Agency Letterhead

Agency Mailing Address
Agency Telephone Number
Internet Address:

Date: (Date)

Claimant: (Enrollee's Name)
Address: (Mailing Address)
(City, CA Zip)

State Hearing: (12345678)
Filing Date: (Date)
Notice Date: (Date)
Hearing Date: (Date)

Case Name: (Enrollee's Name)

Agency Rep.: _____

Aid Pending: (No/Yes)

Agency Contact: _____
Contact Telephone: ( ) ___-____

I. ISSUE:

Whether on _____ (date), the _____ (agency name) correctly assessed _____ (enrollee name) was ineligible for enrollment in the California Community Transitions (CCT) Demonstration Project.

II. STATEMENT OF FACTS:

_____ (enrollee name) is a _____ (age) year-old _____ (fe/male) diagnosed with the following health condition(s): _____.

S/he has the following skilled care need(s): _____.

S/he requires the following Long-Term Services and Supports (LTSS): _____, for a safe and sustainable transition to community living.

On _____ (date), _____ (agency name) received a request for enrollment into CCT from _____.

On _____ (date), _____ (agency name) spoke with _____ (enrollee name), reviewed his/her medical diagnoses, performed a clinical assessment using the standard CCT Assessment Tool, and completed an Initial Transition and Care Plan. Based on the information that was collected, the lead organization determined:

(*Choose **one** of the following options*)

☐ Currently, sufficient LTSS are not available to ensure _____'s (enrollee name) health and safety in the community.

☐ Documented incident(s) of non-compliance, by the either the enrollee/participant or legal representative, that poses(ed) a threat to the health and safety of the enrollee/participant or CCT staff, and/or a failure to comply with all regulatory requirements.

☐ Does not, or no longer, meet(s) the federal eligibility requirements for the Money Follows the Person (MFP) Demonstration, called CCT in California.

The following documentation is attached to this Position Statement (list all supporting documentation):

1. New Enrollee Information Form
2. Assessment Tool
3. Inpatient Facility Face Sheet
4. Initial Transition and Care Plan

The submitted documentation identifies that _____'s (enrollee name) skilled care needs include(ed):

1. **Temperature assessment**
2. **Administration of medications**
3. **GT placement**
4. **Suction of oral cavity after seizures**
5. **Administration of oxygen**
6. **Daily range of motion therapies**
7. **Total care for all Activities of Daily Living (ADLs)**

← *Examples of specific skilled care needs*

On _____ (date), a Notice of Action (NOA) was issued by _____ (agency name).

On _____ (date), staff within the DHCS' Long-Term Care Division (LTCD) was notified that a State Hearing had been requested based on _____'s (enrollee name) denial of CCT services.

III. ANALYSIS:

The medical documentation reviewed described _____'s (enrollee name) required skilled care needs as follows: _____. The completed Assessment Tool and Initial Transition and Care Plan, completed on _____ (date), support this decision.

It is _____'s (agency name) responsibility to enroll individuals into CCT based upon eligibility criteria set forth in section 6071 of the Deficit Reduction Act (DRA) of 2005; 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); CMS grant number 1LICMS300149; the California Code of Regulations; the state's approved Medi-Cal state plan and approved Home and Community-Based Services (HCBS) waivers, CMS Policy Guidance, the Department of Health Care Services' (DHCS') Long-Term Care Division's (LTCD's) 2014-2016 CCT Lead Organization (LO) contract, and CCT Policy and Guidance Letters.

To transition an individual with skilled care need(s) from an inpatient facility to a community living setting, LTSS that meet his/her care need(s) must be available. If the needed services are not available, the CCT Project will not provide transition services.

IV. DEPARTMENT POSITION:

_____'s (enrollee name) skilled care needs are consistent with the services that would be provided in an inpatient skilled nursing facility. After reviewing LTSS available in the community of choice, based on _____'s (enrollee name) skilled care needs and current health condition, _____ (agency name) determined that insufficient services are available to support his/her transition to community living.

In the future, should _____'s (enrollee name) skilled care needs change and/or new LTSS become available within the community, _____ (agency name) will re-evaluate _____ (enrollee name) for transition to community living under CCT.

V. APPLICABLE LAWS AND REGULATIONS:

Money Follows the Person (MFP) Rebalancing Demonstration, is known as California Community Transitions, and is authorized by Section 6071 of the Deficit Reduction Act (DRA) of 2005; 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); CMS grant number 1LICMS300149; the California Code of Regulations; the state's approved Medi-Cal state plan and approved HCBS waivers, CMS Policy Guidance, DHCS-LTCD's 2014-2016 CCT Lead Organization (LO) contract, and CCT Policy and Guidance Letters.

VI. CONCLUSION:

_____ (agency name) has the responsibility to assess LTSS need(s) of individuals seeking enrollment in CCT, based upon his/her current skilled care needs and available LTSS in the community.

Based on the submitted medical documentation, it has been demonstrated that the nursing care services requested for _____ (enrollee name) are: _____.

_____'s (enrollee name) overall skilled care and service needs are such that LTSS are not available at this time to provide a feasible and safe transition to community living under the California Community Transitions Project.

Based on the information above, _____ (agency name) respectfully requests that the claimant's claim be DENIED.

Please send the proposed decision to:

Agency's Name
Agency's Address
City, State, Zip Code
Attn: _____

Respectfully,

Name
Title
Program

Enclosures (enter number)

cc: Name (include every person who will receive a copy of the Position Statement)
Title
Program

Additional Instructions

1. Number every page, including all attachments

2. Include "cc." information for everyone who will receive a copy of the Position Statement

3. Include enclosed documents by type of document:
ex: Attachment A Laws & Regs
Attachment B Documents
Attachment C Notice of Action

4. Distribution:

   - Participant gets the ORIGINAL signed position statement with all attachments

   - The Administrative Law Judge (ALJ) gets copy of position statement with attachments via secure file transfer (SFT)

   - Participant and ALJ must receive the position statement at least 48 hours before the hearing