

California Community Transitions (CCT) Operational Protocol (OP) Benchmarks

Benchmarks are evaluated against the funding requested by the State through the demonstration proposed budget. Grantees must maintain efforts through the life of the demonstration and sustain the rebalancing efforts in the Medicaid system beyond the life of the MFP Demonstration. Benchmarks should reflect the State’s strategies to use the enhanced FMAP in ways that will permanently rebalance the LTC system towards HCBS.

Previous Optional Benchmarks (Approved 6/28/10)	Reason for Changing the Measure
#3 - Annual # of Medi-Cal eligible individuals the state will transition who do not qualify for the demonstration	CA’s enhanced FMAP isn’t set aside in a separate account. The funding we save through CCT’s enhanced FMAP just stays in the general fund. Therefore, rather than connect enhanced FMAP to individual transitions, it is more accurate to measure the state’s overall spending on HCBS vs. institutional care.
#4 - Annual #s of newly-participating community-based organizations to become Medi-Cal Waiver providers during the demonstration period	This measure isn’t changing very much, we are only revising the language to align with the options provided by CMS.
#5 - Annual # of Medi-Cal residents in participating inpatient facilities who become educated about their HCBS options through the Preference Interview process	CA no longer requires CCT LOs to conduct the PIT.

Grantees must include 5 annual benchmarks that empirically measure the State’s progress in transitioning individuals to the community and rebalancing its long-term care system. Two benchmarks are required by statute (# of transitions and qualified HCBS expenditures), but the State has the option of choosing a minimum of 3 additional benchmarks that specifically address rebalancing.

The two required benchmarks are:

1. Meet the projected # of eligible individuals transitioned in each target group from an inpatient facility to a qualified residence during each calendar year of the demonstration.
2. Increase State Medicaid expenditures for HCBS during each calendar year of the demonstration.

Grantees must propose 3 additional measures that show the progress of rebalancing efforts, and the State’s progress to direct savings (from the enhanced FMAP provided by this project) towards the development of systems improvements and enhancing ways in which money can follow the person into the community. Optional benchmarks may include, but are not limited to:

Optional Benchmark	Y/N?	Rationale
The % increase in HCBS versus institutional long-term care expenditures under Medicaid for each year of the demonstration program.	Yes	We’ve been tracking these dollar amounts; we just need to display the data to show the increase in HCBS spending over institutionalized care.

Optional Benchmark	Y/N?	Rationale
Establishment and utilization rates for a system for accessing information and services by a date certain (i.e., the establishment or expansion of one-stop shops, single point of entry).	No	N/A in CA
Establishment and utilization rates for a screening, identification, and assessment process for persons who are candidates for transitioning to the community that are put into use in the general Medicaid program beyond recruitment for the MFP demonstration.	No	N/A in CA
Progress directed by the State to achieve flexible financing strategies, such as global or pooled financing or other budget transfer strategies that allow “money to follow the person”.	No	N/A in CA
Increases in available and accessible supportive services (i.e., progress directed by the State in achieving the full array of health services and community supports for consumers, including the use of “one-time” transition services, purchase and adaptation of medical equipment, environmental modifications, housing and transportation services beyond those used for MFP transition participants).	No	We do not do track this through CCT.
Increases in an available and trained community workforce (i.e., direct interventions, undertaken by the State, to increase the quality, the quantity and the empowerment of direct care workers).	No	We do not do track this through CCT.
Increases in the availability of self-directed services (i.e., progress directed either by the State to expand the opportunities for Medicaid eligible persons beyond those in the MFP transition program to directly, or through representation, to express preferences and desires to self-direct their services and supports).	No	N/A in CA
Increases in the utilization of transition coordinators used to assist individuals in Medicaid find appropriate services and supports in the community.	Yes	We have been tracking the number of new CCT providers
Improvements in quality management systems (i.e., direct inventions undertaken by the State to ensure the health and welfare of participants is protected while also maintaining consumer choice).	No	N/A in CA
Expansions to and improvements in health information technology (i.e., progress directed by the State to build systems that accommodate the business needs of multiple organizations that serve the same populations).	No	N/A in CA
Improvements in cultural and linguistic competence (i.e., language assistance services, including patient-related written materials).	No	N/A in CA

Optional Benchmark	Y/N?	Rationale
Interagency consumer and public/private collaboration (i.e., direct interventions by the State to achieve a higher level of collaboration with private entities, consumer and advocacy organizations, and institutional providers needed to achieve a rebalanced long-term care system).	Yes	We began tracking the number of CCT Participants entering into Managed Care at the beginning of 2015.

Proposed Optional Benchmarks for 2016

Benchmark #3

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

Method for measurement: The total amount of HCBS vs. Institution-based spending is pulled from annual claims data

Benchmark #4

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

Method for measurement:

# of organizations enrolled as CCT Lead Organizations within the Medi-Cal Provider Enrollment System.										
CY	2009	2010	2011	2012	2013	2014	2015	Projections		
								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

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.

Method for measurement: This total will be pulled from the CCT database and can be validated against the beneficiaries' Aid Codes