likelihood that the service or support should not be allowed.

~~B)~~C) The needs, goods, and/or services are above and beyond typical daily living expenses normally incurred by a family raising a child. (this may include all or partial costs) (YES)

CES funds are not intended to mitigate or compensate for a family's general economic situation (i.e. CES is only involved because of the impact of a disability and not due to a general need, such as food, shelter, clothing, entertainment, transportation. These are things needed by all families, and there are other programs or agencies which address these issues.). CES funds can be used for costs related to expenses which are above and

beyond typical daily living expenses (e.g. the cost associated with specialized clothing or adaptive equipment).

~~C)~~D) The needs cannot be reasonably met by some other means. (NO)

It is important to consider the intent of the CES program to build upon existing natural supports and generic community services and wherever possible to use these prior to use of CES funds (what do you have? or what is available to you?). For example, mental health services should be accessed from the Mental Health agency rather than CES funding the service, or behavioral services available through a school district. The intent of CES is to provide "support" for targeted areas of need and not full program services for a child. Sometimes, CES will work in conjunction with other sources, but if a service or support is available elsewhere and can reasonably meet the need, the child should first access those services and supports.

Ä **Note: If the service or support fails to meet any of the Primary factors listed above, the service or support is not allowed for funding under CES.**

Secondary Factors

The following factors require more consideration as to what mitigating circumstances might exist and the impact of these circumstances might have on the child. However, generally an answer of YES would be needed for these questions.

E) Would the decision hold up to public scrutiny?

"How would a reasonable person react if he or she were to read in the newspaper about taxpayer dollars going to fund this activity?" Remember that the general public will view this service in the context of other general societal needs as well, such as programs for the homeless, persons with mental illness, foster care, etc. This does not mean that the general public would have to agree with the service without any information. However, sufficient justification should be available such that the public could be convinced of its necessity and reasonableness. It also does not mean that fear of public scrutiny should keep us from making decisions which are clearly the best use of public funds in meeting the needs of children with developmental disabilities.

~~B)~~F) Are the goods and services appropriate to meet the need?

Even though a service may be technically allowable or meet other factors, consideration must be given to whether the service requested can reasonably be expected to address the identified need. Do the proposed goods or services achieve the outcome intended or have a good chance of achieving it?

~~C)~~G) Are the requested goods or services essential to meeting the basic level of need due to a disability **and** are they cost effective in addressing the identified need relative to other possible service methods?

The parent(s)/guardian's preference is one consideration, and prudent use of public funds is an equal consideration. CES is intended to meet the need at the basic level in a cost-effective manner:

- *First, be clear about what the need is and how it relates to the child's disability. How essential is the need to daily living areas, such as health and safety, or maintaining independence in the home or community?*
- *Second, look for existing personal resources of the family, other funding sources or generic community services which may meet the need.* ***An identified need does not automatically result in CES funding to meet the need.***
- *Third, if CES funds are required, what is the least expensive means which will adequately and cost effectively meet the need? This does not mean that there are not exceptions to the rule. Generally, CCBs should not be funding higher cost items when a similar (available) item for less cost can meet the need. For example, under home modification for wheelchair accessibility, if a doorway needs to be widened, the door and frame should be of standard building materials. CES should not pay for upgrades or costs which are beyond the basic materials needed (i.e. a solid cherry wood door is beyond what is necessary, even if the rest of the doors in the house are cherry wood). The parent(s)/guardian may choose to supplement the difference to accommodate their own tastes. Prudent cost comparison should be used at all time.*

Again, CES funding is to be used to ***Meet the Basic Need in a Cost Effective and Efficient Manner****. At the same time, there are occasions when a more expensive service may be needed to meet the basic need or it may be more cost effective in the long run. The term "cost effective" can have many different factors which influence the interpretation of, "Did I make the best use of the limited funds available?"*

The CCB must support and document such uses which are beyond the least expensive alternative but are still considered to be cost effective.

One area of particular note is the use of computer equipment. There are situations in which a computer might be the most appropriate means by which to meet a communication or habilitative need. However, is it the least expensive means, does it meet the basic need cost effectively?

CHRS/DDS is concerned that use of this viable and important alternative has become common place and is not being adequately considered at the local level for its appropriateness to meet a need in a reasonable and inexpensive manner. Good judgment and supporting documentation must be used in making a determination as to why a more expensive approach should be used to meet a need through use of a personal computer. It is not sufficient that the parent(s)/guardian prefers it or it's within an allowable price range or because someone else received it. Each circumstance must be considered on its own merits, the intended outcome and documented needs.

DDS is recommending that CCBs use a $3,000 benchmark for computers and therapeutic (hot) tubs. Although documentation of need is always required, if the cost for such items exceeds a $3,000 benchmark, there should be heightened scrutiny on the

part of the CCB to ensure that the item is cost effective and that no other reasonable alternatives are available which could meet the need. Another alternative to consider might be the use of leasing arrangements for computers. Check out rule with regard to computers and hot tubs.

H) What is the impact (small or large)?

This factor might apply when considering the impact of the goods or services relative to their costs (i.e. high cost services might be more likely to be approved if the impact is great than if it is small.). Is it a short-term or long-term commitment of funds? Will it reduce or eliminate the need for ongoing system supports?

~~B)~~I)Other

There may be other factors which have not been identified in the above list which pertain to a particular situation and are an important consideration. For example, is this an extended family or a single caregiver, does the family have sufficient resources (income) to cover the cost of the goods or services without assistance, is this a short-term crisis situation, does the timeliness of the need require a quick response, etc.? Be sure to include sufficient documentation as to why an additional factor should be considered.

Frequently Asked Questions

07/02

1) **What risks do CCBs have if it is determined that services could have been provided through the Medicaid State Plan or ESPDT after the CCB has already paid for the service under CES?**

   Under CMS and/or State review, a determination will be based on specific circumstances. However, CCBs should be aware that recovery of funds is one of the outcomes available to the State and Federal government.

2) **Is there any rationale CHRS/DDS will accept for not using the Medicaid State Plan or ESPDT?**

   CHRS/DDS and CCBs are held to the requirement that if a (professional) service is covered under the regular Medicaid State Plan or ESPDT it must be paid for through that source. Proof of denial of that service or the level of that service would meet the requirement. If the CCB decides to make exceptions to this requirement, they will be at risk of fiscal sanctions if audited.

3) **If a CCB is going to provide assistive technology or other services, why does it matter if the CCB accesses Medicaid State Plan funds, or ESPDT, or CES funds, as long as they ensure they don't access both funds?**

   The CES waiver received federal approval on the basis that waiver services would be in addition to those available under the regular Medicaid State Plan or ESPDT. Federal regulations require that "the services proposed to be provided in the waiver must not duplicate services which are provided under the State Medicaid plan or which could be provided under the plan if you choose to do so. However, you may provide services under a waiver similar to those provided under the State plan where they are defined differently under the waiver or where they differ in amount, duration or scope from those provided in the State plan."

4) **If a CCB is having trouble getting an answer from its County DSS regarding whether an item or service is covered under the State Plan, what should the CCB do?**

   Contact the State office of the Department of Health Care Policy and Financing (HCPF).

5) **Are three bids still required for home modification and assistive technology devices over $1,000?**

   The State will not require three bids as a matter of formal practice. However, common sense would indicate that CCBs should be judicious about how they determine whether the purchases are appropriate and reasonable. CCBs are required to have written agency procedures for such expenditures and the child's file should contain documentation of the decisions made.

Frequently Asked Questions

07/02

6) **Why are personal supports the only reimbursable service for family members who live in the same household?**

Personal supports is the one category most easily identified regarding the level of care needed by the child. It covers services which typically make a large impact supporting the child and the family in the family home. It would be difficult for the State to monitoring a broader range of services provided by family member.

~~6)~~7) **Why does CHRS/DDS restrict the amount of funds a family member can be paid as a provider?**

CES is intended to build upon natural supports and generic community services, there must be a means by which to identify a reasonable expectation of what a natural support is and what it provides to the person with a disability. When considering the foundation for supported living, it is important to understand circumstances for each family. Questions such as; "What do you have? What do you need? How can CES help you?" can help with that understanding. CHRS/ DDS realizes the impact of limited funds available and setting limit, however, the developmental disabilities system is one of only a few systems which allow payments to family members, at all.

When a child's needs can be met by utilizing family members, there are several influencing factors which can make this a cost effective means to provide support: 1) there should be reduced administrative and training costs, 2) there is the potential for increased quality of the service provided to the child, as well as reduced turnover rate of providers, 3) there are no workman's compensation payments, 4) there is State precedence for approximately this amount, and 5) reimbursement at a high level would essentially equate to full time employment for a family member to care for another family member in the same household.

8) **Can admissions to entertainment activities be covered for family members similar to that of paid staff?**

No, only the cost of paid staff is covered.

Frequently Asked Questions

07/02

~~8)~~9) **Are any Professional services allowable (e.g. Experimental or alternative therapies, or other services outside of the mainstream)?**

The CES program does allow for a broader interpretation of the types of professional services than those which can be provided under the Medicaid State Plan or ESPDT. Generally, this flexibility is intended to open the door for behavioral services or long-term maintenance therapies which are not covered under the regular Medicaid State Plan benefits. ***Professional services which are commonly viewed as outside of the mainstream must come under increased scrutiny and anything which is experimental in nature should be avoided.*** *CES is a Medicaid waiver funded program and it is expected that CES services are tied back to medical necessity. Therefore, if a professional service being requested is outside of the core professional services: 1) medical (i.e. physician), 2) occupational therapy, 3) physical therapy, 4) speech/language therapy or 5) behavioral services, the service is only allowable if the recommendation for the service has come from one of the core services (with expertise in that area of need) and must still be provided under periodic oversight (re-evaluation) of the referring core professional service.*

For example, it is possible to use a Chiropractor, but there must be a referral from a physician, O.T. or P.T. and a diagnosis supporting the need for such a service. A Chiropractor cannot be used just because the parent(s)/guardian wants to or a Chiropractor says it would be a good idea. Similarly, a behavioral specialist could not make a referral for chiropractic services since a behavioral specialist would not have expertise in this area. Progress is to be monitored by the referring core service, at a minimum, through periodic re-evaluation to determine if the type of intervention is achieving the expected outcomes and continues to be warranted. The referring core discipline should determine the frequency of re-evaluation (considering whether the intervention is for rehabilitation and change is expected which might warrant more frequent but not less than annually deterioration which might involve less frequent reviews). Under behavioral services, the types of intervention are more loosely defined. What is being addressed is an identified behavior and there may be many different means to intervene. For example, music therapy to calm aggressive behaviors, exercise programs developed by a specialist or activities to redirect hyper-energetic individuals. The professional judgment of the behavioral specialist, the IDT and standards of practice should guide the decision-making process.

In their role of overall coordination of services and supports, as well as local authorization for such services, it is recommended that CCBs consider the following types of factors when making a determination of the appropriateness of professional services which would be considered to be outside of the core professional services listed above:

- *the ability to objectively measure progress*
- *how well established is the type of intervention (i.e. is there supporting documentation of the service's efficacy and effectiveness)*
- *how often would the need or benefit of the service be reviewed*
- *should a second opinion be sought*
- *is the cost reasonable given the nature of the service*
- *appropriate federal, state and local licensing, certification or approval may be required.*

10) **Can CES pay for medications beyond what the regular Medicaid State Plan covers?**

No, the CES program is not authorized to cover <u>any</u> medications. *CES participants must access any needed medications through use of the regular Medicaid State Plan, ESPDT or other sources. If a CES participant needs a medication which is not covered by the State Plan or other sources, the parent(s)/guardian must cover the cost on their own or they can submit a request through the normal Medicaid channels to have the medication added to the approved list of medications for the regular State Plan benefits. Over the counter medications are not a benefit of the CES program*

*The child's physician can call **1-800-365-4944** for a prior authorization for medicines which are not routinely covered but may be medically necessary.* ***If a medication is not covered under regular Medicaid State Plan or ESPDT then other sources of funding for prescription medications should be pursued. Often drug companies offer "medical scholarships" and will fund the medication. Ask the child's physician for more information.***

~~5)~~11) **If a family member is accompanying a CES participant to a medical appointment, can mileage be covered under CES?**

No, mileage to and from medical appointments for CES recipients must be covered under the regular Medicaid State Plan benefits and are not covered under CES. Contact your County DSS for information about what options are available for transportation to and from medical appointments.

12) **Can a local CCB refuse to fund a CES service or support?**

As long as a legitimate need has been identified in the IP, it has been determined the service or support is allowed,, it has been prioritized for funding and funding is available within the CCB pool of funds, the CCB would have no basis for denial of a service or support which is allowed within the general parameters of the program (i.e. manual, rules, etc.). A CCB can deny use of a particular provider if the CCB determines the provider does not meet the minimum qualifications. The CCB can deny use of CES funds to support a child in a

situation or environment which would knowingly place that child at risk. In such a situation, the CCB should also consider whether a referral to Child Protection would be appropriate.

13) **Must the Request for Proposal (RFP) process outlined in DDS rules be used for the CES program?**

The rules for the RFP process in DDS rules do not apply to the CES program. The CES program is already designed to maximize the individual's choice of providers.

14) **Can the monthly expense of a telephone be covered if there is documented medical need for such access for which the family cannot otherwise afford?**

Yes, CES funds can be used to pay for basic telephone services. There must be reasonable justification of the need. The first question is; why is this above and beyond what would normally be expected for the family to provide? If the family has the means to pay for a monthly telephone service, they should. If a need is identified in the IP for emergency medical access or a specialized telephone that is needed because of a disability, it might be considered reasonable support for CES to provide these services. CES should pay for only the basic service which will meet the need in a cost-effective manner, and will not pay for long distance calls.

15) **Can a CCB use CES funds for families who travel out-of-state?**

Only under limited circumstances, such as bereavement, medical necessity or short-term trips can CES funds be used for services out-of-state. Out-of-state travel covered under CES cannot exceed two weeks and can only cover personal supports. The personal supports must not otherwise be available under the regular Medicaid State Plan (which will cover up to two weeks). The CCB is still responsible to ensure the provider qualifications, such as using the current provider in the state that travels with the family, using a Medicaid certified provider in another state, or using an adult member of the extended family. Only the cost of the providing the service can be covered (i.e. no food or lodging cost are allowable).

16) **Under CES, can a CCB provide cash funds to a family and have them purchase services directly rather than the CCB?**

No, a CCB cannot provide funds to families for the purchase of services.

Frequently Asked Questions

07/02

17) **The Community Connector role seems similar to the case manager's role. Can you identify the key differences?**

The principle differences are noted below. Based on experience with the CES program, it has become evident that the degree of choice and variety of support options within CES has resulted in an increased workload related to multiple providers, more complex scheduling of supports and more frequent changes in support level. This workload is beyond that originally envisioned for case management, where historically individuals were typically enrolled into a major program which then handled most of the day-to-day scheduling and support need changes. The need for a community connector is dependent on the ability of the family to perform some of these functions themselves. Therefore, a community connector is an optional service which the child/family can receive to the degree needed.

Community Connector	**Case Manager**
• optional service within CES • built into CES plan to the degree needed • key to offering self-determination • personal advisor to assist with day-to-day decisions • can help to select providers - help them to interview, talk to other consumers purchasing from those providers • helps in making arrangements with CES providers, as needed • paid out of CES resources • ability to find own community connector or select from CCB provided list	• not optional, all CCBs must provide this • intake • eligibility determination • assures plan development • helps to find connector, if desired • enrolls into waiver/program • monitors effectiveness of services including connector • paid as separate line in contract

18) **Are there any community connector activities which are not reimbursable?**

Yes, any activities which are necessary to ensure enrollment into to the CES program are considered to be case management functions and are reimbursed only through case management funding. These activities include: gathering information for an eligibility determination, application for Medicaid, application Social Security benefits, gathering and submitting information for a level of care determination (ULTC-100 and LTC-102), CES application, paperwork necessary for DDS Medicaid section prior authorization, and PETI assessments.

Frequently Asked Questions

07/02

19) **What if a child/family doesn't choose to have a community connector and the CCB believes one is needed? What if the plan is approved without a community connector and services aren't being arranged and delivered due to the need for a community connector to help with these arrangements?**

If a CCB believes the child/family needs a community connector in order to implement his or her CES plan and the parent(s)/guardian does not agree, then CCB has a responsibility to work with that parent(s)/guardian to re-negotiate a more appropriate package of supports suited for the child's needs and circumstances. It is difficult to establish a single process by which these types of situations can be resolved. The following are recommended steps which can be taken by the CCB:

1) First, the CCB can counsel the parent(s)/guardian and explain why the CCB believes that he or she has a need for a community connector.

2) If the parent(s)/guardian still disagrees, then allow the plan to proceed without the community connector, but monitor to determine if services are or are not being arranged. (I.e. is the plan being implemented or not?)

3) If all is going well, then no changes are needed.

4) If the plan is not being implemented and some services are not being arranged, then discuss this problem with the parent(s)/guardian.

a) Suggest a community connector again.

b) Counsel that a plan change will be needed to reduce services if they aren't being used.

c) Reconsider appropriateness of CES if the majority of the plan is not being implemented and the parent(s)/guardian continues to refuse a community connector.

20) **What if a parent(s)/guardian wants to select a provider who is more expensive?**

Generally, if the child does not require a higher level of effort to serve, then the resource level associated with their plan will be based on the typical rate for that service. If the parent(s)/guardian wants to select a more expensive provider, the amount of time the provider will be available will be less. Also, the CCB can set restrictions on rates that are appropriate to pay for any given service.

Frequently Asked Questions

07/02

21) **Can a community connector also provide other direct services to the same child?**
The potential for a conflict of interest may increase as role of the community connector and the provider of a direct service becomes the same person, or same agency. Ideally, these two roles should be separated both in the individuals who provide the services, as well as by agencies involved. It is also recognized that there are circumstances when the CCB may be the only provider, thereby limiting choices of providers, and increasing the potential for conflict of interest. Any adjustments which might be necessary should be made gradually with the intent to minimize conflict of interest. For example, if a regularly scheduled provider is unavailable but a service must be provided and no other provider is available, then the community connector might be used as a temporary back-up, providing he or she is otherwise qualified.

It is the CCB's responsibility to make an assessment of service options available within its service area and determine the best course of action. The goal is to minimize the potential for conflict of interest, to the greatest extent possible, in all circumstances, given the available options within a service area. The following chart illustrates the more preferred to least preferred situations.

Degree of Conflict of Interest	Multiple Choice of Providers (different people, different agencies)	Limited Choice of Providers (different people, same agency, different case management agency)
	Low (*most preferred situation*)	**Medium**
	Medium-High	**High** (*least preferred situation*)

Limited Choice of Providers (different people, same service agency, same case management agency)

Single Provider (same person, same provider agency, same case management agency)

Whenever there are multiple provider options available (i.e. in the larger service areas), it is recommended that community connectors not provide other services to the same individual for whom they are the community connector.

Purpose

(Reference C.R.S. 27-10.5-1.2, DDS rule 16.230, HCPF rule 8.503.170, federal application)

What You Will Find

- Purpose
- CMA Agencies
- Service Agencies
- Independent Contractors
- Professionals
- Vendors
- Family Members as Providers
- Background Checks
- Contracting with Agencies
- Frequently Asked Questions

The State has assured the Center for Medicaid Services (CMS) that the standards of any State licensure or certification requirements will be met for services or for individuals furnishing services under the CES waiver. It is important to maintain family choice in selecting providers while keeping in mind that there are serious considerations involving the health, safety and welfare of the child, especially in regards to who is providing what service and under what circumstances. There are basic parameters, which must be followed in order to provide a reasonable balance between the people's right to choose and the State's responsibility to ensure that appropriately qualified service providers are used.

Case Management Agencies

Only Community Centered Boards (CCB) are designated as the Case Management Agency (CMA) for the CES program in each service area. By utilizing the CCB system, CES is able to tap into a greater number of providers and remain flexible in how the providers are utilized while maintaining federal requirements of direct payment to the provider of services. The CMA is authorized to provide services directly; or sub-contract with other agencies/independent contractors for provision of services, to eligible children. It is the responsibility of the CMA (CCB) to ensure the use of qualified providers for CES services.

- **Qualifications**: CCB must receive designation as required by State Developmental Disabilities Services Rules and Regulations Volume 16 (see Appendix C for a copy). Persons employed by the CMA/CCB, as case managers must meet the qualifications for a case manager described in DDS Rules and Regulations. Program Approval for CES must be obtained from CHRS/DDS. The CES agency must also sign the Assurances for the CES program and obtain a Medicaid provider number for the CES program from DDS Medicaid Section. (Contact DDS Medicaid Section for a copy)

Service Agencies

Service Agency means any publicly or privately operated program, organization, or business providing services or supports for persons with developmental disabilities.

- **Qualifications**: The requirements enumerated in DDS Rules and Regulations must be met (see Appendix C for a copy). If an agency provides CES services and is not otherwise regulated by the State or has program approval from CHRS/DDS, then program approval is required for the service agency.

Independent Contractor

Independent Contractor means a free-lance worker who is not employed by an agency and is contracted with to perform a service for a CES participant.

- **Qualifications**: an independent contractor must have experience, training or be able to demonstrate competence to provide the necessary services and support for which he/she is hired. Each CCB must have, at a minimum, a written agreement with the independent contractor, which specifies the expected qualifications and the functions to be performed, and under what conditions. It is the responsibility of the CCB to determine whether an individual meets the definition of an independent contractor according to the federal requirements.

Professionals

Professional means any person performing an occupation that is regulated by the State of Colorado and requires state licensure and/or certification.

- **Qualifications**: any person performing a professional service must possess any and all license(s) and/or certification(s) required by the State of Colorado for the performance of that profession or professional service. Such individuals must meet the federal definition of an independent contractor or be employed by an agency.

Vendors

Vendor means the supplier of a product or service to be purchased for a recipient of services under this waiver.

- **Qualifications**: in order to be approved as a vendor, the product or service to be delivered must meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards. In addition, such expenses must be certified by the Community Centered Board to be within allowable costs.

Family Member as Provider

Family member as provider means an adult eighteen or older, **excluding parent(s) or guardian** such as a sibling or extended blood relative and who lives in the same household as the child receiving services.

- **Qualifications**: any family member paid to provide a service must have experience, knowledge or receive training (per CCB guidelines and hiring expectations) commensurate with the service to be performed. In addition, family members must meet any requirements for special licensure and or certification, if required under Colorado statutes. Family members may only be used as service providers for personal supports under personal assistance services and on an exception basis when no other qualified providers are available or it is clearly demonstrated to be the most cost effective and efficient means to provide the service.

Ä **Note**: **Family members who live outside of the family home are treated the same as any other service provider and must meet all the same qualifications as specified above, depending on employment status or service being performed.**

To prevent a conflict of interest or the appearance of a conflict of interest, family members of program participants, as defined above, will generally not be paid for any services rendered on behalf of a program participant. There may be extenuating circumstances when family members are allowed to provide personal supports. For example, the family lives in a rural area and providers cannot be found, there is documentation of high turnover in paid staff which disrupts the continuity of care, or the person with a disability has very difficult behaviors or special care requirements which are best met by family providing the service (*this is different than just choice or preference*). The CES agency must have procedures, which are applied uniformly for approving and denying such requests.

It is expected that family members who are paid on an exception basis as providers should be able to demonstrate a lower overall cost to provide such services; therefore, a different rate may be paid from that of other agency service providers for the same service. (This is due to the reduction in administrative costs, travel, benefits paid out, etc.) **Reimbursement to family members who live in the same household as the eligible child may not exceed $6,000 per fiscal year.**

Ä **Note: Pursuant to federal regulation, the parent(s)/guardian of a CES participant may not be reimbursed for any services provided.**

Background Checks

(Reference C.R.S. 27-10.5, DDS rule 16.230, federal application)

A critical issue faced by local communities in the effective implementation of CES services is balancing "choice" and "protection" for persons with developmental disabilities. Under the CES program, certain steps must be taken to reduce the potential exposure of CES participants to

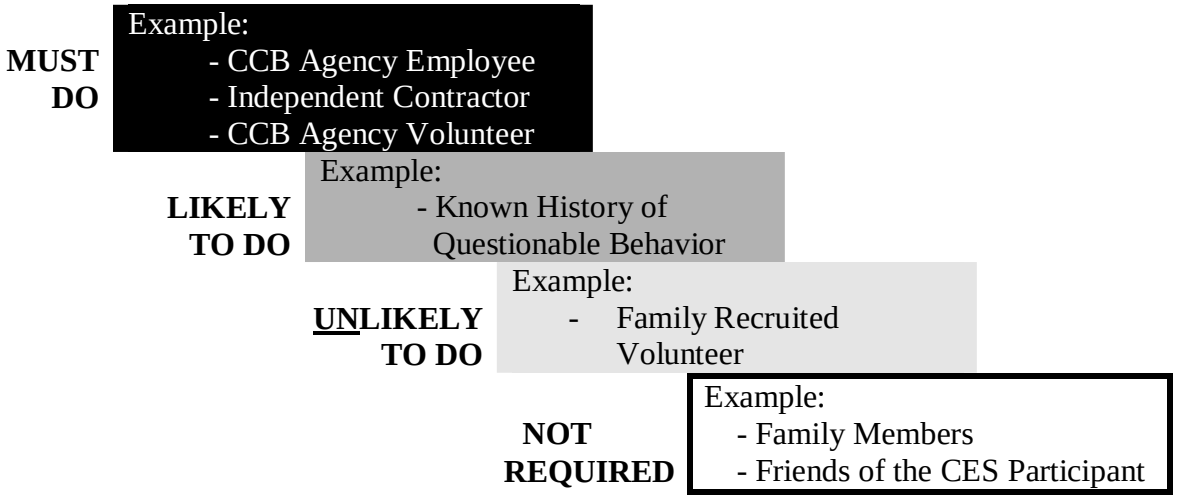
circumstances, which may place their health, safety or well being at unreasonable risk. This section provides information about the use of reference and background checks.

Because the CES program strongly encourages the use of natural and generic community supports in addition to developing community connections, CES participants may experience the same "risk" associated with typical community living as other citizens. However, we must also recognize and actively address the potential vulnerability of CES participants, which may be above and beyond that of other community citizens. With the array of individualized arrangements envisioned for CES participants, there is not a clear-cut answer as to how to address or prevent every circumstance, which may place the participant at risk. The following description creates a framework, which can be used to put into practice a decision-making "process" to determine when reference and background checks are necessary. In some situations, the answer is quite clear and there are no exceptions.

As services and supports are developed for a wider variety of CES participants, the decision who to hire can become a complex issue. In order to make a *reasonable* determination, there are certain factors to consider.

There may be some <u>rare</u> situations in which an otherwise qualified person (even a family member) with a criminal history may appear to be the best person for the job. This is HIGHLY discouraged. It is recommended that CES providers be extremely cautious about knowingly employing, contracting with or accepting volunteer services from <u>individuals</u> who have been convicted of child or recipient abuse, neglect or mistreatment or a felony involving physical harm to an individual. CES providers need to ensure that no other reasonable alternative is possible and that prudent safeguards are in place to prevent any unnecessary risk of harm to CES participants

The following representation illustrates a decision-making process for conducting background checks that includes both ends of the spectrum, the "must do" and the "not needed", as well as what is in between. Each situation requires individual judgment to determine the appropriate course of action. The key objective is the child's health, safety and well being.



MUST DO — There are certain individuals who must have reference and background checks completed regardless of the circumstance. These include:

- All CCB agency employees or purchase of service agency employees who have direct contact with CES participants
- Independent Contractors
- Any CCB agency recruited volunteers

(Exception)

- If a CCB agency directly employs or contracts with a family member to provide services, no reference or background check is required (but may be optional).

LIKELY TO DO — Although not required, it is recommended that background and reference checks be completed on the person involved. Circumstances may indicate additional. Information is needed even though it may not be "automatically" required. Important questions are; How knowledgeable of the provider (paid or volunteer) is the CCB? Would common sense indicate that some extra precaution would be prudent? Are supports being offered in private or without others around? Are reliable references available? Remember that a family does have choice regarding who they select as a provider of services; however, this choice is not unlimited. The CCB agency may exercise its own discretion if it has concerns about the appropriateness of a particular provider.

UNLIKELY TO DO — General indications are that background and reference check is not needed. The CCB is responsible for exercising reasonable judgment when evaluating the Relationship of the person and the CES participant with the potential "risk" versus "benefit" of the relationship. For example, the CES participant may develop a friendship on their own and the CCB agency knows very little about the person; however, there are no questionable factors to support the need for further investigation.

NOT REQUIRED — Connecting to the community, choice, empowerment, control, decision-making, natural and generic community supports are all terms associated with CES services. An agency's intrusiveness needs to be considered when monitoring who has direct contact with a CES participant. What happens in a typical community when an individual makes choices (how would anyone expect to be treated)? The following are examples of when a reference or background check would NOT be required (but may be optional if an agency has reasonable concern):

- The service provider is a family member
- Friends of the CES participant.

Contracting with AGENCIES

There is a distinction between generic community agencies and service agencies that predominantly serve persons with developmental disabilities. When a CCB agency contracts with a generic community service agency, background checks on individual employees of the service agency are not required to be completed by the CCB agency. The generic service agency must demonstrate the same reasonable efforts as the CCB agency would to screen their employees who would have direct contact with CES participants. When considering whether a service agency would be an appropriate provider, the CCB agency should review the following factors:

- The type of service being provided
- Hiring practices of the agency
- Length of time the agency has been in business
- Track record of the agency
- Better Business Bureau (BBB) reports
- References from other agencies
- Whether or not the agency currently receiving Medicaid funds for other services

The following is ***SAMPLE*** contract language, which may be used by a CCB regarding reference and background checks. Each CCB will need to make a determination regarding the adequacy of such language.

"*Provider agrees to cooperate with all reasonable steps taken by the (CCB) to ascertain that the Provider, or its employees, does not have a history indicating involvement in child or recipient abuse, neglect, mistreatment or exploitation, or have a conviction involving physical harm to an individual. Such reasonable steps might include reference and background checks. Provider agrees that any applicable information will be disclosed in writing to the (CCB) prior to execution of this contract*."

Ä Trust but Verify Ã

A guidebook is available which provides greater direction around employment practices, and background and reference checks. Please reference: "Trust but Verify" distributed March 1998.

Frequently Asked Questions

07/02

1) **If a volunteer provides a service, does it still have to meet the same standards as a CES funded service (e.g. volunteer builds a wheelchair ramp)?**

Yes, the same standards must apply for any construction or devices. CCBs should have standards of practice for agency-recruited volunteers. However, volunteer support services (i.e. companionship, supervision, mentoring) provided by a friend, neighbor, etc. (non-agency volunteers) cannot be regulated. Reasonable monitoring by the CCB would be prudent to determine the appropriateness, as well as health and safety of the CES participant when non-agency volunteers are involved.

~~5)~~2) **Does a family have to use a Medicaid provider for an allowable State Plan benefit or can the family pay for the service under CES and use a non-Medicaid provider of their choice?**

The CES waiver contains some services that are available under the State plan. This was done in order to add to the services provided under the State plan when and if those services exceeded the State plan services in amount, duration, or scope. They were not included to supplant services available from the State plan, EPSDT, or third party source or to accommodate a family's choice or desire for a particular provider over those available through other sources. Use of the regular Medicaid State Plan benefits does allow the family to choose between (albeit not unlimited choice of any provider) all qualified Medicaid providers in the area. Therefore, use of regular Medicaid State plan, EPSDT, and Third Party Source is required prior to use of CES funds to purchase the same services, equipment, or supplies. If a local agency uses CES funds for such goods or services, the CCB will place the State and the CCB at risk for loss of Federal Financial Participation (FFP).

3) **What is an Employment/Reference Check?**

An employment/reference check occurs when the CCB agency solicits and collects third party verification of a person's personal character, employment history or professional credentials. The CCB agency may obtain personal references from the person's friends, neighbors, or others who may have pertinent knowledge of the person, which can substantiate the person's statements about who they are. Professional references are generally obtained from previous employers or educational institutions. The CCB agency does have some discretion in determining the validity of the information received and in assessing its usefulness to the situation.

Frequently Asked Questions

07/02

4) **What is a Background Check?**

A background check is an inquiry or investigation into the person's criminal history. An agency is required to make a reasonable determination of whether the person has ever been convicted of child or recipient abuse, neglect or mistreatment, or of a felony involving physical harm to an individual. A background check must be verifiable. The scope of the background check should include local, state and national searches as appropriate. The length of Colorado residency may be one of the determining factors when considering the scope. Sources generally include the Colorado Bureau of Investigation (CBI), Federal Bureau of Investigation (FBI), fingerprint checks and name checks. There are also a variety of local companies, which can perform background checks.

~~8)~~5) **How is the cost of soliciting background checks paid?**

A CCB agency may include this as part of the cost of administration for the CES program, or it may use it as a condition of employment or a contractual requirement with a service provider who would then include these costs in the rate they are charging.

~~9)~~6) **Who should maintain the reference and background check information?**

The CCB agency must have on record any necessary documentation regarding reference or background checks for individuals with whom the CCB agency directly employs or contracts, exception; family members as providers. If services are purchased through another agency, that agency should maintain the necessary documentation. The CCB agency must have a mechanism, at a minimum, for sampling service agency records to verify the documentation.

~~10)~~7) **How far back in time do background checks need to go?**

There is no minimum or maximum amount of time. Reasonable efforts should be made to gather adequate information.

~~11)~~8) **Must both a reference check and a background check be completed?**

If a background check is required, then yes, a reference check must also be completed. If the background check is optional, then the CCB agency may elect to do whatever combination most appropriately addresses the situation (e.g. background check only, reference check only or both reference and background checks).

~~7)~~9) **For CES, what is the difference between a volunteer and a friend?**

A volunteer is someone who agrees to perform specific types of duties or may act under the direction of the CCB agency or participant. Volunteers are generally considered to be "unpaid employees". A friend has no predetermined relationship with the CES participant and there are no assigned duties to be performed or expected levels of interaction. A volunteer may become a friend or vise versa.

10) **Is there a deadline for when reference and background checks must be completed?**

Reference and background checks are to be completed prior to the provision of direct service to the CES participant. A CCB agency may want to consider having a pool of temporary employees or contractors who have had reference and background checks in the event there is an unexpected absence or change in a service provider. There may be exceptional circumstances when it is not possible to complete reference or background checks prior to providing direct service. In these instances, the CCB agency should immediately begin the process so that the information becomes available as soon as possible.

~~9)~~11) **Can a family member automatically be paid to provide personal care services?**

*No, family members, who live in the same household as the eligible child, can be used as service providers on an **exception basis** when no other qualified providers are available or it is clearly demonstrated to be the most cost effective and efficient means to provide the service. It is expected that family members who are paid on an exception basis as providers should be able to demonstrate a lower overall cost to provide such services; therefore, a different rate may be paid from that of other agency service providers for the same service. Another factor regarding payment to family members is the difficulty it poses concerning existing supports available to meet the needs of child. CES is intended to supplement, not supplant, existing supports. Specifically excluded as service providers is the parent(s)/guardian of a CES recipient.*

12) **When a family member who lives in the same household as the child with a disability is providing personal supports, does the CCB have to maintain a written agreement with them?**

Yes, there must be a written agreement as to the expected services to be provided. Since the family member is providing a service for which they are reimbursed, the CCB must clearly communicate to the family the expected level of service and the reimbursement, as well as other pertinent information. Generally, the IP does not contain sufficient information about this level of expectation.

~~7)~~13) **If CES services are purchased from an agency, may that agency utilize an independent contractor to provide those services?**

No, under the CES program only the CCB may be the CES agency. The CCB may sub-contract discrete services but the sub-contractor may not again sub-contract the services.

DDS Contract Information

(Reference C.R.S. 27-10.5-104.5, DDS rule 16.241)

What You Will Find
- ♦ Contract Information
- ♦ General Parameters
- ♦ Service Area Rate Sheet
- ♦ Reporting & Billing Procedures
- ♦ Payment of Funds to CCBs
- ♦ Strategies for Identifying Funds for Emergencies
- ♦ Sub-contracting
- ♦ Audit Procedures
- ♦ Targeted Case Management Services
- ♦ Frequently Asked Questions

As children in each Community Centered Board designated service area become authorized for enrollment in the Children's Extensive Support (CES) program Children's Health and Rehabilitation contracts with each CCB. The CES contract identifies the total amount of Medicaid funds for CES available for each service area. The contract also identifies the contract control points (e.g. the minimum number of children who must be served in CES, the number of Member Months for CES). In addition to the CES contract amounts, each CCB will receive an allocation in its contract for Case Management Services related to CES and a 15% Management Fee for General Administration and Managed Service Organization (GA/MSO) activities related to CES. These latter funds will be reimbursed on a 1/12th basis each month and reported under Management and General in the audited annual financial statements for the Community Centered Boards.

(See Appendix D for a sample copy of Exhibit #1 and #2 of the CHRS/DDS/CCB contract)

General Parameters

- CCBs must establish an accounting system sufficient to track utilization of CES funds. The system must have the capacity for proper classification of revenues and expenditures.
- CCBs must submit information (encounter data) as specified by CHRS/DDS for reporting (e.g. hours of service) or billing (e.g. home modification) CES services.
- CCBs are required to bill and report utilization monthly, and remain within timely filing for Medicaid billings (i.e. 120 days).
- CES participants may not exceed a maximum of $35,000 per fiscal year for services in CES funds.
- CES participants may <u>not</u> exceed a maximum of $10,000 for environmental engineering (combination of home modification, assistive technology and recreational equipment) over a five-year period beginning July 1, 1998, and renewing July 1, 2004.
- Each CCB must manage its CES program funds so that the annual cost of all CES participants is within the overall Medicaid cost effectiveness average* for its service area. CHRS/DDS will notify each CCB as changes occur in its cost effectiveness average but no less than annually.

* Medicaid **cost effectiveness average** means the average cost of all services provided to all CES participants within the service area for the federal fiscal year (October 1 - September 30). Each CCB is required to ensure that the cost of CES services does not exceed the established average cost for its service area. If a CCB does exceed the average cost, the State and the CCB will lose federal matching Medicaid funds for the amount, which exceeds the average cost effectiveness.

Service Area Rate Sheet

CCBs must submit an annual Service Area Rate Sheet for prior approval by the State, which identifies maximum cost of specific CES services (see Appendix D for a copy). Failure to submit a Service Area Rate Sheet annually for approval will jeopardize the CCB's claim for reimbursement. CCBs must maintain sufficient documentation to support the costs in its Rate Sheet.

The cost of services provided must be within the approved range on the Rate Sheet and be for the cost of the purchased or provided services only. No additional overhead costs for CCB administration or Managed Service Organization (MSO) functions may be added. No service can be reported or billed which has not been identified on the Service Area Rate Sheet.

There is NO pre-set rate for CES services. Although each service area has some latitude in negotiating rates for services, these rates must fall within the overall rate sheet prior authorized by CHRS/DDS. The rate must include all costs (e.g. provider administration, personnel, utilities) related to serving each child. CHRS/DDS reserves the right to set limits on the maximum amount of any rate.

CCBs must make available to any CES participant (parent(s)/guardian) or interested party the list of qualified providers, their service rates and payments options for the CES program within its designated service area.

Payment Options –CCBs can use the following payment options with providers -- **other options may be possible**, but must be submitted for CHRS/DDS review and approval before implementing them. It should be noted that since the CES program is cost reimbursed, there are limitations on what CCBs are allowed to use for payment options and all funds reimbursed for a service must go the provider of the service.

1) ***Hourly*** - provider is paid based on hours of service delivered.
2) ***Outcome*** - provider is paid when some specified outcome occurs.
   Must be prior approved by CHRS/DDS.
3) ***One-time Cost for Object/Service/Registration*** - a single item is purchased at its single unit rate or time/materials, such as the cost to (1) construct a ramp, (2) purchase a communications board, (3) obtain an evaluation, (4) register for a conference, etc.
4) ***Daily, Weekly, Monthly Fee*** - a provider is paid a fee for a service which can be accessed multiple times or is more than hourly, such as paying a monthly membership fee to the YMCA which allows you to come as many times as you like that month or paying for a weekend of child care (e.g. daily rate rather than 48 hours). In some cases, the charge/fee is

not dependent on how often / much / long the program is attended, such as the YMCA example. In other cases, such as a regularly scheduled program, the basis for the charge/fee is dependent on the expected utilization and should be monitored for appropriateness. The monthly approach might also be appropriate for an Insurance/ Emergency Response service (i.e. a monthly charge for a service which may never be needed, but if needed will be offered up to some predetermined level). For example, payment for a 24-hour response to an emergency pager. No fee may cover more than a one-month period of time.

5) ***Multiple Services/Supports*** - multiple is defined as having a single agency providing more than one service (e.g. personal supports and community connection services).

- This is an allowable choice for the parent(s)/guardian.
- Encounter data will be required to be reported by the individual supports and services delivered (e.g., personal assistance, community connections, etc.), not by a "package" provided by a single agency or how the provider is paid (i.e. hourly, monthly, etc.).

Annually, CHRS/DDS distributes a rate sheet which identifies any limitations or current rates paid by CHRS/DDS for services with specific pre-defined purchase of service rates attached to them, such as specialized habilitation and pre-vocational rates under comprehensive services, as well as identifying the fiscal year allocation rates for programs, such as CES where no purchase of service rate is pre-defined. (See Appendix D for a sample copy)

Reporting & Billing Procedures

(Reference DDS rules 16.242, 16.243)

CES follows the same monthly reporting and billing requirements as all CHRS/DDS programs (e.g. billings must be submitted by the 10th of the month, must be in a State prescribed format or form, etc.). Please refer to the CCMS manual for complete instructions for entering data.

Reporting

CHRS/DDS has not prescribed a specific format for collecting the hours and costs of services, as the method of collecting and reporting this information may vary by CCB. Services and supports must be reported in one of the monthly reporting categories (encounter data) for services reported and/or billed by individual:

Service Code	CES Service Category	Reporting Frequency	What to Report (On CCMS)
C05	1) Personal Assistance Services, *includes*:	as used	Total support hours [1] & dollar amount
	• *Personal Supports*		
	• *Household Services*		
	• *Child care Services*		
C08	~~4)~~2)Community Connection Services	as used	Total support hours & dollar amount
C02	3) Professional Services	as used	Bill total hours & dollar amount
C11	4) Behavioral Services	as used	Bill total hours & dollar amount
C13	5) Behavioral Services	as used	Per item
C07	~~15)~~6)Home Modification	as used	Bill actual dollar amount & comment [2]
C06	~~16)~~7)Assistive Technology	as used	Bill actual dollar amount & comment [2]

C10	~~17)~~8)Specialized Medical Equipment/Supplies	as used	Bill actual dollar amount & comment (2)	
C12	~~18)~~9)Item billing for PA/Comm. Conn. Services	as used	Per item	
C13	~~19)~~10)Item biling for Professional/Behavioral Services	s used	Per item	

(1) **Total Support Hours -** this is defined as hours for any activity related to a CES service which is performed by a paid staff person (CCB or otherwise) whether face-to-face or non-face-to-face with the person receiving services.

(2) **Comments Field** - CES service categories do not require input of service hours, but do require both the dollar amount and additional information to be entered into the comments section explaining what has been purchased.

See Section 7 for a definition of these reporting and billing categories. Also see CCMS manual Appendix C for detailed instructions

Billing

The total CES amount is included in Exhibit A of the DDS/CCB contract under the Supported Living/CES section.

CCBs are required to report/bill monthly the utilization of specific CES services as identified in the CCMS billing manual. Each CCB must meet the contract control points identified in Exhibit 2 of the CHRS/DDS/CCB contract. (See Appendix D for a sample copy)

The actual cost of approved services provided is to be billed under the appropriate procedure codes (see below).

Authorized CES Procedure Codes

X1200 - Personal Assistance
X1205 - Professional Services
X1225 - Home Modification
X1220 - Assistive Technology
X1230 - Community Connections
X1327 – Item for PA/Comm. connections
X1331- Behavioral Services (per hourly rate)
X1325 - Behavioral Services (per item, i.e. assessment)
X1329 - Specialized Medical Equipment/Supplies

Payment of Funds to CCBs

(Reference DDS rule 16.242)

The State will make payments to CCBs for the CES programs in the same manner in which all CHRS/DDS payments are made (e.g. within 30 days of receipt of an approved billing). If CES funds are not billed-down during the current fiscal year, the remaining unutilized funds will revert from CHRS to the State coffers as unearned funds.

Section 7 of this manual provides examples of the allowable types of expenditures in the CES program.

General Comparison of CES and FSSP

There has been some ongoing confusion about what is allowable between the Children's Extensive Support program (CES) and the Family Support Services Program (FSSP). Often, there is a belief that CES is just like FSSP – it is not. The chart below helps to illustrate some of the key differences.

	CES	FSSP
Method of Disbursement to CCBs	• Fee-for-service • As invoices are submitted to the State, payment is made for that amount up to a maximum of the CES contract for each CCB.	• 1/12th of contract paid per month • CCBs report services used by FSSP participants, however, 1/12 payment is made monthly regardless of hours reported.
Service Recipient	• Services are available for the CES participant only. (some exceptions for training, see Section 7 for more information)	• Services are available for any family member who lives in the household as the eligible child.
Reporting Requirements	• Uses CCMS reporting categories for CES program	• Uses CCMS reporting categories for FSSP program
Paying Families	• Adult family members who live in the same household as the eligible child may be paid to provide personal supports only and only up to $6,000 per fiscal year. (See criteria in Section 7)	• Family members who live in the same household can be paid to provide personal care services up to $6,000 per fiscal year. Family members can also be paid to provide transportation.
Cash Advances	• Families CANNOT be given cash advances and subsequently purchase services from a vendor. Payment must be made directly to the provider of the service.	• Families can be given cash advances and subsequently purchase services from a vendor. Families must submit receipts or proof of purchase after the fact.
Contract Control Points	• Resources "slots" are child specific - minimum number of children to be served as specified in Exhibit 1. • New enrollments required for new resources allocated. • Member Months in Exhibit #1 are for informational purposes only. • Reimbursement is made only for actual services provided. • Reinvestment plans do not apply.	• Minimum number of persons/families to be served as specified in Exhibit 1. • New enrollments required for new resources allocated. • Member Months do not apply to FSSP. • 85% of funds disbursed must be spent for services. • Any funds not spent for services and which are not adjusted by other control points above are subject to a reinvestment plan.

Strategies for Identifying Funds for Emergencies

Local communities face difficult challenges when funds are limited and needs are not. The key to distribution of limited funds is fairness in treatment of CES participants. The following *EXAMPLES* may assist with flexible management of the pool of funds while being responsive to the needs that arise through the fiscal year. It is up to each service area to maintain a balance.

- Anticipating under-utilization - means that the CCB effectively allocates all of its CES resources in current CES plans and expects that throughout the year, some portion of these funds will be un-utilized by enrolled CES participants. These un-utilized funds can be used to address changes that occur during the year which require an increase in the level of service provided, emergencies situations, one-time or short-term increases, or early start-ups for the next fiscal year.
- Unallocated Set-aside - means the CCB purposefully sets aside some of its total CES pool of funds in order to accommodate changes in service needs during the fiscal year. (If un-accessed,

these funds would not have been earned by the CCB and therefore would revert to the State. Un-utilized funds are again in the base contract for the CCB the following fiscal year unless a specific amendment is completed which reduces the CCB base allocations for the CES program.)

- Targeting non-CES resources for back-up - means that each CCB likely has some amount of local funds available for discretionary use. These types of funds can be utilized to help address unexpected fluctuations in needs and expenses in the CES program.

Sub-contracting

CCBs, as the CES agency in each service area, may provide services directly or through sub-contracting with other qualified agencies or individuals. The terms of any contract or agreement between the CCB and any sub-contractor must be specified in writing. All funds paid for services must go to the provider of the service (i.e. CCB may not include any add-on charges). There are three (3) basic types of contracts the CCB may be utilizing:

1) Contracts between the CCB and agencies, which primarily provide services to only persons with developmental disabilities. These contracts must contain certain State prescribed provisions and minimum requirements.

2) Contracts between the CCB and generic agencies, such as Merry Maids, Joe's Plumbing, or Home Health agencies, etc. These agencies or companies typically have service agreements or bids for example, that articulate the terms of the agreement between the two parties, including the scope of work and payment arrangements. These types of agreements or contracts are acceptable and do not require the same provisions as noted in #1 above.

3) Agreements between the CCB and individual contractors. These typically involve host homes (Comprehensive Services), interpreters, etc. The contract or agreement must contain sufficient information so as to clearly describe the expectations of the provider (including family members when used as a provider), the service recipient and the CCB.

In the event of a termination from services, Developmental disabilities "service agencies", as defined in C.R.S 27-10.5-102 (28) and DDS rules, must abide by the requirements of the appeal process, as defined in DDS rule and continue to provide services during the appeal. This includes any new agency that is formed for the purpose of providing CES services and does not meet the definition for a typical community agency or is not regulated by some other state agency.

When generic community providers are used, the individual is subject to the same customer guarantees, assurances and risks as any other citizen of the community. The additional protections (appeal rights) available when "service agencies" are used, do not apply. Individuals/families should be made aware of when a provider is or is not a service agency. CCBs should also include a clause in all contracts with non-service agencies regarding the expectations for cancellation of a contract by either the provider or the person receiving services.

It is strongly recommended that any written contract or agreement include a clause regarding notice of termination or change in the arrangements. This notice should involve both the provider and service recipient (for *example*, each party will provide, in writing, at least 30 days notice for termination of service).

General Exclusions

Sub-contracted agencies or individual providers (independent contractors) may not sub-sub-contract services. Pursuant to the Social Security Act [1902 (a) 32], payment must be made only to the actual provider of the service. Only the CCB, as the CES agency is authorized to sub-contract for services.

Audit Procedures

(Reference C.R.S. 27-10.5-104.5, DDS rule 16.244)

CCBs must follow the Uniform Accounting and Reporting Procedures for Community Centered Boards and Program Approved Services Agencies, July 1, 2002.

Targeted Case Management Services

(Reference C.R.S. 27-10.5-104, DDS rule 16.400, HCPF rule 8.503.60)

CCBs are required to provide Targeted Case Management services for children enrolled in CES according to DDS and HCPF rules.

The CCB case management must have a minimum of one (1) case management activity each month to bill for Targeted Case Management; and, a minimum face-to-face contact with the child receiving services at least once every other month, unless it is determined through the IDT process and requested by the parent(s)/guardian that a different monitoring schedule be arranged in order to reduce intrusion into the family's personal life. The CCB must ensure that the any alternative schedule is still appropriate to the child's situation and needs, and that it is documented in the IP.

CCB case management must ensure that alternative monitoring activities are still sufficient to ensure an ongoing awareness of the health and safety of the CES participant. Under no circumstance should an alternative monitoring schedule be more than six months.

When a child (parent(s)/guardian) chooses to enroll in the CES program, they also choose to enroll in Targeted Case Management (TCM). The parent(s)/guardian must be informed of this before enrollment into the CES program. TCM is paid to the CCBs on a monthly fee-for-service basis. Targeted Case Management is not a CES service; it is paid separately from CES. In order to earn the Targeted Case Management contract, each CCB must provide a TCM activity in each month that the CCB submits a claim for TCM reimbursement.

The monthly TCM fee-for-service consists of two units per month. One unit may be billed for any CES participant who is enrolled 15 calendar days or less during the month and two units may be billed for any participant who is enrolled for more than 15 days in the month. CCBs must maintain records, which document their claims for case management services.

1) **What cost effectiveness average must CCBs manage to for CES?**

CCBs will find in Exhibit A of the CHRS/DDS/CCB contract the annual amount for CES for its service area. This is the (average) amount to which individual CCBs must manage their CES funds.

2) **What happens if our service area average cost per plan for CES exceeds the maximum?**

The CCB would be out of compliance with the federal requirement to demonstrate cost effectiveness for the waiver, and therefore would not be eligible for federal financial participant (FFP). The Center for Medicaid Services (CMS) could deny payment of those costs in excess of the cost effectiveness limit. The CCB would still be responsible for payment of services committed to for the CES participants in their service area.

3) Is the $35,000 maximum per any one child for only CES funds?

No, the $35,000 maximum per any one child is inclusive of all CHRS funds (i.e. Medicaid and State funds). If a child has FSSP, this would be considered part of the overall maximum. The $35,000 does not include any other benefits or sources available to the child (e.g. trust funds, food stamps, SSI); it only applies to CHRS funded services and does not include funding for Targeted Case Management services.

4) Can a CCB pay a family who in-turn pays the provider of the service?

Paying the family or anyone else who is not the provider of the service and then having that person in turn pay the actual provider of the service is not allowed under CES (<u>specifically prohibited under federal legislation</u>). The term "Direct Payment" actually refers to the federal requirement that the provider of the service be paid directly. If a family member is providing the service, they can and must be paid "directly". Direct payment requirements do not allow the family to be paid and then subsequently pay the provider of the service or reimburse the family for payment they already made to the provider. ***Anytime someone other than the provider of the service is reimbursed as an intermediary, this is against federal requirements.***

5) Can a CCB provide cash CES payments to families?

No

6) **Can vouchers be used under the CES program?**

Yes, a CCB can provide the CES participant parent(s)/guardian with a voucher (e.g. coupon for services) which are given to a service provider after services are delivered, as long as payment is made directly to the provider of the service by the CCB and NOT through an intermediary.

7) Does the 5% local match apply to CES funds?

Yes, however, the 5% local match requirement for a CCB is based on the overall agency meeting the requirement and not an individual program. The 5% match can come from many different sources (e.g. cash, in-kind, etc.) and these do not have to be directly provided to CES.

8) Can CES funds be used in the current fiscal year to pay for expenses incurred by a child in the previous fiscal year?

No, only expenses, which take place within the same fiscal year, are allowable to be billed during that fiscal year. However, it is allowable to pay for some items/services, which have a usual and customary business practice, which happens to cross over the State fiscal year. (For example; tuition, which is charged to all participants, not just CES participants, prior to service delivery, such as for an Autism Society membership, would be allowed.) This expense may occur in June of one fiscal year (and should be reported in that fiscal year) at the time payment is due for the tuition but the service does not start until July. Other than these types of situations, <u>CES payment must be for expenses in that fiscal year only</u>.

9) Can a CCB use un-needed funds from the Management Fee or Case Management for CES services?

Yes, a CCB can use un-needed funds from the Management Fee or Case Management funds in other areas as determined by the CCB since the CCB is paid the full management fee contract and CM contract (1/12th per month), as long as the CCB is fulfilling its obligation for receipt of the management fee and/or case management funds. All other un-earned funds disbursed by DDS are subject to reinvestment plan requirements.

10) How can the CCB justify different rates for the same service across providers?

Rates for providers do not have to be identical. However, CCBs when negotiating rates with providers must have a justifiable reason for agreeing to any significant variation in rates charged by different providers for the same service. For instance, a difference in level of effort (staffing ratio, differences in staff qualifications, or differences in quality of service) is required to justify significant differences in rates.

11) When reporting service hours for regularly scheduled programs, does the CCB need to determine the actual hours of service each month, or can the scheduled hours be reported? Can the provider be paid based on the scheduled hours?

Basically, the actual hours of services must be reported with two exceptions (note these are the same rules which have been used for reporting hours under Day program and SLS services).

- *When a generic provider or generic employer provides the service and when it would be too intrusive to determine absences or actual hours or a regular basis, such as a personal care provider.*
- *When the child did not make a scheduled appointment and the provider still requires payment. For example, the cleaning crew arrived, but the building was locked and they are charging a minimum site visit, or a therapist has a no-show charge, etc.*

Even for the above exceptions, CCBs should be monitoring services (e.g. monthly, quarterly) to make sure that they are being attended. If the child is not attending regularly, the CCB should then commence reporting actual hours, and if the CCB was paying based on a monthly rate, the CCB should reconsider if this method continues to be in the best interest of the child or not.

It is expected that providers who specialize in services to children with developmental disabilities will continue to report 'attendance' information to the CCB, which will allow actual hours to always be reported.

What is a Grievance

(Reference DDS rule 16.320)

A grievance is any complaint or dissatisfaction expressed orally or in writing to the Community Centered Board regarding the operation of the CES program within a local service area. For example, an individual may be dissatisfied with the selection process used to find a provider and wishes to file a complaint (or grievance). Each local service area is required to have procedures, which meet State requirements for addressing grievances/complaints. The grievance procedure, at a minimum, must state the following:

- Who within the agency will receive grievances;
- Identification of support person(s) to assist in the submission of a grievance;
- Timelines for the resolution of the grievance; and,
- Consideration by agency director or designee if grievance cannot be resolved at a lower level.

Grievances/complaints differ from a formal Dispute Resolution process, which addresses only the four areas described below.

What can be disputed

(Reference C.R.S. 27-10.5-107, DDS rule 16.320, HCPF rule 8.503.180)
There are only four (4) areas, which can involve formal dispute resolution from the State for Developmental Disabilities Services funded programs:

1) The applicant is not eligible for services or supports,
2) The child is no longer eligible for services or supports,
3) Services or supports are to be terminated, or
4) Services identified in the IP are to be modified, reduced or denied.

A parent(s)/guardian can dispute any of the above actions through a formal appeal procedure at both the local and State level. What is being disputing (i.e. the funding source), will determine who can resolve the issue. For example:

Area under dispute	**Who can resolve this**
ü Eligibility for developmental disabilities services	Department of Human Services
ü Eligibility for Medicaid	Health Care Policy and Financing
ü Eligibility for Children's Extensive Support*	DHS and/or HCPF

* Other areas of appeal (i.e. beyond the four listed above) may be available for Medicaid services

Dispute Resolution Process

Dispute Resolution for CES is to follow DDS rules, which outline the requirements for the dispute resolution process. The process requires notice of the proposed action (defined as 15 days prior to the proposed action) and that there be an opportunity to resolve the dispute locally through informal negotiation. If informal negotiation does not resolve the dispute, then a more formal meeting before a local impartial decision-maker is to be held. If either party objects to the decision of the impartial decision-maker, then the Department of Human Services can be requested to review the decision and render its decision.
(See Appendix K for a flow chart of the dispute resolution process)

Medicaid Dispute Resolution

In addition, there are some decisions which Medicaid related (e.g. Medicaid eligibility); there is an appeal process through the Department of Health Care Policy and Financing (HCPF) which applies to all Medicaid programs. Such decisions would be beyond the scope of authority for the Department of Human Services and should be appealed directly to HCPF.

Additional information about the HCPF dispute resolution process can be found in the Medicaid Manual, Volume 8

Ä **<u>Note</u>: There may be other agencies or programs with which a CES participant is involved or from which a child is receiving services (e.g. Social Security Administration, Part C, Mental Health, etc.). If the CES participant has a dispute with such other entities, the parent(s)/guardian must utilize the dispute resolution process available through those agencies for the programs for which they are responsible.**

Mediation Program

The Mediation Program, which can be utilized, by individuals or agencies to facilitate a fair process that, when possible, results in the disputing parties voluntarily arriving at mutually agreeable solutions(s). Both grievances/complaints and disputes/appeals can utilize the mediation process if both parties agree. For more information contact: The Mediation Hotline: 1-888-815-6684.

1) **Can a CES participant appeal when services are terminated by the provider under CHRS/DDS rules?**

In the event of a termination from services, Developmental disabilities "service agencies", as defined in C.R.S 27-10.5-102 (28) and DDS rules, must abide by the requirements of the appeal process, as defined in DDS rule and continue to provide services during the appeal. This includes any new agency that is formed for the purpose of providing CES services and does not meet the definition for a typical community agency or is not regulated by some other state agency.

When generic community providers are used, the individual is subject to the same customer guarantees, assurances and risks as any other citizen of the community. The additional protections (appeal rights) available when "service agencies" are used, do not apply. Individuals/families should be made aware of when a provider is or is not a service agency. CCBs should also include a clause in all contracts with non-service agencies regarding the expectations for cancellation of a contract by either the provider or the person receiving services.

2) **If, through the resource assignment process, it is decided to reduce the number of hours of service, or amount of a plan, can this be appealed?**
   Yes, it could be appealed.

CCB Responsibilities

(Reference C.R.S. 27-10.5-104, 105, DDS rule 16.460, HCPF 8.503.60)

What You Will Find
- CCB Responsibilities
- Monitoring Responsibilities

A critical element to sustaining an effective and responsive CES program is the ability to evaluate the progress made toward achieving established outcomes. Progress toward the goals identified in the introduction section will be measured at multiple levels. Each CCB should develop an evaluation method to gather sufficient information from CES participants, their parent(s)/guardian and service providers to allow for effective planning, needed improvement, and expansion of the program to meet the wants/needs of eligible children within the local service area.

At a minimum, each CCB must evaluate consumer satisfaction with the CES program at least once every three years.

Overall evaluation should address progress and achievement in meeting the goals of the program. The evaluation should also address the following areas:

Satisfaction and Program Responsiveness, including:

- Ease of access to the program;
- Timeliness of services;
- Effectiveness of services;
- Availability of services; and
- Responsiveness to individual concerns and recommendations.

Effective Coordination and Utilization of Funds, including:

- Variety of local services and supports utilized in conjunction with the Children's Extensive Support program; and,
- Efficiency of required paper documentation to sustain the program while limiting intrusiveness to CES participants/families.

Monitoring Responsibilities

(Reference C.R.S. 27-10.5-104, DDS rule 16.460, HCPF rule 8.503.200)

The primary focus of the evaluation process will be at the local level and will evaluate how each local service area is able to incorporate necessary changes to maintain the effectiveness of the program to meet the needs of eligible children. DDS will evaluate aspects of the program through the following methods or sources:

- The local service area Individualized Plans and evaluations

- Aggregate Billing and Accounting information, including the types and frequency of services and supports accessed
- Audited Annual Financial Statements from CCBs
- Periodic on-site Program Quality surveys
- Periodic surveys/questionnaires of families and service providers, which will provide data, which can be aggregated across the state.

Roles/Responsibilities Community Centered Board

(Reference C.R.S. 27-10.5-105, DDS rule 16.210, HCPF rule 8.503.60)

"Community Centered Board (CCB)" for the purpose of the Children's Extensive Support program means the agency, which has been given Program Approval for CES services and is responsible for the implementation and local fiscal management of the CES program. The following responsibilities pertain to the CES program; the CCB also has responsibilities beyond just the CES program.

What You Will Find

- Community Centered Board
- Developmental Disabilities Services
- Colorado Department of Health Care Policy and Financing
- Federal Health Care Financing Administration
- Colorado Foundation for Medical Care
- County Department of Social Services

Overall CES Coordination

Families and CHRS/DDS should be notified of the name and title of the CCB person responsible for implementation of the CES program within the designated service area.

At a minimum, the following functions need to be performed by the CCB for CES:

- Overseeing the implementation of CES within the designated service area.
- Managing the service area CES budget.
- Coordinating contracts for purchasing services and supports for children enrolled in CES.
- Ensuring compliance with CES implementation requirements, Rules & Regulations, and Statute.
- Providing DDS with requested information regarding disbursements for services and supports in CES and other information about CES as needed.
- Maintaining complete file of all CES records, documents, communications, survey results and other materials, which pertain to the operation, and service delivery of the CES program.

Enrollment into CES

(Reference DDS rule 16.210, HCPF rules 8.503.60))

The CCB is responsible to ensure that the necessary paperwork for enrollment into the CES program is completed for all applicants in a timely manner and to monitor ongoing eligibility. The CCB must coordinate with all other necessary agencies including, but not limited to, CHRS, DDS, the URC, and County DSS. (See Section 2 for more information)

Case Management Services

(Reference C.R.S. 27-10.5-102 (2), 105, DDS rule 16.004, HCPF rules 8.503.611)

Community Centered Boards receive allocations specifically for Targeted Case Management Services related to the Children's Extensive Support program. All children who are referred to the CCB for services will have an eligibility determination completed as a case management

responsibility and, at a minimum, an initial Individualized Plan (IP) for services and supports will be developed. The CCB support person (a.k.a. Case Manager, Resource Coordinator, Service Coordinator, etc.) is responsible to ensure overall service delivery including the coordination of information with the parent(s)/guardian, primary physician, service providers, county department of social services, Social Security Administration and others, as necessary, to ensure the effective delivery of services and support for the child.

Community Contract and Management System

(Reference C.R.S. 27-10.5-104, DDS rule16.243)

The CCB must ensure that eligible children are entered into the Community Contract and Management System (CCMS) per established criteria (see Appendix C). Any child who receives CES funds must be entered into CCMS. It is the CCBs' responsibility to keep the information in CCMS accurate and up-to-date. If a child is not expected to continue to receive funds during a fiscal year, CCMS should be changed to reflect the appropriate current program status.

Resource Assignment

(*Reference C.R.S. 27-10.5-104, DDS rule 16.450)*

It is the responsibility of each local service area to establish procedures for assigning resources which address the identified needs of CES participants, to serve at least the minimum number of child required by the State (i.e. CES allocations are child specific), and for CES to remain within the cost effectiveness average for its service area.

Provider Qualifications

(Reference C.R.S. 27-10.5-102), DDS rule 16.230, federal application)

It is the responsibility of the CES agency (CCB) to ensure the use of qualified providers for CES services.

Training and In-Service

(Reference DDS rule 16.230)

The CCB is responsible to ensure, at a minimum, that agency personnel involved in the Children's Extensive Support program are adequately trained to carry out their assigned functions. CCBs are further encouraged to provide, coordinate or ensure training for other service and support providers.

Program Quality / Monitoring

(*Reference DDS rule 16.460, HCPF rules 8.500.200)*

The CCB must ensure that CES is implemented within their local service area and that all components of the program are in compliance with the CES manual, standards, rules & regulations, and statute. There needs to be a balance between the goals of a person-centered non-intrusive program and the need for accountability for use of public funds. The level of monitoring of the services and supports will vary among CES participants and service providers. The CCB is responsible for establishing a reasonable level of monitoring with each CES participant's parent(s)/guardian. Each CCB shall be responsible for monitoring the health and well-being of each CES participant by conducting child, parent/guardian and provider interviews and any written

reports received from service providers. The case manager must, at a minimum; document at least once every two months whether and how the services are meeting the individual's needs as defined in the IP.

Parent(s)/guardians are responsible to provide information regarding the quality of services and supports to the CCB, as requested or necessary. Parent(s)/guardian will need to provide financial information as needed for determination ongoing eligibility. The CCB should establish any necessary precautions to monitor the appropriateness of service providers within the local service area. The CCB must cooperate with the Program Quality section of DDS regarding any on-site surveys and questionnaires.

Program Evaluation

(*Reference C.R.S. 27-10.5-103, 105, DDS rule 16.460, HCPF 8.503.200)*
Each CCB should develop an evaluation method to gather sufficient information from CES participants, parent(s)/guardians and service providers to allow for effective planning, needed improvement, and expansion of the program to meet the wants/needs of eligible individuals within the local service area. **At a minimum, each CCB must evaluate CES consumer satisfaction every three years.**

Responsibilities of Children's Health and Rehabilitation Services/ Developmental Disabilities Services

(Reference C.R.S. 27-10.5-103)

CHRS/DDS will continue to monitor the statewide implementation of the program, evaluate the achievement of desired results and institute necessary changes. At a minimum, CHRS/DDS is responsible for the following:

- Program design and refinements
- Development of rules, regulations, implementation requirements and standards
- Compliance with State and Medicaid rules and regulations
- Prior Authorization for enrollment of all CES participants and activation of a PAR file
- Allocation of funds to service areas (CCBs) and payment of billings
- Coordination of statewide training
- Technical assistance
- Program quality and monitoring of the CCB's quality control practices
- Program Quality on-site reviews for the CES program will be on a two-year cycle providing no major deficiencies are detected or complaints received.

Roles/Responsibilities Health Care Policy & Financing

The Colorado Department of Health Care Policy and Financing (HCPF) is the State agency responsible for oversight of all Medicaid funded programs. HCPF is the designated single State Medicaid agency and acts as the liaison with the federal Health Care Financing Administration (HCFA). HCPF monitors compliance for implementation of the CES program through on-site reviews and surveys of CHRS/DDS and CCBs. HCPF also monitors and authorizes the use of regular Medicaid State Plan benefits throughout Colorado.

Roles/Responsibilities Health Care Financing Administration

The Health Care Financing Administration (HCFA) is the federal agency responsible for oversight of all Medicaid funded programs in the United States. HCFA has federal authority to approve the Medicaid waiver applications submitted by the States. HCFA also monitors the implementation of the CES program through on-site reviews and surveys of HCPF, CHRS/DDS and CCBs. In addition, HCFA monitors the use of regular Medicaid State Plan benefits in Colorado.

Roles/Responsibilities Utilization Review Contractor

The Utilization Review Contractor (URC) for Colorado is responsible for initial determinations and annual re-determinations in deciding if a CES applicant meets the Level of Care Screen for an ICF-MR and the additional CES eligibility criteria. The URC reviews the ULTC-100 and LTC-102 forms to determine the Level of Care and reviews the CES application information to determine if the child meets CES criteria. The URC also authorizes the period of eligibility for CES, which is usually at twelve (12) month intervals. On occasion, authorization may be for less than twelve months.

Roles/Responsibilities County Department of Social Services

The County Departments of Social Services (DSS), a.k.a. Options for Long-term Care Agencies, are responsible to:

- Determine financial eligibility for long-term care funded under Medicaid, including the MS-10 form (i.e. private insurance coverage).
- Certify that the applicant's own income does not exceed 300% of the current SSI standard maintenance allowance on a monthly basis.
- Obtain written confirmation from the District Office, Social Security Administration, that the applicant would be ineligible for SSI payments due to the deeming of parental income and/or resources.

- Notify the family in writing and forwarding a copy, within 15 working days, to the community centered board (CCB), of approval of eligibility, either at the time of the initial application or during the re-determination process, OR

  Notify the applicant, his or her parents or guardian in writing of the denial and of the applicant's right to an appeal in accordance with the procedures found in the Colorado Department of Human Services Income Maintenance Staff Manual (9 CCR 2503-1) Administrative Procedures Section (3.830).

- Notify the CCB case manager within five (5) working days of any changes in the child's income, which might affect the eligibility status.

These determinations are an ongoing process but are completed no less than annually or more frequently if necessary due to changes in income, medical or living situation.

In the event that the County Department is unable to obtain sufficient documentation, within the allocated time frame, to recommend approval of eligibility, either at the time of the initial application or during the re-determination process, the County Department shall deny the applicant's request.

DSS also monitors and authorizes the use of regular Medicaid State Plan benefits in each county in Colorado.