



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



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GOVERNOR

CCT GL #16-013

Date: February 29, 2016
To: California Community Transitions (CCT) Program Directors
Subject: Shifting of State Residency When Transitioning

PURPOSE

This CCT Guidance Letter (GL) provides directions on how to transition a Money Follows the Person (MFP) Enrollee who lives in an inpatient facility in one state, to live and receive home and community-based long-term services and supports (HCB LTSS) in another state (MFP is known as CCT in California).

BACKGROUND

Sometimes an individual who enrolls in MFP/CCT in one state wishes to leave an inpatient nursing facility to live and receive services in a community setting in another state. In these cases, MFP/CCT Enrollees may still qualify to participate in the MFP Demonstration if the state into which they plan to move has an MFP program (see Attachment 1 for a list of the 44 states with MFP Demonstration grants).

The Centers for Medicare and Medicaid Services (CMS) supports these types of transitions as a way to support person-centered care and rebalance institutional and community-based long-term care on a national level.

GUIDANCE

When a CCT Enrollee wishes to transition into or out of California, the Transition Coordinator (TC) at the CCT Lead Organization of the MFP Enrollee's choice will be

required to collaborate with TCs in the other state. Because all 44 state MFP programs are built upon the principles of consumer-directed transition and care planning, coordinating efforts to implement inter-state, consumer-directed plans will be based on a shared mission and consumer-centered principles. Coordinating transitions into or out of states without MFP programs will require additional guidance and TCs should notify the CCT Project Director for additional direction, if this case ever arises.

Transitioning OUT of California

1. The LO's TC must notify the CCT Project Director of the Enrollee's request to transition out-of-state.
2. Send a secure email to the CCT Project Director. Title the subject line: "CCT Enrollee Transitioning Out of State." The following information should be included in the secure email:
 - a. The Enrollee's name, DOB, and Medi-Cal identification number.
 - b. Summary of the Enrollee's current health status and projected LTSS needs.
 - c. Reason for out-of-state request.
 - d. Family/other support providers in the requested location.
 - e. Proposed street address, if available.
 - f. City and state/district/country name, and zip code.
 - g. Tentative date of transition.
 - h. Proposed method of transportation to the new location.
3. The CCT Project Director will initiate contact with the other state to determine if the Enrollee is eligible to receive Medicaid HCB LTSS in the state. The same target populations are **not** served in all 44 states with MFP grants.
4. If the CCT Enrollee is eligible to receive Medicaid HCB LTSS in the other state the CCT Project Director will provide the out-of-state contact information to the TC to begin coordination efforts.
5. The TC is responsible for working with the MFP Enrollee in compliance with CCT policies and the MFP regulations in both states. If there is a conflict between state rules, the TC must notify the CCT Project Director immediately.

6. The TC will work with the Enrollee and the out-of-state MFP provider to develop a *Transition and Care Plan* that meets the Enrollee's needs and preferences to ensure a safe and sustainable transition to community living.
7. The TC will submit a Treatment Authorization Request (TAR) for the necessary LTSS required to transition the Enrollee out of the state, including transportation to the new home location.
8. Once the *Final Transition and Care Plan* is approved and all LTSS are in place, the two states will work together through the day of transition to ensure continuation of care.
9. The CCT LO is responsible for administering the initial Baseline Quality of Life (QoL) Survey, and forwarding copies of the documents to the out-of-state MFP agency.
10. If transition issues arise during the pre-transition period, the TC will contact the CCT Project Director immediately.

Transitioning TO California

1. The out-of-state MFP Project Director will contact the CCT Project Director regarding the proposed transition.
2. The CCT Project Director will send a secure email to the area LO with the subject line: "MFP Enrollee Transitioning into State."
3. The secure email will include the following information:
 - a. The Enrollee's name, DOB, and Medicaid identification number.
 - b. Summary of the Enrollee's current health status and projected LTSS needs.
 - c. Reason for out-of-state request.
 - d. Family/other support providers in the requested location.
 - e. Proposed street address, if available.
 - f. City and state/district/country name, and zip code.
 - g. Tentative date of transition.
 - h. Proposed method of transportation to new location.

4. If the LO agrees to accept the out-of-state MFP Enrollee as a client, the TC will contact the out-of-state MFP contact to begin planning post-transition services.
5. The TC is responsible for working with the out-of-state MFP provider in compliance with CCT policies and the MFP regulations in both states. If there is a conflict between state rules, the TC must notify the CCT Project Director immediately.
6. The TC will work with the Enrollee and the out-of-state MFP provider to develop a *Transition and Care Plan* that meets the Enrollee's needs and preferences to ensure a safe and sustainable transition to community living. At least two weeks before the out-of-state MFP Enrollee transitions to the community, the CCT TC will need to send the proposed *Final Transition and Care Plan* to their assigned state RN for review.
7. Once the *Final Transition and Care Plan* is approved and all LTSS are in place, the two states will work together through the day of transition to ensure continuity of care.
8. The TC will maintain records for the amount of time spent on pre-transition activities and will be able to submit claims for the time after the individual transitions to the community.
9. The CCT LO is responsible for all follow-up, and for administering the first and second follow-up QoLs.

QUESTIONS

For further questions about this GL, please contact Karli Holkko at (916) 322-5253 or Karli.holkko@dhcs.ca.gov, or a CCT Project Nurse.

Sincerely,

(Original signed by)

Rebecca Schupp, Chief
Long-Term Care Division

Attachment