SRS/CSS Policy

Regarding: Private ICF/MR Gate-Keeping

Approval Date: March 15, 2004

Implementation Date: April 15, 2004

Introduction

The purpose of this protocol is to ensure compliance with the gate-keeping regulation, K.A.R. 30-64-29, the D.D. Reform Act and the core values of HCP/CSS, which emphasizes opportunities of choice, person-centered planning, independence, integration and inclusion into the community.

The state plan requires that an ICF/MR placement is consistent with the preferred lifestyle of the person as specified by the person or their guardian before authorizing Medicaid reimbursement for ICF/MR services. This principle is also reflective of the gate-keeping regulation, K.A.R. 30-64-29. Payment will be denied in situations where the guardian's choice of an ICF/MR is contrary to the person's expressed preference.

Policy

Applications for ICF/MR services can only be initiated by a CDDO in Kansas. A gate-keeping review is required for all persons referred for placement in an ICF/MR. Admission to the ICF/MR is granted only with the recommendation of the CDDO and the expressed opinion of the QEC. HCP/CSS will have final approval, which will be communicated in writing within 10 days after receipt of the fully completed summary. If a placement is actuated before formal approval from Central Office, funding will not be approved. Any situation that merits a more timely consideration can be addressed by phone. Any time admission is requested to an intermediate care facility for persons' with mental retardation (ICF/MR) this criteria and process applies and must be followed. The attached private ICF/MR Gate-keeping Summary must be utilized.

The CDDO should be prepared to demonstrate the following when seeking access to ICF/MR services. The following criteria must be met before seeking and obtaining ICF/MR admission:

1. The CDDO demonstrates that services in an ICF/MR setting would be the least restrictive most appropriate service setting for the person at this time

2. The person is in need of active treatment as defined by the Code of Federal Regulations (CFR) for ICF/MRs in 42 CFR 435.1009 refers to treatment that meets the requirements specified in the Condition of Participation for active treatment at 42 CFR 483.440(a).

3. Verification that the person has a diagnosis of mental retardation with an IQ below 70, and is in need of active treatment (please review the Code of Federal Regulations ICF/MR requirements, specifically the Condition of Participation of Active Treatment).

4. Documentation of the reasons for admission to an ICF/MR and why the service setting is essential to the person's health and safety

5. The request for ICF/MR is made by the person and approved by the person's guardian and the Kansas court (KSA 59-3077, Authority of guardian to admit ward to treatment facility; petition; contents; notice; hearing; procedure).

PRIVATE ICF/MR GATE-KEEPING SUMMARY

Consumer Information			
Consumer Name:		Birth Date:	
Street:		City:	
County:		Zip:	
Medicaid number:		SSN:	
Phone number:		Fax Number:	
Community Developmental Disabilities Organization (CDDO) _____ ____			
Guardian Information			
Guardian Name:			
Street:		City:	
County:		Zip:	
Phone number:		Fax Number:	
E-Mail:	.		
If a guardian, does the guardian approve of this request? ___ Yes ___ No ___N/A Has court approval of this request been obtained? ___ Yes ___ No (K S.A 59-3077) NOTE: If no to either question, this application should not proceed until guardian has filed a petition seeking court approval.			
Proposed ICF/MR Service Provider Information:			
ICF/MR name:			
Contact Person:			
Street:		City:	
Zip:		Phone Number:	
E-Mail:		Fax Number:	
Gate-keeping Efforts:			
Date of Gate-keeping meeting:			
Name and relationship of those attending the gate-keeping meeting: (If the person referred did not attend, why?).			

List the person's preferences in the five life area of the preferred lifestyle plan: (Include information Source)

1. In what type setting does the person want to live?
2. With whom does the person want to live?
3. What work or other valued activity does the person want to do?
4. With whom does the person want to socialize?
5. In what social, leisure, religious or other activities does the person what to participate?

If a person's preferred lifestyle preferences and needs are community based, what community capacities need to be in place to meet these needs?

In what ways are ICF/MR services the most appropriate and least restrictive way to meet the person's lifestyle preferences and needs?

List all community options provided to this person/guardian/support network. Include method of presentation.

What strengths/resources does the person have that could contribute to his/her success in the community?

What are the barriers to the person's successful community living?

State/List efforts to remove the barrier's noted above:

What supports were in place before referral and what were the reasons they were not successful?

Why is the CDDO making this recommendation?

Name/phone # of person responsible to coordinate transition plan to return to the community.

Anticipated timeline for development __________(days) and implementation __________(days) of transition plan to return to the person's community with appropriate supports/services.

QEC/CSS STAFF Name:	Date:	Expressed Opinion:	

CDDO Director Signature and Approval Date: