Health First COLORADO
Colorado's Medicaid Program

Transition Services
Frequently Asked Questions

February 2021

What are Transition Services?

Transition Services helps Health First Colorado members who qualify for services to live effectively in their communities.

Who qualifies for Transition Services?

Health First Colorado (Colorado's Medicaid Program) members aged 18 or older who live in a Long-Term Care facility and wish to return to their communities.

Additionally, Health First Colorado members who are enrolled in one of the six adult Home and Community Based Services (HCBS) Waivers are eligible to participate in Transition Services. For those already enrolled in one of the six HCBS Wavier programs, a qualifying life event is a requirement for eligibility.

What types of facilities are considered "long-term care facilities" under the Transition Services benefit?

A qualified long-term care facility is defined as a nursing home, a Regional Center, or an intermediate care facility for people with intellectual disabilities.

What types of settings are considered "Community settings" under the Transition Services benefit?

Community settings include a family home, individual home, assisted living facility, group home, host home, or supportive living program. For members who live in one of these settings, a qualifying life event is required for eligibility.

What qualifies as a life event for eligibility if a member is not transitioning from a long-term care facility?

When an individual is experiencing a life transition in a com-munity setting, the person will need to access the benefits by working with his or her HCBS Case Manager. Examples of life transitions include, but are not limited to, the following:

- Person's primary caregiver is no longer able to care for the person receiving HCBS services.
- Person is moving to a less restrictive environment, such as from a group home or Alternative Care Facility, to his or her own apartment or into a family home.
- Person is moving out of parent's home to live independently in their own apartment.
- Person has recently aged out of the Medicaid programs for children.

The purpose of Transition Services is to support the person in becoming more independent during a period of transition. If this applies to the member's situation, their first step will be to reach out to their HCBS Case Manager to start the conversation about Transition Services.

What services and benefits are available to someone in a long-term care facility?

Individuals interested in moving from a long-term care facility to live independently in the community can access the following State Plan Benefits and HCBS benefits. The HCBS benefits are available after a member has transitioned to the community.

Targeted Case Management - Transition Coordination

- Transition Coordination is a Health First Colorado (Colorado's Medicaid Program) State Plan benefit under Targeted Case Management.
- Transition Coordination are activities essential to move a member from a nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or Regional Center and establish a community-based residence. Services are provided by a Transition Coordination Agency (TCA).
- TCM-TC services facilitate a process to complete a community needs evaluation to identify supports and services the members' need to return to the community from placement in a qualified facility and to aid the member in attaining their transition and independent living goals.

Expanded HCBS Transition Services

If an individual is eligible for HCBS Waivers once they return to the community, they can access the following HCBS benefits:

- Life Skills Training: training to help meet a member's physical, emotional, social and economic needs.
- Home Delivered Meals: meal planning, preparation and delivery as well as nutrition counseling.
- Peer Mentorship: support from peers to help members during their transition to the community.

For individuals who are moving from a qualified long-term care facility and are NOT moving into a provider owned setting (group home, host home, assisted living facility, or supportive living program), an additional service called **Transition Set-up** is available. This service can help with one-time expenses to get a member set up in their new household when they transition to a community living arrangement.

Please note, that not all services are available under every waiver. The chart below identifies which services are available under each adult waiver. If an HCBS Transition Service is not available under a specific waiver it is because that waiver al-ready has a similar benefit that is available to waiver participants for the duration of their enrollment in the waiver and is not time limited.

Facility to Community Transitions					
Brain Injury Waiver (BI)	Community Mental Health Supports Waiver (CMHS)	Developmental Disabilities Waiver (DD)	Elderly, Blind and Disabled Waiver (EBD)	Spinal Cord Injury Waiver (SCI)	Supported Living Services Waiver (SLS)
Home Delivered Meals Peer Mentorship Transition Setup *Independent Living Skills Training is an existing service in the BI waiver.	Life Skills Training Home Delivered Meals Peer Mentorship Transition Setup	Home Delivered Meals Peer Mentorship Transition Setup *Residential Habilitation Services and Supports assists members to reside as independently as possible in the community and includes independent living training.	Life Skills Training Home Delivered Meals Peer Mentorship Transition Setup	Life Skills Training Home Delivered Meals Peer Mentorship Transition Setup	Life Skills Training Home Delivered Meals Peer Mentorship Transition Setup

What if a member does not have a place to return to in the community after being in a long-term care facility?

The Transition Coordination benefit can help eligible members apply for rental assistance vouchers through the Colorado Di-vision of Housing (DOH). In addition to helping apply for vouchers, members who qualify can access housing navigation services to support them in the search for housing in the community that meets their needs.

What services and benefits are available to someone in the community?

Expanded HCBS Transition Services
Individuals experiencing a qualifying life event can access the following HCBS benefits:

- Life Skills Training: training to help meet a member's physical, emotional, social and economic needs.
- Home Delivered Meals: meal planning, preparation and delivery as well as nutrition counseling.
- Peer Mentorship: support from peers to help a member during their transition to the community.

Please note, that not all services are available under every waiver. The chart below identifies which services are available under each adult waiver. If an HCBS Transition Service is not available under a specific waiver it is because that waiver al-ready has a similar benefit that is available to waiver participants for the duration of their enrollment in the waiver and is not time limited. The Transition Setup benefit of Transitions Services is not available to any individuals residing in the community.

Community to Community Transitions					
Brain Injury Waiver (BI)	Community Mental Health Supports Waiver (CMHS)	Developmental Disabilities Waiver (DD)	Elderly, Blind and Disabled Waiver (EBD)	Spinal Cord Injury Waiver (SCI)	Supported Living Services Waiver (SLS)
Home Delivered Meals Peer Mentorship *Independent Living Skills Training is an existing service in the BI waiver.	Life Skills Training Home Delivered Meals Peer Mentorship	Home Delivered Meals Peer Mentorship *Residential Habilitation Services and Supports assists members to reside as independently as possible in the community and includes independent living training.	Life Skills Training Home Delivered Meals Peer Mentorship	Life Skills Training Home Delivered Meals Peer Mentorship	Life Skills Training Home Delivered Meals Peer Mentorship

Can someone enrolled in the Program of All-Inclusive Care for the Elderly (PACE) access Transition Services?

No. A member enrolled in the PACE program cannot receive Transition Coordination from a Transition Coordination Agency as it would duplicate services and supports already available through their PACE program. Members enrolled in PACE who are interested in transitioning back to the community from a facility should contact their PACE provider first to learn about transition services offered through the PACE Program.

If an individual residing in a nursing facility is not enrolled in PACE they can access Transition Coordination to help support their return to the community. If a member decides to enroll in PACE after they return to the

community they will not continue to receive any Transition Services, as they are considered a duplication of services provided by the PACE program.

If a member would like more information on their options they can reach out to their local options counseling agency or a social worker in their nursing facility.

How long can a member access services?

For members residing in a long-term care facility setting:
The Transition Coordination Agency will work with a member to assess, plan and execute the transition from the long-term care facility to the community. After returning to the community the TCA will support a member based on their needs. If a member needs additional support beyond what is provided, there is a request process for additional support.

Once a member has moved from the long-term care facility to the community, they can access the expanded HCBS services for up to 365 days based on need. Should they have a qualifying life event in the future while living in the community they can access these services again. Additionally, if a member re-turns to a long-term care facility for any reason they can access these services again.

For members residing in the community:
A member can access services for up to 365 days in the community. Should they have another qualifying life event in the future they can access these services again. Additionally, if a member is admitted to a long-term care facility for any reason, they can access Transition Coordination to support their return to the community.

What happens at the end of 365 days?

After 365 days, participants will continue to receive Medicaid services including State Medicaid Benefit Plans and HCBS waiver, if they continue to meet eligibility criteria.

How does a member get started?

Facility to community transitions:
If a member wants to move from a long-term care facility to the community, the first step is a referral to options counseling. Options counseling is a person-centered approach to helping individuals gain an understanding of the benefits and limitations of long-term services and support options, and the knowledge to access these resources, in order to empower them to make choices that reflect their unique needs, values and circumstances. Anyone can make a referral for options counseling, including a Medicaid member. Referrals to options counseling can be made by:

- Long-term care facility staff
- Family members
- Friends
- Community members
- Members
- Or anyone else the member interacts with

Long-term care facilities are required to make an options counseling referral for members if they tell staff they are interested in moving into the community.

Referrals can be directed to the local Options Counseling Agency in a member's area. This information is available in the nursing facility or on the Transition Services website. If a member is interested in learning more about Transition Services, they can contact the local Options Counseling Agencies for options counseling in their area by completing this online Medicaid Member Options Counseling Referral Form.

After a referral is made to the local Options Counseling Agency, an options counselor from that agency will contact the member within 10 business days of the referral. The member will work with the options counselor to discuss availability of appropriate services in the community and learn more about community living options.

If the member decides to begin the transition process, they will choose a local Transition Coordination Agency. A list of all agencies is available on the Transition Services website. The agency will connect the member with a Transition Coordinator to help them begin the process.

Community to community transitions:

Individuals will need to contact their HCBS Case Manager or Case Management Agency when they are experiencing a life changing event. The Case Manager will work with the member to identify, assess and document the need for one or more transition services.

Additional resources:

Targeted Case Management – Transition Services Rule – Colorado Code of Regulations 8.519 and 8.760
Transition Services - Colorado Code of Regulations 8.553
Long-Term Services and Supports Glossary
Transition Coordination Agency List

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