

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop 00-00-00  
Baltimore, Maryland 21244-1850



Division of Community Systems Transformation

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October 19, 2015

Gretchen M. Hammer, Medicaid Director  
Department of Health Care Policy & Financing  
Office of Community Living  
1570 Grant Street  
Denver, CO 80203

Subject: Money Follows the Person (MFP) Sustainability Plan

Dear Ms. Hammer:

I am pleased to inform you that your Money Follows the Person (MFP) Sustainability Plan has been accepted. Please proceed with formulating the 2016 final supplemental budget request to include this plan. An accepted copy of the plan is included with this letter for your reference. Note that it may be necessary to modify this plan as the final budget is being developed.

The official approval of the plan and budget through September 30, 2020 will be issued by the CMS Office of Acquisition and Grants Management pending review of the final supplemental budget request submitted on October 5, 2015.

Thank you for your dedicated efforts in implementing this Demonstration Program. We remain steadfast in our commitment to provide you with the technical assistance and support to accomplish the goals and objectives of the grant. If you have any questions, please do not hesitate to contact your CMS project officer.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael R. Smith". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Michael R. Smith  
Director,  
Division of Community Systems Transformation

Enclosure

cc: Tim Cortez, Manager, Community Options Section  
Sam Murillo, MFP Project Director  
Todd Wilson, CMS Project Officer  
Geoffrey Ntosi, CMS Grants Specialist  
Ernest McKenney, MFP Technical Assistance Lead



## COLORADO

Department of Health Care  
Policy & Financing

Office of Community Living  
1570 Grant Street  
Denver, CO 80203

April 30, 2015

Todd S. Wilson  
Centers for Medicare & Medicaid Services  
7500 Security Blvd  
Baltimore, MD 21244

Dear Mr. Wilson,

The Colorado Department of Health Care Policy and Financing (the Department) is pleased to submit to the Centers for Medicare and Medicaid Services (CMS) Colorado's MFP Sustainability Plan. Our state is committed to continuing efforts to support members transitioning from long-term care facilities to the most integrated community settings.

In response to the Olmstead decision, Colorado developed a Community Living Plan to underscore its commitment to ensuring that people with disabilities and older adults have the same rights as people without disabilities to live in the home of their choice with the supports and services they need to live independent lives. Four principles inform all facets of the Community Living Plan:

- Individuals with disabilities should have the opportunity to live like people without disabilities. They should have the opportunity to be employed, have a place to call home, and be engaged in the community with family and friends.
- Individuals with disabilities should have control over their own day, including which job, educational or social and recreational activities they pursue.
- Individuals with disabilities should have control over meeting their health care needs.
- Individuals with disabilities should have choice and control over where and how they live.

Colorado has historically been a leader among states providing long-term services and supports to people with all types of disabilities and is proud to continue this tradition through its sustainability plan for Colorado Choice Transitions, Colorado's MFP Demonstration program.

We look forward to working with CMS to achieve the many goals established in this plan to ensure that Colorado residents achieve the greatest quality of life and community integration, regardless of disability.

Kind regards,

Gretchen M. Hammer  
Medicaid Director

Our mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.  
[www.colorado.gov/hcpf](http://www.colorado.gov/hcpf)





**COLORADO**  
Department of Health Care  
Policy & Financing



# Colorado Choice Transitions (CCT) Sustainability Plan

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

## **The Colorado Department of Health Care Policy and Financing**

Colorado Choice Transitions  
Long-Term Services and Supports Division  
Office of Community Living  
April 30, 2015

Our mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.  
[www.colorado.gov/hcpf](http://www.colorado.gov/hcpf)





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Appendix 1 – CCT Business Case  
Appendix 2 – CCT Advisory Council Charter



## 1. Executive Summary

Historically, Colorado has demonstrated national leadership among states providing long-term services and supports (LTSS) to people with all types of disabilities. In order to further support these efforts, the Department of Health Care Policy and Financing (the Department) applied to participate in the Money Follows the Person (MFP) Rebalancing Demonstration grant and was awarded \$22M from the Centers for Medicare and Medicaid Services in April 2011. Colorado's goals through Colorado Choice Transitions (CCT), Colorado's MFP Demonstration Program, include transitioning 490 individuals during the 5- year course of the grant as well as improving the state's long-term services and supports delivery systems including waiver simplification and single entry point redesign.

At the conclusion of the grant, Colorado will continue to support individuals with all types of disabilities to live in the least restrictive setting. This plan articulates efforts that are currently underway as well as future endeavors to rebalance Medicaid long-term care support systems, eliminate barriers to transition and support community living. The sections of the plan are:

- Section 2, Stakeholder involvement, briefly describes the Department's plan for engaging stakeholders to partner with the Department to sustain efforts started under or improved by the CCT program to ensure all voices are heard and all individuals are represented.
- Section 3, State's plan to support people to move out of institutions, outlines the Department's plan to continue community transition services in support of moving individuals out of long-term care facilities and to the community.
- Section 4, Demonstration Services delivered to CCT participants, identifies the 12 demonstration services currently available through the program and specifies the state's intent to keep, modify or remove specific services after the MFP grant ends. It also includes the rationale behind that decision and identifies the funding authority for each service going forward.
- Section 5, Administrative staff positions, discusses the Department's desire to retain certain staff positions to continue to administer the CCT program and to sustain transition support to individuals moving out of long-term care facilities after CCT, which would require approval from the General Assembly.
- Section 6, State's plan for utilizing all the rebalancing funds, outlines existing and new program and project ideas that will be supported using remaining rebalancing funds.
- Section 7, Time line for activities, provides a graphical representation of a time line for all efforts described in sections 4, 5, and 6.
- Section 8, Estimated Budget Summary, provides estimated budget for funds needed through Dec 31, 2018 to maintain the MFP grant.
- Section 9, Optional Element: Efforts to sustain an adequate supply of accessible, affordable housing, is the Department's plan to continue to work with the Division of Housing for securing accessible, affordable housing into the future. The Division of Housing in the Department of Local Affairs is Colorado's statewide housing authority.

## 2. Stakeholder Involvement

### a. Process

Stakeholder engagement for the CCT sustainability planning process will continue to be addressed through existing stakeholder groups which include mixed participation from families and individuals whom serve in a consulting capacity. Colorado has a strong stakeholder participation such that the existing efforts should be successful for the duration of the grant demonstration. The CCT team will identify other approaches during the next few years to solicit meaningful input from clients, community leadership, the CCT Advisory Council, the No Wrong Door Planning Advisory Group, Regional Transition Committees (RTC) and other committees working on initiatives related to CCT. Moreover, CCT created a business case (Appendix 1) with input from the Advisory Council that identifies a vision statement, a problem statement, milestones and a cost benefit analysis. The business case will inform future communication and stakeholder engagement activities to support the sustainment of CCT efforts. Additionally, with the input of the Council and the Steering Committee, a communication plan will be developed and disseminated statewide to provide information about the goals and timeline for the sustainability plan.

The CCT Advisory Council (AC) will continue to meet quarterly for the duration of the program and will provide strategic input in the following areas: operational policy; transition processes, solutions to streamline transitions, nursing facility diversion efforts, modifications to demonstration services, use of rebalancing funds and monitoring the implementation of the sustainability plan. The Department will continue to provide the Council with data metrics and other necessary information so they can make informed recommendations that support CCT program operations and sustainability efforts. The AC Charter is included in Appendix 2.

In 2014, the Department received a year-long planning grant from the federal Administration for Community Living to complete a No Wrong Door (NWD) Implementation Plan. The implementation plan will be developed by a Planning Advisory Group, comprised of a diverse group of stakeholders. CCT will leverage the opportunity to engage with the Planning Advisory Group to identify future methods for person-centered transitions, nursing facility diversions and streamlined access to long-term services and supports through a NWD system.

The Department will also engage with RTCs for the duration of the grant. RTCs are collaborative partnerships that share local resources and expertise to prepare and coordinate support in their respective regions to support people transitioning out of nursing facilities. Each RTC will utilize a Department approved toolkit for establishing transition goals, education and outreach efforts, resource development and methods for engaging community partners. The mission of RTCs is to think globally and act locally to support community transitions and report their findings to the Department.

A Department-led Steering Committee is established in the Office of Community Living, which has the responsibility of oversight for all LTSS programs funded through Medicaid. The Steering Committee coordinates multiple initiatives of the Department and will provide and oversee the implementation of the sustainability plan and will have any final decision making authority. This group meets regularly. CCT program staff will make requests to the Steering Committee for their input and approval as needed. Potential topics to be addressed

by the Steering Committees may include, but are not limited to: review of current transition processes, policies, and demonstration services; determine program elements that will be retained, modified or dissolved, including demonstration services, policies and staff positions, after grant ends; brainstorm options for sustainability; approve and implement a communication plan; seek buy-in among leadership from other state agencies and community stakeholders; determine use of rebalancing funds; decide items to include in the sustainability plan; and review and approve final sustainability plan and estimated multi-year budget for submission to CMS.

Members participating in the Steering Committee are:

- The State Medicaid Director;
- The Director of the Office of Community Living;
- The Deputy/Division Directors for the Divisions of Intellectual and Developmental Disabilities Division and LTSS;
- Manager for the Community Options Section, which supervises the CCT Program Director;
- Other Department Staff as needed related to financing, quality improvement, information technology or interpretation of federal rules.
- Leadership from other state agency staff as needed including the Office of Behavioral Health, State Unit on Aging and Division for Vocational Rehabilitation from the Colorado Department of Human Services; the Colorado Department of Public Health and Environment; and the Department of Local Affairs (DOLA).

#### **b. Summary of stakeholders with counts**

The following table demonstrates the stakeholder groups consulted and will be consulted about the sustainability plan, including the number of people in attendance.

<b>Date</b>	<b>Stakeholder Group</b>	<b>Number of people</b>
May 2015	ADAPT (Advocacy group)	~10
May 2015	Aging and Disability Resources for Colorado	25
TBD	Area Agencies on Aging (AAA) Directors	~20
Apr 24, 2015	Advocacy groups for I/IDD	10
	Colorado Behavioral Health Council	
Mar 19, 2015	Mental Health Centers	25
Apr 18, 2015	Behavioral Health Organizations	25
	Community Centered Boards	
Mar 12, 2015	Executive Directors	20
Feb 18, 2015	Case Manager Supervisors	35
Apr 2015	Department of Public Health and Environment	5
Apr 15, 2015	Nursing Facility Advisory Council	20
	Department of Human Services	
TBD	Office of Behavioral Health	TBD
TBD	Office of Community Access DVR	TBD
Feb 25, 2015	State Unit on Aging	2
Dec 2014	Department of Local Affairs – Division of Housing	3
May 2015	Independent Living Centers	~25

March 2, 2015	Single Entry Points	20
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### 3. State's Plan to Continue Transitions

#### a. The state will continue to actively support moving persons out of institutions.

- i. The Department is committed to continuing to support moving persons out of institutions. However, Colorado Revised Statutes (C.R.S) 24-75-1305 prohibits the Department from requesting continuation funding as part of its normal annual budget request for programs previously funded through grants, but the General Assembly may adopt legislation to reauthorize any program previously grant funded. This will require statutory change and assumes future success getting a bill(s) passed amending Colorado Statutes to continue transition support beyond the waiver for the elderly and people with disabilities. The Department cannot assure CMS of success in a future legislative session. However, the Department will be submitting a Legislative report about the current status and next steps of the Colorado Community Living Plan and Community Living Advisory Group recommendations to raise awareness of the major systemic initiatives currently slated over the next few years. Both sets of recommendations are inclusive of language to that asks for the sustainment and expansion of CCT efforts.
- ii. **If yes, briefly explain how you will support persons moving out of institutions (e.g. continue preexisting program, divide current MFP work among operating agencies, etc.)**

Colorado will continue to actively support moving persons out of institutions. Colorado has a strong investment on the part of both state agency representatives and stakeholder groups to implement a comprehensive Olmstead Plan. Recent effort towards that end culminated in the development of "Colorado's Community Living Plan," a comprehensive approach to meeting the requirements of the Olmstead ruling that was jointly endorsed by the Department and the Departments of Human Services and Local Affairs. Two primary goals of Colorado's Community Living Plan are to:

- Proactively identify individuals in institutional care who want to move to a community living option and ensure successful transition through a person centered planning approach; and
- Support successful transitions to community settings, ensure a stable and secure living experience, and prevent re-institutionalization through the provision of responsive community-based services and supports.

Community Transition Services (CTS) will remain an important tool for Colorado to implement the goals of the Community Living Plan. CTS is currently a Home and Community-Based Services (HCBS) benefit provided by Transition Coordination Agencies (TCAs) that employ Transition Coordinators (TCs). TCs facilitate the transition process working with the client. CTS also makes available funds to clients to set-up a household in the community. CTS utilizes a person-centered team approach to transition coordination. The process begins with an informed choice by the client to explore the option of living outside an institutional setting. Transition coordination services begin at that point and end 30 days after institutional discharge.

A transition options team completes a community needs assessment and risk mitigation plan. Service brokering is conducted to determine if the required supports and services are available in the community. If those supports and services are available, a transition can occur. The first thirty days after transition can be the most difficult. Transition coordinators continue to provide support and monitoring services during that time to respond to any risk related incidents.

This comprehensive approach to assessment, service brokering and risk mitigation planning promotes safe discharges from nursing facility. Transition assessment and planning also focuses on community integration which increases the chance of long term success in the community.

CTS was initiated in 2006 as a benefit of the Home and Community Based Services - Elderly, Blind and Disabled (HCBS-EBD) waiver. In 2013 CTS was implemented as a demonstration service of the Colorado Choice Transitions (CCT) program. This expanded eligibility of CTS to individuals with intellectual disabilities (HCBS-DD and HCBS-SLS), brain injuries (HCBS-BI) and mental illness (HCBS-CMHS). Colorado will consider providing person-centered transition support in the future through Medicaid administrative claiming outside of the MFP grant as a function of a comprehensive No Wrong Door System. Covering transition support through Medicaid administrative claiming and possibly through Community First Choice 1915 (k) authority will address some of the financing challenges the Department has experienced with implementing CTS as an HCBS service and a demonstration service. These challenges have made it difficult to retain and recruit transition TCAs. Challenges have included:

- The rate of reimbursement being too low to fully cover costs;
- Cash flow issues created for providers because of the inability of providers to bill for household setup costs prior to transition; and
- Months of services provided by TCs that go unpaid while working with a client makes it difficult for agencies to staff transitions.

#### **b. Populations included in the ongoing support**

Populations included in the ongoing support are:

- Elderly;
- People with Disabilities;
- People with Intellectual or Developmental Disabilities;
- People with Brain Injuries; and
- People with mental illness.

#### **c. Institutions targeted**

The Department will target the following institutions:

- Skilled Nursing Facilities; and
- Intermediate Care for Individuals with Intellectual Disabilities (ICF/IID).

#### **d. If the state is not planning to continue supporting person moving out of institutions,**

**i. What is the reason(s)?**

**ii. If you will continue any MFP activity, describe in 4, 5, and/or 6.**

Not Applicable.

**e. Estimate of funds necessary to continue meeting the submission of MFP grant and programmatic requirements**

The estimated funds necessary to continue meeting the submission of MFP grant and programmatic requirements is \$434,855.00. This includes the salary of the Data Analyst and the cost of the projected number of Quality of Life (QoL) surveys between 2016 and 2019.

**4. CCT Demonstration Services**

The following benefits and services worksheets were developed with the input of Colorado’s HCBS waiver administrators, CCT Advisory Council members and Department stakeholders. The 12 worksheets provide detail on the demonstration services offered to compliment the qualified waiver services in the following waivers: Persons who are Elderly, Blind, or Disabled (HCBS-EBD); Persons with Brain Injury (HCBS-BI); Community Mental Health Supports (HCBS-CMHS); Persons with Developmental Disabilities (HCBS-DD); and the Supported Living Services (HCBS-SLS waivers.

For each demonstration service a definition is provided, the target population(s) is indicated, the state’s decision to keep, modify or remove the service after the MFP grant period ends is justified, and the authorizing authority is specified. The state’s decision to keep, modify or remove the service is based on utilization data, budget forecasts, stakeholder feedback and recommendations from the Community Living Advisory Group (CLAG), which was responsible for creating the Community Living Report to the Governor, which had specific recommendations regarding simplifying Colorado’s waiver programs.

Waiver simplification is focused on changing the design and delivery of HCBS to support person-centered access to LTSS based on choice and individual needs and not solely on diagnosis or disability. It will maximize choice and flexibility to the extent possible so that people receive the services they need when and where they need them in the home or the community. The proposal is for four waivers: HCBS for persons who are Elderly, Blind and Disabled, HCBS for Community Mental Health Supports, HCBS for persons who are Developmentally Disabled, and the Children’s Extensive Support Waiver to serve children with special health care needs or significant disabilities. Colorado will also explore what services might be made available in the State Plan, such as Community First Choice. Colorado has already eliminated one waiver for persons living with AIDS. The individuals served in this waiver have been transitioned to the HCBS-EBD waiver and have access to more services. Next year, the Department will start transitioning to one waiver for adults with intellectual disabilities, which will give clients more choice in services and delivery models. The Department will continue to further simplify its waiver programs over the next few years. Any demonstration services of CCT the Department plans to retain will be factored into the discussions regarding waiver simplification.

<p><b>a. Name and definition of service:</b></p> <p><b>ASSISTIVE TECHNOLOGY, EXTENDED:</b> Devices, items, pieces of equipment, or product systems used to increase, maintain, or improve functional capabilities of clients and training in the use of the technology when the cost is not otherwise covered through the State Plan durable medical equipment benefit or home modification waiver benefit or available through other means.</p>
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<b>b. Target populations</b>
<input checked="" type="checkbox"/> Elderly <input checked="" type="checkbox"/> Physically Disabled <input checked="" type="checkbox"/> Developmentally Disabled <input checked="" type="checkbox"/> Mentally Ill
<b>c. State's decision to retain, retain with modifications, or delete service</b>
<input type="checkbox"/> Retain <input checked="" type="checkbox"/> Retain with modifications <input type="checkbox"/> Delete
<b>Justification</b>
<p>The Department's decision to retain a modification of this extended service is based highly on stakeholder input. Although there was zero utilization of this extended service during the demonstration, numerous stakeholders felt this service should be available to those that would benefit. In addition to clients having access to assistive technology through the Durable Medical Equipment State Plan benefit, the Department is committed to retaining an assistive technology benefit through the waiver simplification process. A specific recommendation by the CLAG asks that clients have access to the support that directly assists a participant in the selection, acquisition, or use of an assistive technology device that maximizes independence and community integration.</p>
<b>Authority</b>
<input checked="" type="checkbox"/> 1915(c) waiver authority <input type="checkbox"/> State Plan Amendment

<b>a. Name and definition of service</b>
<p><b>CAREGIVER EDUCATION:</b> Educational and coaching services that assist clients and family members to recruit other family members and friends to form an informal caregiver network to share caregiving responsibilities.</p>
<b>b. Target populations</b>
<input checked="" type="checkbox"/> Elderly <input checked="" type="checkbox"/> Physically Disabled <input checked="" type="checkbox"/> Developmentally Disabled <input checked="" type="checkbox"/> Mentally Ill
<b>c. State's decision to retain, retain with modifications, or delete service</b>
<input type="checkbox"/> Retain <input checked="" type="checkbox"/> Retain with modifications <input type="checkbox"/> Delete
<b>Justification</b>
<p>The Department plans to engage stakeholders in conversation regarding caregiver supports as part of waiver simplification efforts. The Department wishes to better understand the needs of caregivers and how the state can best support caregivers including education, respite, training on developing informal support networks, etc.</p>
<b>Authority</b>
<input checked="" type="checkbox"/> 1915(c) waiver authority <input type="checkbox"/> State Plan Amendment



<p><b>a. Name and definition of service</b></p> <p><b>INTENSIVE CASE MANAGEMENT:</b> Case management services to assist clients in assessing needed home and community-based services, Medicaid State Plan services and non-Medicaid supports and services to support the clients’ return to the community from placement in a qualified institution and to aid the client in attaining their transition and independent living goals.</p>
<p><b>b. Target populations</b></p> <p><input checked="" type="checkbox"/> Elderly  <input checked="" type="checkbox"/> Physically Disabled  <input type="checkbox"/> Developmentally Disabled  <input checked="" type="checkbox"/> Mentally Ill</p>
<p><b>c. State’s decision to retain, retain with modifications, or delete service</b></p> <p><input type="checkbox"/> Retain  <input checked="" type="checkbox"/> Retain with modifications  <input type="checkbox"/> Delete</p>
<p><b>Justification</b></p> <p>The Department’s decision is to modify this service. The Department is exploring ways to restructure its entry point and case management infrastructure which will be accomplished through the No Wrong Door (NWD) planning and implementation grants funded by the Administration on Community Living. This future structure of case management will also be influenced by the Department’s effort to implement the new HCBS rules regarding conflict-free case management, and person-centered planning. CLAG specifically recommends that case management should be tailored to the individual needs and preferences of clients. To implement this recommendation the Department will explore more flexible models for providing a tiered way to deliver case management.</p>
<p><b>Authority</b></p> <p><input type="checkbox"/> 1915(c) waiver authority  <input type="checkbox"/> State Plan Amendment</p>

<p><b>a. Name and definition of service</b></p> <p><b>COMMUNITY TRANSITION SERVICES:</b> Services that are provided by a Transition Coordination Agency and include items essential to move a client from a nursing facility and establish a community-based residence. Community transition services include the cost of coordination activities such as assisting client in filling out subsidized housing application, 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, and dishes. Items for entertainment and convenience are not included.</p>
<p><b>b. Target populations</b></p> <p><input checked="" type="checkbox"/> Elderly  <input checked="" type="checkbox"/> Physically Disabled  <input checked="" type="checkbox"/> Developmentally Disabled  <input checked="" type="checkbox"/> Mentally Ill</p>

**c. State's decision to retain, retain with modifications, or delete service**

- Retain  
 Retain with modifications  
 Delete

**Justification**

The Department's decision to keep this service is to ensure that waiver clients have access to funding and support for transition activities going forward. Person centered transition support is being considered as part of the NWD planning grant and will be moved from a HCBS service to Medicaid Administrative Claiming. Please see 3.a.ii for more detailed information.

**Authority**

- 1915(c) waiver authority  
 State Plan Amendment

**a. Name and definition of service**

**DENTAL, EXTENDED:** Dental services that are inclusive of diagnostic, preventive, periodontal and prosthodontic services, as well as basic restorative and oral surgery procedures to restore the client to functional dental health. Services are available for clients 21 and over and may not duplicate services available through the Medicaid State Plan.

**b. Target populations**

- Elderly  
 Physically Disabled  
 Developmentally Disabled  
 Mentally Ill

**c. State's decision to retain, retain with modifications, or delete service**

- Retain  
 Retain with modifications  
 Delete

**Justification**

The Department's decision to remove the extended dental benefit is based on the recent implementation of limited dental benefit in the Medicaid state plan for adults age 21 and over. Currently, the dental benefit provides Medicaid members up to \$1,000 in dental services per state fiscal year.

**Authority**

- 1915(c) waiver authority  
 State Plan Amendment

**a. Name and definition of service**

**ENHANCED NURSING:** Medical care coordination provided by a nurse for medically complex clients who are at risk for negative health outcomes associated with fragmented medical care and poor communication between primary care physicians, nursing staff, case managers, community-based providers and specialty care providers.

**b. Target populations**

<input checked="" type="checkbox"/> Elderly <input checked="" type="checkbox"/> Physically Disabled <input checked="" type="checkbox"/> Developmentally Disabled <input checked="" type="checkbox"/> Mentally Ill
<b>c. State’s decision to retain, retain with modifications, or delete service</b>
<input type="checkbox"/> Retain <input type="checkbox"/> Retain with modifications <input checked="" type="checkbox"/> Delete
<b>Justification</b>
<p>This benefit was designed to better coordinate care for medically complex clients. The state’s decision to remove this service is due to low utilization during the demonstration program. Moreover, as coordination and collaboration between Regional Care Collaborative Organizations (RCCOs)* and case management agencies becomes stronger through Colorado’s Medicare Medicaid Program, a duals demonstration project and as the Department further refines approaches to working with complex clients, the state will be able to better address the needs of these clients.</p>
<b>Authority</b>
<input type="checkbox"/> 1915(c) waiver authority <input type="checkbox"/> State Plan Amendment <input checked="" type="checkbox"/> Other

<b>a. Name and definition of service</b>
<b>HOME DELIVERED MEALS:</b> Nutritious meals delivered to homebound clients who are unable to prepare their own meals and have limited or no outside assistance.
<b>b. Target populations</b>
<input checked="" type="checkbox"/> Elderly <input checked="" type="checkbox"/> Physically Disabled <input type="checkbox"/> Developmentally Disabled <input checked="" type="checkbox"/> Mentally Ill
<b>c. State’s decision to retain, retain with modifications, or delete service</b>
<input type="checkbox"/> Retain <input checked="" type="checkbox"/> Retain with modifications <input type="checkbox"/> Delete
<b>Justification</b>
<p>The Department has been researching funding options for ways to finance a home delivered meals program and hopes to include as part of waiver simplification efforts. The Department will continue to engage the State Unit on Aging on existing efforts available through the Older Americans Act that can perhaps serve as a model for the HCBS waivers.</p>
<b>Authority</b>
<input checked="" type="checkbox"/> 1915(c) waiver authority <input type="checkbox"/> State Plan Amendment

<b>a. Name and definition of service</b>
<b>HOME MODIFICATIONS, EXTENDED:</b> Physical adaptations to the home, required by the client’s plan of care, necessary to ensure the health, welfare, safety and independence of the client above and beyond the cost of caps that exist in applicable Home and Community-Based (HCBS) waivers.
<b>b. Target populations</b>
<input checked="" type="checkbox"/> Elderly <input checked="" type="checkbox"/> Physically Disabled <input checked="" type="checkbox"/> Developmentally Disabled <input checked="" type="checkbox"/> Mentally Ill
<b>c. State’s decision to retain, retain with modifications, or delete service</b>
<input type="checkbox"/> Retain <input type="checkbox"/> Retain with modifications <input checked="" type="checkbox"/> Delete
<b>Justification</b>
The state’s decision to remove this extended benefit is due to zero utilization and to a recent increase in the home modification lifetime maximum allocation available to HCBS waiver clients which will help to ensure clients are able to receive the modifications they need to safely live in the community.
<b>Authority</b>
<input type="checkbox"/> 1915(c) waiver authority <input type="checkbox"/> State Plan Amendment

<b>a. Name and definition of service</b>
<b>INDEPENDENT LIVING SKILLS TRAINING (ILST):</b> Services designed to improve or maintain a client’s physical, emotional, and economic independence in the community with or without supports.
<b>b. Target populations</b>
<input checked="" type="checkbox"/> Elderly <input checked="" type="checkbox"/> Physically Disabled <input type="checkbox"/> Developmentally Disabled <input checked="" type="checkbox"/> Mentally Ill
<b>c. State’s decision to retain, retain with modifications, or delete service</b>
<input type="checkbox"/> Retain <input checked="" type="checkbox"/> Retain with modifications <input type="checkbox"/> Delete
<b>Justification</b>
The Department’s decision to keep this service is based on high utilization and recommendations from the waiver simplification subcommittee of the CLAG. ILST activities provides support in skill building to maximize community integration and independence in self-advocacy and completing essential daily tasks and activities to community living. The Department is in the process of revising the HCBS ILST rules to further ensure that providers have the appropriate qualifications and oversight.

**Authority**

- 1915(c) waiver authority  
 State Plan Amendment

**a. Name and definition of service**

**PEER MENTORSHIP:** Services provided by peers to promote self-advocacy and encourage community living among clients by instructing and advising on issues and topics related to community living, describing real-world experiences as example and modeling successful community living and problem-solving.

**b. Target populations**

- Elderly  
 Physically Disabled  
 Developmentally Disabled  
 Mentally Ill

**c. State's decision to retain, retain with modifications, or delete service**

- Retain  
 Retain with modifications  
 Delete

**Justification**

The state's decision to keep this service is based on the recommendations of the waiver simplification subcommittee of the CLAG. This service has been identified as an integral part of community integration and health and safety. The value of peer supports was also highlighted at Colorado's Olmstead Summit as a means of promoting self-advocacy and encouraging community integration.

**Authority**

- 1915(c) waiver authority  
 State Plan Amendment

**a. Name and definition of service**

**TRANSITIONAL BEHAVIORAL HEALTH SUPPORTS:** Services by a qualified paraprofessional to support a client during the transition period to mitigate issues, symptoms, and/or behaviors that are exacerbated during the transition period and negatively affect the client's stability in the community.

**b. Target populations**

- Elderly  
 Physically Disabled  
 Developmentally Disabled  
 Mentally Ill

**c. State's decision to retain, retain with modifications, or delete service**

- Retain  
 Retain with modifications  
 Delete

**Justification**

The state's decision to retain this service with modifications is based on recommendations from the waiver simplification subcommittee. The Department continues to explore how it can better leverage State Plan mental health services offered through the Behavioral Health Organizations (BHOs) to ensure clients are living in the most integrated setting. In addition to coordination with the BHOs, the Department also believes that specific programs should be authorized under HCBS waivers to allow for different delivery modalities and tailored services to individuals. This could include individuals who have co-occurring diagnoses best served in a home environment.

**Authority**

- 1915(c) waiver authority
- State Plan Amendment

**a. Name and definition of service**

**VISION:** Services that include eye exams and diagnosis, glasses, contacts, and other medically necessary methods to improve specific vision system problems when not available through the Medicaid State Plan. Services available through Medicare are not covered.

**b. Target Populations**

- Elderly
- Physically Disabled
- Developmentally Disabled
- Mentally Ill

**c. State's decision to retain, retain with modifications, or delete service**

- Retain
- Retain with modifications
- Delete

**Justification**

An eye care benefit exists in the state plan, however it is limited. To date, we have not had any CCT clients access the vision benefit during the demonstration.

**Authority**

- 1915(c) waiver authority
- State Plan Amendment

### 5. Administrative Staff Positions

The Department plans to sustain certain positions to ensure that efforts supporting transitions are continued and to implement the recommendations of the Community Living Plan, Colorado’s Olmstead Plan. The positions that the Department plans to retain are the following:

- Project Director;
- Transition Administrator;
- LTSS Benefit Manager;
- Outreach Specialist/Section Q Monitor; and
- Data Analyst.

It is expected that these positions will be funded through a federal and state match available through Medicaid Administrative Claiming if authorized by the General Assembly. The Department does not plan to retain a training specialist as the majority of the training material will be developed prior to the end of the grant.

A worksheet for each position and the State’s decision to retain; reduce or combine; or delete is included within this section.

<b>a. Staff position and job description</b>
<p><b>Job Title:</b> Project Director (Position title will transition to Entry Point Operations Manager after grant ends.)</p> <p><b>Job Responsibilities:</b></p> <ul style="list-style-type: none"> <li>• Supervises CCT Team members.</li> <li>• Manages or provides oversight of all CCT Demonstration activities.</li> <li>• Maintains the MFP Operational Protocol and oversight of subsequent revisions.</li> <li>• Liaises with the Centers for Medicare and Medicaid Services (CMS) in all grant-related activities.</li> <li>• Oversees the completion of all CMS- and state-required reports.</li> <li>• Convenes and monitors internal and external workgroups.</li> <li>• Lead staff support to the CCT Advisory Committee.</li> <li>• Analysis of state/federal legislation and public policy.</li> <li>• Makes recommendations to the Department concerning new legislation, statutory and budgetary actions and regulatory modifications.</li> <li>• Reviews and assists in the development of Department policies and programs.</li> <li>• Manages contracts for services provided under the Demonstration project.</li> <li>• Prepares internal and external communications.</li> <li>• Presents information to internal and external stakeholders.</li> <li>• Prepares and Manages the CCT budget and financial reports.</li> <li>• Coordinates the preparation and submission of reports concerning transitions to external stakeholders, Department staff, legislature, Governor’s Office and CMS.</li> </ul>
<b>b. Number of FTEs</b>
1 FTE
<b>c. State’s decision to retain, reduce or combine the number of FTEs, or delete the position</b>
<input checked="" type="checkbox"/> Retain <input type="checkbox"/> Reduce or combine <input type="checkbox"/> Delete

**d. Funding for retained position and the timeframe for ending MFP grant funding**

This position will be funded by Medicaid Administrative Claiming Funds (Federal Match + State Match) effective July 1, 2018.

**a. Staff position and job description**

**Job Title:** Transition Administrator

**Job Responsibilities:**

- Monitors the performance of transition coordination agencies that provide person-centered transition support.
- Identifies transition barriers and develops solutions collaboratively working with stakeholders, state agencies and Department staff.
- Develops and provides training regarding the transition process to transition coordinators, case managers and nursing homes.
- Sets transition goals with Department approval and monitors progress to meeting goals.
- Establishes performance metrics for the transition process.
- Presents data detailing statewide trends on transitions.
- Establishes quality improvement strategies based on performance data and stakeholder feedback.
- Reviews client transition assessment and plans.
- Provides technical assistance to transition coordinators and others involved in the transition process, including problem solving client specific situations.
- Develops and recommend budget actions, regulations and legislative proposals to support the sustainment and improvement of person-centered transition support.
- Coordinates with other state agencies to identify and establish best practices and coordinate transitions through multiple programs and funding streams.
- Initiates budget and legislative actions to sustain transition support through the No Wrong Door system implementation.
- Coordinates the preparation and submission of reports concerning services to external stakeholders, Department staff, legislature, Governor’s Office and CMS.

**b. Number of FTEs**

1 FTE

**c. State’s decision to retain, reduce or combine the number of FTEs, or delete the position**

- Retain
- Reduce or combine
- Delete

**d. Funding for retained position and the timeframe for ending MFP grant funding**

This position will be funded by Medicaid Administrative Claiming Funds (Federal Match + State Match) effective July 1, 2018.

**a. Staff position and job description****Job Title:** LTSS Benefit Manager**Job Responsibilities:**

- Establishes HCBS or State Plan Benefits that support community integration and successful transitions, such as peer mentorship and independent living skills training.
- Monitors and reviews utilization data.
- Develops strategies to monitor the quality of services.
- Develops and monitor strategies for resource development in partnership with local agencies.
- Responds to feedback concerning the delivery of services.
- Develops training as needed regarding services for case managers and providers.
- Coordinates the resolution of billing issues.
- Coordinates as needed HCBS/State Plan amendments, changes to information management systems, implementation of new statutes and changes to regulations.
- Coordinates the preparation and submission of reports concerning services to external stakeholders, Department staff, legislature, Governor's Office and CMS.

**b. Number of FTEs**

1 FTE

**c. State's decision to retain, reduce or combine the number of FTEs, or delete the position**

- Retain  
 Reduce or combine  
 Delete

**d. Funding for retained position and the timeframe for ending MFP grant funding**

This position will be funded by Medicaid Administrative Claiming Funds (Federal Match + State Match) effective July 1, 2018.

**a. Staff position and job description****Job Title:** Outreach Specialist/Section Q Monitor**Job Responsibilities:**

- Monitors the MDS Section Q referral process ensuring that nursing home residents are informed of community-based options.
- Develops and provides technical assistance to nursing homes and local contact agencies regarding Section Q referral process.
- Develops and provides technical assistance to assist the state and local agencies in outreach and marketing and raising awareness about long-term care options.
- Develops and provides technical assistance to assist local agencies with implementing best practices and standards for options counseling and information and referral assistance.
- Monitors the effectiveness of outreach activities, options counseling, and information and referral operations among local contact agencies.
- Develops and recommends budget actions, regulations and legislative proposals to support the implementation of a comprehensive, multi-payer No Wrong Door System that includes transition support as a primary function.
- Identifies performance metrics to monitor the effectiveness of local agencies in responding.
- Develops and implements quality improvement strategies to improve the effectiveness of local agencies in activities supporting a No Wrong Door System.



<b>b. Number of FTEs</b>
1 FTE
<b>c. State’s decision to retain, reduce or combine the number of FTEs, or delete the position</b>
<input checked="" type="checkbox"/> Retain <input type="checkbox"/> Reduce or combine <input type="checkbox"/> Delete
<b>d. Funding for retained position and the timeframe for ending MFP grant funding</b>
This position will be funded by Medicaid Administrative Claiming Funds (Federal Match + State Match) effective July 1, 2018.

<b>a. Staff position and job description</b>
<p><b>Job Title:</b> Data Analyst</p> <p><b>Job Responsibilities:</b></p> <ul style="list-style-type: none"> <li>• Downloads, manages, and summarizes data for the Money Follows the Person (MFP) grant</li> <li>• Uses complex software such as SAS or SPSS to complete research and analysis on both Medicaid and Benefits Utilization System (BUS) data.</li> <li>• Works independently determining the analytical process by selecting statistical procedures or principles to be applied in developing a model or process.</li> <li>• Tailors existing analytical guidelines so they can be applied to particular programs and will use creativity to combine several measures to produce valid, meaningful results.</li> <li>• Acts to educate, train, advise and counsel Department staff and management on principles and theories adopted in models and processes supporting decision items, programs and other areas of analytical analysis for the Money Follows the Person grant.</li> <li>• Educates others on unfamiliar and complex concepts and theories used in database software and analytical models and processes.</li> <li>• Works with external contractors, Federal agencies and stakeholders by providing tactical plans involving combining, modifying or adapting statistical models, theories, etc. to answer questions.</li> <li>• Is the section expert for the BUS and its eventual redesign.</li> <li>• Designs and provides any Access databases required for tracking MFP clients and their services.</li> </ul>
<b>b. Number of FTEs</b>
1 FTE
<b>c. State’s decision to retain, reduce or combine the number of FTEs, or delete the position</b>
<input checked="" type="checkbox"/> Retain <input type="checkbox"/> Reduce or combine <input type="checkbox"/> Delete
<b>d. Funding for retained position and the timeframe for ending MFP grant funding</b>
This position will be funded by Medicaid Administrative Claiming Funds (Federal Match + State Match) effective July 1, 2018.

<b>a. Staff position and job description</b>
<p><b>Job Title:</b> Training Specialist</p> <p><b>Job Responsibilities:</b></p> <ul style="list-style-type: none"> <li>• Develops training materials and train case management agencies, providers and other entities supporting transitions and HCBS programs across the state.</li> <li>• Provides outreach activities, and educational materials for the general public.</li> <li>• Provides proactive education to stakeholders and the general public.</li> </ul>
<b>b. Number of FTEs</b>
1 FTE
<b>c. State’s decision to retain, reduce or combine the number of FTEs, or delete the position</b>
<input type="checkbox"/> Retain <input type="checkbox"/> Reduce or combine <input checked="" type="checkbox"/> Delete
<b>f. Reason for Deletion</b>
The reason for deleting this position is that the majority of the training materials concerning transitions will be developed by the end of the grant. These training materials can be revised and updated as needed by other retained staff.

**6. Rebalancing Funds**

**a. Use of rebalancing funds prior to December 2014.**

As of March 2015, the Department’s rebalancing fund contains approximately \$500,000, none of which has been expended to date. The state, in collaboration with stakeholders, is currently considering different ways to utilize these funds.

**b. Planned future use of rebalancing funds**

The Department does not have any existing projects utilizing the rebalancing funds. The state is currently working with a variety of stakeholder and advocacy groups to fund proposed projects to use rebalancing funds to specifically increase transitions in Colorado.

Ideas for utilizing rebalancing funds were gathered by the Department from the CCT Advisory Council in December 2014. The Advisory Council was presented with all of submitted ideas during the quarterly meeting in January 2014. Based on the number and variety of ideas submitted, the Advisory Council determined that a survey was necessary to edit the list down and determine which ideas to address first. The survey results were narrowed down from seventeen to six items. The Department will explore the feasibility of each project with the assistance of the Advisory Council and other interested stakeholders.

**c. Plans for continuing rebalancing projects after September 30<sup>th</sup> 2020 including identification of assumed funding sources.**

Although the Department has narrowed the list of new project ideas to six, it is still early in the planning stages. The State’s plan for continuing rebalancing projects after grant funding ends in 2020, as well as the identification of assumed funding sources for the continuation of these

projects, will be contingent upon the formal proposal and detailed project planning, including financial modeling, of the proposed ideas.

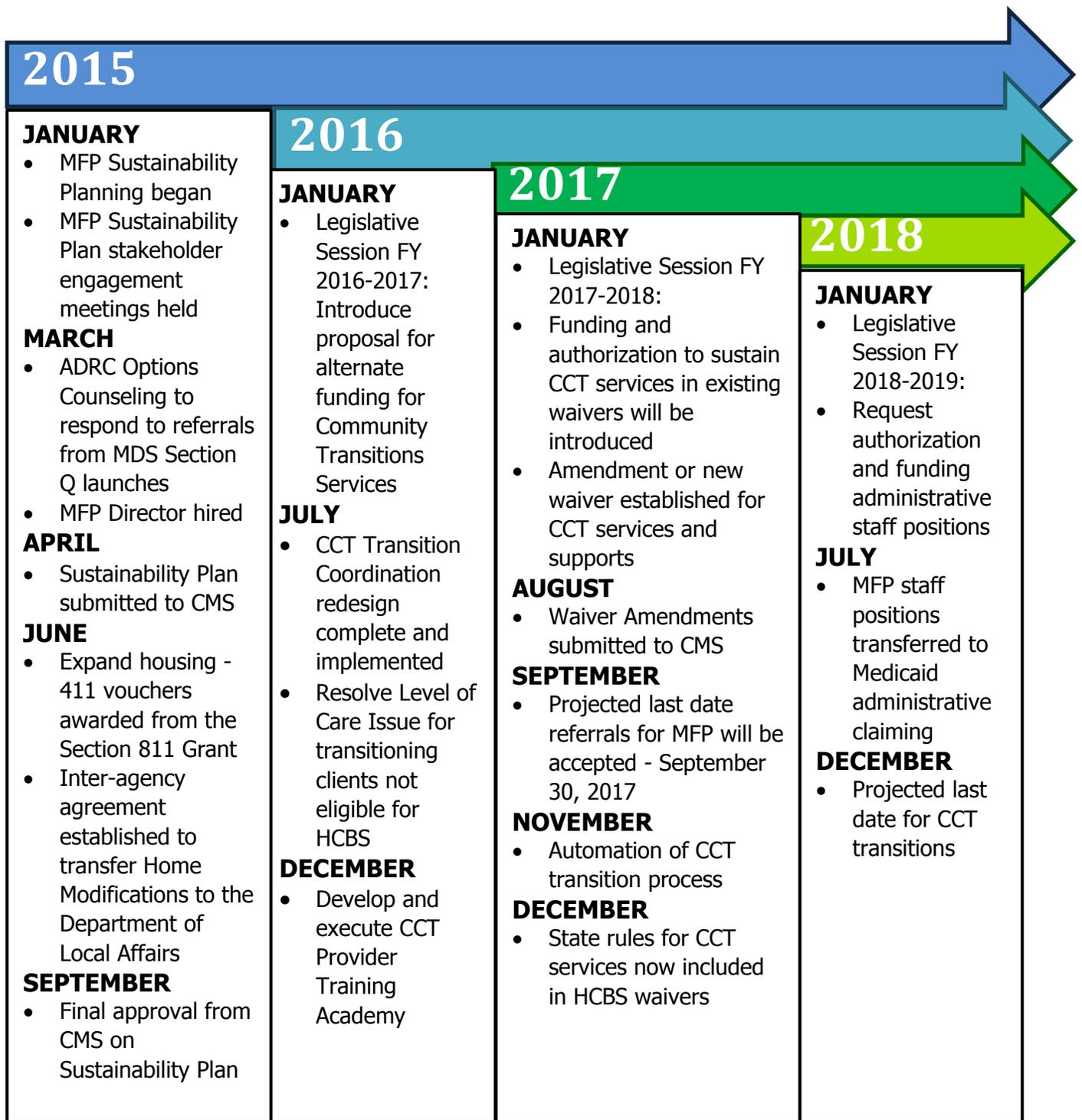
<b>Project #1</b>
Transition Coordination Agency Seed Money
<b>Description</b>
Provides funding to TCAs to set up a revolving fund to cover some of the upfront costs of facilitating a client transition, including the household set up fee. Currently, TCAs are reimbursed for transition coordination activities and household set up expenses retroactively. This is not a sustainable business practice, particularly for smaller agencies.
<b>Plan for continuing project and assumed funding source after September 30, 2020</b>
TBD

<b>Project #2</b>
DME Loaner Program
<b>Description</b>
Local agencies would maintain an inventory of commonly used DME and on an as needed basis would loan out the equipment to clients who have transitioned and are waiting for their permanent equipment to be delivered.
<b>Plan for continuing project and assumed funding source after September 30, 2020</b>
TBD

<b>Project #3</b>
Regional Housing Coordinators
<b>Description</b>
Regional Housing Coordinators would be available to help clients search for and obtain housing in their community. They would be experts on housing options available in their region, liaise between the client and property managers and help maintain relationships with developers and landlords.
<b>Plan for continuing project and assumed funding source after September 30, 2020</b>
TBD

<b>Project #4</b>
Local Grants for Regional Transition Committees
<b>Description</b>
Offer grant funds to Regional Transition Committees (RTCs) to cover expenses necessary to fulfill their mission of preparing communities to support client transitions. Funding could cover outreach and training materials and expenses. The grant funds would assist RTCs in addressing local barriers and solutions to remove the barrier.
<b>Plan for continuing project and assumed funding source after September 30, 2020</b>
TBD

**7. Timeline**



### 8. Budget Summary

MFP Sustainability Plan Estimated Multi-Year Budget							
Grantee Name:		Award Number:					
Estimated Federal Budget							
6. Object Class Categories	(1) CY 2016	(2) CY 2017	(3) CY 2018	(4) CY 2019	(5) CY 2020	(6) Total	
a. Personnel	\$303,780	\$312,894	\$322,279	\$331,946	\$341,905	\$1,612,804	
b. Fringe Benefits	\$95,212	\$98,068	\$101,010	\$104,040	\$107,161	\$505,491	
c. Travel	\$17,365	\$17,365	\$17,365	\$17,365	\$17,365	\$86,825	
d. Equipment	\$0	\$0	\$0	\$0	\$0	\$0	
e. Supplies	\$13,000	\$13,000	\$13,000	\$13,000	\$13,000	\$65,000	
f. Contractual	\$119,143	\$53,000	\$40,800	\$23,640	\$0	\$236,583	
g. Construction	\$0	\$0	\$0	\$0	\$0	\$0	
h. Services	\$5,249,290	\$7,540,939	\$9,560,880	\$8,143,525	\$729,059	\$31,223,693	
<b>i. Total Direct Charges (sum of 6a-6h)</b>	<b>\$5,797,790</b>	<b>\$8,035,266</b>	<b>\$10,055,334</b>	<b>\$8,633,516</b>	<b>\$1,208,490</b>	<b>\$33,730,396</b>	
j. Indirect Charges	\$46,998	\$48,315	\$49,671	\$51,068	\$52,506	\$248,558	
<b>k. Total Federal Budget (sum of 6i-6j)</b>	<b>\$5,844,788</b>	<b>\$8,083,581</b>	<b>\$10,105,005</b>	<b>\$8,684,584</b>	<b>\$1,260,996</b>	<b>\$33,978,954</b>	

### 9. Optional Element: Increase affordable and accessible housing

Affordable, accessible, integrated and available housing continues to be a necessary resource in any plan to assist persons with disabilities moving from long-term care facilities and maintaining independence outside of institutions. These housing options need to meet the individual's needs and reflect a consideration of the individual's preferences. The Department will partner with the Division of Housing (DOH) in the Department of Local Affairs to continue efforts to develop an adequate supply of housing options for people leaving institutions, those at risk of being institutionalized and people with disabilities who are homeless or at risk of being homeless. DOH is the statewide housing authority and will expand housing options through the following activities:

- Update and maintain an online searchable registry that will identify and define geographically the inventory of existing housing units along with available accessibility features.
  - Colorado already has a searchable database of affordable housing managed through [www.coloradohousingsearch.com](http://www.coloradohousingsearch.com). This database contains over 22,000 units of affordable and market housing and provides information on accessible features in those units. There are ongoing discussions with the managers of coloradohousingsearch.com on improving the information on the units, making the system more customer friendly and increasing the information on accessible features.
- Continue efforts to define the need for and resources to address safe, affordable, accessible and integrated housing for people with special needs.
  - There are ongoing efforts to define the need for safe, affordable, accessible and integrated housing with the assistance of the state Demography Office, HUD, Homeless Management Information System (HMIS) and other sources.

- Continue to administer and expand, as funding is available, the Community Living Colorado program, a housing subsidy for persons leaving institutions such as nursing homes.
  - The Community Living Colorado program is a housing resource administered by the DOH for people with disabilities leaving institutions. There are currently two funding sources for this program. The State Housing Vouchers funded by the State of Colorado and Section 811 (see below). DOH will continue to explore ways to expand the current funding and to incorporate additional funding sources.
- Engage key potential partners such as public housing authorities and affordable housing developers in contributions of housing resources (actual units and/or rental assistance).
  - DOH partners with the Colorado Housing and Finance Authority, local for profit and nonprofit housing developers, public housing authorities (PHAs), and local governments to develop affordable housing for special needs populations. DOH will continue to expand housing resources through these partnerships.
- Continue the work to secure additional housing resources through: housing grant applications; and formal and informal agreements and relationships with local housing agencies, developers and landlords to set aside affordable, accessible housing units including the Colorado Housing and Finance Authority (CHFA).
  - The State of Colorado will continue to aggressively pursue housing resources for people with disabilities leaving institutions and to target as many housing resources as possible to assist people with disabilities who are at risk of institutionalization to maintain their homes in the community. DOH has the mission of providing housing solutions for people with special needs.
- Implement the Section 811 Project Rental Assistance program with the support of the affordable housing community and support service agencies.
  - HUD recently announced that DOH is being awarded a five year grant for over \$7 million to develop and implement the Section 811 Project Rental Assistance program. Section 811 will be incorporated into the Community Living Colorado program. It will provide housing and services to people leaving institutions, persons with disabilities who are homeless and those at risk of being homeless.
- Administer the HCBS Home Modification benefit in partnership with the Department and work to improve the efficiency and effectiveness of the program.
  - The Department and DOH have formed a partnership that will take advantage of the expertise of both organizations to ensure that the HCBS Home Modification benefit will be administered in the most efficient, effective and customer service-oriented manner possible. The Department brings its expertise in Medicaid to

- the partnership. DOH provides knowledge and expertise in the housing and housing development arena.
- Develop and implement a common housing application form and work with local Public Housing Agencies (PHA) to expand its use.
    - DOH built upon its experience in developing a common housing application for the public housing authorities involved in the Veterans Affairs Supportive Housing program to develop a similar application for people with disabilities. The application is currently being tested for all housing authorities that provide housing for CCT participants. These PHAs include three local PHAs and the 26 public housing authorities that partner with DOH.
  - Work to extend the number of PHAs who adopt specific preferences for individuals with intellectual and physical disabilities as well as those with mental illness leaving institutional settings.
    - There are over 60 local PHAs in Colorado and two statewide PHAs (DOH and CHFA). DOH has the largest number of Housing Choice Vouchers in the state of Colorado and has adopted a preference for people leaving institutions. DOH and its 26 partner PHAs use this preference for awarding Housing Choice Vouchers statewide. The Denver Housing Authority is the second largest housing authority with Housing Choice Vouchers in Colorado and has established a set aside of vouchers for people leaving institutions. This means that there are a specific number of vouchers available for this population. The Department and DOH will work with other PHAs and stakeholders to establish either a preference or a set aside in their Housing Choice Voucher program.
  - Work with Federal, state and local governments as well as service providers, advocates and consumers to provide training and technical assistance on Fair Housing and Section 504 of the Americans with Disability Act.
    - The Fair Housing Act and Section 504 are effective tools for ensuring that persons with disabilities have full access to available housing. The affordable housing community is very interested in acquiring and improving its knowledge of these resources to ensure effective use of its housing resources. The Department and DOH will work with federal, state and local resources on training and technical assistance in this area.
  - Continue partnerships with service providers and advocates as well as federal, state and local government agencies to implement and expand the housing goals in Colorado's Community Living Plan.
    - The Department with the Departments Human Services and Local Affairs collaborated on Colorado's Community Living Plan. This Plan is Colorado's roadmap for implementing the state's Olmstead goals. Significant progress has

been made on these goals. All three departments will continue to work on implementation of this plan.



## Appendix 1

# Colorado Choice Transitions Business Case

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### Executive Summary

Colorado Choice Transitions (CCT) is, a \$22M project funded by the Centers for Medicare and Medicaid Services (CMS) designed to facilitate the transition of Medicaid-eligible members from long-term care facilities to the community using home and community based services (HCBS) and enhanced supports. Under CCT, Colorado receives an enhanced federal match, along with an additional 25 percent payment which goes into a fund used to expand a variety of services and supports to support transitions statewide.

CCT affords Colorado the opportunity to promote client transitions across the state and redesign and expand HCBS. Moreover, CCT aligns with the Supreme Court decision *Olmstead v L.C.*, 1999, which determined that people shall live in the least restrictive, most integrated setting possible and have a choice about where and how they receive their long-term services and supports. The Department of Health Care Policy and Financing (HCPF), along with other sister State agencies, developed and published the Community Living Plan in August 2014 which details Colorado's plan to implement the *Olmstead* decision, including continued efforts to support CCT.

The CCT grant will end on December 31, 2018 and under the terms of the grant, the state must develop and submit to CMS a sustainability plan that includes a detailed description of how the state will sustain transition activities, demonstration services, structural changes, and staffing by April 30, 2015. Partners to complete the sustainability plan include stakeholders, CCT Staff, State Medicaid Director and other agency staff.

### Vision Statement

Sustaining community transitions for the aging population and individuals with disabilities in Colorado is guided by the following principles:

- Members should have the opportunity to live like people without disabilities. They should have the opportunity to be employed, have a place to call home, and be engaged in the community with family and friends.
- Members should have control over their own day, including which job, educational or social and recreational activities they pursue.
- Members should have control over meeting their health care needs.
- Members should have choice and control over where and how they live.



## **Problem Statement**

The absence of elements of the CCT program, could result in setbacks to gains the State has made in resolving barriers to support clients' desires to live and receive their long-term services and supports (LTSS) in the community, as well as, the State's progress in the implementation of Olmstead. Furthermore, eliminating the program could result in the loss of housing gains, loss of provider development, particularly for transition coordination agencies (TCA) who have been trained and are currently working on successful transitions. Moreover, future long-term care clients may not have access to comprehensive services that support their desire to live independently in the community should the program end.

In fiscal year 2013, according to the Minimum Data Set (MDS) Section Q, there were 1,178 of residents in long-term care facilities who requested information regarding their options for community living. One such client living in a rural region of the State was able to transition out of the facility she had lived in for approximately 18 months by utilizing the CCT program. She faced a number of barriers to her transition, such as limited income and lack of family support and many others, however, she was determined to transition and with the support of her transition options team she moved into an apartment of her own. According to one community partner who assisted with this transition, "Her strong will and desire to live a more normal productive life has inspired all of us who had the privilege of being on her team".

HCPF has partnered with over 29 advocacy and stakeholder groups in recent years to push forward opportunities to support options for community living, including participating in in the development and execution of CCT and in the development of the Community Living Plan. These relationships could become strained and tenuous should the CCT program be dissolved. Continued collaboration between the CCT program and stakeholders is further demonstrated through Regional Transition Committees (RTC). The RTCs are local community partnerships who assess their readiness to support community transitions and resolve transition barriers at a local level. The ongoing support from the Department is essential to assisting local partnerships in removing transition barriers at a local level.

## **Description**

The CCT demonstration period has discovered systemic barriers to transitions. The following proposed CCT implementation solutions will address these barriers in an effort to support future client transitions:

- Improved reimbursement models for TCA;
- Restructuring Benefits and Services;
- Further efforts for outreach and education; and
- Promote affordable and accessible housing efforts

One significant transition barrier is the reimbursement methodology for TCAs. Clients utilize the Community Transition Services (CTS) benefit, which is offered through HCBS to prepare for transitions. HCBS services can only be utilized by clients residing in the community, therefore, TCAs must bill retroactively for services they facilitate while the client is residing in the nursing facility, prior to their transition. Additionally, TCAs must front up to \$1,500 in house hold set up fees for clients. The reimbursement methodology and up-front costs of doing business are not financially viable for most TCAs. The CCT program is currently working on methods to resolve this issue, including the development of a Concept Paper that has been submitted to CMS for review.

The CCT Demonstration period has identified needs for adjustments to some HCBS services that will resolve barriers to community transitions. One proposed solution is to have the Department contract with case management agencies to fulfill the requirements of Intensive Case Management (ICM), rather than offering it as an HCBS service, particularly in high-volume transition areas. CCT also proposes continued efforts around the successful implementation of Peer Mentorship and Independent Living Skills Training (ILST) services statewide. Both services can increase the rates of successful transitions and aid in future diversion efforts. Two demonstration services, Substance Abuse Treatment and Dental, will be offered through Medicaid State Plan Benefits. Others will be modified and included as benefits in HCBS or dissolve based on data supporting limited to no client utilization.

Continued Department outreach, education and engagement efforts will be necessary to the resolution of community transition barriers. CCT proposes securing 1 FTE to manage the Options Counseling contracts with the Aging and Disability Resources for Colorado (ADRC), monitor MDS Section Q data and compliance, provide ongoing Nursing Facility technical assistance and oversee RTC Development. 1 FTE to administer statewide CTS efforts and coordinate CTS provider recruitment efforts with RTCs. 1 FTE to support case management efforts specific to transitioning clients, including assisting in provider recruitment, education and technical assistance and support. The Department has been recognized nationally for gains to improve access to affordable housing. The sustainability plan aims to continue and advance current housing subsidies, improve the availability of affordable and integrated housing, and improve methods for searching for housing for transitioning members.

## **Milestones**

Paulette Steinhoff, is an example of how CCT is critical to supporting client's desire to pursue community living. Paulette resided in a nursing facility for over three years and was committed to transitioning back to the community. After her transition she became a transition coordinator and began assisting other nursing facility residents with transitions. According to Paulette, "It was rewarding to dispel the myth that once you move into an NF, that's it, you won't leave. The CCT program is vital and necessary to offer to people, giving them hope of being restored back to the person they knew

themselves to be. Being part of the community is LIFE; giving a helping hand to get a person into their own place is a valuable commodity this program affords to a select group of people. I am forever grateful, forever changed for the good because of CCT.”

To continue making stories like Paulette’s possible, HCPF needs to enact the following milestones:

- Hire new CCT Project Director - 2015
- Develop and execute CCT Provider Training Academy – 2016
- Resolve Transition Coordinator reimbursement issues - 2016
- Resolve level of care eligibility for transitions - 2016
- Automation of the transition process – 2017
- Continue CCT transition services and other benefits on waivers or alternative funding streams - 2017
- Fund necessary full-time employees - 2018
- Continue housing initiatives – ongoing

The Department will conduct further analysis to determine methods for fulfilling these milestones.

### **Cost Benefit Analysis**

The cost of sustaining community transitions is a financially sound investment for the State. According to AARP: Profiles of Long-Term Services and Supports, in 2012 the cost of providing long-term services and supports in Colorado Medicaid members in the community was \$31,000 - \$36,000 annually, while the cost of providing long-term services and supports in a nursing facility is \$60,000 - \$70,000 annually. Furthermore, AARP states that in Colorado the age 85 and older population, the age group most likely to need long-term services and supports, is going to increase by 369% between the years 2012-2050 and on average Medicaid dollars can support roughly three people with HCBS for every one person in a facility.

A cost benefit analysis of the CCT program for Fiscal Year 2014, on a cost per day basis, determined that CCT yielded a cost savings to Medicaid of **\$23.85** per day over nursing facility costs; and an overall cost savings of **\$319,203** over nursing facility costs, on a community vs. institutional cost basis.

On an individual cost basis, 35 of 54 clients (65%) that have transitioned from a nursing facility to a community based setting, yielded a savings ranging from **\$1 to \$759** over nursing facility costs, with an average of **\$148 less** than nursing facility costs.

There were 19 of 54 clients (35%) that did not yield a cost savings over nursing facility costs with a range from \$1 to \$600 over than their nursing facility costs with an average cost of \$140 over their nursing facility costs. Post transition costs range from **\$6333 to \$269,486** with an average of \$56,199.

**[Department is conducting further research and analysis to examine the program's cost benefits.]**

### **Quality of Life**

Every CCT participant completes a Quality of Life survey prior to their discharge from the facility, 11 months post-transition and 24 months post-transition. The survey was developed by Money Follows the Person (MFP) program and is utilized by each state participating in MFP. The survey assesses three areas:

- Life satisfaction;
- Quality of care; and
- Community life.

According to Mathematica, quality of life improves upon transition to the community and is sustained after two years of living in the community. Four (4) out of five (5) participants were satisfied with the way they lived their lives after one year in the community, and this level of satisfaction is sustained a year after participants have left the MFP program. In addition to overall quality of life, this sustained pattern of improvement was observed for access to personal care, treatment by providers, satisfaction with living arrangements, and community integration. This finding suggests that the quality-of-life effects of the transition are sustainable after participants leave the MFP program. Additional data to support these points is available at:

[http://www.mathematica-mpr.com/~media/publications/pdfs/health/mfp\\_2012\\_annual.pdf](http://www.mathematica-mpr.com/~media/publications/pdfs/health/mfp_2012_annual.pdf)



## Charter for Colorado Choice Transitions Stakeholder Advisory Council

### Primary Functions:

The primary functions of the Colorado Choice Transitions (CCT) advisory council is to provide guidance and recommendations regarding operational policy and procedural changes to the CCT program and to create solutions to streamline community transitions. This group will also be charged with analyzing systemic barriers for transitions and providing recommendations for improved policies and practices. The advisory council will also be responsible for providing recommendations for the use of the rebalancing funds generated through the enhanced federal match for Home and Community-Based Services provided to CCT clients. The work of this committee will directly inform the implementation of Colorado's Olmstead Plan.

The CCT advisory council will meet quarterly for the duration of the grant initiative. Advisory council members are expected to attend quarterly meetings, provide input and recommendations about policy and procedure changes, transition processes and participate in one work group within the committee. Work groups will be created ad hoc to address specific issues and/or complete specific tasks that are identified and prioritized by the committee. Work groups will meet in between the quarterly meetings as needed.

### The Advisory Council Reports to:

Recommendations from the CCT advisory council that involve CCT policy and procedures, transition processes and rebalancing funds will be provided to the Department of Health Care Policy and Financing (HCPF). Recommendations made by the CCT advisory council that address systemic barriers to transitions that have implications for Medicaid and other State agencies will be brought before the Community Living Advisory Group (CLAG). Updates on the work of the CCT advisory council will be provided to the CLAG for informational purposes and to solicit feedback when necessary. Once a council or committee is charged with providing oversight and governance for the implementation of Colorado's Olmstead plan, the advisory council will report to this group as the work of the committee.

### Role and Responsibilities of an Advisory Council Member:

Membership is intended to leverage the experience, subject matter expertise, and insight into the community transition process. Members will:

- Advise on the use of rebalancing funds and adjustments to the benchmarks for the CCT program
- Advise on the transition process

- Problem-solve and make recommendations to resolve transition barriers
- Provide input into services and benefit design
- Identify success stories
- Advise on outreach strategies
- Advise on resource development
- Represent a constituency, which includes, but is not limited to accepting and responding to stakeholder feedback, bringing feedback to the council and serving as a conduit of information between stakeholder groups and the Department. Council members are encouraged to allow the Department to list their names and contact information on the CCT website
- One council member will serve as stakeholder co-chair of the CCT advisory council.

### **Role and Responsibilities of HCPF Staff:**

HCPF staff will engage in collaborative efforts with stakeholders to improve CCT program operational processes and community transition services. HCPF staff will:

- Bring issues to the advisory council related to the items listed in the section above
- Involve the advisory council with changes to the operations of the program
- Inform advisory council of the current status of the rebalancing fund and potential uses for it and how it has been used
- Update advisory council with periodic progress reports that include agreed upon performance metrics
- Respond to advisory council's recommendations
- Be willing to modify and adjust within the federal constraints as the Department sees what works and doesn't, when the advisory council provides feedback and as the Department hears from the broader community

### **Decision Making Authority:**

The Department is committed to working directly with stakeholders to identify areas for systemic changes to promote transitions and to provide recommendations for the CCT demonstration program. Decision making responsibilities will be a collaborative process between the advisory council and the Department. The Department will solicit feedback and recommendations from the advisory council and incorporate them into final determinations or decisions. Ultimately, the Department must make decisions that align with State and Federal laws and regulations and fiscal constraints.

### **Customers:**

Current and future long-term care Medicaid clients pursuing community living options, transition services and HCBS in Colorado.

### **Authority/Delegation: (Statute, Regulation, Rule, etc.)**

- Money Follows the Person federal authorizations
  - Section 6071 of the Deficit Reduction Act of 2005

- Section 2403 of Patient Protection and Affordable Care Act
- Colorado Department of Health Care Policy & Financing
- Colorado Choice Transition Rule 8.555
- Community Transitions Services Rule 8.553

**Funding Authority:**

The United States Department of Health and Human Services awarded the MFP demonstration grant to Colorado. This demonstration program is administered by the Centers for Medicare and Medicaid Services (CMS)

**In scope:**

- Develop and propose recommendations to improve the transition services and support offered through CCT. Recommendations can include procedural changes to streamline the transition process, benefit design for the CCT specific services and the use of rebalancing funds.
- Identify systemic barriers to transitions and provide recommendations to eliminate or mitigate the identified barriers.

**Out of scope:**

- Systemic issues in the delivery of long-term services and supports that are not directly pertaining to the transition of clients from nursing facilities and intermediate care facilities for individuals with intellectual disabilities.
- Other issues, tasks or projects being addressed by other stakeholder groups.