# Support for Transitions from Institutional Settings

**November 1, 2023**

**Report Submitted to: Health and Human Services Committee of the Senate, Public Health Care and Human Services Committee of the House of Representatives, Joint Budget Committee**

COLORADO
Department of Health Care Policy & Financing



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# I. Introduction

The Transition Services program in the Department of Health Care Policy & Financing (the Department) was established April 30, 2018, by House Bill 18-1326, Support for Transition from Institutional Settings. Passed with unanimous support, this enactment directs the Department to provide community transition services and supports to people who are in institutional settings, are eligible for Medicaid, and desire to transition to a home- and community-based setting. The Transition Services program officially began enrolling Medicaid members on January 1, 2019. Implementation of Transition Services is based on the success of the federal Money Follows the Person (MFP) grant program, which Colorado implemented as the Colorado Choice Transitions (CCT) demonstration in 2013. Concluding December 31, 2019, the CCT program helped 702 people transition from institutional settings to the community.

Transition Services are services, in addition to the services provided through the state Medicaid plan and 1915(c) waivers, within Colorado's Medicaid ecosystem that include Targeted Case Management-Transition Coordination (TCM-TC) in addition to four Home and Community-Based Services (HCBS): Home Delivered Meals, Life Skills Training, Peer Mentorship, and Transition Setup. These permanent Medicaid benefits work in combination with the state plan and waiver services to reduce barriers to community access, while supporting a variety of life-changing events for members living in the community. State Housing Vouchers are connected to Transition Services through an Interagency Agreement (IA) with the Department of Local Affairs (DOLA). The bridge to housing is a key function of Transition Services, providing opportunities that are person-centered and cost-effective. As such, Transition Services provide an ongoing pathway to sustainable community living for people who would otherwise likely remain in more restrictive settings were it not for this program.

In August 2023, the Department was awarded a $43 million Money Follows the Person (MFP) demonstration grant by the Centers for Medicare and Medicaid Services (CMS). This grant represents further investment in the services and supports implemented under HB 18-1326 by the Department. Colorado's grant

proposal will create innovative solutions that enhance existing Medicaid benefits.

As part of HB 18-1326, the Department is required to report on the cost effectiveness of Transition Services as well as utilization patterns including: the number of persons that requested services, the number of individuals that received services, the number of persons who transitioned from an institutional setting to a home and community-based setting, and the number of persons who transitioned from an institutional setting but later returned to an institutional setting. That analysis, and summary data, can be found below.

## II. Evaluation of the Cost-Effectiveness of the Services

The Transition Services program is cost-effective in meeting needs and supporting skill acquisition for members who wish to live in the community long-term. The benefits bridge the gap between institution-based and community-based care to help members adjust to living in a different setting with more independence and more personal responsibility. Providing a means to community living for all members reflects the value of choice in where people live and receive services. Informed choice is central to person-centered philosophies and members' potential to thrive in the community. The provision of quality care in the community is also cost-effective because the majority of members' needs can be met in the community for a cost that is less than the cost of living in an institution.

The table below illustrates the State's savings realized by the Transition Services program for members who transitioned from a nursing facility (NF) to the community during State Fiscal Years (SFYs) 2021-22 and 2022-23. This calculation includes 647 members who discharged at any point during these two years and received HCBS services following their transition to the community. The Per Member Per Month (PMPM) costs for NF and HCBS are based on the average monthly costs of all members who transitioned. Extrapolated over the course of the year, the Estimated Average Annual Total Funds Savings Per Capita represents the combined Federal and State's share of the cost, per member.

| Per Member Per Month (PMPM) Expenditures for Members Who Transitioned from a Nursing Facility (NF) to Home- and Community-Based Services (HCBS) | | | |
|---|---|---|---|
| **Row** | **Item** | **Amount** | **Source/Calculation** |
| A | Average NF PMPM - Pre-Transition | $8,029.76 | Department actuals |
| B | Average HCBS PMPM - Post-Transition | $4,637.07 | Department actuals |
| C | Difference in PMPM | ($3,392.69) | Row B - Row A |
| D | Estimated Average Annual Total Funds Savings Per Capita | ($40,712) | Row C * 12 |
| E | Estimated Total Funds Savings for Population Group | ($26,340,825) | Row D * 647 members included in calculation |
| F | Estimated General Funds Savings for Population Group | ($13,170,412) | Row E / 2 |

This table shows that the PMPM expenditures for members who transitioned from a NF to HCBS is $4,637.07, which is significantly less than the PMPM for members in NF, $8,029.76. HCPF estimates that the total funds saved in one year for those who transitioned from a NF to HCBS is $26,340,825 in total funds, of which $13,170,412 is saved in General Funds.

## III. Program by the Numbers

### A. Number of Members Who Requested Services

The Minimum Data Set (MDS) is a federally required tool administered by NF staff to residents upon admission and on a quarterly basis thereafter. Section Q of the tool reviews a member's interest in community living and is a primary referral source for the Transition Services; those who respond "yes" to Section Q are referred to Options Counseling. The following table outlines the number of Medicaid members referred to Options Counseling based on their response to Section Q of the MDS tool.

Options Counseling is provided by Department-contracted Aging and Disability Resource Centers (ADRCs) and non-profit agencies across the state. This is the first step in the Transition Coordination process for members residing in facilities and provides members with information on transition services and their options for living in the community.

| Medicaid Members Referred for Options Counseling | |
|---|---|
| CY 2019 | 470 |
| CY 2020 | 522 |
| CY 2021 | 469 |
| CY 2022 | 569 |
| CY 2023[1] | 158 |
| **Total Medicaid Members Who Received Options Counseling[1][2]** | **1,719** |

## B. Number of Members Who Received Services

The following table outlines the number of Medicaid members who have received Targeted Case Management–Transition Coordination (TCM-TC) since January 1, 2019. To receive TCM-TC, a member must reside in a NF with a desire to transition to community living. Eligible members receive TCM-TC before and after discharge to the community. This data represents all members utilizing TCM-TC during this period, not just those engaged in discharge planning.

| Medicaid Members that Received Targeted Case Management-Transition Coordination | |
|---|---|
| CY 2019 | 275 |
| CY 2020 | 824 |
| CY 2021 | 816 |
| CY 2022 | 847 |
| CY 2023[1] | 631 |
| **Total Medicaid Members Who Received TCM-TC[3]** | **3,393** |

[1] CY 2023 data goes through August 15, 2023.
[2] Reflects total number of unique members referred for Options Counseling through MDS data. Some members received multiple options counseling visits over multiple CYs. Data goes through August 15, 2023.
[3] Reflects total number of unique members who received Targeted Case Management–Transition Coordination. Some members received services over multiple CYs. Data goes through August 15, 2023.

## C. Number of Members Who Transitioned from an Institutional Setting to a Home and Community- Based Setting

The following table outlines the number of Medicaid members who have used TCM-TC and have successfully transitioned to the community. Following Options Counseling there are multiple barriers that may prevent a member from transitioning to the community. Barriers may include but are not limited to exacerbation of condition, death, relocation outside of Colorado, and member choice.

Despite challenges faced by the Public Health Emergency, the number of members that successfully transitioned to the community from institutional settings has continued to increase each year following implementation of transition services.

| Medicaid Members Who Transitioned from an Institutional Setting to a Home- or Community-Based Setting | |
|---|---|
| CY 2019 | 69 |
| CY 2020 | 250 |
| CY 2021 | 275 |
| CY 2022 | 269 |
| CY 2023 [4] | 123 |
| **Total Medicaid Members Who Transitioned** [5] | **961** |

## D. Number of Members Who Transitioned from an Institutional Setting but Later Returned to an Institutional Setting

Some individuals who have received Transition Services have returned to a facility setting; however, because there are 30 or fewer members that returned to facilities, the data has been suppressed to protect confidentiality, in compliance with Health Insurance Portability and Accountability Act (HIPAA) Safe Harbor requirements. This is also true for previous years.

## E. Impact of COVID-19 Public Health Emergency (PHE)

The COVID-19 Public Health Emergency (PHE) had significant impacts on our Transition Services. Challenges for members moving out of a congregate setting included HCBS direct care workforce shortages, NF staff capacity, and

restrictions that limited direct access to members living in facilities. For those members and families who wished to leave facilities, Transition Services offered a path to community living.

## IV. Closing

The data shown in this report demonstrates that despite the challenges faced during the PHE, the Transition Services program has continued to support the most vulnerable members as they pursue options for community living. Additionally, this report shows that the PMPM expenditures for members who transitioned from a nursing facility to home and community-based services is less than it would have been in a NF, demonstrating that the program is cost-effective in meeting needs and supporting skill acquisition for members who wish to live in the community long-term.

As a result of this program, hundreds of individuals who likely would have otherwise remained in a facility setting have been able to successfully live in their local communities. The Department will continue to work closely with stakeholders to support programmatic adjustments as needs evolve.