

Transition Services

Benefits for Those Transitioning Into the Community

August 2022

Our Mission

To improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado. This means that we work to make our members healthier while getting the most for every dollar spent.

Transition Services Overview

Transition Services

Transition Coordination

Transition assessment, risk assessment, transition planning, coordination of transition services and monitoring and follow up activities provided for institution to community transitions

Life Skills Training

Training on skills for living in the community

Home Delivered Meals

Access to nutritious meals for those with special dietary needs or recently discharged from the hospital

Transition Setup

Coordination and funds for setting up a basic living arrangement

Peer Mentorship

Support from a peer with shared experience conducive to transitioning into the community

Rates and Units Chart

Service Name	August 1, 2022 Rates (1 unit = up to 15-min)	Unit Limitation
Transition Coordination	\$8.01 per unit	40 Units (10 hours); available up to 30 days after enrollment
Life Skills Training	\$12.45 per unit	Up to 24 units(6 hours) a day for no more than 160 units a week, up to 365 days post transition
Home Delivered Meals	\$11.97 per meal	2 meals a day up to 14 meals a week, up to 365 days post transition, or up to 30 days post hospital discharge
Transition Setup	--	\$1500, up to 30 days post transition
Peer Mentorship	\$6.19 per unit	24 units (6 hours) a day for 365 days post transition

Note: Chart information as of August 1, 2022. For most up-to-date rates, visit hcpf.colorado.gov/provider-rates-fee-schedule.

Transition Coordination

- Only available to people wishing to transition out of an institutional setting (nursing home, Intermediate Care Facility (ICF), Regional Center)
- Provided through a Transition Coordination Agency (TCA)
- Transition coordination activities include:
 - Community needs assessment
 - Risk mitigation planning
 - Access to housing assistance
 - Discharge planning
 - Post-discharge community-based support

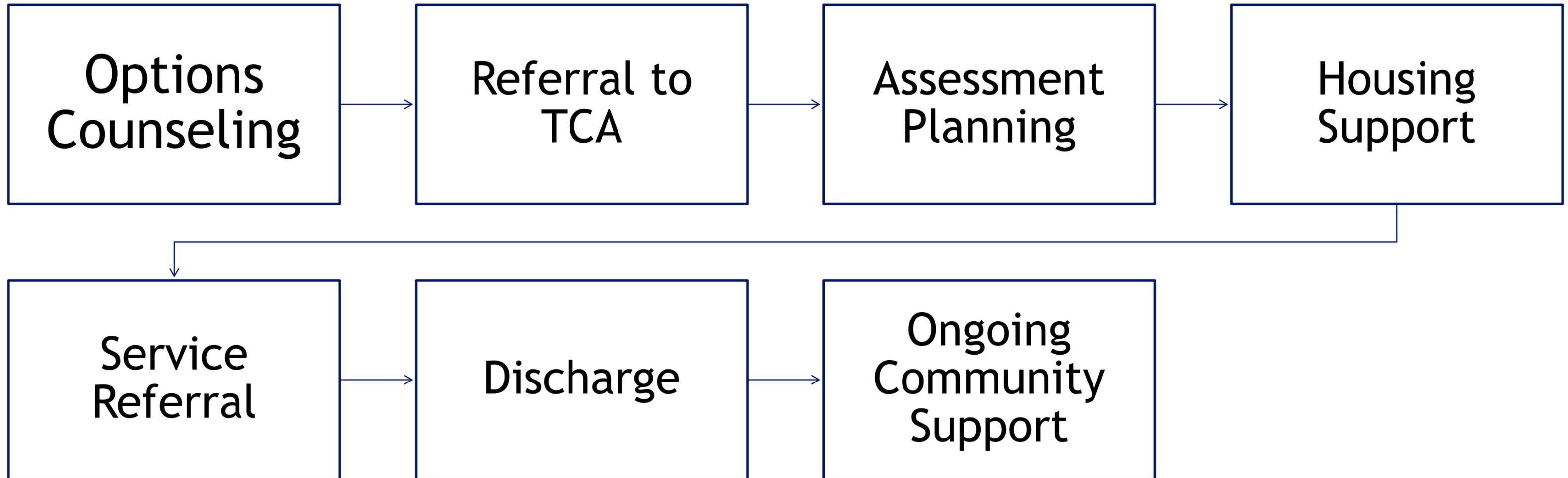
Waiver Transition Services

Transition Services offered through Home and Community-Based Service (HCBS) waivers are available to anyone experiencing a life transition or transitioning from an institutional setting.

Brain Injury Waiver (BI)	Community Mental Health Supports Waiver (CMHS)	Developmental Disabilities Waiver (DD)	Elderly, Blind and Disabled Waiver (EBD)	Complementary and Integrative Health Waiver (CIH)	Supported Living Services Waiver (SLS)
Home Delivered Meals	Life Skills Training	Home Delivered Meals	Life Skills Training	Life Skills Training	Life Skills Training
Peer Mentorship	Home Delivered Meals	Peer Mentorship	Home Delivered Meals	Home Delivered Meals	Home Delivered Meals
Transition Setup	Peer Mentorship	Transition Setup	Peer Mentorship	Peer Mentorship	Peer Mentorship
*Independent Living Skills Training is an existing service in the BI waiver.	Transition Setup		Transition Setup	Transition Setup	Transition Setup

More information about waiver Transition Services can be found in Department rules and regulations at [10 CCR 2505-10, Section 8.553](#).

Institution to Community Transition



Community to Community Transition

- Individuals already living in the community can still access most Transition Services if they are experiencing a life transition
 - Cannot access Transition Coordination. HCBS Case Managers help community to community transitions go smoothly within existing responsibilities.
- Examples of life transitions include, but are not limited to:
 - Person's primary caregiver is no longer able to care for the person receiving HCBS services
 - Person is moving to less restrictive environment, such as from a group home or Alternative Care Facility, to his or her own apartment or into a family home
 - Person is moving out of parent's home to live independently in own apartment
 - Person has recently aged out of the Medicaid programs for children

Community to Community, cont.



*Information for HCBS Case Managers on how to document need for Transition Services can be found in Operational Memo 19-022 at: hcpf.colorado.gov/2019-memo-series-communications

Transition Services Providers

Overview of Transition Providers

Options Counselors

- Helps individuals understand long-term services and support options
- Connect them to community resources

Transition Coordinators

- Facilitates activities to assist an individual to move to a less restrictive living arrangement

HCBS Case Managers

- Determines HCBS eligibility
- Assesses need
- Conducts service referral and authorization
- Monitors service
- Completes critical incident reports

Transition Services Providers

- Enrolled Medicaid provider rendering one or more of the Transition Services

Transition Coordination Agencies

- Must meet qualifications for Transition Coordination Agency (TCA) and Transition Coordinators (TCs)
 - Outlined at [10 CCR 2505-10, Section 8.519.27](#)



Questions

Resources

- Department Memos regarding Transition Services and Transition Coordination:
hcpf.colorado.gov/2022-memo-series-communication
- Link to Department Rules and Regulations:
hcpf.colorado.gov/department-program-rules-and-regulations
 - Transition Coordination at 10 CCR 2505-10, Section 8.519.27
 - All Transition Services at 10 CCR 2505-10, Section 8.553
- LTSS Programs page with links to other resources:
hcpf.colorado.gov/long-term-services-and-supports-programs
- Regularly updated Department provider rates:
hcpf.colorado.gov/provider-rates-fee-schedule

Contact Information

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Thank You!