COLORADO
Department of Health Care Policy & Financing

OPERATIONAL MEMO

Title: Direct Care Services Calculator	**Topic:** LTSS
Audience: Case Managers, Case Management Agencies, Personal Care Providers, Homemaker Providers, Community First Choice Members, In-Home Support Services (IHSS) Agencies, Consumer Directed Attendant Support Services (CDASS) Members, CDASS Attendants	**Sub-Topic:** Case Management: Community First Choice
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Purpose and Audience:

The purpose of this Operational Memo is to inform Health First Colorado (Medicaid) applicants and Members, Home and Community-Based Services (HCBS) waiver participants, Case Managers, Case Management Agencies (CMAs), and Providers about the upcoming implementation of the Direct Care Services Calculator (DCSC).

Information:

The Direct Care Services Calculator (DCSC) is a tool designed for Case Managers to utilize during the service planning process for Homemaker and Personal Care services.

Telligen, the Department's contracted Nurse Assessor, will complete the Health Maintenance Activities (HMA) part of the DCSC, when necessary.

The DCSC was created by combining the existing Consumer-Directed Attendant Support Services (CDASS) Task Worksheet with the In-Home Support Services (IHSS) Care Plan Calculator.

The DCSC will be used for members newly enrolling in CFC, for all three service delivery options to include Agency-Based, CDASS, and IHSS, and then annually thereafter. There are two versions: one for adults and one for children. Each version of the DCSC includes the regulatory definition for each task outlined in the calculator.

The DCSC will also be utilized by the Nurse Assessor when unskilled care needs are identified during the skilled care acuity assessment. When the DCSC is completed by the Nurse Assessor, they will send a copy to the case manager to use in the service planning process. More information will be provided in a forthcoming Nurse Assessor memo and the Nurse Assessor training for Case Management Agencies.

The DCSC incorporates task norms and Age-Appropriate Guidelines to help Case Managers evaluate an individual's level of need relative to typical functional expectations. These norms serve as reference points to guide decision-making while allowing for professional judgment and individualized planning based on the member's specific circumstances. The inclusion of Age-Appropriate Guidelines helps ensure that service allocations reflect realistic needs based on the member's developmental stage, functional ability, and support environment.

The DCSC is intended to enhance—not replace—the person-centered planning process. Case Managers will continue to engage directly with members and their representatives to ensure that authorized services align with each Member's goals, preferences, and care needs.

Action To Be Taken:

For Members with certification start dates of July 1, 2025, and enrolling in Community First Choice (CFC), Case Managers will use the DCSC during the service planning process to support consistent, accurate, and needs-based care planning.

<u>Health First Colorado Members and Current HCBS Waiver Members:</u>

At the time of the Member's initial enrollment into CFC or annual Continued Stay Review (CSR), the Case Manager will utilize the DCSC to help determine the amount of personal care and homemaking services needed. If skilled services are needed, the Case Manager will make a referral to the Nurse Assessor, who will provide a

recommendation for skilled care services and may complete the DCSC for personal care and homemaker, if identified, on behalf of the case manager.

Using information gathered during the Level of Care Assessment, the Case Manager will input details into the calculator to generate a recommended number of service hours. This recommendation will be discussed with Members as part of their overall service planning process. Members will continue to have the opportunity to ask questions, share concerns, preferences, and provide input about their care needs.

Please note that the DCSC is being used to support, not replace, professional judgment and the Member's voice in the planning process. The goal is to make sure the Member's Person-Centered Support Plan is fair, accurate, and aligned with Health First Colorado program guidelines.

Case Managers and Case Management Agencies (CMAs)

The roles and responsibilities of Case Managers and CMAs regarding service authorization will remain fundamentally the same with the implementation of the DCSC. However, the use of the DCSC introduces a standardized and data-informed tool into the service planning workflow to promote consistency, equity, and transparency in the allocation of support hours for CFC members.

Key Responsibilities and Expectations Include:

- Integration into Service Planning: Case Managers are required to use the DCSC during the initial enrollment and annual CSR and for all CFC Members. The tool will assist in translating assessment findings into a recommended number of authorized service hours for personal care and homemaking services.
    - If a member needs skilled care, a referral to the Nurse Assessor must be completed to help determine skilled care hours. Referrals to the Nurse Assessor can be made up to 60 days prior to the members certification end date. Once the Nurse Assessor schedules the Assessment with the member, the Nurse Assessor has 7 business days to complete the Assessment and provide the Recommendation Letter. Case Managers will receive a Recommendation Letter following this assessment.
        - Expedited Assessments may be available; criteria will be provided to Case Managers in the upcoming Nurse Assessor training.
    - If personal care or homemaker service needs are identified during the Nurse Assessor Acuity Assessment, the Nurse Assessor will also complete the DCSC and provide this to the case manager.

- Informed Professional Judgment: While the DCSC provides a calculated recommendation, Case Managers are expected to use their professional judgment to interpret results in the context of the member's unique needs, circumstances, and preferences. If the Case Manager determines that service hour adjustments are necessary beyond what the DCSC recommends, clear justification must be documented in the Member's Care and Case Management System (CCM) record. Additional guidance will be provided in the Nurse Assessor training. Total authorization amounts must be captured in the DCSC in the Bridge.

- Transparency and Member Engagement: Case Managers must review the DCSC results with Members and/or their representatives as part of the person-centered planning process. This ensures the Member and/or their representative are informed and actively involved in decisions about their care.

- Documentation Requirements: All DCSC inputs must be captured in the Bridge. Any deviations from the Nurse Assessor recommendation must be documented on the HMA tab of the DCSC and must be in accordance with age-appropriate guidelines and task norms.

- Compliance and Oversight: CMAs are responsible for ensuring that their staff are fully trained in the use of the DCSC and adhere to all related training and guidance. Supervisory staff should monitor consistent and appropriate use of the calculator and support quality assurance efforts.

Training and reference materials for the DCSC can be found on the Long Term Services and Supports Training Page, under Community First Choice (CFC) III: Enrollments, Service Authorizations, and Scenarios.

Providers:

The Direct Care Services Calculator (DCSC) is a tool developed for exclusive use by the Nurse Assessor and Case Managers during the service planning process for CFC members. It is not to be completed, modified, or submitted by provider agencies under any circumstances. The completion of the DCSC by a provider agency is not valid and cannot be used in the service planning process. Any provider agency found to be completing the DCSC or seeking to influence the outcome of the DCSC may be subject to audit, corrective action, suspension of claims, and/or recoupment.

Providers are essential partners in care implementation and are encouraged to develop their own operational processes to translate these authorizations into individualized care delivery. Providers should work closely with Case Managers to

support high-quality, person-centered care while adhering to established roles and boundaries around the DCSC. Members' needs and services must be accurately reflected in the Agency Care Plan.

Use of the DCSC in the Authorization Process:

- **Case Manager Responsibility:** The Case Manager will receive the completed DCSC on the skilled care needs from the Nurse Assessor in the Qualitrac web portal, when applicable. The Case Manager makes the final determination of the hours that are approved on the Prior Authorization Request (PAR), based on the Member's assessed need. For members with no skilled care needs, the Case Manager completes the DCSC during the member's service planning meeting which results in an official service hour authorization. It is based on the Members' assessed needs and individual circumstances. Once the DCSC is completed and service hours are authorized, the Case Manager must provide a copy of the DCSC to the **member and** provider agency.

- **Provider Access to the DCSC:** Once the DCSC is completed and service hours are authorized, Agencies will receive a copy of the completed DCSC from the Case Manager. This document serves as a tool for providers to use while developing the Agency Care Plan and will help with guiding the delivery and scheduling of support tasks such as personal care, homemaking, and Health Maintenance Activities (IHSS Agencies only). Provider agencies will be provided a PAR with the formal authorization of services.

IHSS provider agencies are required to submit a copy of their Agency Care Plan to the Case Manager for review and approval. While the Agency Care Plan does not need to replicate the format or content of the DCSC, the total service hours outlined in the plan must align with the authorized hours determined through the DCSC. This ensures consistency between the Member's approved service authorization and the provider's delivery of care.

Definition(s):

Task norms refer to standardized benchmarks that estimate the typical amount of time it takes a caregiver or attendant to complete specific support tasks—such as personal care, homemaking, or health maintenance activities—under usual conditions. These norms are based on clinical best practices, industry standards, and observed patterns of care. While task norms provide helpful guidance, they are not rigid time

limits; adjustments may be made based on individual member needs, functional abilities, and circumstances.

Age-Appropriate Guidelines are standardized reference points that reflect the typical developmental abilities and functional expectations for individuals at specific age ranges. These guidelines are used to help assess whether a person's need for assistance with daily tasks—such as personal care, mobility, or household activities—is consistent with what would be expected for their age group. In service planning, Age-Appropriate Guidelines support fair and individualized determinations by distinguishing between age-related norms and care needs resulting from a disability or medical condition.

Attachment(s):

Direct Care Services Calculator – Children

Direct Care Services Calculator - Adults

Age-Appropriate Guidelines

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