Support Level Review Request Form

March 31, 2022

Presented by:
The Department of Health Care Policy & Financing

Our Mission:

Improving health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

Purpose

- **Improve member experience by:**
  - Streamlining process by improving front-end timeliness
  - Focusing on a person-centered approach, including accurate outcomes and appropriate approval periods
- **Support Case Managers by:**
  - Providing clear guidance and training
  - Lessening administrative burden

Member Notification

The CCB must inform the member of:

- the purpose of the SIS,
- the SIS Complaint Process (*SIS Re-Assessment*),
- the Support Level Review Process, and
- that they may receive a copy of the completed SIS.

The CCB shall document that this information was provided and received on the SIS and Support Level disclosure form.

10 CCR 2505-10 8.612.1.F.

Introductions

Parking Lot Jamboard

Support Level Review Request Process

- The CCB shall provide the information required by the Department
  - Initial reviews can be submitted off-cycle at any time
  - SLR Re-exams are due on the 20th of the month prior to the end date
    - SLR Re-exams can be submitted prior to the end date if there is a significant change for the member.

- The Department is required to conduct reviews once a month; however, the Department currently holds reviews twice a month

SLR submitted by 1:00 PM:	Will be reviewed on:
1st Thursday of the month	2nd Thursday of the month
3rd Thursday of the month	4th Thursday of the month

The Department provides a written decision within 15 business days after being reviewed

10-CCR 2505-10 8.612

SLR Essentials: Focus on the Person

Requests are person-centered by nature and must reflect that. Focus on both what is Important To and Important For the member.

Illustrate person-specific needs and how a Support Level increase could address member needs.

Narrative sections are used to demonstrate the member's extraordinary paid support needed when performing Activities of Daily Living, attending services, and/or addressing their behavioral or medical health needs.

REMEMBER:

This is an opportunity to introduce the panel to the member and document how the Support Level Review Request can help situations where a member needs more support than their Support Level allows.

Person-Specific Documentation

Steer clear of information that is not person-specific when presenting your case to justify the request.

For example, *avoid*:

- "Mickey Mouse has access to supports 24/7 because he lives in a Group Home."
- "Mickey Mouse lives in a Group Home with 1:2 staffing."
- "Mickey Mouse's staff receives training specific to complete activities of daily living."

If you would like to include this information in the Support Level Review Request, the information needs to be person-specific.

Person-Specific Documentation

Give an example of the amount of time, degree, and complexity that staffed support is needed to meet needs:

"Mickey Mouse has a g-tube and requires all medication and food be given through this g-tube. Each meal takes extra time to prepare and each mealtime can take up to an hour. Staff are trained by an RN to be able to complete this ADL."

Outline person specific information about supervision, how supervision was determined, and how staff accommodate when a person is not having a good day:

"Micky Mouse had an IDT on January 13, 2022, and it was determined that he will need a 2:1 staffing ratio during awake hours due to increased frequency and duration of physical aggression and property destruction when he is not having a good day."

Cover Page

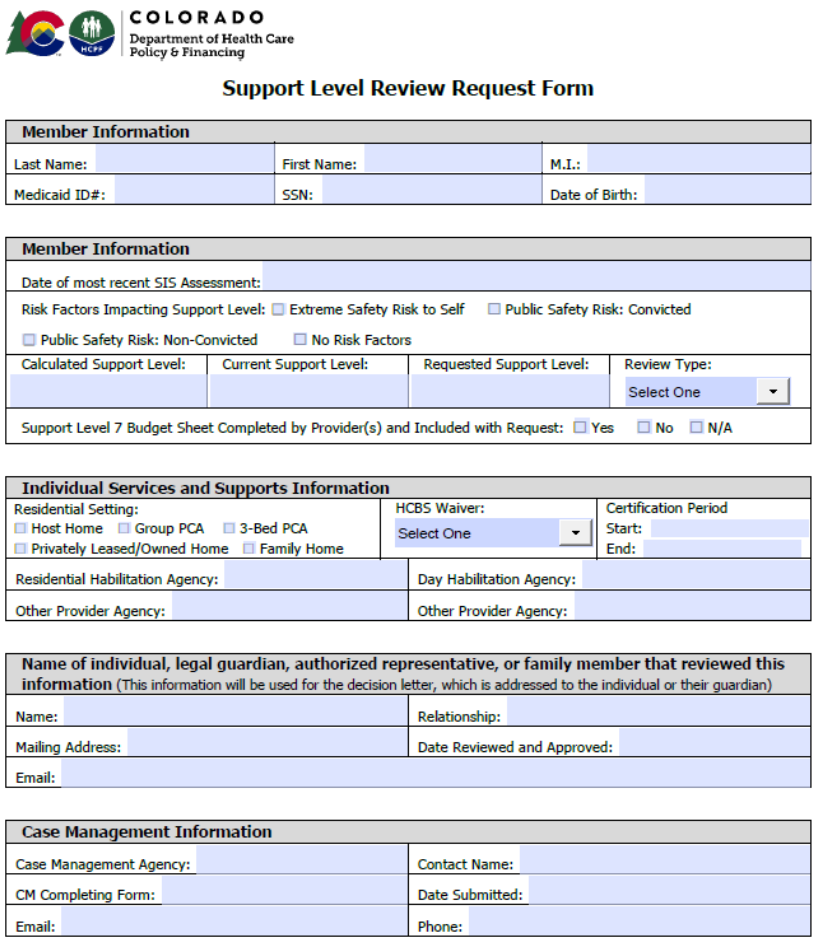
Things to Remember:
Complete Page in Full

Risk Factor: Follow definition as outlined in 10 CCR 2505-10 8.612

Support Level Information:

- Calculated: Algorithm score
- Current: Algorithm if initial, approved Support Level if request is a re-examination
- Requested: Score associated with request

Obtaining a review and approval from the member/guardian prior to submission



COLORADO
Department of Health Care Policy & Financing

Support Level Review Request Form

Member Information		
Last Name:	First Name:	M.I.:
Medicaid ID#:	SSN:	Date of Birth:

Member Information			
Date of most recent SIS Assessment:			
Risk Factors Impacting Support Level: ☐ Extreme Safety Risk to Self ☐ Public Safety Risk: Convicted ☐ Public Safety Risk: Non-Convicted ☐ No Risk Factors			
Calculated Support Level:	Current Support Level:	Requested Support Level:	Review Type: Select One
Support Level 7 Budget Sheet Completed by Provider(s) and Included with Request: ☐ Yes ☐ No ☐ N/A			

Individual Services and Supports Information		
Residential Setting: ☐ Host Home ☐ Group PCA ☐ 3-Bed PCA ☐ Privately Leased/Owned Home ☐ Family Home	HCBS Waiver: Select One	Certification Period Start: End:
Residential Habilitation Agency:	Day Habilitation Agency:	
Other Provider Agency:	Other Provider Agency:	

Name of individual, legal guardian, authorized representative, or family member that reviewed this information (This information will be used for the decision letter, which is addressed to the individual or their guardian)	
Name:	Relationship:
Mailing Address:	Date Reviewed and Approved:
Email:	

Case Management Information	
Case Management Agency:	Contact Name:
CM Completing Form:	Date Submitted:
Email:	Phone:

Interdisciplinary Team (IDT) Information

1. Indicate IDT members who were a part of the Support Level Review planning process; check all that apply.	
☐ Member	☐ Day Habilitation (administration)
☐ Parent(s)	☐ Day Habilitation (staff)
☐ Other Family Member(s)	☐ Residential Habilitation (administration)
☐ Friend(s)	☐ Residential Habilitation (staff)
☐ Other Natural Support	☐ Job Coach
☐ Advocate	☐ Respite Provider
☐ Corrections	☐ Behaviorist
☐ Mentor	☐ Personal Care/Homemaker Staff
☐ Other:	☐ Other:
If any applicable participants were not involved in the planning process, please explain why.	
Conflict of interest evaluated: ☐ Yes ☐ No	

Prior to a Support Level Review submission, the Member's IDT needs to come together to discuss:

- The Member's previous Support Intensity Scale (SIS)
- The Member's current support needs
- Additional State and Waiver funded options for services
- To identify whether a SIS Reassessment or SLR is needed

Overview of Utilization

2. Provide authorized and utilized waiver services outlined in the Support Plan. Explain any over/under utilization.							
Service	**Utilized**	**Authorized**	**%**	**Service**	**Utilized**	**Authorized**	**%**
Res. Hab.				Homemaker (Enhanced)			
SCC Tier I/II				Homemaker (Basic)			
SCC Tier III				Personal Care			
Spec. Hab. Tier I/II				Mentorship			
Spec. Hab. Tier III				Unit Respite			
Prevocational Services				Per Diem Respite			
Behavioral Assessment				Camp/Group Respite			
Behavioral Consultation				Job Development			
Individual Counseling				Job Coaching			
Group Counseling				Group Supported Emp.			
Hippotherapy				Spec. Med Supplies			
Movement Therapy				Spec. Med Equipment			
Massage Therapy				Mileage Band			
Personal Emergency Response				CDASS Health Maintenance			

Case Managers will need to calculate the percentage of utilization relative to the percentage of the certification period that has elapsed.

- This will indicate if services are being utilized and the anticipated frequency.
- Address any overutilization and/or underutilization in this section.

Overview of Services & Supports

3. Indicate State Plan Benefits currently in place, as well as additional or enhanced supports associated with the increase in care needs. If no State Plan Benefits or Additional Supports are indicated, please explain why.

State Plan Benefits

Service	Temp	Ongoing	Service	Temp	Ongoing	Service	Temp	Ongoing
Private Duty Nursing	☐	☐	Behavioral Health	☐	☐	Specialist I	☐	☐
LTHH	☐	☐	EPSDT	☐	☐	Specialist II	☐	☐
Hospice	☐	☐	Dental	☐	☐	Specialist III	☐	☐
Speech Therapy	☐	☐	Physical Therapy	☐	☐	Occupational Therapy	☐	☐

Additional Supports

Service	Temp	Ongoing	Service	Temp	Ongoing	Service	Temp	Ongoing
Exceptional Travel Time	☐	☐	LOS Supervision	☐	☐	CDASS	☐	☐
Specialized Medical Protocols	☐	☐	1:1 Support	☐	☐	Family Caregiver	☐	☐
Specialized Medical Care	☐	☐	2:1 Support	☐	☐	Medication Management	☐	☐
Specialized Non-Medical Training	☐	☐	Other:	☐	☐	Other:	☐	☐

Duplication of services evaluated: ☐ Yes ☐ No

Identify State Plan benefits used by the member to give a comprehensive view of the member's supports

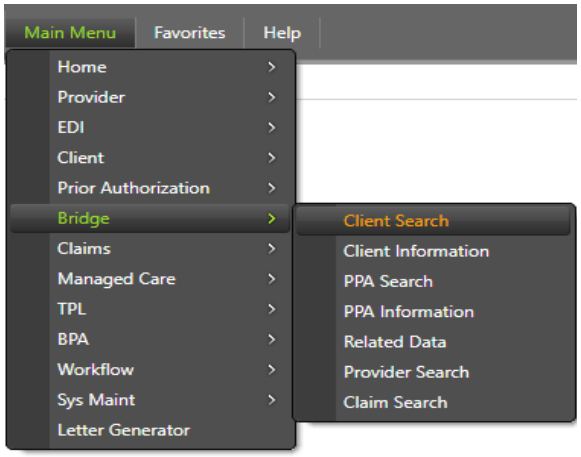
- Indicate all State Plan Benefits by checking the Temporary or ongoing box, as appropriate
- Identify any barriers to access services in this section

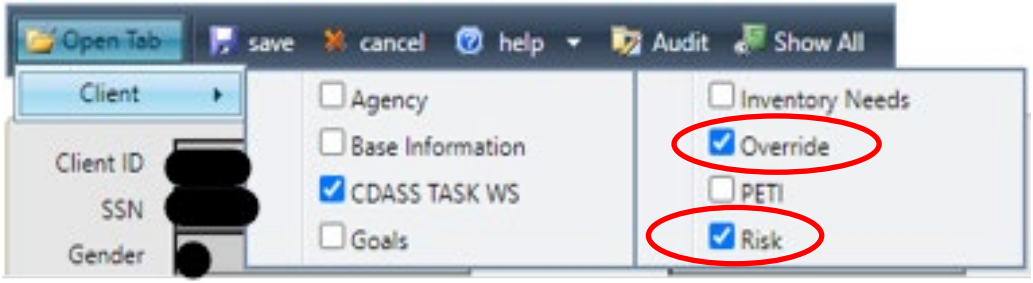
Overview of Assessments & Discrepancies

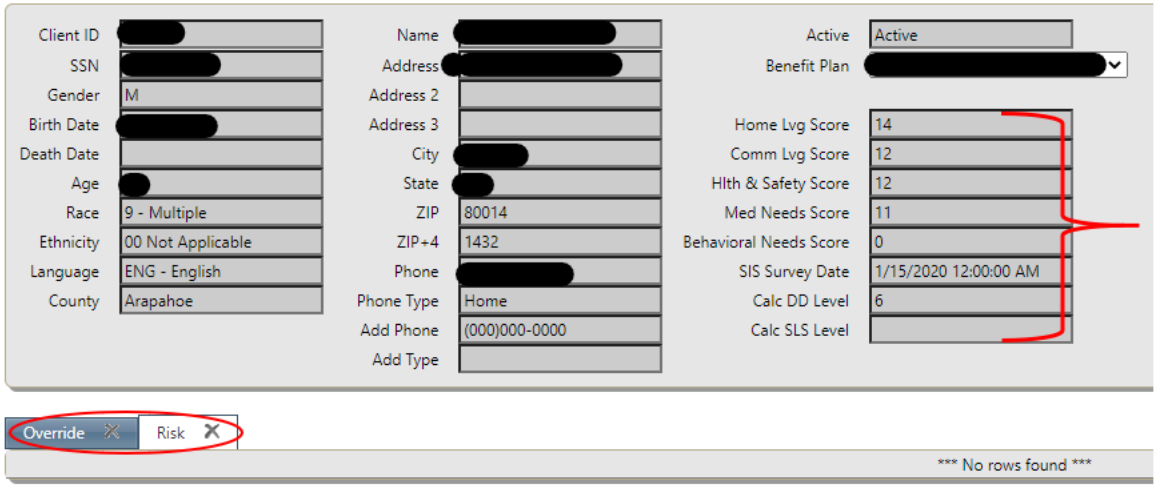
4a. Provide an overview of discrepancies between the SIS Assessment and current ADL/care needs. This summary must **clearly explain** how the circumstances and needs were not properly captured by the SIS Assessment and Support Level determination process.									
SIS Domain Scores									
Home Living		Community Living		Health and Safety		Exceptional Medical		Exceptional Behavioral	
Changes in ADL/Daily Care Needs									
☐ Bathing		☐ Dressing		☐ Transfer		☐ Mobility		☐ Receptive Language	
☐ Paralysis/Loss of Limb		☐ Psychiatric Care		☐ Behavioral Intervention		☐ Toileting		☐ Expressive Language	
☐ Eating		☐ Memory		☐ Decision-Making		☐ Self-Regulation		☐ Planning/Follow-Through	
Summary of discrepancies between care needs and SIS Assessment, and why reassessment is not being pursued; if no discrepancies, please explain why:									

- Provide specific information on discrepancies between the ADL needs and the SIS Assessment when completing the first portion of this section
- Give clear examples of person-specific supports and needs not captured by the SIS Assessment and Support Level determination process
- Explain clearly why a SIS Reassessment is not being pursued

Locating Scores in the Bridge







Extraordinary Need & Factors Impacting Need

4b. Summarize the member's exceptional need and factors impacting need:	
Projected timeline for increased support: ___ years ___ months	Does this request extend beyond the certification period? ☐ Yes ☐ No

- Interventions associated with the Member's needs; hands-on assistance, full dependence, supervision and staffing ratios determined by the IDT, Restrictive Procedure(s), Rights Modification(s), intensive instruction/skill building
- Time dedicated each day/week to meeting person-specific needs
- Specific details on current and/or significant life changes
- Onset date of new diagnosis (if applicable) or changes in condition, and how this has affected the Member's needs
- How pre-existing supports may be enhanced with additional funding

Support Planning & Notable Case Developments

5. Provide a summary of steps taken to meet support needs leading up to this request.			
IDT Planning			
Meeting Date(s):			
Critical Incident Reporting (check all that apply, including reports as witness):			
☐ Mistreatment	☐ Abuse	☐ Neglect	☐ Exploitation
☐ Displacement	☐ Death	☐ Criminal Activity	☐ Excessive Property Damage
☐ Emergency Medical Treatment	☐ Medication Management	☐ N/A	☐ Other:
Referrals & Complaints in Past Year:			
☐ APS	☐ RFP	☐ RAE	☐ HCPF Escalations
☐ CDPHE	☐ Advocate	☐ Provider Integrity	☐ New HRC Submission
☐ Community Support Team	☐ Emergency DD Enrollment Request	☐ Medicaid Fraud Control Unit	☐ Other:
Summary/Outcomes/Recommendations:			

Outline the collaborative effort of the IDT and how incidents have impacted the Member:

- Note dates in which the Member and team have met to discuss concerns
- Outline short-term action steps; discuss referrals and interactions with other agencies
- Document the other options that have been exhausted

Summary of Proposal

6. If approved, how will the additional funds be utilized?		
Indicate the nature of the action plan (check all that apply)		
☐ Aging Out Transition	☐ Progressive/Neurocognitive Diagnosis	☐ Community Transition
☐ Short-Term Injury/Illness	☐ Long-Term Injury/Illness	☐ Other:

- Summarize any new services that will be pursued and/or pre-existing services that will be fortified with additional funding
- Outline how these plan changes/new services will be implemented during the override period, and a projected timeline for carrying out the action plan
- If you are completing a Re-examination please give a detailed explanation regarding the overview of progress, additional supports that were put in place, barriers to finding additional supports or meeting the short-term goals in the past year
- Provide a step-down plan that enables the transition to the assigned Support Level

Review Jamboard Parking Lot

Level 7 Requests

REQUEST FORM FOR NEGOTIATED LEVEL 7 RESIDENTIAL DAILY RATE FOR HCBS-DD

Please read instructions within each part, as well as the general instructions in Tab 1.
Complete all 'ORANGE' highlighted blocks. Enter "N/A", if an orange block is not applicable. Do NOT enter into Green or Gray spaces on this form.

PART I - Agency Information

I.A. - CCB Information	1. CCB Name:	2. CCB Lead Contact:	3. CCB Contact Person's Phone:	4. CCB Contact Person's email address	4. CCB HCBS-DD Medicaid Nr.
I.B. - Residential Provider Agency (if different than CCB)	1. Provider Agency Name: (If CCB, Write 'Same as CCB')	2. Provider Lead Contact:	3. Provider Contact Person's Phone:	4. Provider Contact Person's email address	4. Provider HCBS-DD Medicaid Nr.

PART II - Consumer Information

IIA. - Consumer Identification	1. Name:	2. Medicaid Nr	3. Algorithm Support Level (before approved for Level 7)	ERROR MESSAGE: Algorithm Support Level (cell at left) must be between 1 and 6

IIB. - Consumer Residential Information	1. Current/Planned Residential Setting (Use the drop down list to select the HCBS-DD waiver setting that the individual currently resides in, or if they are not yet in the HCBS-DD waiver, then select the setting that is planned for them.) (1) Click on cell below, then (2) click on arrow at bottom right of cell below. (3) Then click choice from drop down list that best matches the residential setting for HCBS-DD waiver.	2. Current Residential Hab. Daily Rate in the HCBS-DD Waiver (If this consumer is already in the Community HCBS-DD Waiver, then what residential rate does he/she have now. If he/she is NOT in the HCBS-DD waiver currently, then write "N/A".)		3. Requested Res. Rate for Level 7 in the HCBS-DD Waiver (What net daily residential habilitation rate do you believe is needed to serve this individual in the HCBS-DD waiver? NOTE - do NOT include costs met through other services, such as behavioral services, day program, transportation, etc. DO INCLUDE ongoing skilled nursing costs, but not any skilled nursing that can be covered by the Medicaid State Plan.)
USE DROP DOWN LIST FOR II.B.1. – Click cell at right, then click arrow at bottom right of cell to get list to click.				

All Level 7 requests must come with an additional Daily Rate excel spreadsheet for Panel Members to review

All Level 7 requests are set by a negotiated rate, this is based on the requested Daily Rate spreadsheet

Denials

The Department provides a written decision to the CMA regarding Support Level reviews within 15 business days after the panel meeting.

The results of the panel review for a member enrolled on the HCBS-DD Waiver are conclusive. New SLRs can be submitted if there is a significant change for the member.

The results of the panel review for a member enrolled on the HCBS-SLS Waiver:

- Can be contested by the member, legal guardian, authorized representative, or family member within fifteen business days of being notified of the decision.
- The Executive Director* or their designee shall review the request and provide a written decision within fifteen business days of receipt of the request.
- The decision of the Executive Director or their designee shall constitute a final agency decision and will be subject to judicial review pursuant to Section 24-106, C.R.S.

*refers to Department of Health Care Policy & Financing Executive Director

10 CCR 2505-10 8.612.4

When is an 803 required?

A Notice of adverse action (803) is not issued due to a denial of a Support Level Review (SLR). Rather, an 803 would be issued if a member was denied an HCBS Waiver service they have requested.

803 Example

A SLR for a member enrolled in HCBS-SLS Waiver is submitted. The SLR requests an increase from a **support level 2** to a **support level 4**. The SLR documents the need for increased support level to **accommodate Mentorship services which are above the member's current support level 2 SPAL.**

Outcome 1:	Outcome 2:	Outcome 3:
A decision is made by the SLR panel to approve an increase to a support level 4.	**A decision is made by the SLR panel to approve an increase to a support level 3 to but does not approve a level 4.**	**A decision is made by the SLR panel to deny a support level increase.**
Member can access all additional services as requested in SLR request.	Member is not able to access all additional services as requested.	Member is not able to access additional services as requested.
Action by CM: no 803 needed.	**Action by CM: 803 must be sent as a denial of services. ***	**Action by CM: 803 must be sent as a denial of services. ***

* HCBS SLS rule citations can be found at 10 CCR 2502-10 8.500.90

Technical Assistance and Questions?

Contacts

Support Level Review,
SIS Reassessment Request Form Submission, and
updated SIS Reassessment outcomes:
sis_sl@state.co.us

Support Level Review and SIS Reassessment
Request Questions or Concerns:
hcpf_hcbs_casemanagement@state.co.us

Resources

LTSS Case Management Tools
Supports Intensity Scale Section
SIS and Support Level Disclosure Form
SIS Complaint Process
SIS Reassessment Request Form
SLR Desk Guide
SLR Panel Schedule for 2022

2022 Memos:
Risk Factor Determination & Process Flow Memo (IM 22-011)

Overview of Support Level Review Processes and Revised Request Form (OM 22-016)

Thank you!