Colorado's Money Follows the Person (MFP) Rebalancing Demonstration

Colorado Choice Transitions

Grant Award # 1LICMS330819-01-00

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A. PROJECT INTRODUCTION

According to data from 2008-2009, 68 percent of Colorado's residents in nursing homes had a desire to return to the community and receive long-term care. Money Follows the Person (MFP) is a federal grant opportunity to identify these residents and if appropriate assist residents with transitioning to the community with long-term care services and supports. A secondary goal of the initiative is to build and improve the infrastructure supporting home and community-based services (HCBS) for people of all ages with long-term care (LTC) needs. Colorado Choice Transitions (CCT) is Colorado's MFP initiative. While Colorado has a robust HCBS infrastructure, additional funding will improve access to HCBS services, make the system easier to navigate, and support transitions from facility-based care to community-based care. CCT will directly support nursing facilities (NFs) in the implementation of the October 1, 2010 requirement to assist residents in exploring their LTC choices.

A.1. Organization and Administration

a. Part #1 Systems Assessment and Gap Analysis

Current Environment in Institutional and Home and Community Based Services

A description of the current LTC support systems that provide institutional and home and community-based services, including any major legislative initiatives that have affected the system. What State legislative and/or regulatory changes need to be made to further rebalance the LTC system and promote HCBS?

Colorado has demonstrated national leadership serving persons with disabilities, the elderly and their families in the most integrated settings possible. Colorado currently has eleven different HCBS Medicaid waiver programs that serve a variety of populations including: children with disabilities, children with autism, children and adults with developmental disabilities, individuals with acquired brain injury, adults with mental illness and adults who are elderly, blind or disabled. Appendix A gives a description of the 1915(c) HCBS waivers administered by

the Department of Health Care Policy & Financing (the Department) and the Colorado Department of Human Services (CDHS). Clients access HCBS waiver services predominantly via three types of agencies: Community Centered Boards (CCBs), Single Entry Point (SEP) agencies and County Departments of Human or Social Services (CDH/SS). In addition, the Adult Resources for Care and Help (ARCH) Aging and Disabilities Resource Centers (ADRCs) program provides information, assistance and referrals.

Systems Supporting People with Developmental Disabilities: Both CCBs and CDH/SS are entry point agencies supporting people with developmental disabilities. CCBs are private non-profit organizations that serve as the SEP responsible for assessing applicants, determining eligibility, developing service plans, prior authorizing and providing on-going case management for individuals with developmental disabilities. Services are delivered by public and private agencies including CCBs themselves. Each CCB has a non-overlapping geographic service region of one to ten counties. The Department, CDHS and the CCBs have a three way contract that identifies specifically the roles and responsibilities for coordination and oversight between these entities. Additionally, these entities are responsible for implementing the over-arching Quality Improvement Strategies as required by CMS, and are involved in the HCBS Oversight Committee (HOC). The CDH/SS perform case management for children with developmental disabilities placed in out-of-home foster care.

Three Regional Centers (RCs) in Colorado are operated by CDHS and serve persons with developmental disabilities (DD) who have the most intensive needs. RCs provide a number of services including: Intermediate Care Facilities (ICFs), HCBS-DD Medicaid Waiver Homes, 24-hour supervision, residential habilitation, day habilitation, medical services and behavioral intervention. RCs provide treatment services for individuals who are dually diagnosed with

developmental disabilities and mental illness plus short-term emergency/crisis support to the community system. One licensed ICF is located at Grand Junction Regional Center and the remaining 15 ICFs are located at the Wheat Ridge Regional Center.

Systems Supporting People with Mental Illness: Local SEPs are the entry point agencies for HCBS services supporting people with a diagnosed major mental illness. The Medicaid Community Mental Health Services Program (the Program) offers statewide services for persons of all ages with mental illness and co-occurring substance use disorders. Five regional Behavioral Health Organizations (BHOs) are responsible for implementing the Program through contracts with the Department. BHO provider networks include seven specialty clinics, 17 not-for-profit community mental health centers, Federally Qualified Health Centers, and independent mental health providers that serve Medicaid members in assigned geographic areas. Inpatient psychiatric hospitalization is provided in two state Mental Health Institutes (MHI) located in Pueblo (CMHIP) and Denver (Fort Logan - CMHIFL), as well as in a variety of public and private facilities statewide.

Systems Supporting Elders and Adults with Disabilities: Local SEPs support clients eligible for the HCBS-Elderly, Blind, and Disabled (EBD) waiver. Medicaid provides nursing facility (NF) services through 193 facilities licensed by the Colorado Department of Public Health and Environment (CDPHE). Independent Living Centers (ILCs) provide transition support services to individuals in nursing facilities and are the designated Minimum Data Set (MDS) 3.0 Section Q Local Contact Agencies (LCAs). The CDHS State Unit on Aging (SUA) is responsible for administering programs and services funded by the federal Older Americans Act and state Older Coloradans Act including the Family Caregiver Program, LTC Ombudsman Program, Nutrition Program, and Supportive Services including transportation, personal care, homemaking, legal

assistance, adult day programs, chore services, and material aid with items such as eye glasses, dentures, and medical equipment. The SUA also links people to organizations that promote independence for older Coloradans and administers the ARCH program. In addition, Colorado provides assistance to older and disabled adults through two state-only programs, Home Care Allowance and Adult Foster Care.

Systems Supporting Children with Special Health Care Needs: Children with special health care needs at risk for living in an institutional setting benefit from a wide array of services from the Department, CDHS, CDPHE and the Department of Education. Medicaid currently provides HCBS services through several waivers: Children's HCBS, Children with Autism, Pediatric Hospice, Children's Extensive Support, and Children's Habilitation Residential Program. The comprehensiveness of the services available to profoundly disabled children and their caregivers have produced positive results. Very few children in Colorado live in institutional settings for more than a limited amount of time.

Systems Supporting Others at Risk for Institutionalization: Additional waivers serve clients that fall outside the above categories, including individuals with acquired immune deficiency syndrome and people with acquired brain injury.

Despite these available supports, there are barriers to transitioning individuals living in LTC facilities that are qualified for and interested in living in less restrictive settings. In June 2009, Colorado's Governor issued Executive Order D 011 09, "Directing the Development of a Strategic Plan to Promote Community Based Alternatives for the Disabled Citizens of Colorado." Subsequently, the Department of Health Care Policy and Financing (the Department) convened stakeholders to develop Colorado's Olmstead Report (Appendix B) released in July 2010. The Long Term Care Advisory Committee, in partnership with Department staff, worked

with a core team of stakeholders including people receiving services, case management and service providers, mental health professionals, home health providers, academics, additional state staff and advocacy organizations to develop recommendations and policy options to improve community-based LTC services. The Olmstead workgroup identified the following six key issues and strategies to address these issues:

Table 1. Olmstead Report Recommendations

1) ***Sustainable financing***- Identify current and future potential funding sources and reimbursement methodologies in order to maximize the availability of these services.
2) ***Policy integration*** - Identify barriers and enhance access to CBLTC services including systematic, on-going review of progress in implementing recommendations.
3) ***Increasing housing options available for people with all types of disabilities***- Eliminate barriers to accessing affordable housing, inform the community of existing housing options, and increase affordable/accessible housing units through a number of funding strategies.
4) ***Expand the current array of services***- Increase services to all individuals to include the supports available to people in institutions and those available to people in the community to avoid unnecessary institutionalization.
5) ***Stabilize and grow the direct service workforce***- Identifying opportunities to improve retention and recruitment of direct service workers including training/credentialing.
6) ***Better inform the community about the services available***- Identify best practices to encourage informed choice for individuals in need of long-term care services and develop informational tools to disseminate to the public about available HCBS.

State Legislative and Regulatory Changes

There is currently a gap between the services available to people in institutions and those available to people in the community. The Department must explore and identify a mechanism to allow all HCBS clients access to all available services on any of the waivers as well as any future expansion of HCBS services. Previous legislation, including the Pediatric Hospice Waiver (2004) and Children with Autism Waiver (2004), has been designed to fill in gaps in services for specific target populations and expand eligibility for services. Other legislative initiatives to increase access to services include the Disabled Buy-in option for individuals who are disabled but not financially eligible for Medicaid and do not have third party medical insurance. This option will be available to disabled Coloradans within the year.

Additional initiatives include studying a tiered-rate methodology to improve access to assisted living facility services, procurement set-asides for employment for individuals with disabilities, allowing payment for family caregiver services and developing a hospital-to-appropriate long-term–care setting program. The Department, with stakeholder input, will consolidate the HCBS waivers and consider other statutory and financing changes to improve access, choice, quality and care coordination in Colorado's long-term care system.

Current Rebalancing Programs and Services

An assessment of what Medicaid programs and services are working together to rebalance the State's resources and a description of any institutional diversion and/or transitions programs or processes that are currently in operation. What additional Medicaid programs and services are needed to increase HCBS and decrease the use of institutional care?

Colorado has 11 waiver programs serving a variety of populations and currently supports 70.5 % of individuals receiving Medicaid LTC services in community settings. In 2008, Colorado ranked fifth among states in the proportion of Medicaid community based long-term care (CBLTC) spending for persons with developmental disabilities and tenth among states in the proportion of Medicaid CBLTC spending for Aged/Disabled.[1] Since 1983, policy makers, advocates and administrators have sought to downsize and close ICFs. The transition of these residents to community living has been successful. With the exception of a short-term pilot project,[2] the system for persons with disabilities and the elderly has focused on a nursing facility diversion strategy using SEPs as the gatekeeper to the LTC system. They assess and provide choice counseling to Medicaid-eligible clients seeking LTC. This effort continues to reduce the number of Medicaid residents in NFs across the state. Diversion efforts are most effective when an adequate array of services is available to prevent unnecessary institutionalization.

[1] Steve Eiken and Brian Burwell, *Distribution of Medicaid LTC Services, FY 2008.* www.hcbs.org

[2] This three-county project, using mostly referrals from nursing facility staff and paying SEP staff a bonus for each successful transition, transitioned 68 individuals from nursing facilities to community living in its first year. Colorado Department of Health Care Policy and Financing, "*The Deinstitutionalization Pilot Project; Evaluation and Status Report,*" November 30, 1998. The cost-effective project was discontinued for lack of funding.

Table 2. Unduplicated Count in Colorado Long-Term Care Programs, SFY 09-10

LTC Program	Administered by	Number served
Children's HCBS Waiver (CHCBS)	HCPF, CCBs, SEPs	1,314
HCBS-Children with Autism Waiver (CWA)	HCPF, CCBs	113
Children's Extensive Support Waiver (CES)	CDHS, CCBs	431
Children's Habilitation Residential Program Waiver	CDHS, CDH/SS	165
HCBS-Persons with Brain Injury (BI)	HCPF, SEPs	253
HCBS-Persons with Mental Illness (MI)	HCPF, SEPs	2,641
HCBS-Persons Living with AIDS (PLWA)	HCPF, SEPs	67
HCBS-Elderly, Blind and Disabled (EBD)	HCPF, SEPs	19,848
Pediatric Hospice Waiver (PHW)	HCPF, SEPs	84
Supported Living Services (DD) Waiver (SLS)	CDHS, CCBs	3,270
Waiver for Persons Developmentally Disabled (DD)	CDHS, CCBs	4,482
Nursing Facility Services	HCPF, SEPs	13,424
Regional Center (ICF)	CDHS	179
PACE - Program for All-Inclusive Care for the Elderly	HCPF, SEPs	2,641
Home Health Services	HCPF, SEPs	14,167
Home Care Allowance (state, consumer-directed fund)	CDHS, SEPs	3,058
Adult Foster Care (state-only)	CDHS, SEPs	12

Currently, hospitals and nursing homes call SEP agencies to conduct a LTC functional assessment anytime that Medicaid is going to be the primary payer for long-term care services, whether in a nursing home or in the community. As a result of this requirement, SEP agencies can counsel individuals about their community-based options.

Current Opportunities for Transfer from Institutional to Integrated Settings

A description of the number of potential participants who are now living in institutions including the number of residents in nursing homes who have indicated they would like to transition into the community.

In order to best identify qualified individuals who may be interested in discharging to a CBLTC setting, it is important to recognize the unique features of each institutional setting and the needs of individuals served in these settings. Outlined below are Colorado's various institutional settings and the number of participants interested in transitioning to the community from those settings.

Skilled Nursing Facilities (NF): In Colorado, the ULTC 100.2 is utilized to determine whether the client meets the nursing home level of care (LOC) and the client's service options.

Upon admission to a nursing home, the Pre-admission Screening and Resident Review (PASRR) is used to identify whether the individual has needs related to intellectual disability or severe and persistent mental illness (SPMI). Colorado is currently revising its PASRR survey tool to more accurately identify mental health care needs and to provide a reliable baseline for follow-up to ensure an individual's needs are being met related to SPMI or developmental disabilities. PASRR data for FY 2008-2009 indicated that 1,742 nursing facility residents had a major mental illness diagnosis, 275 had a DD diagnosis, 38 had both a major mental illness and DD diagnosis and 33% of residents were age 65 or younger. The MDS is used to evaluate an individual's functional status and clinical needs to formulate the appropriate treatment plan. According to the MDS data for FY 2008-2009, of the 9,459 individuals annually assessed at a NF, 6,461 or 68% expressed a plan or desire to return to the community. Both the MDS and PASRR tools provide an opportunity to identify whether an individual may be more appropriately served in an integrated community-based setting. These statistics indicate a number of opportunities for qualified individuals currently living in a NF to transition to an appropriate community setting.

Regional Centers (RC): RCs typically serve people who are a danger to themselves or others and/or need a combination of services and supports so extensive as to preclude community placement within available appropriated resources. Individuals admitted into an Intermediate Care Facility (ICF) at the RC must meet special criteria specific to this type of institutional setting. These criteria include exhibiting behavior that is highly dangerous to self or others; immediate, consistent and extreme aggression toward others (physical, verbal, sexual); significant socially unacceptable behavior that violates the law, or placement by the courts as an alternative to correctional placement. Residents are assessed regularly to determine if they are suitable for a successful discharge. Recently, the Grand Junction RC SNF serving 32 medically

fragile individuals was closed and all but three individuals were transitioned to a Medicaid HCBS waiver living situation in the community.

Mental Health Institutes: Of the 568 beds operated by the MHIs, 310 beds provide services to individuals referred from the county jails. These "forensic" individuals are typically discharged back to jail, or treated and progressed as appropriate back to the community. Access to affordable housing and independent living resources appropriate for individuals with a history of involvement in the court system can be achieved through exploring opportunities with development of partnerships and resource sharing agreements between community providers.

Opportunities to Self Direct Services

A description of any current efforts to provide individuals with opportunities to self-direct their services and supports. Would your State be developing additional opportunities for participants to self- direct?

Colorado's Consumer Directed Attendant Support Services (CDASS) is a Medicaid benefit under the HCBS-EBD and MI waivers that allow clients to manage their attendant services. CDASS is also included, but not yet implemented, in the SLS and CES waivers. Implementation will begin after program changes planned for the EBD waiver are evaluated for cost-effectiveness. Colorado does not plan to develop additional opportunities for participants to self-direct but will build upon its current program options. CDASS has 1,672 individuals currently enrolled and In Home Support Services (IHSS), a consumer-directed alternative to CDASS, currently has 200 individuals enrolled. CDASS provides flexibility in daily routines, giving an individual the opportunity to take greater control of their life. The Department has the statutory authority to include CDASS as a service delivery option in other HCBS waivers and provide CDASS as a state plan benefit, but current fiscal challenges require creative ways to address program design.

The Department has established a network of program specialists throughout the state to help clients enroll in the CDASS program. Several trainings with case managers will be conducted in 2011 to provide them with information and tools to better understand their role related to CDASS and IHSS clients. Stakeholders involved in the CDASS Advisory Committee recommended changes to the operation of CDASS, which are expected to go into effect March 2011.

Stakeholder Involvement

Describe the stakeholder involvement in your LTC system. How will you include consumers and families as well as other stakeholders in the implementation of the MFP program?

Colorado is committed to stakeholder involvement. The Department's LTC Advisory Committee was created in March of 2008. The Committee solicited membership from a wide variety of perspectives, including rural and urban, client and service provider, advocates and policy analysts. The Committee is responsible for making recommendations for policy changes related to LTC. A sub-committee developed the Olmstead Report. The Department also manages a SEP Administrators' Advisory Council, a Nursing Facilities Advisory Council and a CDASS Advisory Council. In 2011, the Department will establish the following sub-committees of the LTC Advisory Committee: Case Management, Housing, Outreach and Services & Benefits. All of these committees will play a key role with the implementation of the CCT Demonstration in Colorado.

Upon receipt of the CCT planning grant, the Department formed two stakeholder groups. The Participant Recruitment and Enrollment/Stakeholder Engagement Committee focused on ways to identify individuals living in institutions who may be better served in a community based setting. The Benefits and Services Committee focused on developing a menu of services to address the functional needs of CCT Participants. See Appendix C for a complete list of members for each workgroup.

b. Part # 2 Description of the Demonstration's Administrative Structure

Describe the Administrative structure that will oversee the demonstration. Include the oversight of the Medicaid Director, which agency will be the lead agency, all departments and services that will partner together, the administrative support agencies that will provide data and finance support and what formal linkages will be made and by what method, (i.e. Memorandum of Agreement, reorganization).

The Department of Health Care Policy and Financing, as the Single State Medicaid agency, has overall responsibility for organizing and operating the Money Follows the Person demonstration program. The CCT Project Director and the Project Manager will report directly to the Division Director of the Long Term Benefits Division. The Division Director reports to the Medicaid Director. The Division Director and the Project Director will ensure that the Medicaid Director is informed of all decisions and actions of the CCT Demonstration. The Medicaid Director will have the authority to inform, approve or deny decisions and actions based on the Department's strategic goals.

The Department will partner with the other state departments, including the Departments of Human Services (CDH/SS), Public Health and Environment (CDPHE) and Local Affairs (DOLA) to organize, implement and operate various facets of the CCT program. Coordination will occur through joint program development meetings (which will include stakeholders), coordination of division/agency work plans, periodic CCT staff coordination meetings and periodic reporting on program development and operation activities. Project work teams for specific facets of the demonstration, composed of participants from the relevant Departments will be organized and may be led by the CCT Project Director, the CCT Project Manager or subject matter experts. These work teams will coordinate with and report directly to their various operational divisions and departments and with the CCT project leads. Program design, development and implementation activities will be coordinated with the relevant Departments. Stakeholders for each project will provide input and be kept informed by each project lead and

by the relevant departments. CCT project stakeholders will provide input and be kept informed at the periodically scheduled stakeholders meetings and on the State's CCT web site.

Information and data on project implementation, operations and program activities will be obtained from the relevant Departments and reported to the other partner Departments and stakeholders at quarterly meetings and through semi-annual updates.

CCT project and related Department staff will work directly with the CDHS staff on: developing systems and procedures to support the transitions of individuals from Intermediate Care Facilities and Mental Health Facilities to community living, realigning roles and responsibilities of access points to LTC and transition services and improving housing opportunities for elderly and persons with disabilities. CCT project and related Department staff will work directly with the CDHS and CDPHE staff on: improving the quality management activities related to long term care services and supports and licensing new providers. CCT project and related Department staff will work directly with DOLA staff on: increasing housing opportunities for people of all abilities including those transitioning to community living under the CCT program.

Community Centered Boards (CCBs), SEPs, and CDH/SS provide access to Medicaid long-term care services and supports. These organizations will have key roles to play in the CCT project since they provide information and referral, application assistance and case management to the LTC populations in Colorado. Through a three-way contract, CDHS and the Department have oversight of the 20 CCBs. The two departments coordinate monitoring efforts of the CCBS through monthly meetings, joint meetings with CCB staff and other means. CCBs will play an important role in supporting the transitions of residents of ICF-MRs to a less restrictive

environment. CCBs will facilitate the enrollment of clients on the CCT program and HCBS waivers targeting individual with developmental disabilities.

The Department directly oversees the operations of the 23 SEP agencies. SEPs will assist clients with enrollment on the CCT program and HCBS waivers and provide case management services. The Department currently contracts or has provider agreements with SEPs for these services. The Department conducts all monitoring activities of SEPs.

The local CDH/SS offices conduct financial eligibility determination for all clients enrolling or are enrolled in Medicaid programs. SEPs and CCBs work closely with the CDH/SS to coordinate eligibility decisions. CDH/SS will establish the financial eligibility for CCT clients. CDHS has direct oversight of all 60 local CDH/SS agencies.

The State Unit on Aging within CDHS is the lead agency for Colorado's Aging and Disability Resource Center (ADRC) grant that is supporting the existing six Adult Resources Care and Help (ARCH) sites in Colorado and the expansion of ARCHs statewide. The Department partners with the SUA in developing a statewide approach to ARCHs. ARCHs provide information and referral services and application assistance to individuals exploring their long-term care options. ARCHs are not new organizations but represent partnerships between AAAs, ILCs, SEPs and CCBS at a local level. The intent of these partnerships is to streamline access to long-term care services and supports by coordinating activities between these disparate agencies to better inform communities about long-term care options. In those sites with existing ARCHs, the ARCH can play a role in informing nursing home residents and other residents receiving facility-based care.

The Department and CDHS will be key participants, along with stakeholders, in the CCT goal of realigning the roles and responsibilities of the several entry point and case management

agencies to streamline access to LTC services and supports (Benchmark #5). Discussions to better integrate and streamline access to long-term care services by leveraging the ADRC and CCT grant will begin as soon as related CCT staff can be hired.

Table 3 lists the responsibilities of the Department and the various state agencies that will partner with the Department to implement the CCT Demonstration. Each of the departments was involved in the development of the *CCT Operational Protocol.* See Appendix C for a list of the Core Team of state employees who participated in the development of the *Operational Protocol.*

Table 3. Roles and Responsibilities of Colorado State Departments and Related Agencies

Department	Services	Primary Responsibilities
Colorado Department of Health Care Policy and Financing		
Long-Term Benefits Division	The Long Term Benefits Division administers the state's long term care programs such as nursing facility, hospital backup, Home and Community Based Services (HCBS) waiver programs, home health, hospice, and Program of All-inclusive Care for the Elderly (PACE). This Division reports directly to the State Medicaid Director. The unit provides oversight and monitoring for the state's single entry point system for access to long term care programs, including those administered within the Department and those administered under agreement with the Department of Human Services. Staff within the Division is responsible for stakeholder relations, policy development and implementation, contract management and performance, program administration and overall Long Term Care (LTC) Medicaid program performance. The Division provides an important role in working toward the Department's mission to improve access to cost-effective, quality long term care services and supports for Coloradoans.	The LTC Reform Unit in the Division will have primary oversight of the CCT Project. Day-to-day operations for transitions, policy and program development, enrollment, stakeholder engagement and quality monitoring will occur through this office. Monitoring the performance of the CCT program and system benchmarks is the responsibility of the Project Director, supervisor of the LTC Reform Unit, and staff of the LTC Reform Unit.
Rates and Analysis Division	Within this Division, the Data Analysis Section exists to provide data analysis for the entire Department. The unit's analysis is to support policy-making decisions, to support and inform the Department's executive funding requests, to share data with contractors, to enable the performance of vital business functions, and to create and support required federal reports. In addition, the unit analyzes rates and data for various health plans and state plan benefits. Data analysis is performed for the preparation of decision items, fiscal notes, and analysis of ongoing trends in the Medicaid program. The unit collects, develops and evaluates provider cost data for the development of reimbursement rates and to determine the impact on rate changes.	A position within the Data Analysis Section will use database software to download, manage, and summarize data for the CCT grant. Position will be responsible for designing and providing any databases required for tracking CCT clients and their services. The position will complete research and analysis using data from ad hoc databases, MMIS and Benefits Utilization System (BUS). The position acts to educate, train, advise and counsel Department staff and management on principles and theories

Department	Services	Primary Responsibilities
		adopted in models and processes supporting decision items, programs and other areas of analytical analysis for the Money Follows the Person grant. Position is asked to work with external contractors, Federal agencies and stakeholders by providing tactical plans involving combining, modifying or adapting statistical models, theories, etc. to answer questions. This position will also act as the project manager for the overall department Data Strategy for the LTC delivery which will include both the BUS and MMIS-DSS.
Policy and Training Unit & the Public Information Officer	The Policy and Training Unit exists within the Department to work with Department staff to develop external trainings for various audiences, including case management agencies, providers, consumers, county departments of social services, general public and others. The unit assists Department staff with determining the best methodology(ies) for training, including online training, face-to-face workshops, lecture, PowerPoint, public forums, etc. The Public Information Officer and her assistant assist Department staff with designing and planning outreach activities, including brochure development, logos, external messaging, media coverage, Web site design, etc.	The Policy and Training Unit will work with the CCT Project Team to develop external trainings for the general public, case management agencies, transition coordination agencies, nursing facilities and other LTC facilities. As much as possible the CCT trainings will be integrated into already planned trainings for these agencies. The Public Information Officer will assist the CCT project team in the planning and designing of marketing and outreach activities to ensure maximum enrollment and participation in the CCT program.

Colorado Department of Human Services (CDHS)		
Office of Veterans and Disability Services • Division For Developmental Disabilities (DDD) • Division of Regional Center Operations (DRCO) • Division of Aging and Adult Services (DAAS) o State Unit on Aging (SUA)	DDD provides leadership, policy development, direction, service provision, program quality monitoring, evaluation and operational oversight for persons with developmental disabilities within Colorado. Through an IA with the Department, DDD operates three HCBS waivers for people with developmental disabilities. These functions are performed in concert with service providers, advocacy groups, consumers, and their families. DDD will provide financial and programmatic data regarding CCT/HCBS participants and qualified housing for CCT Participants. The IA will be amended to request DDD involvement and monitoring of transitions and services in the CCT program. The DRCO operates RCs to provide direct services to persons with developmental disabilities who have the most intensive and complex needs through ICFs and other services intervention. RCs provide specialty treatment services for individuals who are dually diagnosed with developmental disabilities and MI or individuals with sex offending behaviors, and short-term emergency/crisis support to the community system. The DRCO will provide data on the number of participants transitioned to the community. The DAAS/SUA operates to support seniors to live independently in their homes through the delivery of services funded by the Older Americans Act and Older Coloradans Act programs. The SUA collaborates with 16 Area Agencies on Aging (AAA) to create a comprehensive package of community services. The SUA also manages the Aging and Disability Resource Center (ADRC) Grant from the Administration on Aging/Adult Resources for Care & Help (ARCH). The SUA will provide data related to the expansion and development of the ADRC initiative in support of the CCT benchmark to redesign the LTC entry point system.	By partnering with CDHS, the Department will devote resources to transitioning individuals from the IMDs and ICFs and leverage the ADRC grant to modernize Colorado's SEP System. DDD will appoint staff that provide administrative oversight of, oversee quality and manage the data systems for the HCBS waivers for people with developmental disabilities. These staff will ensure integration of the CCT Program requirements into existing waiver administration activities. DDD and DRCO will provide data on transitions to the Department for inclusion in CCT reports.

Office of Behavioral Health & Housing (OBHH) • Mental Health Institutes	OBHH is responsible for policy development, service provision and coordination, program monitoring, evaluation, and administrative oversight for the public behavioral health system for non-Medicaid eligible citizens of Colorado, including Behavioral Health Services, two IMDs, and the Supportive Housing and Homeless Programs. The MHIs will provide data on the number of residents discharged and enrolled in CCT.	OBHH will assist the CCT Project Team with managing transitions from IMDs to the community. OBHH staff will work closely with the Transitions Administrator at the Department to coordinate these transitions and ensure enrollment into the CCT program. Staff at DDD, DRCO and OBHH will work with Department staff to plan and implement CCT-related training for staff at LTC facilities and appropriate community agencies that will be involved in the transition process.

A.2. Benchmarks (Calendar Year)

Mandatory Benchmarks

Provide a list of proposed annual benchmarks that establish empirical measures to assess the State's progress in transitioning individuals to the community and rebalancing its long-term care system. In the application, two specific benchmarks were required by all awardees.

Benchmark 1: *Meet the projected number of eligible individuals transitioned in each target group from an inpatient facility to a qualified residence during each calendar year of the demonstration.*

The number of individuals to be transitioned from institutions to qualified community living settings, by demonstration project calendar year, is shown in Table 4. In 2010, the base year, there were 11,410 elderly, 2,013 physically disabled, 2,079 mentally ill, 169 individuals with developmental disabilities and 81 clients with a dual diagnosis living in NFs. There were 179 clients with developmental disabilities living in ICFs.

Estimates of the number of individuals to be transitioned were purposely achievable and solidly based on previous Colorado experience and the experience of other states participating in the CCT demonstration program. Estimates for nursing facilities were based on a Colorado pilot project in 1998. See (previous) footnote #2. Estimates of individuals to be transitioned from ICFs were based on recent experience with closing a facility in Grand Junction.

Table 4. Number of People Transitioned to the Community

Calendar Year	Elderly NF (85%)	Physically Disabled NF (15%)	Mentally Ill in NF	Dual Diagnosis MR-DD & MI In NF	Developmental Disabilities, ICF-MR	Total per Calendar Year
2012	34	42	5	1	8	90
2013	31	42	10	1	16	100
2014	31	42	10	1	16	100
2015	31	42	10	1	16	100
2016	31	42	10	1	16	100
Total	158	210	45	5	72	490

To start enrollment into the CCT Demonstration, Colorado will need to secure the state match for services offered through the CCT Demonstration, which will require legislative approval. The Department will run CCT enabling legislation in the 2012 session which runs from January through May, 2012. The State will also need to complete system changes to the Medicaid Management Information System (MMIS), the Colorado Benefits Management System (CBMS) and case management software (Benefits Utilization System or BUS). These information system changes are necessary to identify CCT Demonstration Program participants, monitor their progress, and track their expenditures according to CCT program requirements. Based on timelines associated with each of these, enrollment into the demonstration is expected to begin in July 2012.

Although demonstration enrollment will start in 2012, Colorado is preparing to increase the number of transitions immediately in response to the new Section Q requirements in the MDS 3.0. The Department has been meeting with ILCs, SEPs and NFs to develop a strong transition process for people who have indicated an interest and have the potential to transition.

The development of a specific, detailed plan and timeline for implementation of various marketing, outreach and training activities will be completed and submitted to CMS no later than September 15, 2011. These activities will be directed towards individuals with disabilities and older adults, their friends and family members to provide information regarding the option of community living and the transition process. Referral sources will be provided clear instruction and information regarding the referral process and the role of Transition Coordination Agencies (TCAs). To ensure that providers are available to respond to the expected level of referrals, the capacity of TCAs in the state will be increased by

creating opportunities for agencies with expertise with people with disabilities, people with mental illness and older adults to become certified to provide community transition services (CTS). Referral and transition data will be compiled and monitored closely for early identification and resolution of factors that may negatively impact transition numbers. Collaborative meetings with providers involved with the transition process will occur on a regular basis to assure continuous quality improvement for transition procedures. In addition, meaningful stakeholder involvement in all aspects of development, implementation and maintenance of the CCT program will continue.

Benchmark 2: *Increase State Medicaid expenditures for HCBS during each calendar year of the demonstration program.*

State Medicaid expenditures for HCBS waiver programs are expected to continue to increase for each year of the CCT Demonstration, as shown below.

Table 5. Home and Community Based Services Programs Total Expenditures

Fiscal Year	HCBS Waivers	PACE - HCBS	Home Health	State Plan 1915(i)	Total CCT Expenses	Total Expenditures
2007-08	$513,158,934					**$513,158,934**
2008-09	$556,769,224					**$556,769,224**
2009-10	$567,984,428	$34,376,528	$159,046,227	$3,485,941		**$764,893,124**
Calendar Year						
2011	$593,770,921	$35,937,222	$166,266,926	$3,184,585		**$799,159,654**
2012	$607,249,521	$36,752,997	$170,041,185	$3,271,206	$1,426,270	**$818,741,179**
2013	$621,034,085	$37,587,290	$173,901,120	$3,360,182	$5,705,078	**$841,587,755**
2014	$635,131,559	$38,440,521	$177,848,675	$3,451,579	$5,705,078	**$860,577,412**
2015	$649,549,045	$39,313,121	$181,885,840	$3,545,462	$5,705,078	**$879,998,546**
2016	$664,293,808	$40,205,529	$186,014,649	$3,641,899	$5,705,078	**$899,860,963**

Waivers administered by the Department include: the HCBS-Elderly, Blind and Disabled, Persons with Mental Illness, Persons Living with AIDS, Persons with Brain Injury, Children's waiver, Pediatric Hospice and Children with Autism. Waivers administered by

CDHS include: Children's Extensive Support, Children's Habilitation Residential Program, Supported Living Services, and Developmental Disabilities.

Program for All-inclusive Care for the Elderly (PACE) expenditures reflect only the estimated 50% spent on community-based care. Money Follows the Person program estimates are based on past utilization rates for specific HCBS services. The expected expenditure increase in HCBS is a conservative estimate based on historical averages.

The estimates for this benchmark are based on several factors beyond the control of the Medicaid agency. Colorado has always operated a very frugal Medicaid program; however, state revenue shortfalls have placed severe strains on programs and provider rates. The budget forecast for the near-term continues to show deficits that must be resolved to balance the state budget. As always, future Medicaid expenditures are based on legislative appropriations for each year. The current expenditure trend for HCBS services is 4.54%. The Department conservatively estimated HCBS expenditures to increase at half that rate, or 2.72%, due to potential state budgeting constraints (however CY 2011 expenditures were increased at the full rate of 4.52% to account for the difference between state fiscal year expenditures and CY 2011).

Additional Benchmarks

In addition, awardees must propose at a minimum, three additional measurable benchmarks which address elements of rebalancing. These benchmarks should be measures of the progress made by the State to direct savings from the enhanced FMAP provided by this project towards the development of systems improvements and enhancing ways in which money can follow the person into the community.

Benchmark 3 (Additional): *Expand the array of supports and services available to consumers in community living situations.*

Supports Colorado's Olmstead Recommendation (Appendix B): Expand array of services; Sustainable financing; policy integration to reduce regulatory barriers.

It is necessary to have an appropriate array of supportive services available to HCBS waiver clients to optimize their independence and functional status. Failure to provide an adequate array of services can contribute to the unnecessary institutionalization of people with LTC needs. Currently, cost shifting occurs between systems such as between developmental disability service systems and the mental health service systems as a result of services being available in one waiver but not another. In addition, a HCBS client may need a service in another waiver but cannot access the service because of enrollment restrictions. By consolidating existing HCBS waivers, the Department is embarking on a major reorganization of the Department's HCBS programs and services. Through waiver consolidation the Department hopes to expand access to HCBS benefits by reducing waitlists and to effectively meet increased demand expected through demographic changes, to develop a sustainable cost-effective reimbursement methodology and improve care coordination.

Presently, each of the 11 waivers offers a limited set menu of services. Individuals applying for these waiver programs must meet the target population criteria and functional level of care to gain access to the services. In many cases, clients on a particular waiver would benefit from services on another waiver but cannot access these services because their

diagnosis or disability does not align with the target population for the other waivers. Through consolidation, the waiver specific benefit packages will be merged into a single expanded benefit package offering more service options in a consolidated waiver. For example, independent living skills training is a service currently offered in the HCBS-BI waiver. Many physically disabled clients that are currently enrolled in the HCBS-EBD waiver would benefit from this service. These clients are not able to access this service because they do not fit the target population criteria for HCBS-BI. By consolidating the menu of services between the BI and the EBD waivers, life skills training will be made available to the many clients on the EBD waiver who stand to benefit.

Such consolidation warrants that the Department establish a more person-centered and individualized assessment and care-planning process. Waiver case managers and clients will now be able to select from a wide range of services to accommodate the individual needs identified. The Department will remove an artificial barrier created by target population and diagnosis restrictions that prevent clients from receiving the services they need.

The Department intends to use rebalancing funds to conduct research and make recommendations for waiver consolidation and an appropriate array of services. As part of the process, the Department's LTC Division staff will assure waiver consolidation-designs will meet the target population requirements of Section 42CFR 441.301(b)(6). The Department will work closely with stakeholders and the CMS Region VIII office to ensure future waiver designs meet the needs of LTC clients and comply with maintenance of effort requirements. Activities to consolidate waivers include:

1. Develop recommendations for waiver consolidation and an appropriate array of services;

2. Examine the feasibility of eliminating waitlists through waiver consolidation;
3. Conduct a financial analysis for service expansion and waiver consolidation;
4. Make recommendations for a new, more individualized assessment/care planning process to better allocate services based on needs; and
5. Develop payment reform recommendations to maximize the availability of services and ensure sustainability.
6. Standardize reimbursement rates for services across waivers.

Legislative authorization for waiver consolidation and a new assessment and care planning process will be sought in 2013 with implementation expected in July 2014.

Tables 6 is a measure for Benchmark 3 and illustrates the expansion of services through 2016. Because of the policy and budget implications related to waiver consolidation, the numbers are tentative.

Table 6. Number of Services by Target Population

Calendar Year	Elderly	People with Disabilities	People with Developmental Disabilities	People with Mental Illness
2011	16	16	18	11
2012	16	16	18	11
2013	16	16	18	11
2014	23	23	19	23
2015	23	23	19	23
2016	23	23	19	23

Benchmark 4 (Additional): *Increase in the availability of self-directed services.*

Self-directed services will be made more available to individuals transitioned under the CCT program and to other Medicaid eligible individuals. The current CDASS reimbursement methodology has led to rapid growth in expenditure that the Department is still evaluating. Program standards and utilization management protocols are currently being

developed. Presently, self-directed services are authorized in the HCBS-EBD, -BI, -MI, -SLS waivers and the CHCBS waiver. However, self-direction is only implemented in the HCBS-EBD and -MI waivers at this time. The Department and CDHS will implement consumer-directed services in other HCBS waiver programs after the Department has evaluated the new measures for cost-effectiveness and determined that they are successful. Until the Department can implement a more robust CDASS reimbursement model and benefit, consumer direction will be limited to the EBD and MI waiver. The Department will not use rebalancing funds to accomplish this benchmark because the timeline for completion is before rebalancing funds will have accrued.

Cost-effectiveness for self-directed programs will be calculated by a comparison of cost of similar services outside of the self-directed program on an average per client basis. If the average cost per client varies widely between the two groups and cost effectiveness is not established, CDASS will not be implemented in other waivers under the existing program design. Rather, the consumer-directed services will be modified so that cost effectiveness can be realized. Once Colorado has a cost-effective model, the self-directed services will be implemented in more waivers and potentially expanded in the state plan through 1915(i), option for Home and Community-Based Services or 1915(k), Community First Choice..

Initially, consumer directed services will be implemented in the remaining adult waivers (HCBS-BI and -SLS) in state fiscal year 2012/13. The following year the State will implement consumer direction in the children's waivers (CHCBS, HCBS-CES). Expansion of consumer direction offered in the State Plan through 1915(i) may be considered. The 1915(i) State Plan option for consumer direction was authorized in 2008, specifically for the

purpose of continuing consumer-directed services for clients on an 1115 demonstration waiver that did not meet eligibility criteria for the HCBS waivers.

Table 7. Consumer Direction Expansion

Calendar Year	Annual Goal
2013	Consumer direction available to clients with brain injuries
	Consumer direction available to clients with developmental disabilities
2014	Consumer direction available to children with special health care needs
	Consumer direction in the State Plan approved for expansion

Benchmark 5 (Additional): *Realign the roles and responsibilities of the several entry point and case management agencies to streamline access to LTC services and supports.*

Supports Colorado's Olmstead Recommendations (Appendix B): Better inform the community about services available; Policy integration to reduce regulatory barriers.

Colorado's system to access LTC services and supports currently includes several entry point and case management agencies. These agencies have different funding streams and serve multiple LTC client groups. Currently SEPs, ARCHs (ADRCs), case management agencies, CCBs, AAAs, ILCs and Transition Coordination Agencies (TCAs) provide to varying degrees information and referral, intake and screening, eligibility determination, assessment, care planning and care coordination. While there are many existing options for accessing community-based services and supports, many consumers are confused about how to access these services or do not fully know about their options. The fragmented entry point and case management functions that exist in a community and the lack of awareness among potential LTC consumers are barriers to accessing HCBS services.

The Department plans to address these challenges by streamlining access to LTC services and supports. Creating a consumer-friendly LTC system will occur through the reorganization and integration of entry point functions and the development of collaborative

relationships at the local level to reduce the time it takes clients to access the right services to meet their needs. This realignment of roles and responsibilities of AAAs, ILCs, SEPs and CCBs will be accomplished by leveraging the CCT rebalancing funds with the ADRC grant supporting the statewide expansion of ARCHs. These networks and partnerships through the ARCH will provide options counseling to individuals and their families about LTC services and assist them with accessing the system regardless of funding sources. To ensure successful transitions to appropriate setting some ARCH sites and SEPs have already built relationships with the hospital discharge planners in their communities. These relationships need to be replicated in other parts of the states.

The key tool to accomplish this integration is a new information management system to support person-centered communication and information sharing at the local level. The Department will use rebalancing funds and other funding sources to implement this new system. The information management system will support key ADRC functions, such as information and referral, intake and screening for program eligibility, functional eligibility determination, assessment and service planning.

To ensure that residents in LTC facilities are afforded the same opportunity to explore their options for LTC services and supports, the Department in the short term will increase the number of Transition Coordination Agencies (TCAs) in response to individuals referred through the new section Q Return to Community requirements and to accommodate referrals to the CCT program. The Department is already meeting with TCAs, which are the Local Contact Agencies (LCAs) for Section Q referrals, and NFs to establish a streamlined process for identifying and referring individuals in NFs who want to transition to community living using the MDS.

In Colorado, the TCAs are the agencies responsible for providing client transition services under the HCBS-EBD waiver and will extend transition services to CCT participants. These TCAs serve as the link between NFs, case management agencies and housing authorities by providing NF residents with information about their options and relocation services. The Department will strengthen the network of TCAs and develop collaborative relationships between nursing facilities and TCAs. This will initially involve expanding the number and type of TCAs providing long-term care choice counseling and Community Transition Services (CTS) to residents of NFs. Six ILCs have been providing CTS and are serving as TCAs, but do not have statewide coverage. The Department will recruit other community-based agencies such as behavioral health organizations, ARCH programs (ADRCs), SEPs and AAAs, to become TCAs.

This expansion will increase the Department's capacity to inform NF residents about their community-based options and provide client transition services. It also lays the foundation for a closer working relationship between ILCs, SEPs, CCBS and AAAs as ILCs and AAAs become TCAs. As Colorado expands the ARCH initiative, coordination and collaboration between these agencies will be essential to creating the design of Colorado's ARCH system in the future. Table 8 illustrates the ARCH expansion plan for Colorado. Table 9 outlines the transition coordination agencies expansion plans.

Table 8. ARCH Expansion Plan

Calendar Year	Counties with ARCH Sites
2011	23
2012	33
2013	47
2014	60 (Statewide)
2015	60 (Statewide)
2016	60 (Statewide)

Table 9. Expand the Number of Transition Coordination Agencies Benchmarks

Calendar Year	Number of CCT Client Transition Coordination Agencies
2010	9
2011	14
2012	14
2013	20
2014	20
2015	25
2016	25

CCT project staff, HCPF and DHS staff will organize Medicaid service providers and state contractors to promote the efficient access of all transition candidates to services of their choice. CCT administrative funds, HCPF and DHS in-kind staff support will be used to support the effort to better connect the local agencies that support an individual transitioning from long-term care facilities. CCT rebalancing funds may be used when they become available to support additional system development and training in supporting transitions.

Benchmark 6 (Additional): *Increase access to housing opportunities for individuals of all abilities including those transitioning to community living under the CCT program and to other HCBS clients seeking community residential housing.*

<u>Supports Colorado's Olmstead recommendations (Appendix B):</u> Increase housing options available for people with all types of disabilities.

The Department will focus on expanding the inventory of qualified residences for people with disabilities and older adults by working closely with the Division of Housing. The lack of affordable and accessible housing to individuals who wish to transition from LTC facilities is a major barrier to returning to the community. Increasing the inventory of housing units available for LTC clients, particularly those in facilities, will increase the opportunity for these clients to receive services in a community setting and increase enrollment into HCBS programs. The Department will develop and maintain strong

partnerships with the Department of Local Affairs Division of Housing, Supportive Housing and Homeless Programs, the Colorado Housing and Finance Authority, local public housing authorities and the U.S. Department of Housing and Urban Development (HUD) in support of expanding access to accessible, affordable, and integrated housing options for people with disabilities and seniors transitioning out of institutional settings and into the community. Colorado will create a new Housing Program Coordinator position located in the Department of Local Affairs, Division of Housing (DOH) that will split its time with the DOH and the Department. The Coordinator will work with all the stakeholders, local, state and federal agencies to maximize the use of existing housing resources and will develop a comprehensive housing strategy to guide efforts toward expanding the availability of CCT qualified, affordable and accessible housing for all vulnerable populations.

For those individuals transitioning to a subsidized housing unit, the CCT project may use rebalancing fund dollars to provide a short-term rental subsidy as bridge funding until permanent housing benefits are established. No federally-matched HCBS service dollars or CCT grant funds will be used for the rental subsidy. Permanent housing is an apartment or a house with a month to month or annual lease or even a mortgage, which provides families and individuals with a fixed address for long term in the community. It may or may not be subsidized.

These housing benefits will include 60 Housing Choice Voucher Access Program set asides with preferences for CCT clients and the Tenant-based Rental Assistance (TBRA) program using federal HOME funds to provide a temporary rental subsidy that will be targeted to persons with disabilities and those transitioning out of nursing facilities. This bridge subsidy is intended to provide consumers with supportive housing rental assistance

while creating a structured link to a more permanent subsidy through the Section 8 Housing Choice Voucher program. Other housing benefits that Colorado will leverage included project based units, HUD 202 and 811 projects, tax credit units and other federal and state funded housing projects.

In addition, the Division of Housing and Housing Program Coordinator will meet with and solicit support from local housing authorities for local preferences and set-asides for CCT individuals, starting with the largest metropolitan areas. A web-based application, Coloradohousingsearch.com developed by the Colorado Housing Finance Authority and the DOH Division of Housing, will become a key tool used by case managers and transition coordinators statewide to provide real time information on available, affordable, and accessible units throughout the state. The availability of the registry will be publicized through other information and referral sources such as AAAs and ARCHs (ADRCs) so that individuals and families interested in obtaining affordable, accessible housing will be able to search this Web site. The inventory/registry will include the number of affordable housing units and accessible units. Another Web site will display the number of housing vouchers currently available and the number dedicated to individuals with disabilities and identifies existing subsidized units, including supportive housing for people with disabilities and the elderly. Table 11 illustrates the number of CCT participants accessing subsidized housing options. The other 120 participants will either transition to a group home setting of four or less unrelated individuals or transition to a family home.

Table 11. Increase access to housing opportunities for CCT Clients

Calendar Year	Percentage of new CCT participants accessing subsidized housing options
2011	0
2012	50%
2013	50%
2014	50%
2015	50%
2016	50%

B. DEMONSTRATION POLICIES AND PROCEDURES

B. 1. Participant Recruitment and Enrollment

a. Provider Selection

How will the service provider be selected and does the State intend to engage the State's Centers for Independent Living in some role in the transition process.

Collaboration between state agencies, Transition Coordination Agencies (TCAs), local service providers, case management agencies, NFs and other LTC facilities will be critical to the success of CCT Participants transitioning to the community. Existing Transition Coordination Agencies (TCAs) will perform as service providers in the transition process for CCT clients. These agencies are the designated Local Contact Agencies (LCAs) for the Section Q Return to Community requirements that NFs follow as of October 1, 2010. The TCA has the responsibility to follow-up on Section Q and CCT referrals and assess the residents' interest and potential to transition.

The Department will increase the number of TCAs by extending TCA certification to providers qualified to provide specialized services to the elderly, mentally ill and developmental disabled. Potential agencies could include ARCHs and AAAs for older adults; Community Centered Boards (CCBs) and Program Approved Service Agencies (PASAs) for people with developmental disabilities; or BHOs or Mental Health Centers (MHCs) for people with mental illness. Most ILCs in Colorado are certified as TCAs and will play a key role in coordinating the transitions of the CCT clients.

TCAs are certified by the Department to provide Community Transition Services (CTS), which are a benefit in the HCBS-Elderly, Blind and Disabled Waiver (EBD). Transition services are activities essential to move a client from a LTC facility to a community-based residence. CTS will be extended to all CCT clients as a demonstration service. Transition coordinators providing transition services will be required to meet qualifications identified in

waiver rules. Transition coordinators will have experience working with nursing facility residents and staff. They will be social workers, nurses, or other individuals with documented expertise with senior services, independent living or other related work. The transition coordinator will lead the team that will facilitate the resident transition. The transition team consists of the client, family members, facility staff, the transition coordinator, the intensive case manager and the primary care provider at a minimum. The transition coordinator will include other essential team members as necessary such as mental health providers and community-based providers.

Transition coordinators provide one-on-one relocation assistance during the transition to community settings. The transition coordinator will assess whether or not the client has the potential to transition based on input from the transition team. Once transition potential is established, the transition coordinator works with the client and transition team to create and implement a transition plan. The transition coordinator will use the Transition Assessment/Plan (Appendix D) to assess potential and plan for the transition.

The assessment portion is a quick inventory of the client's needs, reasons for admission, medical conditions, social supports and transition history and is completed in first few visits with the client. In addition, the assessment documents support for the decision to return to the community from the transition team and the client's interest in pursuing the transition. In consultation with the transition team, the transition coordinator will make a decision about the potential for transition. In those instances where supports and services are not adequate in the community and the client is wanting to transition, transition team will inform the client and guardian if one is appointed of the safety concerns associated with returning to the community and may determine that the client does not have the potential to transition.

However, the team will make every effort to accommodate the client's choice provided costs do not exceed the costs for facility placement and an appropriate risk mitigation plan is in place. If the Community Transitions Administrator sees a trend among clients interested in transitioning facing common barriers with accessing specific resources either geographically or statewide, the Department will work with the local TCAs and case management agencies to develop resources.

The transition plan will include coordination with other agencies as needed, including the nursing facility, intensive case management agency, senior services, ombudsman, CCBs, primary care and mental health centers. The coordinator will also work with the client to find housing, services and items needed to establish a community-based residence following the goals of the transition plan. The transition plan is a short-term plan designed to identify the immediate relocation needs of the client upon discharge from LTC facility and is designed to quickly inform the transition team about the needs of the client that need to be addressed. It directs the transition coordinator in obtaining household items for the client, making a complete referral to a case management agency, locating qualified housing and verifying CCT program eligibility and obtaining informed consent from the client or guardian.

CTS will begin while an individual is residing in an institutional setting and continue during transition and post transition for 30 days to ensure a stable relocation. Upon referral from a LTC facility, the transition coordinator has 10 days to respond and meet with the resident and facility staff. One week following the meeting, the transition coordinator will complete an initial transition assessment, which will be shared with the transition team.

The CTS benefit includes a one-time $2,500 allowance to help the client establish a community residence. Household items must be for the benefit of the client only and may be

purchased only when they cannot be provided by other means. Items that may be purchased with CTS funds include the following:

- Security deposits that are required to obtain a lease on a residence;
- Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- Household items and furnishings such as a bed, linens, seating, lighting, dishes, utensils and food preparation items;
- Moving expenses required to occupy a community-based residence;
- Health and safety assurances including one-time pest eradication and a one-time cleaning prior to occupancy; and
- A one-time purchase of food not to exceed $100.

CTS funds cannot be used to purchase the following:

- Monthly rental expenses or other ongoing periodic residential expenses; and
- Recreation, entertainment or convenience items.

TCAs are monitored by the Community Transitions Administrator at the Department. TCAs report all transitions to the Administrator and problem-solve difficult transitions. The administrator is responsible for reviewing client files to ensure eligibility for the CCT programs, training staff at TCAs, identifying and resolving common barriers to transitions and improving the transition process. The administrator will also have responsibility for recruiting new TCAs as Medicaid providers to meet the requirements for CCT and Section Q.

Intensive case management services will be provided to CCT participants thorough intensive case management agencies and takes the place of case management under the

traditional HCBS waiver services. The client pursuing enrollment into the CCT Program will have a choice of agencies. After the transition coordinator has established the potential to transition and obtained the resident's consent to participate in the CCT program, the transition coordinator will inform the client of their options for case management agencies. After selection, the transition coordinator will make a referral to the selected intensive case management agency. Once a case manager is assigned, the intensive case manager will be an active participant on the resident's transition team. The assigned case manager will review the Colorado's universal LTC assessment tool (ULTC 100.2), which is used to determine functional eligibility for Medicaid long-term services and support. After review, the case manager will generate a new program certification page authorizing enrollment into the CCT program no later than 10 days after the referral. A new ULTC 100.2 assessment is not needed unless it has been more than a year since the last assessment or there has been a significant change in the client's functional status.

The Transition Coordinator will notify the case manager of the targeted discharge date. Prior to discharge, the case manager will develop an initial CCT Plan of Care (POC) (Appendix F) with input from the transition coordinator, LTC facility staff, resident, family and other members of the transition team. The Transition Assessment/Plan and MDS will inform the development of the POC. The CCT POC will be an addendum to the existing plans of care specific to each HCBS waiver. The POC in conjunction with data from the LTC facility, ULTC 100.2 and the transition assessment will provide a comprehensive evaluation. The CCT POC will identify risks to community placement and outline a contingency plan and services and support, paid and unpaid, necessary to mitigate the risk. The POC is approved by the Transition Administrator at the Department before transition begins.

Assessment and care planning activities will include input from the client and appropriate collaterals (such as family members, physicians, advocates, friends, and/or caregivers). The POC will be informed by the client's level of functioning, service needs, available resources and potential funding resources. Through this process, the intensive case manager will document the client's goals and choices for services and service providers.

The intensive case manager will arrange for long-term home health and/or HCBS services to be in place at the time of discharge. The transition coordinator will work with the resident to find a permanent housing option in the community and obtaining necessary household items to establish a safe and adequate home environment.

The transition coordinator and the case manager will provide joint services with the transition coordinator during the 30-day post transition period. During this time, the transition coordinator and the intensive case manager will conduct a joint visit the day of discharge and two additional joint visits in the first month of the transition. After any of the home visits and assessing the new home environment, the intensive case manager will revise the POC as needed to ensure that the client's needs are met in the community. Additionally, the transition coordinator will check-in telephonically with the client 48 hours post-discharge and weekly during the first month. The intensive case manager will assume monitoring responsibilities for the CCT participant at the end of the 30 day post-transition period. Table 12 lists the responsibilities of the transitions coordinator and the intensive case manger.

Table 12. Table of Responsibilities

Transition Coordinator	Intensive Case Manager
Act as advocate for Medicaid LTC facility resident	Complete intake and screening for Medicaid long-term services and supports
Identify potential facility residents that desire to return to their community	Conduct functional assessment & reassessment
Receive referrals from facility resident, family, friends, case managers, LTC facility staff	Develop HCBS/CCT care plans

Transition Coordinator	Intensive Case Manager
Provide Options Counseling to referred facility residents	Determine functional eligibility for Medicaid LTC programs
Obtain informed consent to participate in the CCT Program from the client or guardian	Coordinate community transitions with the transitions coordinator
Make a referral to an intensive case management agency	Arrange and broker long-term care services and supports
Convene transition team	Coordinate and monitor the delivery of needed services
Complete the Transition Assessment/Plan	Communicate with service providers regarding service delivery and concerns
Review the Consumer Transition Guide with the client and coach the client with completing questions	Review and revise services, as necessary
Assist the resident with finding qualified housing upon discharge (group home, assisted living, apartment, subsidized housing or family home)	Notify clients regarding any change in services
Purchase household goods and assistive devices with relocation funds available through CTS benefit	Notify clients when services are denied, suspended, terminated, or reduced
Complete other activities necessary to establishing a community residence	Document, report, and resolve client complaints and concerns
Coordinate the facility discharge with the transition team	Report abuse, neglect, mistreatment, and exploitation to the appropriate authority
Monitor the client for the first 30 days following the transition with the intensive case manager	Coordinate the transition to another case manager if necessary upon disenrollment from the CCT program and enrollment into a traditional HCBS program

Intensive case management services include functional needs assessment, care planning, intake, screening, referral and coordination and monitoring of service delivery. Intensive case management services are provided at a higher level of frequency than traditional HCBS case management to support the continued success of the community placement. CCT participants will be monitored closely and reassessed monthly to ensure that required services and supports are made available as needed. An important objective of intensive case management is to ensure the uninterrupted provision of services identified in the transition plan and the

POC. Monthly reassessments will be conducted to ensure that the type and level of services needed by the client are in place. Evaluation of the effectiveness and appropriateness of those services will be achieved through steady and consistent contacts with the client, appropriate collaterals and service providers. Revisions to the CCT POC will be made based on the required monthly contacts. Towards the end of the demonstration period, the intensive case manager will prepare the CCT client to disenroll from the demonstration and continue with HCBS waiver services.

Intensive case managers will have at least a bachelor degree. They will be social workers, nurses or have related experience. They will have documented expertise with the specific client population they will serve.

For people with developmental disabilities transitioning out of Intermediate Care Facilities, CDHS staff will support participants to access case management and CCT-related community-based services. Staff at the Division for Developmental Disabilities (DDD) in CDHS will work to build community capacity specific to deinstitutionalization, provider capacity, housing options and other support needs. They will also work with case management agencies in order to build capacity to work with individuals from nursing facilities and ICFs. Additionally, the DDD staff will work directly with the ICF staff to identify individuals living in ICFs and match them with the appropriate agencies and services to ensure a smooth transition. DDD staff and case management agencies assisting with transitions will follow the same protocols for CCT enrollment, transitions and informed consent as described in this protocol.

The CCT Community Transitions Administrator at the Department will work with BHOs to build highly specialized community behavioral health capacity related to

deinstitutionalization from state hospitals and nursing homes. The BHOs and Institutes for Mental Disease (IMD) staff will help identify eligible residents in IMDs and coordinate their return to the community with local Mental Health Centers (MHCs) or BHOs serving as a CTA. The CCT Operational Protocol will apply to those transitioning from IMDs.

Effective system collaboration will be crucial to the health and well-being of CCT clients. A CTS meeting which includes all providers involved with transition process will be held monthly with the Community Transitions Administrator. The purpose of this meeting will be to promote quality assurance for the CCT transition process through ongoing provider communication, problem identification and resolution and continual program evaluation.

b. Participant Selection Mechanism

The participant selection mechanism including the criteria and processes utilized to identify individuals for transitioning. Describe the process that will be implemented to identify eligible individuals for transition from an inpatient facility to a qualified residence. Please include a discussion of: the information/data that will be utilized (i.e., use of MDS Section "Q" or other institutional data); how access to facilities and residents will be accomplished; the information that will be provided to individuals to explain the transition process and their options, as well as the state process for dissemination of such information.

Colorado will adopt the least restrictive CCT eligibility criteria permitted by the authorizing legislation:

- CCT Participants will have one paid day of Medicaid eligibility in an inpatient facility prior to transition; and
- CCT Participants will have resided in an inpatient facility for at least 90 days. If an individual is admitted to a facility to receive rehabilitative services, the days will not count towards the 90 day residency requirement.

The populations that will be transitioned through the demonstration include the following:

- Elderly and disabled adults aged 18 or older residing in Medicaid NFs;
- Adults aged 18 and older with developmental disabilities residing in ICFs and NFs;

- Adults 65 years and older and individuals under 22 residing in institutions for mental disease (IMDs).

To identify candidates for transition and participation in CCT, the Department, LTC facilities, TCAs and case managers will use data from the Minimum Data Set (MDS) data, Pre-Admission Screening and Resident Review (PASRR) data and IMD and ICF patient information. Individuals who request transition information through the MDS 3.0 Section Q procedure will be included in transition efforts. The numerous referral sources to the CCT program include residents, friends, family members, ombudsman, nursing facility social workers, and IMD and ICF staff. Individuals who are interested in CCT transition services are referred directly to a TCA in the region of his/her residence. Initial CCT referrals are made by telephone. The Department, case management agencies and TCAs will provide education to facility residents, facility staff, providers, stakeholders, family members, provider associations and ombudsman through flyers, informational meetings and the CCT Web page. The Department will target specific training efforts to LTC facility residents and staff regarding MDS 3.0 Section Q and the CCT demonstration. MDS Section Q requires NFs to ask residents if they have an interest in learning about LTC community-based options. If the resident says yes, the NF is required to make a referral to a local contact agency that can inform the resident of his or her options.

Access to NFs and residents will occur through the MDS 3.0 Section Q procedure. Recently, the Department formed a workgroup in response to the new Section Q requirements in the MDS 3.0. This workgroup consists mostly of ILCs that provide community transition services. This workgroup has met with the Colorado Health Care Association, which is a membership organization for nursing and assisted living facilities.

Together they have developed protocols for MDS Section Q (Appendix E) to ensure timely and appropriate response to NF residents requesting information about community living option. The workgroup is also considering the development of an ethics committee to decide on cases where transition potential is very difficult to ascertain. This workgroup will directly contribute to the development of a consistent transition process for both CCT and non-CCT Medicaid clients. Per MDS Section Q referral protocols, the nursing facility must contact the TCA within 10 days of resident responding "Yes" to the return to community question. The TCA has 10 days to respond to a CCT referral.

Access to ICF-MRs and IMDs will occur through CDHS staff in the Division of Regional Center Operations and Office of Behavioral Health and Housing.

The PASRR Level II Enhanced Evaluation will contain a transition section requiring comprehensive assessment of transition potential and community resource need. Individuals assessed as having transition potential will be referred to transition readiness services as a mandated Level II Specialized Services. The PASRR client data from the Level II will be reported to the Department's PASRR Program Administrator on a monthly basis. For those clients identified to have transition potential, the PASRR evaluator will refer the names to the PASRR Program Administrator. The Administrator will make the referral to the local TCA.

A State referral database will be developed and will include the following data: TCA monthly referral logs; MDS data from Colorado Department of Public Health and Environment (CDPHE); and Monthly PASRR Level II outcome report. The CCT LTC Facility Resident Transition Coordinator will monitor the State referral database to assure that required referrals are being made to the TCA, that an initial resident visit is conducted

and that a determination is made regarding client choice to continue transition assessment process.

The Resident Transition Coordinator will monitor all referrals to ensure continuity of care between providers involved in the transition process. Providers who are involved with the institution to community transition process meet on a monthly basis to identify and resolve issues that create obstacles to transitions. Providers involved in this meeting include TCAs, case management agencies, ombudsman programs and nursing facilities. Continuity of care issues are discussed on a regular basis at these meetings. The Facility Resident Transition Coordinator will also work with TCAs to problem-solve obstacles to individual transitions.

c. Qualified Institutional Settings

The qualified institutional settings that individuals will be transitioning from, including geographical considerations and targeting. If targeting certain facilities, the names of the identified facilities and an explanation of how the facilities being targeted meet the statutory requirements of an eligible institution.

All Medicaid-licensed nursing facilities, institutions for mental disease and state-operated ICFs in Colorado will be included in the CCT Demonstration. The Department will not direct attention to certain geographic areas but will instead focus on developing the capacity to reach out to all areas of the state.

d. Minimum Residency Period

The minimum residency period to conform to the changes made to Section 6071 by the ACA reducing the minimum number of consecutive days to 90 in an institutional setting with the statutory exception noted in the ACA; and who is responsible for assuring that the requirement has been met.

CCT clients will meet the minimum residency requirement of at least 90 days. If admitted for a rehabilitation stay, clients will not be eligible until 90 days after the rehab stay is complete. The transition coordinator and the assigned case manager will review individual client records to confirm the residency requirement as part of the transition

assessment and transition plan development. In addition, the CCT Project Manager at the Department will assure that the residency period requirement has been met.

e. Participant Eligibility for CCT Demonstration

The process (who and when) for assuring that the MFP participant has been eligible for Medicaid at least one day prior to transition from the institution to the community.

The Department will implement a process for assuring that CCT clients have been eligible for Medicaid. The TCA and case management agency will send all CCT Demonstration enrollment documentation to the CCT Project Manager. The documentation will include the transition assessment/plan, the informed consent form, POC, Prior Authorization Requests for Services and any required level of care (LOC) determinations. The Project Manager will review the enrollment documents and verify eligibility with the Department's Eligibility Section. The Project Manager will assure that the CCT Participant has been eligible for Medicaid at least one day prior to transition to the community.

f. HCBS Service Provision Determination

The process for determining that the provision of HCBS to a participant enables that participant to be transitioned from a qualified institution. Formal Level of Care determinations are not required prior to transitioning into the MFP program for the 365 day period. States may elect to develop an assessment of eligibility that takes into consideration the readiness for an individual to transition into the community with identified transition services and appropriate long-term care services.

Clients will be enrolled into the CCT Demonstration and the appropriate HCBS waiver. The CCT project manager will manage the enrollment. The assigned intensive case manager will complete a formal LOC determination using the ULTC 100.2 Assessment Form only if a LOC determination for nursing home or ICF-MR placement has not been completed or if the most recent determination was completed more than six months ago. Transition coordinators will use the attached Transition Assessment/Plan (Appendix D) to determine the individual's readiness for transition, to identify risk and associated strategies to mitigate risk and to plan for the needed LTC services and supports. The philosophy of independent living and the

direct experience of many ILCs and community service providers is that level of community supports available to the client, not the type or severity of disability, is the key factor in successful community integration. The goal of the Transition Assessment Plan is not to determine if the individual has the capacity to transition to the community but rather to identify specific service needs and to build a support system to mitigate risk. The philosophy is based on the assumption that individuals can live successfully in the community with appropriate supports and services. Key components are assessed to ensure that the assessment will provide a thorough understanding of the individual's needs, preferences and desires. The assessment will identify areas that may present higher risk for the client. For each identified need there is a documented strategy for supporting the client in addressing the need in the community. Assessments for each service will specifically describe the type of service necessary and the required frequency and/or intensity as well as the purpose of the service. This information will be assessed in collaboration with the intensive case manager and other members of the transition team with the final decision on the readiness of the individual for transition being made by the transition coordinator.

g. Re-Enrollment into the Demonstration

The State's policy regarding re-enrollment into the demonstration. That is, if a participant completes 12 months of demonstration services and is readmitted to an institution including a hospital, is that participant a candidate for another 12 months of demonstration services? If so, describe the provisions that will be taken to identify and address any existing conditions that led to re-institutionalization in order to assure a sustainable transition.

For those individuals readmitted to an institution before reaching twelve months in the CCT Demonstration, their 365-day demonstration period will resume upon re-entering the community setting. Former CCT clients who have completed their demonstration period and have been re-institutionalized are eligible to re-enroll as new CCT clients so long as they meet the institutional residency requirement (90 days) and continue to be Medicaid eligible.

In all cases, a thorough review of the original transition by the transition coordinator, the intensive case manager and other providers will be conducted to mitigate any problems for a second transition If an individual's condition changes indicating a better chance for a successful transition into the community they may re-enroll. A new POC, using updated information from the Transition Assessment/Plan, with input from the CCT applicant, the family, the intensive case manager, transition coordinator and facility staff will be written each time there is a significant change in an individual's condition. The new POC will be developed to address the reasons for the individual's re-institutionalization. Every attempt to have the new POC meet the needs of the individual and prevent re-institutionalization will be made.

An individual has the right to be served in the least restrictive environment and thus the decision to re-enroll in the demonstration program will reside with the individual and or his/her legal guardian.

h. Training and Dissemination of Information

The State's procedures and processes to ensure those participants, and their families will have the requisite information to make informed choices about supports and services. The description shall address:

i. How training and/or information is provided to participants (and involved family or other unpaid caregivers, as appropriate) concerning the State's protections from abuse, neglect, and exploitation, including how participants (or other informal caregivers) can notify appropriate authorities or entities when the participants may have experienced abuse, neglect or exploitation.

ii. Identify the entity or entities that are responsible for providing training and/or information and how frequently training and education are furnished.

The Department will establish procedures and processes to ensure that CCT Participants have the requisite information to make choices about their care available through the CCT Demonstration. The ability of an individual to receive adequate information and make informed choices about their living arrangements and the type of

services available in CCT is essential. The CCT Demonstration services that will be used to transition individuals from NFs, ICFs or IMDs back into the community require that the Department develop methods to substantiate that CCT Participants are afforded choice. The state must substantiate that CCT Participants are afforded choice between 1915(c) waiver services and institutional care, between the Demonstration and institutional care and among service providers.

During the process of outreach to nursing facility and ICF residents, transition coordinators visit residents to discuss the transition process. Over the course of one or more visits, a transition assessment/plan is completed. The transition coordinator will provide the client with a list of case management agencies in the area that can provide intensive case management. Upon selection, the transition coordinator makes a referral to a local case management agency for assignment of an intensive case manager. The intensive case manager provides information about the transition process, long-term service and supports, options available to the resident, consumer-directed service options and the types of residential settings available under the programs. The same type of information identified is provided to residents of NFs, ICFs and IMDs. During this process, the applicant, guardian, authorized representative or family member is provided with verbal and written explanation of the services and supports for which the applicant may be eligible. The CCT Applicant will indicate their preference for services on the POC.

Transition coordinators and intensive case managers will provide information in writing about reporting policies and procedures for incidents of abuse, neglect, exploitation and critical incidents. This information will include local and toll free numbers for Adult Protective Services, for the local LTC ombudsman, for filing complaints about service

providers with case management agencies or the Colorado Department of Public Health and Environment (CDPHE) and the phone number for the CCT Project Manager. This information will also be discussed and reviewed during the reviews of the POC by the intensive case managers. The Department will conduct a desk review of all critical incident reports and coordinate with the appropriate agency to investigate allegations.

The following entities are responsible for training of CCT clients:

- Community transition coordinators;
- Intensive Case managers;
- Nursing Facility staff;
- Mental Health Center staff (MI);
- Intermediate Care Facilities staff;
- Long-Term Care Ombudsman; and
- ARCH (ADRC) staff.

The Department and partnering state departments will routinely hold training conferences for providers of long-term services and supports. The type and frequency of training is addressed in the Outreach/Marketing/Education section of the *Operational Protocol.*

B.2. Informed Consent and Guardianship

a. Informed Consent

a. Provide a narrative describing the procedures used to obtain informed consent from participants to enroll in the demonstration. Specifically include the State's criteria for who can provide informed consent and what the requirements are to "represent" an individual in this matter. In addition, the informed consent procedures must ensure all demonstration participants are aware of all aspects of the transition process, have full knowledge of the services and supports that will be provided both during the demonstration year and after the demonstration year, and are informed of their rights and responsibilities as a participant of the demonstration. Include copies of all informed consent forms and informational materials.

CCT Applicants will be part of the transition from the very beginning of the process, assuming the highest degree of self-direction possible. Each eligible applicant will receive a Consumer Transition Guide that will be developed with stakeholder input by January or February 2012 (see Appendix G for draft Table of Contents). The Transition Assessment/Plan form in Appendix D will also be used. The Transition Guide will provide a step-by-step guide to the transition process for the potential CCT client, including a self-assessment tool. Facility staff or the transition coordinator will provide informational materials and the Transition Guide to potential clients and encourage them to complete the self-assessment tool prior to meeting with the transition coordinator. Completion of the self-assessment is an important first step in considering the risks and responsibilities associated with independent living in the community. Those applicants who need assistance with the self-assessment process will be supported by transition coordinators during their first meeting.

For Section Q – Return to Community referrals, nursing facility staff will make a referral to the Local Contact Agency (LCA) or TCA within ten days for those residents who express a desire to learn about their community-based options. The nursing facility, the assigned intensive case manager and the transition coordinator will meaningfully engage the resident in their discharge and transition plan and collaboratively work to arrange for all necessary community-based long-term care services and supports. The same collaborative approach to planning transitions and informing applicants will occur for residents in IMDs and ICFs. Transition coordinators will review the applicants' responses to the self-assessment tool and provide information materials at the first planning meeting. The initial meeting will include the following objectives:

- The applicant will understand the purpose, procedures, risks and benefits of participating in CCT;
- The applicant will understand the transition process and will have full knowledge of the services and supports he or she can expect both during the demonstration and after the demonstration year;
- The applicant will understand procedures designed to ensure privacy of the participants and confidentiality of the data;
- The applicant will understand their options for self-direction;
- The applicant will understand the ways in which they will have a choice in selecting their community-based residence;
- The applicant will understand their rights; and
- The applicant will understand the responsibilities of participating in the demonstration.

Applicants should already have some level of understanding regarding the program as a result of reviewing materials and completing the self-assessment tool. The meeting with the transition coordinators will provide an additional opportunity for discussion to ensure a clear understanding and to ask additional questions. After discussion, residents interested in moving to the community who do not require a guardian will indicate their preference by completing the intake process, which includes the CCT Informed Consent Form (see Appendix H) and the Transition Assessment/Plan. When a guardian has been appointed, the transition coordinator will have the guardian sign the informed consent form and be engaged in care planning and other health care or everyday needs of the client.

Colorado statute addresses criteria for determining who can provide informed consent and what the requirements are to represent an individual in this matter. Statute requires that a

functional analysis be used in determining incapacity, whether the person can make decisions that are in the individual's best interest regarding his or her personal affairs. The other important aspect of the definition of an incapacitated adult is its encouragement of the use of appropriate, reasonably available technological assistance. If such technological assistance enables an otherwise incapacitated adult to receive the information necessary to make decisions regarding his or her personal affairs that are in his or her best interests, and allows the person to communicate such decisions, then a guardianship is unnecessary.

Any person age 21 or older may be appointed as a guardian regardless of whether that person is a resident of Colorado. Family members, professional guardians, volunteers, or in some counties, the Department of Human Services may serve as guardians. The Colorado court considers qualified persons as guardians in the following order of priority: (1) a currently acting guardian; (2) a person nominated as guardian by the respondent; (3) an agent under a medical durable power of attorney; (4) an agent under a general durable power of attorney; (5) the spouse of the respondent or a person nominated by a will or other signed writing of a deceased spouse; (6) an adult child of the respondent; (7) a parent of the respondent or an individual nominated by a will or other signed writing of a deceased parent; and (8) an adult with whom the respondent has resided for more than six months immediately before the filing of the petition. If good cause is shown, the court can appoint as guardian someone who has lower priority or no priority at all.

A guardian living out-of-state can hire a local case manager to assist in carrying out the guardian's duties. Frequently, the scope of a guardian's authority includes determining where the ward should live, and arranging for and making decisions for the ward's care, medical treatment, and other services. If no conservator is appointed and the ward has

limited assets, the guardian may also need to address basic financial management issues for the ward. A guardian should make decisions after consulting with the ward, taking into account the ward's wishes and personal values, to the extent it is reasonably possible to do so. The guardian should encourage the ward to participate in decision-making.

A ward or a person interested in the welfare of the ward may petition for removal of a guardian on the grounds that removal would be in the best interest of the ward or for other good cause. In Colorado, this may include Ombudsman or other advocates. A guardian may also petition to resign. Either a petition to resign or a petition for removal may include a request for appointment of a successor guardian.

Under Colorado law, long-term care providers are prohibited from serving as guardian or conservator of a person for whom they provide care unless related by blood, marriage, or adoption. In addition, a professional guardian ordinarily will not be allowed to serve as both guardian and conservator, or as guardian and direct service provider, unless the court determines that good cause exists to allow the professional to serve in dual roles. In the event that a resident or CCT client's rights are violated by a provider while exploring his or her options related to transitioning or while participating in CCT, then the client, guardian or provider can file a complaint with the case management agency that provides intensive case management services, CDPHE or the Department. An assigned intensive case manager will investigate the incident and resolve the complaint at the lowest level possible. If the CCT client or nursing home resident believes his or her rights were violated by the intensive case manager, then the client can make a complaint to a supervisor at the case management agency. If the supervisor does not satisfactorily address the complaint, the client or guardian can escalate the complaint to the Department. In either case, the supervisor at the case

management agency or the Department's CCT program staff will investigate and work towards a resolution.

CCT clients, family members or providers can report all critical incident reports to their assigned intensive case manager. The case manager will document the incident using the critical incident reporting system (CIRS) in the Benefits Utilization Systems (BUS) and work with the client, family or service providers to implement strategies to prevent future occurrences. If the critical incident involves the intensive case manager, then clients, family members or providers can report the critical incident to the supervisor at the case management agency. The supervisor will document the incident in the BUS and investigate the incident to verify the incident's occurrence. In the event that the critical incident is confirmed, the supervisor will take appropriate action to remediate the situation and prevent future occurrences. The CIRS Coordinator at the Department is responsible for reviewing critical incidents, ensuring that the case managers and supervisors at case management agencies follow through with implementing measures to resolve or prevent specific critical incidents from reoccurring and if necessary develop remediation training to respond to trends in critical incidents.

b. Guardianship

Provide the policy and corollary documentation to demonstrate that the MFP demonstration participants' guardians have a known relationship and do interact with the participants on an ongoing basis; and have recent knowledge of the participants' welfare if the guardians are making decisions on behalf of these participants. The policy should specify the level of interaction that is required by the State.

Specific questions in the Transition Assessment/Plan Form ask the resident and the guardian to describe their relationship, including the type and frequency of visits. The transition coordinator will review other sources of documentation, such as nurse notes, care plan notes, social service notes or other facility records, to determine the relationship

between the guardian and the client. Supporting documentation illustrating the guardian's involvement will be kept in the transition coordinator's care file. Sources of documentation will reflect participation of the guardian in care planning, including but not limited to, attendance at meetings, phone conversations and case notes reflecting active participation in decision making.

In the event that the applicant/guardian relationship is inadequate or the guardian is uncooperative, the transition coordinator can use his or her discretion to work with an ombudsman or other advocate to petition the court for removal of the guardian and, if necessary, a request for the appointment of a new guardian. If a new guardian is appointed, the resident may reconsider participation in CCT when there is consensus between the resident, guardian and the transition team.

B.3. Outreach/Marketing/Education

Submit the State's outreach, marketing, education, and staff training strategy. NOTE: The OP Draft required in this application does not require a State to submit marketing materials at this time. *All marketing materials will be submitted during the final approval process for the Operational Protocol.*
Please provide:
a. The information that will be communicated to enrollees, participating providers, and State outreach/education/intake staff (such as social services workers and caseworkers);
b. Types of media to be used;
c. Specific geographical areas to be targeted;
d. Locations where such information will be disseminated;
e. Staff training plans, plans for State forums or seminars to educate the public;
f. The availability of bilingual materials/interpretation services and services for individuals with special needs; and
g. A description of how eligible individuals will be informed of cost sharing responsibilities.

Specific details of the Department's strategy for outreach, marketing, education, and staff training regarding CCT have been guided by a multidisciplinary team of stakeholders represented on the Long Term Care Advisory Committee (LTCAC) in coordination with the Medicaid Infrastructure Grant (MIG) sub-committee, called Communication, Training and

Outreach, or CTO. Consisting of members of the disability community, service agencies, health professionals, housing authorities and others, the LTCAC serves as the steering committee for CCT marketing and outreach efforts. An inter-agency Outreach and Marketing workteam was formed and worked on the CCT Public Outreach Plan (Appendix I), which was presented to members of the LTCAC in September 2011 for comment and feedback.

In implementing the outreach plan, the workteam, in collaboration with the LTCAC and CCT staff, will identify target audiences (including LTC clients and their friends and family, health professionals, case management agencies, SEPs, CCBs, transition coordinators, housing authorities, advocates and disability coalitions, and staff at NFs, ICFs, and IMDs); develop specific messaging for these audiences; and determine the best vehicles for communicating these messages to the intended audiences. The target population liaison hired through the MFP Grant will have primary responsibility for implementing and managing the outreach plan.

The workteam worked with a professional marketing consultant firm to develop a logo, program name specific to Colorado, and marketing collateral in consultation with our stakeholders. The consultant will complete this work by November 30, 2011. A draft brochure representative of potential marketing collateral is included in Appendix J.

a. Information to be Communicated

The information to be communicated to clients, service providers, and outreach staff will include an overview of CCT, client eligibility criteria, how to enroll, what kinds of services CCT includes and how to access CCT services and other LTC services and benefits, client responsibilities, how long it lasts, what housing options and other community services are

available, and where to find additional information, ask questions, or express concerns or problems. This information will be tailored to fit each identified target audience. See Colorado's Outreach Plan.

b. Types of Media

The communication vehicles the Department intends to use for dissemination of this information include written materials such as fact sheets, brochures, fliers, newsletters and posters; a CCT Web page; and face-to-face venues such as public forums, open houses, and resource fairs. See the CCT Outreach Plan for more detail.

c. Geographical Area

No specific state geographic area will be targeted; eligible clients from all over the state will be encouraged to participate in CCT. The Department intends to disseminate information about CCT to target audiences through several mechanisms and locations. Potential CCT Participants will be primarily contacted through LTC institutions and case management agencies where transition coordinators will respond to requests for alternative living arrangements followed by intensive case management activities to assist LTC residents with a transition to the community settings of their choice. In addition to ensuring this information is available to potential CCT clients through their current LTC institutional residence, efforts will be made by the Department, its marketing consultant, and CCT staff to identify opportunities to place CCT materials in health care offices, human services offices, city and county buildings, pharmacies, libraries, with advocacy organizations and at and other areas where consumers look for information. Plans for additional communication and education vehicles and locations will be discussed and prioritized with the LTCAC.

d. Locations of Information

As discussed above, and in addition to posting information at the physical locations described above, the Department has and will continue to promote awareness of CCT through print, electronic, and radio media venues. Activities to increase general awareness of the CCT grant opportunity and the Department's intent to apply has already begun. Initial outreach has included issuing a press release (see Appendix J), developing a CCT Web page on the Department's Web site, and posting of a CCT fact sheet (see Appendix K). The Department's public information officer arranged for statewide newspaper and national radio coverage on National Public Radio of Colorado's CCT grant efforts from December 5 through December 7, 2010.

Further, Department staff hosted a public forum on December 16, 2010 (see Appendix L) with the goal of increasing awareness, educating target audiences, shaping positive perceptions about CCT, and emphasizing the importance of choice when it comes to community-based living or institutional settings. Additional statewide conferences may be held each year of the grant to continue to provide general stakeholder education as well as topic-specific forums, and to provide training, technical assistance and establish best practices for continued success. Regional conferences throughout Colorado will provide trainings on federal and state rules and regulations, outreach techniques and tools, best practices, networking and technical assistance to community partners providing services to CCT Participants. Targeted audiences for technical assistance conferences will include LTC service providers, transition coordinators, case management agencies, community-based organizations, county departments of human/social services and other identified community partners.

e. Staff Training Plans

The CCT team will develop all CCT-related training for the target audiences and for the Department's staff in collaboration with the Department's Program and Policy Training Unit. The Unit will assist the CCT staff in translating their subject matter expertise into trainings or presentations that meet the needs of audiences impacted by the CCT Program. Program and Policy Training Unit staff will work with CCT staff in developing trainings and creating learning aids for both internal and external stakeholders. The trainers and staff will determine the most appropriate training method to reach internal staff and external audiences and assist in the delivery of these trainings. The Unit will be responsible for ensuring that all target audiences for CCT receive consistent and accurate program information through professional training. All CCT-related training materials will be reviewed by appropriate subject matter experts through an internal clearance process and will receive final review and approval from the Unit prior to delivery. The Unit will evaluate and report the effectiveness of training and knowledge transfer, providing CCT staff with observational feedback and data received from training participant evaluations to aid in continuous improvement of training tools. CCT-related training will be provided to all case management staff assisting in the enrollment of CCT applicants via the regularly scheduled quarterly meetings. Trainings will commence starting October 2011.

The Department will continue to spread awareness through press releases and other "earned" media or news stories about the program. Additional media relations may include public service announcements (PSA), promoting stories to print, radio and television outlets, staffing "call-in" lines at local television stations, developing and distributing community columns and editorials for placement in statewide publications, and encouraging media

outlets to include links from their Web sites to the CCT Web page. The Department also plans to develop a CCT story bank, regularly seeking out CCT Participants who are willing to share their positive program experiences and personal testimonials with the media and with other potential CCT clients.

The Department will utilize its collaborative alliances with community organizations, taskforces, and coalitions that can help share information about CCT. A list of these organizations has been started and will be further developed by the CCT Outreach Advisory Sub-committee in order to broaden the scope of outreach and ensure other community organizations dedicated to the disability community are familiar with CCT resources (see Appendix M). The Department intends to participate at statewide and national conferences as well as professional membership meetings to spread awareness about CCT and share best practices. The Department also plans to schedule speaking engagements at other organizations' forums (e.g. Continuing Legal Education conferences, American Association of Retired Persons conferences, etc.). The Department will maintain a database of contact information and email addresses of partners and stakeholders to be used for the immediate mass release of critical program news.

f. Bilingual Materials

Materials will be developed in both English and Spanish in compliance with the Office of Civil Rights' Limited English Proficiency Title VI provisions, and will be available in formats accessible to those with special needs including persons with hearing or visual impairments, or cognitive issues.

g. Cost-Sharing Responsibility

Information about cost-sharing will be described in the information that will be communicated to enrollees, participating providers, and Department and other staff.

B. 4. Stakeholder Involvement

Describe how the State will involve stakeholders including consumer representatives in the Implementation Phase of this demonstration, and how these stakeholders will be meaningfully involved throughout the life of the demonstration grant. Please include: a. A chart that reflects how the stakeholders relate to the organizational structure of the grant and how they influence the project. b. A brief description of how consumers' will be involved in the demonstration. c. A brief description of community and institutional providers' involvement in the demonstration. d. A description of the consumers' and community and institutional providers' roles and responsibilities throughout the demonstration. e. The operational activities in which the consumers and community and institutional providers are involved.

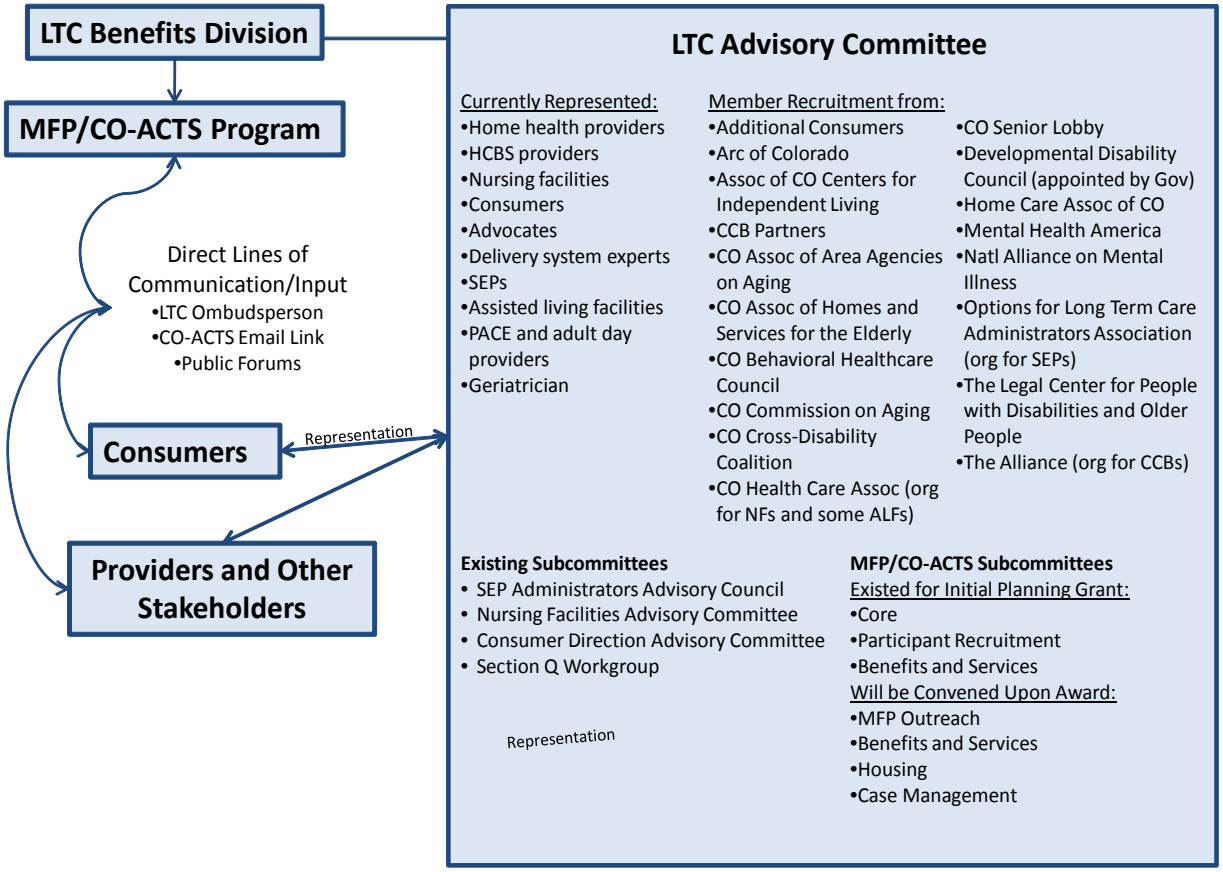
Meaningful stakeholder involvement in all aspects of development, implementation, and maintenance of the CCT program is critical to the success of the program, and, ultimately, to improvement in the health and welfare of Colorado's vulnerable populations. A central focus of this project is ensuring, for each and every individual, that the right care is provided at the right time and in the right setting. Just as these decisions made at the individual level about appropriate care should involve those with first-hand knowledge of the specific circumstances, so too should the global, high-level decisions about how best to ensure program-wide success. From initial development of outreach materials all the way through program evaluation, continuous interaction, dialogue, assistance, and advice from a variety of stakeholders is essential. The CTT Public Outreach Plan (Appendix I) offers more detail about stakeholder engagement activities the Department will pursue.

Primary involvement of stakeholders will be through expansion and representation on the LTC Advisory Committee (LTCAC) and subcommittees. The LTCAC will assume

responsibility for advising the Department on implementation of the CCT Demonstration. The LTCAC, established in 2008, provides input on policy directions such as delivery system capacity and models, accountability and responsiveness of the system and eligibility determination. The Committee meets monthly. The LTCAC is an advisory body to the Department's Division of Long Term Benefits, including the CCT Demonstration. Department staff is responsible for preparing and facilitating meetings.

To assure maximum stakeholder representation on the LTCAC, the Department will expand the current membership to include more stakeholder perspectives specifically with regard to CCT implementation. The organizations that will be targeted for membership include existing boards and committees of other state agencies, associations and advocacy organizations. The expanded LTCAC will include consumers, institutional and community-based providers, entry point agencies, case management agencies, independent living centers and consumer advocacy organizations. Other state agencies that offer services to LTC populations will have the option of participating in an ex officio status. To ensure the coordination of strategic planning for Colorado's LTC system, the Department will recruit members from other advisory groups that make recommendations concerning LTC policy, such as the Colorado Commission on Aging and the Developmental Disability Council.

During the grant period, the Department will form LTCAC subcommittees that are aligned with various components of the *Operational Protocol.* These subcommittees will plan, monitor, evaluate and modify policies and procedures as needed to improve the person-centeredness and quality of services; plan and increase outreach; and plan and inform training. The Department will also create workgroups centered on CCT benchmarks. Members of the LTCAC will co-chair the subcommittees with State staff. Workgroups will


LTC Benefits Division
MFP/CO-ACTS Program
Direct Lines of Communication/Input
•LTC Ombudsperson
•CO-ACTS Email Link
•Public Forums
Consumers
Representation
Providers and Other Stakeholders
LTC Advisory Committee
Currently Represented:
•Home health providers
•HCBS providers
•Nursing facilities
•Consumers
•Advocates
•Delivery system experts
•SEPs
•Assisted living facilities
•PACE and adult day providers
•Geriatrician
Member Recruitment from:
•Additional Consumers
•Arc of Colorado
•Assoc of CO Centers for Independent Living
•CCB Partners
•CO Assoc of Area Agencies on Aging
•CO Assoc of Homes and Services for the Elderly
•CO Behavioral Healthcare Council
•CO Commission on Aging
•CO Cross-Disability Coalition
•CO Health Care Assoc (org for NFs and some ALFs)
•CO Senior Lobby
•Developmental Disability Council (appointed by Gov)
•Home Care Assoc of CO
•Mental Health America
•Natl Alliance on Mental Illness
•Options for Long Term Care Administrators Association (org for SEPs)
•The Legal Center for People with Disabilities and Older People
•The Alliance (org for CCBs)
Existing Subcommittees
• SEP Administrators Advisory Council
• Nursing Facilities Advisory Committee
• Consumer Direction Advisory Committee
• Section Q Workgroup
Representation
MFP/CO-ACTS Subcommittees
Existed for Initial Planning Grant:
•Core
•Participant Recruitment
•Benefits and Services
Will be Convened Upon Award:
•MFP Outreach
•Benefits and Services
•Housing
•Case Management

b. Consumer Involvement

Consumers will be involved in CCT at all levels of operation, from project design and implementation to receipt of CCT services. Consumers and consumer advocates will be represented on the LTCAC and its subcommittees. The Department will engage consumers in the development of outreach materials, in discussing benefits and services, in addressing housing issues, in identifying and addressing other barriers to deinstitutionalization, and in recommending areas for ongoing improvement in the CCT program. The advocacy organizations and providers will assist the Department in recruiting consumers and families to participate in the LTCAC and its subcommittees.

In addition to formal assistance and advice provided through participation in the various committees, individual consumers and consumer advocates will have lines of direct communication with the Department through such methods as the LTC ombudsman, an already-established CCT email address, and face-to-face or electronic public forums.

c. Community and Institutional Provider Involvement

As with consumers, community and institutional providers will be involved at all levels of planning, implementation, and continuation primarily through the committee structure described above. Perspectives from these providers and other community agencies will be included in outreach planning, workforce development strategies, benefits and services, and identifying and addressing barriers to community living.

d. Roles and Responsibilities

All members of the LTCAC and its subcommittees and workteams are responsible to attend meetings on a regular basis and to serve as representatives of their respective organizations and stakeholder groups, rather than providing purely personal or individual

views. The Department expects representatives to communicate back to their organizations through their respective associations or constituencies to ensure maximum transparency across the state regarding the implementation of CCT. Additional responsibilities of members include active participation and respectful debate.

The Department has already had great success with stakeholder involvement for this project. Colorado's CCT planning grant was based on stakeholder input. Once the planning grant was received, an announcement was posted on Department Web pages and staff began an extensive process to convene, listen and respond to stakeholder concerns, questions and recommendations that continued throughout the planning process.

e. Operational Activities

The Department formed two initial stakeholder groups (See Appendix C). The first, Participant Recruitment and Enrollment/Stakeholder Engagement workgroup, focused on the best ways to identify individuals living in institutional settings who may be better served in a supported community based setting, and the best ways to engage stakeholders throughout the five year grant period. The second group focused on benefits and services and developed an appropriate array of HCBS waiver services to address the functional needs of transitioning individuals. The groups met every two weeks from October 2010 to January 2011 and discussed issues including informed consent and the transition assessment form. A public forum was also held on December 16, 2010, with 79 attendees in Denver and nine attendees in Grand Junction. Twenty-two specific questions and comments were shared, including topics such as conflict of interest for case managers, continuity of care, vocational rehabilitation, expansions in consumer-directed care and the experience of states already implementing CCT Demonstrations. To provide another opportunity for stakeholder input

and public comment, the Department posted the Operational Protocol on its CCT Web page and invited the general public to post comments through the CCT email link.

In addition, the Department formed a workgroup in response to the new Section Q requirements in the MDS 3.0. This workgroup consists mainly of Independent Living Centers (ILCs) that provide community transition services. This workgroup has met with the Colorado Health Care Association, a membership organization for nursing and assisted living facilities, and both have agreed to work on standards of conduct for community transition coordinators and nursing facility staff as well as defining the roles and responsibilities of the facility and the Local Contact Agencies (LCA). The standards of conduct will ensure a mutually respectful relationship between nursing facilities and LCAs, which are mostly ILCs at this time. The workgroup is also developing a common Transition Assessment/Plan Form (Appendix D) and considering development of an ethics committee to determine cases where transition potential is very difficult to ascertain. Outputs from this workgroup will be incorporated into future drafts of this *Operational Protocol.*

B.5. Benefits and Services

Provide a description of the service delivery system(s) used for each population that the State will serve through the MFP demonstration. Include both the delivery mechanism (fee-for-service, managed care, self-directed, etc.) and the Medicaid mechanism through which qualified HCBS will be provided at the termination of the demonstration period (waiver, 1115 demonstration, Medicaid State Plan, etc.).

List the service package that will be available to each population served by the demonstration program. Include only services that are provided through the demonstration (home and community-based long-term care services and supplemental services). Divide the service list(s) into Qualified Home and Community-Based Program services, demonstration services, and supplemental demonstration services reflecting the categories of services that are listed in the solicitation. For demonstration services and supplemental services, indicate the billable unit of service and the rate proposed by the State. For supplemental demonstration services,

provide any medical necessity criteria that will be applied as well as the provider qualifications.

a. Service Delivery System

Long-term care services and supports are provided under the Medicaid State Plan and 1915(c) waivers, State-funded programs and the Older Americans Act. Colorado currently administers 11 HCBS waivers that were created under section 1915(c) of the Social Security Act. All services through the 1915(c) HCBS waivers are fee-for-service. While the Department has authority to implement consumer direction in other waivers, the HCBS-EBD and MI waivers are the only waivers that offer consumer direction at this time.

The Department also administers 1915(i) State Plan Option for the provision of consumer directed personal care, homemaker and health maintenance activities to a limited population who were not eligible for HCBS waivers with consumer direction. Participants of the CCT demonstration project will be enrolled in the adult 1915(c) waiver programs.

Another available option in Colorado's State Plan for those who are seeking long-term care services is the Program for All-Inclusive Care for the Elderly (PACE), a managed care program that blends Medicare and Medicaid funding to pay for both healthcare and long-term care services. HCBS services are part of the service package offered by PACE. Additional long-term benefits in Colorado's State Plan include skilled nursing, occupational therapy, physical therapy, speech therapy, home health and PACE.

Case management in long-term programs supported by Medicaid is funded through a variety of mechanisms. In the State Plan targeted case management is a benefit available to people with developmental disabilities. In the CHCBS and Children with Autism waivers case management is offered as a 1915(c) waiver benefit. Case management for all other waivers is paid for as an administrative activity. Intensive case management will be offered

through the CCT initiative as a demonstration service and takes the place of case management offered through the traditional HCBS waivers.

CCT clients will be concurrently enrolled into a 1915 (c) waiver and the CCT demonstration. The 1915(i) state plan option and PACE have not been identified as an option for CCT participants. Upon completion of the demonstration period, CCT clients will continue receiving HCBS services through an HCBS waiver unless the client chooses to discontinue services, enrolls in the PACE program, returns to a nursing facility or is no longer eligible for Medicaid long-term care services.

b. CCT Service Package

Table 13, below, provides a visual representation of changes to Colorado's existing HCBS service and delivery infrastructure demonstrated under CCT. Services available to target populations through existing HCBS waivers are indicated in the "QS" column for Qualified Service. Qualified HCBS services are HCBS waiver services that will continue once the CCT Demonstration Program has ended. The Department will rely on the existing provider networks for qualified services. Colorado will provide qualified HCBS services during the demonstration period through its existing 1915(c) waivers. Table 14 offers service definitions for those services listed in Table 13.

The "Demo" column represents Demonstration Services. Demonstration services are services that can be covered under Medicaid and that will only be billed to grant funding during an individual's 12-month transition period. After the demonstration period, the State is not obligated to continue the demonstration services, but may choose to fund them through Medicaid for eligible individuals, or through other funding streams.

The Demonstration Services are a direct result of gap analysis. The absence of these services was identified as a barrier to transition and/or to participation in the community. The addition of the services for the benefit of the target populations is predicted to reduce reliance on institutional care. CCT Participants with brain injuries will be included in the physically disabled target population, but are displayed as a separate category in the chart below due to significant differences in the availability of qualified services.

Current rates under CCT were established according to the following methodology:

- Consideration of existing rates and concerns or problems with vendors
- Consideration of variances between agencies for similar services
- Comparison of Medicaid rates for transition services in other state Medicaid programs
- Analysis of reasonableness of private market rates compared to public rates

All services will be paid fee for service. Providers will submit claims to be reimbursed through the Department's Medicaid Management Information System.

Table 13. Colorado CCTServices and Rates as of July 1, 2011-June 30, 2012

Elderly Persons (EBD Waiver + Demonstration Services)				
Services	**DS**	**QS**	**Rate**	**Unit**
Adult Day Health Services				
Basic		X	$21.79	4-5 Hours
Specialized		X	$27.83	3-5 Hours
Alternative Care Facility (ACF)		X	$46.14	1 Day
Assistive Technology	X		Negotiated by SEP Through Prior Authorization, $5,000 Max	
Behavioral Health Support	X		$16.03	30 Minutes
Community Transition Service (CTS)		X	$3,500 Max	Per Transition
Consumer Directed Attendant Support Services (CDASS)		X	Assessed by CM; varies by client	Monthly Allocation
Dental/Vision - Extended	X		$2,000/yr $10,000/lifetime on major services	
Enhanced Nursing Services				
RN	X		$37.17	1 Hour
LPN	X		$38.19	1 Hour
Family Services	X		$7.50	15 minutes
Home Delivered Meals	X		$10.00	Home Delivery
Home Modifications		X	$10,000 Max	Lifetime
Home Modifications – Extended	X		$5,000 Max	Lifetime
Homemaker		X	$3.47	15 Minutes
In Home Support Services (IHSS)				
Health Maintenance Activities		X	$6.55	15 Minutes
Personal Care		X	$3.47	15 Minutes
Relative Personal Care		X	$3.47	15 Minutes
Homemaker		X	$3.47	15 Minutes
Independent Living Skills Training (ILST)	X		$9.00	15 Minutes
Intensive Case Management	X		$150.00	1 Month
Medication Reminder		X	Assessed by CM; varies by client	1 Month
Mental Health Counseling, Transition				
Family	X		$13.44	15 Minutes
Group	X		$7.53	15 Minutes
Individual	X		$13.44	15 Minutes
Mentorship	X		$6.50	15 Minutes
Non Medical Transportation				
Taxi		X	$46.98	1 Way Trip
Mobility Van		X	$12.07	1 Way Trip
Wheelchair Van		X	$15.02	1 Way Trip
On-Call Attendant Services	X		$5.00	15 Minutes
Personal Care		X	$3.47	15 minutes
Elderly Persons (EBD Waiver + Demonstration Services)				
Services	**DS**	**QS**	**Rate**	**Unit**

Personal Emergency Response Systems (PERS)		X	Assessed by CM; varies by client	1 Day
Respite Care				
ACF		X	$51.38	1 Day
In Home		X	$2.95	15 Minutes
NF		X	$114.57	1 Day
Specialized Day Rehabilitation Services	X		$7.50	15 Minutes
Substance Abuse Counseling, Transitional				
Individual	X		$64.00	1 Hour
Group	X		$17.00	1 Hour
Transitional Living Program	X		$127.25	1 Day

Persons with Physical Disabilities (EBD Waiver + Demonstration Services)

Services	DS	QS	Rate	Unit
Adult Day Health Services				
Basic		X	$21.79	4-5 Hours
Specialized		X	$27.83	4-5 Hours
Alternative Care Facility (ACF)		X	$46.14	1 Day
Assistive Technology	X		Negotiated by SEP Through Prior Authorization, $5,000 Max	
Behavioral Health Support	X		$16.03	30 Minutes
Community Transition Service (CTS)	X		$3,500 Max	Per Transition
Consumer Directed Attendant Support Services (CDASS)		X	Assessed by CM; varies by client	Monthly Allocation
Dental/Vision - Extended	X		$2,000/yr $10,000/lifetime on major services	Charge Per Procedure
Enhanced Nursing Services				
RN	X		$37.17	1 Hour
LPN	X		$38.19	1 Hour
Family Services	X		$7.50	15 minutes
Home Delivered Meals	X		$10.00	Home Delivery
Home Modifications		X	$10,000 Max	Lifetime
Home Modifications – Extended	X		$5,000 Max	Lifetime
Homemaker		X	$3.47	15 Minutes
In Home Support Services (IHSS)				
Health Maintenance Activities		X	$6.55	15 Minutes
Personal Care		X	$3.47	15 Minutes
Relative Personal Care		X	$3.47	15 Minutes
Homemaker		X	$3.47	15 Minutes

Persons with Physical Disabilities (EBD Waiver + Demonstration Services)				
Services	**DS**	**QS**	**Rate**	**Unit**
Independent Living Skills Training (ILST)	X		$9.00	15 Minutes
Intensive Case Management	X		$150.00	1 Month
Medication Reminder		X	Assessed by CM; varies by client	1 Month
Mental Health Counseling, Transition				
Family	X		$13.44	15 Minutes
Group	X		$7.53	15 Minutes
Individual	X		$13.44	15 Minutes
Mentorship	X		$6.50	15 Minutes
Non Medical Transportation				
Taxi		X	$46.98	1 Way Trip
Mobility Van		X	$12.07	1 Way Trip
Wheelchair Van		X	$15.02	1 Way Trip
On-Call Attendant Services	X		$5.00	15 Minutes
Personal Care		X	$3.47	15 minutes
Personal Emergency Response Systems (PERS)		X	Assessed by CM; varies by client	1 Day
Respite Care				
ACF		X	$51.38	1 Day
In Home		X	$2.94	15 Minutes
NF		X	$114.57	1 Day
Specialized Day Rehabilitation Services	X		$7.50	15 Minutes
Substance Abuse Counseling, Transitional				
Individual	X		$64.00	1 Hour
Group	X		$17.00	1 Hour
Transitional Living Program	X		$127.25	1 Day

Persons with Brain Injury (BI Waiver + Demonstration Services)				
Services	**DS**	**QS**	**Rate**	**Unit**
Adult Day Health Services		X	$45.88	1 Day
Assistive Technology		X	Negotiated by SEP Through Prior Authorization, $5,000 Max	
Behavioral Health Support	X		$13.01	30 Minutes
Community Transition Service (CTS)	X		$3,500 Max	Per Transition
Consumer Directed Attendant Support Services (CDASS)		X	Assessed by CM; varies by client	Monthly Allocation
Day Treatment		X	$72.78	1 Day
Dental/Vision - Extended	X		$2,000/yr $10,000/lifetime on major services	Charge Per Procedure

Persons with Brain Injury (BI Waiver + Demonstration Services)				
Services	**DS**	**QS**	**Rate**	**Unit**
Enhanced Nursing Services				
RN	X		$37.17	1 Hour
LPN	X		$38.19	1 Hour
Family Services	X		$7.50	15 minutes
Home Delivered Meals	X		$10.00	Home Delivery
Home Modifications		X	$10,000 Max	Lifetime
Home Modifications – Extended	X		$5,000 Max	Lifetime
Intensive Case Management	X		$150.00	1 Month
Independent Living Skills Training (ILST)		X	$23.55	1 Hour
Mental Health Counseling				
Family		X	$13.37	15 Minutes
Group		X	$7.49	15 Minutes
Individual		X	$13.37	15 Minutes
Mentorship	X		$6.50	15 Minutes
Non Medical Transportation				
Taxi		X	$46.98	1 Way Trip
Mobility Van		X	$12.07	1 Way Trip
Wheelchair Van		X	$15.02	1 Way Trip
On-Call Attendant Services	X		$5.00	15 Minutes
Personal Care		X	$3.53	15 minutes
Personal Emergency Response Systems (PERS)		X	Assessed by CM; varies by client	1 Day
Respite Care				
In Home		X	$2.94	15 Minutes
NF		X	$108.40	1 Day
Specialized Day Rehabilitation Services	X		$7.50	15 Minutes
Specialized Medical Equipment and Supplies		X	Assessed by CM; varies by client	
Substance Abuse Counseling				
Family		X	$53.53	1 Hour
Group		X	$29.98	1 Hour
Individual		X	$53.53	1 Hour
Substance Abuse Counseling, Transitional				
Individual	X		$64.00	1 Hour
Group	X		$17.00	1 Hour
Supported Living Program		X	Per diem rate set by HCPF using acuity levels of client population	1 Day
Transitional Living Program		X	$127.25	1 Day

Persons with Developmental Disabilities (DD, SLS, + Demonstration Services)				
Services	**DS**	**QS**	**Rate**	**Unit**
Assistive Technology		X	Negotiated by SEP through prior authorization, $10,000.00 Max	
Behavioral Health Services				
Line Staff		X	$6.12	15 Minutes
Plan Specialist		X	$11.60	15 Minutes
Senior		X	$23.16	15 Minutes
Lead		X	$29.34	15 Minutes
Community Transition Service (CTS)	X		$3,500 Max	Per Transition
Dental			Based on charges, varies by client.	
Enhanced Nursing Services				
RN	X		$37.17	1 Hour
LPN	X		$38.19	1 Hour
Family Services	X		$7.50	15 Minutes
Home Modifications		X	$10,000 Max	Lifetime
Home Modifications – Extended	X		$5,000 Max	Lifetime
Mentorship		X	$9.22	15 Minutes
Non Medical Transportation				
Mileage Range 1 (0 to 10 Miles)		X	$5.34	2 Trips/Day
Mileage Range 2 (11 to 20 Miles)		X	$11.19	2 Trips/Day
Mileage Range 3 (21 and up 10 Miles)		X	$17.04	2 Trips/Day
Mileage Not Day Program		X	$5.34	10 Trips/Week
Professional Services				
Massage Therapy		X	$17.20	15 minutes
Movement Therapy Bachelors		X	$14.34	15 minutes
Movement Therapy Masters		X	$21.02	15 minutes
Hippotherapy (Individual)		X	$19.11	15 minutes
Hippotherapy (Group)		X	$8.12	15 minutes

Persons with Developmental Disabilities (DD, SLS, + Demonstration Services)				
Services	**DS**	**QS**	**Rate**	**Unit**
Respite Care				
Individual		X	$4.57	15 Minutes
			$182.55	1 Day
Specialized Day Rehabilitation Services	X		$7.50	15 Minutes
Substance Abuse Counseling, Transitional				
Individual	X		$64.00	1 Hour
Group	X		$17.00	1 Hour
Vehicle Modifications		X	$10,000	Lifetime

Persons with Major Mental Illness (MI Waiver + Demonstration Services)				
Services	**DS**	**QS**	**Rate**	**Unit**
Adult Day Health Services				
Basic		X	$21.79	4-5 Hours
Specialized		X	$27.83	3-5 Hours
Alternative Care Facility (ACF)		X	$46.14	1 Day
Assistive Technology	X		Negotiated by SEP Through Prior Authorization, $5,000 Max	
Behavioral Health Support	X		$16.03	30 Minutes
Community Transition Service (CTS)	X		$3,500 Max	Per Transition
Consumer Directed Attendant Support Services (CDASS)		X	Assessed by CM; varies by client	Monthly Allocation
Dental/Vision - Extended	X		$2,000/yr $10,000/lifetime on major services	
Enhanced Nursing Services				
RN	X		$37.17	1 Hour
LPN	X		$38.19	1 Hour
Family Services	X		$7.50	15 minutes
Home Delivered Meals	X		$10.00	Home Delivery
Home Modifications		X	$10,000 Max	Lifetime
Home Modifications – Extended	X		$5,000 Max	Lifetime
Homemaker		X	$3.47	15 Minutes
Independent Living Skills Training (ILST)	X		$9.00	15 Minutes
Intensive Case Management	X		$150.00	1 Month
Medication Reminder		X	Assessed by CM; varies by client	1 Month

Persons with Major Mental Illness (MI Waiver + Demonstration Services)				
Services	**DS**	**QS**	**Rate**	**Unit**
Mentorship	X		$6.50	15 Minutes
Non Medical Transportation				
Taxi		X	$46.98	1 Way Trip
Mobility Van		X	$12.07	1 Way Trip
Wheelchair Van		X	$15.02	1 Way Trip
On-Call Attendant Services	X		$5.00	15 Minutes

Personal Care			$3.49	15 minutes
Personal Emergency Response Systems (PERS)		X	Assessed by CM; varies by client	1 Day
Respite Care				
ACF		X	$51.38	1 Day
In Home		X	$2.94	15 Minutes
NF		X	$114.57	1 Day
Specialized Day Rehabilitation Services	X		$7.50	15 Minutes
Substance Abuse Counseling, Transitional				
Individual	X		$64.00	1 Hour
Group	X		$17.00	1 Hour
Transitional Living Program	X		$127.25	1 Day
Service rates, units provided in this document are draft rates for budget-forecasting purposes only and are subject to change.				

Table 14. Service Definitions

Service	Definition
Adult Day	Services provided four or more hours per day one or more days a week on a regularly scheduled basis in an outpatient setting, encompassing both health and social services needed for the individuals optimal functioning.
Alternative Care Facility	Licensed Assisted Living Residences (LALR) that provides homemaker and individual care services.
Assistive Technology	Devices, items, pieces of equipment, or product system used to increase, maintain, or improve functional capabilities of participants when the cost is above and beyond that of typical expenses and not available through other means.
Behavioral Health Support	Services by a paraprofessional to support an individual during the transition period to mitigate issues, symptoms, and/or behaviors that are exacerbated during the transition period and negatively affect the individual's stability in the community. Support could include problem-solving with the challenges of transitions, deescalating emotional situations, coaching to reduce maladaptive behaviors, coaching family members and friends to follow a behavioral plan, reminders to take medications and accessing community resources and support groups. When necessary, a community mental health center will develop behavioral health plan prior to discharge from the nursing facility. To the extent possible, the behavioral health support specialist will help develop the behavioral health plan.
Community Transition Services	Services provided by a Transition Coordination Agency (TCA) to help an individual relocate to a community setting upon discharge from a Long Term Care (LTC) facility. CTS include the purchase of items essential to move a client from a nursing facility and establish community-based residence. Examples include security and utility deposits, moving expenses, one-time pest eradication, one-time cleaning expenses and essential household furnishings such as beds, linens, utensils, pots and pans, dishes, etc.

Service	Definition
Consumer Directed Attendant Support Services (CDASS)	Services that help an individual in accomplish activities of daily living, including health maintenance, individual care, homemaker activities, and protective oversight. Health maintenance activities are those routine and repetitive activities of daily living that require skilled assistance for health and normal bodily functioning, and which would be carried out by an individual with a disability if physically/cognitively able. Attendants are hired and fired by the individual or an authorized representative.
Day Treatment	Intensive therapeutic services including social skills training, sensory motor development, reduction/elimination of maladaptive behavior, and services aimed at preparing the individual for community reintegration. Services take place in a non-residential setting separate from the home in which the individual lives.
Day Habilitation	Day habilitation includes assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement, except for the occasion of extreme medical and/or safety needs when the service is pre-approved by Division of Developmental Disabilities of the Department of Human Services. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and individual choice. These services are individually coordinated through the individual's service plan. Day Habilitation Services and Supports encompass two types of habilitative environments: Specialized Habilitation (SH) and Supported Community Connections (SCC).
Specialized Habilitation	Specialized Habilitation services focus on enabling the individual to attain his or her maximum functional level or to be supported in such a manner to allow the individual to gain an increased level of self-sufficiency. These services are generally provided in non-integrated settings where a majority of the individuals have a disability, such as program sites and supervised work settings. Such services include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency, maintenance skills, and supervision. Specialized habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings and, where appropriate, are coordinated with any physical, occupational, or speech therapies listed in the service plan. Day habilitation does not include sheltered workshop activities.
Supported Community Connection (SCC)	Supported Community Connection supports the abilities and skills necessary to enable the individual to access typical activities and functions of community life such as those chosen by the general population, including community education or training, retirement and volunteer activities. SCC provides a wide variety of opportunities to facilitate and build relationships and natural supports in the community, while utilizing the community as a

Service	Definition
	learning environment to provide services and supports as identified in a individual's Service Plan. These activities are conducted in a variety of settings in which participants interact with non-disabled individuals (other than those individuals who are providing services to the participant). These types of services may include socialization, adaptive skills and individual to accompany and support the individual in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement. Supported Community Connections may be provided in a group setting (or groups traveling together into the community) and/or may be provided on a one-to-one basis as a learning environment to provide instruction when identified in the service plan developed by case managers.
Dental	Dental services are those services, including periodic examination and diagnosis, radiographs, when indicated that dental problems are sufficient to lead to more generalized disease due to infection or improper care or nutrition.
Enhanced nursing services	Services providing intensive medical care coordination for participants who are at risk for negative health outcomes associated with fragmented medical care and poor communication between PCPs, nursing staff, case managers, community-based providers and specialty care providers. Enhanced Nursing Services Professionals serve as the liaison between the discharging facilities and community-based care provided in the Qualified Residence into which the participant is transitioning. These services are provided during the first 30 days post-transition.
Family Services	Training for crucial informal support network on service availability, appropriate expectations, health and safety issues, problem-solving, care-giving, best practices and models for organizing and coordinating informal support networks. Models such as Share the Care™ may be used.
Group Residential Services and Supports (GRSS)	(GRSS) encompass group living environments of four to eight participants* receiving services who may live in a single residential setting which is licensed by the State as a Residential Care Facility/Residential Community Home.
Hippotherapy	A therapeutic treatment strategy that uses the movement of the horse to assist in the development/enhancement of gross motor, sensory integration, attention, cognitive, social, behavioral and communication skills. This service is included as part of professional services.
Home Delivered Meals	Nutritious meals delivered to homebound individuals who are unable to prepare their own meals and have no outside assistance. Time limited for CCT clients - may be provided more often during the initial weeks after discharge from an institution.
Home Modification	Physical adaptations to the home, required by the individual's plan of care, necessary to ensure the health, welfare, and safety of the individual.

Service	Definition
Homemaker	Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker.
In Home Support Services	Services provided by an attendant that includes health maintenance activities, support for activities of daily living or instrumental activities of daily living, individual care services and homemaker services provided under the direction of the consumer or an authorized representative designated by the consumer. The consumer or the authorized representative selects the attendant. A home health agency has responsibility for hiring and firing the attendant.
Independent Living Skills Training	Services designed to support an individual's ability to develop and maintain physical, emotional, and economic independence in the community with or without supports. Includes assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills which takes place in the participant's private residence, other residential living arrangement, and the community, except when due to medical and/or safety needs. Includes nutritional training and guidance especially for those with special dietary requirements.
Individual Residential Services and Supports (IRSS)	(IRSS) in which three or fewer participants receiving services live in a single residential setting or in a host home setting. The living environment does not require state licensure. However, the Division for Developmental Disabilities (DDD) must approve the service agencies that provide such services.
Intensive Case Management	Services assist individuals' access to needed CCT/HCBS services and other State Plan services as well as needed medical, social, educational and other services regardless of the funding source. Case Management is responsible for eligibility determination, care planning, service authorization, care coordination and service monitoring.
Massage Therapy	The physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation, and muscle tension including Watsu. This service is included as part of professional services.
Medication Reminder	The devices, controls, or appliances which assists an individual at high risk of institutionalization with following a medication regimen, includes devices or items that remind or signal the client to take prescribed medications or other devices necessary for the proper functioning of such items, and durable and non-durable medical equipment not available as a State plan benefit. Medication Reminders are considered a benefit only when reasonable and necessary for the treatment of an individual's illness, impairment, or disability.
Mental Health Counseling	Services designed to assist the client in managing and overcoming as effectively as possible the difficulties and stresses confronted after brain injury.
Mental Health Counseling, Transition	Mental health counseling offered to clients diagnosed with mild to serious mental illness who are pursuing enrollment into the MFP program. The mental health counselor develops a behavioral health plan prior to discharge

Service	Definition
	and mentally prepares an MFP client for the return to the community. After discharging from a nursing home, mental health counseling services are offered at a greater frequency to manage the issues, symptoms, and/or behaviors that are exacerbated during the transition period and negatively affect the individual's stability in the community. Once stabilized, the mental health counselor gradually tapers off services to align the scope and duration of services with the Behavioral Health Organization Managed Care Contract.
Mentorship	Services provided to participants by peers to promote self-advocacy by instructing, providing experiences, modeling and advising. For CCT clients, peers will provide mentoring throughout the first year of the transition. This service includes assistance in interviewing potential providers, understanding complicated health and safety issues, and assistance with participation on private and public boards, advisory groups and commissions. This service may also include training in child and infant care for parent(s) who themselves have a developmental disability. This service does not duplicate case management or waiver services such as Day Habilitation.
Movement Therapy	Music and/or dance used as a therapeutic tool for the habilitation, rehabilitation and maintenance of behavioral, developmental, physical, social, communication, pain management, cognition and gross motor skills. This service is included as part of professional services.
Non-medical Transportation	Transportation shall include but is not limited to transportation between the individual's home and non-medical services or resources. Examples include adult day care, shopping, therapeutic swimming, a dentist appointment, counseling sessions, and other services as required by the plan of care.
On-call Attendant Services	Attendant services that are available when regular attendant services are not.
Individual Care Service	Assistance with eating, bathing, dressing, individual hygiene, and activities of daily living.
Individual Emergency Response System (PERS)	An electronic device that enables certain individuals at high risk to secure help in an emergency.
Professional Services	Professional services include Hippo-therapy, Movement Therapy and Massage. These services can be funded only when 1) the provider is licensed, certified, registered, and/or accredited by an appropriate national accreditation association in that profession; and 2) the intervention is related to an identified medical or behavioral need. The service must be an identified need in the Service Plan. In addition, the service must be a need that has been identified by a licensed Medicaid State Plan therapist/physician and that therapist/physician has identified a goal for the treatment and will monitor the progress of that goal at least quarterly. The identified

Service	Definition
	"Professional Service" cannot be available under the regular Medicaid State Plan or from a third party source. Passes to community recreation centers are allowed if they're used to access professional services. Recreational passes should be purchased in the most cost effective manner i.e., day passes or monthly passes.
Residential Habilitation Services and Supports (RHSS)	(RHSS) are designed to ensure the health, safety and welfare of the participant, and to assist in the acquisition, retention and/or improvement in skills necessary to support the individual to live and participate successfully in their community. These services are individually planned and coordinated through the participants' Service Plan. The Service Plan identifies the participants, needs and determines the frequency, duration, and scope of the services. Services may include a combination of lifelong - or extended duration - supervision, training and/or support (i.e. support is any task performed for the individual, where learning is secondary or incidental to the task itself, or an adaptation is provided) which are essential to daily community living, including assessment and evaluation and the cost of training materials, transportation, fees and supplies.
Respite Care	Services provided to individuals unable to care for themselves furnished on a short-term basis because of the absence or need for relief of those individuals normally providing the care.
Specialized Day Rehabilitation Services	Services offered in a group setting designed and directed at the development and maintenance of the individual's ability to independently, or with support, sustain himself/herself physically, emotionally and economically in the community. Includes assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement, except when due to medical and/or safety needs.
Specialized Medical Equipment and Supplies	Includes devices, controls, and appliances specified in the plan of care, which enable individuals to improve performance of their abilities to perform activities of daily living or to perceive, control, or communicate with the environment which they live in.
Substance Abuse Counseling	Individual or group counseling, behavioral interventions, or consultations to address issues, symptoms, and/or behaviors that are exacerbated during the transition period and negatively affect the individual's sobriety.
Supported Living Program	This program is designed for individuals who have maximized his/her rehabilitative potential and requires 24-hour supervision, structure, and supportive services provided in a community-based facility. Services include protective oversight and supervision, behavioral management and cognitive supports, interpersonal and social skills development, household management supports, and medical management.
Supported Employment	Supported Employment services consists of intensive, ongoing supports that enable individuals, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who,

Service	Definition
	because of their disabilities, need supports, to perform in a regular work setting. Supported employment may include assessment and identification of vocational interests and capabilities in preparation for job development, assisting the participant to locate a job or job development on behalf of the individual. Supported employment is conducted in a variety of settings in which individuals interact with non-disabled individuals (other than those individuals who are providing services to the individual) to the same extent that individuals employed in comparable positions would interact. Individuals must be involved in work outside of a base site. Included are individuals in community jobs, in enclaves, and on mobile crews. Group employment (e.g. mobile crews and enclaves) shall not exceed eight individuals. Supported employment includes activities needed to sustain paid work by participants, including supervision and training.
Transitional Living Services	Short term (6 month) supervised residence designed to prepare individuals to move into unsupervised independent living arrangements. Services include assessment, training, and supervision of self-care, medication management, communication skills, interpersonal skills, socialization, sensory/motor skills, money management, behavior management and household maintenance. Residence will have four or less unrelated individuals living together or will be an apartment setting.
Vehicle Modifications	Physical adaptations to a vehicle, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual.
Vision	Vision services include eye exams and diagnosis, glasses, contacts, and other medically necessary methods to improve specific vision system problems.

c. Supplemental Demonstration Services

Colorado will not offer supplemental demonstration services.

B.6. Consumer Supports

Describe the process and activities that the state will implement to ensure that the participants have access to the assistance and support that is available under the demonstration including back–up systems and supports, and supplemental support services that are in addition to the usual HCBS package of services.

a. Educational Materials

Transition coordinators and case managers will ensure that CCT Participants are informed about and have access to the assistance and support provided by the CCT

demonstration. A CCT Consumer Transition Guide (see Appendix G for draft Table of Contents) will be developed by January or February 2012 that describes each CCT demonstration service and the procedures for accessing services. The CCT Transition Guide will also specifically identify access to 24-hour emergency back-up supports. All potential participants will receive a copy of educational materials including additional contact information. Portions of the guide will also be used for training providers and other stakeholders.

b. Twenty-Four Hour Emergency Back-Up

During the service planning process, case managers and/or transition coordinators will collaborate with the client, service providers and the client's informal support network to create an emergency back-up plan. The backup plan will encompass CCT Demonstration Services as well as transportation, direct service workers, repair and replacement of equipment, the determination of the need for an emergency response system and how to use 911 for emergencies. The standardized Service Plan for waiver programs and the CCT POC includes a specific section that must be completed entitled "Contingency Plan" in which the above areas of the backup plan would be included.

For individuals moving from the ICFs, the CCBs are required to have an emergency plan for each person and to be available to deal with emergency issues.

For non-emergent situations, CCT Participants will have access to their intensive case managers during regular business hours. Clients receiving case management services from a Community Centered Board (CCB) are also provided an emergency after-hours contact. The Department also offers a 24 hour nurse advice line.

Medicaid home health, personal care, and homemaker providers must be licensed as home care agencies by the Colorado Department of Public Health and Environment (CDPHE). Current CDPHE licensure and certification requirements include that HCBS providers maintain a backup system for critical services including 24-hour a day emergency services and for coverage of employee illness, vacation, holidays and unexpected voluntary or involuntary termination of employment. The agency must also ensure that qualified staff in sufficient quantity are employed by the agency or have other effective back-up plans to ensure the needs of the consumer are met. Monitoring of effectiveness is done through site surveys using a random client sample once every 36 months, unless required more frequently by CMS.

Providers certified to supply Durable Medical Equipment (DME) to Medicaid clients are required to complete services or repairs in a timely manner and advise the clients of the estimated completion time. In the event that a client's warranted DME fails or malfunctions and the client does not have backup equipment, the provider must also arrange for an appropriate alternative at no cost or arrange for temporary equipment rental through the Department. Repairs to and replacement of DME may also covered for items no longer covered by a warranty, and the provider may bill a monthly service charge for rental equipment to replace DME in repair when no backup equipment is available.

Before CCT Participants choosing CDASS can begin managing their own care through attendant services, they must develop an emergency backup plan and complete a training course that addresses planning for emergencies such as medical emergencies, hospitalizations, fires, power outages, severe weather, and other natural disasters. This course is provided by the staff of the CDASS fiscal intermediary agency or by a peer trainer.

CDASS clients are also given a resource guide that includes information about emergency back-up planning and safety and prevention strategies (Appendix N). New regulations also require that CDASS clients must select at least two attendants so that a back-up attendant is accessible should the client's primary attendant be unavailable. The Transition Guide will adapt the strategies from the guide and incorporate them in the CCT Transition Guide.

CDHS/DDD Rules require that persons receiving Comprehensive/DD waiver services and supports shall have 24-hour supervision. The level of supervision required is documented in the Service Plan and may include on-site or readily accessible support personnel. Program approved service agencies for people with developmental disabilities must ensure staffing arrangements are adequate to ensure the health, safety and welfare of persons receiving services and the needs of the individual are met as determined by the Service Plan. CCT clients with developmental disabilities will have access to the same level of backup support based on their service plan.

CCT Participants with mental illness will also have access to services offered by the State's network of Behavioral Health Organizations (BHOs). Providers in the BHO system are required to offer a call center that is staffed by trained customer service representatives and at least one 24-hour toll-free customer service information line. Both phone numbers must be published in local phone books, on the contractor's Web site and in other written materials provided to clients.

House Bill 10-1032, "Behavioral Health Crisis Response Services," requires that the Colorado Department of Human Services (CDHS) must investigate the lack of a coordinated behavioral health crisis response system in Colorado and develop a comprehensive plan to

remedy this situation. Stakeholder meetings will convene over the next two years and recommendations will be presented to the Legislature in 2013.

The Department is also working with a contractor to develop Community Crisis Triage Centers, located throughout the Denver Metro region. These centers will provide intervention, assessment, psychiatric urgent care, stabilization and support for people in crisis as a result of mental health, substance abuse, or co-occurring issues.

c. Complaints about Failures of Back-Up Systems

The CCT Transition Guide will contain instruction on how to file a complaint with when a back-up system fails to the case management agency. Monitoring the failure of backup systems for services provided by the CCT Demonstration Program will be integrated into the existing incident reporting and complaint systems. The Department will add criteria in the CIRS for tracking complaints when agencies fail to provide back-up supports as required by Colorado's Medicaid rules. The Department will maintain a system to review and resolve complaints about backup systems, to include monitoring the timeliness of responses to emergency backup calls, tracking and documenting the number and type of calls and, monitoring the effectiveness of back-up systems. This information will be used in the Department's Global Quality Improvement Strategy (QIS) to improve services to CCT participants and systemically for all waiver participants.

Clients will be directed to contact their Intensive case manager and file a complaint when a provider agency fails to send back-up support when necessary. The case manager will document the complaints, including any information related to the timeliness of the responses to calls for emergency back-up. The case manager will resolve any compliance issues regarding compliance with state requirements concerning back-up support. The Critical

Incident Reporting System (CIRS) Coordinator at the Department will review the CIRS report specifically for complaints regarding back-up systems from CCT clients. If trends indicate that providers routinely fail to provide back-up when needed, the Department will develop a remediation plan.

The Department is currently working to enhance the reporting, tracking and monitoring of CIRs through a new interactive web tool called Captivate. Requirements for CIRS specific to CCT will be integrated. The Department routinely conducts statewide training for case management agencies which includes the reporting guidelines for critical incidents and is in process of building a training model that will require existing as well as new case managers to pass a critical incident test as a condition of employment. Using Captivate, the case manager will walk through an incident report step by step, learn the criteria for critical incident definitions for incident types and sub-types, and learn correct procedures for remediation. Using the same program, a case manager will be required to pass a critical incident test prior to working with waiver clients. The Department will use this opportunity to identify appropriate timeframes for investigation and will use the Captivate tool to track compliance. This tool is anticipated to be operational by July 2011.

The service agencies and case management agencies have policies and procedures regarding the processing client complaints. CDPHE administers a home health hotline for clients wishing to file complaints specific to home care agencies. The Department offers a Medicaid Consumer Hotline for filing complaints anonymously. CCT clients will be provided all of this information by the intensive case manager as well as a web address for filing complaints online.

B.7. Self-Direction

Colorado's Consumer Directed Attendant Support Services (CDASS) is a Medicaid benefit under the Home and Community-Based Services for persons who are Elderly, Blind, and Disabled (HCBS-EBD) and Persons with Mental Illness (HCBS-MI) waivers, allowing clients to manage their attendant services. The Department has authorization for CDASS in the HCBS-BI, -CES, -PLWA and -SLS and the CHCBS waivers. However, CDASS has yet to be implemented in these waivers. See Appendix O for the Self-Direction Submittal Form. CDASS was developed as an alternative to the delivery model of personal care, health maintenance and homemaker services provided by traditional home health agencies. The program provides increased choice, control and flexibility of services by giving the client and/or the client's authorized representative (AR) the ability to recruit, hire, train and terminate attendants. The Department has established a network of program specialists throughout the state to help clients enroll in this program.

The CDASS program includes assistance with activities of daily living such as bathing, dressing, personal hygiene and health maintenance activities as well as homemaker activities such as cleaning, laundry and meal preparation. These services are intended to increase the independence and self sufficiency of clients and to improve the quality of services. The CDASS program utilizes a contracted Financial Management Services (FMS) organization to provide skills training to clients and/or ARs to ensure they understand consumer direction and are able to recognize and monitor the quality of service he/she receives. Clients in the program are given an allocation of funds based on the client's current level of need as identified in a service plan developed by the client and case manager. Clients can seek one-on-one support from the FMS for assistance in managing and/or budgeting services.

In 2005, House Bill 05-1243 expanded the potential for the self-direction of care by authorizing the Department to seek federal approval for the provision of CDASS in any of the State's HCBS waivers. The Department has obtained federal approval for the addition of the program to the Children's HCBS, Persons with Brain Injury, and Persons Living with Aids waivers. The Department is making policy and program administration changes to ensure that the program is cost-effective and sustainable before it is made available to clients enrolled in these waivers. As of December 2010, more than 1,600 clients are enrolled in the CDASS program.

CCT Participants will be able to access CDASS through either the Elderly Blind and Disabled (EBD) waiver or the waiver for individuals with Mental Illness (MI) until such time as the Department is able to expand the services into additional waivers. See Benchmark 4.

Colorado has multiple methods for monitoring the number of CCT participants choosing self-direction as Colorado currently offers two programs for self-direction. Under Colorado's Consumer Directed Attendant Support Services (CDASS) program, intensive case managers refer clients, their Authorized Representatives (ARs) and prospective attendants to the Fiscal Management Service (FMS) for a required training. The FMS regularly reports the number of participants scheduled for training, the number of trainings completed in a given month, the total number of participants served, the total number of attendants who serve them and any program attrition.

Under the state's In Home Support Services (IHSS) program, participant refers their choice of attendant to a home health agency serving their area with a recommendation for hire. Unless the agency can present a compelling reason why the prospective attendant is ineligible for hire (such as immigration status or criminal background), participant requests

are granted. Intensive case managers and IHSS home health agencies will report statistics with respect to program participation.

The Department's Benefit Utilization System (BUS) also records the status of each client receiving long-term care including the specific programs they are being served.

a. Terminating Self-Direction

Describe how the State accommodates a participant who voluntarily terminates self-direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from self-direction to the alternative service delivery method.

Any individual self-directing their services can choose to change to provider-managed services at any time. Intensive case managers will work with clients and/or Authorized Representatives (ARs) to ensure participant health and welfare, the services are the most appropriate for the client and continuity of services. The intensive case managers are responsible for securing adequate care for clients choosing to transition from CDASS.

In-Home Support Services (IHSS) is an alternative service delivery option for a client who needs the support of agency care, but wishes to hire attendants personally. IHSS enables clients to decide which services to use, which workers to hire, and what time of day they will come. However, a certified home health agency is responsible for recruiting, hiring, training and terminating direct service workers.

b. Involuntary Termination

Specify the circumstances under which the State will involuntarily terminate the use of self-direction and thus require the participant to receive provider-managed services instead. Please include information describing how continuity of services and participant health and welfare will be assured during the transition.

Clients may be involuntarily terminated for the following reasons:

- A client and/or AR no longer meet(s) program criteria due to deterioration in physical or cognitive health;
- The client and/or AR demonstrate(s) a consistent pattern of overspending their monthly allocation leading to the premature depletion of funds and the Department has determined that adequate attempts to assist the client/AR to correct the pattern of overspending are not successful;
- The client and/or AR exhibit(s) inappropriate behavior toward attendants, case managers or the Financial Management Service (FMS), and the Department has determined that the FMS has made adequate attempts to assist but has failed to resolve the inappropriate behavior;
- There is documented misuse of the monthly Allocation by client and/or AR;
- There is intentional submission of fraudulent CDASS documents to case managers, the Department or the FMS; and
- Instances of convicted fraud and/or abuse.

Before a client is involuntarily terminated, several attempts are made to improve the management of CDASS services. Clients may select or re-select an AR, receive additional training, and seek assistance from the FMS program support specialists. Clients and/or ARs found to be intentionally misusing CDASS funds may be terminated without warning.

In the event of an involuntary termination, intensive case managers shall notify the client and/or AR within 20 calendar days prior to the termination and are responsible for securing

an adequate alternative to CDASS services. Clients have the right to appeal an involuntary termination.

Only those participants determined by their primary care physician to need an AR in order to properly direct their care are required to have an AR. Colorado statute requires an AR to: "Submit an affidavit, which shall become part of the eligible person's file, stating that:

- He or she is at least eighteen years of age;
- He or she has known the eligible person for at least two years;
- He or she has not been convicted of any crime involving exploitation, abuse, or assault on another person; and
- He or she does not have a mental, emotional, or physical condition that could result in harm to the eligible person.
- If a client is required to have an AR, they may be affected by actions, circumstances involving the AR in the following instances:
- The AR no longer meets the statutory criteria (e.g., is convicted of a crime involving abuse);
- The AR consistently mismanages the participant's budget allocation;
- The AR exhibits inappropriate behavior toward attendants, case managers or FMS staff;
- The AR approves fraudulent time sheets without demonstrating due diligence in determining their validity.

In all instances, intensive case managers and FMS staff will work with the client and/or AR to correct any deficiencies that may lead to the loss of an AR. In the event the AR

relationship must be severed, the intensive case manager will work with the client to find a replacement.

b. Goals for Self-Direction

Specify the State's goal for the unduplicated number of demonstration participants who are expected to avail themselves of the demonstration's self-direction opportunities.

Currently, about seven percent of the HCBS-EBD waiver population utilizes the CDASS program. Based on that percentage the Department estimates a similar 32 participants out of the 490 total CCT clients over the five years will pursue opportunities for self-directed care.

B.8. Quality

a. Written Assurance for Level of Quality

If the State plans to integrate the demonstration into a new or existing 1915(c) waiver or HCBS SPA, the State must provide written assurance that the MFP demonstration program will incorporate, at a minimum, the same level of quality assurance and improvement activities articulated in Appendix H of the existing 1915(c) HCBS waiver application during the transition and during the 12 month demonstration period in the community.

CCT participants will be reviewed and monitored as a specific group during the 365 days after being transitioned from the institution by the CCT staff. CCT enrollment and Transition Assessment/Plans will be shared with the project staff. CCT staff will randomly review case files of the CCT clients in the BUS, the LTC case management software system, and will monitor CCT service utilizations. A monthly random selection of CCT POCs and related log notes will be reviewed to assure appropriate level and type of services are being provided and client progress towards identified goals.

Colorado will apply the same level of quality assurance and improvement activities to CCT as it applies to its current 1915(c) waivers. During the summer of 2008, CMS and the Department began working collaboratively to develop an overarching strategy for quality improvement for all Colorado Medicaid waivers, called the global Quality Improvement

Strategy (QIS). The Department's CCT Quality Assurance/Quality Improvement Specialist will ensure that the QIS is employed for the CCT Demonstration.

Discovery and Remediation: The Department draws from multiple sources when determining the need for and methods to accomplish system design changes, including improvement and remediation. The Department's Quality Improvement (QI) Section and Office of Information Technology (OIT), in conjunction with the Department of Human Services Division for Developmental Disabilities (DHS/DDD) uses an interdisciplinary approach to review and monitor the system to determine the need for design changes, including those to the Benefits Utilization System (BUS), provider data base and CIRS system. This interdisciplinary approach uses data gathered from the following:

- Colorado Department of Public Health and Environment (CDPHE) surveys;
- Critical incident information collected through the CIRS System;
- Annual DHS program quality surveys of program approved service agencies;
- Programmatic and administrative evaluation of case management agencies;
- Performance data from on-site and desk reviews of waiver service providers;
- Reviews of a representative sample of complaints;
- Retrospective and Post Payment reviews;
- Client satisfaction data; and
- Stakeholder input.

Work groups form as necessary to discuss prioritization and selection of system design changes. The Department also uses standardized tools for service planning and Level of Care (LOC) assessments (with an addendum assessment tool for medically fragile children), that are entered electronically using the BUS. These tools are integrated for the Home and

Community-Based Services (HCBS) waiver populations. Through use of the BUS, data generated from assessments, POC critical incident reporting and concomitant follow-up are electronically available at both the case management agencies (CMAs) and state level. Making data available in this manner allows for effective access and use for clinical and administrative functions as well as for system improvement activities. This standardization and electronic availability provide for comparability across CMAs, programs and time, and form the basis for on-going analysis. The use of standardized data sources for many of the performance measures in the QIS strongly supports inter-rater reliability and data integrity. The Department has adapted the FOCUS/PDCA (plan-do-check-act) process (an extension of the Deming cycle) for improving processes.

Data Aggregation, Analysis and Review: Through development and implementation of the QIS, the Department will be able to provide uniform performance data across all eleven HCBS waivers. For example, uniform aggregated data reports for performance measures related to completion of LOC re-evaluations will be generated for each HCBS waiver on an annual basis. Operating agencies are responsible for collecting and reviewing data on case management performance measures related to level of care re-evaluation. The Department believes that the use of uniform performance measures for all waiver assurances, uniform or commensurate processes for reviewing performance data and uniform data aggregation and remediation processes will provide a robust system for discovery and remediation of quality problems and for demonstrating compliance with waiver assurances to both Colorado stakeholders and CMS. Each waiver will collect data on additional performance measures where needed. For example, the HCBS-DD waiver QIS includes performance measures related to quality issues specific to the services provided in that waiver (e.g., use of restraints,

direct care staff training on reporting abuse, neglect and exploitation, etc.) to ensure potential quality issues are discovered and that quality improvement projects are implemented where indicated. Management reports containing performance data will be generated on a quarterly and annual basis and on an ad-hoc basis when specific quality problems are suspected or identified.

Performance Measure Report Reviews: All performance measure data included in the QIS and waiver specific performance measures data will be reviewed by the HCBS Oversight Committee (HOC). The HOC is established as a means for the Department to oversee the operations of all eleven HCBS waivers. The HOC's primary responsibility is to ensure that all HCBS waivers comply with the Department's QIS and work plan. Included in the QIS and work plan are the action steps to comply with the six waiver assurances (and their component elements) that the Department is required to meet in the submission of a waiver application. The HOC is convened and operated by the Department and meets quarterly. The HOC includes key Department staff and staff responsible for quality functions in the operating agencies.

As the single-state Medicaid agency, the Department has overall responsibility for ensuring waiver processes and the outcomes of waiver services meet the requirements of the waiver assurances. The Department is responsible for submission of all data related to DHS/DDD implementation of quality management practices that conform to the QIS. This role includes receipt and review of regular summary data reports generated by the waiver-operating agency (DHS/DDD), convening monthly meetings with the operating agency, participating on the Quality Advisory Committee and ongoing monitoring of critical incidents and complaints involving waiver participants.

The DHS/DDD CIRS includes incidents related to 24-hour backup systems for critical services and incidents related to the health and welfare of CCT and waiver participants. It includes monitor timely responses to emergency back-up calls. The Department will be making modifications the BUS to modify its CIRS process to monitor back-up systems for CCT clients in the non-DD waivers.

This Quality Advisory Committee structure will be expanded to include other waiver participants for the CCT Demonstration. Specific requirements of Colorado's QIS include:

Table 15. Requirements of Colorado's QIS

Service Dimensions	Quality Activities	Desired Outcomes
Participant Access	· Performance improvement projects as determined by prioritization table	· Individuals have access to home and community-based services and supports in their communities. · Improve outcomes
Participant Centered Service Planning and Delivery	· Department on-site visits to SEP/CCB agencies. · Department comparison of service plan to billed services · SEP/CCB agency designation process · Performance improvement projects as determined by prioritization table	· Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community. · Assure participants receive the service plan services · Assure the SEP/CCB agency has providers to provide all services · Improve outcomes
Provider Capacity and Capabilities	· Provider licensure or certification verified upon initial application and then as identified in the approved waiver · Mandatory training of all providers · Performance improvement projects as determined by prioritization table	· There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants. · Minimum standard for all providers applied · Minimum knowledge base is established for all providers · Improve outcomes
Participant Safeguards	· Instances of abuse, neglect and exploitation are identified and acted upon. · Monitoring use of restraints and seclusion	· Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices. · Eliminate instances of abuse, neglect

Service Dimensions	Quality Activities	Desired Outcomes
	· Performance improvement projects as determined by prioritization table	and exploitation. · Assure appropriate safeguards are implemented · Improve outcomes
Participants Rights and Responsibilities	· Performance improvement projects as determined by prioritization table	· Participants receive support to exercise their rights and in accepting personal responsibilities. · Improve outcomes
Participant Outcomes and Satisfaction	· Participant complaint reporting · Performance improvement projects as determined by prioritization table · Client satisfaction survey	· Participants are satisfied with their services and achieve desired outcomes. · Improve outcomes · Identify potential areas for improvement
System Performance	· Performance improvement projects as determined by prioritization table	· The system supports participants efficiently and effectively and constantly strives to improve quality. · Improve outcomes

b. Use of 1915(b), State Plan Amendment (SPA) or an 1115 waiver

If the State plans to utilize existing 1915(b), State Plan Amendment (SPA) or an 1115 waiver to serve individuals during and after the MFP transition year, the State must provide a written assurance that the MFP demonstration program will incorporate the same level of quality assurance and improvement activities required under the 1915(c) waiver program during the individual's transition and for the first year the individual is in the community.

The Department does not intend to utilize 1915(b) waivers, SPAs, or an 1115 waiver to serve individuals during and after the CCT transition year.

c. The Quality Improvement System and Waiver Assurances

The Quality Improvement System under the MFP demonstration must address the waiver assurances articulated in version 3.5 of the 1915(c) HCBS waiver application.

The Department assures that the QIS used for the CCTDemonstration will incorporate the same level of quality assurance and improvement activities as required by Appendix H of the current 1915(c) HCBS waiver application including:

- Level of care determinations;
- Service plan description;
- Identification of qualified HCBS providers for those participants being transitioned;

- Health and welfare;
- Administrative authority; and
- Financial accountability.

d. Quality Assurance Process for Supplement Services

If the State provides supplemental demonstration services (SDS), the State must provide:
1. A description of the quality assurance process for monitoring and evaluating the adequacy of SDS service(s) to manage the barrier it was selected to address; and,
2. A description of the remediation and improvement process.

Colorado will not offer any supplemental demonstration services.

B.9. Housing

Describe the State's process for documenting the type of residence in which each participant is living (See chart for examples in Sub-Appendix II). The process should categorize each setting in which an MFP participant resides by its type of "qualified residence" and by how the State defines the supported housing setting, such as:
i. Owned or rented by individual,
ii. Group home,
iii. Adult foster care home,
iv. Assisted living facility, etc. (Please see the Policy Guidance in Sub-Appendix VI)
If appropriate, identify how each setting is regulated. Describe how the State will plan to achieve a supply of qualified residences so that each eligible individual or the individual's authorized representative can choose a qualified residence prior to transitioning. This narrative must:
i. Describe existing or planned inventories and/or needs assessments of accessible and affordable community housing for persons with disabilities/chronic conditions; and
ii. Explain how the State will plan to address any identified housing shortages for persons transitioning under the MFP demonstration grant, including:
iii. Address how the State Medicaid Agency and other MFP stakeholders will work with Housing Finance Agencies, Public Housing Authorities and the various housing programs they fund to meet these needs; and
iv. Identify the strategies the State is pursuing to promote availability, affordability or accessibility of housing for MFP participants.

The lack of affordable and accessible housing is a major barrier to community transition. There are few options for integrated supportive housing for people with disabilities or others with long-term care (LTC) needs. This is even more the case for people with mental illness. Ideal supportive housing for people with LTC needs is located in rural, suburban and urban

areas; adaptable to individuals' needs throughout their lifespan; allows for individual interaction in the community, and is affordable. While there are some housing options in Colorado that meet these expectations, demand far outweighs capacity at this time. The Division of Housing (DOH) in the Colorado Department of Local Affairs, the Supportive Housing and Homeless Program (SHHP) in CDHS and the Department will partner to expand housing options for people of all abilities.

a. Documenting Type of Affordable Housing Available

Table 16 categorizes each setting in which an CCT Participant can reside by its type and by how the State defines the qualified housing setting.

Table 16. Framework for Documenting Participants' Type of Residence

Type of Qualified Residence	Number of Each Type of Qualified Residences	State Definition of Housing Settings	Number in each Setting	Regulations
Home owned or leased by individual or individual's family member	49	Home leased by individual or family	29	Lease with landlord
		Home owned by individual	0	N/A
		Home owned by family	20	N/A
		Co-op owned by individual	0	N/A
Apartment with an individual lease lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual's	363	Apartment building	67	Lease with landlord
		Assisted Living[3]	0	State regulations, CDPHE

[3] Most assisted living facilities in Colorado do not currently meet CMS policy guidance to qualify as an option for housing in the demonstration. Colorado will conduct an inventory assessment of Assisted Living Facilities to see how many comply and investigate options to increase the inventory available to CCT Participants.

Type of Qualified Residence	Number of Each Type of Qualified Residences	State Definition of Housing Settings	Number in each Setting	Regulations
family has domain and control		Public Housing Units	269	Public Housing agency
Individual apartments or residences, in a community-based residential setting, in which no more than 4 unrelated individuals reside	78	Group Home[4]	78	Agency regulations, DDD

b. Addressing Housing Shortages

A shared Housing Coordinator, in conjunction with staff at DOH and SHHP will work collaboratively with local, state and federal agencies to create and implement a comprehensive statewide housing strategy using a regional approach. The Housing Coordinator will work with public housing authorities, private developers and property managers to achieve CCT goals and build system capacity. In addition, he/she will also provide training and tools to service organizations and to case mangers to help coach and assist consumers searching for rental housing. The program will also address renting fundamentals, budgeting, personal history and locating an apartment.

The Department will pursue five initiatives to expand qualified housing:

1. *Fully utilize the CDHS Project Access Program*

This program provides a set aside of 60 Housing Choice Vouchers to non-elderly disabled individuals residing in LTC settings. Currently there are 15 vacant/available units under this program.

[4] Most group homes in Colorado have a census of more than four so do not qualify as housing options in the MPF Demonstration. The Housing Coordinator funded through the grant will further examine this issue

2. Secure more housing vouchers for people with disabilities and elderly

The Housing Coordinator will meet with local housing authorities and encourage public housing authorities to prioritize people with disabilities and seniors discharging from LTC facilities.

3. Develop local preference set-asides for LTC clients statewide

The Housing Coordinator will meet with and encourage housing authorities to develop local preference for LTC individuals by setting aside a certain percentage of designated affordable housing for people with LTC needs. The Housing Coordinator and CCT staff will identify and convene community stakeholders to participate in local housing plan meetings. The Housing Coordinator will also inform local housing authorities about the need for and best practices of set-asides and work with DOH to create incentives to stimulate interest.

4. *Leverage Temporary Rental Subsidy*

Tenant-based Rental Assistance (TBRA) program using federal HOME funds to provide a temporary rental subsidy (up to two years) will be targeted to persons with disabilities, seniors and those transitioning out of nursing facilities. This bridge subsidy is intended to provide consumers with supportive housing rental assistance while creating a structured link to a more permanent subsidy through the Section 8 Housing Choice Voucher program.

5. Extend the use of the Colorado Housing Registry

Coloradohousingsearch.com will become a key tool used by case managers and transition coordinators statewide. This web-based application was developed by the Colorado Housing Finance Authority and the DOH Division of Housing to provide an important tool for people seeking housing, providing real time information on available, affordable, and accessible units throughout the state. The availability of the registry will be publicized

through other information and referral sources such as AAAs and ARCHs (ADRCs) so that individuals and families interested in obtaining affordable, accessible housing will be able to search this Web site. The inventory/registry will include the number of affordable housing units and accessible units. Another Web site will display the number of housing vouchers currently available and the number dedicated to individuals with disabilities.

c. Existing and planned inventories

A major responsibility of the Housing Coordinator will be to maintain an inventory of supportive housing. The coordinator will encourage local housing authorities to contribute monthly to a list of what is available and accessible. This effort will build upon the State Consolidated Plan (needs assessment) on the DOH Web site. It will also keep the availability of affordable and accessible housing listed on ColoradoHousingSearch.com web site current. The site was developed through collaboration of multiple agencies with a common stake in developing, financing and preserving affordable housing throughout Colorado. It is a statewide web site that provides an inventory of affordable and accessible housing. All development projects that are funded by DOH and Colorado Housing and Finance Authority (CHAFA) are requested to be listed on the Web site. The Department plans to fund a Web site that will provide real time availability of section 8 vouchers statewide, to be managed by DOH.

B.10. Continuity of Care Post Demonstration

To the extent necessary to enable a State initiative to meet the demonstration requirements and accomplish the purposes of the demonstration, provide a description of how the following waiver provisions or amendments to the State plan will be utilized to promote effective outcomes from the demonstration and to ensure continuity of care:
a. Managed Care/Freedom of Choice (Section 1915(b)) – for participants eligible for managed care/freedom of choice services, provides evidence that: i. 1915(b) waivers and managed care contracts are amended to include the necessary services. ii. appropriate HCBS are ensured for the eligible participants; or iii. A new waiver will be created.
b. Home and Community-Based (Section 1915(c)) – for participants eligible for "qualified home and community-based program" services, provide evidence that: i. capacity is available under the cap; ii. A new waiver will be created; or iii. There is a mechanism to reserve a specified capacity for people via an amendment to the current 1915(c) waiver.
c. Research and Demonstration (Section 1115) – for participants eligible for the research and demonstration waiver services, provide evidence that: i. Slots are available under the cap; ii. A new waiver will be created; or iii. There is a mechanism to reserve a specified number of slots via an amendment to the current Section 1115 waiver.
d. State Plan and Plan Amendments - for participants eligible for the State plan optional HCBS services, provide evidence that there is a mechanism where there would be no disruption of services when transitioning eligible participants from the demonstration program

Clients will be concurrently enrolled into a 1915(c) waiver as well as the CCT Demonstration. Participants will receive CCT demonstration services consisting of all qualified waiver services plus additional services. After one year, clients will be removed from the demonstration and will remain on their respective HCBS waiver.

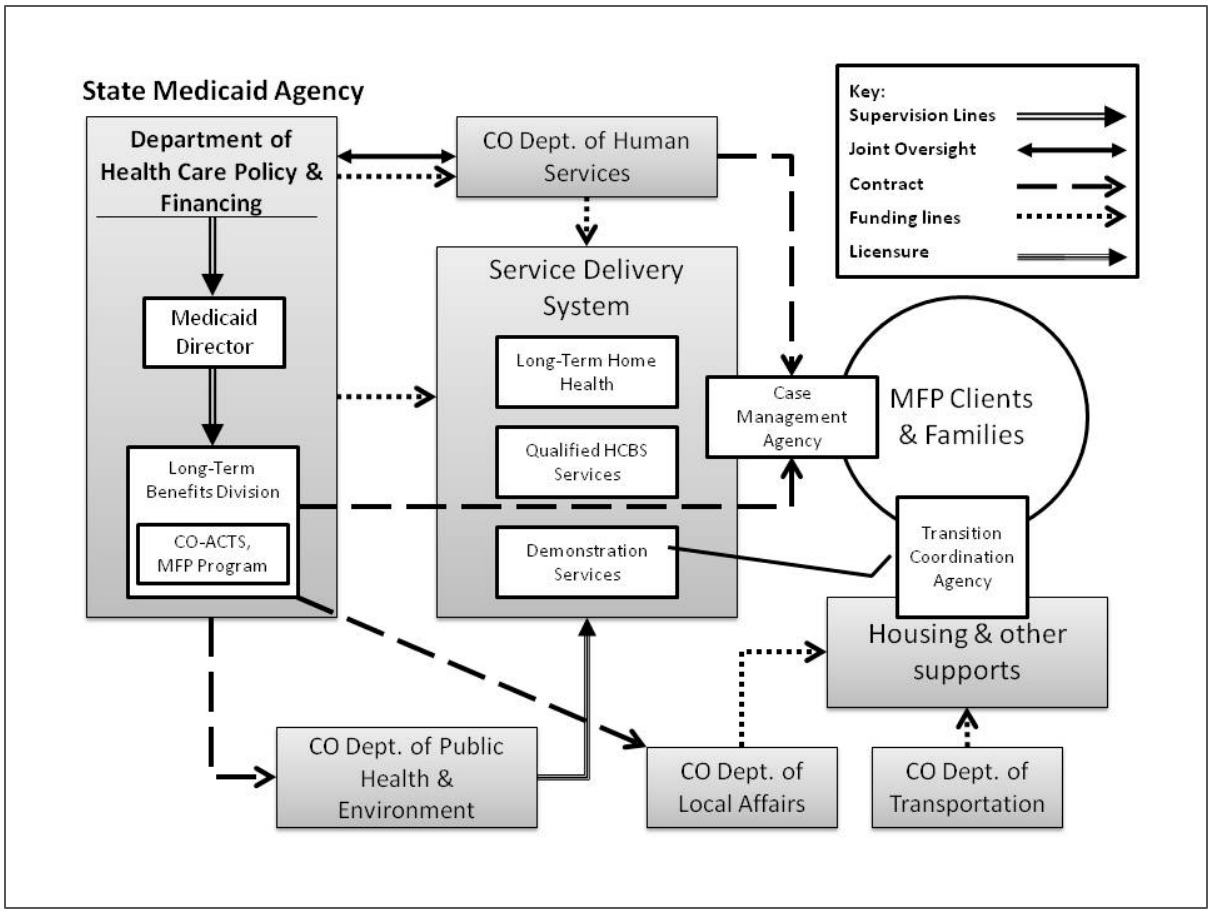
At least 90 days prior to the end of demonstration period, the intensive case manager will begin preparing the CCT client for discharge from the CCT Demonstration. The intensive case manager will meet with the client and the providers of demonstration services that will not continue after the demonstration. The purpose of these meetings is to develop a plan to end services with minimal disruption to the client and to ease the transition to qualified HCBS services and appropriate State Plan benefits. If the intensive case manager needs to transition the client to a new case manager after the demonstration, the intensive case manager will begin coordinating the transfer of the client within the same 90 day period.

Assistive technology will be a one-time benefit to the client available during the demonstration period. The client will be made aware of this benefit during the demonstration. The behavioral health support, substance abuse counseling and mental health counseling offered as demonstration services are specifically for providing additional support for issues, symptoms and challenges associated with the transition. These CCT providers for behavioral health services will gradually reduce services as the client becomes stabilized in the community and during the demonstration year transition the client to the relevant behavioral health services offered through Colorado's contracts with the regional BHOs and MHCs if necessary. Enhanced nursing services will be available only for a limited time after transition to ensure continuity of care between the LTC facility and community-based service providers. This nursing service allows a LTC facility staff to coach the community-based provider and make known the client's preferences for care. LTC facility at the time of transition is in the best position to know the client and his/her needs. This benefit is not expected to last more than one month post transition. It is expected that as the client stabilizes over the demonstration period and develops an informal support system that reliance on an on-call attendant is diminished. By the end of the year, the client accessing consumer direction is expected to have a back-up attendant for emergency. The intent of the independent skills training and specialized day rehabilitation services is to assist the client with community reintegration and to become as independent as possible by end of the demonstration period. It is expected that the day program and the life skills coach to help the client establish a support network to help the client in those areas where dependence still exists.

The intensive case manager will coordinate the financial eligibility redetermination and conduct the annual functional assessment during this same time period. If the client continues to meet financial and functional level of care criteria, a new POC will be developed and services will continue without interruption for the client under an HCBS waiver. At anytime, the client can choose to end services, decide to receive services from PACE or explore other options for long-term care services and supports.

PROJECT ADMINISTRATION

C.1. Organizational Chart



C.2. Staffing Plan

The Department of Health Care Policy and Financing is the single State Medicaid agency in Colorado. Sue Birch was appointed the executive director of the Department of Health Care Policy and Financing by Governor Hickenlooper in January 2011. As a member of the governor's cabinet, Sue directs the Department's efforts to improve the health of Medicaid and CHP+ clients, increase access to care and contain costs. Sue was previously the Chief Executive Officer of Northwest Colorado Visiting Nurse Association in Steamboat Springs, Colorado. She was instrumental in expanding programs, developing strategic partnerships and strengthening operations. The agency moved into a nurse- led model of integrated community health services including primary care, home and hospice care, public health and aging services.

The Director of Medicaid and CHP+ Program Administration Office (MCPAO) provides oversight for all Medicaid program divisions and activities. Medicaid's programs and benefits include physical health and behavioral health services and long-term services and supports. The Director of the Long Term Benefits Division provides direct oversight for Colorado's Money Follows the Person Demonstration Program and reports to the MCPAO Director. Tim Cortez will serve as the full-time Project Director for the Money Follows the Person Demonstration. Tim will devote 100% of his time to this project. Tim currently serves as the Long Term Care Reform/Policy Unit Director in Medicaid. Prior to assuming this position, Tim was a program officer at the Colorado Health Foundation, where he managed grant-funded projects that included care coordination projects for vulnerable populations and health care quality improvement. Tim is responsible for leading the design, development and implementation and plans for sustaining the CCT Rebalancing

Demonstration program. His duties and responsibilities include: management of the CCT Demonstration activities, preparation of the Operational Protocol and subsequent revisions, liaison with the Centers for Medicare and Medicaid Services in all grant-related activities, oversight of all CMS and state required reports, convening and monitoring the internal and external workgroups, analysis of state/federal legislation and public policy, preparation of internal communications, presenting information to internal and external stakeholders. Tim's resume is attached in Appendix Q.

The CCT Demonstration includes funding for 7.5 additional positions. These personnel are needed to design, develop and implement the infrastructure changes needed to create a self-sustaining long term care system in Colorado. These individuals will be responsible for implementing CCT, Colorado's CCT initiative.

17. CCT Demonstration Administration

The Department of Health Care Policy and Financing FTE			
FTE	**Job Title**	**Role/Responsibilities**	**Office, Division, Department**
1 100%	CCT Project Director Years 1-5	Tim Cortez is responsible for leading the design, development and implementation and plans for sustaining the CCT Demonstration program. His duties and responsibilities include: management or oversight of all CCT Demonstration activities, development of the Operational Protocol and oversight of subsequent revisions, liaison with the Centers for Medicare and Medicaid Services in all grant-related activities, oversight of all CMS- and state-required reports, convening and monitoring the internal and external workgroups, lead staff support to the CCT Advisory Committee, analysis of state/federal legislation and public policy, makes recommendations to the Department Executive Director concerning new legislation, reviews and assists in the development of Department policies and programs, manages contracts for services provided under the Demonstration project, preparation of internal communications, presenting information to internal and external stakeholders, supervises preparation of the budget for assigned programs.	CCT, Long Term Care Benefits Division, HCPF
1 100%	CCT Project Manager Years 1-5	This (deputy) position's responsibilities include: daily management of the CCT Demonstration activities, preparation of revisions to the Operational Protocol as needed, ensures preparation and submittal of all CMS- and state-required reports on time, staff support to the several internal and external workgroups, analysis of state/federal legislation and public policy, preparation of internal communications, presenting information to internal and external stakeholders. Manages the multiple projects involved in this Demonstration to assure accountability and timely delivery of project components, provides input in shaping program decisions. Works with contractors to develop materials related	CCT, Long Term Care Benefits Division, HCPF

The Department of Health Care Policy and Financing FTE			
		to the project. This position will have authority to act in the absence of the Project Director.	
1 100%	Target Population Coordinator Years 1-5	Coordinates and manages efforts related target populations. Maintains external relationships with advocacy organizations, aging network agencies and providers, independent living centers, Adult Resources for Care and Help agencies, and other departments. Serves as liaison to the CDHS Division for Developmental Disabilities.	CCT, Long Term Care Benefits Division, HCPF
1 100%	Housing Coordinator Years 1-5	CCT lead person on the use and development of housing opportunities, expanding the inventory of qualified residences for people with disabilities and older adults. The housing programs coordinator will improve the home modification program and coordinate with the Division of Housing in the Department of Local Affairs and the Supported Housing & Homeless Programs at CDHS and local public housing authorities. CCT resource for HUD regulations and policies. Develops relationships with other states to learn best practices for developing housing opportunities for persons with disabilities.	CCT, Long Term Care Benefits Division, HCPF Department of Local Affairs, Division of Housing
1 100%	LTC Facility Resident Transition Manager Years 1-5	This position is the key operational position for nursing facility transitions. Works with facility staff to build support for resident transition before transition begins. Works with facility staff and local contact agency staff in collaborative efforts to transition an individual. Facilitates the identification of individual service needs related to transition and the development of services to meet those needs in coordination with case managers. Works with Community Transition Agencies to coordinate meetings with families, residents and providers. Build and maintain family support for the transition of each resident. Works with individual providers and case managers to assure a smooth and safe transition for residents. Develops and provides input to Training Specialists on best practices. Manages Section Q Referral process.	CCT, Long Term Care Benefits Division, HCPF
100%	CCT Outreach &	Train case management agencies, providers and other entities supporting	CCT, HCPF

The Department of Health Care Policy and Financing FTE			
	Training Specialist Years 1-3	transitions and HCBS programs across the state. Provides outreach activities, and educational materials for the general public. Provides proactive education to stakeholders and the general public.	
1 100%	CCT Grant Data Analyst Years 1-5	This position will be responsible for primary data extraction, contractor data education, ad hoc requests, and oversight of on-going reporting associated with each of the target CCT populations. This position is also needed to follow the target populations for internal evaluation and program needs.	CCT, Data Section, HCPF
0.5	Grant Accountant Years 1-5	This position will track and coordinate all accounting functions under the CCT grant program, including payables, requisitions, and purchase orders; and to ensure proper coding and reporting for federal grant budget lines. Position is needed to meet regularly with program staff managing the grant, as well as with procurement and budget staff to ensure that the grant dollars are spent in accordance with the grant objectives. This position will need to prepare the federal report for this grant as well as analyze, monitor and review all associated financial transactions. Included in this will be the Federal grant award and the reconciliation of the federal accounts receivables related to this grant. This position will also be the lead on any inquires related to reporting for internal or external customers.	

C3. Billing and Reimbursement Procedures

Billing and reimbursement will be managed through the Medicaid Management Information System (MMIS) currently used for HCBS waiver and State Plan services. The Department has extensive fraud control and financial monitoring systems in place.

Prior to processing claims, the MMIS edits claims for validity of the information and compliance with business rules for the service/program, and calculates the payment amount and applicable reductions for claims approved for payment. For example, unless the system verifies that a participant's current prior authorization request (PAR) contains sufficient approved units to cover amounts claimed and that an authorized level of care is registered in the claims management system, the claim will be rejected. The Medicaid Management Information System (MMIS) will require some modifications in order to assure the system is set up to deny duplicate claims for waiver and State Plan services that will be utilized under the CCT Demonstration.

The State uses the Colorado Benefits Management System (CBMS) to verify that a participant was Medicaid eligible on the date of service delivery specified in the request for reimbursement. This information is sent to the MMIS so that payment is only allowed on claims for services provided within the eligibility period. The CBMS will also require modifications in order to assure eligibility for the CCT Demonstration is processed correctly. As with the MMIS, changes to CBMS will be consistent with current policies in order to assure proper eligibility determinations.

The Department's Program Integrity Section monitors for fraudulent claims billing through a review process to ensure providers for the various HCBS waivers, State Plan services and other Medicaid services are complying with program and billing

requirements. These reviews may include on-site audits or desk reviews. The methods used in the review process include examination of financial and service records, as well as plans of care and other records, comparison of provider billings to service delivery, and other supporting documentation.

Through the survey and certification process, the Department contracts with the Colorado Department of Public Health and Environment for onsite reviews to examine a provider agency's service delivery and financial records, and verify that payments made to the provider agency were supported with documentation. Examples of records reviewed include assessment documents, service delivery documents and complaints. The provider must maintain documentation that supports the claims. If the provider fails to maintain the required documentation, all improper payments are recovered. The State also recovers payments when it verifies the provider was overpaid because of improper billing. The State may take adverse action against the provider's contract or require a corrective action plan for any fiscal review finding.

D. EVALUATION

Colorado does not plan to contract for an independent evaluation of its CCT Demonstration nor propose any additional evaluation activities. At this time, the Department will rely on the activities of the national evaluator, Mathematica. After receiving the grant, the Department will meet with the Colorado's Long Term Care Advisory Committee and state staff to determine if there are any other unmet evaluation needs unique to Colorado. If there are any other evaluation requirements, Colorado will propose an amendment to this *Operational Protocol*.