State of California—Health and Human Services Agency
Department of Health Care Services

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MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION

CALIFORNIA COMMUNITY TRANSITIONS OPERATIONAL PROTOCOL 1.5

SUBMITTED TO THE CENTERS FOR
MEDICARE & MEDICAID SERVICES

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Appendix

Money Follows the Person Rebalancing Demonstration

Project Introduction

In California, the Money Follows the Person (MFP) Rebalancing Demonstration is known as the **California Community Transitions (CCT)** Project, and is administrated by the Department of Health Care Services' (DHCS') Long-Term Care Division (LTCD). CCT is implemented under the authority of Section 6071 of the Deficit Reduction Act (DRA) of 2005; the Money Follows the Person Rebalancing Demonstration (P.L. 109-171); Section 2403 of the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148); the Centers for Medicare & Medicaid Services (CMS) grant number 1LICMS300149; the California Code of Regulations; and California's approved Medi-Cal State Plan and 1915(c) Home and Community-Based Services (HCBS) Waivers.

The State of California is committed to providing health care services and supports to Medi-Cal members (Medi-Cal is the name of California's Medicaid Program) in the least restrictive and most integrated setting of their choice, as envisioned by the 1999 U.S. Supreme Court's Olmstead decision.[1] The MFP grant provides California with the opportunity, in coordination with stakeholders and local organizations, to proactively implement systems changes that benefit people who have resided in an inpatient facility for at least 90 days (with at least one day paid by Medicaid) and wish to return home or to the community.[2] Medi-Cal members who meet MFP eligibility requirements and who wish to live and receive services in an area of the state served by a local CCT provider, known as Lead Organizations (LOs), may choose to work with the LOs' Transition Coordinators (TCs) to identify and secure the community-based services and supports they require to remain in the community.

The Governor's Office, the California Health and Human Services Agency (CHHS), and the DHCS are committed to implementing CCT as part of a larger effort to make systems improvements that increase accessibility of HCB Long-Term Services and Supports (LTSS) in California.

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[1] US Department of Justice, Civil Rights Division. "Olmstead: Community Integration for Everyone." https://www.ada.gov/olmstead/olmstead_about.htm

[2] Section 6071 of the DRA defines "inpatient facility" as a hospital, nursing or subacute care facility, or intermediate care facility for persons with developmental disabilities.

Section A. Organization and Administration

A.1a. Systems Assessment and Gap Analysis

California's Long-Term Care Delivery System

In 2013, California spent over 60% of all Medi-Cal long-term care costs on HCBS, compared to under 40% on institutional care. Although California dedicates substantial resources towards HCBS, the system still confronts multiple barriers to expanding capacity and infrastructure. In December 2014, California's Senate Select Committee on Aging and Long Term Care issued a report, "A Shattered System: Reforming Long-Term Care in California: Envisioning and Implementing an IDEAL Long-Term Care System in California." In their report, the Committee concluded that "The most critical issue facing California's LTC [long-term care] system is the fragmentation of programs at the state, regional, and local levels."[3] Funding stream restrictions and "a lack of capacity -- especially in rural areas -- in services, supports, and workforce across a range of disciplines" create a LTC system within the State that limits HCBS providers from providing services to anyone outside of their targeted sub-population and/or geographical service area. California's provider networks exist as a "patchwork" of distinct referral/service systems, but the HCB LTSS they provide are largely the same, which results in parallel service systems providing nearly identical services to parts of an eligible population. Therefore, in line with the DRA, California's efforts to "Eliminate barriers or mechanisms…that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice,"[4] began by reaching out to the different provider networks to present them with information about CCT and the opportunity to provide HCB LTSS with greater flexibility. Although there is still work to be done to address the fragmentation of state and local LTC delivery systems, DHCS has worked to strengthen collaborations with other state Departments and local service providers to expand HCBS options for eligible Medi-Cal members since well before 2007. DHCS currently collaborates with the California Department of Aging (CDA), the California Department of Public Health (CDPH), the Department of Developmental Services (DDS), the California Department of

[3] Senate Select Committee on Aging and Long-Term Care. "A Shattered System: Reforming Long-Term Care in California: Envisioning and Implementing an IDEAL Long-Term Care System in California." December 2014.

[4] U.S. Deficit Reduction Act of 2005, Section 6071 (P.L. 109-171)

Social Services (CDSS), and the Department of Rehabilitation (DOR), on the administration of HCBS waiver programs and the development of the state's HCBS Final Rule Transition Plan.

At the time California was awarded the MFP Demonstration Grant, the state, like the nation, fell into a great recession and was faced with extensive measures to reduce spending. California's efforts to collaborate with state and local partners began slowly as State and local governments were endeavoring to limit growth to preserve existing programs. With this in mind, CCT project staff used existing frameworks created by and for other Medi-Cal HCBS Waivers[5] as the foundation for CCT, but secured approval for modifiers to service codes to expand service definitions. Expanding the scope of existing services provided under other HCBS Waivers allowed CCT to provide facility-to-community transitions and HCBS to eligible Medi-Cal members who would not normally have access to, or who may not believe they could benefit from, transition and community care services. Ultimately, CCT allows LOs to provide essential planning, transition, and follow-up services that are built upon a proven service and reimbursement structure, at the same time similar Programs were coping with funding cuts and restrictions to growth.

When CCT began in 2007, access to HCB LTSS was primarily limited to Medi-Cal provider networks serving distinct segments of the LTC population. As CCT was implemented, DHCS recruited community-based organizations (CBOs) with transition planning/implementation experience to serve the entire LTC population within their service areas. CCT LOs include: Independent Living Centers (ILCs), Aging and Disability Resource Centers (ADRCs), Home Health Agencies (HHAs), and other community-based agencies. Most of the CBOs that became CCT LOs were not previously enrolled as Medi-Cal service providers; and, including these localized experts under the Medi-Cal payment system has proven to be a major systems change within the state. Prior to receiving the MFP grant, California's ILCs, administered by the DOR, were transitioning residents from nursing facilities to a home environment without the benefits of being a Medi-Cal provider able to bill for transition coordination, case management, and other HCBS waiver services. The MFP Demonstration Grant provided additional impetus for DHCS and the DOR to partner to ensure ILCs could use their community-based experience to benefit Medi-Cal members. Other examples of linkages influenced by the Demonstration include a partnership between DHCS and DDS to allow state Regional Centers to become transition teams to assist greater numbers of eligible Medi-Cal members in the state. Likewise, the CCT Project

[5] CCT services were originally based on the services provided under California's 1915(c) Nursing Facility/Acute Hospital (NF/AH) Waiver

has partnered with state and federal housing agencies (i.e., U.S. Department of Housing and Urban Development (HUD), local Public Housing Authorities (PHAs), etc.) to utilize the Non-Elderly Disabled (NED) 2 and 811 Vouchers to secure accessible and affordable housing for CCT participants.

The state believes local programs, local service providers, and local caregivers are best equipped to work directly with individuals who want to transition from inpatient facilities to the local community. The state oversees local program implementation, which includes but is not limited to: authorization of new CCT LOs, approval of CCT enrollees' Transition and Care Plans (TCPs), and statewide performance in meeting benchmarks. CCT LOs enter into contracts with DHCS and convene transition teams who meet with CCT enrollees and participants to help them navigate the complex array of Medi-Cal waivers, programs, and state plan services. CCT LO transition coordinators also assist CCT enrollees with identifying and securing affordable housing, accessible transportation, income maintenance, and any/all other services that need to be included to support an individual transitioning to the community from a facility. Since 2008, California's ability to provide comprehensive transition and care planning services to ensure CCT participants receive comprehensive and continuous care in the community setting of their choice has grown more robust. Utilizing community-based service providers in the implementation of the CCT Project, has also demonstrated why the need for "local service provider" involvement is so valuable. Local area services cannot be fully known at the state, or even regional levels; especially when the enrollee choses to move to a county other than where s/he is residing in an inpatient facility. Even as California shifts from fee-for-service reimbursement to managed care, local service provider collaboration with managed care plans (MCPs) is just as important. While the HPs are very knowledgeable about managing health care needs, most are not familiar with local social services and supports that are essential to individuals returning to the community after they may have lost their housing and/or community support structure. DHCS is in the process of facilitating "long-term" collaborations between CCT LOs and the managed care plans in their "sphere of influence".

Statewide Rebalancing Efforts and Existing Gaps

The state does not propose to limit facility services, nor does the state propose reducing the number of available inpatient facility "beds" at this time. The number of Medi-Cal facility beds has remained relatively flat for well over 20 years. By continuing that pattern, the state projects that the ballooning aging demographic will, in essence, be a reduction of facility

options as the increase in available and accessible HCBS alternatives occur. Rebalancing in favor of HCBS will continue to happen as a result of strengthening HCBS options and networks and keeping flat the number of facility options.

California offers multiple 1915(c) Waiver programs that provide institutional diversion and/or transition services to eligible members to limit the use of institutional care. The 1915(c) HCBS waiver programs are either directly administered or overseen by DHCS as the single state agency for Medicaid/Medi-Cal. However, several of the HCBS waivers and the 1915(i) State Plan program are administered jointly by DHCS and the State or local entity with program responsibility. Existing 1915(c) HCBS Waivers and the corresponding State department/entity with program responsibility include:

1. **Multipurpose Senior Services Program (MSSP), CDA, Long Term Care & Aging Services**

   Provides opportunities for frail older adults to maintain their independence and dignity in community settings by preventing or delaying avoidable nursing facility placement through care management.

2. **HIV/AIDS Medi-Cal Waiver, CDPH, Office of AIDS**

   Provides HCBS as an alternative to nursing facility care for Medi-Cal eligible members diagnosed with mid- to late-stage HIV/AIDS through a continuum of care designed to stabilize and maintain an optimal level of health, improve quality of life, and provide an alternative to institutional care in hospitals or nursing facilities.

3. **HCBS Waiver for Persons with Developmental Disabilities (DD Waiver), DDS, Community Services**

   Serves Persons with Developmental Disabilities of all ages who meet the ICF/DD level-of-care requirement in the setting of their choice (such as with their families, in their own homes or apartments, or in licensed settings), as an alternative to placement in hospitals, nursing facilities, or intermediate care facilities for persons with developmental disabilities (ICF/DD).

4. **Assisted Living Waiver (ALW), DHCS, Long-Term Care Division**

   Provides transition and diversion services to Medi-Cal eligible seniors and persons with disabilities currently living in and institution, or who are at risk of institutionalization, who choose to receive HCBS in a home-like Assisted Living Facility.

5. **Nursing Facility/Acute Hospital (NF/AH) Waiver, DHCS, Long-Term Care Division**

Offers services in the home to Medi-Cal members with long-term medical conditions, who meet one of the required levels of care, with the option of returning to, and/or remaining in, their home or home-like setting in the community in lieu of institutionalization.

6. **Pediatric Palliative Care Waiver (PPC) Waiver, DHCS, Systems of Care Division**

Offers children with life limiting conditions a range of home-based hospice-like services while they maintain the option of receiving curative treatment. According to diagnosed need and an approved plan of care, services include: care coordination, expressive therapies, family training, individual and family caregiver counseling/bereavement services, pain and symptom management, personal care and respite care.

In addition to the 1915(c) waiver programs, California offers a variety of services and programs to eligible Medi-Cal members that support them in the community setting of their choice. Several, but not all of the state's other HCBS options include:

- **1915(i) State Plan Amendment (SPA)**

  Allows California to provide HCBS to Medi-Cal member who are developmentally disabled without a waiver, as long as the eligibility criteria for these services are less stringent than the institutional level of care criteria required under existing waivers. The state has two approved 1915(i) State Plan Amendments (SPA), which allow community services to be provided to individuals who do not meet the eligibility criteria of the current HCBS-DD Waiver.

- **1915(k) Community First Choice (CFC) – In-Home Supportive Services (IHSS)**

  Allows eligible members to live safely in their own home and avoid the need for out of home care by offering them self-directed with personal care services.

- **Program of All Inclusive Care for the Elderly (PACE)**

  The PACE program provides a comprehensive medical/social service delivery system using an interdisciplinary team approach in a PACE Center that provides and coordinates all needed preventive, primary, acute and long-term care services. Services are provided to older adults who would otherwise reside in nursing facilities and affords eligible individuals the option to remain independent and in their homes for as long as possible.

- **Community-Based Adult Services (CBAS) 1115 Medicaid Waiver**

  CBAS is a Medi-Cal Managed Care benefit available to eligible Medi-Cal members enrolled in Medi-Cal Managed Care. CBAS offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization.

- **Senior Care Action Network (SCAN) Health Plan**

  SCAN Health Plan is a Medicare Advantage Special Needs Plan that contracts with DHCS to provide services for the dual eligible Medicare/Medi-Cal population subset residing in Los Angeles, San Bernardino, and Riverside counties. SCAN provides all services in the Medi-Cal State Plan; including HCBS to SCAN members who are assessed at the Nursing Facility Level of Care and nursing home custodial care, following the member in the nursing facility.

Target Population Demographics

Medi-Cal members who are inpatients beyond a short visit or rehabilitation period remain in the facility for a variety of reasons. There is no single consumer profile that represents the ideal candidate for the Demonstration. For this reason, the state requires CCT transition services to be all-inclusive and for transition teams to exercise no assumptions about who is likely or unlikely to prefer community living.

The target populations for CCT were proposed in the state's application dated November 2006 and are described in narratives below.

- **Elders Who Have One or More Medical, Functional or Cognitive Disabilities**: Includes Medi-Cal members who are age 65 and older who have one or more functional, medical or chronic conditions. Other terms used for this group are older adults and seniors. This group also includes elders who have Alzheimer's disease or other dementias.
- **Persons with Developmental Disabilities**: This group includes Medi-Cal members of any age who have intellectual and/or developmental disabilities that manifested before their 18th birthday.
- **Persons Who Have One or More Physical Disabilities**: This group includes Medi-Cal members under the age of 65 years who have at least one physical disability. People who are HIV positive or have AIDS are included in this group.
- **Persons Who Have Mental Illness**: This group includes Medi-Cal members who have been diagnosed with chronic mental illness.
- **Persons Who Have Experienced an Acquired Brain Injury/Traumatic Brain Injury (TBI)**: This group includes Medi-Cal members who do not have a mental illness but have experienced brain trauma resulting in functional challenges, such as physical, cognitive, and psychosocial, behavioral, or emotional impairments. Stakeholders requested that these Medi-Cal members be included in the demonstration. Medi-Cal members in this category will be included and reported to CMS under the physically disabled federal category.
- **Adults and Children Who Are Hard-to-Place**: This group of Medi-Cal members includes children and adults who are residents of nursing facilities with few or no care options outside of the institution because of their medical or behavioral conditions. Stakeholders requested that these Medi-Cal members be included in the demonstration. Medi-Cal

members in this category will be included and reported to CMS under the most-applicable federal category.

Increasing Self-Direction

California initiated several self-direction programs prior to the onset of the CCT Project. The NF/AH waiver, the Personal Care Services Program (PSCP) administered by the counties under IHSS, and the DDS waiver, all provide opportunities for Medi-Cal members to direct their own services while living in the community. This self-direction was built into the CCT Project at its inception, and remains an integral piece of the LTSS for California Medi-Cal members.

Stakeholder Involvement

DHCS is committed to engaging stakeholders, including consumers and family members, to provide meaningful, ongoing input to state policy makers. Since the original grant award in 2008, the composition of CCT's stakeholder group has gone through several iterations based on the evolution of the program. Most recently, in June 2015, DHCS convened the first of five HCBS Stakeholder Advisory Workgroups to engage experts to provide recommended on building the longevity of institutional transitions to HCBS, the future of HCBS under a Managed Care delivery system, and establishing an adequate HCBS provider network.

DHCS is confident that the additional structure and focused input of the specialized work groups will provide the state with valuable input on the phase-out of CCT, and the future of California's network of HCB LTSS available to eligible residents living in long-term care facilities. See Section B.4. "Stakeholder Involvement" for more information on CCT's HCBS Advisory Workgroup.

A.1b. Administrative Structure

State Organizational Structure

DHCS is one of 16 State Departments and Offices within the CA Health and Human Services (CHHS) Agency, all of which function under the authority of the CHHS Secretary. The Secretary administers state and federal programs for health care, social services, public assistance, and rehabilitation, and is responsible for informing the Governor's Administration about current health and human services issues and providing leadership in developing future initiatives. CHHS convenes and facilitates the Olmstead Advisory Committee to assist in identifying issues, barriers, and potential policies for the Administration to consider as the state moves forward with the implementation of California's Olmstead Plan, and to support and provide guidance for projects such as CCT.

While each Department/Office within CHHS focuses on distinct issues or target populations, all of the Departments/Offices share five central goals identified in the CHHS Action Plan. The services delivered through CCT directly support the fourth goal in the CHHS Action Plan, which affirms:

> Disabled and aged Californians will have the opportunity to live in their own homes and communities, rather than institutional settings, in the most integrated setting possible.

CCT enables eligible Medi-Cal members to maintain their independence in less-restrictive settings of their choice.

DHCS is California's single authorized Medicaid Agency, and is under the authority of the State's Medicaid Director (SMD), who is responsible for certifying that California abides by the Terms and Conditions of the MFP Grant, and that the demonstration is operated to continuously meet the requirements spelled out in the DRA. DHCS is comprised of 32 distinct Divisions. CCT is administered within the LTCD, which is closely connected to initiatives of California's Olmstead Plan and works to ensure the provision of LTSS to Medi-Cal-eligible frail seniors and persons with disabilities to allow them to live in their own homes or community-based settings, instead of in facilities. The LTCD operates and/or administers five HCBS waivers within the Department, and provides monitoring and oversight for four HCBS waivers and the In-Home Supportive Services (IHSS) state plan benefit, which are administered by sister Departments. In addition, the LTCD operates two managed care programs, PACE, and SCAN; as well as the California

Partnership for Long-Term Care, a long-term care insurance program. Finally, the LTCD works collaboratively with the Managed Care Operations Division (MCOD) to integrate LTSS for seniors and persons with disabilities and Medicare/Medi-Cal dual eligible members in a managed care delivery system.

Administrative Support Agencies

As the single-state agency for the administration of the state's Medicaid program, DHCS has administrative and fiscal monitoring and oversight responsibilities for all Medi-Cal State Plan and Waiver Services, including any Medi-Cal waivers administered by other state departments. DHCS is acting as the overall coordinator for CCT policy and operational issues and will work with stakeholders including state departments, local governments, community-based organizations, inpatient health care facilities, advocates, direct service providers, and consumer groups to implement the demonstration at state and local levels.

All required administrative support structures required by CCT are currently established within DHCS. CCT Project Staff request and obtain administrative support services from the following internal Divisions and sub-Divisions, as required:

- Administration
  - Fiscal Forecasting & Data Management
  - Financial Management
    - Accounting
    - Budgets
  - Contract Management
  - Human Resources
- Audits & Investigations
- CA-Medicaid Management Information Systems (CA-MMIS)
- Information Technology Services
- Office of Administrative Hearings & Appeals
- Office of Civil Rights
- Office of HIPAA Compliance
- Office of Legal Services
- Office of Legislative & Governmental Affairs
- Office of the Medical Director
- Office of Public Affairs
- Provider Enrollment Division

The LTCD Chief and the CCT Project Director maintain ongoing communication with internal and external partners to ensure successful implementation and administration of the CCT Project.

DHCS will submit any information contained in this protocol to the CHHS Agency Institutional Review Board (IRB), if appropriate, after CMS approves the protocol. This will eliminate the need to submit revised documents to the IRB at a later date.

Subsequent changes to the demonstration and the protocol must be reviewed by the project director and stakeholders, and approved by DHCS management and CMS. A request for change(s) must be submitted to CMS 60 days prior to the date of implementing the proposed change(s). All aspects of the demonstration, including any changes to this document, will be coordinated through the DHCS project office at:

California Community Transitions
Department of Health Care Services
Long-Term Care Division
1501 Capitol Avenue, MS 0018
P.O. Box 997413
Sacramento, CA 95899-7413

Phone: (916) 322-5253
Fax: (916) 552-9150
E-mail: California.CommunityTransitions@dhcs.ca.gov

A.2 Benchmarks

California will reach two required and three optional benchmarks to assess progress in transitioning inpatient facility residents to community living arrangements, as depicted in the data tables below. Through utilizing new transition planning procedures and expanding service options, the state will enhance availability of local HCBS providers and build infrastructure. The demonstration project team will have the opportunity to facilitate changes to statewide electronic systems and administrative practices across multiple HCBS, resulting in a larger number of informed consumers who can express and act on a personal preference for HCBS, in lieu of facility care. Each benchmark achieves minor and comprehensive system changes. Systems changes will go well beyond the demonstration period.

Benchmark #1 (required). The state will identify and enroll eligible Medi-Cal members according to the chart below during each year of the demonstration. Community-based organizations that have entered into contracts with DHCS, the CCTs project team members, and other state department partners may enroll CCT participants.

Target Group Members Successfully Transitioned

Calendar Year	Elderly	Develop-mental Disability	Physical Disability	Mental Illness	Dual Diagnosis	CY Total
Completed Transitions						
2008	0	0	2	0	0	2
2009	14	70	38	2	5	129
2010	45	95	61	6	24	231
2011	83	113	111	12	37	356
2012	103	149	226	4	***CATEGORY DISCONTINUED***	482
2013	127	138	224	2		491
2014	191	154	180	4		529
2015	193	87	205	9		494

Subtotal	756	806	1047	39	66	2714
2016	195	140	200	5		540
2017	205	140	240	5		590
2018	203	0	230	5		438
Subtotal	603	280	670	15	0	1568
Project Total	**1359**	**1086**	**1717**	**54**	**66**	**4282**

This operational protocol must be followed when enrolling and transitioning all participants. The state assumes oversight responsibility for the demonstration and will add additional CCT LOs to increase enrollment and ensure project benchmarks are met for each calendar year.

Benchmark #2 (required).

The chart below illustrates the state's annual benchmarks for total federal and state expenditures on HCBS during years 2005 – 2018, and for the demonstration period. Data will be gathered by date of payment. These benchmarks were based on past payments for NF/AH Waiver services, AIDS Waiver services, HCBS-DD Waiver services, MSSP Waiver services, ALW services, and IHSS.

Calendar Year by Date of Payment	HCBS Expenditures	Members Served
2005	$4,806,738,795.26 (Actual)	480,981
2006	$5,367,184,040.34 (Actual)	503,907
2007	$6,014,777,197.77 (Actual)	526,882
2008	$6,815,431,583.30 (Actual)	573,591
2009	$7,374,399,527.71 (Actual)	587,155
2010	$7,397,282,447.02 (Actual)	588,994
2011	$7.385,588,741.48 (Actual)	589,173
2012	$7,626,734,981.44 (Actual)	616,829
2013	$7,814,997,416.41 (Actual)	625,076
2014	$8,432,864,069.67 (Actual)	642,262
2015	$9,234,076,132.71 (Actual)	668,120
2016	$9,418,757,655 (Estimated)	
2017	$9,607,132,808 (Estimated)	
2018	$9,799,275,465 (Estimated)	
Data Source: MIS/DSS and DHCS Fiscal Forecasting and Data Management		

Benchmark #3 (optional).

Percentage increase in HCBS verses institutional long-term care expenditures under Medicaid for each year of the Demonstration.

Cost of HCBS spending versus the cost of institution-based care, and the percentage increase of HCBS over institutionalized care each year, pulled from annual claims data.

Year		Total Costs of Long-Term Care in California	Institutional Care		HCBS Care	
			Total Cost of Institutionalized Care	% of Long-Term Care Costs	Total Cost of HCBS Care in CA	% of Long-Term Care Costs
2009		$16,836,934,832	$5,363,251,144	31.85%	$11,473,683,688	68.15%
2010		$17,564,362,312	$5,455,844,534	31.06%	$12,108,517,778	68.94%
2011		$13,251,173,064	$5,866,237,180	44.27%	$7,384,935,884	55.73%
2012		$13,388,026,604	$5,761,291,623	43.03%	$7,626,734,981	56.97%
2013		$16,456,971,861	$6,057,839,758	36.81%	$10,399,132,103	63.19%
2014		$17,000,751,975	$5,930,540,820	34.88%	$11,070,211,155	65.12%
2015		$17,309,405,260	$5,588,539,528	32.29%	$11,720,865,732	67.71%
Projected	**2016**	$17,643,580,882	$5,272,207,102	29.88%	$12,371,373,780	70.12%
	2017	$18,031,765,310	$4,973,780,285	27.58%	$13,057,985,025	72.42%
	2018	$18,474,948,746	$4,692,245,552	25.40%	$13,782,703,194	74.60%
	2019	$18,974,289,968	$4,426,646,747	23.33%	$14,547,643,221	76.67%
	2020	$19,531,119,257	$4,176,081,837	21.38%	$15,355,037,420	78.62%

Data Source = MIS/DSS and DHCS Fiscal Forecasting and Data Management

Benchmark #4 (optional)

Increases in the utilization of transition coordinators used to assist individuals in Medicaid find appropriate services and supports in the community.

Number of organizations enrolled as CCT service providers within the Medi-Cal Provider Enrollment System.

								Projections		
CY	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
New LOs	10	6	6	0	1	9	7	*6*	*4*	*2*
Total LOs	10	16	22	22	23	32	39	*45*	*49*	*51*

Data Source = Provider Enrollment System

Benchmark #5 (optional)

Total number of CCT participants in managed care.

Interagency consumer and public/private collaboration (direct interventions by the state to achieve a higher level of collaboration with the private entities, consumer and advocacy organizations, and the institutional providers needed to achieve a rebalanced long term care system).

In addition to expanding the network of 1915(c) HCBS waiver service provider network, when MFP transitions end in 2018, CA proposes to redirect local CCT enrollment from CCT LOs to existing HCBS waiver programs and which will coordinate closely with MCPs who assume responsibility for the delivery of an integrated medical care coverage to enable the full continuum of care coordination. As an MFP grantee, CA will work towards building collaborations between these evolving MCPs in the phased-in counties and the HCBS providers currently serving as local MFP LOs. We will also work with these MCPs to formulate partnerships with the expanding California network of Aging and Disability Resource Centers and 1915(c) waiver service providers to continue to provide transition services to Medi-Cal members who wish to return to community living. We may be working with more than one MCP per county.

Measure #1 - Number of CCT participants enrolled in an MCP each year								
	Actuals					**Estimated**		
CY	2011	2012	2013	2014	2015	2016	2017	2018
						300	350	380
Data Source = MIS-DSS								

Section B. Demonstration Implementation Policies and Procedures

B.1 Participant Recruitment and Enrollment

Service Provider Selection

Community organizations that are interested in becoming CCT providers must submit a six point *CCT Lead Organization Provider Proposal*, before they begin the Medi-Cal provider application process (if they are not already a Medi-Cal HCBS provider). In the proposal, applicants are asked to respond to the following:

1. Describe your organization's capacity for keeping confidential participant data, recording team activities, and reporting to DHCS. Participant records storage and transactions must meet HIPAA standards.
2. List inpatient facilities within your proposed region with which a transition team could work.
3. Describe your organization's experience with facility transition work, independent living peer support of transitioning individuals, and/or de-institutionalization service planning. Identify any first-hand best practices that your team will bring to the Demonstration.
4. Describe the Demonstration population(s) your organization will serve. Additional information about the CCT target populations can be found in the CCT Operational Protocol, available on the DHCS website.
5. Describe how your organization will actively furnish transition candidates with an individualized search for affordable and accessible housing. Describe any existing local affordable housing initiative, clearinghouse, or inventory of single public housing units or accessible housing. Mention any shared housing match initiatives or programs and how the team will actively implement best practices in coordinating affordable housing with Medi-Cal HCBS services.
6. Describe your organizations' access to other funding sources for flexible, one-time funding of goods or services that could be used in transitioning facility residents. Flexible funding has been identified as a component of successful facility-to-home transitions, especially in the case of individuals who have been in inpatient facilities for six months or longer.

The CCT Project Director reviews all *CCT Lead Organization Provider Proposals* and directly follows up with organizations if and when there are any questions. After the Project Director has approved the proposal, organizations that are not enrolled as Medi-Cal service providers are instructed to begin the standard Medi-Cal application process.

Once approved by the Project Director and enrolled as a Medi-Cal service provider, DHCS enters into zero-dollar service contracts with community-based organizations that are authorized to provide CCT services outlined in the contract scope of work, and modified through DHCS-issued Policy and Guidance Letters. California currently contracts with 36 agencies contracted to provide transition and care planning services as CCT LOs.

CCT LOs work directly with the state project team to ensure transition team members receive adequate training to meet demonstration requirements and goals (see Appendix 6 for more information about CCT Training topics). The state project team provides on-going guidance to CCT LOs through bi-monthly roundtable conference calls, CCT Policy and Guidance Letters, and training materials and official CCT documents posted to the CCT webpage. In addition, CCT LOs maintain regular communication with their assigned state Nurse Evaluator and the CCT Project Director, as needed.

Participant Selection

The success of CCT LOs to identify and work collaboratively with Medi-Cal members who are eligible to enroll in CCT and who are interested in transitioning, depends in large part, on the working relationships their TCs build with area facilities. The state CCT Program has developed tools and information packets for LOs to utilize when working with potential CCT participants, but no amount of administrative structure can replace the front-line experience and knowledge of the TCs and facility staff.

The table included on the following page was created to illustrate the first two steps in the CCT Transition Process.

Revised CCT Transition Process

Steps	Deliverable(s)		State Approval	Outcome(s)	CCT Lead Organization Performance Measures
	Keep On-site	Submit to State			
1. **Outreach & Targeting** • Develop relationships with area SNF (building relationships with MCHPs is recommended, but not required) • Receive SNF referrals of residents requesting more information about community integration (MDS, Section Q)	• LO & MCHP contracts • MDS Referral Tracking Log	• ***CCT Monthly Event/Issue Report*** • ***Tracking Data Sheet for MDS 3.0 Section Q Referral Encounters***		Regional recognition & on-going business relationships; sustainable network of service providers	
2. **Information Gathering** • Conduct an initial interview with Medi-cal member • For interested members who sign the ***CCT Enrollees'/ Participants Rights & Responsibilities/ Consent Form & Authorization for Release of Protected Health Info.***, TC will collect records necessary to conduct local-level Clinical Assessment • ***Assessment Tool*** o RN completes clinical assessment of member • ***CCT Initial Transition & Care Plan*** o Developed with the majority of needs, services, & supports identified	• ***Authorization for Release of Protected Health Info*** • ***CCT Enrollees'/ Participants' Rights & Responsibilities/ Consent Form*** • ***24-7 Back-up Plan*** • ***Independent Housing Disclosure*** • *Copy of the signed Lease Agreement*	• ***CCT EI Form*** (submitted by email to CCT Inbox) — • ***INITIAL TAR*** Attach the following documents: o ***Assessment Tool*** o ***CCT Initial Transition & Care Plan*** o *Facility Face Sheet*	$908.60 "dollar amount" for TC (dollar amount is = to 20 hrs. of TC)	1. Member is enrolled in CCT, or LO informed additional information is required 2. LO will receive TC hours for work performed from the START of the Assessment Tool & if all documentation is provided, regardless of NEII approval; however, subsequent TARs will require an approved I-TCP	Ratio between the number of members who were referred to CCT, & the # of those individuals who signed the ***CCT Enrollees'/ Participants' Rights & Responsibilities/ Consent Form*** to enroll in CCT

Last Revised: 6-29-16

In collaboration with the CDPH and Nursing Facility Associations, the state CCT program has also distributed letters of support to facilities to inform them of the CCT program and encourage them to work with the CCT LOs in their area; and follow up information has been posted to CDPH's website, and included in association newsletters. [CDPH is CA's Survey and Certification Agency and is responsible for Nursing Facility licensing and performance audits.]

The state has also developed information packets and enrollment forms, including a clinical assessment tool for CCT LOs to utilize when working with potential CCT Enrollees. Enrollment forms include:

- CCT Enrollee Information Form
- Notice of Privacy Practices
- CCT Release of PHI
- CCT Rights, Responsibilities, & Consent
- Initial Transition and Care Plan
- CCT Home Set-Up Resource
- CCT Independent Housing Disclosure
- CCT 24-7 Backup Plan

The selection of Medi-Cal members for CCT enrollment begins with the federal MFP demonstration eligibility requirements, as specified in Section 6071 of the Deficit Reduction Act (DRA) of 2005. An "eligible individual" is someone:

(a) who, immediately before beginning participation in the MFP demonstration project--

(i) resides (and has resided, for a period of not less than [90 days]*) in an inpatient facility;*

(ii) is receiving Medicaid benefits for inpatient services furnished by such inpatient facility [for at least one day]*; and*

(iii) with respect to whom a determination has been made that, but for the provision of home and community-based long-term care services, the individual would continue to require the level of care provided in an inpatient facility and, in any case in which the State applies a more stringent level of care standard as a result of implementing the State plan option permitted under section 1915(i) of the Social Security Act, the individual must continue to require at least the level of care which had resulted in admission to the institution; and

(b) who resides in a qualified residence beginning on the initial date of participation in the demonstration project.

Please Note: *Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the 90-day period required under subparagraph (A)(i),* as noted in Section 2403 of the Patient Protection and Affordable Care Act (PPACA).

Verification that each enrollee meets MFP requirements is the responsibility of all CCT LOs that contract with DHCS to provide CCT services. By submitting the *CCT New Enrollee Information Form*, each LO verifies that they have checked and verified the individual's required Medi-Cal status and that the individual meets the MFP inpatient residency requirements. In addition, all LOs will be required to perform monthly Medi-Cal eligibility verification on all enrollees/ participants, to insure they remain eligible to receive ongoing services.

California residency and Medi-Cal eligibility of at least one day is re-verified by a state CCT nurse on receipt of enrollment packet with the submission of an initial Transition Coordination Treatment Authorization Request (TAR). The CCT new enrollee packet includes the following documents:

- CCT Assessment Tool (Clinical Assessment)
- CCT Initial Transition and Care Plan (I-TCP)
- CCT New Enrollee Information Form (NEI Form)
- Copy of Facility Face Sheet and Medications Sheet

A Medi-Cal Eligibility Data System (MEDS) report allows the state CCT nurse to view the initial date of Medi-Cal eligibility, and the current month's aid code, as well as the pending aid code and the aid code for the past 12 months. In addition, the code for the name of the Medi-Cal managed care plan under which the member is or may be receiving services is listed. This is important for verifying CCT eligibility, ensuring the member will retain eligibility upon discharge from the facility, and for connecting with payers of HCBS and LTSS.

Nurse Evaluator II (NE II) will review the facility face sheet to double check the new enrollee's 90-day minimum non-Medicare or rehabilitation period of institutional stay. The MEDS report shows if the individual is receiving FFS Medi-Cal or Managed Care Medi-Cal. If the individual is in a SNF paid by FFS Medi-Cal, the Treatment Authorization Request (TAR) System will contain a

TAR showing the inpatient number of days covered by Medi-Cal. This allows the NE II to verify the 90-day non-Medicare requirement.

California is in the process of moving away from providing fee-for-service (FFS) benefits to its Medi-Cal recipients to providing benefits covered by managed care plans. Under California's Medi-Cal Managed Care Expansion initiated in November 2013, 20 counties previously Medi-Cal FFS began providing organized health care delivery using managed care. For those individuals whose inpatient stay is being paid by Managed Care, the service requests are sent to and approved by the managed care plan instead of state Medi-Cal office. If the potential enrollee is covered by Medi-Cal Managed Care services, and more information is needed, the NE II will request the LO procure the documents needed to establish the 90 non-Medicare days of institutionalization.

Individuals who want transition assistance but do not meet the MFP – CCT enrollment requirements, will be referred to a local transition group, if they choose that option. Eligibility to enroll in the CCT Project is governed by the Deficit Reduction Act of 2005, Section 6071, "Money Follows the Person Rebalancing Demonstration".

Identifying Individuals Whose Preference it is to Transition

All CCT LOs specify the county and/or area(s) they will serve, and establish a working relationship with local inpatient nursing facilities therein. SNF residents receive information about the CCT from many sources, including but not limited to: general outreach; word-of-mouth from family or friends; discharge planners and social workers; regional center service coordinators; external LCAs; CCT marketing materials; etc. Although, most CCT enrollees are identified through outreach done by individual TCs, some CCT enrollees are identified through referrals from inpatient nursing facility staff based on their residents' responses to Section Q of the Minimum Data Set (MDS), version 3.0.

The MDS 3.0 is the clinical assessment component the SNF Resident Assessment Instrument (RAI) Medicare- and Medicaid-certified facilities are required to complete for every resident. The MDS 3.0 is comprised of many sections to assess residents' current health conditions, treatments, abilities, and plans for discharge over time.[6] Section Q of the MDS 3.0 is intended

[6] The MDS 3.0 is completed for every resident at the time of their admission to the facility, quarterly, annually, when there is a change in the resident's condition, and during discharge planning.

to explore meaningful opportunities for nursing home residents to set their own goals and to ensure all individuals have the opportunity to learn about HCB LTSS available in their community. To do this, every resident is asked, "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?" If and when the resident indicates that they would like to speak with someone about returning to community living, SNF staff are required to refer the individual to the DHCS-designated Local Contact Agency (LCA). Every CCT LO is designated, through the CCT LO Provider Contract, as an LCA responsible for responding to SNF referrals of residents who are interested in learning more about transition services and the resources, services, and supports that would be available to them in the community.

To augment SNF referrals to CCT LOs, DHCS piloted an effort to identify potential CCT enrollees within each LO's service area using MDS, Section Q data. Unfortunately, by the time the data went from the facility to the federal database, to CDPH (CA's authorized Survey and Certification Agency), over to DHCS, and out to the CCT LO TCs, the information was outdated and inaccurate. Every LO that participated in the pilot concluded that the relationships their TCs build with individual facilities bear much better results.

Transition Planning

Transition coordination begins weeks before the day of discharge and encompasses all the details, decisions, and events that need to happen to support the enrollee/ participant for the short and long term in a community setting. These components include, but are not limited to:

- Medi-Cal eligibility change
- Re-establishment of income maintenance (Social Security, SSI/SSP)
- Re-establishment of access to medical care in the community (Primary care physician, eye care, dental care, specialist(s), etc.)
- Housing search
- Transportation options for ongoing needs outside the home
- Formal and informal support needs and preferences
- Home set-up and readiness
- Availability and training for caregivers and paid and unpaid personal care attendants

- Level of self-direction desired by the participant
- Service types, service authorizations and provider types

The Transition and Care Plan (TCP) for each participant will vary depending on which sets of services s/he chooses. A full range of enrollees/participants preferences for service coordination and ongoing management will include choices among existing Medi-Cal waivers, programs, and state plan services.

CCT Transition Process

The CCT Transition Process consists of the following five phases. Each transition must adhere to these phases, but the actual steps may differ slightly, due to individual's situation and his/her transition and care plan needs.

1. Outreach and Targeting: LO will develop relationships with skilled nursing facilities and managed care health plans (MCHP).
2. Information Gathering: LO will conduct initial CCT Interview, perform/obtain a clinical assessment, and develop an initial transition and care plan.
3. DHCS Nurse Evaluator (NE) Review: NE will perform a clinical review of enrollee's Clinical Assessment and Initial CCT Transition and Care Plan, as supporting documents.
4. Implementation: LO will submit Final CCT Transition and Care Plan.
5. Follow-Up: LO will collaborate with other service providers to ensure a smooth transition to IHSS Social Worker, MCHP, or HCBS Case Manager; Review the Final Transition and Care Plan with the participant and address any needs and/or concerns during the 365 days of participation and prior to completion of demonstration period; and remind that the CCT project ends on day 366, but that existing services will continue as long as the person remains eligible for HCB Medi-Cal services.

Specific time frames have been built into each pre- and post-transition phase of this process, to insure that all enrollees receive continued contact and follow-up by the LO/ agency providing transition services to insure their service and skilled care needs are being met.

Health Care Assessment and CCT Transition and Care Planning (TCP)

As of October 01, 2015, per CCT Policy Letter PL #15-002, CCT LOs are required to secure the services of a Registered Nurse (RN), to conduct all medical, functional, and cognitive needs portions of the Consolidated ALW-CCT Assessment tool for an eligible Medi-Cal member. The RN must certify via signature that the assessment accurately identifies all medical, social, and psychosocial needs of the member. The purpose of the licensed RN is to help ensure that the TCPs address a member's needs to help mitigate risk and facilitate sustainable transitions. DHCS recognizes that there may be other clinical and service experts familiar with the Medi-Cal nursing facility population. Therefore, DHCS is providing an exemption to the non-RN staff within a lead organization, if they are able to meet ALL of the criteria included in the Competence Matrix attached to PL #15-002. Exemptions will be made on an individual basis and do not exempt all persons staffed by an LO, and renewed with each CCT LO contract.

Demonstration and Waiver Enrollment

Enrollees who meet the medical necessity requirement for one of the following existing HCBS waiver/programs, will be offered the option of applying, and if accepted, will begin to receive LTSS on the first day of waiver admission on or after the day of discharge from facility:

- Acquired Immune Deficiency Syndrome (AIDS) waiver
- Assisted Living Waiver (ALW) Program
- HCBS Waiver for the Developmentally Disabled (DD)
- Duals Demonstration (Cal MediConnect)
- Multipurpose Senior Services Program (MSSP)
- Nursing Facility/Acute Hospital (NF/AH) waiver
- Pediatric Palliative Care Waiver (PPC)
- Specialty Mental Health Consolidation (SMHC) waiver

Pending CMS Authorization

- Self-Directed Services/Developmental Disabilities Waiver (as of 05-03-2017)

HCBS Programs

- PACE
- SCAN

The services provided under Medi-Cal waivers and in state plan services are not standardized and all-inclusive. The Medi-Cal Waivers/Programs Chart in Appendix 2F describes the waivers and programs that are available to enrollees/participants, and Appendix 2E contains a chart listing the level of care for each of California's HCBS LTSS.

Enrollment into the Demonstration

Once an individual is enrolled in CCT, a state project team member will utilize the Client Identification Number (CIN) to track service authorizations and benefits, and enable LTCD to track all HCBS services provided under the demonstration.

During the 365 Days of Participation

When an enrollee transitions from the inpatient nursing facility to living and receiving services in the community setting, s/he will change their CCT Project status from an enrollee to a participant, per CMS policy. Information on services provided during the actual "participation" period will be found in Sections B.5 Benefits and Services and B.10 Continuity of Care Post Demonstration.

Readmission to Inpatient Facility during 365 Days of CCT Participation

The goal of service coordination and service monitoring is to avoid unscheduled emergency department visits and re-admissions to inpatient facilities by carefully managing or facilitating self-management of long-term disabilities and/or health conditions. Sometimes CCT participants who have not completed their 365 days in the MFP Program are readmitted into an inpatient nursing facility during that time.

All unscheduled emergency department visits and/or inpatient facility admissions, will be recorded on an Event/Issue form. These occurrences will be reviewed by the CCT TC, and if applicable, the HCBS waiver case manager (per waiver requirements), to determine if changes need to be made to the participant's TCP and Plan of Treatment (POT), to ensure his/her health and safety. Information on all Event/Issue occurrences will be listed on the CCT Monthly Event/Issue Report. The CCT Project Director will speak with each LO to discuss notable event/issues occurrences. [See Section B.8 for more information.]

Sometimes, CCT participants may need to be re-admitted to an inpatient facility for a scheduled visit to assist and/or improve their health status so they can stay living in the community. This type of admission may include treatment for an unexpected injury, requiring hospitalization.

Leave of Absence Hold Protocol

The goal of service coordination and service monitoring is to avoid unscheduled emergency department visits and re-admissions to inpatient facilities by carefully managing or facilitating self-management of long-term disabilities and conditions. All unscheduled emergency department visits and/or inpatient facility admissions, will be recorded on an Event/Issue form. These occurrences will be reviewed by the TC and/or waiver case manager or nurse (per waiver requirements), to determine if changes need to be made to the participant's TCP to ensure his/her health and safety.

Sometimes a CCT participant may need to be re-admitted to an inpatient facility. Unscheduled hospital admissions may be grouped into two categories: Injury and Medical, or Mental Health condition. Scheduled admissions may be required to assist and/or improve their health status so they can stay living in the community. This includes treatment for an unexpected injury, requiring hospitalization.

CCT Re-Enrollment Requirements

Re-enrollment requirements for CCT participants who are temporarily re-admitted to inpatient facilities during the 365-day demonstration period are determined by the length of their stay in the facility.

- When a CCT participant is re-admitted to an inpatient facility for a period of less than 30 days, the individual remains enrolled in CCT and the 365-day demonstration period begins where it was on the day the individual was admitted to the inpatient facility. No disenrollment process is involved.
- When a CCT participant is re-admitted to an inpatient facility for a period of more than 30 days, a new clinical assessment must be completed and a new TCP must be developed to ensure the individual's needs and preferences will be met in the community. Upon approval of the new TCP, the individual may re-enroll enroll in the MFP demonstration without re-establishing the 90-day institutional residence

requirement. S/he is eligible to continue to receive MFP services for any remaining days up to the maximum of 365 days of demonstration participation.

Waiver Re-Enrollment Requirements

- **Assisted Living Waiver (ALW)**

  If a demonstration participant enrolled in the ALW is admitted to an inpatient facility for greater than 30 days, s/he is dis-enrolled from the waiver. When discharge is planned, the ALW care coordinator will re-assess the participant's situation to determine any changes in care needs and that the participant's functional eligibility for the project meets the level of care determination as listed in the waiver.

- **Home and Community-Based Services Waiver for the Developmentally Disabled (DD)**

  If a demonstration participant enrolled in the DD waiver is admitted to an inpatient facility for between 24 hours and 120 days, their position on the DD waiver is placed on hold and the leave of absence is listed as a "short-term absence." The participant may return to receiving waiver services within the 120 days. If an absence extends beyond 120 days, the participant's eligibility for the waiver is terminated. When the participant begins the transition to the community again, s/he may reapply for the DD waiver again. Currently there is waiver capacity for demonstration participants, and for purposes of the demonstration, there will continue to be capacity as needed.

- **Multipurpose Senior Services Program (MSSP)**

  If a demonstration participant enrolled in the MSSP waiver is admitted to an inpatient facility for 30 days or longer, s/he will become dis-enrolled from the waiver. Once the participant begins the transition to the community again, s/he may reapply for the MSSP waiver. Currently there is waiver capacity for demonstration participants, and for purposes of the demonstration, there will continue to be capacity as needed.

- **Nursing Facility/Acute Hospital (NF/AH) Waiver**

  If a demonstration participant is admitted to an inpatient facility for greater than 30 days, a Notice of Action (NOA) is issued for one or more of the three following reasons: a) lack of accessing waiver services; b) no provider available; and c) no Plan of Treatment exists. For the remainder of the calendar year in which the participant was readmitted to a facility, s/he remains eligible to re-enter the waiver. If the participant is

in an inpatient facility over December 31 to January 1 of any year, s/he must re-apply to be on the waiver when beginning the discharge transition again. A 30-day closure notice will be issued to the participant.

Re-enrollment Requirements for CCT Participants into State Plan Programs

All CCT participants who are eligible for full-scope Medi-Cal may access any and all state plan services for which they have need, including inpatient facility services. If they dis-enroll from the demonstration, they are still eligible for Medi-Cal state plan services.

Re-enrollment Requirements for CCT Participants into Medi-Cal Managed Care Plans

All CCT participants who are eligible for full-scope Medi-Cal and enrolled in a Medi-Cal managed care plan (MCP), may access any and all managed care plan services for which they have need, according to the agreed upon Medi-Cal service contract. The MCP provides those services "carved-in" to their contract. All other Medi-Cal services "carved-out" will be provided under Medi-Cal fee-for-service.

Request for Transition Services Denied

Sometimes it is not possible to set-up a TCP that provides LTSS to supply the health and welfare needs for the enrollee to move to community living. If a resident's request to transition is denied, s/he or the surrogate decision maker, will receive a detailed explanation and a written NOA, accompanied by information on the enrollee's right for state hearing due to denial of services. Written information about how to file for a state hearing will be provided to each participant. This process is detailed in section B.6, and more information may be found in published CCT Guidance Letter(s) related to the Medi-Cal State Fair Hearing process.

Participant Loses Medi-Cal Eligibility

Occasionally, a Medi-Cal member may lose Medi-Cal eligibility at some point in the CCT enrollment or demonstration process. Sometimes, this is due to Medi-Cal renewal paperwork not being received by the enrollee/participant. Should this situation occur, the LO will assist the enrollee/participant in obtaining and submitting the appropriate paperwork to reinstate

Medi-Cal benefits. If reinstatement of benefits is delayed, or not possible, the LO will discontinue working with the individual and services will be stopped until Medi-Cal benefits are reinstated. If the individual is in the SNF, s/he will continue receiving inpatient services until the situation is resolved. If the participant is in the community, s/he will be provided with information on non-Medi-Cal LTSS, so s/he may make an informed decision about the service needs. If Medi-Cal services stop, a NOA will be issued.

Participant is Unable to Continue in Demonstration

On occasion, a participant may be unable to continue in the demonstration. In this case, the TC, or a member of the transition team, will meet with the participant or his or her decision maker, and family members to answer questions and provide closure. The TC or a transition team member will be available to assist the participant in the community setting in setting up needed non-CCT services.

Reasons for a CCT participant's inability to continue in the demonstration will vary, but the most common are health condition changes requiring inpatient skilled care needs, death of the participant, participant becomes Medi-Cal ineligible, or participant moves out of state.

B.2 Informed Consent and Guardianship

All CCT LO TCs and clinicians are responsible for providing information on all community transition options and HCB LTSS available to interested and eligible Medi-Cal members and, if applicable, their guardians/representatives, from the onset of the CCT process to facilitate informed decision making.

CCT LO TCs are also responsible for providing comprehensive and accessible information on:

- CCT Enrollee/Participants' rights and responsibilities
- The responsibilities of the CCT LO and TC to the Enrollee/Participant
- CCT services and available alternatives
- What to expect at each stage of the transition planning and implementation process
- Who they may include in the planning process (and that they are not required to include anyone without legal decision-making authority if they choose not to do so)
- Resources available to them during the 365 days of community living
- Options and requirements for HCB LTSS after the 365 days of participation ends

- Potential risk(s) associated with different choices
- And any other factor that may impact the Medi-Cal member participating in the demonstration and upon transition from a facility to the community

No decision will be made about transition services without the CCT Participant's active involvement (unless the individual states (s)he does not want to be involved); even when there is a legally-authorized agent or surrogate decision maker for health care decisions.

California Code of Regulations (CCR), Title 22, requires nursing facilities to document when a resident lacks capacity to make some or all health care decisions. In California only an individual's primary/attending physician is able to determine the degree to which he/she has capacity to make health care decisions for him/herself; however, only a court of law has the authority to determine that an individual is no longer capable of providing informed consent. It will be up to the transition coordinator to work with inpatient facility staff to determine which residents have authorized decision makers and what decisions they are authorized to make.

Ideally, everyone would have a valid Durable Power of Attorney (DPOA) for Health Care in which a surrogate decision-maker is identified to make health care decisions if/when a primary physician determines (s)he no longer has capacity to make decisions. However, DHCS acknowledges that there are instances in which there is no DPOA, guardian, conservator, or next of kin. It is in these instances CCT LOs must take extra care to protect the potential Enrollees' Civil Rights, and be mindful that some individuals will have cognitive limits that will require support and/or accommodation when obtaining informed consent.

Accommodating Disabilities to Support Informed Consent

Whenever there is a question about a Medi-Cal member's capacity to understand the implications of a decision that involves a significant risk, it is appropriate to involve a legally-authorized representative to ensure the individual's interests are protected. When there is no legally-authorized representative, CCT LO TCs must fulfill and protect the rights of potential CCT Participants to give or withhold informed consent for themselves, regardless of medical diagnosis.

California Health and Safety Code defines "Capacity" as the ability to understand the nature and consequences of the proposed medical treatment, including its risks and benefits; or when an individual is unable to express a preference regarding the treatment. (Probate Code 4609)

To obtain informed consent from inpatient facility residents with limited capacity (which, again, can ONLY be determined by the individual's primary physician), the CCT LO must incorporate supports and/or accommodations to ensure residents receive and understand the information they are provided. Supports/accommodations may include, but are not limited to, modifications to following factors:

- Location of the interview
- Time of day
- Primary culture and language of the resident
- Level of language and understanding of words (literacy)
- Adequate time to engage in conversation and to ask questions
- Clarity and sequence of questions and follow-up discussions
- Opportunity and desire to have (or not have) others present during the information and consent process

Individuals are "sufficiently informed of their rights" when they are aware of the:

- Proposed treatment, procedures to follow, and who will perform the treatment;
- Intended outcomes or benefits of the treatment;
- Possible risks of receiving/undergoing the treatment;
- Ramifications of refusing treatment;
- Alternatives to the treatment; and
- The voluntary nature of his or her consent.

It will be up to the lead organization to work with inpatient facility staff members to determine who has an authorized decision-maker, and what decisions they are authorized to make. In California, inpatient nursing facility staff members are not allowed to serve as guardians of individuals living in their facility.

B.3 Outreach/Marketing/Education

Outreach Strategy

CCT Outreach and Marketing will involve a two-fold process, CCT LOs will:

1. Educate inpatient nursing facility staff, county LTC ombudsman, and industry associations about CCT; and,
2. Disseminate marketing materials within their service area to increase public awareness about CCT.

DHCS delegates public outreach responsibilities to the CCT LOs because they are significantly more familiar with the cultural characteristics of the local communities they serve. DHCS provides general materials to the LOs, but historically, the most successful outreach efforts have been made by LO staffs who build strong relationships with facility staff and community organizations.

Each CCT LO is designated as an MDS 3.0, Section Q, Local Contact Agency (LCA). As such, CCT LO/LCAs receive referrals from inpatient facilities when a resident indicates (s)he would like more information about moving to, and receiving services in, the community. LCAs will provide Information & Referral (I&R) services to all residents of inpatient facilities, regardless of payer-source; and will utilize the face-to-face interviews as an opportunity to identify Medi-Cal members who meet CCT eligibility requirements. The LCAs who are not CCT LOs will provide information about the CCT Project to individuals when they are eligible to enroll.

Marketing Strategy

In 2014, DHCS worked with stakeholders to update the CCT marketing materials used to target consumers residing in long-term, in-patient facilities across the state. The intended audience includes: potential CCT participants, friends and family members of residents living in inpatient facilities, patients' rights advocates, SNF staff and administrators, and other community members and service providers. Within the marketing materials, the demonstration is presented as a way to learn more about alternatives to inpatient facility living. The language that is used is intentionally brief and provides a simple introduction to CCT, including eligibility requirements. The content of the materials is not specific to any subpopulation.

CCT Marketing Materials

All of the CCT marketing materials are available on the CCT webpage in English and Spanish: http://www.dhcs.ca.gov/services/ltc/Pages/CCT.aspx

CCT Marketing Materials include:

8.5 x 14	Brochures (tri-fold)
24 x 36	Posters

Brochure:

CCT LOs provide copies of the brochures to the residents, families, and significant others they meet within facilities. In many cases the CCT brochure is a resident's first exposure to CCT DHCS will provide LOs with the CCT brochures and the LOs will add their organization's contact information to the space provided on the back of the folded document. If residents, their family members or significant others are interested in learning more about CCT, they can choose to call the local organization, or send an e-mail inquiry to DHCS at California.CommunityTransitions@dhcs.ca.gov. Brochures will be distributed to facility residents and their families without regard to a person's current eligibility for the demonstration.

Posters:

Posters with acrylic stands and brochure holders will be included with each shipment of brochures to allow CCT LO staff to leave materials at facilities, county health departments, and with other community-based service providers who work with the target populations eligible to receive CCT services.

CCT Website

Information about CCT is available online at the following URL: http://www.dhcs.ca.gov/services/ltc/Pages/CCT.aspx.

The CCT website features:

1. A high-level overview of the program;
2. State and federal authority;
3. CCT LO Directory;
4. A copy of the CCT Operational Protocol;
5. CCT 2014-2016 Lead Organization Contract;

6. CCT Policy and Guidance Letters;
7. CCT Forms;
8. CCT Roundtable Meeting Minutes;
9. Information on how to become a CCT provider;
10. Training PowerPoint presentations;
11. Links to affiliated webpages, including:
    a. MDS 3.0, Section Q information and LCA directory,
    b. HCBS Advisory Workgroup, and
    c. ADRC Program.

LOs are encouraged to include a link to the CCT website on their organization and/or program's home page.

Cultural and Linguistic Considerations

DHCS plays a critical role in providing health care to the state's diverse cultural populations, and is committed to ensuring cultural competency training for state and local staffs that develop, administer, and evaluate health care services. California will continue to follow current state policies regarding the provision of bilingual and alternate format materials, and interpretation services to CCT enrollees and participants.

In California, "threshold language" means a language that has been identified in the Medi-Cal Eligibility Data System (MEDS) as the primary language for 3,000 Medi-Cal members in an identified geographic area, or five percent of the Medi-Cal population, whichever is lower. The identified threshold languages are Spanish, Hmong, Vietnamese, Cantonese, Mandarin, Armenian, Korean, Cambodian, Russian, Tagalog, Farsi, and Arabic (see Appendix 3).

All CCT forms and marketing materials are available in English and Spanish. DHCS will work with CCT LOs to translate materials into other threshold languages and alternative formats, upon request. CCT LOs and their transition teams will determine what formats are needed to ensure accommodations are made for individuals with various disabilities. In addition, sign language interpreters will be available at local presentations and training sessions, when requested.

Training Plans

Lead Organization Training

California currently has 36 LOs contracted to support CCT transitions from facilities to community living. All CCT Project training webinars and update on new CCT processes, procedures, and forms are available on the DHCS website for anyone unable to attend the training in person. New LOs will be trained by CCT Project staff as they are enrolled, and subject-specific training can be requested at any time. See Appendix 6 for links to the training modules available on the CCT website.

Other avenues of training include: issuance of CCT Policy and Guidance Letters, CCT webinars, and presentations during bi-monthly Roundtable teleconferences. Bi-monthly teleconferences, or Roundtables, began in 2009 so the CCT project team could speak directly with CCT LOs to provide updates and to facilitate the exchange of ideas. The Bi-monthly Roundtables serve as a forum for state CCT Project Team to receive feedback from CCT LOs. Each LO is encouraged to have a representative attend each Bi-monthly Roundtable, to ensure the quality/usefulness of the calls; and, Roundtable meeting minutes are posted to the DHCS website after each meeting for easy reference.

In February 2014, California began issuing CCT Policy and Guidance Letters to communicate new or revised policies, and to provide guidance on important issues. Every time a new policy is written or revised, the state sends a draft of the letter to CCT LOs for review and comment before moving forward with changes. Once feedback is incorporated and final changes are approved by management, an electronic copy of the finalized Policy Letter is sent to CCT LOs and posted to the CCT website.

CCT Guidance Letters are issued to clarify and/or expand upon existing policy, so drafts are not sent to LOs for comment. Like CCT Policy Letters, finalized Guidance Letters are sent to CCT LOs electronically, and posted to the CCT website.

Training for State CCT Project Staff

CCT Project Staff receives project training based on the CCT Policy and Guidance Letters, the revised CCT OP, and DHCS-LTCD changes. On-going training will be provided to NE IIs as the unit grows and the staffing needs change.

B.4 Stakeholder Involvement

DHCS has engaged stakeholders in California's MFP projects since September 2003 when CMS awarded the state a three-year Real Choice Systems Change Grant. The "California Pathways: Money Follows the Person" project focused on addressing the lack of a uniform process to identify interested inpatient facility residents who prefer community living.

On September 27, 2004, Governor Schwarzenegger issued Executive Order S-18-04, which directed CHHS to establish the Olmstead Advisory Committee (OAC) to inform the Administration's understanding of the current system of long-term care and provide leadership in developing future initiatives. The OAC consists of consumers, family members, providers, advocates, and state representatives who serve on a voluntary basis. The OAC meets for a full day approximately three times per year.

Stakeholder Involvement

DHCS is required by federal statute, SEC. 6071 [42 U.S.C. 1396a note] under the federal Medicaid MFP demonstration project to engage stakeholders, including consumers and family members, to provide meaningful, ongoing input to state policy makers.

DHCS is committed to engaging stakeholders, including consumers and family members, to provide meaningful, ongoing input to state policy makers. Since the original grant award in 2008, the composition of CCT's stakeholder group has gone through several iterations based on the evolution of the program.

However, the primary role of the stakeholders has always been to:

- Provide input on CCT policies and procedures to enhance transitions from institution to community settings; which includes CCT transition services managed care plans and the fee-for-service State Plan, and a variety of state waiver programs.
- Provide input on the development of monitoring procedures, continuous quality improvement, and changes to enhance the capacity and coordination among LTSS providers, care management organizations, housing providers, and Managed Care Health Plans; and

- Serve as ambassadors to promote expansion and increase the visibility of the CCT Demonstration and the statewide network of HCBS providers.

In the past, the LTSS Advisory Committee provided input to DHCS and CDA on the CCT and ADRC programs. However, in 2015 members determined that the group of over thirty (30+) stakeholders was too large to effectively provide informed and focused direction to the state on the CCT program and Sustainability Plan, as well as the Aging and Disability Resource Connection (ADRC) Program. As a result, members voted to stop meeting as a joint advisory committee, and to re-establish separate committees; one to advise the California Department of Aging (CDA) on the ADRC Program, and one to advise DHCS on the development and implementation of the CCT Sustainability Plan.

The CCT-focused members of the LTSS Advisory Committee emphasized the importance of involving stakeholders and subject-matter experts across state HCBS programs and beyond the development of the Sustainability Plan. Stakeholders recognized that five-year-plans often need to be updated and/or revised to meet the evolving needs and/or changing circumstances within a state over time, upon real-time implementation, and/or after assessing the success of the efforts through monitoring and oversight.

The LTCD is facilitating the work of multiple stakeholder groups providing input on HCBS Waiver renewals, the Statewide Transition Plan, in addition to the HCBS Stakeholder Advisory Workgroup convened to meet public input requirements for CCT. The goal of coordinating the work of different long-term care stakeholder groups is to leverage the insights, recommendations, and momentum of diverse groups of stakeholders with similar visions and goals to build a stronger network of HCBS providers.

The restructured CCT/HCBS Stakeholder Advisory Workgroup has been split into two specialized workgroups to make the most of the expertise of representatives with experience and knowledge relative to specific initiatives. The *HCBS Stakeholder Advisory Workgroup Charter* (see Appendix 7), includes an overview of the purpose of workgroup and a list of the members and their affiliations. All workgroup meetings will be held in person and members are encouraged to send a proxy representative, or to join by phone, if they are unable to attend. The composition of the two workgroups will be different to ensure subject-matter experts are included in the discussions and to provide the state with targeted and informed recommendations; though, consumers of Medi-Cal HCB LTSS will be included as advisors in both workgroups. Workgroup members from the first set of meetings will have the option to apply to participate in the second set of meetings. LTCD management will act as the liaison

between stakeholders, managed care plans, state leadership, and California's MFP Project Officer and Technical Assistance Lead. Current CCT staff will provide workgroup members with relevant policy guidance, institutional knowledge, and analytical support.

The primary goal of the June 2015 – March 2016 workgroup was to "Enhance CCT Delivery" to improve the quality of services provided to CCT enrollees and participants through 2019. The goal of the March 2017 – September 2017 workgroup will be to identify CCT best practices to integrate in HCB programs beyond the end of the MFP grant. DHCS will vet and utilize stakeholder recommendations to strengthen the state's existing 1915(c) HCBS waivers through waiver renewals and the State Transition Plan. The State is committed to ongoing stakeholder dialogue with the ultimate goal of identifying the most effective waiver structure for providing the highest level of quality of care, community integration, independent living, quality of life, and availability of providers and services for CCT participants. DHCS is confident that the additional structure and focused input of the specialized workgroups will provide the state with an appropriate level of Stakeholder input on the phase-out of CCT and the future of California's network of HCB LTSS available to Medi-Cal members who wish to transition from institutions to live and receive services in the community.

B.5 Benefits and Services

California's HCBS Delivery Systems

Based on the county in which an individual resides, (s)he may receive transition planning and HCBS through one of two Medi-Cal delivery systems: fee-for-service, or managed care.

The state Medi-Cal program and the federal Medicare program partnered to launch a three-year demonstration project to coordinate care for individuals who are dually eligible for both Medi-Cal and Medicare (dual-eligible). This project, the Coordinated Care Initiative (CCI), will take place in seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Under CCI, nearly all Medi-Cal members age 21 and older, including dual-eligible members, are required to join a Medi-Cal MCP to receive their Medi-Cal benefits.

Dual-eligible members can choose to receive LTSS benefits in one of two ways:

1. ***Cal MediConnect:*** A voluntary three-year demonstration program for Medicare and Medi-Cal dual eligible members will coordinate medical, behavioral health, long-term institutional, and home- and community-based services (HCBS) through a single health plan.

2. ***Managed Medi-Cal Long-Term Supports and Services (MLTSS):*** In addition to their Medi-Cal MCP benefits, members who choose not to enroll into Cal MediConnect will receive LTSS via Medi-Cal MCP.

The goal of Cal MediConnect is to improve care coordination for dual-eligible members and provide high quality care that helps people stay healthy and in their homes for as long as possible. Additionally, shifting services out of institutional settings and into the home and community will help create a person-centered health care system that is also sustainable.

Dual-eligible members who opt-out of Cal MediConnect are required to join a Medi-Cal MCP to receive their Medi-Cal benefits, including LTSS.

The services available through Cal MediConnect include all Medicare benefits, ranging from doctor visits to prescription drugs, all current Medi-Cal Managed Care benefits, and Medi-Cal LTSS.

LTSS benefits include:

- Short-term and long-term nursing facility care;
- In-Home Supportive Services (IHSS);
- Multipurpose Senior Services Program (MSSP);
- Community-Based Adult Services (CBAS); and
- Care plan options that could include the following home- and community-based plan benefits:
    - In-home and out-of-home respite;
    - Nutritional assessment, counseling, and supplements;
    - Minor home or environmental adaptations, habilitation, and other services that may be deemed necessary by the Cal MediConnect Plan, including care coordination.

Members who are enrolled in the HCBS Waivers listed below are excluded from passive enrollment into Cal MediConnect. If a member is enrolled in a HCBS Waiver and would like to enroll in Cal MediConnect, he or she must first disenroll from the HCBS Waiver before joining Cal MediConnect.

- Nursing Facility/Acute Hospital (NF/AH) Waiver
- HIV/AIDS Waiver
- Assisted Living Waiver

- Home and Community-Based Services for the Developmentally Disabled (HCBS-DD) Waiver

CCT within Cal MediConnect Counties

CCT transition services is available to Medi-Cal members under both Cal MediConnect and MLTSS. People's needs and preferences will drive the care they receive regardless of the system under which they receive their Medi-Cal benefits.

In CCI counties, CCT Lead Organizations (LOs) have the option to contract with MCPs to provide comprehensive transition planning, implementation, and follow-up services to Participants. Since MCPs are familiarizing themselves with providing MLTSS, CCT LOs offer a wealth of knowledge about transition coordination and community-based services and supports available to Medi-Cal members living in long-term care institutions who wish to return to the community.

CCT LOs will continue to bill the state fee-for-service reimbursement system for pre-transition home set-up and post-transition services. Since MCPs are at full risk for institutional long-term care, and some HCBS; CCT LOs will need to coordinate HCBS and person-centered planning with MCP case managers in CCI counties. Depending on a CCT Participant's eligibility in Medi-Cal or Medicare, the MCP will be responsible for more than just the MLTSS portion of the participant's care plan.

CCT Service Package

There are multiple approved HCBS service planning models in use in California under an array of waivers and Medi-Cal state plan services designed for diversion from inpatient facilities. However, most do not include coordination of housing searches, income maintenance, and transportation. The services provided under CCT are comprised of seven service areas that build the foundation for a successful transition. Not all of the categories include Medi-Cal services, but all are necessary to provide the support for a safe community environment based on each participant's unique needs and circle of community supports.

The comprehensive **Long-Term Services and Supports** list includes:

Health Care Services

- Plan of treatment
- Nursing care services
- Nutrition services
- Allied health and therapies
- Durable medical equipment and supplies

Supportive Services

- Family and friends
- Personal attendants
- Emergency back-Up
- Housing
- Transportation

Social Services

- Peer support and mentoring
- Recreational, cultural and spiritual connections

Environmental Services

- Home and vehicle adaptation
- Assistive technology
- Household set-up

Education and Training Services

- Independent living skills and life skills development
- Caregiver training and management
- Emergency planning

Financial Services

- Medi-Cal codes
- Money management
- SSI/SSP payments

Other Services

- Demonstration
- Employment
- Supplemental

The CCT transition and care plan (TCP) is more than a medical plan of treatment, and more than a paper with phone numbers of social services available to those in the community. It is a living document that is continuously revised in response to changes in a Participant's health status and situational needs. Periodic re-assessment of CCT Participants' needs and preferences will take place throughout the 365-day demonstration period to accommodate ongoing needs. And ongoing care coordination will be provided to ensure beneficiary support after discharge, and to prevent poor health outcomes, such as repeated hospitalizations, serious illnesses, re-institutionalizations, and even death.

CCT transition and care planning is directed by the Medi-Cal member and his/her legal representative, if applicable. The Medi-Cal member plays a major role in defining his/her needs and in selecting the LTSS to be put in place. Overall responsibility for the development of each

person-centered TCP is shared by the Medi-Cal member and/or legal representative, his/her circle of support, the TCs, and other transition team members.

Creating a Transition and Care Plan (TCP) is the foundation of the transition process and is created using the Medi-Cal member's assessment of skilled care needs. Medical care orders are determined by the physician and incorporated in the TCP. The TCP is signed by the Participant and/or the Participant's legal representative, and the CCT LO's TC and RN. The TCP then becomes a living document to ensure the Participant's needs continue to be met in the community.

HCBS Waivers and Programs

DHCS administers or monitors multiple HCBS waivers to provide necessary services and supports to different sub-populations of Medi-Cal members in a variety of community-based settings instead of in inpatient facilities.

One of the CCT NE's roles in the pre-transition process is to ensure participants are enrolled in an appropriate waiver, as determined by their skilled care and service needs.

California currently has the following approved waivers (refer to Appendices 2A and 2F for additional information on services provided under each):

- 1915(c) Home and Community-Based Services (HCBS) Waivers
  - Acquired Immune Deficiency Syndrome (AIDS)
  - Assisted Living Waiver (ALW) Project
  - HCBS Waiver for the Developmentally Disabled (DD Waiver)
  - Multipurpose Senior Services Program (MSSP)
  - Nursing Facility/Acute Hospital (NF/AH)
  - Pediatric Palliative Care Waiver (PPC)
- 1115 Demonstration Project Waivers
  - Medi-Cal 2020 (Cal MediConnect)

State Plan Services

California offers many Medi-Cal state plan optional benefits. The state will continue to receive regular FMAP for provision of these services to demonstration enrollees/participants:

1. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program – applies only to full-scope eligible persons under 21 years of age.
2. Supportive services: Sign language interpretation
3. Prevention and health teaching, e.g., smoking cessation
4. Prosthetic and orthotic appliances
5. Durable medical supplies and equipment – purchase and/or rental
6. Non-emergency medical transportation
7. Mental health services
8. Medical supplies (includes incontinence supplies)
9. Oxygen
10. Ventilator (rental)
11. Other more commonly utilized services not billed through a home health agency, such as physician; dentist; outpatient clinic services such as dialysis and wound care clinics; physical, occupational, or speech therapy; acupuncture; family therapy; and MSW services.

The following optional state plan benefits are also available to demonstration participants:

Community-Based Adult Services (CBAS)

Adult Day Health Care (ADHC) centers offer health, therapeutic and social services in a community-based Skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals, and transportation are provided in an outpatient setting to Medi-Cal beneficiaries who are 18 years of older and meet the CBAS-eligibility criteria. The services are designed to keep recipients as independent as possible in a community setting. This service may be an option for some CCT enrollees/participants.

Home Health Agency Services

Intermittent skilled nursing care services provided through HHAs: registered nurse; licensed vocational nurse; licensed therapist (physical, occupational, and speech); social worker;

home health aide; psychology services; infusion services; hospice; and medical supplies, equipment, and appliances.

Personal Care Services

Personal care services (PCS) are an optional Medi-Cal benefit provided in every county of the state. The PCS Program is generally referred to as In-Home Supportive Services (IHSS). PCS is open to all eligible members who are at risk for placement in an inpatient facility because they are unable to remain safely in their own home without assistance; there is no enrollment cap. Services offered include housekeeping and supportive tasks such as laundry, shopping, meal preparation, and light housecleaning. PCS also includes assistance with eating, bathing, and mobility assistance; transportation to and from medical appointments; and paramedical services ordered by a physician. Currently, county staff members determine a member's program eligibility, the number of hours, and type of services approved to meet each individual's needs. The maximum number of monthly PCS hours that can be authorized is 283 hours, depending on the level of need.

IHSS is a self-directed program allows members to hire and manage their own caregivers. The pool of trained personal care services providers has grown over the past few years as the demand for their services has increased. With the expansion of IHSS, there are more opportunities for eligible, qualified individuals to be hired, trained, and serve as personal care workers (including enrollees'/participants' family members and friends).

Demonstration Services

CMS allows states to test ideas for potential program changes through demonstration projects. The purpose of demonstrations is to "… study the likely impact of new methods of service delivery, coverage of new types of service, and new payment approaches on beneficiaries, providers, health plans, [and] states..."[7] Because CCT is a demonstration, DHCS was able to modify services provided by existing HCBS waiver programs to determine if greater flexibility would enhance the members' health and safety in the community. CCT demonstration services include:

1. Pre- and Post- Transition Coordination

[7] CMS.gov. https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/index.html

2. Home Set-Up
3. Home Modification
4. Habilitation
5. Personal Care Services
6. Family and Informal Caregiver Training
7. Vehicle Adaptations
8. Assistive Devices

Demonstration services are available to members based on individual need for 365 days after the day of transition with the goal of helping them integrate back into the community. Demonstration services are identified in each participant's TCP, which is monitored to ensure unidentified need(s) continue to be met throughout the entire 365-day demonstration period.

The grid in Appendix 2F shows the HCBS services in the California State Plan and existing waivers that are available to CCT enrollees and participants.

<table>
<tr><th colspan="3">DEMONSTRATION SERVICES</th></tr>
<tr><td>Transition Coordination</td><td colspan="2">Transition Coordination is care management provided to transition an eligible member from a health facility to a home and community-based setting. Services include identifying, organizing, managing, and monitoring the appropriateness and quality of the services included in the TCP to ensure the health and safety of the CCT participant in the community.
Transition Coordination services can be approved for three phases: transition planning, coordination, and follow-up.</td></tr>
<tr><td colspan="3">Pre-Transition Services
The enrollment TAR allows for 20 hours of transition coordination for interviewing a potential enrollee, conducting a clinical assessment, developing a person-centered Initial-Transition and Care Plan (I-TCP), and all enrollment paper work, to determine if LTSS are available for the individual’s proposed transition to be successful.</td></tr>
<tr><td>Service Code</td><td>Approval Status</td><td>Rate Range</td></tr>
<tr><td rowspan="2">G9012 U6</td><td><u>Approved</u>[8] Enrollment:
Pre-Transition Coordination</td><td>Fixed amount of $908.60</td></tr>
<tr><td><u>Denied</u> Enrollment:
Pre-Transition Coordination</td><td>$45.43/hour x number of hour worked, up to 20 hours</td></tr>
<tr><td colspan="3">Transition and Care Planning Services
TAR for 100 hours is submitted to set-up the proposed HCB LTSS included in the approved I-TCP. More hours are available with documented justification.</td></tr>
<tr><td>Service Code</td><td colspan="2">Rate Range</td></tr>
<tr><td>G9012 U6</td><td colspan="2">$45.43/hour, up to 100 hours</td></tr>
<tr><td colspan="3">Post-Transition Services
TAR for follow-up hours after transition to work with participant to ensure needed LTSS are in place. More hours are available with documented justification. Initial approval of hours will be based on type of housing chosen by enrollee and services provided with that housing. More hours are available with documented justification.</td></tr>
<tr><td>Service Code</td><td colspan="2">Rate Range</td></tr>
</table>

[8] Enrollments are “approved’ when the members’ risks and needs are identified and addressed in the TCP to ensure a safe and sustainable transition.

G9012-U6	$45.43/hour x number of hour worked and based on type of housing
Service Boundaries – If the participant is enrolled in an HCBS waiver, CCT allows up to 100 hours of Post-Transition Coordination **in addition to** the services received under the waiver. If the participant is not enrolled in an HCBS waiver, up to 100 hours of Post-Transition Coordination may be provided.	

DEMONSTRATION SERVICES	
Wellness Assessment	**Quality of Life (QoL) Surveys** Assessment used to evaluate the quality of life individuals experience after they have transitioned into the community, as compared to their quality of life prior to transitioning. As of June 1, 2016, the Baseline survey was no longer eligible for reimbursement. QOL surveys are conducted two times per beneficiary. The first follow up QOL is completed 11 months after the day of transition and the second follow up QOL is completed 24 months after the day of transition, *even if participant has returned to an inpatient nursing facility* NOTE: As of January 1, 2017, first and second follow-up QOL Surveys will no longer be eligible for reimbursement.
Service Code	Rate Range
S5190 TS	$100.00 per survey (maximum of 2 x transition)
Service Boundaries – Not to exceed a lifetime maximum of two per participant transition.	

DEMONSTRATION SERVICES	
Habilitation	Habilitation is coaching and life skills development / training for the individual to learn, improve, or retain adaptive, self-advocacy, and/or social skills, as identified in the TCP. Helps to support successful transitions and improved quality of life in the community.
Pre-Transition Services	
Service Code	Rate Range

T2017 U6	$11.36 per 15-minute increment for an agency provider, up to 15 hours
Post-Transition Services	
Service Code	Rate Range
T2017 U6	$11.36 per 15-minute increment for an agency provider, up to 50 hours
Service Boundaries – If the participant is enrolled in an HCBS waiver, CCT allows up to 50 hours of habilitation in addition to habilitation services received under the waiver. If the participant is not enrolled in an HCBS waiver, up to 50 hours of habilitation may be provided.	

DEMONSTRATION SERVICES	
Personal Care Services	Personal care services are supportive services to assist an individual to remain at home and include assistance to independent activities of daily living and adult companionship. Post-transition personal care services may only be provided to Participants by LOs before In-Home Supportive Services (IHSS) is in place.
Service Code	Rate Range
T1019 U6	**$45.44 per 1-hour session, or $11.36/ 15 min session.** This is the rate used in the NF/AH waiver.
Service Boundaries: Not for an inpatient or resident of a hospital, nursing facility, Intermediate Care Facility/Mental Retarded (ICF/MR) or Institution for Mental Disease (IMD). Part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant). Approval is contingent on prior DSS approval of specified IHSS hours of service.	

DEMONSTRATION SERVICES	
Family and Informal Caregiver Training	One-on-one individually tailored sessions conducted in person or electronically by an approved trainer, to assist caregivers in developing the skills and gaining the knowledge they need to enhance a participant's health, nutrition, and/or financial literacy. Examples include, but are not limited to, daily care management, fall prevention, coping skills, emergency response and long-term care planning.

Service Code	Rate Range
S5111 U6	**$45.44 per 1-hour session**
Service Boundaries – If covered under an existing waiver chosen by the participant, the demonstration service provides for service provision in addition to that covered by the waiver, not to exceed 50 hours. If not covered under a waiver chosen by the participant, the demonstration service provides for up to 50 hours.	

DEMONSTRATION SERVICES	
Home Set-Up	Non-recurring set-up expenses for goods and services included in a CCT enrollee's Transition and Care Plan (TCP). Household set-up goods and services are available to CCT enrollees who will be directly responsible for their own living expenses when they transition to community living.
Service Code	Rate Range
T2038 HT	**Up to $7,500**
Service Boundaries – If home set-up is covered under an existing waiver chosen by an Enrollee, CCT covers the difference between what is covered under the waiver and the identified home set-up need(s) of the Enrollee, not to exceed $7,500.00, as long as the services do not duplicate those provided under the waiver.	

DEMONSTRATION SERVICES	
Home Modification	Environmental adaptations to a participant's home identified in the comprehensive service plan, including, but not limited to, grab-bar and ramp installation; modifications to existing doorways and bathrooms; installation and removal of specialized electric and plumbing systems.
Service Code	Rate Range
S5165 HT	**Cost not to exceed $7,500.00.**
Service Boundaries – If covered under an existing waiver chosen by the participant, the demonstration service covers the difference between what is covered under the waiver and the identified need, not to exceed $7,500. If not covered under a waiver chosen by the participant, the demonstration service provides up to $7,500.	

DEMONSTRATION SERVICES	
Vehicle Adaptations	Devices and controls required to enable demonstration participants and/or family members and caregivers to transport participants in their own vehicles. It must be documented in the comprehensive service plan how these items will sustain participants' independence or physical safety, and allow them to live in their homes. Includes but is not limited to installation and training in the care and use of these items.
Service Code	Rate Range
T2039	**Cost not to exceed $12,000**.
Service Boundaries – If covered under an existing waiver chosen by the participant, the demonstration service covers the difference between what is authorized under the waiver and the identified need, not to exceed $12,000. If not covered under a waiver chosen by the participant, the demonstration service provides for up to $12,000. Approval is contingent on denial from all other potential funding sources.	

DEMONSTRATION SERVICES	
Assistive Devices	Adaptive equipment designed to accommodate a participant's functional limitations and promote independence, including, but not limited to, lift chairs, stair lifts, diabetic shoes, and adaptations to personal computers. The need for items must be documented in the comprehensive service plan with an explanation of how they would prevent elevation to a higher level of care or return to an inpatient facility.
Service Code	Rate Range
T2028	**Cost not to exceed $7,500.**
Service Boundaries – If covered under an existing waiver chosen by the participant, the demonstration service covers the difference between what is covered under the waiver and the identified need, not to exceed $7,500. If not covered under a waiver chosen by the participant, the demonstration service provides for up to $7,500. Approval is contingent on denial from all other potential funding sources.	

No supplemental services are proposed at this time.

Home and Community-Based Services / End of CCT Participation

CCT follow up services end when a participant's demonstration period is over after 365 days in the community. However, as long as the member remains eligible for Medi-Cal (s)he will continue to receive the HCB LTSS that were put in place to sustain him/her in the community. In addition, at the end of the demonstration period, CCT participants will have transitioned into community-based residences, purchased needed household items and assistive devices, secured paid and/or unpaid caregivers and health care providers, and received training and support to sustain themselves in the community.

California intends to continue to work with stakeholders to identify and adapt the best practices identified in the MFP Rebalancing Demonstration for future Medicaid HCBS waivers, renewals, and amendments. To date, stakeholders have expressed interest in the following:

1. Statewide training on person-centered planning
2. Greater flexibility in household set-up reimbursement
3. Less-burdensome authorization and payment structures that allow providers to meet the immediate needs of Participants, in real time
4. Improved cross-discipline collaboration

Finally, as one of the leading states in demonstrating the value of managed care delivery systems providing cost-effective coverage of the Medicaid population, California has shown that managed care is a viable option for members of all ages and health conditions. Currently, over 80% of all Medi-Cal members are enrolled in managed care. In addition, MCP support is growing as the plans become more familiar with HCB LTSS provided by community-based organizations serving members outside of the acute care medical network. California remains committed to providing long-term services and supports to Medi-Cal members in the least restrictive setting of their choice through the oversight and guidance provided by the State's Olmstead Advisory Committee, ADRC Stakeholder Committee, California's HCBS waivers, and the Medicaid Health Home State Plan Option[9].

[9] California's Medicaid Health Home State Plan Option is intended to provide supplemental services that coordinate the full range of physical health, behavioral health, and community-based LTSS needed by beneficiaries with chronic conditions.

B.6 Consumer Supports

Consumer supports are a fundamental part of the CCT planning process. Each service an enrollee/participant chooses becomes a building block in the framework that makes up the TCP.

It is unreasonable to list the myriad home and community-based programs and services available within California because communities are diverse in size, geography, culture, primary languages, economics, social supports, health care networks, housing and transportation options, and other demographic features. [Section B.5 lists some of the LTSS available to enrollees/participants.]

CCT enrollees/participants play the major role in planning and defining their post-transition services which will be documented in their TCP. The process begins with his or her circle of support, if there is one, and the transition coordinator who works with the transition team to make contact with various chosen LTSS agencies.

Transition coordinators will provide CCT enrollees/participants with informational packets that include local resources and other specific information related to the demonstration.

- Medi-Cal LTSS available to participants during and after the demonstration period.
- Non-Medi-Cal LTSS not provided by the demonstration (for example, ongoing rent, income, support, and food, etc.).
- Roles and responsibilities of the transition coordinator, waiver case manager, and other service coordinators
- Enrollee/Participant roles and responsibilities
- Emergency telephone numbers and what to do in various types of emergencies
- Situations that may result in suspension from receiving CCT services or termination of demonstration services.

<u>24-Hour Back-up Systems</u>

Every CCT Enrollee is required to have a comprehensive 24-hour backup plan by the time they transition to the community. In April 3, 2013, CMS released Policy Guidance Letter "MFP Quality Requirements" to clarify MFP grant requirements for 24-7 community living backup plans. In that policy guidance letter, CMS confirmed that 24/7 backup plans improve participants' safety in the community and reduces recidivism by ensuring every individual who moves out of a 24/7 full-care environment has reliable supports in the community. For many

states, the requirement was easily met through pre-existing 24/7 non-emergency assistance hotlines available throughout the entire state. Regrettably for California, the most populous state in the nation (our state contains more people than the 21 least populous states combined), creating, funding, and staffing a 24/7 hotline to serve the entire state was well beyond the capacity of the MFP grant. However, CCT enrollees who are transitioned into one of the state's HCBS waivers receive the backup services identified in the chart below.

Waiver / Program	Description	Response	% of CCT Population
AIDS Waiver	Provides HCBS to Medi-Cal members with mid- to late-stage HIV/AIDS disease as an alternative to nursing facility or hospital care.	No mandatory backup plan is required (since it is not a state plan service); but most waiver agencies staff 24/7 on-call case managers.	> 1%
Assisted Living Waiver (ALW)	Provides HCBS as an alternative to long-term nursing facility placement to Medi-Cal members over the age of 21 in either of two settings: an assisted living facility (ALF); or in Publicly Subsidized Housing (PSH) with an HHA providing the assisted care services.	ALW facilities are required to have 24-hour staffing, and 24-hour accessible call systems in each room.	28%
Cal Medi-Connect	Fully-integrated managed Medicare and Medi-Cal delivery system through local managed care health plans. Serves persons 21-years and older who are dually-eligible for both Medicare and Medi-Cal.	Medicare is required to have a 24/7 nurse advice line available to members.	Beneficiaries enrolled in Cal Medi-Connect are included in the Medi-Cal Managed Care % on the following page
Medi-Cal Managed Care	Provides high quality, accessible, and cost-effective health care through managed care	Contracted service providers must ensure that a Member needing Urgent Care is seen within 24 hours	33%

Waiver / Program	Description	Response	% of CCT Population
	delivery systems (established networks of organized systems of care) that emphasize primary and preventive care.	upon request; and that a Physician (or an appropriate licensed professional under his/her supervision) is available for after-hours calls.	
DD Waiver	Provides HCBS to Regional Center consumers with developmental disabilities, enabling them to live in the community rather than in an intermediate care facility for the developmentally disabled (ICF/DD), or State Developmental Center.	Yes, 24/7 backup for each Regional Center.	20%
In-Home Supportive Services (IHSS)	In-Home Supportive Services (IHSS) refers to a variety of non-medical personal care, paramedical, domestic, and other attendant care services offered to Medi-Cal eligible beneficiaries who have a "chronic, disabling condition that causes functional impairment that is expected to last 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services."	No overall backup; Public Authority will help replace worker during normal business hours.	33%

Waiver / Program	Description	Response	% of CCT Population
NOTE: The CCT Population percentages included in this table should be read independently (not as a part of the whole). Many beneficiaries are eligible for, and receive, multiple services. For example – a CCT Enrollee receiving care under a Managed Care Health Plan may also receive IHSS.			

Because there is a patchwork of services providing 24/7 backup to the majority of CCT participants, State CCT staff worked closely with CMS and California's assigned Technical Assistance Lead to create a tool that would fill-in the gaps for participants who did not receive waiver or managed care services after transitioning to the community. The tool is available on the CCT webpage located at: http://www.dhcs.ca.gov/services/ltc/Documents/extdCCT24-7Back-UpPlan3-08-16.pdf.

In addition to requiring a backup plan for every CCT Enrollee prior to transitioning to the community, the CCT TC must ensure:

1. A copy of the most-current 24/7 backup plan is provided to the CCT Participant and is posted/kept in an accessible location near the telephone inside the Participant's home.
2. A copy of the most-current 24/7 backup plan is included in every CCT Participant's case file.
    - If the individual receives 24/7 backup through a waiver or managed care plan, the CCT Transition Coordinator (TC) must secure documentation on the plan from those service providers to include a copy in the participant's care file.
3. The tool is discussed, in-depth, with every CCT Enrollee to provide everyone with additional resources and a better understanding of the ways in which their life will be different in the community.
4. Development of the backup plan is person-centered and assembled with the CCT Enrollee, and/or the CCT Enrollee's legal representative.
    - This requires the TC to actively engage beneficiaries in discussions about the risks and/or challenges (s)he may face post-transition, and about how to manage those risks through the development of a strong network of support.
        - Some people will not need to include a phone number for every service listed in the tool, but every person must have a comprehensive plan that meets his/her individualized needs.

- Handing a completed list of phone numbers to a CCT Enrollee is not sufficient. The open, supportive, and informative dialogue between the TC and the individual is the greatest determining factor in the success of a useful and reliable 24/7 backup plan, and potentially, in the success of a sustainable transition.

5. The 24/7 backup plans are reviewed and discussed at every follow-up meeting with the Participant, both face-to-face and by phone.
    - Follow-up discussions must include direct questions about how often the Participant uses his/her plan, and if the plan continues to meet the Participant's needs.
6. Copies of the most recent 24/7 backup plans are made available to state CCT staff upon request and during on-site monitoring and oversight visits.

For emergency situations, 9-1-1 is the option of choice. For non-emergency situations, participants are instructed to call their CCT TC during regular business hours.

With California's move to provide Medi-Cal services under MCPs, connecting CCT participants with a live person available for 24/7 backup has become much more feasible. All CCT participants enrolled in a MCP are able to contact the plan's emergency back-up system. Advice hotlines are the most-common method through which MCPs respond to their members' needs "after hours".

<u>Complaints about Failures of Back-Up Systems</u>

The *24/7 Backup Plan* is designed to provide the participant with resources to utilize in a variety of situations that might occur after transition. However, if at any time during the 365-day demonstration period, the back-up plan does not help the Participant contact someone able to assist them with their problem, the Participant should notify his/her TC as soon as possible. TCs are responsible for monitoring the effectiveness of the backup plan and for making modifications to the plan, as needed.

All incidents in which a Participant's backup plan fails to meet his/her need(s) must be documented and reported in the *Quarterly Event/Issue Report Form* the CCT LOs complete and submit to the state. The state CCT staff use the information in the *Quarterly Event/Issue Report*

Form to track common occurrences to help CCT LOs prevent the same or a similar occurrence in the future.

Complaint and Resolution Process

CCT Participants are informed of their right to a Medi-Cal state hearing prior to enrolling in CCT and any time there is a change in their services, and are provided an informational brochure on how to file a request for a Medi-Cal state hearing. Medi-Cal members, CCT Enrollees/Participants, and/or their legal representatives may also call the DHCS Public Inquiry and Response Unit at 1 (800) 952-5253; persons with a hearing impairment can call TDD 1 (800) 952-8349. A copy of the brochure is available online at: http://www.dhcs.ca.gov/services/medi-cal/Pages/WhereToGetHelp.aspx.

California's Medi-Cal state hearing process allows Medi-Cal members to continue to receive Medi-Cal services through the hearing request process. The continuation of services is also available to CCT Participants, if they follow the aid-paid-pending requirements listed in the *Right to a State Hearing* document provided to participants and/or their designated representatives.

Notice of Action

A Notice of Action (NOA) is a legal document used to inform the CCT Participant (and/or his/her legal representative, if applicable) that an action related to a Medi-Cal service has been taken.

Some of the reasons a NOA may be issued to a CCT Enrollee/Participant, or someone who has requested to be enrolled in CCT include, but are not limited to:

- Insufficient information may have been submitted by service provider when treatment authorization (TAR) was requested
- Loss of Medi-Cal eligibility, such that individual no longer meets CCT eligibility requirements and will be dis-enrolled from the demonstration
- Inability of the LO to set-up LTSS to meet enrollee's/participant's skilled care needs to insure a safe and sustainable transition

- Non-compliance[10] with CCT Rights and Responsibilities

The NOA also includes information on how to request a State Hearing in response to a NOA.

State Hearing Process

A State Hearing, previously known as a Fair Hearing, is the process available to Medi-Cal beneficiaries, and/or their legal representative, to dispute a decision made by DHCS, to reduce or deny services, prior to the administration of the requested services. [CCR Title 22, Sec. 51014.1] State Hearings include representatives from each side and an Administrative Law Judge (ALJ). The hearing may be held in person or by teleconference (audio or video), depending on the ability of the Medi-Cal member to attend. The ALJ shall render a decision on the matter in a timely fashion. After a review by the DHCS Director and/or his/her designee, the final decision will be released to both parties. The CDSS has been delegated to perform DHCS State Hearings.

B.7 Self-Direction

Introduction

CMS defines a self-directed program as "a state Medicaid program that presents individuals with the option to control and direct Medicaid funds identified in an individual budget." California did not include self-direction in CCT. However, the program is 100% person-centered, which includes the development of the TCP. Opportunities for self-directed services are available to CCT Participants based on the HCBS programs into which they enroll.

Currently, there are several self-direction programs in California: the NF/AH waiver personal care services (WPCS), the Personal Care Services Program (PSCP) administered by the counties under IHSS, and the HCBS-DD Waiver.

[10] Non-compliance is a documented incident of the enrollee/participant not adhering to the CCT requirements agreed to on enrollment.

Enrollee/Participant Choices for Self-Direction under the demonstration include:

Personal Care Services (PCS) Program

PCS is an optional Medi-Cal benefit and is administered individually by each county in the state. PCS is generally referred to as In-Home Supportive Services (IHSS) in California. The IHSS program is the cornerstone of self-directed services in California. Self-direction is provided in accordance with the terms of the waiver/state plan service being utilized by the participant. For years, California's IHSS program has played a significant role in helping people remain at home and avoid institutionalization, as well as in developing a model system of self-directed services. IHSS provides personal care and domestic services to more than 355,500 elders and people with disabilities to allow these individuals to live safely in their own homes rather than in inpatient facilities.

Self-Direction allows the enrollee/participant or their designee (a parent or guardian in the case of a minor child, or another individual recognized by state law to act on behalf of an incapacitated adult), to exercise choice and control of the budget, planning, and purchase of self-directed personal assistance services, including the amount, duration, scope, provider, and location of service provision. In addition, the participant has the ability to hire, fire, supervise, and manage employees of their own choosing, including, at the state's option, legally liable relatives, and to direct a budget from which they purchase their PCS.

Based on an assessment of the needs, strengths, and preferences of the enrollee/participant, performed by a social worker from the Department of Social Services (DSS), a plan of service is written for the needed IHSS hours, and approved by the county IHSS office. The methodology for determining the number of assigned IHSS hours uses valid, reliable cost data, and includes a calculation of expected cost of such services if those services were not self-directed. The methodology is open to public inspection.

IHSS is operated at the county level in accordance with the California Welfare and Institutions Code. The Department of Social Services (DSS) and the counties share administrative responsibilities for the IHSS program. CDSS performs the following functions: oversees the IHSS data and payroll system, known as the Case Management and Information and Payroll System (CMIPS), serves as the payroll agent for the IHSS providers, and writes the IHSS regulations.

Currently, based on an assessment of the needs, strengths, and preferences of the enrollee/participant, performed by a social worker from the DSS, utilizing a computer program, county staff members determine beneficiaries' program eligibility, the number of

hours, and type of services approved to meet their needs. The maximum number of monthly PCS hours that can be authorized is 283 hours. With the awarded hours, a plan of service is written for the needed IHSS hours, and approved by the county IHSS office. While IHSS regulations determine the range of services, it is the consumer who drives the provision of services. The consumer decides how, when, and in what manner IHSS services will be provided.

CMS requires states to assure that necessary safeguards have been taken to protect the health and welfare of all Medi-Cal beneficiaries served under this state plan program and to assure the financial accountability for funds expended for self-directed services. Before participants are allowed to self-manage their personal assistance services, the county IHSS office staff will take necessary safeguards to protect their health and welfare and ensure financial accountability for funds expended. In addition, the state will provide for a support system that ensures participants in self-directed programs are appropriately assessed and counseled prior to enrollment and are able to manage their budgets.

Waiver Personal Care Services (WPCS)

WPCS, similar to PCSP, or IHSS, are authorized by DHCS's In-Home Operations (IHO) Branch, for participants enrolled in the HCBS Nursing Facility/Acute Hospital (NF/AH Waiver). These services are both supportive and health related, substitute for the absence, loss, or impairment of a physical or cognitive function. WPCS- awarded hours are in addition to the services provided by the IHSS Program.

Levels of Self-Direction

I. Self-directed services – An individual is allowed to manage their employees and budget. Control of the time sheet processing is maintained by the individual county and/or their designated public authority, and paychecks are issued by the state.
II. Minimal self-direction – An individual requests IHSS services and maintains control of who comes in to perform the services, but leaves all the other decisions and management to the county.
III. No self-direction – A member requests that the county be responsible for all portions of IHSS care management and any other decision needed.

B.8 Quality

Quality management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement. Quality management is a system of accountability used in health care to allow oversight and evaluation of the provision of services to persons not directly involved in the program administration. This allows a non-biased interpretation of evaluation findings.

Overall QMS

The purpose of establishing a quality management strategy (QMS) is to ensure the provision of effective and quality services in order to maintain the health and welfare of demonstration participants. CMS requires the state to provide assurances that six QMS areas are in place for demonstration participants:

1. Determination of level of care/need for skilled care
2. Description of service plan
3. Identification of qualified HCBS providers
4. Assurance of health and welfare
5. Administrative authority
6. Financial accountability

Collectively, these areas provide checks and balances to ensure that demonstration participants receive safe, competent care to support good health and wellbeing. Besides collecting data on all of these areas, on-site Program Compliance Reviews will be instituted. Specific QMS information for each waiver, program and/or state plan service is listed under its specific area at the end of this section.

CMS Quality Requirements

CMS requires that DHCS adhere to the quality requirements associated with the Medicaid 1915c HCBS waiver programs be applied to the CCT Project, which are the basis for its quality

system. In addition, three other requirements have been added to this requirements, which are more specific than the waiver requirements:

- Critical Incident Reporting Management
- 24-Hour Back-Up System
- Risk Assessment/Mitigation

See the section below entitled QMS for MFP Demonstration, for specific information about these three requirements.

State QMS Monitoring

A variety of health and welfare issues can occur when health care services are involved. The following occurrence areas will be reported by lead organizations through the CCT Monthly Reporting process:

- Elder or dependent adult abuse
- Medication monitoring
- Health and safety issues (equipment malfunction, visits to emergency department, and/or hospital admission, etc.)

The state assures that at minimum, standards outlined in Appendix E of the NF/AH waiver will govern the quality component of CCT. The same level of quality assurance and improvement activities will govern an enrollee's/participant's transition and the first year of community living. Standards and procedures for clinical eligibility assessments and LTSS planning have previously been approved under each specific HCBS waiver and/or state plan service.

DHCS Long-Term Care Division QMS

The DHCS Long-Term Care Division's (LTCD) quality management strategy (QMS) is to develop and implement discovery tools and methods to evaluate LTCD's effectiveness in compliance with the waiver assurances and policies and procedures. As a result of discovery activities, LTCD will develop, implement, and evaluate remediation actions to enhance, correct, and/or improve LTCD's compliance. The LTCD Quality Assurance (QA) Unit is responsible for developing discovery activities, collecting, and analyzing the data from the discovery activities. The QA Unit utilizes the following tools for discovery: Internet-based Case Management

Information Systems (CMIS); Case Record Review; Provider Visit Review; Event/Issue database; CA-MMIS; and California Department of Developmental Services' Case Management Information Payroll System (CMIPS).

The QA Unit and the DHCS LTCD's Medical Consultant, a licensed physician, are responsible for conducting the Annual Case Record Reviews on active NF/AH waiver cases. The selected sample size for the number of case records to be reviewed is determined by using the Sample Size Calculator located at: http://www.surveysystem.com/sscalc.htm. The CCT Project Team will work with the QA Unit to institute a retrospective audit on a semi-annual basis, reviewing completion of the Transition and Care Plans (both initial and final), submitted by LOs on each CCT participant.

QMS for MFP Demonstration

Quality management is an integral part of CCT Project, on several levels. The CCT Project Team will perform routine fiscal and service oversight, as well as a review of event/issue occurrence information submitted monthly by each Lead Organization. This information will be included in the required CMS reports. In addition, the CCT Project Team staff will perform onsite- semi-annual reviews of each Lead Organization to insure compliance with CMS requirements and DHCS Contract.

Critical Incident Reporting Management

The CCT Project's "critical incident" reporting management system/program goes by another name. As not all events tracked in the system are "critical", California chose to name their program the "Event/Issue System". The event/issue system uses the same structure as that of the LTCD's waiver systems.

California Community Transitions Event/Issue System

Rather than create a new program the project team will:

1. Use Appendix G: Participation Safeguards of HCBS Waiver Application Version 3.4 - the DDS Reporting Requirements, dated 03/26/2008 as a baseline and work within the requirements of each waiver/program and/or state plan service utilized by their participants.

2. Work closely with the DHCS QA Unit and/or other program staff, in both monitoring oversight of event occurrence reporting, incident evaluation, investigation, follow-up, and file auditing.
3. Work with the California Department of Public Health's Licensing & Certification program and other state agencies as required by regulation and law.

The system will begin on the first day participants are at home and continue for the duration of the demonstration. In addition, the same system will be in place after the demonstration year ends, when the participant's services continue under the waiver.

The Lead Organization is responsible for the review and evaluation of all event/issue reports for their demonstration participants. The participant's health and /or welfare will be reviewed by LO to determine if any measures can be taken to provide a different outcome that may have prevented the occurrence or reduced the risk of occurrence to the participant. Modification(s) will be made to reflect needed changes.

The CCT Project clinical staff members will be available to lead organizations for consultation on enrollee/participant health and welfare issues. In addition to investigating these occurrences and modifying the TCP as needed, the LO will complete a CCT Monthly Report to be submitted to the CCT Project Team. This information will be logged into the CCT Project database, and used to complete required CMS reports.

24-Hour Back-Up System

CMS requires that all CCT participants have a 24/7 Back-Up Plan in place when the participant transitions to living and receiving LTSS in the community. Due to the California's large size, diversity geography, and service locations, utilizing a 24/7 in-person telephone contact line is not possible at this time. DHCS has begun an options review of all the HCBS waiver services, analyzing how each waiver, program, service, project, and/or demonstration provides a 24-Hour back-up system for their participants.

As Medi-Cal shifts from FFS providers to Managed Care Plan service providers, DHCS will be looking at how the managed care plans which provide 24-Hour back-up services, as most Medi-Cal beneficiaries will be enrolled in managed care services. A thorough review of all current availabilities and future options will need to be understood before a state 24/7 back-up system may be designated, to avoid duplication of services.

Most participants transitioning to community living have had little possibility for decision making regarding their LTSS during their inpatient facility stay. Because of this lack of recent experience, having pre-determined options in a 24-Hour system set up for the participant and/or service provider, allows easier determination of what to do if an urgent or emergent incident occurs.

The CCT staff designed a three-page document to provide information to CCT participants who transition to community living. Page one is a flow chart/algorithm listing the participant's options and actions to be taken based on what is happening in various emergency situations. Space is available to fill in the community telephone numbers. Page two provides a categorized area for all the participants providers' name and telephone numbers to be listed and held for future use. Page three provides pictures of service types with the providers' names .and numbers. CMS approved California's these documents as a 24-Hour Back-Up System.

Risk Assessment & Mitigation

Risk Assessment and Mitigation is an ongoing, proactive program to provide a safe transition and service provision for the CCT participant as s/he moves from the inpatient facility to living and receiving LTSS in the community. Using specific techniques, the enrollee, the CCT transition team, and the CCT Nurse Evaluator, work to identify the following prior to transition:

- Identify initial risks (potential problems) in transition to community living.
- Outline how those risks will be addressed (mitigated).

Risk assessment/mitigation information is included on both the I-TCP and the F-TCP to ensure the risk areas are evaluated and addressed prior to transition. Transitions teams are required to develop plans for addressing/mitigating identified risks. TCPs that do not identify and develop plans for addressing potential risks that could arise in a community setting, will not be accepted by the CCT Project Nurse Evaluators, and if the risk of transition to community living is too high, such that the individual's health and welfare are jeopardized, then his/her transition will not be approved, and a NOA will be issued.

The LO's follow-up visits to demonstration participants after transition occurs on a preset schedule to review of the participant's skilled care needs, current LTSS being provided, and the participant's living situation. A Participant's Transition Coordinator is required to meet the participant at his/her home on the day of transition, to ensure needed LTSS are in place as planned. Any last minute concerns will be addressed at that time. After the initial day of

transition visit, the CCT has set a TC visitation schedule based on the type of housing the participant chose. Additional visits may be added, as needed to ensure the participant's health and safety.

One of the goals of each post-transition contact/visit is to insure LTSS needs continue to be met in their new home. Any new concerns or issues with original LTSS set-up will addressed, with changes made to the TCP, as needed. The overall goal of the CCT Project is to assist is providing the individual with a transition that benefits their health and welfare, and allows them to remain in the community for as long as possible.

Monitoring activities include on-site Program Compliance Reviews (PCR), provider quality improvement/quality management evaluations, and financial audits. DHCS staff shall conduct a one-two day PCR for each CCT provider annually. The purpose of the on-site visit is to assure compliance with the CCT Project requirements and provide technical assistance (TA) as needed. The PCR consists of the review of:

- Staff qualifications
- Policies and procedures
- Billing records
- Subcontracts
- Transition and Care Plans
- Medical records
- Case notes
- Purchase Receipts

The PCR client's chart reviews will confirm compliance with eligibility, enrollments, dis-enrollments, service plan updates, and the delivery of service pre-transition and post-transition. DHCS conducts an exit interview with CCT providers on-site, and sends a written report identifying PCR findings and areas requiring corrective action to the Lead Organization, and the LO is required to submit a Corrective Action Plan (CAP) to DHCS after reviewing the report.

Quality Improvement

Quality is a constant goal throughout the CCT transition process. We will look briefly at quality improvement in each of the three phases of the transition: pre-transition, demonstration period, and post demonstration.

Pre-Transition Services to Enrollees

Individuals enrolling in the CCT Project are assured of quality services provided by their chosen lead organization and CCT project team members as described in this operational protocol. On enrollment, an initial assessment is conducted to determine the individual's skilled care need requirements, and the types of LTSS needed to ensure the enrollee's health and welfare in the community. In addition, the enrollee is consulted on the type of housing s/he would like, and assisted in finding what is available in the enrollee's chosen area of residence. In addition, an Initial Transition and Care Plan (I-TCP) is developed by the enrollee and the transition coordinator, outlining the work plan. The I-TCP includes a risk assessment section to help determine the LTSS needed to meet the enrollee's skilled care needs for transition, services. Information from the risk assessment section will be double checked to see that individualized LTSS are set up according to each enrollee's skilled care need requirements.

The TCPs for each enrollee will be reviewed by the Lead Organization and CCT NE to ensure all health care service needs are addressed prior to transition. In addition, the CCT nurse will determine the enrollee's level of skilled care need (LOC), and notify the transition coordinator of the state HCBS programs and/or waivers for which the enrollee qualifies. The enrollee then will choose from that list in designing services to meet their skilled care needs. Once the needed services and supports are in place to insure the enrollee's health and welfare, a move date will be set by the nursing facility physician, and then when all LTSS are in place, the transition will occur.

In the rare situation where needed services are not available in the enrollee's chosen community, other options in other communities will be considered. If needed services cannot be provided in the setting of their choice, the enrollee will be given the option of moving to another location that has the needed services. If changing residence location is not an option, or the needed services are not available, the enrollee will be notified in writing by the Lead Organization, and the transition will be cancelled, until such time as the services are able to be established. A Notice of Action will be issued and the enrollee will be dropped from the CCT Project, with the understanding that s/he will be eligible to re-enroll during the period of the CCT Project, if required LTSS become available, and/or his/her skilled care needs change such that available services and supports will insure the enrollee's health and welfare upon transition.

Demonstration Period

Once an enrollee and the transition team have concluded the pre-transition work of locating needed LTSS and housing, a Final Transition and Care Plan (F-TCP) will be written and signed by the enrollee, transition coordinator, and the enrollee's physician, signifying the all needed services and supports are in place and ready for the transitioning enrollee to move home. On discharge from the inpatient nursing facility, the enrollee becomes a "participant" the Demonstration for 365 days living and receiving their chosen LTSS in the community.

DHCS' transition follow-up and oversight schedule is based on the type of housing and services chosen by the participant. All planned follow-up visits and telephone calls will occur more frequently in the initial days and weeks after transition, to confirm that the set-up LTSS are meeting the participant's skilled care needs, and if not, changes will be made to their F-TCP to insure the enrollee's health and welfare. A copy of the post-transition contact schedule can be found on pages 4 and 5 of the Revised CCT Transition Process document posted to the CCT webpage, and included below. Modifications to the follow-up and oversight schedule will be adjusted on an individual basis as determined by participant, transition coordinator, and CCT nurse evaluator.

Revised CCT Transition Process

Post-transition Follow-up*				
Service Code ➡ **Participant's post-transition HCB Services ⬇**	**G9012 – U6: Transitional Case Management (TCM)** Coordinated care fee, risk adjusted maintenance, other specified care management. Services to transition an eligible individual from a health facility to a HCB setting. $11.36 / 15 minutes ($45.44 / hour) Additional care coordination required for re-establishing care, if necessary	**T2017 – U6: Habilitation, residential, waiver** Services to assist the CCT Participant in acquiring, retaining, & improving the self-help, socialization, & adaptive skills necessary to reside successfully in a participant's natural environment. $11.36 / 15 minutes ($45.44 / hour)	**S5111 – U6: Home care training, family** Family training services provided to the families of individuals served under the waivers. Training includes instruction about treatment regimens & use of equipment specified in the plan of care, & shall include updates as necessary to maintain the individual's safety at home. **HHAs only**** $11.36 / 15 minutes ($45.44 / hour)	**T1019 – U6: Personal Care Services before IHSS starts** Supportive services to assist an individual to remain at home & includes assistance to independent activities of daily living & adult companionship. $3.62 / 15 minutes ($14.48 / hour)
Informal Support OR State Plan Services	Months 1 – 3 after transition: Face-to-face 2X / month Months 4 – 12 after transition: Face-to-face 1X / month	As required (based on medical necessity), within the first 3 months after transition, capped at 50 hours	As necessary	N/A
In-Home Support Services	1st Month after transition: Face-to-face 2X / month Months 4, 8 & 12 (Quarterly) after transition: Face-to-face 1X / month Months 2, 3, 5, 6, 7, 9, 10 & 11 after transition: Phone call 1X / month	50 hours, post-transition (based on medical necessity)	As necessary	As required, # of hours based on IHSS Assessment &/or RN Assessment (based on medical necessity)

Revised CCT Transition Process

Post-transition Follow-up*				
Service Code ➡ **Participant's post-transition HCB Services ⬇**	**G9012 – U6: Transitional Case Management (TCM)** Coordinated care fee, risk adjusted maintenance, other specified care management. Services to transition an eligible individual from a health facility to a HCB setting. $11.36 / 15 minutes ($45.44 / hour)	**T2017 – U6: Habilitation, residential, waiver** Services to assist the CCT Participant in acquiring, retaining, & improving the self-help, socialization, & adaptive skills necessary to reside successfully in a participant's natural environment. $11.36 / 15 minutes ($45.44 / hour)	**S5111 – U6: Home care training, family** Family training services provided for the families of individuals served under the waivers. Training includes instruction about treatment regimens & use of equipment specified in the plan of care, & shall include updates as necessary to maintain the individual's safety at home. **HHAs only**** $11.36 / 15 minutes ($45.44 / hour)	**T1019 – U6: Personal Care Services before IHSS starts** Supportive services to assist an individual to remain at home & includes assistance to independent activities of daily living & adult companionship. $3.62 / 15 minutes ($14.48 / hour)
Waiver Services **NF/AH Waiver, Assisted Living Waiver, & other Waiver (AIDS, MSSP, SMHCP)**	Months 1, 4, 8 & 12 (Quarterly) after transition: Face-to-face 1X / month Months 2, 3, 5, 6, 7, 9, 10 & 11 after transition: Phone Call 1X / month	50 hours, post-transition (based on medical necessity)	N/A	N/A

* The hours allocated in this chart are the maximum number allowed for each post-transition service package; if additional hours are required based on individual needs &/or circumstances, submit a request for approval of additional hours with a detailed explanation to the assigned state Nurse Evaluator (NE).

** This service code may only be used by Home Health Agencies to train care takers on how to provide medical treatments & maintenance, & the services must be reviewed & approved by state NEs before any training is provided.

Post Demonstration - HCBS Services after 365-Day Demonstration Period

When the 365 days of CCT participation have ended, the individual will no longer receive CCT services. Whatever LTSS the person had been receiving will continue, as long as s/he maintains his/her Medi-Cal and service level of care eligibility. Prior to ending CCT service provision, the LO is responsible for ensuring that the individual has an up-to-date TCP, contact information for services provided, and a back-up plan for day 366 and beyond.

As discussed above, demonstration enrollees/participants will be enrolled in the state's currently approved HCBS waivers for which they are eligible. Each of these systems has an approved quality oversight plan in place. Demonstration enrollees'/participants' TCPs/waiver plans of treatment/care will be part of the quality and monitoring reviews pertinent to each system. Because they will be immediately enrolled in existing systems, there is no issue with transition from the demonstration to HCBS at the end of each participant's 12-month demonstration period. [See Section b.10 for further information on post-demonstration services.]

The following information is related to QMS once the demonstration ends after 12 months, or if the participant chooses to dis-enroll early. The State's approved HCBS waivers have quality monitoring and oversight plans in place. These plans include:

- Delegated authority through an existing Interagency Agreement (DDS, CDA, DMH, and DSS) to administer and oversee service provision.
- Back-up emergency plans
- Incident reporting
- Risk assessment and remediation

Potential Conflict of Interest

Another level of quality management that occurs at the state level is the prevention of potential conflicts of interest with organizations contracting to provide CCT services. As a measure of prevention, the CCT project team worked with the DHCS Office of Legal Services (OLS) to develop zero-dollar contracts for lead organizations. The only remuneration the CCT Lead Organizations will receive from DHCS will be reimbursement for those CCT services provided and for which a Medi-Cal claim is submitted, according to the DHCS's fiscal intermediary requirements. The project director will consult OLS, as needed, if conflicts of

interest are suspected. If a conflict of interest should arise, the project director will follow the DHCS policy to investigate and remedy the situation as soon as possible.

HCBS WAIVERS

HCBS QMS for 1915(c) Waivers

The six QMS assurance areas which apply to the 1915(c) waivers are the same as for the CCT Project. All areas together provide a checks and balance system to assure that demonstration participants receive safe and competent care to meet their health and welfare needs. Below is listed information on each specific waiver to which participants might be enrolled. Once the participant's time in the demonstration is completed, s/he will continue in the chosen waiver so long as s/he continues to meet clinical and Medi-Cal eligibility requirements.

Assisted Living Waiver (ALW)

DHCS is responsible for administration and oversight of the ALW. DHCS contracted with the NCB Corporation to design and implement The ALW Quality Assurance and Improvement program which covers the following areas: quality of care; participant experience; care coordination; complaint monitoring and incident report monitoring; individual service plan; providers; assisted living bundled services; participant access; client-centered service; planning and delivery; provider capability and capacity; client safeguards; client outcomes and satisfaction; and system performance.

Developmental Disability (DD) Waiver

The QMS model is built upon the premise that quality assurance is an essential component of the manner in which the work is accomplished. According to the renewal DD waiver application, "It embodies the notion that discovery is a by-product of the work at hand and does not require participants in the system to generate special reports to satisfy the need to understand how the system is performing. Within this context, remediation and improvement will not only benefit the system, but will make the day-to-day work of the participants in the system more meaningful and effective." All levels of the system will be involved in QMS, to include the entire developmental disability service delivery system.

Multipurpose Senior Services Program (MSSP) Waiver

The California Department of Aging (CDA) and DHCS monitor the quality control measures described in the waiver and MSSP Site Manual in order to ensure that the quality of services provided under the waiver and the state plan, to persons served under the waiver, are based on the monitoring activities of both departments pursuant to the CDA and DHCS Monitoring and Oversight Protocol(s).

Nursing Facility/Acute Hospital (NF/AH) Waiver

The Department of Health Care Services (DHCS) is responsible for monitoring quality control measures described in the NF/AH Waiver; as described in the waiver language and special terms and conditions approved by CMS.

Other Quality Topics Specified by CMS

Unique Demonstration Identifier

Demonstration participants will be assigned a unique identifier so that claims and records can be extracted from TARs and the existing Medi-Cal MMIS and paid claims files. Parallel manually kept records will augment the electronic files so that the state can supply demonstration participant data to:

- Report participant demographics
- Report utilization of QHCBS, demonstration and supplemental (if any) services
- Inform the CMS evaluation

Waiver Capacity

The state currently has capacity, as applicable, in each of its approved waivers. DHCS will ensure capacity is available when needed. Project staff members will continue to collaborate with waiver administrators from partnering departments to ensure capacity in the future.

HCBS Waiver Wait Lists

Demonstration participants' service needs will be accommodated immediately by one of the state's HCBS waivers or state plan programs. Participants will not be placed on HCBS wait lists; therefore, management of wait lists is not applicable to CCT.

QMS and Managed Care Health Plan (MCHP)

During the Demonstration Phase of the CCT Project, the CCT participants will be covered under the LTCD's QMS system, and for those who received Medi-Cal services through a managed care plan, that plan's QMS system will also be involved. Currently, most California Medi-Cal services are provided using the Managed Care model. The state goal is to have almost all Medi-Cal beneficiaries covered by managed care instead of fee-for-service. Because of its diverse geography and immense land spread, a few areas may remain fee-for-service.

Once the individual's participation in the CCT Project is completed, most Medi-Cal beneficiaries will be receiving health care services through managed care plans. The QMS system for this time period will be under the Coordinated Care Initiative. DHCS has contracted with each MCHP, insuring that their QMS systems meet CMS requirements.

Supply of Trained Personal Care Service Providers

The supply of trained personal care services (PCS) providers has grown over the past few years as the demand for their services has increased. More opportunities are available for eligible, qualified individuals (including participants' family members and friends) to be hired, trained and serve as personal care workers.

In California, Personal Care Service Provider may be accessed through two routes. The first is the In-Home Supportive Services (IHSS) option through Department of Social Services (DSS). This State Plan Service is available to individuals who meet entry requirements. DSS utilizes an established assessment protocol performed by a DSS social worker, and then enters the information into a pre-set program that assigns personal care service hours based on need category. Once IHSS services are approved, the participant hires personal service workers, while DSS provides oversight for the IHSS program.

If the participant is eligible for DHCS Waiver services, and requests more PCS hours within their waiver menu of health services budget cost neutrality, there is a Waiver Personal Care Services

Program available. The individual must be eligible for IHSS services to take advantage of this WPCS service. DHCS' In-Home Operations Branch is responsible for monitoring and oversight of this service.

IHSS and WPCS give CCT participants the ability to hire people who might otherwise be giving care as a volunteer. Thus, provision of these services contributes to an expansion of the workforce. Additionally, these personal attendants are receiving training which may become a billable skill of their own. See Section B.7 Self-Determination, for more information on personal care services.

B.9 Housing

Researchers and practitioners have demonstrated that people living in institutions with nursing level of care can successfully live in the community if they are able to secure safe, accessible, and affordable housing, in addition to community-based health and assistance supports. However, as with the rest of the nation, a lack of affordable and accessible housing is California's most significant barrier to transitioning more people from institutions to the community. Because Medicaid funds generally cannot be used for housing, the MFP grant provides CCT with, "…the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice." Under CCT, the flexible use of Medicaid funds has helped to bridge the gap between health care and housing, by allowing grant funding to be spent on first-month's rent, household set-up, and medically-necessary home modifications. Even so, the supply of available housing within California that meets the needs of CCT Enrollees/Participants remains low.

To meet grant requirements established in the Deficit Reduction Act of 2005 and CMS supplemental policy guidance provided in 2009, CCT Enrollees must move into one of the following categories of qualified housing:

- A home owned or leased by the individual or the individual's family member. (California does not regulate a home owned or leased by the Enrollee/Participant or their family member.)
- An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and, that is regulated by a lease with a landlord, county and/or city guidelines, or a public housing agency.
- A licensed community-based residential setting, in which no more than 4 unrelated individuals reside.

Finally, all housing options for beneficiaries who receive waiver services must comply with CMS' 2014 Final Rule on Home and Community-Based Settings Requirements, CMS 2249-F and CMS 2296-F. For more information on the Final Rule, and California's plan for statewide compliance, visit the State Transition Plan available on DHCS' webpage at: http://www.dhcs.ca.gov/services/ltc/Pages/HCBSStatewideTransitionPlan.aspx.

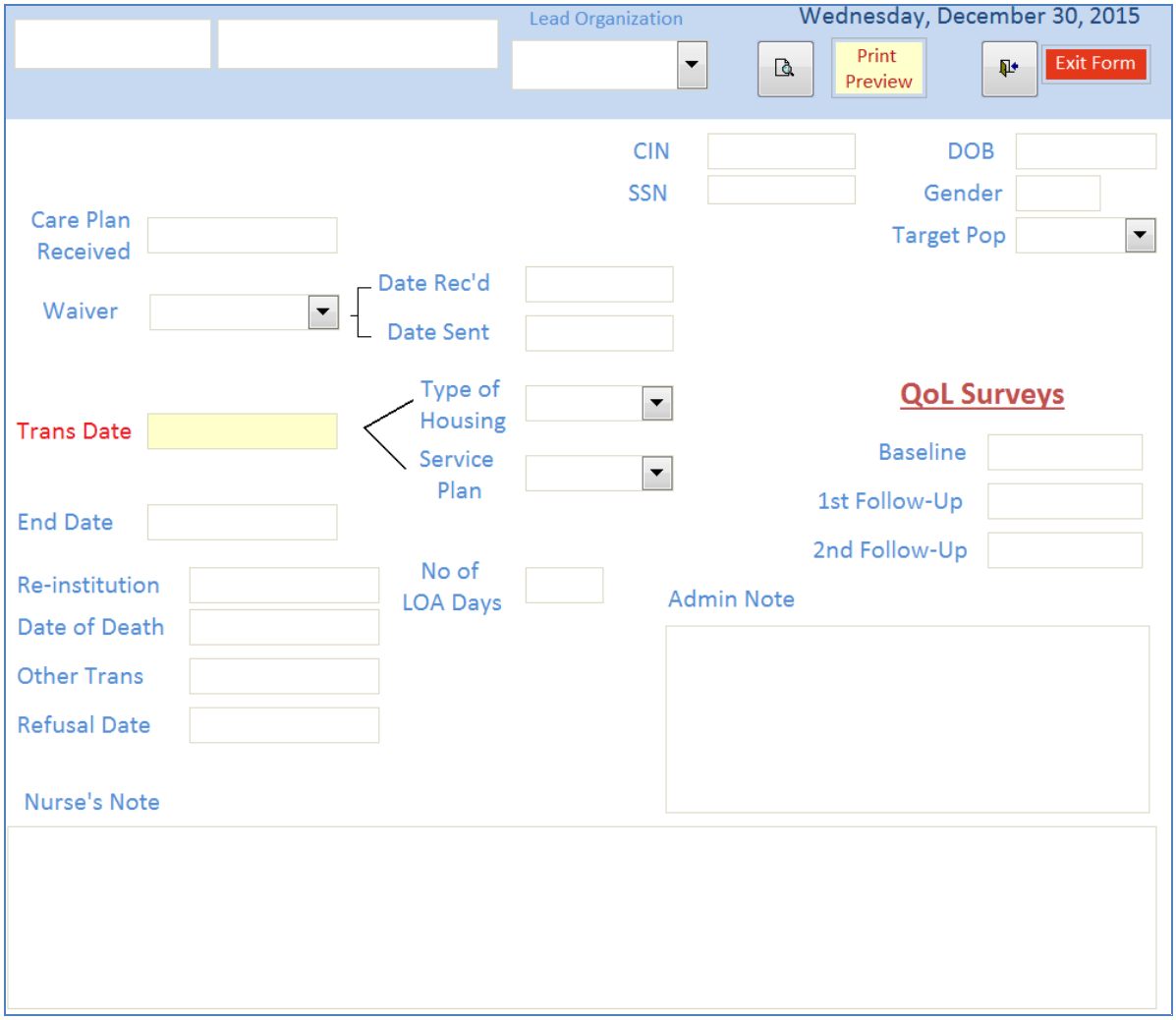
Documenting Qualified Residences

Information on the type of qualified residence selected by an Enrollee is reviewed by a state Nurse Evaluator (state RN) approximately two weeks prior to the day of transition as part of the adjudication of the *CCT Final - Transition and Care Plan* (F-TCP). Local CCT service providers document the type of qualified housing into which the Enrollee transitions by submitting the *CCT Day of Transition* (DOT) *Report Form* to the state CCT email inbox. The *DOT Report Form* is submitted to confirm that the necessary services and supports included in the Enrollee's/Participant's *CCT F-TCP* were in place on the day of transition, and/or that measures have been taken to cover necessary services that will be in place within 30-days post-transition. The *CCT DOT Report Form* is available on the CCT website at: http://www.dhcs.ca.gov/services/ltc/Pages/CCTForms.aspx .

The housing data extracted from the *CCT DOT Report Form* is entered into the CCT database developed by project team members to record and track enrollees'/participants' community living settings, as well as all other Project-related information required to oversee the Demonstration (see Image 1, included below).

In addition, the physical addresses of all Demonstration Participants enrolled in home and community-based services waivers are entered into DHCS' Medi-Cal Information System, Service Utilization Review, Guidance, and Evaluation (SURGE), and the Case Management Information Systems (CMIS) database within the larger Medi-Cal system.

Image 1. CCT Database Interface



State Plan to Achieve a Supply of Qualified Residences

Existing or Planned Inventories

In California, subsidized rental housing is available through a patchwork of disparate programs, which can create challenges in coordinating housing policy for developing needs. However, one advantage to the different approaches has been the involvement of a variety of entities, including the federal government, state and local governments, nonprofit groups and for-profit developers, each bringing different resources and expertise to address affordable housing issues.

Plan to Address Identified Housing Shortage

In response, a CCT housing specialist was hired at the end of 2012 to expand and coordinate the availability of affordable and accessible housing for CCT Enrollees/Participants. Merging affordable and accessible housing with community-based healthcare services and supports is viewed by DHCS as a key component in ensuring successful reintegration of Medi-Cal members into the community. DHCS is actively working to build partnerships with both state and local housing authorities and housing developers to secure set asides in new developments for seniors and persons with disabilities transitioning from institutional settings, project based section 8 vouchers with tenancy-based support services, and exploring options for establishing preference to fund tax credit projects for these target populations.

Collaboration between CCT Stakeholders and Housing Partners

DHCS convenes stakeholder advisory workgroups at the onset of each funding opportunity, and meets on a regular basis thereafter, based on the needs of, and input from, stakeholder members.

Separately, DHCS meets with the California Housing Finance Agency (CalHFA), the California Department of Developmental Services (DDS), the California Department of Housing and Community Development (HCD) and the California Tax Credit Allocation Committee (TCAC) every two weeks to discuss the available PRA grant awards. The housing departments keep DHCS informed of any housing opportunities that may benefit Medi-Cal members.

Strategies to Promote the Availability, Affordability or Accessibility of Housing

Non-Elderly Disabled (NED) Vouchers, Category 2

In 2009, California was one of 15 states awarded NED Category 2 vouchers by the U.S. Department of Housing and Urban Development (HUD). The vouchers were awarded to states to enable non-elderly persons with disabilities to transition from nursing homes

and other healthcare institutions into the community. To be eligible to receive one of the 135 NED Category 2 vouchers awarded to California, the individual, head of the family, or co-head of the family, must be:

1. Transitioning from a nursing home or other inpatient institution, and
2. Provided the services required for him/her to live independently in the community.

Section 811 Project Rental Assistance (PRA) Demonstration Program FY 2012

In February 2013, California was awarded nearly $12 million in HUD's 811 PRA funds to provide five-year renewable rental assistance for affordable housing projects serving persons with disabilities. Five State Agencies are collaborating to administer the program:

1. California Housing Finance Agency (CalHFA);
2. California Department of Health Care Services (DHCS);
3. California Department of Housing and Community Development (HCD);
4. California Tax Credit Allocation Committee (TCAC); and
5. Department of Developmental Services.

The 811 PRA Target Population is Medicaid (Medi-Cal) beneficiaries with disabilities, ages 18-61, who have resided in a long-term health care facility for at least 90 days and wish to return to community living, or who are at risk of institutionalization due to loss of housing.

<u>Project Rental Assistance (PRA) Unit/Project Restrictions:</u>

1. No more than 25% of the project's total units can be restricted to/set aside for persons with disabilities, regardless of the source of that restriction.
2. PRA funds must not go to units already restricted to persons with disabilities. Existing units receiving PRA must not have received any form of long-term operating subsidy within a six-month period prior to receiving PRA funds.

3. PRA assistance will be targeted to units already restricted to 50% Average Median Income (AMI) or below through a TCAC, HCD, or CalHFA development source. PRA assistance will pay the difference between the allowable rent and 30% of the tenant's income. Funds may also be available for costs of an on-site supportive services coordinator for units restricted below 50% AMI.
4. Existing projects and projects under construction may apply for PRA funds; however, all PRA-assisted units must be fully occupied by Summer 2019.
5. Certain federal overlays apply to PRA-funded projects, including but not limited to, federal accessibility standards and environmental analysis. Federal prevailing wage and energy efficiency requirements may also apply.
6. PRA funds cannot be used for capital development expenses.

The Notice of Funding (NOFA) was released on August 1, 2014; project applications continue to be accepted until all funds are awarded. Awards have been made to six developers for a total of 99 units, and the first tenants began moving into the rental units in January 2015.

Section 811 Project Rental Assistance Demonstration Program FY 2013

In May 2014, California was awarded nearly $12 million in HUD's 811 PRA funds to provide five-year renewable rental assistance for affordable housing projects serving persons with disabilities. Five State Agencies are collaborating to administer the program:

1. California Housing Finance Agency (CalHFA);
2. California Department of Health Care Services (DHCS);
3. California Department of Housing and Community Development (HCD);
4. California Tax Credit Allocation Committee (TCAC); and
5. Department of Developmental Services.

The target population is Los Angeles County homeless persons, as well as, those institutionalized in long-term care facilities, and persons with developmental disabilities or mental illness who are at risk of institutionalization and need affordable housing and services to remain in the community. Applications will be accepted starting March 2016.

Match Funding:

1. The City Los Angeles' Housing Authority for 100 Section 8 housing vouchers, and
2. The Housing Authority for the County of Los Angeles for 50 Section 8 vouchers

Section 811 PRA Eligibility Requirements:

1. Medi-Cal members with disabilities whose income does not exceed 30% of the Area Median Income (AMI), as determined by the housing provider;
2. Age 18-61 at the time of initial occupancy in a Section 811 unit;
3. Eligible for and require Long-term Services and Supports, including but not limited to, Medi-Cal Home and Community Based Waiver services (1915 (i) or 1915 (c)), other Medicaid waiver services, Rehabilitation Option specialty mental health services, or other State Plan services, including but not limited to, In-Home Supportive Services (IHSS) or new Health Home services; and
4. Qualify for one or more of the target population groups below:
    a. *Non-Homeless:* Individuals who are currently institutionalized or are at at-risk of institutionalization, as set forth below:
        i. *Institutionalized:* Individuals residing in an inpatient facility for at least 90 consecutive days, for which Medi-Cal has paid for at least one of those days, who are enrolled in CCT. Among those qualifying as Non-Homeless, priority for PRA unit occupancy will be given to the Institutionalized population. For this population, it must have been determined by the individual's physician that without the provision of Long-term Services and Supports the individual would continue to require a level of care provided by an inpatient facility.

ii. *At-Risk of Institutionalization:* Individuals with Developmental Disabilities or Chronic Mental Illness who are currently receiving or eligible to receive Long-term Services and Supports, who are at risk of placement in an inpatient facility if they do not receive PRA assistance.

b. *Homeless*: Individuals who qualify as literally homeless under Category (1) of HUD's Homeless definition at 24 CFR 576.2.

Other Housing opportunities for CCT Medi-Cal Beneficiaries

DHCS is in partnership with the Housing Authority City of Los Angeles (HACLA) through a NOFA process, which was released June 2015, to provide up to 100 units of affordable housing through the use of Section 8 Project Based Vouchers (PBV) for Medi-Cal members who are 62 years of age or older and who have resided in an institutional setting for a period of 90 days or more. Developers need to partner with a health service provider. An award was made to a developer with a 64-unit apartment building that needed to be rehabbed. Occupancy of the units is expected in the fall of 2016.

In addition, DHCS is working on a pilot project with the Los Angeles Department of Health Services to provide HCBS, in partnership with local providers, to eligible Homeless Medicaid County clients. The pilot began in Spring of 2016 and will serve between 20 to 100 nursing home certifiable Medicaid members or "Frequent Utilizers." The pilot project is intended to provide data for the analysis of Medicaid savings that may be derived from this model of care. The pilot is also intended to demonstrate if the services can be produced at scale, without capital subsidies.

California will continue, and intends to build upon, current efforts to develop an adequate supply of accessible, affordable housing beyond the term of the MFP/CCT Demonstration.

Medi-Cal 2020 - 1115 Waiver

As part of the overall vision for Medi-Cal 2020 and specifically in an attempt to improve care coordination for the state's most vulnerable populations, DHCS has proposed Whole Person Care (WPC) regional pilots. The WPC pilots will focus on the coordination of health,

behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and well-being through more efficient and effective use of resources.

The overarching goal of the Whole Person Care (WPC) Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC Pilots will provide an option to a county, a city and county, a health or hospital authority, or a consortium of any of the above entities serving a county or region consisting of more than one county, or a health authority, to receive support to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes. Through collaborative leadership and systematic coordination among public and private entities, WPC Pilot entities will identify target populations, share data between systems, coordinate care real time, and evaluate individual and population progress – all with the goal of providing comprehensive coordinated care for the beneficiary resulting in better health outcomes.

WPC pilots will be utilized to develop interventions and other strategies to provide integrated services to high users of multiple systems. WPC pilots can include specific strategies to:

1. Increase integration among county agencies, health plans, providers, and other entities within the participating county or counties that serve high-risk, high-utilizing beneficiaries and develop an infrastructure that will ensure local collaboration among the entities participating in the WPC pilots over the long term;
2. Increase coordination and appropriate access to care for the most vulnerable Medi-Cal beneficiaries;
3. Reduce inappropriate emergency and inpatient utilization;

4. Improve data collection and sharing among local entities to support ongoing case management, monitoring, and strategic program improvements in a sustainable fashion;
5. Achieve targeted quality and administrative improvement benchmarks;
6. Increase access to or utilization of housing or other non-medical supportive services (optional); and
7. Improve health outcomes for the WPC population.

WPC pilot payments will support: 1) infrastructure to integrate services among local entities that serve the target population; 2) services not otherwise covered or directly reimbursed by Medi-Cal to improve care for the target population, such as housing components; and 3) other strategies to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes.

B.10 Continuity of Care Post Demonstration

CCT participants will be enrolled in a waiver and/or MCP on the day of transition. When the demonstration period ends, the participant will continue to receive services at home without interruption, unless their clinical eligibility and/or Medi-Cal eligibility status changes. Because of this, the state will ensure continuity of needed care to CCT participants after they have been in the demonstration for 12 months.

If/when a CCT participant is no longer eligible to receive the same level of services at the end of the demonstration period, California has several medically needy programs available to assist individuals living in the community, including but not limited to:

County Indigent Program

Under California law (Welf. & Inst. Code, § 17000), all 58 counties are the "providers of last resort" for health services to low-income uninsured people with no other source of income. Counties serve the "medically indigent" population with one of two types of programs. For small rural counties, the California Medical Services Program exists, with standardized benefits modeled after the state's Medi-Cal program. For larger, urban counties, the Medically Indigent

Service Program offers a highly variable array of services. Information is available on each county's website and at the following websites:

- California Health Care Foundation (http://www.chcf.org)
  - County Programs for the Medically Indigent in California: Fact Sheet (http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CountyIndigentPrograms.pdf)
- County Medical Services Program (http://www.cmspcounties.org)

Affordable Care Act

The ACA is providing more options for individuals to receive needed health care coverage and LTSS. The state will continue to work with future changes, to provide LTSS options to it Medi-Cal beneficiaries.

Medi-Cal Working Disabled Program

It is not unusual for Medi-Cal beneficiaries who return to the workforce to lose their Medi-Cal benefits because of income eligibility restrictions. Many times they do not have enough income to provide for their skilled care needs, but earn too much to receive Medi-Cal benefits.

The Medi-Cal Working Disabled Program, administered by the California Health Incentives Improvement Project, enables individuals with disabilities who need services, yet would like to return to the workforce, to do so with certain restrictions.

Enrollees pay a small monthly premium based on countable earned income. They are allowed to earn a pre-determined amount each year, as an individual, and still qualify for affordable Medi-Cal coverage. For more information, consult the California Health Incentives Improvement Project website at http://chiip.org/; or DHCS' website at http://www.dhcs.ca.gov/services/Pages/TPLRD_WD_cont.aspx.

Managed Care Plans

Currently, DHCS is in the process of moving Medi-Cal services to the managed care model. There are six models of managed care in California, being utilized in all 58 counties, covering more than 80% of the total Medi-Cal population. Utilizing the managed care's coordinated

delivery system, beneficiaries will receive high quality, integrated health care designed to improve their health and quality of life, while reducing health delivery fragmentation and inefficiencies. In addition, CCT participants now have access to MCPs after-hours advice lines.

The California Duals Demonstration, entitled Cal MediConnect, provides an option for Medicare and Medi-Cal beneficiaries to receive services. Currently beneficiaries may choose to enroll in managed care services or remain in fee-for-service.

Section C. Organization and Administration

C.1 Staffing Plan

Organizational Structure

As described in Section A1b., "Administrative Structure," of this Protocol, DHCS is California's single authorized Medicaid Agency. CCT is administered by DHCS within the LTCD, one of 32 distinct Divisions/Offices in the department. DHCS collaborates with MCPs and sister state departments, including: CDA, CDPH, DDS, CDSS, and DOR, to ensure CCT participants continue to have access to HCB LTSS beyond the 365-day demonstration period. Moreover, it is through these partnerships that DHCS will ensure the continuation of transition and HCBS for eligible Medi-Cal members beyond the end date of the MFP grant.

The following charts are included as appendices to the OP to illustrate the organization of different layers of CA government and how they relate to one another.

Appendix	Chart	Description
1A	Internal and External Stakeholders	Comprehensive overview of the network of, and relationships between, all stakeholders/partners connected to CCT.
1B	California State Government	Organizational Chart illustrating the high-level organization of CA's state departments under the Governor.
1C	Department of Health Care Services	Organizational Chart illustrating LTCD's place within DHCS.
2B	Waiver Administration	Chart illustrating the break out of HCB LTSS waivers and programs among state departments.
9	CCT Organizational Chart	Organizational Chart illustrating the staffing structure within LTCD, and the relationship of divisions that provide administrative support to CCT.

CCT Project Team (DHCS staff)

There are currently 8.0 limited-term positions and 2.75 permanent positions funded using MFP/CCT Administrative funds.

During MFP/CCT Demonstration				Post-MFP/CCT	
Position	FTE	Permanent / Limited-Term	FMAP	Funding Source	FMAP
Health Program Manager I	1.0	Permanent	100%	Title XIX	50%
Health Program Specialist I	1.0	Permanent	100%		50%
Health Program Specialist I	1.0	Limited-Term	100%		50%
Research Program Specialist II	1.0	Limited-Term	100%		50%
Research Analyst II	1.0	Limited-Term	100%		50%
Associate Governmental Program Analyst	1.0	Limited-Term	100%		50%
Staff Services Analyst	1.0	Limited-Term	100%		50%
Nurse Evaluator II	1.0	Limited-Term	100%		75%
Nurse Evaluator II	1.0	Limited-Term	100%		75%
Nurse Evaluator II	1.0	Limited-Term	100%		75%
Nurse Consultant III	1.0	Permanent	75%		75%

CCT-funded State Staff

Health Program Manager I (HPM I) = 1.0 FTE, Permanent

During MFP/CCT Demonstration				Post-MFP/CCT	
Position	FTE	Permanent / Limited-Term	FMAP	Funding Source	FMAP
Health Program Manager I	1.0	Permanent	100%	Title XIX	50%

The CCT Project Director is an HPM I responsible for planning, directing, and managing the design and implementation of LTC waiver programs under the Medi-Cal program, including CCT.

In this capacity, the HPM I is responsible for managing a staff of analysts to provide recommendations to upper-management on high-level policy and operational issues, consulting with management and stakeholders on politically-sensitive and technical issues related to all programs administered by the LTCD, and communicating with project partners, including CHHS, sister state departments, the Olmstead Advisory Committee, health care providers, advocates, consumers, and stakeholders. The CCT Project Director duties include:

- Providing overall supervision of Unit staff/CCT team members including, but not limited to, conducting performance reviews, approving absence requests, and authorizing training and travel requests.
- Recruiting new CCT Lead Organizations.
- Managing global CCT issues such as improved access to affordable and accessible housing for participants.
- Supervising the drafting and production of the CCT quarterly and semi-annual reports.
- Overall administration of CCT, including project planning, coordination with internal and external partners, and coordination, monitoring, evaluation and reporting functions.
- Ensuring compliance with this protocol.
- Providing technical assistance to local partners and other departments.
- Convening and conducting regular meetings of the HCBS Stakeholder Advisory Workgroups.
- Acting as liaison with other state department partners.
- Sharing CCT activities and progress with partners and other interested stakeholders.
- Fostering important intra-departmental relationships.
- Ensuring compliance with all federally required demonstration and reporting requirements.
- Performing other duties as directed by the LTCD Section Chief and/or Division Chief.

Although this position is currently funded using MFP/CCT administrative funding, it is a permanent position within DHCS. When CCT Administrative funds are no longer available, the

position will be funded under Title XIX at 50/50 FMAP. The HPM I will oversee the closeout of the CCT and then be reassigned to manage a Unit under the new HCB Alternatives Waiver.

Health Program Specialists I (HPS I or Specialists)

During MFP/CCT Demonstration				**Post-MFP/CCT**	
Position	FTE	Permanent / Limited-Term	FMAP	Funding Source	FMAP
Health Program Specialist I	2.0	1 = Permanent 1 = Limited-Term	100%	Title XIX	50%

Under CCT, the Specialists work on a variety of projects, including but not limited to, the expansion and/or development of: affordable and accessible housing; service provider and support contracts; reports to the State Legislature; MFP/CCT policies, procedures, resources, and reports; etc. The Specialists are subject-matter experts who provide consultation and technical assistance to project team members, other state department representatives, stakeholders, and CCT LOs regarding state and federal laws, grant requirements, procedures governing the Medi-Cal program, the array of HCBS waivers, and how they coordinate with CCT. The Specialists are responsible for planning and facilitating stakeholder meetings and ad hoc work group meetings with project team members and partnering state department representatives; drafting official correspondence, briefing papers, technical assistance curriculum, and other products on inpatient facility transitions for review by executive management, state department partners, CHHS, and CMS. Finally, the Specialists secure project resources via Budget Change Concepts and Proposals (BCC and BCP) for future project years; and respond to legislative proposals, requests for bill analyses, and other administrative initiatives relative to long term care and the demonstration.

The Housing Coordinator's duties include:

- Provides focused assistance to LOs attempting to transition interested and eligible consumers into affordable and accessible housing.
- Working with state and local Public Housing Authorities (PHAs) and social service organizations to increase housing options for CCT participants. This includes the NED II and 811 voucher programs.

- Manage e-files and other paper documents pertaining to affordable and accessible housing.
- Performing other duties as directed by the Project Director and/or Section Chief.

The CCT – MDS State Point of Contact's duties include:

- Functioning as the California MDS State Point of Contact for inpatient nursing facility staff with questions on local contact area (LCA) referral agencies.
- Maintaining accurate information on the CCT and MDS websites.
- Ensuring all California counties have an active LCA to respond to nursing facility referrals.
- Working with CDPH on MDS reports due to CMS.
- Coordinating with the CCT Project Director to document, research, and assist with modifying and updating internal policies and processes for CCT services.
- Coordinating with the Project Director to document, research, and assist with resolution of barriers that make it difficult for lead organizations to transition interested and eligible consumers.
- Performing other duties as directed by the Project Director and/or Section Chief.

One Specialist position is permanent within the DHCS, and one is a limited-term position that will be reassigned to an open, or newly created position within the Department. When CCT Administrative funds are no longer available, both positions will be funded under Title XIX at 50/50 FMAP. The Specialists will work under the HCB Alternatives Waiver, and will continue to work to expand the availability of affordable and accessible housing; provide updates on MDS activities to executive management, the Olmstead Advisory Committee, nursing facility member associations, and other interested stakeholders; and continue to work on special projects and administrative initiatives.

Research Program Specialist II (RPS II)

During MFP/CCT Demonstration				**Post-MFP/CCT**	
Position	FTE	Permanent / Limited-Term	FMAP	Funding Source	FMAP

Research Program Specialist II	1.0	Limited-Term	100%	Title XIX	50%

The RPS II is responsible for complex research, analytical, consulting, and administrative services related to the financial, statistical, budgeting, fiscal forecasting, program evaluation, and policy development needs of the MFP/CCT Demonstration. The RPS II oversees research, analyst, and support staff in the collection, validation, organization and maintenance of data; and, collaborates with the Division's senior research staff in formulating appropriate methodologies for continuously evolving systems change. The RPS II is responsible for maintaining the central MFP/CCT database for developing data access protocols necessary for: 1) Federal and State fiscal, demographic, and performance reporting requirements; 2) Federal grant funding drawdowns, account transfers, and interdepartmental reimbursements; and 3) investigative study and consultation on the feasibility, impact, and alternative approaches for incorporating project changes, revising operations, and improving service access, quality and outcomes. The RPS II also plans, organizes, and assumes full responsibility for completion of fiscal, demographic, and performance reporting documents required for: 1) accurate and maximum drawdown of federal grant funds in accordance with complex allocations; 2) Medi-Cal and department General Fund allocation adjustments, in addition to applicable departmental program support expenditures; 3) inter-departmental service agreements; 4) Health and Human Services Agency Olmstead Committees; 5) ad hoc Directorate requests, departmental Medi-Cal cash flow investigations, and stakeholder and advisory groups for various Unit projects and programs; and 6) statistical and qualitative data analyses of the Federally-mandated Minimum Data Set 3.0 Section Q compliance requirements.

The CCT Data Coordinator's duties include:

- Maintaining CCT data systems and reporting requirements on the status of the CCT Project, which is reported to executive management, and Olmstead advisory committees, and CMS.
- Establishing and maintaining effective working relationships with staff from numerous DHCS divisions including Information Technology Services, Budgets, Accounting, and Fiscal Forecasting to ensure access to fiscal and programmatic data and consistency with claiming federal financial participation.
- Calculating and reporting on CCT's cost savings impact to the Medi-Cal program by tracking the QHCBS services selected by demonstration participants.
- Providing technical assistance and performing analysis on complex accounting documents to prevent duplication of payments.

- Ensuring consistency of reporting Medi-Cal expenditures under CCT's benchmarks, drawing upon data from multiple existing Medi-Cal systems.
- Performing other duties as directed by the Project Director and/or Section Chief.

As one of eight limited-term positions under the MFP/CCT Demonstration, the RPS II will be reassigned to an open, or newly created position within the Department when CCT Administrative funds are no longer available. The position will be funded under Title XIX at 50/50 FMAP and shall be responsible for collaborating with LTCD senior research staff to formulate and test new research and statistical methodologies and databases; independently refines, tests, and applies departmental methodologies, and mines data from CA-MMIS, MIS/DSS, SURS Prospector, and other departmental data warehouses for systematic, critical, and intensive investigation and resolution of program and project-related evolving issues. The RPS II will also interpret and provide recommendations on fiscal, demographic, and performance findings for their relevance and application to systems change leading to reduced reliance on long-term institutionalization of Medi-Cal members, compliance with the U.S. Supreme Court Olmstead decision for care within least restrictive settings, and improved quality of life for elders and persons with disabilities that have long-term service and support needs.

Research Analyst II (RA II)

During MFP/CCT Demonstration				**Post-MFP/CCT**	
Position	FTE	Permanent / Limited-Term	FMAP	Funding Source	FMAP
Research Analyst II	1.0	Limited-Term	100%	Title XIX	50%

The RA II performs a range of research and and analytical activities involved in the implementation, and evolution of MFP/CCT. The RA II works directly with the MFP/CCT RPS II, other state agencies, CMS, project management staff, and local governmental staff to perform tasks related to the administration of the demonstration. The RA II is responsible for meeting both federal and state cost reporting and Medicaid claiming requirements, and assists in the maintenance of the central MFP/CCT database. Finally, the RA II works with CCT nurses to

provide historical claims data and identifies participants' Medi-Cal and MFP/CCT eligibility status.

When the MFP/CCT Demonstration ends, this limited-term positon will be re-assigned within the DHCS' LTCS, and will be funded under Title XIX. Within DHCS, RA II's are assigned to work with data from CA-MMIS, MIS/DSS, SURS Prospector, and other departmental data warehouses.

Associate Governmental Program Analyst (AGPA)

During MFP/CCT Demonstration				**Post-MFP/CCT**	
Position	FTE	Permanent / Limited-Term	FMAP	Funding Source	FMAP
Associate Governmental Program Analyst	1.0	Limited-Term	100%	Title XIX	50%

The AGPA performs a range of analytical tasks relating to the MFP/CCT Demonstration, including but not limited to: processing Medi-Cal provider eligibility applications and service contracts for new CCT Lead Organizations; resolving conflicts in service eligibility and provider payments; and acts as a liaison between the Long-Term Care Projects Unit, other DHCS Divisions and the state's Fiscal Intermediary.

The Associate Governmental Program Analyst's duties include:

- Independently reviews the Quality of Life Surveys (QOLs) collected for each CCT participant and submitted by the LOs, and enters the data into the CMS Mathematica data collection system.
- Faxes monthly QOL reminder notices to each CCT LO reminding them of the QOLs that are due for their CCT participants each month.
- Prepares Operation Letters when billing codes or billing processes need to be changed or implemented.
- Processes all new CCT provider applications and contracts for eligible organizations.
- Collects and reviews all CCT provider re-validation notices and writes re-validation exemption request memos to exempt CCT providers from the re-validation fees.
- Performing other duties as directed by the Project Director and/or Unit Chief.

When the MFP/CCT Demonstration ends, this limited-term positon will be reassigned within the DHCS' LTCD, and will be funded under Title XIX. Within DHCS, AGPAs are responsible for the organization of information, research and analysis of operational and health care issues, research and application of federal statutes and regulations, and technical tasks related to provider and program operations. AGPAs are often also required to provide reports to management and technical assistance to providers on issues related to program quality and/or consumer satisfaction.

Staff Services Analyst (SSA)

During MFP/CCT Demonstration				**Post-MFP/CCT**	
Position	FTE	Permanent / Limited-Term	FMAP	Funding Source	FMAP
Staff Services Analyst	1.0	Limited-Term	100%	Title XIX	50%

The SSA is responsible for a variety of standardized and recurring analytical tasks relating to the MFP/CCT Demonstration. The SSA is responsible for the validation and organization of data and information submitted by CCT Lead Organizations providing services to CCT Enrollees and Participants. The SSA also screens data for anomalies and pursues resolution when appropriate.

The Staff Services Analyst duties include:

- Maintaining CCT enrollee's/participant's transition coordination documents according to HIPAA regulations.
- Organizes and facilitates meetings related to assigned tasks.
- Performing other duties as directed by the Project Director and/or Unit Chief.

When the MFP/CCT Demonstration ends, this limited-term positon will be re-assigned within the DHCS' LTCD, and will be funded under Title XIX. Within DHCS, SSAs provide analysis of operational and health care delivery system issues, and they conduct research on federal statutes, directives, and regulations, and technical tasks related to provider and program operations. SSAs are often responsible for analyzing processes on a continuous basis for

opportunities for cost-savings and efficiencies, and for monitoring public information for accuracy and consistency as it relates to the State Medicaid Program and the DHCS.

Nurse Evaluator II (NE II)

During MFP/CCT Demonstration				**Post-MFP/CCT**	
Position	FTE	Permanent / Limited-Term	FMAP	Funding Source	FMAP
Nurse Evaluator II	3.0	Limited-Term	100%	Title XIX	75%

The NE IIs are responsible for the evaluation of TCPs developed for CCT enrollees through the application of clinical standards and concepts necessary to ensure safe and sustainable transitions. The NE IIs are responsible for: conducting, reviewing, validating, and documenting compliance with HCBS waiver requirements; evaluating LOC determinations; and monitoring the integration of HCB LTSS for seniors and persons with disabilities and Medicare/Medi-Cal Dual eligible members under a managed care delivery system. As integral members of the CCT Project team, the NEIIs review CCT eligibility, participants' service plans to insure needed LTSS are in place prior to the member leaving the institution, mechanisms put in place to mitigate risk, and the final Medi-Cal funded home and community based services plan. The NE IIs are also responsible for adjudicating TARs submitted by CCT LOs and for providing technical assistance to LOs on an ongoing basis, particularly on quality management relevant to CCT participants' health and welfare.

The NE II duties include:

- Reviewing the TCPs to ensure they are comprehensive, and clearly address identified LOC needs and individual preferences of enrollees.
- Working with TCs on CCT and waiver enrollment issues to ensure participants remain safe and sustained in a community setting.
- Adjudicating TARs for enrollee/participant services.
- Monitoring the quality and effectiveness of the transitions
- Coordinating with the appropriate waiver case managers to synchronize delivery of services on the first day of the demonstration.

- Providing guidance, training, and technical assistance to TCs as they follow the demonstration participants during the 365-day participation.
- Performing other duties as directed by the Project Director and/or Unit Chief.

When the MFP/CCT Demonstration ends, these three limited-term positons will be re-assigned within the DHCS' LTCD, and will be funded under Title XIX. Within DHCS, NE IIs are responsible for clinical administration of HCBS waivers, adjudicating HCBS TARs, and for monitoring and oversight activities which includes but is not limited to: review and inspection of provider facilities and records and also ensures contractor's medical personnel meet applicable professional licensing and accreditation requirements. NE IIs prepare and present written and verbal reports of findings; provides technical assistance to service providers and others on required corrective actions and improvements to waiver operations. Finally, NE IIs are also responsible for providing training and education to new home and community-based services waiver providers.

Nurse Consultant III (NC III)

During MFP/CCT Demonstration				**Post-MFP/CCT**	
Position	FTE	Permanent / Limited-Term	FMAP	Funding Source	FMAP
Nurse Consultant III	1.0	Limited-Term	75%	Title XIX	75%

The NC III develops and applies specialized clinical knowledge and skills to support the implementation of CCT. The NC III is a subject matter expert in the medical and supportive service needs of older adults and persons with disabilities who have long-term health care needs. The NC III provides technical assistance and training to CCT LOs, and drafts policy recommendations for facilitating innovative changes to Medi-Cal HCBS waivers and services. The NC III drafts written policy and procedures and provides in-service training and educational materials to analytical staff, other state department representatives, and community organizations.

The NC III duties include:

- Serving as a resource for clinical issues around transition.

- Providing direct technical assistance to resolve problems related to complex and sensitive transition cases.
- Serving as a member of team updating CCT Operational Protocol.
- Draft clinical policies and procedures, as well as guidance letters for CCT Project.
- Performing other duties as directed by the Project Director, Section Chief, and/or Division Chief.

The NC III position is a permanent position within the DHCS. When the MFP/CCT Demonstration ends, this positon will remain within the DHCS' LTCD, and will be funded under Title XIX. At the end of the MFP/CCT Demonstration, the NC III will shift her focus from the MFP/CCT Demonstration to the development of policies and change relative to Medi-Cal HCBS waivers, the California Health and Human Services Agency's Olmstead Plan, and the Americans with Disabilities Act. The NC III also reviews clinical literature and shares her perspective with LTCD team members; provides information on best practices relative to: quality assessment, utilization review, health care and supportive services delivery, case management, and benefits. Finally, the NC III is responsible for attending training and educational forums to become familiar with, and stay current on, Medi-Cal policy issues and to share what she learns with both state and local stakeholders.

C.2 Billing and Reimbursement Procedures

All services offered to CCT enrollees and participants will comply with DHCS' existing guidelines to prevent duplication of services, fraud, and/or financial abuses. The CCT program will operate within guidelines and procedures currently established for Medi-Cal (Medicaid) programs in the State of California, unless specifically stated otherwise, utilizing the state's current systems. A Treatment Authorization Request (TAR) will be submitted by the CCT LOs for every CCT service. Once approved, the CCT LO will submit a claim for payment to the contracted fiscal intermediary.

CCT providers will submit claims for individual CCT services to the fiscal intermediary through the existing Medi-Cal fee-for-service payment mechanism. CCT project staff maintain records in a Microsoft Access database of all CCT enrollees and participants for the purposes of tracking

service utilization and appropriate billing. CCT project staff utilize the Management Information System/Decision Support System (MIS/DSS) to review CCT service claims to ensure accurate and appropriate billing. The MIS/DSS is a subsystem of the California Medicaid Management Information System (CA-MMIS) and serves as DHCS' Medi-Cal Data Warehouse. In the event that incorrect billing is discovered, the CCT Project Director (PD) will follow up with the CCT provider to inform them of the need to submit a claim inquiry form (CIF) to return the money to DHCS. The CCT PD also takes this opportunity to provide technical assistance (TA) on appropriate billing practice. Any egregious billing errors will be referred to DHCS' CA-MMIS and/or Audits & Investigations (A&I) Division for follow up.

DHCS' CA-MMIS Division will administer the Medi-Cal claiming system and manages the state's contract with the fiscal intermediary. All claims processed through the fiscal intermediary are subject to random post adjudication, pre-payment verification for detection of errors, irregularities, and potential for waste, fraud, or abuse. Specific criteria for appropriate claims processing has been established and measurements against these criteria occur weekly before the release of payments. All CCT LOs will be required to receive training from the state fiscal intermediary in order to submit claims for CCT services rendered.

The DCHS' A&I Division is responsible for ensuring the fiscal integrity and medical necessity of Medi-Cal services. All claims submitted by HCBS waiver and state plan providers are subject to random review regardless of provider type, specialty, or service rendered. A&I auditors verify that claims selected have sufficient documentation to approve the claim for payment. Providers are notified if a claim requires additional documentation before approval for payment. Failure to comply with the request for additional documentation may result in suspension from the Medi-Cal program, pursuant to Welfare and Institutions (W&I) Code § 14124.2.

There are three branches within the A&I Division that conduct reviews using various methodologies to ensure program integrity and the validity of claims for reimbursement.

1. The A&I Medical Review Branch (MRB) performs essential medical reviews of non-institutional providers. Providers may also be subject to a more comprehensive review on a weekly basis known as a pre-check write review. This review is based on a set of criteria, such as irregular billing patterns, designed to identify potential fraud or abuse. Providers selected for this comprehensive review may also receive an on-site visit by A&I staff. The outcome of these reviews may result in program removal, monetary penalties, or less intrusive sanctions and utilization controls.

2. MRB also conducts Medi-Cal provider anti-fraud activities which include performing field reviews on new Medi-Cal providers and providers undergoing re-enrollment. MRB is charged with bringing closure to sanctioned providers through audits designed to quantify the abuse, settlement agreement, or permissive suspensions (exclusions) from the Medi-Cal program. Failure to comply with any request by A&I staff for documentation may result in administrative sanctions, including suspension from the Medi-Cal program, pursuant to W&I Code, Section 14124.2. MRB staff work closely with CA-MMIS and the fiscal intermediary in data mining and extracting processes as well as the performance of the annual Medi-Cal Payment Error Study.
3. The A&I Financial Audits Branch performs cost settlement and rate setting audits of institutional providers, including hospitals, nursing facilities, and certain clinics.
4. The A&I Investigations Branch (IB) conducts investigations of suspected Medi-Cal beneficiary fraud as well as preliminary investigations of provider fraud. IB is also responsible for coordinating provider fraud referrals to the Department of Justice (DOJ) and Federal Bureau of Investigation. Suspected fraud or abuse identified through any audit or investigation process is referred to DOJ via the IB. IB and MRB coordinate the placing of administrative sanctions on providers with substantiated evidence of fraud. IB serves as DHCS' principal liaison with outside law enforcement and prosecutorial entities regarding Medi-Cal fraud.

Section D – Independent State Evaluation

The state does not propose to administer a distinct evaluation of CCT. Demonstration enrollees/participants will, however, participate in the federally required QOLs and in quality improvement activities DHCS carries out in the course of overseeing the provision of Medi-Cal HCBS.

Section E – Final Project Budget

MFP Demonstration Service Cost Estimates

Demonstration service expenditures of former CCT enrollees and participants were used to estimate costs. All CCT enrollees and participants will receive appropriate demonstration services up to the existing caps. Enrollment trends were evaluated and an average, per transition cost for each target population was established.

Demonstration service expenditures are in addition to QHCBS and state plan service expenditures. For purposes of this budget, it is estimated that 100% of non-DD CCT participants will receive demonstration services valued at $8,357. It is estimated that 100% of DD CCT participants will receive demonstration services valued at $64,587. Demonstration services include pre- and post-transition coordination, home set-up, home modification, habilitation, personal care services, family and informal caregiver training, vehicle adaptations, and assistive devices. Demonstration services may or may not be available through existing HCBS waivers. To ensure successful transitions, these demonstration services are made available to all CCT enrollees and participants and documented in each individual's TCP.

Refer to section B.5 for more information on demonstration HCBS.

MFP Qualified Home and Community-Based Services (QHCBS) Cost Estimates

All CCT participants will utilize QHCBS post-transition. QHCBS service expenditures of former CCT participants were used to estimate costs. Enrollment and transition trends were evaluated and an average per transition cost for each target population was established.

QHCBS expenditures are in addition to demonstration service expenditures and state plan service expenditures. For the purposes of this budget, it is estimated that 100% of non-DD CCT participants will receive QHCBS valued at $18,000. It is estimated that 100% of DD CCT participants will received QHCBS valued at $105,000. QHCBS include the HCBS utilized post-transition through a 1915(c) HCBS waiver or the state plan. See Appendix 11 for a crosswalk of QHCBS captured for each CCT participant. To ensure successful transitions, CCT LOs work with the CCT enrollee and/or his/her legal representative to determine the QHCBS that will best meet the CCT enrollees needs. All QHCBS are in the CCT enrollees' TCP.

MFP Administrative Cost Estimates

Administrative – 100%

Administrative costs reimbursed at 100% include the following:

1. Personnel expenditures including salary, fringe benefits, travel, equipment, and supplies were calculated for each CCT project team member.
2. Contracts.
    a. California Department of Aging (CDA) support staff and activities for the Aging Disability Resource Centers (ADRCs). Trainings to CCT Lead Organizations (LOs). CDA maintains the state level infrastructure to support, expand and strengthen ADRC "no wrong door" partnerships and services in California. CDA will develop, in collaboration with CCT Project Staff, an on-going statewide MFP orientation and resource guide program, inclusive of transition coordination, CCT Program requirements, and person-centered counseling interviewing techniques. CDA will also maintain the state infrastructure to support, expand, and strengthen ADRC "no wrong door" partnerships and services in California including, but not limited to, providing ongoing technical assistance to local organizations, conducting or facilitating access to person-centered counseling training, maintaining the ADRC website, and conducting outreach. This contract and the work performed by CDA to expand ADRC partnerships and provide on-going training and support to CCT LOs aides in the achievement of benchmark #4 which is to increase the utilization of transition coordinators used to assist individuals in Medicaid find appropriate services and supports in the community.
3. Costs for CCT enrollees who do not transition.

Administrative – 75%

Administrative costs reimbursed at 75% include the personnel expenditures including salary, fringe benefits, travel, equipment, and supplies for one Nurse Consultant III.

Administrative – 90%

Administrative costs reimbursed at 90% include the costs related to MMIS programming modifications to enable tracking of the associated expenditures/claims for all CCT enrollees and participants.

1. Support from the Enterprise Information Technology Services (EITS) Division within DHCS. This is a cost for the services performed by EITS to process large reports containing MFP claims data. This data is utilized to build quarterly memos which are submitted to accounting and used to draw down MFP grants funds. In the initial Operational Protocol, an estimated amount of $500,000 was projected for a 5-year demonstration period under Administrative – 90% for the costs related to MMIS programming modifications to enable tracking of demonstration participants and the associated expenditures/claims in addition to costs for modifying existing databases utilized by partner agencies or managed care plans that will provide qualified HCBS, demonstration, and/or supplemental services to demonstration. The continued costs for this work equals $27,000 each calendar year which is reimbursed 90% Federal and 10% Non-Federal.
2. The data received through support from EITS assists in the achievement of benchmark #2 to determine the total federal and state expenditures on HCBS throughout the MFP demonstration period.

Position Title	Position Status	Federal	Non-Federal Match
Associate Governmental Program Analyst	Filled	100%	0%
Health Program Manager I	Filled	100%	0%
Health Program Specialist II - MDS	Filled	100%	0%
Health Program Specialist I - Housing	Filled	100%	0%
Nurse Evaluator II	Filled	100%	0%
Nurse Evaluator II	Filled	100%	0%

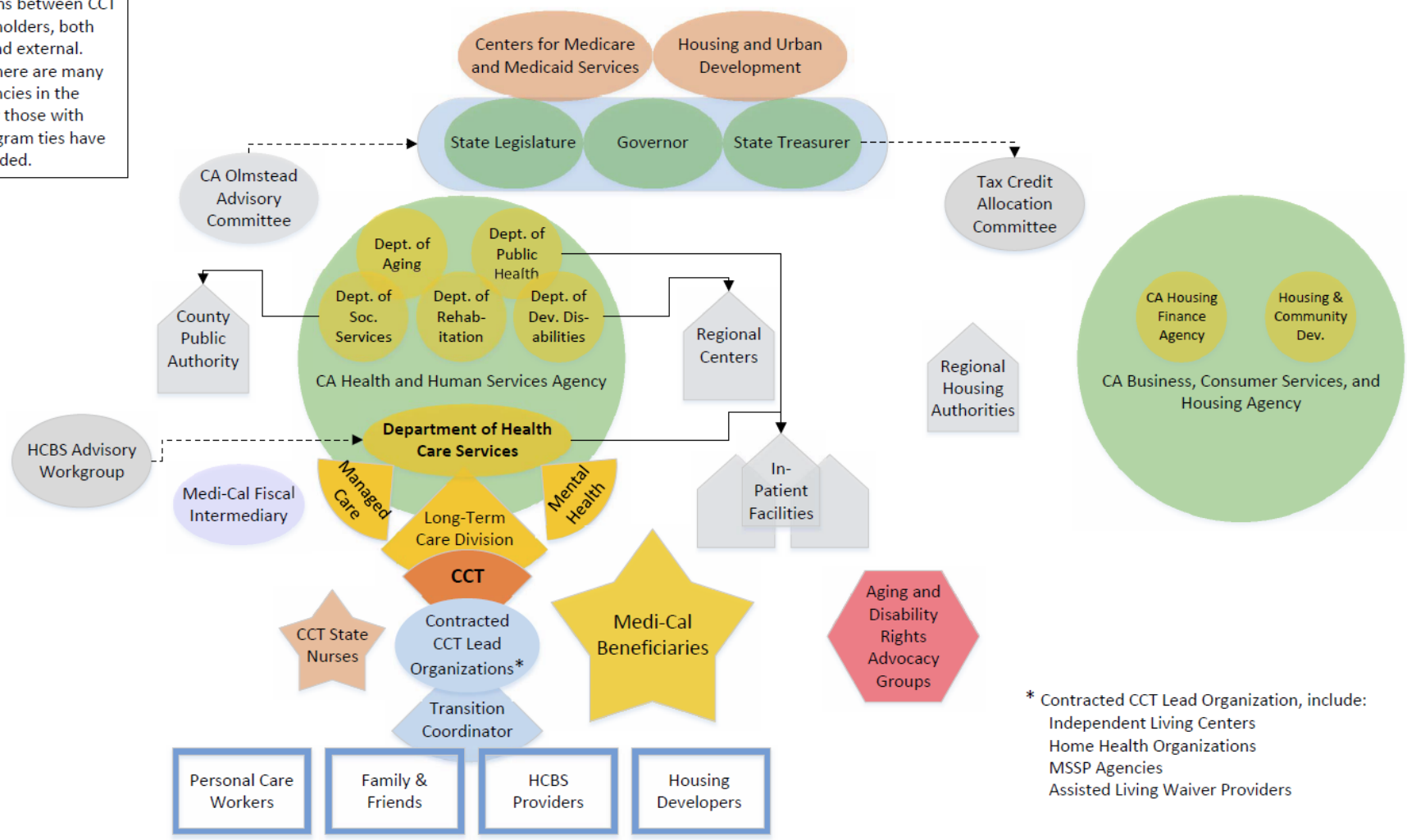
Nurse Evaluator II	Filled	100%	0%
Research Analyst II - Data	Filled	100%	0%
Research Program Specialist I - Fiscal	Filled	100%	0%
Staff Services Analyst	Filled	100%	0%
Nurse Consultant III	Filled	75%	25%

Appendices

This chart depicts connections between CCT and stakeholders, both internal and external. Because there are many other agencies in the state, only those with direct program ties have been included.

California Community Transitions (CCT) Project
Internal and External Stakeholders

Appendix 1A

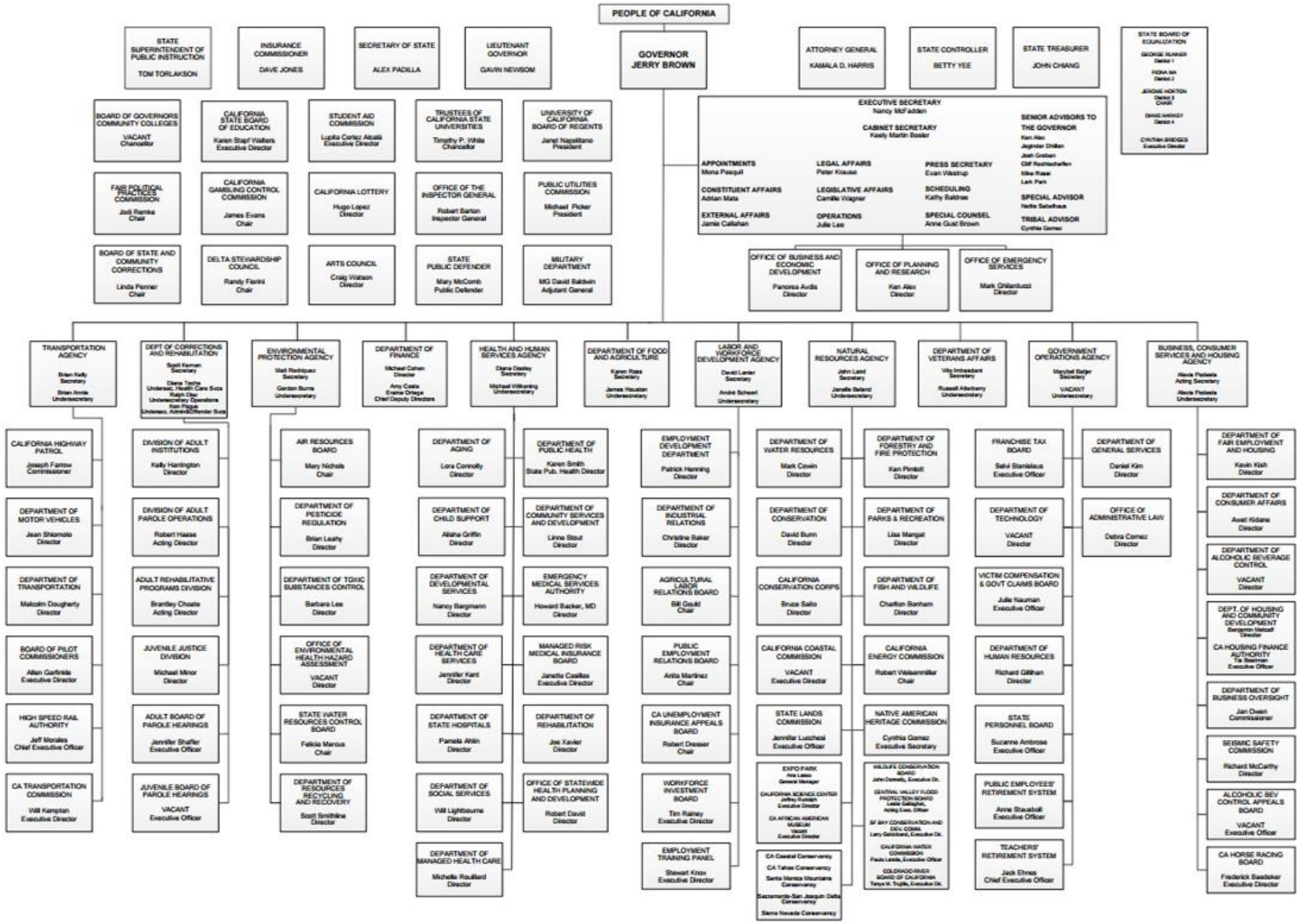


* Contracted CCT Lead Organization, include:
Independent Living Centers
Home Health Organizations
MSSP Agencies
Assisted Living Waiver Providers

Appendix 1B

5.26.16

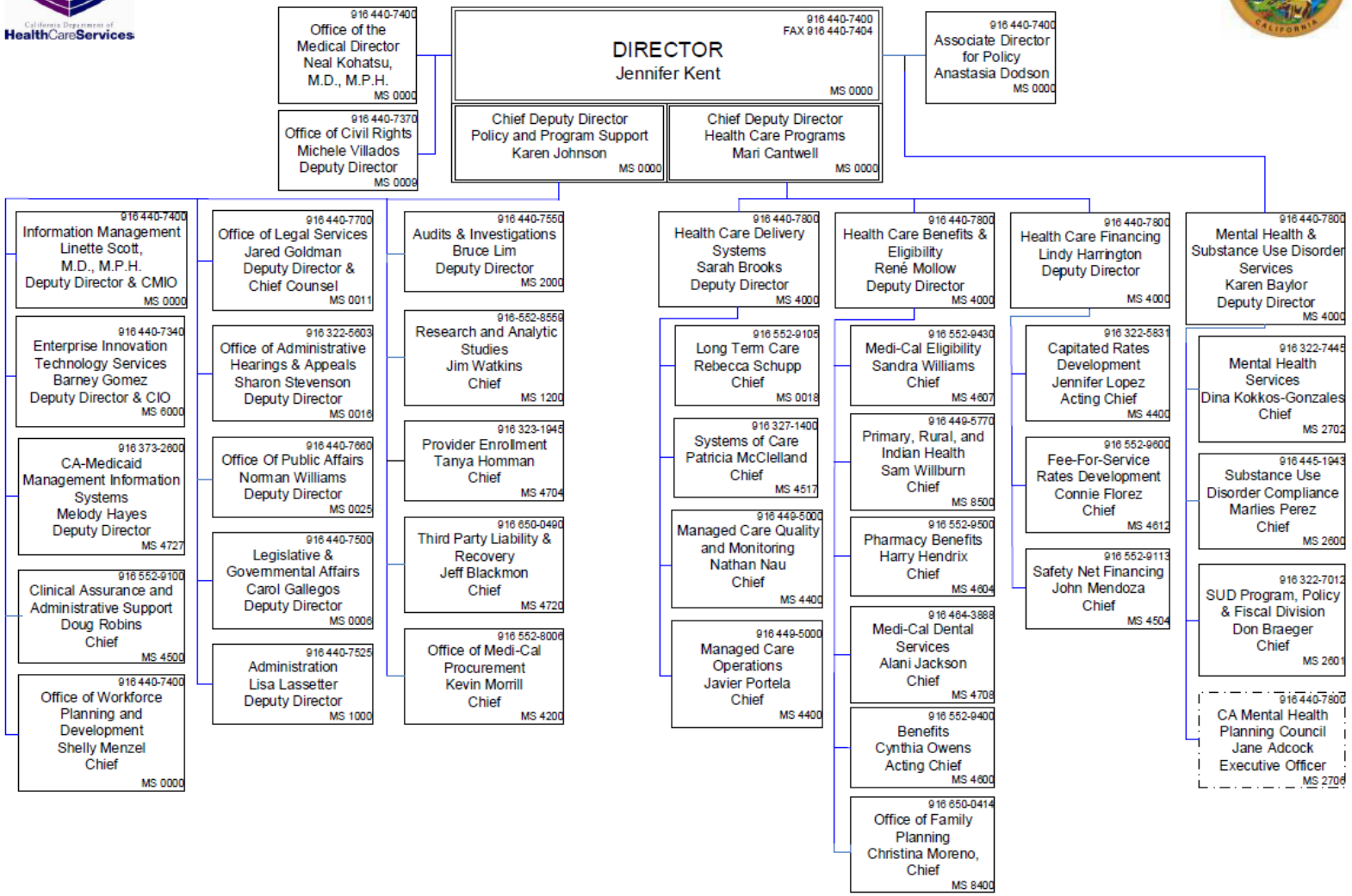
CALIFORNIA STATE GOVERNMENT – THE EXECUTIVE BRANCH



Appendix 1C

Department of Health Care Services

June 14, 2016



1915(c) Home and Community-Based Services Waivers (HCBS)

Title	Description	Enrollment Capacity[11]	Term
Acquired Immune Deficiency Syndrome (AIDS) Medi-Cal Waiver	Provides HCBS to Medi-Cal beneficiaries with mid to late-stage HIV/AIDS as an alternative to long-term nursing facility or hospital care. Services include: minor home modifications, case management, home health aide/attendant care, skilled nursing, non-emergency medical transportation, homemaker services, nutritional counseling, specialized medical equipment, home delivered meals, psychotherapy, and nutritional supplements.	3,560 – CY 2007 3,720 – CY 2008 3,890 – CY 2009 4,070 – CY 2010 4,250 – CY 2011 4,330 – CY 2012 4,410 – CY 2013 4,490 – CY 2014 4,570 – CY 2015 4,660 – CY 2016	01-01-17 – 12-31-21

[11] By Waiver Year (WY), or by Calendar Year (CY)

1915(c) Home and Community-Based Services Waivers (HCBS)

Title	Description	Enrollment Capacity[12]	Term
Assisted Living Waiver (ALW)	Provides HCBS services as an alternative to long-term nursing facility placement to Medi-Cal beneficiaries over the age of 21 in either of two settings: a Residential Care Facility (RCF) for the Elderly; or in Publicly Subsidized Housing (PSH) with a Home Health Agency providing the assisted care services. Qualified participants have full-scope Medi-Cal benefits with zero share of cost and are determined to meet the Skilled Nursing Facility Level of Care, A or B. Services include: nursing home transitional services,[13] care coordination, assisted living services in the PSH setting, assisted care services in the RCFE setting, residential habilitation, and augmented plan of care development and follow-up.	200 – CY 2006 600 – CY 2007 1000 – CY 2008 1,300 – CY 2009 1,720 – CY 2010 2,260 – CY 2011 2,920 – CY 2012 3,700 – CY 2013 3,700 – CY 2014 3,700 – CY 2015 3,700 – CY 2016	03/01/14 – 02/28/19

[12] By Waiver Year (WY), or by Calendar Year (CY)

[13] Nursing home transitional services is a one-time benefit to compensate the Care Coordination Agency (CCA) for the higher cost/effort of transitioning someone from skilled nursing into the assisted living setting. It is equivalent to five months of on-going care coordination, or $1000.

1915(c) Home and Community-Based Services Waivers (HCBS)

Title	Description	Enrollment Capacity[14]	Term
Home and Community-Based Services for the Developmentally Disabled (HCBS-DD) Waiver	Provides HCBS to developmentally disabled persons who are regional center clients and reside in the community as an alternative to care provided in an intermediate care facility for the developmentally disabled (ICF/DD). Services include: minor home modifications, respite care, personal emergency response system, home health aide services, habilitation, transportation, communication aides, family training, homemaker / chore services, nutritional consultation, specialized medical equipment/supplies, crisis intervention, and supported employment and living services.	75,000 – WY 06-07 80,000 – WY 07-08 85,000 – WY 08-09 90,000 – WY 09-10 95,000 – WY 10-11 105,000 – WY 11-12 100,000 – WY 12-13 105,000 – WY 13-14 115,000 – WY 14-15 120,000 – WY 15-16	3/29/12 – 6/26/2017* *Waiver renewal pending, as of 5-5-17

[14] By Waiver Year (WY), or by Calendar Year (CY)

1915(c) Home and Community-Based Services Waivers (HCBS)

Title	Description	Enrollment Capacity[15]	Term
Multipurpose Senior Services Program (MSSP) Waiver	Provides HCBS to Medi-Cal beneficiaries who are 65 or over and disabled as an alternative to nursing facility placement. HCBS allow the individuals to remain in their homes. Services include: health care and personal care assistance, respite care, housing assistance, meal services, transportation, protective services, communication services[16] and chore services.	16,335 – WY 06-11 16,335 – WY 11-12 12,080 – WY 12-13 12,080 – WY 13-14 12,000 – WY 14-15 11,864 – WY 15-16 11,797 – WY 16-17	07/01/14 – 06/30/19

[15] By Waiver Year (WY), or by Calendar Year (CY)

[16] The communication service is the personal emergency response system, a 24-hour emergency assistance electronic device that enables the beneficiary to contact EMS in the event of an emergency.

1915(c) Home and Community-Based Services Waivers (HCBS)

Title	Description	Enrollment Capacity[17]	Term
Nursing Facility/Acute Hospital Transition and Diversion Waivers (NF/AH Waiver)	The waiver now is a combination of the previous Nursing Facility/Acute Hospital (NF/AH) Waiver and the Developmentally Disabled Continuous Nursing Care (DD-CNC) Waiver which were merged in late 2012. Services include: minor home modifications, case management, respite care (home & facility), personal emergency response system, community transition services, habilitation, family training, personal care services, transitional case management, medical equipment operating expenses, and private duty nursing, including shared services.	2,552 – CY 2008 2,712 – CY 2009 2,872 – CY 2010 3,032 – CY 2011 3,192 – CY 2012 3448 – CY 2013 3620 – CY 2014 3,792 – CY 2015 3,964 – CY 2016	01/01/12 – 06/30/17* *Renewal pending under a different name, as of 5-5-17

[17] By Waiver Year (WY), or by Calendar Year (CY)

1915(c) Home and Community-Based Services Waivers (HCBS)

Title	Description	Enrollment Capacity[17]	Term
Pediatric Palliative Care Waiver (PPCW)	This waiver offers children with complex life threatening conditions care coordination and a range of home-based palliative care services while they maintain the option of receiving curative treatment. According to diagnosed need and an approved plan of care, services include: care coordination, pain and symptom management, expressive therapies, family training, client and family anticipatory grief and bereavement counseling, and respite care.	N/A – CYs 2007-2009 801 – CY 2010 1,802 – CY 2011 1,802 – CY 2012 1,800 – CY 2013 1,800 – CY 2014 1,800 – CY 2015 1,800 – CY 2016	12/27/12 – 12/26/17

1915(b) Freedom of Choice Waivers

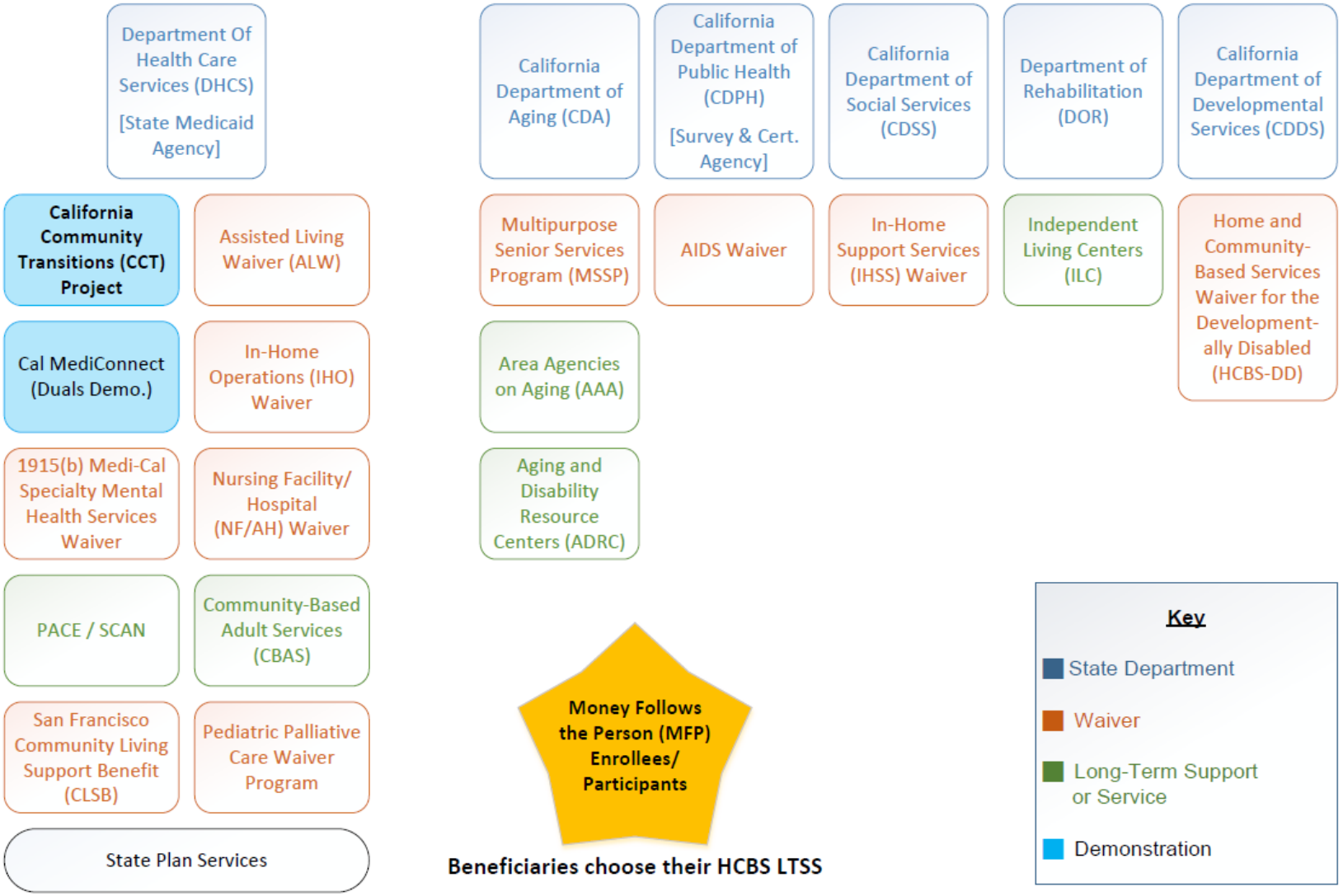
Title	Description	Enrollment Capacity	Term
Medi-Cal Specialty Mental Health Services (SMHS) Waiver	Provides specialty mental health services for Medi-Cal beneficiaries with specified diagnoses requiring treatment by licensed mental health professionals through county mental health plans.	N/A	Through 06/30/20

1115 Demonstration Project Waivers

Title	Description	Enrollment Capacity	Term
Duals Demonstration Waiver - Managed Medi-Cal Long Term Supports and Services (MMLTSS)	For eligible adults age 21 and older who are full benefit Medicare and Medi-Cal dual eligible or full benefit Medi-Cal eligible, the waiver combines a full continuum of acute, primary, institutional, and home- and community-based services for dually eligible beneficiaries into a single benefit package, delivered through an organized service delivery system. This waiver also provides for Medi-Cal managed care plans to include HCBS in the plan benefit package to Medi-Cal only SPDs or persons who opt out of Cal MediConnect, Nearly all Medi-Cal beneficiaries age 21 and older, including dual eligible beneficiaries, will be required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including LTSS and Medicare wrap-around benefits.	N/A	N/A
Duals Demonstration Waiver - Coordinated Care Initiative (Cal MediConnect)	A voluntary three-year demonstration program for Medicare and Medi-Cal dual eligible beneficiaries will coordinate medical, behavioral health, long-term institutional, and home-and community-based services through a single health plan. The CCI provides state authority for Cal MediConnect. The MOU executed in March 2013 with the federal Centers for Medicare & Medicaid Services (CMS) provides federal approval.	N/A	_____

Appendix 2B

California Community Transitions (CCT) Rebalancing Demonstration
Home and Community-Based Waivers & Long-Term Services and Supports Programs



Initial and Current Strategies for Establishing New Waiver and State Plan Services

Appendix 2C

2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Pre-Implementation Phase: Write Operational Protocol Develop partnerships with potential lead organizations Work with stakeholders to determine demonstration and supplemental services	A1. Begin transitioning residents using existing Medi-Cal transition coordination services procedure codes	Continue A1.	Continue A1.	Continue A1.	Continue A1.	Continue A1.	Continue A1.	Continue A1.	Continue A1.
	B1. Compare QHCBS across all waivers	B2. Analyze differences in existing HCBS and state plan services B3. Evaluate findings on waiver service comparison	B4. Develop standardized terminology and definitions for specific HCBS services across waivers	B5. Recommend standardized terminology for similar QHCBS across waivers	Continue B5.	Continue B5.	Continue B5.	Continue B5.	Continue B5.
	C1. Determine initial demonstration and supplemental services C2. Develop enhanced/expanded HCBS waiver and state plan service definitions for demonstration and supplemental services	Continue C2. C3. Analyze the use of demonstration and supplemental (if any) services	Continue C3. C4. Evaluate effectiveness of making certain demonstration and supplemental services a core QHCBS	Continue C4. C5. Make recommendations for inclusion of enhanced/expanded services into existing waivers and/or state plan	Continue C5.	Continue C5.	Continue C5.	Continue C5.	Continue C5.
				D1. Build capacity to leave a LTSS network in place once CCT Project funding ends.	Continue D1.	Continue D1.	Continue D1.	Continue D1.	Continue D1.

Appendix 2D

State Plan and Waiver Services Available to the CCT Demonstration Sub-Populations

Target Population	State Plan Services	In-Home Support Services (IHSS)	AIDS Medi-Cal Waiver Program	Assisted Living Waiver (ALW)	Community Living Support Benefit (CLSB) Waiver - San Francisco Only -	Home and Community-Based Services for the Developmentally Disabled (HCBS-DD)	* Duals Demonstration * Medicaid Managed Long-Term Services & Supports (MMLTSS)	* Duals Demonstration * California Coordinated Care Initiative (Cal MediConnect)	Multipurpose Senior Services Program (MSSP) Waiver	In-Home Operations & Nursing Facility/Acute Hospital Waivers (NF/AH Waiver)	Pediatric Palliative Care Waiver (PPCW)	Medi-Cal Specialty Mental Health Services (SMHS) Waiver	CCT Demonstration
A. Elders	X	X		X	X		X	X	X	X			X
B. MR/DD	X	X				X	X	X			X		X
C. Physical Disability	X	X	X	X	X		X	X		X	X		X
D. Mental Illness	X	X		X			X	X		X	X	X	X

A Elders (65+) with one or more medical, functional, or cognitive disability
B Persons with developmental disabilities
C Persons with one or more physical disabilities
D Persons with mental illness

Appendix 2E

State Plan and Waiver Services - Level of Care Overview

	Acute Hospital	Sub-Acute	Nursing Facility B	Nursing Facility A	No LOC Required
State Plan Services					•
In-Home Support Services (IHSS)					•
AIDS Medi-Cal Waiver Program - 1915(c)			•	•	
Assisted Living Waiver (ALW) Program - 1915(c)			•	•	
Community Living Support Benefit (CLSB) Waiver - 1115 *- - - San Francisco Only - - -*			•	•	
Home and Community-Based Services for the Developmentally Disabled (HCBS-DD) - 1915(c)			•	•	
* Duals Demonstration * Medicaid Managed Long-Term Services and Supports (MMLTSS) - 1115			•	•	
* Duals Demonstration * California Coordinated Care Initiative (Cal MediConnect) - 1115					•
Multipurpose Senior Services Program (MSSP) Waiver - 1915(c)			•	•	
Nursing Facility/Acute Hospital (NF/AH) Waiver - 1915(c)	•	•	•	•	
Pediatric Palliative Care Waiver - 1915(c) Partners For Children (PFC)	•				
Medi-Cal Specialty Mental Health Services (SMHS) Waiver - 1915(b)	Mental health services requiring treatment by licensed mental health professionals are provided through county mental health plans				

California Community Transitions (CCT) Project
Services Available under Medi-Cal
- State Plan - Home and Community-Based (HCBS) Waivers - Demonstrations -

Appendix 2F

	State Plan Services	AIDS Waiver Services	Assisted Living Waiver Services	Community Living Support Benefit Waiver	Developmental Disabilities Waiver Services	Duals Demonstration (MLTSS)	Duals Demonstration (Cal MediConnect)	MSSP Waiver Services	NF/AH Waiver Services	Pediatric Palliative Care Waiver Services	Specialty Mental Health Services	CCT Demonstration Services
Level(s) of Care (LOC)	**All LOC**	**NF-A NF-B**	**NF-A NF-B**	**NF-A NF-B**	**NF-A NF-B**	**All LOC**	**All LOC**	**NF-A NF-B**	**NF-A NF-B Sub-Acute Acute**	**Acute**	**All LOC**	
Service Categories												
Transition Coordination Services		D	*Q/D*		D		Q	*Q/D*	*Q/D*		D	
Health Care Services												
Allied Health/Other Therapies	Q				Q							
Behavioral Intervention	Q	Q			Q	Q		Q			Q	
Case Management/ Care Coordination-Ongoing	Q[1]	Q	Q		Q	Q	Q	Q	Q	Q	Q[1]	
Day Health Care - Adult	Q					Q	Q					
Day Health Care - Pediatric	Q											
Durable Medical Equipment	Q	Q			Q		Q					
Hospice Care	Q											
Medication Administration	Q	Q	Q		Q				Q			
Medical Social Services	Q											

[1] Optional through Care Plan Option (CPO) Services

Key: Q = Qualified State Plan of Waiver Service
D = Demonstration Service

Appendix 3

Medi-Cal Threshold Language Summary

Population Totals as of July 2012 (information updated through August 2013)

Note: Percent of County Totals Only Valid within Counties

Languages by County	Sum of Eligibles	Sum of Percent of County
Alameda	**91,540**	**33.85%**
Spanish	65,252	24.13%
Cantonese	14,792	5.47%
Vietnamese	7,687	2.84%
Mandarin	3,809	1.41%
Amador	**277**	**5.68%**
Spanish	277	5.68%
Butte	**4,901**	**9.03%**
Spanish	4,901	9.03%
Calaveras	**404**	**5.48%**
Spanish	404	5.48%
Colusa	**2,597**	**49.99%**
Spanish	2,597	49.99%
Contra Costa	**44,264**	**29.02%**
Spanish	44,264	29.02%
Del Norte	**451**	**5.30%**
Spanish	451	5.30%
El Dorado	**2,914**	**14.28%**
Spanish	2,914	14.28%
Fresno	**117,601**	**35.77%**
Spanish	106,383	32.35%
Hmong	11,218	3.41%
Glenn	**2,326**	**30.52%**
Spanish	2,326	30.52%
Humboldt	**1,510**	**5.29%**
Spanish	1,510	5.29%
Imperial	**34,547**	**56.41%**
Spanish	34,547	56.41%
Inyo	**856**	**21.44%**
Spanish	856	21.44%
Kern	**86,167**	**34.30%**
Spanish	86,167	34.30%
Kings	**12,752**	**33.43%**
Spanish	12,752	33.43%
Lake	**2,095**	**11.10%**
Spanish	2,095	11.10%
Los Angeles	**1,316,299**	**52.07%**
Spanish	1,113,223	44.04%
Armenian	61,755	2.44%
Cantonese	27,284	1.08%
Vietnamese	22,936	0.91%
Korean	20,769	0.82%
Mandarin	18,934	0.75%

Appendix 3

Tagalog	11,999	0.47%
Farsi	11,695	0.46%
Russian	10,792	0.43%
Cambodian	8,788	0.35%
Arabic	4,474	0.18%
Other Chinese	3,650	0.14%
Madera	**22,579**	**47.22%**
Spanish	22,579	47.22%
Marin	**11,260**	**46.75%**
Spanish	11,260	46.75%
Mendocino	**5,600**	**22.41%**
Spanish	5,600	22.41%
Merced	**34,215**	**38.50%**
Spanish	31,179	35.09%
Hmong	3,036	3.42%
Modoc	**210**	**9.72%**
Spanish	210	9.72%
Mono	**809**	**51.23%**
Spanish	809	51.23%
Monterey	**59,901**	**58.58%**
Spanish	59,901	58.58%
Napa	**8,426**	**45.23%**
Spanish	8,426	45.23%
Nevada	**978**	**8.01%**
Spanish	978	8.01%
Orange	**255,679**	**52.79%**
Spanish	202,058	41.72%
Vietnamese	49,655	10.25%
Farsi	3,966	0.82%
Placer	**4,030**	**12.15%**
Spanish	4,030	12.15%
Riverside	**135,407**	**31.85%**
Spanish	135,407	31.85%
Sacramento	**85,598**	**25.33%**
Spanish	47,130	13.95%
Russian	16,732	4.95%
Hmong	9,364	2.77%
Vietnamese	7,517	2.22%
Cantonese	4,855	1.44%
San Benito	**4,596**	**42.09%**
Spanish	4,596	42.09%
San Bernardino	**132,135**	**26.11%**
Spanish	132,135	26.11%
San Diego	**174,032**	**37.72%**
Spanish	146,484	31.75%
Arabic	12,387	2.69%
Vietnamese	9,272	2.01%

Appendix 3

Tagalog	5,889	1.28%
San Francisco	**73,023**	**50.94%**
Cantonese	34,637	24.16%
Spanish	26,797	18.69%
Russian	4,578	3.19%
Vietnamese	3,510	2.45%
Tagalog	3,501	2.44%
San Joaquin	**49,217**	**25.90%**
Spanish	49,217	25.90%
San Luis Obispo	**9,259**	**26.00%**
Spanish	9,259	26.00%
San Mateo	**35,476**	**42.09%**
Spanish	35,476	42.09%
Santa Barbara	**44,810**	**52.04%**
Spanish	44,810	52.04%
Santa Clara	**138,834**	**50.31%**
Spanish	93,599	33.92%
Vietnamese	32,676	11.84%
Mandarin	7,410	2.69%
Tagalog	5,149	1.87%
Santa Cruz	**21,654**	**48.14%**
Spanish	21,654	48.14%
Solano	**16,312**	**22.35%**
Spanish	16,312	22.35%
Sonoma	**24,272**	**35.73%**
Spanish	24,272	35.73%
Stanislaus	**39,170**	**27.13%**
Spanish	39,170	27.13%
Sutter	**5,820**	**23.29%**
Spanish	5,820	23.29%
Tehama	**3,222**	**17.58%**
Spanish	3,222	17.58%
Tulare	**71,618**	**40.52%**
Spanish	71,618	40.52%
Ventura	**63,893**	**48.31%**
Spanish	63,893	48.31%
Yolo	**11,087**	**33.75%**
Spanish	9,293	28.29%
Russian	1,794	5.46%
Yuba	**3,342**	**15.69%**
Spanish	3,342	15.69%
Grand Total	**3,267,965**	

Appendix 4
Last Rev 1/15

CALIFORNIA COMMUNITY TRANSITIONS (CCT) ENROLLEE AND PARTICIPANT RIGHTS AND RESPONSIBILITIES/CONSENT

All individuals participating in the CCT Demonstration Project are entitled to specific rights regarding delivery of CCT services.

ENROLLEE AND PARTICIPANT RIGHTS

As a CCT enrollee or participant, you have the following rights:

1. Be informed of your rights and available services prior to agreeing to participate in CCT.
2. Receive services without regard to race, religion, age, color, creed, gender, national origin, sexual orientation, marital status, or disability.
3. Be treated with consideration, dignity, and respect.
4. Assume reasonable risks and have the opportunity to learn from these experiences.
5. Be provided with an explanation of available Medi-Cal Home and Community-Based Services, and other community Long-Term Services and Supports that may benefit you.
6. Have the opportunity to participate in the development, review, and approval of your own Transition and Care Plan (TCP), including any subsequent revisions to the TCP.
7. Select service providers and choose to receive additional services from different agencies or staff within the same agency without jeopardizing your enrollment or participation in CCT.
8. Be fully informed of the process for requesting an informal conference and/or state hearing.
9. Be informed of the name and duties of any person providing CCT services to you.
10. Have input into when and how CCT services will be provided to you.
11. Receive services from approved and qualified individuals.
12. Receive, in writing, a list of names, telephone numbers, and supervisors for all CCT service providers from your CCT Transition Coordinator.

Appendix 4

13. Receive, in writing, a copy of the complaint and resolution process from your CCT Transition Coordinator.

14. Refuse care, treatment, services, and/or supports after you have been fully informed of the potential risks and consequences of such actions.

15. Refusal of care must be in writing to indicate you understand the potential for associated risks and consequences. If you decide to refuse care, you may take back your choice, in writing, at any time.

16. Have your privacy respected, including the confidentiality of personal records, and have the right to refuse the release of the information to anyone not authorized to have such records, except in the case of your transfer to a health care facility or as required by law or Medi-Cal requirements.

17. Submit complaints about any violation of rights and/or any concerns regarding provided services, without jeopardizing your participation in the CCT and not being subjected to restraint, interference, coercion, discrimination, or reprisal as a result of submitting a complaint.

18. Receive support and direction from the lead organization/transition coordinator during the transition process to resolve your concerns.

19. Receive additional support and direction from the CCT Lead Organization in the event that your transition coordinator is not successful in resolving concerns.

20. Have your transition coordinator protect and promote your ability to exercise all rights identified in this document.

21. If appropriate, have all rights and responsibilities outlined in this document forwarded to your court-appointed legal guardian or others authorized to act on your behalf.

22. Participate in surveys inquiring about your experience as a CCT participant, including about the quality of services your received under the demonstration and your general satisfaction with your return to community living.

Appendix 4

ENROLLEE AND PARTICIPANT RESPONSIBILITIES

As a CCT enrollee/participant your responsibility is to:

1. Work with your lead organization/transition coordinator to develop, and as appropriate, revise your TCP, to provide long-term services and supports needed to support your health and welfare during and after transitioning to community living.

2. Work with the service providers as described in your TCP.

3. Follow your TCP, and notify your CCT Transition Coordinator during the transition process if you want to change your goals or services.

4. Provide, to the best of your knowledge, complete and accurate health history including all prescribed and over-the-counter medications you are taking, and communicate the risk(s) associated with your decision about the services and supports you choose.

5. Inform your CCT Transition Coordinator about all treatments and interventions you are receiving.

6. Maintain your home in a manner that enables you to maintain good health and welfare while living in the community.

7. Ask questions of health professionals and other service providers when you do not understand your services.

8. Respond to questions in all three (3) required Quality of Life Surveys; generally before leaving a facility, and then at approximately 11 months and 24 months after transition.

9. Refrain from becoming involved in any criminal behavior. You understand that, if you do, your service provider(s) may leave, the police may be called, and your continuation in CCT may be jeopardized.

10. Report any significant changes in your health condition, circumstances, informal supports, and/or formal supports to the appropriate service provider.

11. Provide accurate information related to your coverage under Medi-Cal (including recertification and spend-down), Medicare, or other medically-related insurance programs to your lead organization/transition coordinator.

12. Notify the appropriate providers as soon as possible if the scheduled service visit needs to be rescheduled or changed.

13. Notify the appropriate person(s) if any problems occur, or if you are dissatisfied, with the services you are receiving.

14. Show respect and consideration for all persons and their property.

Appendix 4

ENROLLEE AND PARTICIPANT ACKNOWLEDGEMENT AND CONSENT

I, _____ have had an opportunity to learn about and discuss the California Community Transitions (CCT) Demonstration and I am interested in participating in the program.

By signing this form, I am acknowledging:

1. I understand that the CCT Demonstration is authorized through an agreement between the California Department of Health Care Services (DHCS) and the federal Centers for Medicare & Medicaid Services.
2. I have read the CCT Enrollee and Participant Rights and Responsibilities included in this document, or they have been read to me as written.
3. I understand the content and purpose of the CCT Enrollee and Participant Rights and Responsibilities included in this document.
4. I understand that failure to adhere to the responsibilities described in this document and/or in my signed TCP may result in termination from CCT.
5. The CCT Lead Organization of my choice will work with me to develop a Transition and Care Plan (TCP) for Long-Term Services and Supports that meet my skilled care and transition needs, to ensure my health and welfare when I leave the inpatient nursing facility and return to living and receiving services in the community.
6. I will be making decisions about Long-Term Services and Supports and that, once I transition to community living, there may be risks that may affect my services, my providers, and my well-being.
7. I am willing to assume the transition risks identified and discussed with my CCT Transition Coordinator.
8. I have received information on the following Home- and Community-Based Services and Housing Options that are available in the community of my choice:

HCB SERVICES		HOUSING
AIDS Waivers	In-Home Operations	Independent Apartment
Assisted Living Waiver	NF/AH Waiver	Established Household
DD Waiver	MSSP Program	Group Home
Pediatric Palliative Care Waiver		Assisted Living Facility

Appendix 4

By signing this form, I am consenting to the following provisions:

1. CCT lead organization staff members working with me have my informed consent to access my Personal Health Information (PHI), and my permission to discuss my transition with my personal physician and other service providers.

2. Enrollment allows me to work with a CCT lead organization to arrange for services I will receive during the 365 days following my transition to the community (including, my day of discharge from the inpatient facility). On the 366th (three hundred sixty sixth) day, the Long-Term Services and Supports (LTSS) I continue to need at home will be provided under a Medi-Cal Home and Community-Based Services waiver and/or with Medi-Cal state plan services, as long as I maintain my Medi-Cal eligibility and meet all LTSS requirements.

3. Prior to completion of my 365 days changes in my Transition and Care Plan (TCP) will be discussed with me and updated to reflect the services I will continue to receive after my participation in the CCT Demonstration ends. I will make decisions about services and any risks that may affect my services, my providers, and my well-being.

4. I can contact my CCT Transition Coordinator at any time to arrange for and/or make changes to my transition and care plan under the demonstration.

5. I will promptly contact someone that I trust if I feel that I am at risk in any way of failing to get the needed supports and services to allow me to stay in my community home.

6. I can report suspected elder and dependent abuse by calling my local:

   Adult Protective Services Office: _____

   Police/Sheriff's Office: _____

7. If my request for Medi-Cal services are denied or modified for reasons unknown to me, I have the choice of filing a request for a state hearing.

Appendix 4

Lead Organization

Name:

Telephone:

Transition Coordinator

Name:

Telephone:

Applicant's Name

Applicant's Signature

Date

Legal Guardian/Representative

Legal Guardian/Representative's Signature

Date

LO-Transition Coordinator

LO-Transition Coordinator's Signature

Date

Appendix 5

What Do I Do?

Many people feel overwhelmed at the thought of moving out of a nursing home and into their own place. There's so much paperwork to be completed, with so many choices to be made, that it's just easier to stay put.

A lack of family or funds can make a person feel trapped. But there's a program designed specifically for someone like you. Local Contact Agencies can assist you with all the paperwork and choices, so you can make the best decision based on your current circumstances.

Your Local Contact Agency is here to assist you physically and financially with transitioning from your nursing home back to the community. You have a choice. Make the call to your Local Contact Agency today.

Place Sticker Here

This document was developed under grant CFDA 93.791 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government.

Are you interested in moving out of here?

We can help make that happen.

Appendix 5

To ensure a successful transition back to a community setting, the California Community Transitions program covers things like:

- Household set-up costs
- Home modifications
- Vehicle adaptions
- Assistive devices

Talk to a Local Contact Agency transition coordinator who will:

- Explain all the services available such as home and vehicle adaptation, home set up, assistive devices, wheelchairs and other medical equipment, training on self care, nursing visits, and how to get a personal care attendant.
- Meet with your friends, family, or other people you trust to discuss your options.
- Plan and coordinate your return to community living.

Community settings include:

- Independent living
- Assisted living

Appendix 6

CCT Lead Organization Training

All CCT training is available on the DHCS website, and can be accessed by clicking on the hyperlinks included below:

Training Module 1	Becoming a CCT Provider
Training Module 2	CCT Overview
Training Module 3	CCT Transition Process
Training Module 4	Person-Centered Planning
Training Module 5	Local Contact Agency Services
Training Module 6	CCT Reimbursement Structure
Training Module 7	CCT Reporting Requirements

Appendix 7

Money Follows the Person (MFP) / California Community Transitions (CCT)
Rebalancing Demonstration

HCBS Advisory Workgroup #1 – Enhancing CCT Delivery

CHARTER

Purpose/Mission:

To engage experts to provide recommended solutions to the Department of Health Care Services (DHCS) on ways to strengthen ongoing CCT operations; identify opportunities to align CCT with the Home and Community-Based Services (HCBS) Final Rule; enhance the beneficiary experience, health outcomes, and the quality of services provided.

The Role of Workgroup Members:

HCBS Advisory Workgroup Members were selected based on their knowledge of, and experience with, serving seniors and persons with disabilities, the CCT Demonstration, and/or Home and Community-Based Services. As subject-matter experts, we are grateful to you for partnering with DHCS to inform and make recommendations on CCT-related topics which will help us enhance the delivery of CCT services. We plan to present recommendations to the CCT service providers for their input and implementation, if applicable. DHCS will develop policies based on the recommendations provided by workgroup members and the comments submitted by CCT service providers; however, the U.S. Centers for Medicare and Medicaid Services (CMS) has final authority over the grant.

CCT Workgroup #1 Objectives:

1. Integrating the Social and Medical Models of Care – finding a balance between ensuring the health and safety of consumers while upholding autonomy, independence and self-determination
2. Ensuring Person-Centeredness within CCT to better align the Demonstration with the Home and Community-Based Final Rule
3. Enhancing the CCT Redesign

Outcomes:

HCSB Advisory Workgroup #1 will:

1. Provide a consensus-based philosophy to present to CCT Service Providers that describes California's philosophy on the integration of the Social and Medical Models of Care.
2. Provide a list of consensus recommendations on ways to integrate the Social and Medical Models of Care in CCT to meet the holistic needs of every individual, including: program-wide standards, flexibilities, gaps, areas of concerns, etc.
3. Provide recommendations on opportunities to adapt and implement CCT policies, procedures, tools, and resources to strengthen and enhance person-centeredness to better align with CMS' final rule.
4. Develop clear person-centeredness standards for CCT transitions, and identify measures for determining if CCT transition services are meeting the standards.
5. Provide a list of recommended strategies for DHCS to present to CCT Service Providers on ways to

Appendix 7

Money Follows the Person (MFP) / California Community Transitions (CCT)
Rebalancing Demonstration

HCBS Advisory Workgroup #1 – Enhancing CCT Delivery

CHARTER

strengthen the role of the consumer throughout the entire CCT transition process.

6. Provide a list of recommended strategies or solutions for DHCS to present to CCT Service Providers on ways to improve the delivery and efficacy of CCT.

Workgroup Meeting Schedule:

Meeting #1:	June 22, 2015	Introduction to the Workgroup, CCT Overview, & Framing Models of Care
Meeting #2:	September 30, 2015	Integrating Medical and Social Models of Care
Meeting #3:	December 2015 (TBD)	Ensuring Person-Centeredness
Meeting #4:	March 2016 (TBD)	Enhancing CCT Redesign

Guidance & Restrictions:

Statute	SEC. 2403. of the Affordable Care Act (ACA) of 2010
	SEC. 6071(h) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note)
	Americans with Disabilities Act of 1990 (ADA)
Legal Rulings	Olmstead v. L.C., 527 U.S. 581 (1991)
Funding	CMS Grant #1LICMS300149-01-10

Appendix 7

Stakeholder Membership:		
Member	Affiliation	Representing
Denise Likar	SCAN / Independence At Home	CCT Lead Organizations (nonprofit)
Casandra "Cassie" Eastwood	Resources for Independence, Central Valley	CCT Lead Organizations (nonprofit)
John Beleutz	Health Projects Center	CCT Lead Organizations (nonprofit)
Julie Lehmann	Home and Health Care Management	CCT Lead Organizations (for Profit)
Jonathan Istrin	Libertana Home Health	CCT Lead Organizations (for Profit)
Kristin Ansell	CCT	Consumer
Sherie Abel	CCT	Consumer
Chris Mathias	California Social Work Education Center (CalSWEC) - Title IV-E Program UC Berkeley School of Social Welfare	Family Member
David Nolan	LTSS Director at Anthem Blue Cross	Health Plan
Mary Jane " Janie" Whiteford	CA IHSS Consumer Alliance	Organizations that Services Persons with Disabilities
Anwar Zoueihid	Partners in Care Foundation	Organizations that Transition Persons with Disabilities

Appendix 7

State Department Representatives:	
Department of Health Care Services (DHCS), Long-Term Care Division (LTCD)	Rebecca Schupp, Acting Division Chief Joseph Billingsley, Acting LTSS Operations Branch Chief Karli Holkko, CCT Project Director
CA Department of Aging (CDA)	Robin Jordan, ADRC Program Director Joe Rodrigues, Long-Term Care Ombudsman
CA Department of Social Services (CDSS)	Aron Smith, CCI Coordinator with DSS Adult Programs

Appendix 8

Summary of the CCT Transition Process

The CCT transition process is broken into five stages to simplify program administration and the billing process. Each stage of the process builds upon the ones that come before; and therefore, must be completed in the following order:

1. OUTREACH AND TARGETING

A. CCT Lead Organizations (LOs) identify local Medicaid-certified nursing facilities

B. LOs meet and develop relationships with facility administrators, and educate facility staff about the CCT Demonstration

C. LOs identify, develop relationships with, and educate potential CCT Participants

D. It is recommended, but not required, for LOs to establish relationships with the Managed Care Plans in the service area

Anticipated Outcome(s):

- Increased recognition of, and knowledge about, CCT
- Stronger on-going business relationships between institutional care providers and HCBS organizations
- Growth of a sustainable network of HCBS providers

2. INFORMATION GATHERING AND ENROLLMENT

A. CCT LO Transition Coordinators (TCs) conduct initial interview(s) with individuals who indicate they want more information on returning to live and receive services in the community

B. When an individual decides to pursue transition, the TC provides him/her with a copy of the CCT Information Packet and thoroughly walks the individual through the contents

i. The CCT Information Packet ***MUST*** include, but is not limited to, the following documents:

- ✓ *Authorization for Release of PHI*
- ✓ *CCT Rights, Responsibilities, & Consent*
- ✓ *Notice of Privacy Practices*
- ✓ *Your Hearing Rights*

ii. The CCT Information Packet ***may*** also include:

- ✓ *Home Set-Up Resource*
- ✓ *Independent Housing Disclosure*
- ✓ *24-7 Backup Plan*
- ✓ *Initial Transition and Care Plan*
- ✓ *Final Transition and Care Plan*
- ✓ **Documents included by the CCT LO**

C. In order to continue to work with, and on behalf of, the individual pursuing a transition to community-living, the TC must obtain signed consent from the individual (and, if required, the individual's Legal Representative)

D. With the consent of the individual (or the individual's Legal Authority), the TC collects necessary records,[18] and the LO's Registered Nurse (RN) completes the *CCT Assessment Tool*

E. Using Person-Centered Planning techniques and the information within the individual's completed *CCT Assessment Tool*, facility face sheet, and medications list, the CCT LO works with the individual, the individual's legal representative (if applicable), friends and family (as requested by the individual), facility discharge planner, and the assigned managed care case manager (as appropriate) to develop the *Initial Transition and Care Plan* (I-TCP) based on the individual's preferences

F. The I-TCP includes initial information pertaining to:

i. Health Care Services
ii. Education/Training
iii. Supportive Services
iv. Social Services
v. Financial Services
vi. Environmental Services
vii. Other Services

G. Upon completion of the I-TCP, the TC submits the initial Treatment Authorization Request (TAR), with attachments,[19] to the assigned DHCS Nurse Evaluator (NE) for adjudication

H. DHCS NE adjudicates the initial TAR

i. If the I-TCP fulfills the individual's identified preference(s), need(s), and risk(s), (s)he is enrolled in CCT

[18] Necessary records include: Medical file face-sheet, medication list and schedule, and other documentation necessary to inform the development of a comprehensive Transition and Care Plan.

[19] Attachments to the initial TAR include: the individual's *CCT Assessment Tool*, face sheet, medication list and schedule, and the I-TCP. Concurrently, if not before the initial TAR is submitted to DHCS, the TC must submit the *CCT New Enrollee Information Form* to the central CCT mailbox.

ii. If the I-TCP does ***NOT*** meet the individual's identified preference(s), need(s), and risk(s), the DHCS NE notifies the LO that the plan must be revised to meet them

Anticipated Outcome(s):

- Individuals enrolled in CCT will be provided comprehensive transition planning services that meet their preference(s), and address their need(s) and risk(s)

iii. IMPLEMENTATION

A. Once the individual is enrolled in CCT, the transition team begins working with the enrollee to implement the I-TCP by securing the necessary LTSS prior to discharge from the facility

B. Appropriate medical and social supports are key to a successful transition, and the transition team works to secure appropriate and available HCBS waiver, program, project, and/or demonstration services, housing, in home support worker(s), etc. to meet identified needs and preferences

Anticipated Outcome(s):

- Comprehensive transition and care plan is prepared, as directed by the Enrollee
- Robust and on-going communication between members of the transition team

iv. TRANSITION TO COMMUNITY LIVING

A. When all of the HCB LTSS are in place, the LO:

i. Obtains the Enrollee's community physician's signature on the *CCT Final Transition and Care Plan* (F-TCP) to indicate there will be no gaps in care post-transition to the community

ii. Submits the home set-up TAR for review and approval

iii. Conducts the first Quality of Life (QoL) Survey (Baseline)

iv. Attaches the *CCT Final Transition and Care Plan* (F-TCP) to the Post-Transition TAR for review and approval

B. On the day of discharge:

i. The TC must be with the Enrollee/Participant

ii. Services must be in place, including: household set-up, delivery of equipment, financial arrangements, health care, and other services

iii. Waiver and/or personal care services may still be in process, in which case, the LO shall provide "gap" services

iv. The Participant must sign the *Day of Transition Report* to indicate all services and supports are in place and adhere to the F-TCP as planned

Anticipated Outcome(s):

- The comprehensive supports and services provided to the Participant in the community maintain, if not improve, the individual's quality of life

v. FOLLOW-UP

A. Post-Transition, CCT LOs continue to collaborate with the Participant and other service providers to:

i. Ensure the ongoing safety and sustainability of the transition

ii. Address any needs and/or concerns that may come up during the 365-day demonstration period, and prior to the completion of demonstration

iii. Remind the Participant that the last day of the CCT demonstration is day 365, and that existing services will continue as long as the individual remains eligible for HCB Medi-Cal services

B. Follow-up visits and/or phone calls are required at specific points of the 365-day demonstration period based on the Participant's qualified housing arrangement and HCB LTSS

C. In the twelfth (12^{th}) month of the 365-day demonstration period, the LO will:

i. Ensure the ongoing safety and sustainability of the individual in the community

ii. Address any needs and/or concerns that have come up, prior to the completion of demonstration

iii. Remind the Participant that the last day of the CCT demonstration is day 365, and that existing services will continue as long as the individual remains eligible for HCB Medi-Cal services

iv. Conduct the Second QoL Survey (1^{st} follow-up)

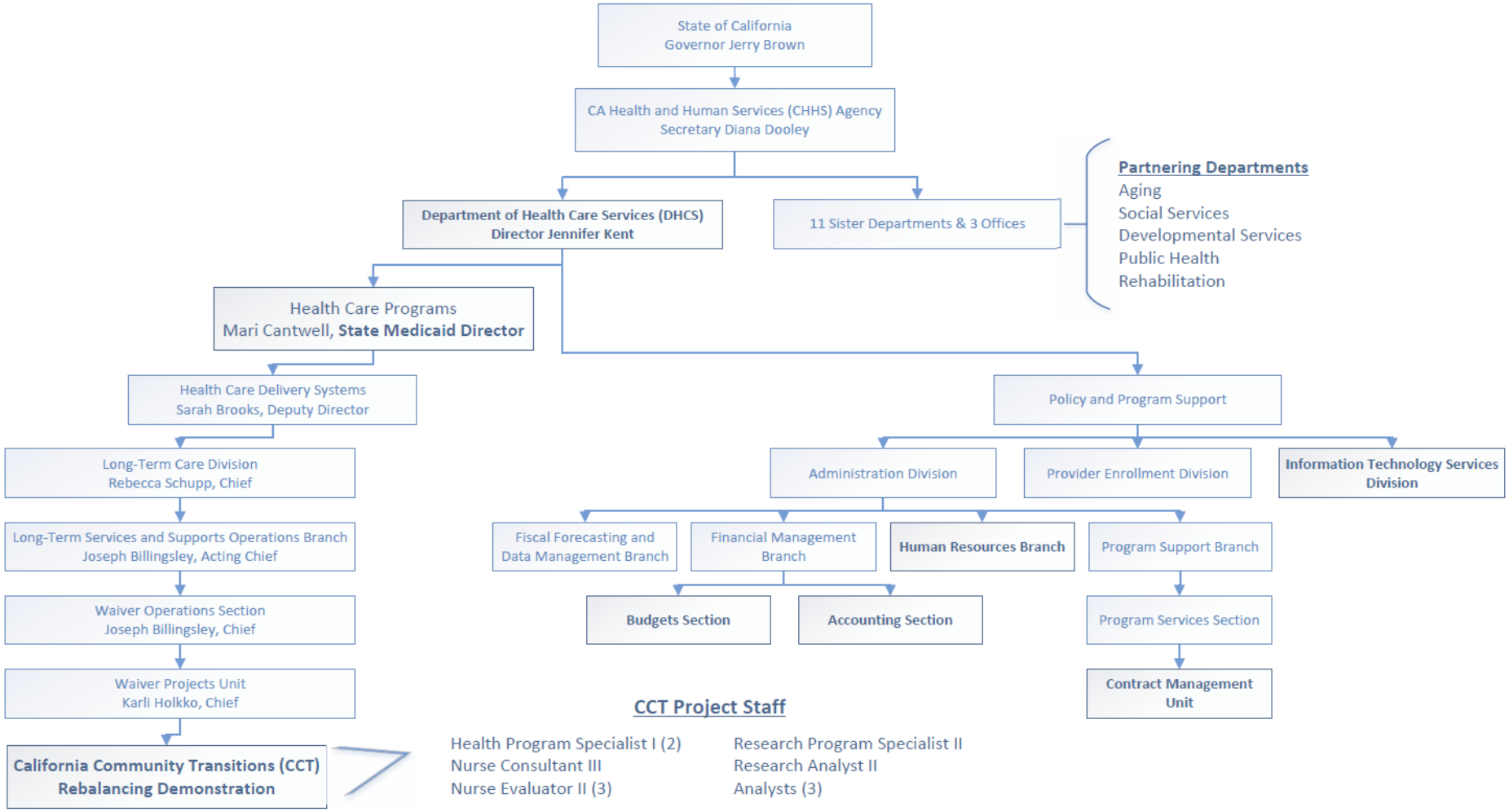
D. Finally, in the twenty-third (23^{rd}) month after the date of transition, the LO will visit the individual to conduct the third QoL Survey (2^{nd} follow-up)

Anticipated Outcome(s):

- Safe and sustainable home or community-based living

Appendix 9

CCT Organization Chart



Appendix 10

Karli Holkko

Profile

- Excellent interpersonal, written and verbal communication skills. A team player; ability to train, motivate, and supervise.
- Ability to work independently and prioritize work to ensure all compliance elements are met.
- Knowledge of governmental programs, regulations, billing processes, managed care contracts and coordination of benefits.
- Possess solid computer skills. Excellent working knowledge using Microsoft Word, Microsoft Excel, Microsoft Outlook, Microsoft PowerPoint, Microsoft Publisher, Adobe Acrobat, Photoshop.

Experience

06/15/2015 – Present | Department of Health Care Services | Sacramento, CA

Health Program Manager – Full-Time

Responsible for oversight of the Money Follows the Person (MFP) Rebalancing Demonstration, California Community Transitions (CCT), and the Assisted Living Waiver (ALW) operations. Develops, manages and directs operation of the CA MFP / CCT program and ALW. Responsible for recruiting, hiring, training, supervising and evaluating interdisciplinary staff who develop program policy and guidance letters, operational guidance, and other work products required by the state and CMS. Develop, implement and manage CCT and waiver provider contracts, as well as contracts / agreements with related California state departments. Process CCT and ALW provider applications and coordinate provider enrollment process. Maintain CCT and ALW program intake through oversight of CCT and ALW dedicated mailboxes and databases, conduct case assignment to nurse evaluator staff. Provide direct technical assistance to CCT Lead Organizations and ALW Care Coordination Agencies and Assisted Living facilities. Convene large and small workgroups, as necessary. Analyze proposed legislation, budget initiatives or other administrative proposals relative to CCT and HCBS waiver programs. Collect and evaluate operational data for CCT and ALW program operations, including enrollment / transition timeframes, intake by provider organization, sustained transitions, and other measures of program performance. Produce PowerPoint presentations, databases, issue papers, progress reports, forms and other work products necessary to meet program goals and objectives.

05/21/2013 – 06/12/2015 | CalPACE | Sacramento, CA

Program Analyst – Full-Time

Dedicated to the expansion of comprehensive health care services to seniors with chronic care needs through the Program of All-inclusive Care for Elderly (PACE). Work through education and advocacy to support, maintain, and safeguard the PACE model and promote high-quality health care services to California's seniors. Specific job duties include developing and maintaining strong relationships with association members. Provide regulatory compliance education and technical assistance to association members. Assist in the management of work plans for consultants, subcontractors and work groups. Maintain and update strategic plan. Manage outcomes and quality measure data collection and prepare final report. Review and analyze proposed legislation and State proposals for potential effect on PACE organizations. Implement the association's messaging strategy to become a key resource on aging and long-term care issues for policy makers/engaged stakeholders and informed consumers. Create and manage the association's communication products by developing and editing written content including: press releases, presentations/talking points, quarterly e-mail newsletter, social media, association reports/fact sheets and outreach efforts. Assist in preparation and distribution of meeting summaries and reports.

12/01/2011 – 05/17/2013 | Department of Health Care Services | Sacramento, CA

Associate Governmental Program Analyst – Permanent/Full-Time

Contract Manager for the Medicare/Medi-Cal funded Program of All Inclusive Care for the Elderly (PACE) and the Senior Care Action Network (SCAN) health plans. Responsible for the development, implementation, evaluation and expansion of plans. Other duties include the preparation and management of state contracts including renewals and amendments. Ensure compliance with all state managed care requirements including Knox-Keane licensure compliance. Oversight of federal program agreements to ensure that the regulatory and contractual requirements are being met. Conduct site visits to examine if record keeping and operating practices meet state, federal and contract standards pertaining to facility requirements; provide technical assistance on regulatory and contractual requirements to contract providers and other interested parties. Act as unit lead when unit manager is absent or unavailable. Act as a liaison to coordinate tasks and resolve issues related to program compliance. Provide technical assistance on Medi-Cal Eligibility Data System (MEDS) transactions. Research, write, and formulate recommendations on legislative bill analyses; prepare written reports, controlled correspondence, budget change proposals, issue memos and briefing papers. Maintain and update program webpage.

Appendix 10

Experience	08/19/2010 – 11/30/2011	Department of Health Care Services	Sacramento, CA

Staff Services Analyst (Range C) – Permanent/Full-Time

Determine eligibility for the Health Insurance Premium Payment (HIPP) program. Prepare quarterly payments directly to private insurance companies and reimbursement payments to HIPP program clients. Maintain the HIPP, CAPMAN and MEDS databases. Answer client phone calls, faxes and emails. Maintain HIPP program data spreadsheets. Perform other duties as required by Branch, Section and Unit Chief.

Education

California State University, Sacramento – 08/2009 - Present
Course of Study: Gerontology
Degree Pursuing: Special Masters in Gerontology/Health Science

California State University, Sacramento – Completed 05/2007
Course of Study: Kinesiology
Degree Acquired: Bachelor of Science

Appendix 11

California Community Transitions
Deficit of Reduction Act of 2005 Money Follows the Person (MFP) Rebalancing Demonstration

CROSSWALK BETWEEN STATE SERVICE CODES AND TYPE OF MFP SERVICES FOR MFP FINANCIAL REPORTING FORMS A AND B

CALIFORNIA

Instructions:
1. Include codes for *all* services approved in the MFP Operational Protocol
2. Use a single line for each service code
3. Add lines to each type of service if necessary
4. Update and submit this crosswalk with each MFP Services File sent to the federal MFP evaluator

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
State Plan Home and Community-Based Services			
Clinic Services			
Targeted Case Management for Long Term Care			
PACE (Program for All Inclusive Care for the Elderly)			
SCAN			
Rehabilitation Services			
Home Health Services	Z6902 G0156	Home Health Aide Services	
	Z6900 G0154	Skilled Nursing Services	
	Z6904 G0151	Physical Therapy Services	
	Z6906 G0152	Occupational Therapy Services	
	Z6908 G0153	Speech Therapy Services	
	Z6910 G0155	Medical Social Services	
	Z6914 G0162	Case Evaluation-Initial Treatment Plan	
	Z6916 G0162	Monthly Case Eval-Extension of Treatment Plan	
	Z6918 A9999	Unlisted Services including Administered Drugs and Supplies	

Continuation of previous table.

Appendix 11

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
Hospice	Z7100	Hospice Care	
Personal Care Services	Z9525	Personal Care Services	
		Domestic Services	
		Meal Preparation/Clean Up	
		Food Shopping and Errands	
		Routine Laundry	
		Transportation to Medical Appointments	
		Heavy Cleaning/Yard Hazard Abatement	
		Protective Supervision	
		Paramedical Services	
		Restaurant Meal Allowance	
		Advanced Pay	
Optional Medicaid Plan Services	Z8500	Adult Day Health Care	
	Z5868	Pediatric Day Health Care	

Appendix 11

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
Community-Based Adult Services (1115 Bridge to Reform Demonstration)			
Case Management			
Homemaker Services			
Personal Care			
Adult Day Health	S5102	Day Care Services	
Habilitation a. Residental Habilitation			
b. Day Habilitation			
Expanded Habilitation Services a. Prevocational Services			
b. Supported Employment			
c. Education			
Respite Care			
Day Treatment			
Partial Hospitalization			
Psychosocial Rehabilitation			
Clinic Services			
Live-In Caregiver			
Capitated Payments for Long Term Care Services			
Other	H2000	Comprehensive Multidisciplinary Evaluation	
	T1023	Screening for evaluation of program participation	

Appendix 11

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
Demonstration Services			
Case Management			
Homemaker Services			
Personal Care			
Adult Day Health			
Habilitation			
a. Residental Habilitation			
b. Day Habilitation			
Expanded Habilitation Services			
a. Prevocational Services			
b. Supported Employment			
c. Education			
Respite Care			
Day Treatment			
Partial Hospitalization			
Psychosocial Rehabilitation			
Clinic Services			
Live-In Caregiver			
Capitated Payments for Long Term Care Services			
Other	T2028	Specialized Supply (Assistive Device)	
	T2039	Vehicle Modifications	

Appendix 11

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
MSSP Waiver Services (1915(c) Home and Community-Based Services Waiver)			
Case Management	Z8550 (Month) T2022	Case Mgnt/Care Mgnt Support	
Homemaker Services	Z8559 (Day) S5121 Z8560 (Hour) S5120	Chore Services	
Personal Care	Z8561 (Day) T1020 Z8562 (Hour) T1019	Personal Care Services	
Adult Day Health	Z8552 (Day) S5105 Z8553 (Hour) Z8554 (Day) S5102 Z8555 (Hour) S5100	Adult Day Care/Support Center /Health Care	
Habilitation **a. Residental Habilitation**	Z8556 S5165 Z8557 T2028	Environmental Accessibility Adaptations Housing Assistance/Minor Home Repair, etc. Non-Medical Home Equipment	
b. Day Habilitation			
Expanded Habilitation Svcs **a. Prevocational Services**			
b. Supported Employment			
c. Education			
Respite Care	Z8574 (Day)S5151Z8575 (Hour) Z8591 (Day) Z8576 (Hour)	Respite Care (In-Home and Out-of-Home)	
Day Treatment			
Partial Hospitalization			
Psychosocial Rehabilitation			
Clinic Services			
Live-In Caregiver			
Capitated Payments for Long Term Care Services			
Other	Z8597 (Regular) T2003 Z8593 (Escort) T2001	Transportation	
	Z8589 (Month) S5161	Personal Emergency Response Systems (PERS)/Communication	

Continuation of previous table.

Appendix 11

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
		Device	
	Z8588 S5162	PERS Install/Set Up	
	Z8567 (Day) S5126 Z8568 (Hour) S5125	Protective Supervision	
	Z8580 S5170 Z8581	Meal Services - Congregate/ Home Delivered	
	Z8595 (Day) S5136 Z8583 (Hour) S5135 Z8584 (Hour) 99404 Z8596 (Month) S5136	Social Reassurance/ Therapeutic Counseling	
	Z8586(Hour) T2040 Z8585(Visit)	Money Management	
	Z8587 (Hour) T1013	Communication Services: Translation/Interpretation	

Appendix 11

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service or Restrictions for Billing)
Assisted Living Waiver Services (1915(c) Home and Community-Based Services Waiver)			
Case Management	G9002	Care Coordination (per month). Coordination of waiver and non-waiver benefits and services, assessments and reassessments; capitated per month.	Once per client, per month; pro-rated first and last months of service.
	G9001	Nursing Facility Transition Svcs (One time benefit). Care coordination for the transition of a client from a nursing home into an Assisted Living Waiver Pilot Project (ALWPP) setting.	Once per client, per lifetime, only available if client transitions from a NF into an ALWPP setting.
	S5165	Environmental Accessibility Services (assessment of home, physical, and family environment to determine suitability to meet client's medical needs). Adaptations to the home as medically necessary including grab bars, ramps, and minor modifications.	Limited to a maximum of $1,500 per client and only available in a Publicly Subsidized Housing (PSH) setting.
Homemaker Services			
Personal Care			
Adult Day Health			
Habilitation **a. Residental Habilitation**			
b. Day Habilitation			
Expanded Habilitation Svcs **a. Prevocational Services**			
b. Supported Employment			
c. Education			
Respite Care			
Day Treatment			
Partial Hospitalization			
Psychosocial Rehabilitation			
Clinic Services			

Continuation of previous table.

Appendix 11

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service or Restrictions for Billing)
Live-In Caregiver			
Capitated Payments for Long Term Care Services			
Other	T2031 (RCF) T2015	The Assisted Living Waiver Benefit in the RCFE Setting (Tier 1-4)	One tier per client per day, in the RCFE setting.
	T2015 (HHA) T2015	The Assisted Care Benefit in the Public Housing Setting (Tier 1-4: PSH setting, HHA provider)	One tier per client per day, in the PSH setting.

Appendix 11

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
AIDS Waiver Services (1915(c) Home and Community-Based Services Waiver)			
Case Management	Z5000 T2022	Case Management	
Homemaker Services	Z5010 S5130	Homemaker	
	Z5008 G0156	Home Health Aid-Attendant Care	
Personal Care			
Adult Day Health			
Habilitation **a. Residental Habilitation**			
b. Day Habilitation			
Expanded Habilitation Svcs **a. Prevocational Services**			
b. Supported Employment			
c. Education			
Respite Care			
Day Treatment			
Partial Hospitalization			
Psychosocial Rehabilitation	Z5006 90806	Psychotherapy	
Clinic Services			
Live-In Caregiver			
Capitated Payments for Long Term Care Services			
Other	Z5012 T2026	Medi-Cal Supplements for Infants and Children in Foster Care	
	Z5014 S5165 T2028 T2029	Specialized Medical Equipment/Supplies and Minor Adaptations to the Home	
	Z5016 T2003	Non-Emergency Medical Transportation	
	Z5020 S9470	Nutritional Counseling	
	Z5022 S5170	Nutritional Supplements/ Home-Delivered Meals	

Appendix 11

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
Specialty Mental Health Services (1915(b) Freedom of Choice Waiver)			
Case Management	00012-00019	Targeted Case Management	
Homemaker Services			
Personal Care			
Adult Day Health			
Habilitation **a. Residental Habilitation**			
b. Day Habilitation			
Expanded Habilitation Services **a. Prevocational Services**			
b. Supported Employment			
c. Education			
Respite Care			
Day Treatment	08011-08019	Partial Day or Day Treatment	
Partial Hospitalization			
Psychosocial Rehabilitation	01010-01018; 02010-02019 03010-03018 04010-04018 05010-05018; 06010-06018 07010-07018 09011-09019	Crisis Stabilization/Urgent Care Professional Svcs by Psychiatrists Psychologists, LCSWs, & Marriage & Family Therapists Adult Crisis Residential Medication Support Services Crisis Intervention Day Treatment Rehabilitation	
Clinic Services			
Live-In Caregiver			
Capitated Payments for Long Term Care Services			
Other			

Appendix 11

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
Developmental Disabilities Waiver Services (1915(c) Home and Community-Based Services Waiver)			
Case Management			
Homemaker Services	Z9027	Homemaker	
	Z9026	Home Health Aid Services	
Personal Care			
Adult Day Health	Z9121, Z9060, Z9123, Z9124 thru Z9126, Z9069, Z9103, Z9105	Adult Residential Care	
	Z9069	Adult Foster Care	
		Assisted Living	
	Z9125	Supported Living Services	
Habilitation	See attachment	Habilitation	
a. Residental Habilitation	Z9121, Z9123, Z9124, Z9104, Z9106	Residential Habilitation for Children Services	
	Z9062 (Env. Modifications)	Environmental Accessibility Adaptations	
	Z9014	Chore Services	
b. Day Habilitation	See attachment	Day Habilitation	
Expanded Habilitation Svcs			
a. Prevocational Services	Z9312	Prevocational Services	
b. Supported Employment	Z9310 (group) Z9311 (individual)	Supported Employment Services	
c. Education			
Respite Care	Z9113, Z9025, Z9026, Z9029 thru Z9032, Z9073	Respite Care	
Day Treatment			
Partial Hospitalization			
Psychosocial Rehabilitation			
Clinic Services			
Live-In Caregiver			
Capitated Payments for Long Term Care Services			
Other	Z9300, Z9302, Z9303, Z9307, Z9304, Z9308, Z9999, Z9074	Transportation	
	Z9043 Z9047	Specialized Medical Equipment/Supplies Skilled Nursing R.N.	

Continuation of previous table.

Appendix 11

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
	Z9015	Personal Emergency Response System (PERS)	
	Z9110	Vehicle Adaptations	
	Z9065, Z9022, Z9023	Communication Aides	
	Z9007, Z9008	Speech, Hearing & Language Svcs	
		Crisis Interventions:	
	Z9122	Crisis Intervention Facility Svcs	
	Z9050	Mobile Crisis Intervention	
	Z9075	Community-Based Training Svcs	
	Z9076, Z9077	Financial Management Svcs	
	Z9101	Nutritional Consultation	
	Z9056, Z9209, Z9038, Z9039, Z9067, Z9012, Z9048, Z9401, Z9072	Behavior Intervention Services	
	Z9314	Transition/Set-Up Expenses	

Appendix 11

HCFA CATEGORY	HCPCS	SERVICE CODE	DESCRIPTION
A-1 HOMEMAKER	Z9027	858	Homemaker
	Z9028	860	Homemaker Program
A-2 HOME HEALTH AIDE	Z9102	854	Home Health Agency
	Z9026	856	Home Health Aide
A-3 RESPITE CARE	Z9113	008	Sports Club
	Z9053	420	Respite Family Member (Vouchers)
	Z9025	850	Camping Services
	Z9026	855	Adult Day Care
	Z9029	862	In-Home Respite Service Agency
	Z9030	864	In-Home Respite Worker
	Z9031	868	Out-of-Home Services
	Z9032	869	Respite Facility
A-4 RESIDENTIAL HABILITATION FOR CHILDREN SERVICES	Z9121	058	Out of State Residential Treatment Program for Children
	Z9123	109	Supplemental Residential Program Support
	Z9124	113	Specialized Residential Facility (Habilitation)
	Z9104	910	Foster Family Agency Certified Family Homes Foster Family Homes Small Family Homes Group Homes
	Z9106	920	Foster Family Agency Certified Family Homes Foster Family Homes Small Family Homes Group Homes
A-5 DAY HABILITATION	Z9200	028	Socialization Training Program
	Z9034	055	Community Integration Training Program
	Z9111	062	Personal Assistance: Individual
	Z9112	063	Community Activities Support Service
	Z9058	084	Special Olympics
	Z9207	091	In-Home Day Program
	Z9059	094	Creative Art Program
	Z9063	106	Specialized Recreation Therapy
	Z9208	110	Supplemental Day Services - Program Support
	Z9202	505	Activity Center
	Z9203	510	Adult Development Center

Continuation of previous table.

Appendix 11

HCFA CATEGORY	HCPCS	SERVICE CODE	DESCRIPTION
	Z9204	515	Behavior Management Program
	Z9205	520	Independent Living Program
	Z9206	525	Social Recreation Program
	Z9016	605	Adaptive Skills Trainers
	Z9066	630	Driver Trainer - Individual
	Z9021	635	Independent Living Specialist
	Z9305	645	Mobility Training Service Agency
	Z9306	650	Mobility Training Specialist
	Z9024	670	Developmental Specialist
	Z9002	691	Art Therapist
	Z9003	692	Dance Therapist
	Z9004	693	Music Therapist
	Z9005	694	Recreational Therapist
	Z9201	805	Infant Development Program
A-6 PREVOCATIONAL SERVICES	Z9070	DRP	
	Z9312	954	Work Activity Program
A-7 SUPPORTED EMPLOYMENT SERVICES	Z9071	DRS	
	Z9310	950	Supported Employment Program - Group Services
	Z9311	952	Supported Employment Program - Individual Services
A-8 ENVIRONMENTAL MODIFICATIONS	Z9062	104	Construction Company
A-9 SKILLED NURSING	Z9046	742	L.V.N.
	Z9047	744	R.N.
A-10 NON-MEDICAL TRANSPORTATION	Z9300	425	Transportation - Family Member
	Z9302	875	Transportation Company
	Z9303	880	Transportation - Additional Component
	Z9307	882	Transportation - Assistant
	Z9304	883	Transportation Broker
	Z9308	890	Transportation - Auto Driver
	Z9999	895	Transportation - Public/Rental/Taxi

Continuation of previous table.

Appendix 11

HCFA CATEGORY	HCPCS	SERVICE CODE	DESCRIPTION
A-11 SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES	Z9043	725	Durable Medical Equipment Dealer
A-12 CHORE SERVICE	Z9014	042	Repair Services
A-13 PERSONAL EMERGENCY RESPONSE SYSTEM	Z9015	051	Personal Emergency Response System
A-14 ~~FAMILY TRAINING~~ No longer available as of 3/29/12 --- per DD Waiver Revised List	~~Z9061~~	102	~~Individual or Family Training Services~~
	~~Z9064~~	108	~~Parenting Support Services~~
	~~Z9020~~	625	~~Counseling Services~~
A-15 ADULT RESIDENTIAL	Z9121	058	Out-of-State Residential Treatment Program
	Z9060	096	Geriatric Facility
	Z9123	109	Program Support - Group
	Z9124	113	Specialized Residential Facility
	Z9126	894	Supported Living Vendor Administration
	Z9125	896	Supported Living Service
	Z9069	904	Adult Foster Care
	Z9103	905	Residential Facility Service Adults - Owner Operated
	Z9105	915	Residential Facility Service Adults - Staff Operated
A-16 VEHICLE ADAPTATIONS	Z9110	021	Vehicle Modification & Adaptation
A-17 COMMUNICATION AIDES	Z9065	112	Interpreter/Translator - Group
	Z9022	642	Interpreter
	Z9023	643	Translator
A-18 MOBILE CRISIS INTERVENTION	Z9050	017	Crisis Team - Evaluation and Behavior Intervention
A-19 CRSIS INTERVENTION FACILITY	Z9122	090	Crisis Intervention Facility/Bed
A-20 NUTRITION	Z9101	720	Dietary Services
A-21 BEHAVIOR INTERVENTION SERVICES	Z9056	048	Client/Parent Support Training
	Z9209	111	Supplemental Program Support
	Z9038	615	Behavior Management Assistant
	Z9039	620	Behavior Management Consultant
	Z9067	780	Psychiatrist
	Z9012	785	Clinical Psychologist
	Z9048	790	Psychiatric Technician
A-22 SPECIALIZED THERAPEUTIC SERVICES	Z9313 Z9315	117	Specialized Therapeutic Services
A-23 TRANSITION/SET UP EXPENSES	Z9314	020	Transition/Set Up Expenses