COLORADO
Department of Health Care Policy & Financing

OPERATIONAL MEMO

Title: Rapid Reintegration (RR) and Level of Care (LOC) Screen	**Topic:** LTSS
Audience: Case Managers, Transition Coordination Agencies, Nursing Facilities, Advocates, Stakeholders	**Sub-Topic:** Implementation
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Purpose and Audience

This Operational Memo informs stakeholders of upcoming changes to the Level of Care (LOC) Screen to implement the Rapid Reintegration (RR) procedure for members seeking nursing facility admissions. Rapid Reintegration ensures Medicaid members are informed about available Home and Community Based Services (HCBS) and supports to encourage timely transitions back into the community.

Case Management Agencies (CMAs) shall operationalize this process for implementation on January 1, 2026. This memo outlines CMA roles, responsibilities, documentation requirements, and system requirements.

Background

Based on stakeholder feedback and the FY 2024-25 BA-07 "Increase Access to Community-Based Services" budget request (updated in BA-08), the Department of Health Care Policy & Financing (HCPF) is implementing enhancements to the LOC Screen and implementing RR. These changes aim to:

- Educate individuals about community living options during the LOC Screen process.
- Support timely transitions to the community.
- Refer interested individuals to appropriate transition services.

Implementation Process before admission into a nursing facility:

1. Case Managers must complete the Nursing Facility LOC Screen in the Care and Case Management (CCM) system.

2. Case Managers will ask applicants additional questions under the Community Living Education Section in CCM which is designed to support the following RR process:
    a. Present all available LTSS options.
    b. Identify and document member preferences by referring to the LTSS Member Preference Form located under “Page Resources” in CCM
    c. Confirm community options were offered (even if the member chooses nursing facility care).
    d. Record concerns or questions from the member or their representative.
    e. If the member states an interest in Rapid Reintegration, then the process begins.

Rapid Reintegration (RR) Process

The RR process begins when community living options are presented during the LOC Screen and the individual expresses a desire to return to the community following their nursing facility stay. The process continues through the member's full transition back into the community. All changes to the LOC Screen and additions of Rapid Reintegration are integrated into CCM.

Step 1: Barrier Questions

- Case Managers complete the Rapid Reintegration Plan Barrier Questions in CCM at the time of the LOC Screen with the Individual and/or Individual’s representative(s).

- These questions help identify barriers to a successful transition.

Step 2: Next Steps Based on Barrier Question Responses

Based on the responses to the barrier questions, Case Managers will be prompted in the system to take the appropriate next step, as follows:

- No Medicaid - Complete a Transition Escalation, via the webform also known as the Health First Colorado Grievance Form, make sure to note under "Describe the issue or incident" that it is a Rapid Reintegration case. No further steps are required by the Case Manager.
- Low Barriers - Conduct a Rapid Reintegration Plan Assessment, in the CCM, at the time of the LOC Screen to evaluate risks and identify supports. Case Managers will need to keep the Rapid Reintegration Plan Assessment updated with planned discharged date and services. The Case Manager will need communicate with the social worker involved at the Nursing Facility throughout the process. (Note if member is in the nursing facility for over 30 days, then the CM will submit a Transition Escalation webform).

    If additional referrals for services are needed, then the Case Manager will submit referrals after the member has been admitted to the Nursing Facility. For example, the Case Manager would make referrals to Home and Community Based Services (HCBS), or Program for All- Inclusive Care for the Elderly (PACE)

- High Barriers: Initiate a Rapid Referral to a Transition Coordination Agency (TCA) within the CCM within two business days of the LOC Screen date to ensure the member receives necessary Transition Coordination Services.

Step 3: Post Rapid Reintegration Satisfaction Survey

- The CMA will conduct a Post Rapid Reintegration Satisfaction Survey in the CCM within 90 days after the member transitions to the community for members who received a Rapid Reintegration Plan Assessment or a Rapid Referral.
- The survey gathers the Member's feedback on their reintegration experience.

Case Managers must complete all assessments, referrals, and document activities in the CCM system within the timelines outlined in contract, regulations and policy guidance.

Policy Additions

Per 10 CCR 2505-10 8.7202.C1a and 8.7202E8:

- CMAs must ensure Case Managers document all discussions about community living options.
- Document preferences.
- If the member selects nursing facility care, it must be documented under the Community Living Education Section in the CCM, that alternative community living choices were presented.
- Case Managers must complete Rapid Reintegration Barrier questions if an individual expresses a desire to live in, or does not oppose living in, the community with additional support and is interested in Rapid Reintegration.

CMA Payment

CMAs will be reimbursed through their contracts for completing the following activities in the CCM:

- Rapid Reintegration Plan Barrier Questions
- Rapid Reintegration Plan Assessment
- Post Rapid Reintegration Satisfaction Survey

Payments will be issued on the 15th of each month for activities completed the previous month.

Required Action

CMAs must:

- Distribute this memo to relevant staff.
- Update internal training materials and standard operating procedures.
- Ensure all Case Managers complete the required "Rapid Reintegration" training as outlined below:

Training Details and Schedule

Rapid Reintegration training for Case Managers begins in December 2025. HCPF has developed a web-based training, a virtual, live training, job aids (available November) and will hold office hours to support the implementation of Rapid Reintegration. These new resources include an outline of changes to the LOC Screen and an introduction to Rapid Reintegration.

CMA Leadership will receive information about the availability of the WBT for November and registration links for the virtual trainings in December for Case Managers.
WBT training must be completed in the Learning Management System no later than December 31, 2025.

Participants are encouraged to utilize a computer and/or a phone line to join the live, virtual training. This training will be recorded and posted on the HCPF's website for future reference.

This will be a mandatory training for any staff who support Nursing Facility admission processes/assessments.

The trainings will be offered through three separate sessions, each providing the same information. Please provide the following dates to applicable staff at your agency so that they may plan to attend one of the sessions below.

December 2, 2025, 9:00 to 10:30 a.m.
December 3, 2025, 1:00 to 2:30 p.m.
December 4, 2025, 9:00 to 10:30 a.m.

Office hours are scheduled to provide Case Managers with an opportunity to ask questions, provide feedback, and seek out assistance. Case Managers are encouraged, but not required, to attend office hours. Additional information regarding registration for office hours will be provided during the training sessions.

January 6, 2026, 9:00 a.m.
January 14, 2026, 1:00 p.m.
January 28, 2026, 9:00 a.m.

Definitions

Case Management Agency (CMA): An agency certified by HCPF to provide case management services for HCBS waivers.

Long Term Services and Support Level of Care Eligibility Determination Screen (Level of Care Screen): A comprehensive evaluation with the individual seeking services and appropriate support persons (such as Family Members, friends, and or caregivers) to determine an Applicant or Member's eligibility for Long- Term Service

and Supports based on their need for institutional Level of Care as determined using the Department's prescribed Assessment instrument.

LTSS Member Preference Guide: A guide located under Web References in CCM, to refer to when educating the member about their community living choices.

Rapid Reintegration (RR): A process for individuals interested in, or not opposed to, returning to the community after nursing facility admission.

Rapid Reintegration Barrier Questions: A set of required questions to identify potential challenges to transitioning.

Rapid Reintegration Plan Assessment: A tool to document risks and plan for necessary services to enable a safe transition.

Rapid Referral: Referral to a TCA for transition coordination when a member needs support services.

Transition Coordination Agency (TCA): An agency that provides transition support services.

Post Reintegration Satisfaction Survey: Final step in the RR process, conducted within 90 days of community transition.

Attachment(s):

None

Resources:

LTSS Member Preference Guide

Informational Memo Number: HCPF IM 23-003, Office of Community Living BA-07 Budget Request

Transition Escalation webform

HCPF Nursing Facility Diversion Projects

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