



Benefits & Services Overview

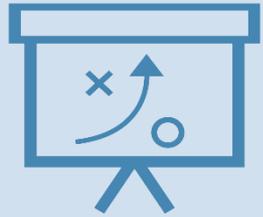
This guide is intended to be used in conjunction with the CCT Services and Supports Desk Reference located on our web site at <https://www.colorado.gov/pacific/hcpf/hcbs> and the CCT rule *10 CCR 2505-10*, Section 8.555.



PERSON-CENTERED SERVICE PLANNING



Planning to identify each waiver participant's needs, goals, & preferences.



Strategies developed to meet those needs, goals, & preferences.



Identifies, incorporates, & maximizes the resources & supports present in the person's life & community.



Identifies waiver services & other services & supports that a person needs in order to live successfully in the community.



Process through which risks are assessed & are planned for and emergency backup services are identified.

For detailed instruction, please refer to “[Entering a Service Plan into the Bus](#)”

www.Colorado.gov/hcpf

PERSON-CENTERED SERVICE PLANNING



Assurances

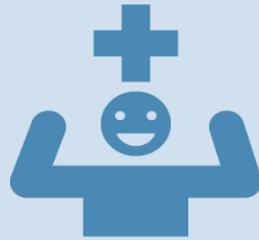
Delivery



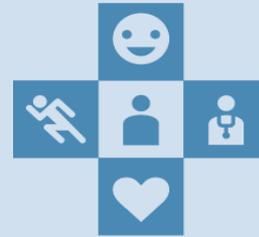
PERSON-CENTERED SERVICE PLANNING



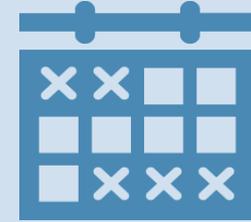
CMS/HCPF encourages and supports person/family-centered planning methods



Engages & empowers participant & individuals selected by the participant in design of service plan



Ensures plan reflects the needs and preferences of the participant



Service plans must be reviewed annually, or as necessary with a change in the participant's needs

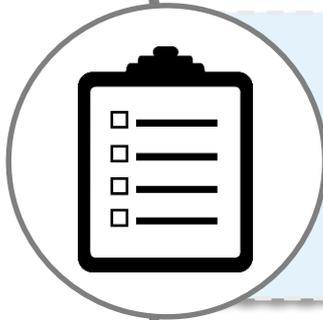


CONTINGENCY PLANNING



Players

- CCT Intensive Case Managers
- Single Entry Points (SEP)
- Community Centered Boards (CCB)



Tasks

- ICMs develop Risk Mitigation and Emergency Back-up plans
- ICM with Client must review and revise the Risk Mitigation Plan after each Critical Incident



BUS and Service Plan

- SEPs enter both plans in the Contingency Plan section of the BUS
- CCBs enter the Emergency Back-up plan in the Contingency Plan section of the BUS and the Risk Mitigation plan in the Risk Assessment Section of the Service Plan.



CCT Demonstration Services



CREATION OF CCT BENEFITS & SERVICES

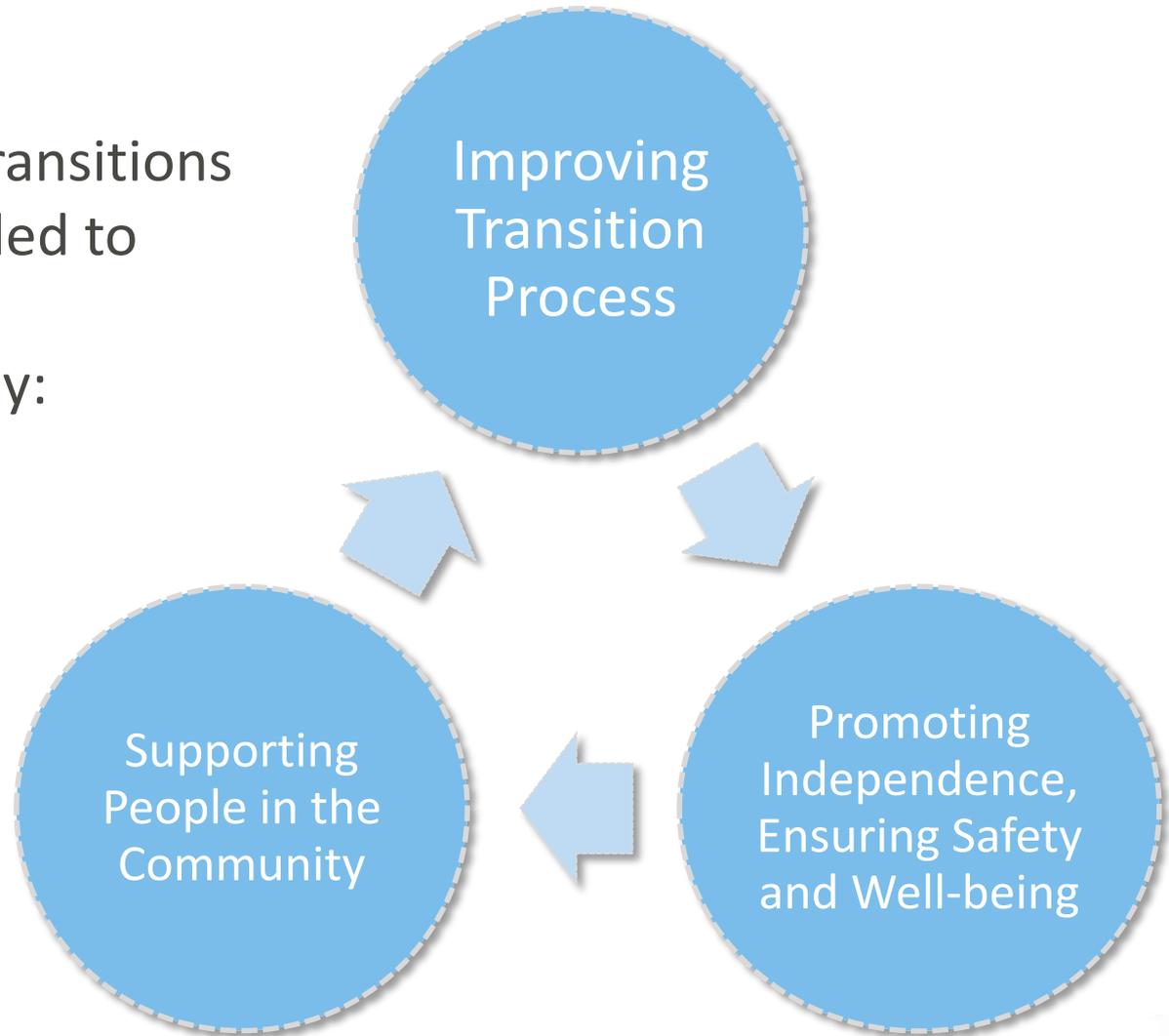
A group of diverse stakeholders across the state including service providers, clients, family members, advocates, and other state agencies worked together to identify:

- Gaps in existing services
- Services that provide greatest support of successful transition and continued stability in the community



BENEFITS & SERVICES

Colorado Choice Transitions services are intended to reduce reliance on institutional care by:



CCT BENEFITS & SERVICES

- Provide 14 demonstration services for 365 days
- Participants receive qualified HCBS (Home and Community Based Services) waiver services from one of 5 waivers
- Qualified services are HCBS waiver services that will continue once the CCT Demonstration Program has ended.
- Demonstration services serve to compliment HCBS waiver services and are provided during an individual's enrollment in the demonstration program.
- After 365 days, participants remain on HCBS waiver
 - Continue to receive HCBS waiver services **and** State Plan benefits as long as they are eligible.



QUALIFIED HCBS WAIVERS

**Persons with
brain injury**

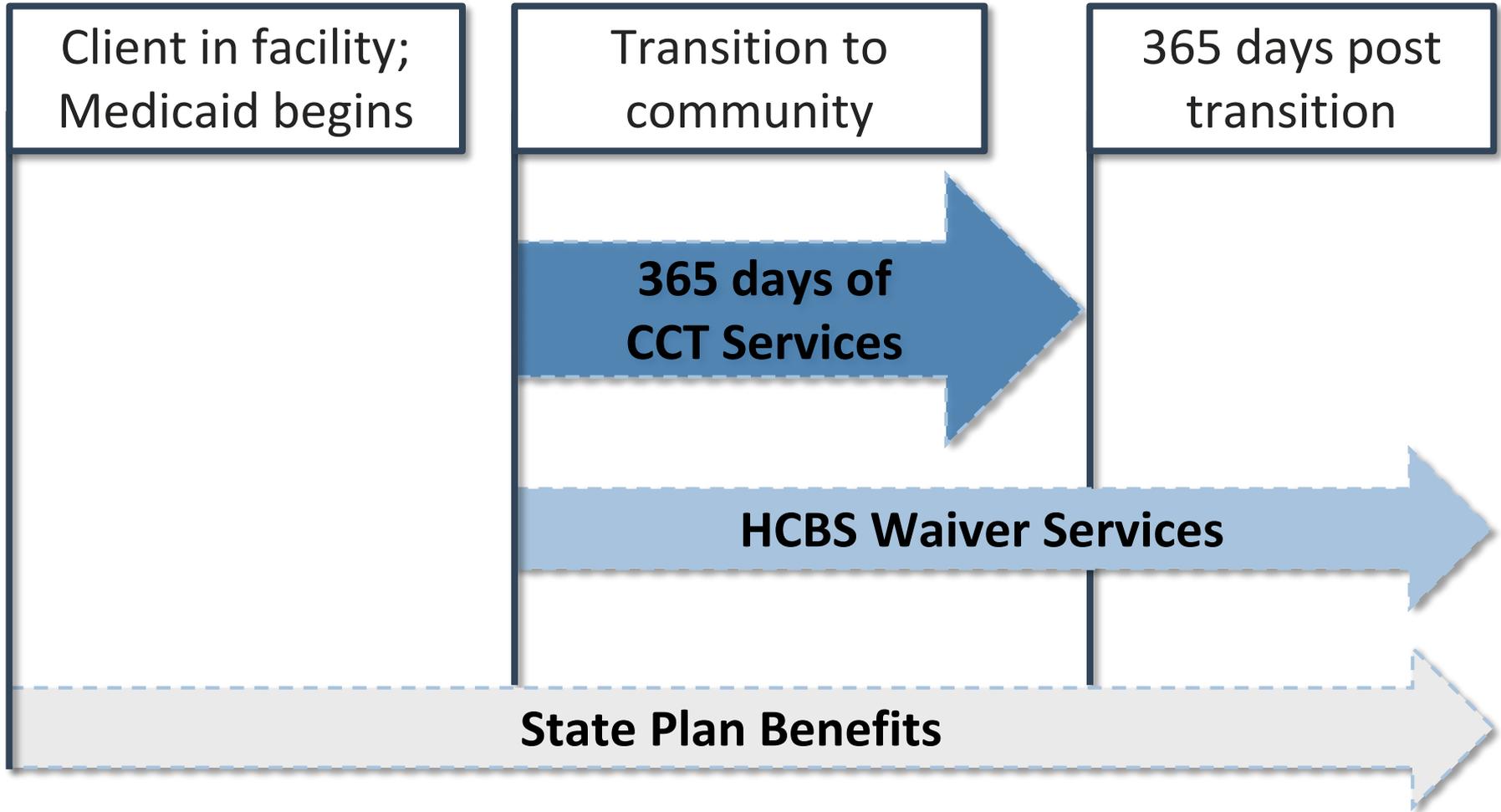
**Community mental
health supports**

**Persons who are
elderly, blind, &
disabled**

**Supported living
services**

**Persons with
developmental
disabilities**

CCT BENEFITS & SERVICES



CCT DEMONSTRATION SERVICES

**Assistive
Technology,
Extended**

**Caregiver
Education**

**Community
Transition
Services**

**Dental Services,
Extended**

**Enhanced
Nursing**

**Home Delivered
Meals**

**Home
Modifications,
Extended**

**Independent
Living Skills
Training**

**Intensive Case
Management**

**Peer
Mentorship**

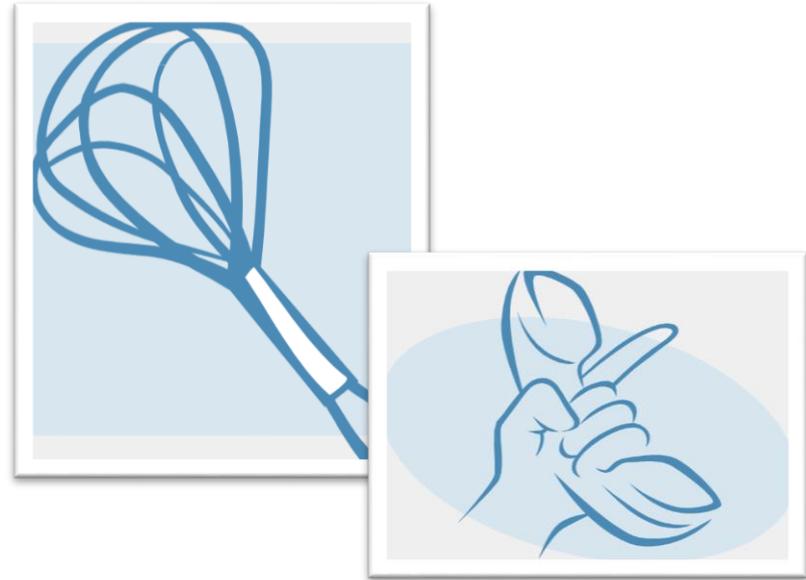
**Transitional
Behavioral
Health Supports**

Vision Services



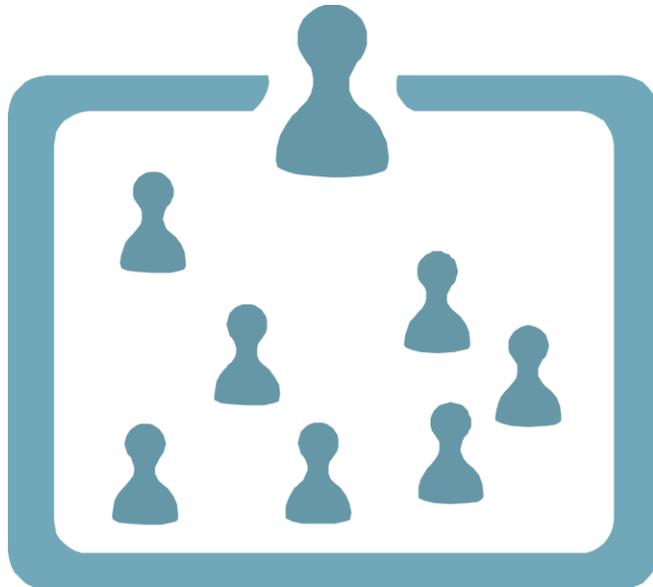
ASSISTIVE TECHNOLOGY – EXTENDED*

- Adaptive cooking utensils
- Communication devices such as phones & tablets
- Environmental control units



**Extended service only available once HCBS qualified waiver service has been expended.*

CAREGIVER EDUCATION



Educational & coaching services that assist clients & family members to recruit other family members and friends to form an informal caregiver network to share caregiving responsibilities.

Consider this service when family members, friends, or loved ones will help share caregiving to support the client in the community.

COMMUNITY TRANSITION SERVICES



Services provided by a Transition
Coordination Agency

Includes items essential to move from
a long-term care facility & establish
community-based residence.

Coordinator Services
\$2,000 Flat Rate

Household Setup
Up to \$1,500

Dental Services, Extended



Services that are inclusive of diagnostic, preventive, periodontal and prosthodontic services, as well as basic restorative and oral surgery procedures to restore the client to functional dental health. May not duplicate services available through the Medicaid Adult Dental State Plan benefit.



ENHANCED NURSING

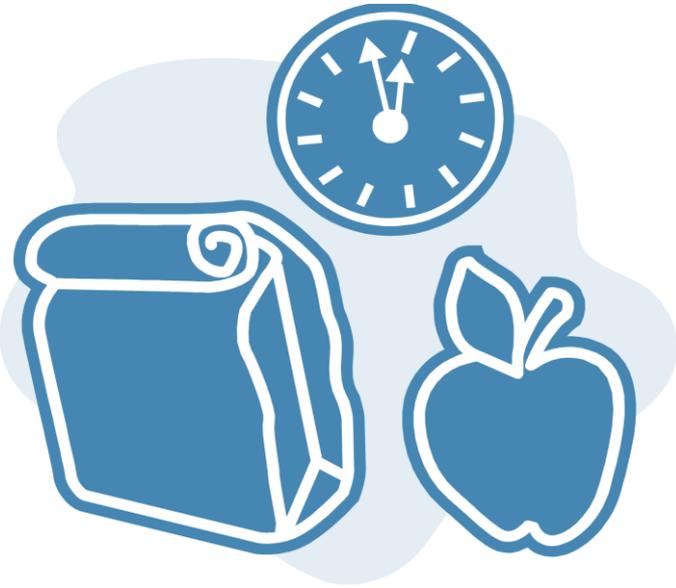


Medical care coordination provided by a nurse for medically complex clients who are at risk for negative health outcomes associated with fragmented medical care and poor communication between primary care physicians, nursing staff, case managers, community-based providers and specialty care providers.

Consider this service for clients with highly complex, persistent health needs such as someone with comorbidities, including behavioral or mental disorders.



HOME DELIVERED MEALS



- Nutritious meals delivered to homebound clients who are unable to prepare their own meals and have limited or no outside assistance
- Meals can be delivered hot, frozen, or shelf stable depending on the ability of the consumer, or caregiver, to complete the preparation of the meal.
- Nutrition service provider agencies will set up a delivery schedule based on the type of meal provided and preference of the client.

HOME MODIFICATIONS – EXTENDED*



Physical adaptations to the home, required by the client's plan of care, necessary to ensure the health, welfare, safety & independence of the client.

Examples include:

- Installation of ramps or grab bars
- Accessible shower
- Lowered kitchen sink
- Widening of doorways

**Extended service only available once HCBS qualified waiver service has been expended.*



INTENSIVE CASE MANAGEMENT



Intensive case manager is responsible for:

- Assessing needs
- Determining eligibility
- Service planning and authorization
- Care coordination
- Risk mitigation
- Service monitoring
- Monitoring the health, welfare & safety of the client
- Promotion of client's self-advocacy



INDEPENDENT LIVING SKILLS TRAINING



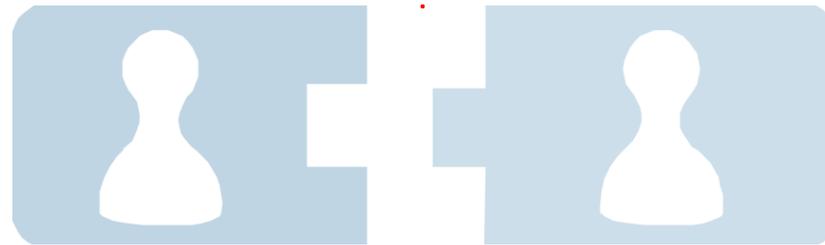
Consider this service for clients who have been institutionalized for long periods of time or who may need help adjusting to a new disability, decision-making and planning their day.

Services designed to improve or maintain a client's physical, emotional, & economic independence in the community with or without supports. Includes assistance with acquisition, retention, or improvement in self-help, socialization, & adaptive skills which takes place in the participant's home, other residential living arrangement, & the community.



PEER MENTORSHIP

Services provided by peers to promote self-advocacy and encourage community living among clients by instructing and advising on issues and topics related to community living, describing real-world experiences as examples and modeling successful community living and problem-solving.



Consider this service for clients who may suffer from social isolation or who will benefit from exposure to life-experiences of others, such as mentors with a similar disability or disorder that can help orient the client to their community and navigate new systems.

TRANSITIONAL BEHAVIORAL HEALTH SUPPORTS

Services by a qualified paraprofessional to support a client during the transition period to mitigate issues, symptoms, and/or behaviors that are exacerbated during the transition period and negatively affect the client's stability in the community.

- Frequency of services higher than typical behavioral health services.
- When necessary, a community mental health center will develop behavioral health plan prior to discharge from the nursing facility or ICF/IDD.

Consider this service for clients who have a need for both behavioral and physical health services and may experience anxiety, fear, or extreme stress during the transition or during community living.



VISION



Services that include eye exams and diagnosis, glasses, contacts, and other medically necessary methods to improve specific vision system problems when not available through the Medicaid State Plan. Services available through Medicare are not covered.



	HCBS	EBD	BI	CMHS	SLS	DD
Assistive Technology, Extended		X		X		X
Caregiver Education		X	X	X	X	X
Community Transition Services		X	X	X	X	X
Dental, Extended		X	X	X		
Enhanced Nursing		X	X	X	X	X
Home Delivered Meals		X	X	X		
Home Modifications, Extended		X	X	X	X	X
Independent Living Skills Training		X		X	X	
Intensive Case Management		X	X	X	X	X
Peer Mentorship		X	X	X		X
Transitional Behavioral Health Supports		X		X		
Vision		X	X	X		



HCBS WAIVER COST CONTAINMENT

Cost containment is the determination that, on an individual basis, the cost of providing care in the community is *less than the cost of providing care in an institutional setting*. Cost of providing care in the community includes cost of care under an HCBS waiver plus Long Term Home Health (LTHH) services.

Waiver	*HCBS Per Diem Cap	*HCBS Per Month Cap
HCBS-EBD	\$167.09	\$5,082.88
HCBS-MI	\$175.24	\$5,361.22
HCBS-BI	\$284.20	\$8,645.26



COST CONTAINMENT

DD & SLS WAIVERS

- The DD waiver does not have individual cost containment limits, only the aggregate cost neutrality calculation that must fall below the costs of ICF/ID aggregate.
- DD Waiver uses Support Levels which determine the rate paid for Residential and Day Habilitation Services.
- SLS Waiver has Service Plan Authorization Limits (SPALs) that serve as cost containment for each individual. SPALs are based on the person's Support Level Determination, levels 1-6.
- The SLS Waiver total expenditure per person may not exceed the \$35,000 overall waiver cap.



INFORMAL SUPPORTS

Coordinating Informal Supports

- Family
- Friends
- Spiritual Counselors
- Community Volunteers

Connecting People to Community

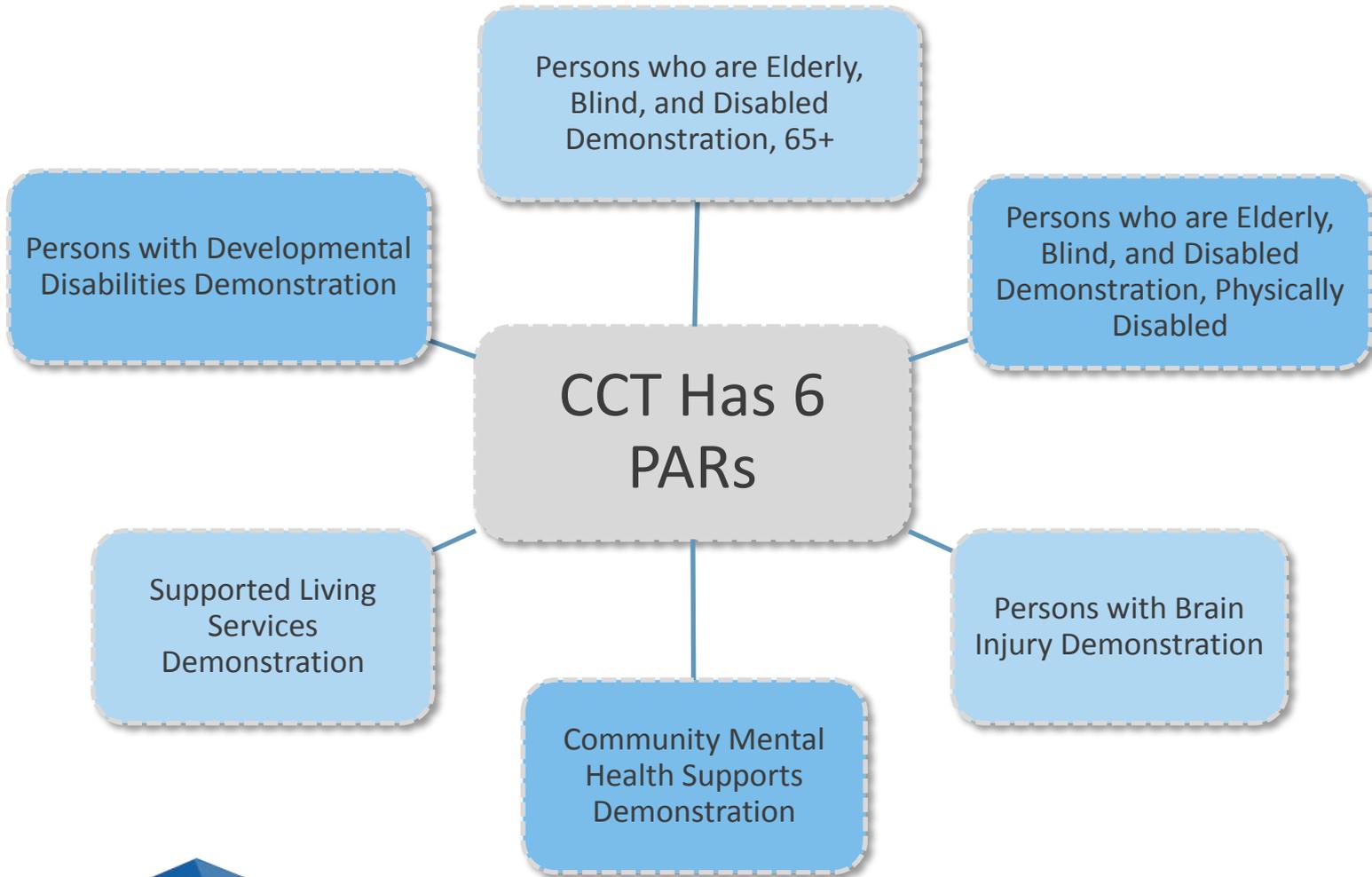
- Information & Assistance
- Access & Training
- Counseling & Support Groups

Why?

- True integration, safety, Community, Opportunity, Hope, Independence, Careers, Empowerment, Success, & Safety Net



PRIOR AUTHORIZATION REQUEST FORMS (PAR)



THINGS TO REMEMBER

DI

- CCT clients must be designated Deinstitutionalized (DI) as the service plan type in the BUS and on the 100.2

365

- Certification span and PAR span should match and be equal to 365 days

30

- Any days of reinstitutionalization up to a total of 30 will be added to the cert/PAR span at the end of the client's initial enrollment period
- ICMs can request state approval for 30 day exception in writing, for example, if the client was waiting for DME equipment before returning to community.

PAR

- All boxes should be filled out on the PAR per the instructions on the back

Resources for ICMs can be found on our web site



For more information, please contact Nicole Storm, CCT Project Manager at 303-866-2858 or Nicole.Storm@state.co.us

