

ETHICS COMMITTEE UPDATES

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Jenny Albertson

Director of Quality &
Regulatory Affairs

(720) 675-3478

cohca.org

jalbertson@cohca.org



WHAT IS THE COLORADO TRANSITIONS PROGRAM?

Are you living in a **Nursing Facility**?

Do you want to
RETURN to a
COMMUNITY
SETTING?



Health First Colorado (Colorado's Medicaid Program)
can help you **understand your options.**

Transition Services help you:

- Determine if transition to a **community setting** is possible, e.g. assisted living, your own home, or with family and friends
- Coordinate your transition
- Explore different housing opportunities
- Improve your access to an array of Home and Community Based Services (HCBS)

Learn more:

hcpf.colorado.gov/tsm



In-Reach Counseling is a service designed to engage and provide members living in a nursing facility with information regarding housing, transition, and other community-based services available to support them in living in the community and answer any questions. In-Reach Counseling provides the referral process to transition coordination and other services while supporting members with making an educated choice about their options for where they live.

In-Reach Counseling comes in two forms, Group and Individual:

- **Group In-Reach** is conducted in a group setting and provides a referral process to either Individual In-Reach or Transition Coordination Services while supporting members with making an educated choice about their options for where they live.
- **Individual In-Reach** is conducted one-on-one with a member and their chosen supports, if needed. Individual In-Reach provides an opportunity for the resident to receive a person-centered informational session regarding community transitions options, local resources, and other available services.

<https://hcpf.colorado.gov/transition-services>

WHERE DID ALL THIS COME FROM?

<https://hcpf.colorado.gov/doj-findings>



Department of Health Care
Policy & Financing

303 E. 17th Ave., Suite 1100
Denver, CO 80203

Colorado Department of Justice Settlement Agreement Summary

November 2024

Background

In September 2023, the Department of Justice (DOJ) filed a lawsuit against the State of Colorado, alleging non-compliance with the Americans with Disabilities Act (ADA) for operating our long-term services and supports system in a way that results in institutionalization. This action was surprising given that, unlike some other states, Colorado consistently serves most individuals requiring long-term services and support in community settings.

All Medicaid programs, including Colorado's, were built upon antiquated systems that historically only required institutional care. However, Colorado has made exceptional strides in building community-based programs in recent years. This commitment has increased the percentage of individuals receiving support in their communities, which has steadily risen year over year—including throughout the duration of the DOJ's investigation of Colorado.

While Colorado disagreed with the DOJ's allegations, it viewed the situation as an opportunity to reinforce its ongoing commitment to improvement and community living. Desiring to divert money that would otherwise go to legal fees to advance the efforts to improve our system, the state decided to engage in settlement talks with the DOJ in February 2024.

March 2022 - In response to several complaints, we [US DOJ] assessed the State's compliance with Title II of the Americans with Disabilities Act ("ADA"), which requires public entities to administer services to individuals with disabilities in the most integrated setting appropriate to their needs. We have determined that **Colorado is violating the ADA by administering its long-term care system in a way that unnecessarily segregates individuals with physical disabilities in nursing facilities** and places others with physical disabilities at serious risk of **unnecessary institutionalization**.

Colorado could remedy these deficiencies by reasonably modifying its service system for individuals with physical disabilities. (1) providing individuals with an **informed choice** about community-based alternatives to nursing facility care; (2) providing effective **transition services**; (3) **expanding community-based service capacity**; and (4) increasing **access to integrated community-based housing** opportunities.

...our finding that **community-based services are appropriate for nearly all Colorado nursing facility residents with physical disabilities**. Colorado serves more people with low care needs in nursing facilities than all but nine states; it could likely serve most of these individuals in the community.



Group In-Reach (GIR)

This will be a facility-wide education for residents regardless of payment source. **All residents and their POAs or Guardians should be invited by the SNF staff.** This should be occurring twice per year, approximately every 6 months.



Individual In-Reach (IIR)

Every SNF resident who has a payor source of NF Medicaid or PACE should be offered Individual In-Reach. No one is required to receive it, as anyone can decline the education. Expect a push in June and Dec. 2026 as deadlines approach.

CONTACT EXPECTATIONS

PART OF A BROADER EFFORT

Nursing Facility Diversion Projects

At-Risk Diversion

Transition Escalations

Rapid Reintegration

At-Risk Diversion - Health First Colorado members who have been identified as At-Risk will receive targeted outreach to offer additional support, services, resources, and education to support these members in the community with services and necessary support before a need for institutional admission. At-Risk Diversion will include support from Case Management Agencies (CMA), Regional Accountable Entity (RAE) organizations, and Transition Coordination Agencies (TCA). As part of this outreach, CMAs and RAEs will complete an At-Risk Assessment with members to determine any factors that put them most at risk of nursing facility admission and identify community-based resources to support them. You can review the new [At-Risk Assessment](#)

Transition Escalation - select this ticket type for general concerns or issues related to a member's transition, or specific incidents with transitioning back into the community. There's an online "ticket" submission process available.

For example:

- Delays in services outside of expected wait times
- Eligibility delays
- Lack of available providers in the area
- Challenges obtaining equipment for members
- Resistance from nursing facility staff to support transitions

RAPID REINTEGRATION FOR "AT-RISK"

Rapid Reintegration is the Person-Centered process that occurs when an At-Risk Population member, who is admitted to a nursing facility, does not oppose living in the Community, and **is not experiencing Unstable Housing** is transitioned in 30 days or less from a nursing facility to the Community and receives services as described in the member's Rapid Reintegration Plan.

For the purposes of this Agreement (with DOJ), the Target Population consists of individuals with a **physical disability over the age of 21 who are either enrolled in Medicaid or presumptively eligible for Medicaid and have a persistent condition likely requiring the use of State administered long-term services and supports to live in the Community.**

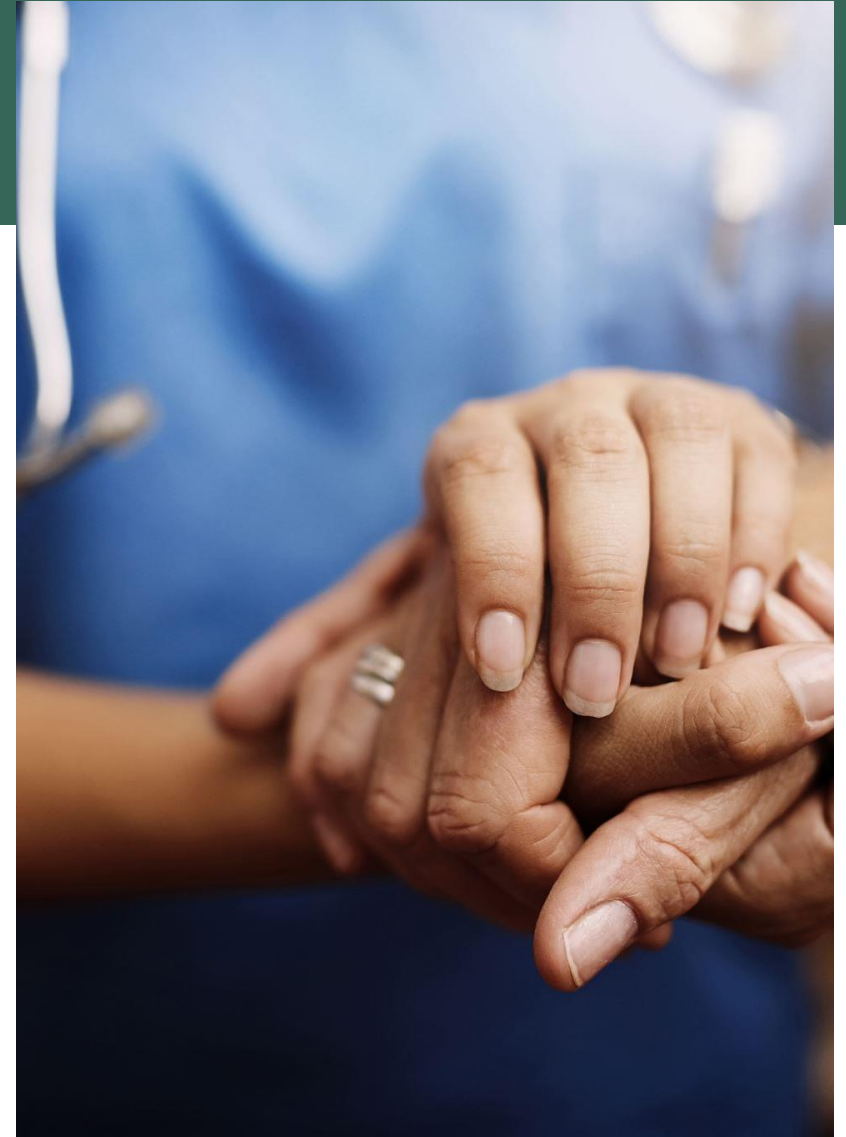
- The Target Population consists of the following two sub-populations:

The "At-Risk Population." Medicaid members or presumptively eligible Medicaid members who live outside of a nursing facility (including those who have been in a nursing facility for 30 days or less) and

(a) have received a Level of Care Screening to access Medicaid nursing facility services; or

(b) may need nursing facility services as identified by the Case Manager or Care Coordinator; or

(c) are otherwise at risk for institutionalization as the State has determined through the methodology described in Section VII(A)."



HOW MANY NEED TO TRANSITION OUT OF NURSING HOMES?

- By December 31, 2026, all Institutionalized Population members will have received, or have opted out of, Individual In-Reach at least once.
- **Nursing Facility Role in In-Reach.** The State will require nursing facilities to make private space available for In-Reach counseling, out of the presence of nursing facility staff, unless the member requests the presence of nursing facility staff. The State will prohibit nursing facilities from interfering with In-Reach and will respond to reports of interference with In-Reach activities.
- A Community Transition means **any Institutionalized Population member transitioned from a nursing facility into the Community**, except Community Transitions do not include discharges: (a) from a nursing facility to a hospital, assisted living facility, or different nursing facility, (b) occurring within 30 days from admission to the nursing facility, or (c) where a member returns to a nursing facility (excluding brief or rehabilitative stays) caused in substantial part by insufficient provision of Community Based Services.
- The State shall ensure that at least **950** receive Transition Coordination Services and successfully complete Community Transition within the term of the Agreement. The State will ensure that at least **1,050 additional** Institutionalized Population members complete Community Transition within the term of this Agreement while receiving Community-Based Services within six months after Community Transition. The State will achieve 35% of the transition totals **[700] by the end of the second year of the Agreement's term [10/1/2026]**.

IF THE RESIDENT INITIATES

Long-term care facilities are required to make a referral for individual in-reach for a member who has indicated they are interested in moving into the community.

- Referrals can be directed to the [Local Contact Agency](#) in a member's area. This information is available in the nursing facility or on the [Transition Services website](#). If a member is interested in learning more about Transition Services they can contact the [Local Contact Agency](#) for individual in-reach in their area by completing this online [Medicaid Transition to Community Information Request Form](#).
- After a referral is made to the [Local Contact Agency](#), an In-Reach counselor from that agency will contact the member within 10 business days of the referral. The member will work with the in-reach counselor to discuss the availability of appropriate services in the community and learn more about community living options.
- If the member decides to begin the transition process, they will choose a local [Transition Coordination Agency](#). A list of all agencies is available on the [Transition Services website](#) under Resources. The agency will connect the member with a Transition Coordinator to help them begin the process.

OPT-OUT REASONS



Anyone who is **on active hospice care** can be opted out due to not disrupting end-of-life services. If residents in hospice want to transition back home, the TransitionCare Coordination (TCA) can expedite their processing of the transition.



Anyone who has been assessed by a doctorate-level provider can be opted out due to having a **significant cognitive decline or if they have been deemed incapacitated**. This can be verified by the provider writing a letter with the resident(s) name listed. A sample letter has been provided. They can also verify a previous progress note, completed assessment with the results written in the margin & signed by the provider, as neurocognitive disorders typically are not expected to improve.



Legal Guardians or Conservators can also opt residents from receiving this education. The In-Reach Counselors should be verifying the paperwork and will need to speak directly to the guardian to verify that they wish to opt the member out.

Date

I, (Doctorate Level Provider's Name), have personally assessed (member name), and I have deemed them to have significant cognitive decline or incapacitation to where they can't make an educated choice.

(Medical Provider Name)

(Medical Provider Signature)

MEETING THEIR GOALS

- 35% of total Individuals who have received Transition Services is to be achieved by the end of the second year of the agreement. That is 700 transitioned individuals by 10/1/2026.
- In the 3rd year of the agreement, the monitor will be conducting a study to assess how many residents were provided education, how many are waiting to transition into the community, and how many are not interested in these services. Essentially, if that study shows that fewer than the required number of people don't want to transition, then we do not have to go by the 35%. We are focusing our efforts on truly making this member's choice.
- Given the below definition, should nursing facilities be reporting to the Transition Services group or requesting their involvement in the discharge process for residents who have the following combined circumstances?
 - end their rehabilitation coverage (Medicare/Managed Care),
 - convert to Medicaid or are presumptively eligible, and
 - are anticipated returns to community settings that exceed 30 days?
- Anyone who has any Medicaid coverage can use the support of our Transition Coordination Agencies (TCAs). If the residents are interested in the support and will be transitioning into Medicaid from Medicare, or transitioning into Medicaid from other circumstances, they can submit that JotForm referral.

Per the Settlement Agreement: *The “Institutionalized Population.” Medicaid members or presumptively eligible Medicaid members living in a nursing facility for more than 30 days who are receiving Medicaid-funded nursing facility services.*

FURTHER INFORMATION

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- [HCPF Transition Services Website](#) - Resources regarding all of the transition programs, including In-Reach and diversion efforts.
 - [HCPF - DOJ Settlement Agreement Resources](#)
 - [Escalation Form](#) - Anyone can use this to submit concerns, ask for status updates, or ask general questions regarding anything Medicaid-related.
 - [Transition to Community Request Form \(JotForm Referral\)](#)
 - [Transitions Stakeholder Advisory Council \(TSAC\)](#) - This is the meeting that includes all stakeholders who are involved in the community transitions process.
 - [SNF Social Work Office Hours](#) - This meeting is specifically for SNF staff, but other stakeholders can join. This is a time for HCPF to connect with SNF staff to present on program updates, offer open forum discussion to talk through concerns/questions, and presentations on community resource presentations.