COLORADO
Department of Health Care Policy & Financing

OPERATIONAL MEMO

Title: Nursing Facility Discharge Roles and Responsibilities	**Topic:** Long Term Care
Audience: Case Management Agencies (CMA), Nursing Facilities (NF), Intermediate Care Facilities (ICF), Transition Coordination Agencies (TCA)	**Sub-Topic:** HCBS
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Purpose and Audience:

The purpose of this Operational Memo is to provide resources and guidance on the steps that should be taken to ensure Members transitioning to the community from institutional settings have access to Home and Community Based Services (HCBS) upon discharge. The Memo also clarifies existing regulations and guidance regarding the roles and responsibilities for Case Management Agencies (CMA), Institutional Settings, Transition Coordination Agencies (TCA) and County Department of Human Services (DHS) and Eligibility Sites when a Member is transitioning to the community.

Information:

Successfully transitioning Medicaid Members from institutional settings to community living is a shared effort that depends on strong collaboration among Transition Coordination Agencies (TCAs), Case Management Agencies (CMAs), counties and

eligibility sites, and the institutional settings themselves. Each partner plays a vital role in ensuring that Members have timely access to essential services—such as Home Health and Home and Community-Based Services—from the very first day in the community. These services are critical to supporting the safety, stability, and well-being of Members as they reintegrate into community life.

This memo is intended to respond to stakeholder feedback about the transition eligibility process and offer a new financial eligibility tool for TCAs and best practices for CMAs to help streamline and support the transition eligibility process, as well as reinforce existing standards and regulations outlined in program guidance. We appreciate your continued partnership and shared commitment to person-centered timely care.

New Operational Guidance:

New Financial Eligibility Resource for Transition Coordination Agencies (TCAs)

TCAs will now be able to verify a member's Medicaid financial eligibility once a Member's housing has been identified, using the Health First Colorado and Child Health Plan Plus Grievance webform and selecting the "TCA Eligibility Check" Ticket Type. After receiving this request, the Department will check the identified member's financial eligibility status in the state's system and send that information to the TCA within two (2) business days of form submission. To support the financial eligibility process, TCAs can take the following action based on the information received from the Department:

- If the Member has active LTC Medicaid (HCBS-MH) coverage and is not missing verifications and is not in a renewal period, no action by the TCA is needed.
- If the Member has active LTC Medicaid coverage and is not in their renewal period, but is missing verifications such as asset verification, the TCA shall work with the Member to collect and submit needed documents to the county or eligibility site.
- If the Member has active LTC Medicaid coverage and is within two months of their renewal period, the TCA shall work with the Member to obtain and submit any verifications needed for renewal.
- If the Member does not have active LTC Medicaid coverage, the TCA shall work with the Member to obtain and submit verifications needed for LTC Medicaid, including a disability determination, when applicable.
- The TCA will communicate with the County DHS or Eligibility Site and CMA, as needed, to support the Member's eligibility determination process. If issues arise and cannot be resolved directly with either the CMA or eligibility site, as appropriate, the Health First Colorado and Child Health Plan Plus Grievance webform can be used to receive departmental support.

Case Management Agency Service Planning Prior to Transition

The Case Management Agency shall outreach the Member to review available service options within 2 business days of financial approval (10 CCR 2505-10 8.7202.C(2)(c)(i)(v). Case Managers cannot submit a prior authorization in the Bridge until the AP-5615 form is processed and the HCBS Health Coverage Record is received; however, to ensure services and supports are available to a Member as soon as they move into the community, it is important for Case Managers to coordinate with the TCA during the transition planning process to determine the discharge date and the support needed from case management for discharge planning. Using information provided by the TCA and in coordination with the Transition Options Team (TOT), Case Managers should be prepared to complete the Person-Centered Support Plan, with services and providers identified, as the Member approaches their discharge date.

Institutional Setting Transition Roles and Responsibilities:

The entities involved in coordinating this process will vary depending on the individual circumstances; however, the information in this memo shall be used in conjunction with regulations and other available training and resources for guidance for each entity in fulfilling its respective role and responsibilities in collaboration with one another. The time-sensitive nature required to ensure the needed services and supports are in place at discharge make communication and collaboration across the Health First Colorado and Long-Term Care systems essential for a successful transition experience for Members.

Discharges with a Transition Coordination Agency (TCA) Involved

Targeted Case Management-Transition Coordination (TCM-TC) represents an intensive support model that assists Members moving from an institutional facility to the community. When a TCA is involved with a Member's discharge from an institutional setting into an eligible HCBS program, Transition Coordinators (TCs) coordinate Pre-Transition Coordination and Transition Options Team (TOT) activities (10 CCR 2505-10 8.519.27). The TCA facilitates the transition process by assisting the Member and coordinating with the discharging facility, County DHSS/Eligibility Sites, and the CMA completing the HCBS intake and enrollment process.

TCA Role- Assessment, Coordination and Planning

- Respond to referrals for transition coordination support and indicate whether they accept or decline the referral within two business days by completing the Transition Services Referral form (10 CCR 2505-10 8.519.27.C.1.e) and returning it to the Local Contact Agency.

- Contact the Department to establish access to the Member's record in the CCM. The Department will update the Member's Care Team record in the system with the TCA and Transition Coordinator (TC) information.
- Assign a TC to meet with the Member within ten (10) state business days after accepting a transition referral (10 CCR 2505-10 8.519.27.C.1.f and g.) to explain the transition assessment process and identify the members of the Transition Options Team (TOT) with the Member.
- Coordinate TOT activities which include:
    - Facilitate completion of a Transition Coordination - Community Needs Assessment in the CCM within six (6) weeks of first meeting with the Member for a transition plan which identifies preferences, needs, and any risk factors the Member may have in a community-based setting (10 CCR 2505-10 8.519.27.F.1.a.i).
    - Facilitate development of a Transition Coordination-Risk Mitigation Plan in the CCM to address identified risk factors within eight (8) weeks of accepting a transition referral (10 CCR 2505-10 8.519.27.F.1.a.ii).
    - Complete a transition recommendation from the TOT within six (6) weeks of first meeting with the Member but not before the first TOT meeting (10 CCR 2505-10 8.519.27.F.1.a.iv). The recommendation is documented in the CCM.
        - A transition recommendation may be made by the TOT if all necessary supports and services are available at the level required to meet the Member's needs and risk factors in the region where the member desires to live.
        - Facilitate transition planning, if the Member chooses to proceed.
- Coordinate transition planning with TOT, Regional Accountability Entity (RAE), CMA and facility, based on the transition plan[i] developed by the TOT in the Community Needs Assessment and Risk Mitigation Plan.
    - Refer Member to the appropriate RAE and notify them of future discharge.
    - Send the Community Services Information Form[ii] to the CMA TCA primary contact after the TOT has completed the Community Needs Assessment in the CCM.
    - Coordinate any HCBS services, medication, Long-Term Home Health, home modifications and/or durable medical equipment needs with the facility, RAE, or CMA, as appropriate, prior to discharge to ensure that all identified services and supports are in place prior to discharge.
    - TCAs may also support Members with provider referrals and selection, as needed.

TCA Role- Housing Assistance

- Collaborate with the Division of Housing, voucher administrators, or property managers in accordance with 10 CCR 2505-10 8.519.27.F.1.b.v.
- If the Member requires housing rental assistance and/or assistance finding housing, the TCA assists the Member with completing the Community Access Team (CAT) voucher application and the Housing Navigation Services Referral for submission to the housing navigation provider.
- Assist the Member with touring available housing options, as well as with completing leasing documents.
- Assist the Member to create a transition budget.
- Collaborate with the Transition Setup provider, once the Member is determined eligible for enrollment into an eligible HCBS waiver, to set up the member's new home.

TCA Role- Eligibility Assistance

- Once housing is secured, the TCA requests that the facility make a referral for an LTSS LOC Eligibility Determination assessment to the CMA.
    - Support the member with obtaining needed documents and coordination of CMA communication for HCBS enrollment.
- Once housing is secured, the TCA verifies a member's Medicaid eligibility using the Health First Colorado and Child Health Plan Plus Grievance webform and supports counties or eligibility sites in resolving documentation and other issues to determine financial eligibility.

TCA Role- Transition Support

- Assist the Member in preparing for discharge, including being present at the facility on the day of discharge to ensure the requirements of the Transition Plan are addressed in accordance with 10 CCR 2505-10 8.519.27.F.1.b.vii.
- Meet with the Member at their home on the day of discharge to ensure that providers and services needed upon discharge are in place and the household set-up is complete (10 CCR 2505-10 8.519.27.F.1.b.viii).
- The Department will monitor transition timelines through monthly reporting and if the Member has not transitioned to the community within 120 days of the TCA referral acceptance date, the Department will contact the TCA to offer assistance in mitigating remaining barriers.

TCA Role- Monitoring

The TCA provides post-transition support to ensure that the Member maintains access to critical resources once they are in the community. Post-transition activities are outlined in 10 CCR 2505-10 8.519.27.F.1.c. and include:

- Provision of support services to aid in sustaining community-based living
- Response to risk incidents and notifying the CMA and Adult Protection Services (APS), as required
- Revision of Risk Mitigation Plan, as needed
- Assessing the need for independent living skills training
- Problem-solving and supporting community integration issues
- Monitoring service provision, to include contacting guardians, providers, and the CMA
- Requesting for the Member to complete a TCM-TCA satisfaction survey prior to discharge and at the end of the transition

Facility Role

When Transition Coordination services are involved in a Member's discharge from a facility, the facility may have initiated the process by referring the Member to the Local Contact Agency (LCA) for Options Counseling using the In-Reach process through the state prescribed referral system. The TCA will then complete the previously outlined activities in coordination with the facility. The facility is not required, but may participate on the TOT and is responsible for the following:

- The facility makes a referral, after housing is found, to the CMA for the Long-Term Care Level of Care Eligibility Determination assessment to be completed.
- The facility must facilitate ordering needed Durable Medical Equipment, including obtaining medical authorization in accordance with 10 CCR 2505-10 8.590.2.
- The facility must coordinate with the TCA, and other appropriate entities, the acquisition of skilled care services, e.g., Long-Term Home Health (LTHH) in the community, prior to discharge.
- The facility completes and submits the AP-5615 for discharge to the County DHS or Eligibility Site.

Even when a TCA is assisting Members by facilitating and coordinating the transition process, the facility is responsible for determining that all requirements for a safe discharge are met before relinquishing their responsibility to the resident (10 CCR 2505-10 8.415.20.C).

Case Management Agency (CMA) Role

HCBS Case Managers are minimally involved with facility to HCBS transitions when TCM-TC services are being utilized. They may, but are not required to, participate in the TOT. In these cases, the TCA facilitates the transition process, assists the Member, and coordinates transition planning activities, except as follows:

- Receive and review the Community Services Information Form from the TCA.
- Review the Transition Coordination-Community Needs Assessment in the CCM and provide input regarding the general availability of the outlined services in the region where the member wants to live and an anticipated discharge date.
- Coordinate with the TCA and TOT, as needed, to identify appropriate services and providers.
- Perform referral, intake, and enrollment activities according to OM 25-025 and in accordance with superseding memos.
    - Use the information provided in the Community Services Information Form to inform service planning and authorization in preparation for the discharge date.
    - Outreach the Member to review available service options within 2 business days of financial approval (10 CCR 2505-10 8.7202.C(2)(c)(i)(v).
    - Authorize services available through the member's approved waiver after HCBS enrollment (10 CCR 2505-10 8.7202.CC).
- Complete Targeted Case Management, monitoring, and other activities post-transition as required by state, federal regulations and contractual requirements.

County DHSS or Eligibility Site Role

Process the Health First Colorado application within 45 days if no disability determination is needed, and 90 days to process if a disability determination is needed.

The county has 30 days to process financial eligibility verification documentation once submitted.

Review and process data on the AP-5615 form after receipt within 5 working days (10 CCR 2505-10 8.100.7.V.1.c, h).

Discharge Without a TCA Involved

Facility Role

When a TCA is not involved in a Member transitioning from a facility to HCBS services, the facility will work directly with the CMA as follows:

- Notify the CMA that discharge into the community is being considered, refer the Member by phone, fax or email, or by submitting a LTSS- Level of Care

Referral Form, for a Long-Term Care Level of Care Eligibility Determination assessment and coordinate a discharge date (8.7202.C.2. a, b and 3).
- The facility must facilitate ordering needed Durable Medical Equipment, including obtaining medical authorization in accordance with 10 CCR 2505-10 8.590.2.
- The facility must coordinate with appropriate entities the acquisition of skilled care services, e.g., Long-Term Home Health (LTHH) in the community, prior to discharge.
- Determine that all requirements for an orderly transfer or discharge are met before relinquishing their responsibility to the resident (10 CCR 2505-10 8.415.20.C).
- Complete and submit the AP-5615 for discharge to the County DHS or eligibility site (10 CCR 2505-10 8.482.34.B).

CMA Role

The CMA is required to provide informed choice and counseling on the options available to Members for services for which they are eligible and their choice to receive those services in an institutional or community-based setting, as applicable. Providing this information is especially important when the Member has not previously received Options Counseling and Transition Coordination Services. This must be done at a minimum, upon initial enrollment, and at each subsequent reassessment and upon changes in condition (10 CCR 2505-10 8.7202.F.2.d, 8.7202.E.2. and 8.7202.C.1.a). In addition, when a TCA is not involved in the transition process from a facility to HCBS, the CMA is responsible for the following:

Referral to and facilitation of Health First Colorado Medicaid eligibility process, including the coordination of the financial eligibility process as required in (10 CR 2505 10-8.7202.B.1.d. and 8.7202.B3).

- Perform referral, intake, and enrollment activities according to OM 25-025 and superseding memos.
    - Refer to the appropriate RAE and notify them of future discharge into the community.
    - Refer to service providers according to the needs identified in the LOC Screen and Person-Centered Planning Process.
        - Support Members in provider selection to the degree and extent that the Member or Family requests or requires for successful placement (10 CF 2505 10 Section 8.7202.J.6.c.)
        - Case Managers shall support Members in identifying qualified Provider Agencies and assist them in determining the best fit for their needs and service plan approvals, including but not limited to: setting up tours, communicating with potential providers

about the Member's needs or soliciting entrance to programs on behalf of the Member, depending on Member preferences and needs. (10 CF 2505 10 Section 8.7202.J.6.c.)
        - Contact the Member to review available service options within 2 business days of financial approval (10 CCR 2505-10 8.7202.C(2)(c)(i)(v).
    - Authorize services available through the member's approved waiver after HCBS enrollment (10 CCR 2505-10 8.7202.CC).
- Complete Targeted Case Management, monitoring, and other ongoing activities as required by state, federal regulations and contractual requirements, including mitigating risks identified during monitoring activities (10CR2505 10 8.7202.K.3).

County DHS and Eligibility Sites Role

There is no difference in the roles and responsibilities of the County DHS and Eligibility Sites when a TCA is not involved.

Process the Health First Colorado application within 45 days if no disability determination is needed, and 90 days to process if a disability determination is needed.

The county has 30 days to process financial eligibility verification documentation once submitted.

Review and process data on the AP-5615 form after receipt within 5 working days (10 CCR 2505-10 8.100.7.V.1.c, h).

Action To Be Taken:

TCA and CMA agencies shall distribute this operational memo to appropriate staff for review and incorporate its information into the agency's existing training structure and standard operating procedures to ensure compliance with existing expectations.

CMA agencies shall select a TCA primary contact at their agency and provide the CMA TCA Primary Contact name and contact information to the Transitions Administrator for distribution to TCAs to use for initial notification to the CMA of their involvement in a Member's transition. The CMA shall notify the Transition Administrator of any changes to the CMA TCA Primary Contact information within 2 (two) business days of the change.

Definition(s):

Case Management Agency (CMA) means a public, private, or non-governmental non-profit Agency that meets all applicable state and federal requirements and is certified by the Department to provide Case Management services for Home and Community-Based Services (HCBS) waivers.

Home and Community-Based Services (HCBS) means services and supports authorized by a waiver and provided in community settings to a member who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities.

Transition Coordination Services means support provided to a member who is transitioning or being diverted from a skilled nursing facility, extended hospital stay, intermediate care facility, or regional center. Transition Coordination Services include the following activities: comprehensive assessment for transition or diversion, community risk assessment, development of a transition or diversion plan, referral and related activities, and monitoring and follow up activities as they relate to the transition or diversion.

Transition Coordinator (TCA) means a person who provides Transition or Diversion Coordination Services and meets all regulatory requirements for a TCA.

Transition Coordination Agency (TCA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide Transition/Diversion Coordination Transition or Diversion support pursuant to a provider participation agreement with the State Department.

Transition Options Team (TOT) means the group of people involved in supporting and implementing the transition, to include the person receiving services, the TCA, the guardian, may include the home- and community- based services case manager, nursing facility social worker and others chosen by the individual receiving services as being valuable to participate in the transition process. The TOT is convened to work

in a cooperative and supportive manner to develop and implement the transition plan, and to serve in an advocacy role with the member.

Resources:

Transition Coordination Referral Information Form

Community Services Information Form

Transition Plan

1. Community Needs Assessment
2. Risk Mitigation Plan

Transition Services Training

Attachment(s):

None

HCPF Contact:

Transition Coordination questions:

Jay Jackson, Transitions Administrator

jay.jackson@state.co.us

Case Management questions: hcpf_hcbs_casemanagement@state.co.us

Facility questions: Christine.bates1@state.co.us

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[i] The transition plan is described in the TC-Community Needs Assessment and Risk Mitigation Plan in the CCM.

[ii] This is currently located in the TCA-Community Needs Assessment in the "Targeted Case Management - Transition Coordination (TCM-TC) Services Summary section and will be removed and become a separate document in the future.