

Section B. Demonstration Policies and Procedures

(Approved by CMS August 2010)

B.1 Participant Recruitment and Enrollment

California's vision for the California Community Transitions (CCT) demonstration includes participation by hospitals, subacute care facilities, nursing facilities, and intermediate care facilities for persons with developmental disabilities (ICF/DD) (hereinafter "inpatient facilities") and Medi-Cal residents of those facilities. CCT participants must meet the federal demonstration eligibility requirements—six months or longer residency in an inpatient facility and 30 days in the Medi-Cal program—and choose to live outside a facility and receive Medi-Cal HCBS waiver and/or state plan services. Appendix XI displays waiver and state plan services available to demonstration participants, and the target populations which may be served under each waiver.

The target populations for CCT were proposed in the state's application dated November 2006 and are described in narratives below. Based on input from stakeholders, the state added two subcategories of demonstration participants who will be counted in one of the following federal categories¹ based on the primary reason they are residing in an inpatient facility.

- Elders Who Have One or More Medical, Functional or Cognitive Disabilities – Includes individuals 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. This group does not have a state-sponsored centralized intake system for Medi-Cal long-term care or care management services, unless local areas have established a single point of entry system using city or county, Older Americans Act, Older Californians Act, or other categorical funding source(s). The California Department of Aging (CDA) supports local planning for demographic trends and targets the development of community-based programs through area agencies on aging (AAA). Each AAA network is unique and each contracts with local programs and provider networks. The DHCS will coordinate the demonstration, where possible, with AAAs and the Aging and Disability Resource Connection (ADRC) programs.

- Persons With Developmental Disabilities – This group includes individuals of any age who have intellectual and/or developmental disabilities which manifested before their 18th birthday.

¹ Federally defined categories may be used in this section to ensure proper reporting under this federal demonstration.

Individuals in this group are served by a network of regional centers located through out the state. Regional centers have a state mandate and ongoing state funding to provide case management across a variety of services and treatment settings. DHCS delegates administration of the DD HCBS waiver to the Department of Developmental Services (DDS) which contracts with regional centers statewide to enroll individuals into the DD HCBS waiver. Regional centers conduct the Preadmission Screening and Resident Review (PASRR) Level II assessments for nursing facility residents.

- Persons Who Have One or More Physical Disabilities – This group includes individuals under the age of 65 years who have a physical disability and are able to live independently and participate in their community. People who are HIV positive or have AIDS will be included in this group.

Persons with physical disabilities obtain services through a variety of networks and programs, depending on the nature of their service need and the degree and nature of their disability. The Department of Rehabilitation sponsors a network of Independent Living Centers (ILCs) which assist with a variety of service needs. Other networks involved in serving persons with disabilities include vocational education, local and higher education, public and private employment counseling, and community-based services targeted to certain subgroups (for example, services to train and support people who are blind, or have a hearing or other impairment). Until very recently, ILCs have not been providers of long-term care Medi-Cal services and supports. Currently, ILCs have begun applying to be Medi-Cal HCBS waiver providers.

For people who have AIDS, and meet the eligibility for the AIDS Medi-Cal waiver program, a range of home and community-based services may be available.

- Persons Who Have Mental Illness – This group includes individuals who have been diagnosed with chronic mental illness.

DHCS delegates Medi-Cal specialty mental health services to the Department of Mental Health, which in turn, delegates funding and responsibilities to each county health department, which create county-based specialty mental health plans. These plans receive capitated funding to provide mental health case management and community-based mental health services in their respective county.

- Persons Who Have Dual Diagnoses – This group includes individuals who have one or more medical or physical disabilities and, at the same time, are living with mental illness, a developmental disability, or substance abuse issues.

This group of individuals may or may not be supported by a county-based, mental health case manager. They may or may not have a primary care physician. Depending on which conditions have become exacerbated,

individuals with these illnesses and disabilities typically are seen frequently by networks in at least two of the state's major service delivery systems—health care and mental health care.

- Persons Who Have Experienced an Acquired Brain Injury/Traumatic Brain Injury (TBI) – This group includes individuals 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 this category of individuals be included in the demonstration. The state has developed some specialized TBI services that are provided to adults with traumatic brain injury and to their families in need of respite care. These services are funded through designated funds (TBI Trust Fund) and state appropriations. Individuals with traumatic brain injury may also seek services through the California Department of Vocational Rehabilitation or other state, local or non-profit agencies, such as ILCs, which offer services to individuals with disabilities. In addition to state supported services, there are a number of private for profit or non-profit agencies which offer rehabilitation and other services and supports for those with other financial resources, e.g., insurance, workers' compensation, or settlements. **Individuals transitioned 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 individuals includes children and adults who are residents of nursing facilities and have few or no care options due to their medical conditions, or behavioral or other issues. One such medical condition is that of being morbidly obese.

Stakeholders requested that these categories of individuals be included in the demonstration. **Individuals transitioned in this category will be included and reported to CMS under the physically disabled, mental health, or dual diagnosis federal categories.**

California Historical Perspective – Assessment of Need and Preference

In late 2003, the Centers for Medicare & Medicaid Services awarded DHCS a Real Choice Systems Change Grant for Community Living for the “California Pathways: Money Follows the Person,” Grant No. 11-P-92077/9-01. Since then, DHCS has been working with the California Department of Rehabilitation and the University of California at Los Angeles (UCLA)² to conduct work described in the original federal grant application for California Pathways.

² Dr. Jack Schnelle, Director, UCLA Borun Center for Gerontological Research and subsequently, Dr. Dan Osterweil, Professor of Medicine & Geriatrics

One of the goals of the California Pathways project was to examine issues surrounding the identification of, and process for, working with nursing facility residents who wish to transition to community living. To identify best practices, UCLA partnered with the University of Southern California (USC)³ to analyze thirteen existing assessment instruments used in California or by other states to assess an individual's need for services and other pertinent data. Various stakeholders were asked to provide input on which instruments to analyze. Input was also given about how the existing instruments: how they are used, what items are included, and how much training is required for users. Care was taken to identify tools and items that identify personal preference along with, or separate from, an assessment of need.

The California Pathways project identified technical issues related to assessment protocols. For example, of the thirteen tools analyzed, all measure ability to perform activities of daily living, but only some ask about the person's ability to perform these tasks independently, while others ask about difficulty performing the tasks with or without assistance. This demonstrates that even a common bit of information can be assessed and recorded differently by multiple programs.

Methods for gathering information vary from tool to tool and may be based on self-report, proxy report, assessor determination, or a performance assessment. These and other technical issues are discussed in the final grant report on the California Pathways project completed and sent to CMS on December 28, 2007.

During the work on assessment tools, it became clear that there was no "gold standard" for systematically identifying and documenting personal preference to transition back to community living. Existing assessment tools are focused on functional deficits and medical diagnosis rather than on a person's preferences for services and supports or where a person prefers to receive services and supports. As a result, the California Pathways project team developed the *California Nursing Facility Transition Preference Interview tool*. The tool was tested in 13 nursing facilities in the Los Angeles area.

Project results are summarized in final report to CMS and an article published in the January 2008 edition of the *Journal of American Geriatrics Society*.

Selecting Lead Organizations

In November 2007, DHCS widely distributed a memorandum stating DHCS' interest in identifying lead organizations to form regional transition teams in up to ten regions of the state. The memo described core activities of the teams and explained the focus was to engage organizations with recognized experience in planning and carrying out successful transitions of nursing facility residents to community living

As previously stated, DHCS' vision was to select from two to four lead organizations initially to provide technical details for the protocol based on past successes with

³ Dr. Kate Wilber, Professor of Gerontology

transitioning residents from local inpatient facilities. It was further envisioned that these teams would assist DHCS in training other lead organizations in Years 3, 4 and 5. Interested persons and organizations were requested to complete a voluntary and non-binding “Statement of Interest” form and return it via e-mail to the California Community Transitions e-mail box at OLTC_CCT@dhcs.ca.gov.

In December 2007, DHCS sent an e-mail to: contact people who expressed written interest in participating in the demonstration; members of the Transitions Advisory Committee and Olmstead Advisory Committee; representatives of state departments; and other interested persons. Attachments sent included:

1. A Word table summarizing organizations’ completed statements of interest by County
2. A proposal template for interested lead organizations
3. Guidance for completing the lead organization proposal template (see following table)

Information Item	Desired Criteria Description and Responses
<p style="text-align: center;">Lead Organization</p>	<p>The lead organization will:</p> <ol style="list-style-type: none"> a. Be responsible for facilitating transition teams, maintaining data on the team’s activities, monitoring HIPAA standards for the team’s case-level work and reporting the team’s activities to DHCS. b. Be an active Medi-Cal provider and be required to enter into an Agreement with the DHCS. c. Agree to ensure the team’s compliance with the state and federal requirements under the Deficit Reduction Act of 2005 Money Follows the Person Rebalancing Demonstration as described in the state’s application and the approved protocol. <p>Ideally, the initial Lead Organizations will:</p> <ol style="list-style-type: none"> a. Already be engaged in providing local leadership on long-term care issues, facilitating consumer access to HCBS long-term care services, establishing “single points of entry” or other high levels of coordination across the existing HCBS delivery networks. b. Work with the state to provide training to other teams in subsequent years of the demonstration. <p>Certain recordkeeping and reporting activities may be reimbursable under Medi-Cal Administrative Activities claiming protocols⁴. Funding is not available for start-up organizations or administrative overhead.</p>
<p>Lead Organization Contact Person</p>	<p>Provide the contact information for an employee of the organization who will be responsible for communications with the state. Include name, address, telephone, email, and FAX.</p>

⁴ See <http://www.dhs.ca.gov/maa/WebPages-MAA-LEC/MAADescription.htm>

Information Item	Desired Criteria Description and Responses
Participant Outreach ⁵ and Transition Team Performance <i>(Reimbursable under Medi-Cal Administrative claiming)</i>	The lead organization must have the capacity for keeping confidential participant data, recording team activities and reporting to the state on behalf of the team. Costs for administrative activities relative to the demonstration are reimbursable under Medi-Cal Administrative Claiming procedures. Participant records storage and transactions must meet HIPAA standards as a Business Associate of the DHCS. Monthly reports on team activities and enrolled participants will be required of all demonstration partner organizations.
Qualifying Inpatient Facilities	Each lead organization and its transition teams will focus on specific partner facilities and their residents. Each facility will be signing a written agreement that includes the expectation to provide transition opportunities to eligible residents and the roles and responsibilities for communications during the transition processes.
Access to and Relationships with Inpatient Facilities	The lead organization must describe existing local relationships, expertise and significant experience in interacting directly and privately with the health facility residents who are eligible for the demonstration (e.g. long-stay facility residents who are Medi-Cal eligible).
Anticipated Local Benchmark No. of Transitioned Individuals	Individuals eligible for services under the demonstration must have resided continuously in one or more inpatient facilities for a combined total of six months or more. They must also be eligible for Medi-Cal for at least 30 days. The lead organization must estimate the number of eligible individuals the team plans to transition to community living between implementation and December 31, 2008. The statewide benchmark for 2008 has been revised to 51. The lead organization must briefly describe the evidence or experience that provides the basis for the estimate.
Target Sub-Population(s)	The lead organization must estimate the number of individuals in subpopulation categories, e.g., elders, persons with a disability, a developmental disability, mental illness, traumatic brain injury, or a dual diagnosis, or children or adults who are hard to place.
Transition coordinator See also Appendix I for transition coordinator job duties	Transition coordinators will be required to meet qualifications identified in the protocol and in the approved NF/AH, ALWPP, or MSSP HCBS waivers so that the transition coordination service can be reimbursed under existing Medi-Cal provider and service codes. Transition coordinators should have experience working with facility residents, must be social workers, nurses or other individuals with documented expertise with senior services, independent living or other related work, and will interact directly with facility staff and residents. A regional transition team must have at least one transition coordinator but may have more.

⁵ May be reimbursable under the Medi-Cal Administrative Activities (MAA) program; for more information, refer to <http://www.dhs.ca.gov/maa/WebPages-MAA-LEC/MAADescription.htm>

Information Item	Desired Criteria Description and Responses
Financing for the transition coordinator(s)	In the first year (CCT implementation through Dec 31, 2008), transition coordination most likely will be billed and reimbursed through NF/AH, ALWPP, or MSSP HCBS waivers as service definitions, codes and rates have already been approved under the state and federal authorities of those waivers. Other options for financing transition coordination services may be approved for subsequent years of the demonstration.
Members of the Transition Team and Other Local Stakeholders	Name the organizations and the expertise of members of the transition team. Indicate team size and how that size can effectively provide timely, case-specific transition planning before facility discharge through follow-up after discharge. The primary function of the team is to provide confidential individual planning for residents to receive ongoing services in the community on a case-by-case basis. The team must adhere to HIPAA privacy rules. Transition teams identify transition candidates and work together to create a comprehensive service plan which will set up ongoing services in the community. This plan begins on day of discharge and is ongoing with set reviews to revise the plan as needed. The goal is a successful and sustainable plan for ongoing services in the community setting. The number of team members can vary and the mix of represented disciplines can vary. DHCS has identified the following core functions and expertise (some overlap may occur and there may be more): Transition coordination, housing, independent living, Medi-Cal eligibility, IHSS, home health care services , nurse, social worker, ombudsman, senior services, information & assistance. Teams may vary; for example, there may be a core group, with others available for technical assistance. Team members must be willing and available to supply training in their area of expertise to other team members and teams in other areas of the state.
Peer Representation and Cultural Competence	Teams should be representative of the target populations identified in the CCT Operational Protocol. Ideally, team members will provide peer role models for independent living, whenever possible. Team members should represent cultures, languages and other strengths of the local community.
Number of Teams	Each lead organization will have at least one transition team. Based on the number of facilities and the number of successful transitions proposed above, that number may increase.
Single Point of Entry or Aging or Disabled Resource Center, and Adequate Community-Based Provider Network	The lead organization will: <ul style="list-style-type: none"> a. Briefly describe their relationship with, or expectation of a partnership with, a “single point of entry/no wrong door,” aging and disability resource center, or other local collaborative initiative. b. Indicate any existing or planned collaboration among community and Medi-Cal waiver HCBS provider organizations that will support the local transition team work. c. Indicate the likelihood of successfully securing services from an adequate supply of community-based service providers; including family support services, home health agencies, personal care service providers, home-delivered meals, assistive device providers, volunteer and philanthropic organizations, etc.

Information Item	Desired Criteria Description and Responses
Affordable and Accessible Housing	Each regional transition team must have the active participation of an individual who can provide expertise and knowledge of local affordable and accessible housing. Describe how the team 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. Describe whether or not the area participates in the Assisted Living Waiver Pilot Project through the public housing models. Describe 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. Indicate coordination with a HUD consolidated plan; specifically the disability component.
Past Experience with Facility to Home Transition Planning	Describe local 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 the team will bring to the demonstration. Describe any locally-implemented acute hospital-to-home or hospital-to-nursing facility-to-home initiatives, or demonstrations or research projects implemented in the local area and a willingness to train teams in other areas of the state.
Availability of Local Flexible Funding	Describe the team's access to other funding sources for flexible, one-time funding of goods or services needed by 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 (6) months or more.

Interested organizations were asked to submit completed proposals no later than close of business on Friday, December 28, 2007. DHCS received four responses from agencies seeking to be lead organizations. In January 2008, all four applicants were designated primarily due to their experience with transitioning residents from inpatient facilities. Subsequently, one of the original lead organizations selected (Access to Independence (A2i), a non-profit independent living center working in partnership with the Aging and Disability Resource Connection (ADRC) program in San Diego County) withdrew and requested consideration for designation in subsequent recruitment efforts. A fifth response received in January 2008 was subsequently considered and designated as the fourth lead organization.

Initial training of lead organizations was conducted in April 2008, with the intention that when CMS approves the protocol, all processes would be in place, and implementation can begin. The regions of California served by four lead organizations are diverse in geography and population demographics:

Lead Organization	Description	Region
Home Health Care Management, Inc.	Private, for-profit corporation	Butte, Colusa, Glenn, Sacramento, Shasta, Sutter, Tehama and Yuba Counties

Lead Organization	Description	Region
Independent Living Resource	A 501(c)(3) not-for-profit, private organization	Contra Costa and Solano Counties
Independence at Home™ a division of SCAN Health Plan	A division of SCAN Health Plan, a private, non-profit 501(c)(3) organization	Southern Los Angeles County
Westside Center for Independent Living	A 501(c)(3) not-for-profit, private organization	Northwestern Los Angeles County

Lead organizations are responsible for choosing one or more regional transition teams as needed for the population and inpatient facilities in their service area. In addition they will choose the person(s) who will serve as the transition coordinator(s) for the team. The lead organization will work directly with the project director and project nurse to ensure team members receive adequate training to meet demonstration requirements and goals. The project team will provide guidance to lead organizations via the protocol and training tools developed by the CCT project nurse.

Transition Teams

Each lead organization will establish one (or more) transition team(s) comprised of individuals with a variety of expertise and from a variety of organizations. The team will have some flexibility in identifying the resource professions necessary to arrange transitions from inpatient facilities to meet the specific needs of the demonstration participant. Working together, the transition team will strengthen the infrastructure and local resource network with which the transition coordinator will work.

The typical profile of a transition team includes, but is not limited to, the following individuals who are or represent:

- Transition coordinator
- Area agency on aging
- Regional center
- Affordable housing representative or expert
- County Medi-Cal eligibility worker
- County IHSS worker or IHSS public authority representative
- Home health care agency
- HCBS waiver program
- Independent living center
- Long-term care Ombudsman (staff or volunteers)

Every transition team will have a person designated as transition coordinator. Transition coordinators will facilitate service coordination for residents who choose to relocate from an inpatient facility to community living. In addition, the team will keep records and report to the DHCS according to the requirements of the demonstration and this protocol.

Transition Coordinator

Transition coordinators will lead a transition teams who provide resources for participants choosing to relocate to community living. They will work with the CCT project team, lead organization, transition team members, demonstration participants, and other healthcare and service providers to coordinate planning for all demonstration participants in their area. In addition, they will lend special expertise as needed.

The case studies provide examples of transition coordination efforts. Each transition is unique, depending on available and appropriate community-based program, HCBS waiver and state plan services for the target populations. For example, in the case of coordinating a transition for a person with a developmental disability, a regional center service coordinator holds statutory responsibilities to coordinate a consumer's Individual Program Plan (IPP). Since the IPP drives the consumers' services and supports, the transition coordinator would work in tandem with the regional center service coordinator to ensure application of the consumer's IPP. Transition coordinator duties are shown in Appendix I.

Training for Lead Organizations, Regional Transition Team Members and Transition Coordinators

Prior to beginning work with inpatient facility residents, surrogate decision makers, and local agencies and services, members of the lead organizations, transition teams and transition coordinators will receive training on the following areas:

- Overview of demonstration
- Project standards and legal issues
- Eligibility
- Administration and use of the Preference Interview Tool & Quality of Life Surveys
- Elder and dependent adult abuse and reporting requirements
- Community resources and services
- Transition process
- Medi-Cal coverage under waivers, programs, and state plan services
- Treatment Authorization Request submission and service codes
- Billing for provision of services

The first training for lead organizations held on April 9, 2008 is discussed in section B.3.

Education of Stakeholders and Community on the California Community Transitions Demonstration

1. Transitions Advisory Committee (TAC) gives input to the DHCS project team who issues guidance for lead organizations.
2. Lead organizations recruit transition team members in their area.

3. Transition team members will provide outreach materials in the community to:
 - Local stakeholders
 - Hospital & nursing facility staff and volunteers
 - Discharge planners
 - Physicians
 - Local ombudsman
 - HCBS staff
 - Public housing agencies
 - Senior centers
 - Adult day centers
 - Service agencies
4. Transition team members will distribute information to families and friends of residents who have expressed an interest in transitioning to the community, and discuss options and considerations as needed.

Informing Inpatient Facilities

All inpatient facilities will be advised of the demonstration through direct communication from DHCS, other state departments, or through a "Facility Informing Notice" from lead organizations.

At the request of lead organizations, the project team developed a PowerPoint presentation describing key components of the demonstration to use in service area education efforts. In addition, the general recruitment brochure (see Appendix II) reviewed by the DHCS Office of Public Affairs will be placed in facility lobbies, and in discharge planners' and social workers' offices to assist in educating residents and staff about California Community Transitions. It is intended as tool for general outreach and provides a simple and general introduction to the demonstration. It includes broad eligibility criteria with a local telephone number to call, and a DHCS e-mail address for more information.

Identifying Individuals Eligible for the Demonstration

The state has identified several data sources with the capacity to list potential demonstration participants by inpatient facility showing which residents are nearing an inpatient facility stay of six months or longer, and are Medi-Cal beneficiaries. These include:

- Treatment Authorization Request (TAR) (prior authorization) data for inpatient facility stays beyond three months.
- Paid Medi-Cal claims data – by inpatient facility.
- Medi-Cal eligibility lists – by aid code.
- Management Information System/Decision Support System (MIS/DSS) Data Warehouse

DHCS will provide lead organizations with the minimally necessary data to help them identify and interview residents; however, lead organizations are responsible for verifying that demonstration participants meet:

- Minimum residency period of six months of institutional living, with any combination of facility stay.
- Eligibility for Medi-Cal for a month prior to transition.

Identifying Individuals Whose Preference it is to Transition

Inpatient facility residents will receive information about the demonstration through several venues – general outreach (discussed in section B.3) and word-of-mouth from family, friends, social worker, regional center service coordinator, etc., and a proactive and standardized, individual Preference Interview.

Stakeholders have cautioned the project team that some Individuals who have lived in a facility for a long time may not respond, or may not be able to respond to indirect or printed material recruitment efforts for a wide variety of reasons. They may:

- Have vision, speech or hearing impairments
- Not believe relocation is possible
- Not have access to stamps or telephone
- Not be able to read or understand English
- Be afraid to bring up the subject with a caregiver or family/friend
- Be fearful of the unknown
- Have lost contact with support in the community
- Have an infinite variety of other reasons

For these reasons, whenever possible, it is recommended that transition teams include cohorts or peers of targeted populations. Peers have the ability to understand the issues, concerns, and questions that may be on a resident's mind as s/he considers transitioning.

The purpose of a proactive process is to assist inpatient residents who have little or no information about HCBS and support services. Therefore, it is crucial for transition teams to have the ability to provide information about community alternatives when they meet with residents. Advocates have advised the state that a long-stay inpatient facility resident often has lost touch with the housing and social supports that were previously available during their independent community living. Consumers and their families have also acknowledged that a facility resident often becomes adjusted to facility living and may be timid or even frightened of making a change to community living. Any individual considering a major life change decision often requires informational and psychological support. This is especially true of residents who have been living in facilities for some time. As a result, it is important to allow adequate time, privacy and accommodation for residents, as they make informed choices about moving back to community living.

While the state recognizes and respects every individual's right to make his or her own choices, in cases where the success of a transition is dependent on care provided by family or friend caregivers, it is critical to involve family members and caregivers early in the decision making process.

The following transition protocols will be used to proactively identify potential demonstration participants by conducting Preference Interviews once the lead organization has a list of Medi-Cal eligible inpatient facility residents who fit the length of stay criteria:

- The team will identify which member can best carry out the scripted interviews. UCLA researchers advised the project team that Interviews take approximately 20-30 minutes. The interview questions and record-keeping do not require administration by a nurse or social worker. The CCT project nurse has conducted four two-hour training sessions on the interview process.
- A designated team member will arrange time to conduct a focused one-on-one interview with each resident. Finding the best time for each resident may take several attempts.
- Transition teams will use the California Transition Preference Interview Tool and Guidance (Appendix III and Appendix III-A) to discover residents' preference for leaving a facility and receiving services in the community. This standardized interview establishes the preference to relocate, the stability of the preference (a second interview indicates capacity for decision making), the resident's own perception of the feasibility to relocate (understanding his or her own care needs), and offers an opportunity to request more information and additional time to discuss available community-based services and supports.
- The teams will collect data by tracking and compiling residents' responses to the Preference Interview and report them to the project director.
- Residents who express a stable preference to relocate will be provided with more information about HCBS in general and specific services available under the demonstration.
- Residents who prefer to live in the facility will be given a brochure and information on local resources, in the event they change their minds at a later time. The facility social worker may also redirect them to a lead organization at a later time. Residents who want to transition but who do not wish to participate in the demonstration will be provided information on existing Medi-Cal HCBS waivers, IHSS, Older Americans Act or regional center programs, and other community-based providers which might be helpful to them. Teams will make every effort to accommodate any level of interest in HCBS or request for HCBS information.
- Residents who want to explore transition opportunities and participate in the demonstration will be informed of the service options and requirements. These individuals will sign the *Participant Information Form* that documents the fact that they have been informed about the demonstration, and also that after 12 months

of demonstration services they will continue to receive existing, ongoing HCBS waiver or state plan services.

- Residents who want to pursue a transition to community living and who have given written consent to access PHI will be put in touch with a lead organization.

Individuals Who are Undecided about Transitioning

In situations where residents are undecided about whether or not to participate in the demonstration, or decide to forego participation, they can be re-referred to a lead organization or team member at any time through a self-referral, or referrals from a family member, community social services staff, and/or facility staff.

If a resident's request to transition is denied, he or she, or the surrogate decision maker, will receive a detailed explanation and a clearly noticed right for state hearing. Written information about how to file for a state hearing will be provided to each participant. This process is detailed in section B.6.

Service Coordination and Ongoing Comprehensive Service Planning Models

Transition coordination begins weeks before the day of discharge and encompasses all the details, decisions, and events that need to happen to support the individual in 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 comprehensive service plan for each participant will vary depending on which sets of services s/he chooses. A full range of resident preferences for service coordination and ongoing management will include choices among existing Medi-Cal waivers, programs, and state plan services.

Additionally, numerous local advocacy and non-Medi-Cal service organizations which represent older adults, elders, and/or persons with disabilities can provide peer support and/or expertise. These agencies include but are not limited to:

- AARP
- Arthritis Foundation
- Alzheimer's Association
- Gray Panthers
- Multiple Sclerosis Society
- Older Women's League

Under an approved 1915(c) waiver, transition coordination time can be tracked and billed against a TAR which will be adjudicated by the CCT project nurse. When appropriate, demonstration funds will also be used to reimburse provision of transition coordination. Transition coordinators are typically separate and different from waiver case managers who have ongoing oversight of waiver enrollees and their service plans. For example, when a demonstration participant is eligible for the existing Nursing Facility/Acute Hospital waiver, transition coordinators will be involved with demonstration participants for up to 180 days prior to discharge. The waiver case manager will assume primary responsibility once the participant is enrolled in a waiver, and the transition coordinator will be intermittently involved for approximately two months after discharge to ensure the sustainability of comprehensive service plans. The project nurse will also maintain oversight of participants during the 12 months they are in the demonstration.

Demonstration and Waiver Enrollment

DHCS intends to enroll demonstration participants into one of the following existing HCBS waivers, as appropriate, beginning on the first day following discharge from facility:

- Acquired Immune Deficiency Syndrome (AIDS) waiver
- Assisted Living Waiver Pilot Project (ALWPP)
- Home and Community-Based Services Waiver for the Developmentally Disabled (DD)
- Multipurpose Senior Services Program (MSSP)
- Nursing Facility/Acute Hospital (NF/AH) waiver
- In-Home Supportive Services Plus (IHSS Plus) demonstration
- Specialty Mental Health Consolidation (SMHC) waiver

The Medi-Cal Waivers Chart in Appendix V describes the waivers and programs that are available to participants. In addition, there are several new waivers currently under review that may be available to participants. These include two new 1915(c) waivers, the Pediatric Palliative Care and Self-Directed Services/ Developmental Disabilities waivers. In the event CMS approves these waivers and the approved services are appropriate for demonstration participants, DHCS will request approval from CMS and will modify this protocol as needed.

Initially, CCT participants will not be enrolled into the County Organized Health Systems—Health Insuring Organizations of California 1915(b) waivers referenced in Appendix V, nor will they have the option of enrolling into the Program of All-Inclusive Care for the Elderly (PACE) at this time. While the programs may be appropriate HCBS for some of the targeted populations, HCBS codes and rates are not readily available for federal reporting purposes under the MFP Rebalancing Demonstration. DHCS will work with programs and plans to establish an acceptable methodology to capture expenditures and seek CMS' approval before these waivers can be a resource to participants.

The services provided under Medi-Cal waivers and in state plan services are not standardized and all-inclusive. The project team is currently comparing services offered across all waivers and in the state plan, and will analyze differences, evaluate findings, and develop recommendations for use of specific services across the waivers. The table on page 7 presents a snapshot of the state's strategy for establishing recommendations for new waiver and state plan services.

Enrollment into the Demonstration

Once a participant is enrolled in the demonstration, a project team member will assign a unique identifier for each participant. This will be used to track service authorizations and benefits and will enable the LTCD to track all HCBS services provided under the demonstration.

General Transition Process for the Demonstration

1. A request for information about the transition process is received by the DHCS project staff, lead organization or transition team member through self-referral, family request, facility staff referral, or other method.
2. Trained interviewers conduct Preference Interviews with facility residents who are Medi-Cal eligible and have lived continuously at a facility for at least six months. If the resident expresses an interest in transitioning to the community or is unsure but would like more information, a second Preference Interview will be conducted two to three weeks after the initial interview, to allow the resident and their surrogate decision maker to reflect on the important decisions and information on transitioning to the community.
3. The lead organization determines a resident is eligible and if the resident requests enrollment, accepts the resident as a participant in the demonstration.
4. The lead organization sends an executed copy of the *Participant Information Form* to the project director. Upon acceptance into the demonstration, development of a comprehensive service plan begins. If the applicant wants to transition but is not

eligible for the demonstration, the application will be forwarded to an appropriate HCBS waiver intake process.

5. Once all requirements are met and HIPAA permissions secured, with the resident's permission, the transition coordinator meets with appropriate nursing facility staff to gather information and coordinate transition plans. Approved access to, and use of personal identification information (PII) and person health information (PHI) by the transition coordinator is directed by the signed informed consent provided by the inpatient facility. Data sources will include, but not be limited to the following: MDS form, Preference Interview Tool, facility discharge plan, and physician orders.
6. The transition coordinator meets with the resident (and/or support person) again, to provide information and discuss the events necessary to make the transition to community living (required change in Medi-Cal eligibility code; housing; types of services available; individual preferences; home start-up; discharge date; etc.). This is the beginning of the transition coordination services.
7. Based on participant needs and preferences, the transition coordinator works with the participant or the decision maker to identify which service options would help sustain them once they move from the facility. This planning includes choosing the agency or individual provider previously approved under the state's existing waivers who will take the service coordination lead (waiver case manager) after discharge.
8. The transition team develops the comprehensive service plan, and consults with the project nurse concerning the participant's eligibility in various waivers. The transition coordinator initiates the HCBS waiver/service application process by supplying forms and discussing information with waiver case manager/service agency.
9. Once the choice is determined, with participant's agreement, the transition coordinator will oversee enrollment applications/paperwork for the services of the resident's choice: HCBS waivers, IHSS, and other supports. In addition, the project nurse will be notified of the waiver service choice, to facilitate completion of application paperwork.
10. Demonstration participants will meet regularly with the transition coordinator as transition services are set up for them. In addition, a target discharge date will be established with the physician, so community services can be set up at a participant's new home.
11. The transition coordinator oversees any other assessments of need and submission of applications, e.g., housing, financial (SSI & Medi-Cal status), that may be necessary before discharge to match the demonstration participant's needs with preferred types of services and living arrangements.
12. The project team contacts the chosen waiver intake staff regarding enrollment paperwork, to facilitate submission of necessary information.

13. A project team member electronically assigns a unique identifier to each demonstration participant record to enable claims and records to be extracted from existing Medi-Cal systems for MFP data reporting purposes.
14. Prior to discharge, the CCT project nurse adjudicates all TARs for participants' chosen QHCBS and demonstration services; after discharge, the waiver/program case manager assumes management of ongoing TARs.
15. The transition coordinator and the chosen ongoing waiver case manager collaborate with the demonstration participant to complete the comprehensive service plan that will be implemented starting the day of discharge to the community.
16. When the day of discharge is identified the actual transition process begins. The transition coordinator reviews the comprehensive service plan to make sure all services are in place. This will include: delivery of all equipment prior to discharge, how the ongoing case management process works, and an emergency back-up plan for service, in case service provider does not show up. Depending on the level of self-determination chosen by the participant, steps for the process of hiring and firing service providers will be discussed.
17. The chosen waiver/service program will start on the day of discharge. This will ensure continuity of care and service for the demonstration participant and accomplish the purposes of the demonstration. The beneficiary will remain a participant in the demonstration for 12 months, but the case manager/service program will oversee all care for months three through twelve. The CCT project nurse will stay in contact with the waiver case manager, and a transition team member will remain in monthly contact with the participant for the duration of the demonstration.
18. The transition coordinator and the HCBS waiver/service program case manager will share oversight of the comprehensive service plan for the first two months following discharge, with lead responsibility belonging to the transition coordinator. Together they will manage any changes to the goals in the comprehensive service plan. Beginning in month three, the HCBS waiver/service program case manager will assume ongoing lead responsibilities for service coordination.
19. A transition team member conducts the federally-required Quality of Life Survey. Administration will take place approximately two weeks prior to discharge, at about 11 months after discharge, and at 24 months after discharge, per CMS' requirements. Project staff will collect data and coordinate with the federal evaluation contractor to provide required CCT data.
20. Project staff, lead organization, transition coordinator and waiver case manager synchronize dates of approval and enrollment of a demonstration participant for case records.

21. When there is a scheduled or unscheduled admission to an inpatient facility during a participant's 12-month demonstration periods, the participant is allowed a 30-day window before mandatory disenrollment from the demonstration will occur. The former participant may re-apply to the demonstration, if the total of unscheduled admission days is no more than 30 days. Up to 60 days are allowed for scheduled admissions. The re-application process will be the same as the initial process; however, information from prior participation may be reviewed when determining services to be provided.
22. Existing billing codes and processes will be used for billing the state for transition coordination services.

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 transition coordinator and/or waiver case manager and project nurse (per waiver requirements), to determine if changes need to be made to the participant's service plan to ensure his/her health and safety. Sometimes, however, a demonstration participant may need to be re-admitted to an inpatient facility.

Unscheduled Hospital Visit/Admission

Unscheduled hospital admissions are grouped into two categories: Injury and Medical or Mental Health condition. If any unscheduled admission is due to a single unexpected injury, such as a fractured bone requiring several weeks of treatment in a hospital and rehabilitation facility, the occurrence will be considered a scheduled admission, since the actual treatment is of a scheduled nature. All other inpatient admissions, with few exceptions, due to a medical/mental health condition will be considered unscheduled admissions.

During the demonstration year, participants are allowed one unscheduled absence of up to 30 days. Demonstration participants who have been re-admitted to an inpatient facility for a period of time greater than 30 days will be disenrolled from California Community Transitions. The state may, however, re-enroll a former demonstration participant with one unscheduled absence of 30 days or fewer into the demonstration without re-establishing the 6-month inpatient facility residency requirement. At that time, a demonstration participant's service plan will be re-evaluated, and s/he will be monitored by the waiver case manager to address any issues that may affect his/her health and safety.

If a demonstration participant has more than one unscheduled absence period of up to 30 days, s/he will not be re-enrolled in the demonstration upon discharge from the

inpatient facility. S/he may however be re-enrolled in the waiver, program, or state plan service, for which he/she is eligible.

Scheduled Hospital Admission

Sometimes, demonstration 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 includes treatment for an unexpected injury, requiring hospitalization. Participants will be provided greater than a 30-day approved leave of absence (cumulative days or one visit) that will enable them to resume the remaining days of the demonstration period. When a participant is ready to return home, s/he may resume services and complete the remaining days left in the demonstration (for a total of 365 days), with an updated service plan to reflect any service need changes.

Requests for Re-enrollment

Participants who have requested, and have been approved for, a leave of absence may be disenrolled from the demonstration. When applying to return to the demonstration upon an inpatient facility discharge, the institutional residency requirement is waived, as the person already met the criteria for his/her original enrollment. In addition, two other criteria must be met. First, the participant's leave time must not have exceeded the "number of days" limit set for unscheduled/scheduled hospital visit/admission (see above section). In addition, the participant's comprehensive service plan (CSP) will be re-evaluated to ensure the participant's health and safety in the community. The CSP may be updated based on the knowledge of what has worked during the initial transition and what might need to be changed considering the current status of the participant.

Any demonstration participant who exceeds the "number of days" limit set for unscheduled or scheduled hospital admissions will not be eligible for re-enrollment in the demonstration. It may not, however, make him/her ineligible for HBCS under the state's current Medi-Cal waivers or state plan.

Re-enrollment requirements for Demonstration participants into specific waivers

- Assisted Living Waiver Pilot Project (ALWPP)
If a demonstration participant enrolled in the ALWPP is admitted to an inpatient facility for greater than 30 days, s/he is disenrolled from the waiver. When discharge is planned, the ALWPP 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 disenrolled 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 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.
- Specialty Mental Health Consolidation (SMHC) Program
If a demonstration participant is admitted to an inpatient facility for any duration, the admission does not affect their enrollment in the SMHC program. Anyone with a mental health diagnosis is automatically enrolled in the program. If they meet clinical eligibility, they may also choose to receive appropriate waiver services.

Re-enrollment Requirements for Demonstration Participants into State Plan Programs

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

Participant is Unable to Continue in Demonstration

On occasion, a participant may be unable to continue in the demonstration. In this case, the transition coordinator, 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 transition coordinator or a transition team member will be available for support for 30 days after the close of care.

Reasons for a 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.