

Title of Rule: Revision to Medical Assistance Long Term Services and Supports Rule Concerning Community Transition Services (CTS), Section 8.553.1
Rule Number: MSB 14-02-12-A
Division / Contact / Phone: Office of Community Living / Nora Brahe / 303-866-3566

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

This rule will revise Community Transition Services (CTS), a benefit of the Home and Community Based Services - Elderly, Blind and Disabled (HCBS-EBD) waiver since 2006. The revision will implement CTS as a demonstration service of the Colorado Choice Transitions (CCT) program. CTS will continue to be a benefit of the HCBS-EBD waiver. The revision will expand eligibility of CTS to individuals with intellectual disabilities, brain injuries and mental illness.

2. An emergency rule-making is imperatively necessary

- to comply with state or federal law or federal regulation and/or
- for the preservation of public health, safety and welfare.

Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

§§25.5-1-301 through 25.5-1-303, C.R.S. (2014);

Initial Review **03/13/2015**
Proposed Effective Date **05/30/2015**

Final Adoption **04/10/2015**
Emergency Adoption

DOCUMENT #02

AB

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REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

The CTS rule provides guidelines for services to elderly and disabled individuals 18 years and older residing in Medicaid skilled nursing facilities (SNFs) and adults aged 18 and older with intellectual or developmental disabilities residing in intermediate care facilities and SNFs.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

The primary intent of CTS is to assist people residing in nursing homes and other long-term care facilities in Colorado who may have the desire to return to a community based living arrangement. CTS will provide supports and services to facilitate their transition to the community.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

None.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

Provision of CTS services supports the successful transition of individuals from costly institutional care to less restrictive and expensive settings where they can receive home and community-based services. This impacts state Olmstead compliance, promotes the Department's strategic goal to transition institutionalized individuals and Colorado Choice Transition (CCT) ability to meet Money Follows the Person (MFP) transition goals.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

There are no less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

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Revisions to the rule are based on input solicited from stakeholders. There were no other alternative methods identified.

1 **8.553 COMMUNITY TRANSITION SERVICES**

2 **8.553.1 DEFINITIONS**

3 Authorization Request (AR) -means a request submitted by the Transition Coordination Agency to
4 the Single Entry Point agency to authorize payment for delivery of Community Transition
5 Services.

6 Case Management means the assessment of a long-term care client's needs, the development
7 and implementation of a care plan for such client, the coordination and monitoring of long-term
8 care service delivery, the evaluation of service effectiveness, and the periodic assessment of
9 such client's needs.

10 Case Management Agency means the organization selected to provide case management
11 functions for person in need of long term care services.

12 Community Transition Services (CTS) means activities essential to move a client from a skilled
13 nursing facility and establish a community-based residence.

14 Independent Living Core Services means information and referral services; independent living
15 skills training; peer counseling, including cross-disability peer counseling; and individual and
16 systems advocacy.

17 Transition Coordinator means a person employed by a Transition Coordination Agency to provide
18 Transitional Case Management.

19 Transition Coordination Agency (TCA) means an agency that is certified by the Department to
20 provide CTS and provides at least two Independent Living Core Services.

21 ~~Transitional Case Management means case management exclusively supporting a client's~~
22 ~~transition from a skilled nursing facility to a community-based residence.~~

23 ~~Transition Options Team means a group of individuals, chosen by the client and/or providing~~
24 ~~services to the client, who participate in the transition assessment and planning process.~~

25 **8.553.2 BENEFITS**

26 8.553.2. A. CTS shall only be available to clients currently residing in a skilled nursing facility
27 or an Intermediate Care Facility-Individuals with Intellectual Disabilities (ICF-IID), who are
28 eligible for adult Home and Community- Based Services ~~for the Elderly, Blind and~~
29 ~~Disabled~~ (HCBS-EBD) waivers except the Spinal Cord Injury Waiver.

30

31 8.553.2. B. CTS includes transition coordination services and funds to assist the client to set-
32 up a household.~~shall only be for the benefit of the client and may include the following:~~

- 1 ~~1. Transitional Case Management.~~
- 2 ~~2. Payment made for the following:~~
- 3 ~~a. Security deposits that are required to obtain a lease on a residence.~~
- 4 ~~b. Set-up fees or deposits for utility or service access, including telephone,~~
- 5 ~~electricity, heating and water.~~
- 6 ~~c. Essential household items and furnishings such as a bed, linens,~~
- 7 ~~seating, lighting, dishes, utensils and food preparation items.~~
- 8 ~~d. Moving expenses required to occupy a community-based residence.~~
- 9 ~~e. Health and safety assurances including a one-time pest eradication and~~
- 10 ~~a one-time cleaning prior to occupancy.~~
- 11 ~~f. A one-time purchase of food not to exceed \$100.~~
- 12 ~~8.553.2. C. CTS shall be provided by Transition Coordinators who are employed by~~
- 13 ~~Transition Coordination Agencies certified by the Department. The cost of CTS shall not~~
- 14 ~~exceed \$2,000 per client unless otherwise authorized by the Department.~~
- 15 ~~8.553.2. D. CTS shall be provided using procedures and guidelines provided in the~~
- 16 ~~Department transition coordination and intensive case management training. Items~~
- 17 ~~purchased through CTS shall be the property of the client. The client may take the~~
- 18 ~~property with him or her in the event of a move to another residence.~~
- 19 ~~8.553.2. E. The CTS household set-up assistance shall only be for the benefit of the client to~~
- 20 ~~set up a less restrictive living arrangement and may include the following:~~
- 21 ~~a. Security deposits that are required to obtain a lease on a residence.~~
- 22 ~~b. Set-up fees or deposits for utility or service access, including telephone,~~
- 23 ~~electricity, heating and water.~~
- 24 ~~c. Essential household items and furnishings such as a bed, linens,~~
- 25 ~~seating, lighting, dishes, utensils and food preparation items.~~
- 26 ~~d. Moving expenses required to occupy a community-based residence.~~
- 27 ~~e. Health and safety assurances including a one-time pest eradication and~~
- 28 ~~one-time cleaning prior to occupancy.~~
- 29 ~~f. A one-time purchase of food not to exceed \$100.~~
- 30 ~~g. Purchase of a cell phone to be used for safety monitoring.~~

1 h. First month rent.

2 i. Bus pass for period that covers the time period from referral to CTS to 30
3 days past the date of discharge from a facility described at 10 C.C.R.
4 2505-10, Section 8.553.2.Aa.

5 j. Computer that is determined to be medically necessary to sustain a less
6 restrictive living arrangement. (Client is required to complete computer
7 training prior to receiving computer).

8 k. Clothing that is appropriate for the community.

9 8.553.2. F. The cost of CTS shall not exceed the established amount per client unless
10 otherwise authorized by the Department.

11 8.553.2. G. Items purchased through CTS, returned security deposits described at 10 C.C.R.
12 2505-10, Section 8.553.2.E.a. and returned deposits described at 10 C.C.R. 2505-10,
13 Section 8.553.2.E.b. shall be the property of the client. The client may take the property
14 with him or her in the event of a move to another residence.

15
16 **8.553.3 NON-BENEFITS**

17 8.553.3.A. CTS shall not include the following:

18 1. Monthly rental expenses or other ongoing periodic residential expenses.

19 2. Recreation, entertainment or convenience items.

20 3. Items as described in 10.C.C.R. 2505-10, Section 8.553.2.EB.2 when already
21 provided through other means.

22 4. Items as described in 10.C.C.R. 2505-10, Section 8.553.2.EB.2 when provided
23 for the benefit of persons other than the client.

24 5. Monthly cell phone expenses.

25 6. Monthly bus pass expenses not described in 10 C.C.R. 2505-10, Section
26 8.553.2.E.i.

27 **8.553.4 TCA QUALIFICATIONS**

28 8.553.4.A. A TCA shall conform to all certification standards and procedures described in 10
29 C.C.R. 2505-10, Section 8.487 for HCBS-EBD Provider Agencies.

30 8.553.4.B. A TCA shall meet all requirements as set forth in 10 C.C.R. 2505-10, Section
31 8.553.5.

1 **8.553.5 TCA RESPONSIBILITIES**

2 8.553.5.A. TCAs shall administer the CTS benefit.

3 8.553.5.B. The TCA shall perform administrative functions, including supervision of
 4 Transition Coordinators, attendance at required meetings, ensuring timely reporting,
 5 compliance with transition procedures defined by the Department with input from
 6 stakeholders, on-site visits to clients, community coordination and outreach, client
 7 monitoring and on-site visits.

8 8.553.5.C. Staffing Requirements

9 1. The TCA shall ensure and document that each Transition Coordinator has
 10 completed the required Department Transition Coordinator training and has
 11 received a satisfactory proficiency rating, received 20 hours of training or passed
 12 a Department-approved skills validation test in transition coordination knowledge
 13 and skills. The Transition Coordinator training or skills validation test shall
 14 include, but not be limited to:

15 2. The TCA shall ensure that each Transition Coordinator has received training in
 16 the following:

17 a. Knowledge of populations served by the TCA and the target population
 18 served by the HCBS-EBD waivers.

19 b. Client interviewing and assessment skills.

20 c. Intervention and interpersonal communication skills.

21 d. Knowledge of available community resources and public assistance
 22 programs.

23 e. Team coordination skills.

24 fe. Meeting facilitation skills, Transition plan development.

25 3. The TCA supervisor(s), at a minimum, shall have two years supervisory
 26 experience and meet all qualifications for a Transition Coordinator.

27 4. The TCA supervisor shall complete the Department transition coordination
 28 supervision training.

29 5. Supervision of Transition Coordinators shall include, but not be limited to, the
 30 following activities: Supervision shall include, but not be limited to, the following
 31 activities:

32 a

- 1 a.- Arrangement and documentation of training or skills validation testing.
- 2 b. Review of transition aAssessments and plans and risk mitigation plans.
3 of client's satisfaction with services.
- 4 c. Oversight of transition coordination activities.Investigation of complaints.
- 5 d. Assessment of client's satisfaction with services.
- 6 Counseling with staff on difficult cases.
- 7 e. Investigation of complaints regarding provision of CTS.
- 8 f. Counseling with staff on difficult cases.
- 9 g. Oversight of recordkeeping by staff.Oversight of record keeping by staff.
- 10 63. Training ~~and skills validation~~ shall be completed prior to the delivery of CTS.
- 11 8.553.5. D. The Transition Coordinator shall conduct transition activities in accordance with
12 training, policies and procedures defined by the Department.
- 13 8.553.5. E. The Transition Coordinator shall, in collaboration with the client's Transition
14 Options Team, complete a Department-approved assessment to determine the client's
15 preferences, desires, and needs for housing, services and items necessary to establish a
16 community-based residence.
- 17 8.553.5. F The Transition Coordinator shall work with the client and the Transition Options
18 Team to create and implement a transition plan that meets the client's preferences,
19 desires and needs identified on the transition assessment. The Transition Coordinator
20 and the client shall sign the transition plan to signify agreement.
- 21 1. The Transition Coordinator shall submit the completed transition assessment,
22 transition plan and risk mitigation plan to the Department Transitions
23 Administrator (TA) for review prior to implementation of both plans.
- 24 a. The transition plan shall include the items needed for the client to
25 transition to a community-based residence.
- 26 8.553.5. G. The Transition Coordinator shall work with the client and Transition Options
27 Team to create and implement a risk mitigation plan that identifies known risk factors and
28 a strategy to mitigate each factor.
- 29 8.553.5. H. The Transition Coordinator shall work with the client to obtain a residence and
30 any items necessary to establish a community-based residence.

1 8.553.5. I. The Transition Coordinator shall conduct a minimum of four visits of the
2 residence to ensure all essential furnishings, utilities, community resources and services
3 are in place.

4 8.553.5. J. If the Transition Coordinator finds any of the supports to be insufficient for the
5 client to live successfully in the community, the Transition Coordinator shall work with the
6 case manager to correct the deficiencies.

7 8.553.5. K. The Transition Coordinator shall perform on-site visits to the client's community-
8 based residence at the following intervals:

9 1. Prior to the client's discharge from the skilled nursing facility.

10 a. If possible, the client shall accompany the Transition Coordinator during
11 the on-site visit prior to discharge.

12 b. If the client is unable to participate in the on-site visit, the Transition
13 Coordinator shall document the reason in the client's file.

14 2. The day of the move to ensure that the client's belongings and medications are
15 moved from the facility; that all required services are in place; and that the
16 necessary household set-up is complete.

17 3. One week after the transition to ensure that the supports and services identified
18 on the transition assessment and plan are being provided and received.

19 4. One month after the transition to ensure the client has the proper supports to
20 continue successfully living in the community.

21 5. The Transition Coordinator shall complete a transition report after the last on-site
22 visit.

23 **8.553.6 CASE MANAGEMENT AGENCY RESPONSIBILITIES**

24 8.553.6. A. The case manager shall participate in the Transition Options Team meetings.

25 8.553.6. B. The case manager shall conduct service brokering for Medicaid services,
26 including HCBS and state plan benefits, such as behavioral health services and home
27 health. Service brokering includes determining whether services that meet the client's
28 needs are available in the community where the client wants to live.

29 8.553.6. C. The case manager shall authorize CTS services.

30 8.553.6. D. The case manager shall provide joint monitoring with the transition coordinator of
31 the client during the 30 day post-discharge period.

32 **8.553.7 AUTHORIZATION REQUESTS**

- 1 8.553.7. A. The TCA shall submit the CTS AR form to the case management agency to
2 authorize payment for CTS and for any purchases or deposits after client discharges from
3 the facility.
- 4 1. The AR shall include copies of cancelled checks and copies of receipts detailing
5 the items purchased and the cost.
- 6 2. Any expenses submitted on the CTS AR for items that are not included in the
7 approved transition plan shall be considered non-allowable expenses and shall
8 not be reimbursed.
- 9 3. The case manager shall complete a review of the AR and shall notify the TCA of
10 approval or denial of the AR and, if applicable, any non-allowable expenses on
11 the cost report within ten business days of receipt.
- 12 4. The TCA shall submit the AR for Transitional Case Management once the client
13 has discharged from the facility.
- 14 a. The case manager shall verify that the client is established in a
15 community-based residence.
- 16 b. The case manager shall complete a review of the AR and shall notify the
17 TCA of approval or denial within ten business days of receipt.
- 18 c. The case manager shall notify the TCA of approval of any non-allowable
19 expenses on the cost report, if applicable.
- 20 d. Incomplete ARs shall be returned to the TCA for correction within 10
21 business days of receipt by the case management agency.
- 22 8.553.7. B. If after the transition plan has been reviewed the Transition Coordinator
23 determines additional purchases are required, the Transition Coordinator shall submit a
24 revised AR to the case management agency.
- 25 8.553.7. C. Approval of the AR by the case manager shall authorize the TCA to submit
26 claims to the Department's fiscal agent. Payment of claims is conditional upon the client's
27 financial eligibility on the dates of service and the TCA's use of correct billing procedures.

28 **8.553.8 REIMBURSEMENT**

- 29 8.553.8. A. The TCA shall conform to all reimbursement procedures described in 10 C.C.R.
30 2505-10, Section 8.487.200 Provider Reimbursement.
- 31 8.553.8. B. Payment for CTS shall be the lower of the billed charges or the maximum rate of
32 reimbursement.

1 8.553.8. C. The cost of transitional coordination services shall be reimbursed by one unit of
2 service completed when the client is established in a community-based residence as
3 verified by the case manager.

4 8.553.8. D. Reimbursement for household set-up shall be made only for items listed on the
5 transition plan with an accompanying receipt. The cost of household set-up shall be
6 reimbursed at one unit of service completed when the client is established in a
7 community-based residence as verified by the case manager.

8 **8.553.9 CONFLICT- FREE TRANSITION COORDINATION**

9 8.553.9. A. TCAs shall separate transition coordination from direct service provision.
10 Examples of this separation are separate staff, intake lines, office space and client files.

11 1. Transition Coordinators who are involved in the determination that a transition is
12 feasible are required to do so distinctly so that there is not an incentive to
13 increase business for their organization.

14 2. In circumstances when one entity is responsible for providing transition
15 coordination and service delivery, appropriate safeguards and firewalls shall exist
16 to mitigate risk of potential conflicts of interest and to ensure that consumer
17 choice and control are not compromised. The safeguards and firewalls shall be
18 submitted to the Department for approval.

19 3. In circumstances where the TC is an employee of an agency providing other
20 services, the TC shall comply with safeguards and firewalls established to
21 mitigate conflict of interest and to ensure client choice and control.

22 8.553.9. B. Determination that a transition is feasible is made by the Transition Options
23 Team.

24 8.553.9. C. Transition Coordinators shall not be related to the parent, child, spouse, sibling,
25 grandparent, niece, nephew, uncle or aunt of any of the individual's caregivers; or to
26 anyone financially responsible for the individual or empowered to make financial or
27 health-related decisions on the beneficiary's behalf.