

Money Follows the Person Rebalancing Demonstration

California

Community Transitions

Submitted By
California Department of Health Services

Sandra Shewry
Director

State Partners

- ★ *Department of Rehabilitation*
- ★ *Department of Aging*
- ★ *Department of Social Services*
- ★ *Department of Developmental Services*
- ★ *Department of Housing and Community Development*
- ★ *Department of Transportation*
- ★ *California Housing Finance Agency*
- ★ *Department of Mental Health*
- ★ *California Health and Human Services Agency*



Arnold Schwarzenegger
Governor

October 31, 2006

Table of Contents

Section I: Notice of Intent to Apply

Section II: Standard Forms

Section III: Required Letters of Endorsement

Section IV: Project Abstract and Profile

Section V: Cover Letters

Section VI: Application Narrative

1. Systems Assessment & Gap Analysis
2. Demonstration Design
3. Preliminary Budget & Organizational Staffing Plan
4. Assurances

Section VII: Required Attachments

1. Prohibited Use of Grant Funds
2. State Profile & Summary of Project
3. Resumes of Key Project Staff
4. MOE Forms & Certifications

Section VIII: Additional Appendices

1. HCBS Services Across State Departments (Matrix)
2. Preference Survey Analysis and Tool
3. Quality Management Strategy from NF A/H Waiver
4. Additional State Long-Term Care Legislative Initiatives
5. Distribution of Medi-Cal Spending on Long-Term Care
6. California Office of Statewide Health Planning and Development (OSHPD): Long-Term Care Services, Statewide Trends
7. Letters of Support from Stakeholders
8. Organizational Charts
9. HCBS Informing Notice
10. Acronyms

Section I

Notice of Intent to Apply

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



California
Department of
Health Services

SANDRA SHEWRY
Director

SEP - 1 2006



ARNOLD SCHWARZENEGGER
Governor

Ms. Sona Sepp
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
Phone: (410) 786-6815 Fax (410) 786-9004

Dear Ms. Sepp:

The California Department of Health Services intends to submit an application for the Money Follows the Person Rebalancing Demonstration, Funding Opportunity No. HHS-2007-CMS-RCMFTP-0003. The requested information is below:

1. Name of State: California
2. Applicant Agency/Organization: CA Department of Health Services
3. Contact Name and Title: Stan Rosenstein, Deputy Director
4. Address: 1501 Capitol Avenue, P.O. Box 997413, MS 4000
Sacramento, CA 95899-7413
5. Phone: (916) 440-7800 Fax: (916) 440-7805
6. E-mail address: SRosenst@dhs.ca.gov

Please contact me at (916) 440-7800, if further information is required.

Sincerely,

Stan Rosenstein
Deputy Director
Medical Care Services

Section II

Standard Forms

The following required Standard Forms were submitted on-line through our electronic grant submittal through grants.gov:

- **SF424: Official Application for Federal Assistance**
- **SF424A: Budget Information**
- **SF424B: Assurances – Non-Construction Programs**
- **SFLLL: Disclosure of Lobbying Activities**

Hard copies of the above forms, as well as Additional Assurances and Certifications, are included in this section.

Opportunity Title:	Money Follows the Person Rebalancing Demonstration		
Offering Agency:	Centers for Medicare & Medicaid Services		
CFDA Number:	93.779		
CFDA Description:	Centers for Medicare and Medicaid Services (CMS) Resear		
Opportunity Number:	HHS-2007-CMS-RCMFTP-01		
Competition ID:			
Opportunity Open Date:	07/26/2006		
Opportunity Close Date:	11/01/2006		
Agency Contact:	Nicole Nicholson	▲ ▼	
	Grants Management Specialist		
	E-mail: nnicholson@cms.hhs.gov		

This electronic grants application is intended to be used to apply for the specific Federal funding opportunity referenced here.

If the Federal funding opportunity listed is not the opportunity for which you want to apply, close this application package by clicking on the "Cancel" button at the top of this screen. You will then need to locate the correct Federal funding opportunity, download its application and then apply.

This opportunity is only open to organizations, applicants who are submitting grant applications on behalf of a company, state, local or tribal government, academia, or other type of organization.

* Application Filing Name:

Mandatory Documents

- Application for Federal Assistance (SF-424)
- Disclosure of Lobbying Activities (SF-LLL)
- Assurances for Non-Construction Programs (SF-424B)
- Budget Information for Non-Construction Programs (SF-424A)

Move Form to Submission List

Move Form to Documents List

Mandatory Completed Documents for Submission

Optional Documents

- Project Narrative Attachment Form
- Budget Narrative Attachment Form

Move Form to Submission List

Move Form to Documents List

Optional Completed Documents for Submission

Instructions

- 1** Enter a name for the application in the Application Filing Name field.

 - This application can be completed in its entirety offline; however, you will need to login to the Grants.gov website during the submission process.
 - You can save your application at any time by clicking the "Save" button at the top of your screen.
 - The "Submit" button will not be functional until the application is complete and saved.
- 2** Open and complete all of the documents listed in the "Mandatory Documents" box. Complete the SF-424 form first.

 - It is recommended that the SF-424 form be the first form completed for the application package. Data entered on the SF-424 will populate data fields in other mandatory and optional forms and the user cannot enter data in these fields.
 - The forms listed in the "Mandatory Documents" box and "Optional Documents" may be predefined forms, such as SF-424, forms where a document needs to be attached, such as the Project Narrative or a combination of both. "Mandatory Documents" are required for this application. "Optional Documents" can be used to provide additional support for this application or may be required for specific types of grant activity. Reference the application package instructions for more information regarding "Optional Documents".
 - To open an item, simply click on it to select the item and then click on the "Open" button. When you have completed a form or document, click the form/document name to select it, and then click the => button. This will move the form/document to the "Completed Documents" box. To remove a form/document from the "Completed Documents" box, click the form/document name to select it, and then click the <= button. This will return the form/document to the "Mandatory Documents" or "Optional Documents" box.
 - When you open a required form, the fields which must be completed are highlighted in yellow. Optional fields and completed fields are displayed in white. If you enter invalid or incomplete information in a field, you will receive an error message.
- 3** Click the "Submit" button to submit your application to Grants.gov.

 - Once you have properly completed all required documents and saved the application, the "Submit" button will become active.
 - You will be taken to a confirmation page where you will be asked to verify that this is the funding opportunity and Agency to which you want to submit an application.

Application Submission Verification and Signature

Opportunity Title: **Money Follows the Person Rebalancing Demonstration**

Offering Agency: **Centers for Medicare & Medicaid Services**

CFDA Number: **93.779**

CFDA Description: **Centers for Medicare and Medicaid Services (CMS) Research, Demonstrations and Eval**

Opportunity Number: **HHS-2007-CMS-RCMFTP-0003**

Competition ID:

Opportunity Open Date: **07/26/2006**

Opportunity Close Date: **11/01/2006**

Application Filing Name : **California Community Transitions**

Do you wish to sign and submit this Application?

Please review the summary provided to ensure that the information listed is correct and that you are submitting an application to the opportunity for which you want to apply.

If you want to submit the application package for the listed funding opportunity, click on the "Sign and Submit Application" button below to complete the process. You will then see a screen prompting you to enter your user ID and password.

If you do not want to submit the application at this time, click the "Exit Application" button. You will then be returned to the previous page where you can make changes to the required forms and documents or exit the process.

If this is not the application for the funding opportunity for which you wish to apply, you must exit this application package and then download and complete the correct application package.

Sign and Submit Application

Exit Application

Application for Federal Assistance SF-424

Version 02

* 1. Type of Submission: <input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application	* 2. Type of Application: <input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> Revision	* If Revision, select appropriate letter(s): _____ * Other (Specify) _____
---	---	---

* 3. Date Received: Completed by Grants.gov upon submission.	4. Applicant Identifier: _____
--	--

5a. Federal Entity Identifier: 68-0317191	* 5b. Federal Award Identifier: HHS-2007-CMS-RCMFTP-003
---	---

State Use Only:

6. Date Received by State: 11/01/2006	7. State Application Identifier: _____
--	---

8. APPLICANT INFORMATION:

*** a. Legal Name:** California Department of Health Services

* b. Employer/Taxpayer Identification Number (EIN/TIN): 68 031 7191	* c. Organizational DUNS: 624878349
---	---

d. Address:

* Street1: 1501 Capitol Avenue Suite 71.6031, MS 0018
Street2: _____
* City: Sacramento
County: Sacramento
* State: CA: California
Province: _____
* Country: USA: UNITED STATES
* Zip / Postal Code: 95899 7413

e. Organizational Unit:

Department Name: Department of Health Services	Division Name: Office of Long-Term Care
--	---

f. Name and contact information of person to be contacted on matters involving this application:

Prefix: Ms. * First Name: Carol
Middle Name: _____
* Last Name: Freels
Suffix: _____
Title: Chief, Office of Long-Term Care

Organizational Affiliation:

* Telephone Number: 916 440-7534	Fax Number: 916 440-7540
* Email: cfreels@dhs.ca.gov	

Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type:

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Centers for Medicare & Medicaid Services

11. Catalog of Federal Domestic Assistance Number:

93.779

CFDA Title:

Centers for Medicare and Medicaid Services (CMS) Research, Demonstrations and Evaluations

*** 12. Funding Opportunity Number:**

HHS-2007-CMS-RCMFTP-0003

* Title:

Money Follows the Person Rebalancing Demonstration

13. Competition Identification Number:

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

Multiple Regions throughout California

*** 15. Descriptive Title of Applicant's Project:**

Transition of Nursing facilities to qualify home and community based alternatives.

Attach supporting documents as specified in agency instructions.

Add Attachments

Delete Attachments

View Attachments

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

* a. Applicant:

* b. Program/Project:

Attach an additional list of Program/Project Congressional Districts if needed.

17. Proposed Project:

* a. Start Date:

* b. End Date:

18. Estimated Funding (\$):

* a. Federal	<input type="text" value="130,387,502.00"/>
* b. Applicant	<input type="text" value="0.00"/>
* c. State	<input type="text" value="51,804,000.00"/>
* d. Local	<input type="text" value="0.00"/>
* e. Other	<input type="text" value="0.00"/>
* f. Program Income	<input type="text" value="0.00"/>
* g. TOTAL	<input type="text" value="182,191,502.00"/>

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

- a. This application was made available to the State under the Executive Order 12372 Process for review on
- b. Program is subject to E.O. 12372 but has not been selected by the State for review.
- c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes", provide explanation.)**

- Yes
- No

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

**** I AGREE**

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: * First Name:
Middle Name:
* Last Name:
Suffix:

* Title:

* Telephone Number: Fax Number:

* Email:

* Signature of Authorized Representative: * Date Signed:

Application for Federal Assistance SF-424

Version 02

*** Applicant Federal Debt Delinquency Explanation**

The following field should contain an explanation if the Applicant organization is delinquent on any Federal Debt. Maximum number of characters that can be entered is 4,000. Try and avoid extra spaces and carriage returns to maximize the availability of space.

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

<p>* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL</p> <p>Completed on submission to Grants.gov</p> 	<p>* TITLE</p> <p>Chief, Office of Long Term Care</p>
<p>* APPLICANT ORGANIZATION</p> <p>California Department of Health Services</p>	<p>* DATE SUBMITTED</p> <p>Completed on submission to Grants.gov 11/1/06</p>

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 4040-0006
Expiration Date 04/30/2008

SECTION A - BUDGET SUMMARY						
Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1.	93.779.	\$ 130,387,502.00				\$ 130,387,502.00
2.						0.00
3.						0.00
4.						0.00
5. Totals						
SECTION B - BUDGET CATEGORIES						
6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total	
	(1)	(2)	(3)	(4)	(5)	
a. Personnel	\$ 90,000.00					
b. Fringe Benefits	0.00					
c. Travel	0.00					
d. Equipment	0.00					
e. Supplies	0.00					
f. Contractual	0.00					
g. Construction	0.00					
h. Other	130,297,502.00					
i. Total Direct Charges (sum of 6a-6h)						
j. Indirect Charges	0.00					
k. TOTALS (sum of 6i and 6j)						
7. Program Income		\$ 0.00		\$ 0.00	\$ 0.00	

Authorized for Local Reproduction

Standard Form 424A (Rev. 7-97)
Prescribed by OMB (Circular A -102)

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. State General Fund	\$	\$ 51,804,000.00	\$	\$
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	\$	\$	\$	\$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	\$	\$ 22,500.00	\$ 22,500.00	\$ 22,500.00	\$ 22,500.00
14. Non-Federal	\$				
15. TOTAL (sum of lines 13 and 14)	\$	\$	\$	\$	\$

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. 93.779	\$ 6,273,000.00	\$ 32,625,000.00	\$ 42,428,250.00	\$ 48,971,250.00
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	\$	\$	\$	\$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	▲ ▼	22. Indirect Charges: N/A	▲ ▼
23. Remarks:			▲ ▼

Project Narrative File(s)

* Mandatory Project Narrative File Filename:

Add Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File

Delete Optional Project Narrative File

View Optional Project Narrative File

Budget Narrative File(s)

* **Mandatory Budget Narrative**

Add Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative

Delete Optional Budget Narrative

View Optional Budget Narrative

ADDITIONAL ASSURANCES
CERTIFICATIONS

1. CERTIFICATION REGARDING DRUG-FREE WORK-PLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that it will provide a drug-free workplace in accordance with the Drug-Free Workplace Act of 1988, 45 CFR Part 76, subpart F. The undersigned (authorized official signing for the applicant organization) certifies that it will provide a drug-free workplace in accordance with the Drug-Free Workplace Act of 1988, 45 CFR Part 76, subpart F. The certification set out below is a material representation of fact upon which reliance will be placed when SSA determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, SSA, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants or governmentwide suspension or debarment. The grantee certifies that it will or will continue to provide a drug-free workplace by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--

(1) The dangers of drug abuse in the workplace;

(2) The grantee's policy of maintaining a drug-free workplace;

(3) Any available drug counseling, rehabilitation, and employee assistance programs; and

(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that as a condition of employment under the grant, the employee will:

(1) Abide by the terms of the statement; and

(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency within ten calendar days after receiving notice under subparagraph (d)(2), above, from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices.

Notices shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(2), above, with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f), above.

The grantee certifies that, as a condition of the grant, it will not engage in the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance in conducting any activity with the grant.

2. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(a) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(b) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(c) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure."

3. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS

NOTE: In accordance with 45 CFR Part 76, amended June 26, 1995, any debarment, suspension, proposed debarment or other governmentwide exclusion initiated under the Federal Acquisition Regulation (FAR) on or after August 25, 1995, shall be recognized by and effective for Executive Branch agencies and participants as an exclusion under 45 CFR Part 76.

(a) Primary Covered Transactions

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(1) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

(2) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(3) are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (a)(2) of this certification; and

(4) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed under the assurances page in the application package.

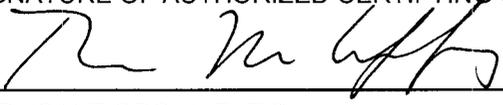
(b) Lower Tier Covered Transactions

The applicant agrees by submitting this proposal that it will include, without modification, **the following clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transaction"** (Appendix B to 45 CFR Part 76) in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions:

Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions

(1) The prospective lower tier participant certifies by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

(2) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL 	* TITLE Chief Deputy Director
* APPLICANT ORGANIZATION Calif. Department of Health Services	* DATE SUBMITTED 08-13-1967

Section III

Required Letters of Endorsement

**Money Follows The Person
Letters of Endorsement**

#	ORGANIZATION	NAME	ADDRESS	PHONE NUMBERS
1	California Department of Aging (CDA)	LORA CONNOLLY, Acting Director	1300 National Drive Ste 200 Sacramento, CA. 95834	(916) 419-7500 Fax (916) 928-2268
2	California Housing Finance Agency	THERESA A. PARKER, Executive Director	Sacramento Headquarters P.O. Box 4034 Sacramento, CA. 95812	(916) 322-3991
3	Department of Housing and Community Development	LYNN JACOBS, Director	1800 third Street , Room 450 Sacramento, CA. 94252-2050	(916)445-4775 Fax (916) 324-5107
4	Department of Developmental Services (DDS)	TERRI DELGADILLO, Director	1600 9th Street Room 460 Sacramento, CA. 95814	(916) 654-3454 Fax (916) 654-3343
5	Department of Mental Health	STEPHEN W. MAYBERG, Ph.D Director	1600 9th Street Sacramento, CA. 95814	(916) 654-3576 (916) 654-5591
6	Department of Rehabilitation (DOR)	CATHERINE CAMPISI, Ph.D. Director	2000 Evergreen Street Sacramento, CA. 95815	(916) 263-8987 Fax (916) 263-7474
7	Department of Social Services (DSS)	CLIFF ALLENBY, Interim Director	744 P Street Sacramento, Ca. 95814	(916) 654-2598 Fax (916) 654-6012
8	Department of Transportation Division of Mass Transportation (DOT)	PETER J. STEINERT, Interagency Coordination Liaison	1120 N Street P.O. Box 942874 Sacramento, CA. 94274	(916) 654-9446 Fax (916) 654-4816
9	State of California Health and Human Services Agency (CHHS)	KIMBERLY BELSHE', Secretary	1600 9th Street Room 400 Sacramento, CA. 95814	(916) 654-3454 Fax (916) 654-3343

DEPARTMENT OF AGING

1300 NATIONAL DRIVE, SUITE 200
SACRAMENTO, CA 95834-1992
Internet Home Page: www.aging.ca.gov
TDD Only 1-800-735-2929
FAX Only (916) 928-2268
Main Office (916) 419-7500



October 20, 2006

Kimberly Belshé
Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Secretary ^{Kim} Belshé:

On behalf of the California Department of Aging (CDA), I am writing to express our support of California's application for the Money Follows the Person (MFP) Rebalancing Demonstration. We look forward to the opportunity to participate in this important initiative.

CDA serves as both a unifying force for services to seniors and adults with disabilities, and as a focal point for federal, State and local agencies which serve the elderly and adults with disabilities in California. Our mission is to promote the independence and well-being of older adults, adults with disabilities, and families through access to information and services to improve the quality of their lives; opportunities for community involvement; and, support for family members providing care.

California's MFP Demonstration proposal to facilitate transitions from institutional settings to the community is fundamental to our department's mission. We endorse the project's objectives to improve the State's long-term care system infrastructure by developing community-based models that facilitate transitions to community living and to increase the capacity of home and community based services. In addition, the project responds to key policy initiatives for the State as identified by the California Olmstead Advisory Committee.

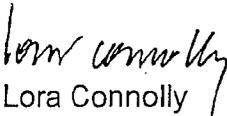
CDA will demonstrate support for the project by participating in the pre-implementation process and providing technical expertise on various project components. In order to maximize the State's efforts to improve and expand the delivery of home and community-based services in California, CDA will actively participate in the grant implementation so that these new activities coordinate with and build upon the existing home and community-based programs we administer, such as the Multipurpose Senior Services Program (MSSP), Older Americans Act programs, and Older Californians Act programs such as the State's Linkages case management program, all of which provide

Kimberly Belshé, Secretary
October 20, 2006
Page 2

critical care management and community-based support to avoid, delay, or remedy inappropriate placement of persons in nursing facilities.

We look forward to working with the California Health and Human Services Agency and the Department of Health Services on these endeavors.

Sincerely,


Lora Connolly
Acting Director

State of California

CalHFASM California Housing Finance Agency

October 25, 2006

John A. Courson
Chair, Board of Directors

Theresa A. Parker
Executive Director

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Subject: California's Money Follows the Person Rebalancing Demonstration Application

Dear Kim,

On behalf of the California Housing Finance Agency, I am writing to express support of California's application for the Money Follows the Person (MFP) Rebalancing Demonstration. The California Housing Finance Agency looks forward to the opportunity to assist in this important initiative.

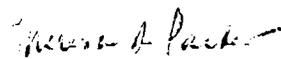
The California Housing Finance Agency was created in 1975 with the goal of helping more Californians live in a home they can afford. Created as the state's affordable housing bank, the California Housing Finance Agency has invested over \$12 billion in non-taxpayer funds to help more than 140,000 California families live in a home of their own with a mortgage they can afford. Our Multifamily Division has invested more than \$2 billion for the construction and preservation of 36,000 affordable rental housing units to assist very low and low income Californians.

We endorse California's MFP Demonstration proposal to facilitate transitions from institutional settings to the community and its objectives to build upon the state's long-term care system infrastructure to increase the capacity of home and community-based services and develop community-based models that facilitate transitions to community living.

The California Housing Finance Agency will demonstrate support for the project by providing technical expertise on various project components in order to maximize the State's efforts to improve and expand the delivery of home and community-based services in California.

We look forward to working with the California Health and Human Services Agency and the Department of Health Services on these endeavors.

Sincerely,



Theresa A. Parker
Executive Director

Sacramento Headquarters
P.O. Box 4034
Sacramento, CA 95812
(916) 322-3991

Los Angeles Office
100 Corporate Pointe, Ste. 250
Culver City, CA 90230
(310) 342-1250

www.calhfa.ca.gov

DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT**OFFICE OF THE DIRECTOR**

1800 Third Street, Room, 450
Sacramento, CA 94252-2050
www.hcd.ca.gov
(916) 445-4775
Fax (916) 324-5107



October 27, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, California 95814

Dear Secretary Belshé:

Support of California's Money Follows the Person Rebalancing Demonstration Application

On behalf of the Department of Housing and Community Development (HCD), I am writing to express support of California's application for the Money Follows the Person (MFP) Rebalancing Demonstration. The Department of Housing and Community Development looks forward to the opportunity to participate in this important initiative.

The Department of Housing and Community Development is one of 13 departments within the Business, Transportation and Housing Agency (BTH). As California's principal housing agency, the mission of HCD is to provide leadership, policies, and programs to expand and preserve safe and affordable housing opportunities and promote strong communities for all Californians.

California's MFP Demonstration proposal to facilitate transitions from institutional settings to the community are fundamental to our Department's mission. We endorse the project's objectives to build upon the State's long-term care system infrastructure to increase the capacity of home and community-based services and develop community-based models that facilitate transitions to community living. In addition, the project responds to key policy initiatives for the State identified by the California Olmstead Advisory Committee.

The Department of Housing and Community Development will demonstrate support for the project by participating in the pre-implementation process and providing technical expertise on various project components. In addition, we plan to coordinate these efforts with current projects we administer in order to maximize the State's efforts to improve and expand the delivery of home and community-based services in California.

We look forward to working with the California Health and Human Services Agency and the Department of Health Services on these endeavors.

Sincerely,

Lynn L. Jacobs
Director

DEPARTMENT OF DEVELOPMENTAL SERVICES

1600 NINTH STREET, Room 240, MS 2-13
SACRAMENTO, CA 95814
TDD 654-2054 (For the Hearing Impaired)
(916) 654-1897



October 25, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 Ninth Street, Suite 460
Sacramento, CA 95814

Dear Ms. Belshé:

Support of California's Money Follows the Person
Rebalancing Demonstration Application

On behalf of the Department of Developmental Services (Department), I am writing to express support of California's application for the Money Follows the Person (MFP) Rebalancing Demonstration proposal. The Department looks forward to the opportunity to participate in this important initiative.

The Department currently serves approximately 210,000 individuals with developmental disabilities. The vast majority of these individuals reside in the community in an array of community living options. The Department contracts with 21 private, non-profit entities called regional centers to provide services to those individuals residing in the community. Many (approximately 69,000) of the regional center consumers receive services through the Home and Community-based Services (HCBS) Waiver operated by this Department. This is the largest waiver of its kind in the nation. Additionally, the Department through its Community Placement Plan process is providing options and opportunities for individuals residing in our developmental centers to transition into the community.

California's MFP Demonstration proposal to facilitate transitions from institutional settings to the community is fundamental to our Department's mission. We endorse the proposal's objectives to build upon the State's long-term care system infrastructure to increase the capacity of home and community-based services and develop community-based models that facilitate transitions to community living. In addition, the proposal responds to key policy initiatives for the State identified by the California Olmstead Advisory Committee.

"Building Partnerships, Supporting Choices"

Kimberly Belshé, Secretary

October 25, 2006

Page two

The Department will demonstrate support for the proposal by participating in the pre-implementation process and providing technical expertise on various proposal components. In addition, we plan to coordinate these efforts with current projects we administer such as our HCBS Waiver which provides a wide array of community services to consumers who would otherwise reside in intermediate care facilities, in order to maximize the State's efforts to improve and expand the delivery of home and community-based services in California.

We look forward to working with the California Health and Human Services Agency and the Department of Health Services on these endeavors.

Sincerely,

A handwritten signature in cursive script, appearing to read "Terri Delgadillo". The signature is written in black ink and is positioned above the printed name.

TERRI DELGADILLO

Director



1600 9th Street, Sacramento, CA 95814
(916) 654-3576

October 27, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Subject: Support of California's Money Follows the Person Rebalancing Demonstration Application

On behalf of the Department of Mental Health (DMH), I am writing to express support of California's application for the Money Follows the Person (MFP) Rebalancing Demonstration. DMH looks forward to the opportunity to participate in this important initiative.

DMH, located in Sacramento, has oversight of a public mental health budget of more than \$4 billion, including local assistance funding. DMH employs more than 10,000 employees at its headquarters office and at its five facilities. Its responsibilities include providing leadership for local county mental health departments, evaluation and monitoring of public mental health programs, administration of federal funds for mental health programs and services, the care and treatment of the severely mentally ill at the five state mental hospitals and at the Acute Psychiatric Programs located at the two California Medical Facilities. DMH has the responsibility for the implementation of the Mental Health Services Act (Proposition 63), which provides state tax dollars for specific county mental health programs and services.

As a state public agency, DMH has worked hard to transform and improve the state's mental health systems of care by working with the mental health constituency to develop a system of partnerships and coordinated interagency efforts. These models have provided the framework for success in developing department programs and coordinating services in the treatment of children and adults who are mentally ill. DMH staff is committed to finding the most effective use of resources and innovation at all levels – not just in treatment, but in prevention and intervention as well. All programs are designed with the recovery process in mind.

Kimberly Belshé, Secretary

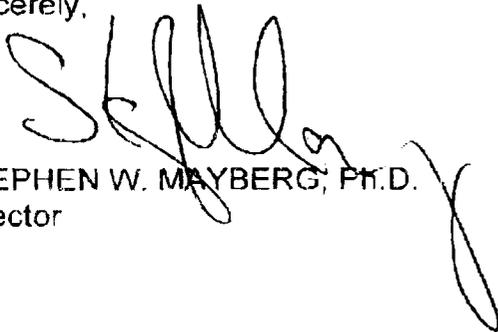
Page Two

California's MFP Demonstration proposals to facilitate the transition of individuals from institutional settings to the community are fundamental to our department's mission. We endorse the project's objectives to build upon the state's long-term care system infrastructure to increase the capacity of home and community-based services and develop community-based models that facilitate transitions to community living. In addition, the project responds to key policy initiatives for the State identified by the California Olmstead Advisory Committee.

DMH will demonstrate support for the project by participating in the pre-implementation process and providing technical expertise on various project components. In addition, we plan to coordinate these efforts with current efforts that DMH supports, such as the efforts of some counties to increase housing alternatives, increased intensive case management services, supported employment, increased participation in the coordination of the care and treatment of patients admitted to Institutions for Mental Disease and other long-term care facilities, the paying of patches to place more clients in Augmented group homes, and transforming the mental health system in principles of Recovery and Wellness. All of these efforts will help to maximize the State's efforts to improve and expand the delivery of home and community-based services in California.

We look forward to working with the California Health and Human Services Agency and the Department of Health Services on these endeavors.

Sincerely,



STEPHEN W. MAYBERG, Ph.D.
Director



**DEPARTMENT OF
REHABILITATION**

Employment, Independence & Equality

Arnold Schwarzenegger, Governor



State of California
Health and Human Services Agency

Office of the Director
2000 Evergreen Street
Sacramento, CA 95815
(916) 263-8987 Phone
(916) 263-7474 FAX
(916) 263-7477 TTY

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

October 19, 2006

**Subject: Support of California's Money Follows the Person Rebalancing
Demonstration Application**

Dear Secretary Belshé:

On behalf of the Department of Rehabilitation (DOR), I am writing to support California's application for the Money Follows the Person (MFP) Rebalancing Demonstration Grant. The DOR looks forward to the opportunity to participate in this important initiative.

As the "home in government" for Centers for Independent Living (CIL), the DOR has been deeply involved in planning for long term care and implementation of the Olmstead decision since 1998, helping to bring the consumer's perspective to the process. The DOR has worked collaboratively with the Department of Health Services, the Department of Aging and the Health and Human Services Agency on a variety of projects, and is currently funding three demonstration projects. The DOR has also been providing support and technical assistance to the Olmstead Advisory Committee.

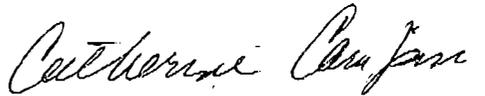
California's MFP Demonstration proposal to facilitate transitions from institutional settings to the community are fundamental to the DOR's mission. The DOR endorsed the project's objectives to build upon the state's long-term care system infrastructure to increase the capacity of home and community-based services and develop community-based models that facilitate transitions to community living. In addition, the project responds to key policy initiatives for the State identified by the California Olmstead Advisory Committee.

Kimberly Belshé, Secretary
Page Two

The DOR will support the project by participating in the pre-implementation process and providing technical expertise on various project components. In addition, the DOR will coordinate these efforts with three current projects we administer: (1) Transition Funding, which provides CIL with one-time costs for nursing home transitions; (2) Project DIAL (Deinstitutionalization Is About Living), which is providing both transition and diversion services at a CIL in Los Angeles; and (3) a project to review the State's Medicaid Plan from an independent living perspective. This collaboration will help maximize California's efforts to improve and expand the delivery of home and community-based services.

We look forward to working with the California Health and Human Services Agency and the Department of Health Services on these endeavors.

Sincerely,

A handwritten signature in cursive script that reads "Catherine Campisi".

CATHERINE CAMPISI, Ph.D.
Director

DEPARTMENT OF SOCIAL SERVICES

744 P Street, MS 19-96, Sacramento, CA 95814



October 19, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

SUBJECT: Support of California's Money Follows the Person Rebalancing Demonstration Application

On behalf of the California Department of Social Services, (CDSS), I am writing to express support of California's application for the Money Follows the Person (MFP) Rebalancing Demonstration. CDSS looks forward to the opportunity to participate in this important initiative.

CDSS oversees the In-Home Supportive Services (IHSS) program, which is administered through the 58 counties. The IHSS program provides personal care and domestic services to aged, blind, and disabled individuals in their own homes. The purpose of the program is to allow these individuals to live safely at home rather than in costly and less desirable out-of-home placement facilities. IHSS is an alternative to out-of-home care. Services are determined based upon a social worker's evaluation which is completed through the assessment process. A uniform IHSS needs assessment tool is used in ranking the individuals by observing their ability to function in activities of daily living.

California's MFP Demonstration proposal to facilitate transitions from institutional settings to the community is fundamental to our department's mission. We endorse the project's objectives to build upon the state's long-term care system infrastructure to increase the capacity of home and community-based services and develop community-based models that facilitate transitions to community living. In addition, the project responds to key policy initiatives for the State identified by the California Olmstead Advisory Committee.

Kimberly Belshé, Secretary
Page Two

CDSS will demonstrate support for the project by participating in the pre-implementation process and providing technical expertise on various project components. In addition, we plan to coordinate these efforts with current projects/programs we administer – the IHSS program, which serves the elderly, disabled, and blind Californians with the quality of care that is essential for them to remain safely in their own homes; therefore, maximizing the State's efforts to improve and expand the delivery of home and community-based services in California.

We look forward to working with the California Health and Human Services Agency and the Department of Health Services on these endeavors.

Sincerely,

A handwritten signature in black ink, appearing to read "Cliff Allenby". The signature is written in a cursive style with a vertical line extending downwards from the end of the name.

CLIFF ALLENBY
Interim Director

DEPARTMENT OF TRANSPORTATION

DIVISION OF MASS TRANSPORTATION MS 39

1120 N STREET

P. O. BOX 942874

SACRAMENTO, CA 94274-0001

PHONE (916) 654-9446

FAX (916) 654-4816

TTY (916) 653-4086

*Flex your power!
Be energy efficient!*

October 23, 2006

Ms. Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

The California Department of Transportation (Caltrans) is submitting this letter in support of the California Department of Health Services (DHS) application for the "Money Follows the Person Rebalancing Demonstration."

Caltrans is committed to working with our other state partners on projects to improve mobility choices, especially for older persons, persons with disabilities, and those on low incomes who often lack the ability to access adequate transportation options. We are currently leading a related effort to implement a Mobility Action Plan to establish a high-level state infrastructure to address the mobility barriers and issues faced by these transportation-disadvantaged groups. The Health and Human Services Agency and DHS are supporting partners in this endeavor.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. We feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

It is our intent to partner with DHS throughout the term of this demonstration project to provide a continuum of services to assist those individuals who wish to transition to the community. Access to transportation is a necessary component of this effort to ensure the availability of medical care and other community-based services. We strongly hope that you will look favorably upon California's proposal.

Sincerely,

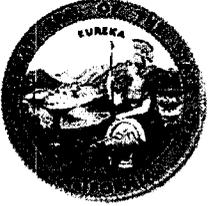
A handwritten signature in black ink that reads "Peter J. Steinert".

PETER J. STEINERT

Interagency Coordination Liaison

c: Sarah Steehausen, California Health and Human Services Agency

State of California HEALTH AND HUMAN SERVICES AGENCY



October 23, 2006

S. KIMBERLY BELSHÉ
SECRETARY

Ms. Judith Norris
Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management
Mail Stop C2-21-15
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Ms. Norris:

Aging
Alcohol and
Drug Programs
Child Support
Services
Community Services
and Development
Developmental
Services
Emergency Medical
Services Authority
Health Services
Managed Risk
Medical Insurance Board
Mental Health
Rehabilitation
Social Services
Statewide Health
Planning and
Development

On behalf of the California Health and Human Services Agency, I am writing to express strong support for California's application for the Money Follows the Person (MFP) Demonstration. The Health and Human Services Agency (Agency) looks forward to working with the Department of Health Services (DHS) to implement this important initiative.

The Agency oversees state and federal programs for health care, social services, public assistance and rehabilitation. Responsibility for administering major programs, which provide direct services to millions of Californians, is divided among the Agency's 11 departments and one board; including DHS. The Agency mission is to ensure that all Californians, especially those most at risk or in need, have the opportunity to enjoy a high quality of life as measured by the sound physical, mental and financial health of children, adolescents and adults; strong and well-functioning families; safe and sustainable communities; and dignity for all.

California's MFP Demonstration proposal, which seeks to facilitate transitions from institutional settings to the community, is fundamental to our Agency's mission. We endorse the project's objectives to build upon the state's long-term care system infrastructure, to increase the capacity of home and community-based services and to develop community-based models that facilitate transitions to community living. In addition, the project responds to key policy initiatives identified by the Agency's Olmstead Advisory Committee, established in 2005, to guide and inform the Administration's efforts to support the ability of seniors and persons with disabilities to live in the most integrated setting possible.

Our Assistant Secretary for Long-Term Care, Sarah Steenhausen, will play a key role in coordinating grant efforts between departments and seeking the input and active participation of the Olmstead Advisory Committee.

We look forward to working with the Department of Health Services in implementing this important endeavor.

Sincerely,

KIMBERLY BELSHÉ
Secretary

KB/SS/mcv

Section IV

Project Abstract and Profile

CALIFORNIA COMMUNITY TRANSITIONS GRANT ABSTRACT

The California Community Transitions demonstration will bring together the state's resources to develop culturally competent and self-directed community-based living options for persons who have been institutionalized for longer than six months.

To achieve this, local entities will design comprehensive transition models most appropriate for addressing their community's long-term care needs. Local entities will establish and manage Community Transition Teams (CTTs) to support the transition process. The state will be responsible for reviewing competitive applications and ensuring compliance with all state and federal rules. The state will conduct strategic planning during the year-long pre-implementation phase, which will be followed by the phase-in of the CTTs and participant enrollment during the remainder of the demonstration.

As the single state Medicaid agency, the California Department of Health Services (CDHS) will act as the overall coordinator for policy and operational issues related to the demonstration. CDHS will work with various stakeholders including state departments, community-based organizations, institutional providers, and consumer groups to implement the demonstration with the greatest possible level of collaboration.

The California Community Transitions demonstration will seek to successfully transition 2,000 persons from up to 10 regions in the state back into the community at a total cost of \$130,387,502 federal dollars over a five year period. Questions about the demonstration should be forwarded to Carol Freels or Paula Acosta at the California Department of Health Services, Office of Long Term Care (916) 440-7535.

State Profile & Summary of Project

Name of State: *California*

Primary Contact Name and Title: *Carol Freels (Chief, Office of Long-Term Care) or Paula Acosta (Chief, Long-Term Care Projects Unit)*

Year of Demonstration: *Year 2 – January 1 through December 31, 2008*

Estimated Number of Individuals to be Transitioned*	20	15	45	10	10
Statewide (SW) or Not Statewide (NSW)	NSW	NSW	NSW	NSW	NSW
Qualified Institutional Settings*	NF, ICF or Hospital				
Qualified Community Settings**	Home, Apartment or Assisted Living				
Qualified HCB Services	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care
HCB Demonstration* Services	Transition Coordination Excess Personal Care				
Supplemental Demonstration Services*	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers

- ***Subject to control agency approvals.***
- ***Defined during pre – implementation***
- ***Total number of slots is 100***

Name of State: California

Primary Contact Name and Title: Carol Freels (Chief, Office of Long-Term Care) or Paula Acosta (Chief, Long-Term Care Projects Unit)

Year of Demonstration: Year 3 – January 1 through December 31, 2009

Populations to be transitioned (unduplicated count)	Elderly	Mental Retardation/ Developmental Disability (MR/DD)	Physical Disability (PD)	Mental Illness (MI)	Dual Diagnosis: Chronic Medical & Mental Illness
Estimated number of individuals to be transitioned *	100	75	225	50	50
Statewide (SW) or Not Statewide (NSW)	NSW	NSW	NSW	NSW	NSW
Qualified Institutional Settings*	NF, ICF or Hospital	NF, ICF or Hospital	NF, ICF or Hospital	NF, ICF or Hospital	NF, ICF or Hospital
Qualified Community Settings**	Home, Apartment or Assisted Living	Home, Apartment or Assisted Living	Home, Apartment or Assisted Living	Home, Apartment or Assisted Living	Home, Apartment or Assisted Living
Qualified HCB Services	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care
HCB Demonstration* Services	Transition Coordination Excess Personal Care	Transition Coordination Excess Personal Care	Transition Coordination Excess Personal Care	Transition Coordination Excess Personal Care	Transition Coordination Excess Personal Care
Supplemental Demonstration Services*	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers

- **Subject to control agency approvals.**
- **Total Slots 500.**

*

Name of State: California

Primary Contact Name and Title: Carol Freels (Chief, Office of Long-Term Care) or Paula Acosta (Chief, Long-Term Care Projects Unit)

Year of Demonstration: Year 4 – January 1 through December 31, 2010

Populations to be transitioned (unduplicated count)	Elderly	Mental Retardation/ Developmental Disability (MR/DD)	Physical Disability (PD)	Mental Illness (MI)	Dual Diagnosis: Chronic Medical & Mental Illness
Estimated number of individuals to be transitioned *	130	98	292	65	65
Statewide (SW) or Not Statewide (NSW)	NSW	NSW	NSW	NSW	NSW
Qualified Institutional Settings*	NF, ICF or Hospital	NF, ICF or Hospital	NF, ICF or Hospital	NF, ICF or Hospital	NF, ICF or Hospital
Qualified Community Settings**	Home, Apartment or Assisted Living	Home, Apartment or Assisted Living	Home, Apartment or Assisted Living	Home, Apartment or Assisted Living	Home, Apartment or Assisted Living
Qualified HCB Services	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care
HCB Demonstration* Services	Transition Coordination Excess Personal Care	Transition Coordination Excess Personal Care	Transition Coordination Excess Personal Care	Transition Coordination Excess Personal Care	Transition Coordination Excess Personal Care
Supplemental Demonstration Services*	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers

- **Subject to control agency approvals.**
- **Total slots 650**

Name of State: California

Primary Contact Name and Title: Carol Freels (Chief, Office of Long-Term Care) or Paula Acosta (Chief, Long-Term Care Projects Unit)

Year of Demonstration: Year 5 – January 1 through December 31, 2011

Populations to be transitioned (unduplicated count)	Elderly	Mental Retardation/ Developmental Disability (MR/DD)	Physical Disability (PD)	Mental Illness (MI)	Dual Diagnosis: Chronic Medical & Mental Illness
Estimated number of individuals to be transitioned *	150	143	337	75	75
Statewide (SW) or Not Statewide (NSW)	NSW	NSW	NSW	NSW	NSW
Qualified Institutional Settings*	NF, ICF or Hospital	NF, ICF or Hospital	NF, ICF or Hospital	NF, ICF or Hospital	NF, ICF or Hospital
Qualified Community Settings**	Home, Apartment or Assisted Living	Home, Apartment or Assisted Living	Home, Apartment or Assisted Living	Home, Apartment or Assisted Living	Home, Apartment or Assisted Living
Qualified HCB Services	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care
HCB Demonstration* Services	Transition Coordination Excess Personal Care	Transition Coordination Excess Personal Care	Transition Coordination Excess Personal Care	Transition Coordination Excess Personal Care	Transition Coordination Excess Personal Care
Supplemental Demonstration Services*	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers

- **Subject to control agency approvals.**
- **Total slots 750**

Name of State: *California*

Primary Contact Name and Title: *Carol Freels (Chief, Office of Long-Term Care) or
Paula Acosta (Chief, Long-Term Care Projects Unit)*

Budget Estimate Presentation						
Demonstration Federal Funding Request						
Fiscal Year	Qualified HCBS program services (demonstration share at enhanced FMAP) of 75% FFP	Demonstration HCBS services (demonstration share at enhanced FMAP) of 75% FFP	Supplemental Demonstration Service Costs (demonstration share at regular FMAP) of 50% FFP	Administrative Costs and Evaluation Costs (at 50% FFP admin FMAP rate)	State Proposed Evaluation Costs (at 50%FFP admin FMAP rate)	Total FY Estimated Funding Request
2007	0	0	0	\$90,000	0	\$90,000.
2008	3,885,000.	1,773,900	523,800	\$90,000	0	\$6,273,000.
2009	19,426,500.	10,084,500	3,024,000	\$90,000	0	\$32,625,000.
2010	25,254,450.	13,133,475	3,950,325	\$90,000	0	\$42,428,250.
2011	29,139,750.	15,177,375	4,564,125	\$90,000	0	\$48,971,250.
TOTAL:	\$77,706,000.	*\$40,169,250.	\$12,062,250.	\$450,000	\$0	\$130,387,500.

* Transition Coordination and HCB Demo (other) included.

Section V

Cover Letters

- **Arnold Schwarzenegger, Governor of California**
- **Stan Rosenstein, California Medicaid Director**



GOVERNOR ARNOLD SCHWARZENEGGER

November 1, 2006

Ms. Nicole Nicholson
Centers for Medicare and Medicaid Services
Office of Operations Management, Acquisition and Grants Group
Mail Stop C2-21-15
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Nicholson,

This letter provides my endorsement and commitment to the application for a Money Follows the Person Rebalancing Demonstration Grant (CFDA 93.779) submitted by the California Department of Health Services (CDHS).

On September 27, 2004, I signed Executive Order S-18-04 to affirm the state's commitment to provide services to people with disabilities in the most integrated setting, and to adopt and adhere to policies and practices that make it possible for persons with disabilities to remain in their communities and avoid unnecessary institutionalization. Among other tasks, in that Order, I asked the California Health and Human Services Agency (CHHSA) to do the following:

- Identify additional strategies to identify Californians who could be served successfully in non-institutional settings and the barriers to these individuals moving at a reasonable pace from, or avoiding admittance to, institutional long-term care facilities;
- Develop recommendations for changes in state policies that will remove programmatic and fiscal incentives for institutional placement and increase opportunities to utilize community-based services.

The Olmstead Advisory Committee, also established under Executive Order S-18-04, includes consumers, providers, family members and advocates representing persons with disabilities and seniors. The Committee provides input to HHSa on its efforts to implement the California Olmstead Plan, recommending actions to improve California's long-term care system and creating opportunities to fund expanded or new activities to support individuals with disabilities in their community.

Ms. Nicole Nicholson
November 1, 2006
Page two

The proposed Money Follows the Person Demonstration project directly supports policy initiatives of the Olmsted Committee that seek to provide nursing home residents opportunities to return to their communities. As the lead entity, the CDHS will facilitate collaboration between the project team, community organizations, the Olmstead Advisory Committee, state departments and agencies and other stakeholders. This project will support development of local community-level infrastructure that will enable interested individuals to transition back into the community.

We appreciate your consideration of this grant proposal. If you have any questions, please contact Kristin Triepke of my staff at (916) 445-6131.

Sincerely,

A handwritten signature in black ink, appearing to read "Arnold Schwarzenegger". The signature is stylized and cursive, with a long horizontal stroke extending to the right.

Arnold Schwarzenegger

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



California
Department of
Health Services

SANDRA SHEWRY
Director

001 31 2006



ARNOLD SCHWARZENEGGER
Governor

Ms. Judith Norris
Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management
Mail Stop C2-21-15
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Ms. Norris:

The California Department of Health Services (CDHS) is pleased to submit California's application for the Money Follows the Person (MFP) Rebalancing Demonstration Grant to the Centers for Medicare & Medicaid Services (CMS). CDHS, as the Single State Medicaid Agency, will act as lead organization in development, implementation and oversight of the proposed demonstration.

California is committed to moving towards a more balanced long-term care system focused on home and community-based services (HCBS). This commitment is demonstrated by the fact that California already spends over 60% of all long-term care dollars on HCBS, ranking 11th in the nation. The MFP demonstration will allow the state to address multiple challenges with service delivery and consumer access. If awarded by CMS, the proposed demonstration grant will help California continue efforts in supporting home and community-based services across multiple state departments, across single service programs and service delivery in multiple regions throughout the state.

Project Title: California Community Transitions
Lead Agency: California Department of Health Services
Primary Contacts:

Carol A. Freels
Chief, Office of Long Term Care
1501 Capitol Ave, MS 0018
PO Box 997413
Sacramento, CA 95899-7413
Tel. 916.440.7535
Fax. 916.440.7540
cfreels@dhs.ca.gov

Paula Acosta
Chief, Long Term Care Projects Unit
Office of Long Term Care
Tel. 916.440.7544
pacosta@dhs.ca.gov

Ms. Judith Norris

Page 2

OCT 31 2006

Total Federal Funds Request: \$130,387,500

Major Partners:

- California Health & Human Services Agency (CHHSA)
- California Department of Aging
- Department of Social Services
- Department of Rehabilitation
- Department of Developmental Services
- Department of Mental Health
- Department of Transportation
- California Housing Finance Agency
- Department of Housing and Community Development

California's proposed demonstration, California Community Transitions, will provide state-level leadership and will support community-level teams who will facilitate individual residents of health facilities who prefer to transition to community living. The California Community Transitions project will help California fill a critical need by providing outreach and support to long-stay institutional residents who prefer to transition to community living. During the five years of the demonstration, we anticipate that 2,000 individuals will achieve that goal.

CDHS will work closely with a variety of both state-level and community-level partners and stakeholders, including the California Olmstead Advisory Committee. The Olmstead Advisory Committee includes consumers, family members, providers and advocates. CDHS will ensure stakeholder and consumer involvement and decision making during all stages of the demonstration.

CDHS and our major partners are strongly committed to improving consumer access to California's network of home and community-based services and programs. Thank you for consideration of the California Community Transitions application. If there are questions regarding this application, please contact Ms. Carol A. Freels or Ms. Paula Acosta at (916) 440-7535.

Sincerely,



Stan Rosenstein
Deputy Director
Medical Care Services

Section VI

Application Narrative

Application Narrative is divided into the following parts, per the grant solicitation:

- **Part I: Systems Assessment & Gap Analysis**
- **Part II: Demonstration Design**
- **Part III: Preliminary Budget and Organizational Staffing Plan**
- **Part IV: Assurances**

Part I: Systems Assessment and Gap Analysis

California is committed to providing services in the least restrictive and most integrated setting. The proposed California Money Follows the Person (MFP) Demonstration project, California Community Transitions, seeks to develop the infrastructure necessary to facilitate transitions from institutions to the community, while also outlining mechanisms to better promote access to home and community-based care.

With over half of all long-term care dollars spent on home and community-based services, California ranks eleventh nationwide in the percent of funding spent on home and community-based compared to institutional services. In 2006, the state will provide home and community-based services to an estimated 375,000 individuals for an estimated expenditure of \$8.4 billion. Comparatively, the state forecasts spending \$5.3 billion to serve fewer than 100,000 patients through institutional services.

Although California dedicates substantial resources towards home and community-based services, the system still confronts multiple barriers to expanding capacity and developing infrastructure. In particular, individuals who are institutionalized are challenged when seeking alternatives such as individualized case management services and supports, a consumer-centered package of services, and affordable, accessible housing—all of which are necessary to ensure successful transitions to the community.

The California Community Transitions demonstration will link institutional residents with home and community-based services, allowing for coordination over multiple programs and waivers, focused on a consumer control and self-direction. In addition,

the demonstration will coordinate efforts with California Community Choices, California's 2006 Real Choice Systems Transformation grant, to identify barriers and policy solutions necessary for long-term care systems rebalancing.

This Gap Analysis outlines California's long-term care support system, provides background on progress in expanding home and community-based capacity, and identifies barriers to address in developing infrastructure for institutional transitions and long-term care systems rebalancing.

THE LONG-TERM CARE CONTINUUM IN CALIFORNIA

Long-term care services can be grouped into two categories: 1) institutional or facility-based services; and 2) community-based services received in a home, apartment or group/community living arrangement. Institutional care services include Intermediate Care Facilities (including Intermediate Care Facilities for the Developmentally Disabled), Institutions for Mental Disease, and nursing facilities (including skilled nursing facilities, distinct part, and subacute facilities). Community-based services include Medi-Cal¹ State Plan services, Medi-Cal Home and Community-Based Services (HCBS) waiver programs, and other programs funded outside the Medi-Cal system.

Multiple State Departments Administer Long-Term Care Services

In California, the Departments of Aging (CDA), Health Services (CDHS), Social Services (CDSS), Developmental Services (DDS), Mental Health (DMH), and Rehabilitation (DOR), directly administer long-term care programs and services. (Appendix 1) The California Health and Human Services Agency (CHHSA) provides policy oversight and coordination among these entities, in addition to other departments

¹ Medicaid is called Medi-Cal in California.

and commissions, including the Office of Statewide Health Planning and Development (OSHPD), Alcohol and Drug Programs, Child Support Services, Major Risk Medical Insurance Board, Emergency Medical Services Authority, and Community Services and Development.

California Facility-Based Services

Intermediate-Care Facilities (ICFs). ICFs provide room and board along with regular medical, nursing, social and rehabilitative services. ICFs are Medi-Cal and/or Medicare certified by CDHS, and funded primarily by Medi-Cal, as well as Medicare and private pay.

ICFs for the Developmentally Disabled (ICF/DDs). Known at the federal level as ICFs/MR (mental retardation), ICF/DDs provide services for persons of all ages with mental retardation and/or developmental disabilities. ICF/DDs have 16 or more beds; ICF/DD-H (habilitative) and ICF/DD-Ns (nursing) have 15 or fewer beds and average six beds in a home setting. All ICF/DDs are Medi-Cal certified by CDHS, while DDS and Regional Centers are responsible for placement and quality assurance. These facilities are nearly 100% funded by Medi-Cal.

Institutes for Mental Disease (IMDs). IMDs provide extended treatment for persons of all ages with chronic mental health problems; many consumers are younger than 65. Specialized staff serves consumers in a secured environment. IMDs are Medi-Cal certified by CDHS and funded by a combination of state and county dollars. Local mental health departments are responsible for placement and program content.

Nursing Facilities (NFs). Sometimes called skilled-nursing facilities, nursing homes or convalescent hospitals, NFs provide comprehensive nursing care for the chronically

ill or short-term consumers of all ages, as well as rehabilitation and specialized medical programs. NFs are Medi-Cal and/or Medicare certified by CDHS and funded primarily by Medi-Cal, with some funding through Medicare, managed care and private pay.

Subacute Facilities. Subacute Facilities focus on intensive rehabilitation, complex wound care and post-surgical recovery for consumers of all ages. These facilities are Medi-Cal and/or Medicare certified by CDHS and funded primarily by Medi-Cal, with some funding through Medicare, managed care and private pay.

California's Home and Community-Based Programs

California's framework for delivering long-term care services largely reflects the state's central role as an administrative entity for disbursing federal funds and for providing quality oversight to ensure the health and safety of all Californians. As the state's single state Medicaid administrative entity, CDHS receives all federal Medicaid funding and disburses these funds to other departments that administer programs providing health care and long-term care services.

Medi-Cal funds a majority of California's institutional and home and community-based long-term care services, either through optional state plan services or home and community-based waivers. CDHS provides oversight for the home and community-based state plan optional benefits and Medi-Cal HCBS waiver programs.

Medi-Cal Optional State Plan Services

In-Home Supportive Services (IHSS) Program. California's IHSS program assists 355,778 aged, blind, or disabled persons with activities of daily living, enabling them to remain safely in their own homes. Through IHSS, qualified recipients receive assistance with daily tasks, such as bathing, dressing, cooking, cleaning, grooming, and

feeding. The IHSS program plays 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 is both a state plan and demonstration waiver service. While IHSS regulations determine the range of services, the consumer directs his/her services by deciding how, when, and in what manner IHSS services will be provided. To this end, consumers who chose the Advance Pay Option are responsible for hiring, training, and supervising providers.

Home Health Agency (HHA) Services. HHA services are covered benefits under both the Medi-Cal State Plan and HCBS waivers. Under the state plan, intermittent HHA services can cover short-term assistance with wound care, therapies, and medication monitoring, for example. Under HCBS waivers, HHA and independent nurse provider services can cover shift nursing for long-term, chronic conditions. HCBS HHA services often combine registered nurse oversight of a plan of care and services by licensed vocational nurses and personal care attendants, as allowed under a specific HCBS waiver. Both state plan HHA and HCBS HHA services are prior authorized under the state's utilization control procedures which require state approval, physician's orders and medical necessity documentation prior to the onset of services. The consumer has choice of a qualified and available HHA or independent nurse provider.

Adult Day Health Care (ADHC). In California, ADHC programs are licensed community-based day care program providing a variety of health, therapeutic, and social services to those at risk of being placed in a nursing home. While ADHC centers are licensed by CDHS, CDA is responsible for program administration and certification of each center for Medi-Cal reimbursement. The primary objectives of ADHC are to

restore or maintain optimal capacity for self-care to frail elderly persons and other adults with physical or mental disabilities and to delay or prevent institutionalization.

Established by the Legislature in 1978, ADHCs represent one of the early community-based programs aimed at providing support to caregivers and delaying nursing home placement for seniors and adults with disabilities. In 2005/06, 350 ADHC centers will serve 44,000 clients statewide at an approximate cost of \$409 million, with Medi-Cal providing reimbursement for more than 90% of the ADHC participants.

Targeted Case Management. TCM provides assistance in obtaining services covered under the Medi-Cal State Plan, such as home health, IHSS, and durable medical equipment, as well as through other public and private providers, such as emergency food and housing. Covered TCM activities also include assessment, service/support planning, and monitoring services and supports. In California, TCM is offered through local governmental agencies that provide services directly or by contracting with non-governmental entities or the University of California. CDHS provides assistance to local governments in processing claims and monitoring. TCM is reimbursed through the Medi-Cal State plan on a 50% local government, 50% federal dollar matching basis.

Medi-Cal Home and Community-Based (1915c) Waivers

Acquired Immune Deficiency Syndrome (AIDS) Waiver. The AIDS waiver provides home and community-based services to persons diagnosed with symptomatic HIV disease or AIDS with symptoms. Today, there are 2,676 enrollees; the program is capped at 3,410 in calendar year (CY) 2006.

Assisted Living Waiver Pilot Project (ALWPP). The ALWPP provides home and community-based services, as an alternative to long-term nursing facility placement, to Medi-Cal beneficiaries over the age of 21 in two settings: Residential Care Facilities for the Elderly or publicly subsidized housing with an HHA providing services. There are 106 current enrollees and the program cap is 200 in CY 2006.

Developmentally Disabled (DD) Waiver. The DD waiver provides home and community-based services to persons with developmental disabilities who are Regional Center consumers and reside in the community as an alternative to ICFs. The current number of enrollees is 69,416; the cap on enrollees is 70,000 in waiver year (WY) 2005/06.

Multipurpose Senior Services Program (MSSP) Waiver. The MSSP waiver provides case management and limited purchase of services to Medi-Cal beneficiaries who are 65 or over and at-risk of institutionalization, allowing individuals to live independently in their homes. Currently, MSSP has 10,860 enrollees and is capped at 11,789 in WY 2005/06.

In-Home Operations (IHO) Waivers. There are three IHO waiver programs – Nursing Facility (NF) Level A and B, NF Subacute, and In-Home Medical Care (IHMC). These waivers will soon be restructured into one "mega-waiver", the NF Acute Hospital (NF A/H) Waiver. IHO waivers provide community-based alternatives to people who would otherwise be living in an institution:

- In-Home Medical Care Waiver: The IHMC waiver provides an alternative to hospitalization for persons with disabilities who would otherwise require acute care for a minimum of 90 days. Enrollees typically have a catastrophic illness or injury and are dependent on medical technology to replace or supplant major organ systems. Currently, there are 66 enrollees; the cap is 300 in WY 2005/06.

- Nursing Facility Subacute Waiver: The NF Subacute waiver provides an alternative to hospitalization for persons with disabilities who would otherwise require subacute nursing care for a minimum of 180 days. Enrollees typically have a significant illness or injury and are dependent upon some medical technology to supplant or assist major organ function. The current number of enrollees is 635; the cap on enrollees is 905 in WY 2005/06.
- Nursing Facility Level A and B (NF A/B) Waiver: The NF A/B waiver provides services to persons with disabilities who would otherwise require skilled nursing care at level A or level B for a minimum of 365 days. Enrollees typically require assistance with either personal care and/or have some skilled nursing care needs. The current number of enrollees is 890; the cap on enrollees is 890 in WY 2005/06 and 649 individuals are currently on a waitlist.

Other Home and Community-Based Services

Several CHHSA departments administer a range of home and community-based services for seniors and persons with disabilities:

Department of Aging. CDA administers Older Americans Act programs for supportive services, congregate and home-delivered meals and MSSP. CDA also administers program for community service employment, advocacy and protection, health insurance counseling, case management (Linkages), Alzheimer's Day Care Resource Centers and ADHC services.

Department of Rehabilitation. DOR assists Californians with disabilities obtain and retain employment and maximize their ability to live independently in their communities. Working with individuals of every type and category of disability, DOR provides vocational rehabilitation services to eligible Californians. DOR also provides Americans with Disabilities Act technical assistance, and training and funds 29 Independent Living Centers, which offer information and referral services to assist individuals with disabilities live active, independent lives.

Department of Social Services. CDSS administers the IHSS Program, described earlier, the cornerstone of self-directed services in California.

Department of Developmental Services. DDS serves approximately 210,000 individuals with developmental disabilities. The vast majority of these individuals reside in the community in an array of community living options. DDS contracts with 21 private, non-profit Regional Centers to provide services to those residing in the community. Approximately 69,000 Regional Center consumers receive services through the DD Waiver. Additionally, DDS, through its Community Placement Plan process, is providing options and opportunities for individuals residing in developmental centers to transition into the community.

Department of Mental Health. DMH develops, evaluates, monitors and supports an array of coordinated services that deliver care to California's adults and older adults who are severely mentally ill, and children who are seriously emotionally disturbed. DMH oversees California's community mental health services and services available under the Mental Health Services Act. DMH also oversees 11 nonprofit Caregiver Resource Centers that serve more than 14,000 families and caregivers of persons with adult-onset brain impairments.

Promoting Access to Employment

The California Health Incentives Improvement Project (CHIIP) is a multi-agency collaborative effort targeting barriers to the gainful employment of persons with disabilities, particularly health care and personal assistance barriers, initiated in 2002 with Medicaid Infrastructure Grant from the Federal Centers for Medicare and Medicaid Services (CMS). CHIIP provides outreach and training in two areas:

1. The Medi-Cal 250% Working Disabled Program is a Medicaid Buy-In program that allows persons with disabilities to earn income and maintain healthcare benefits by buying into Medi-Cal with a monthly premium; and
2. The provisions of IHSS that allow individuals to use personal assistant services in the workplace, as well as at home.

Since May 2005, the enrollment rate for the Medi-Cal Working Disabled Program has increased by 67%. While usage of these work incentive initiatives has grown over the last two years, many consumers with disabilities remain unaware of them. CHIP continues to build communication and outreach through multiple strategies.

MFP PILOT PROJECT: CALIFORNIA PATHWAYS

The Real Choice Systems Change Grant for Community Living, California Pathways, is in its fourth year of implementation. The state received \$750,000 federal funding and has been approved for a no-cost extension through September 30, 2007. The University of California at Los Angeles is the CDHS lead partner on the project.

The pilot project is based on a uniform assessment instrument for the purposes of identifying nursing facility residents who wish to return to community living. CDHS is also partnering with the DOR, CDA, CDSS and the University of Southern California.

The project team developed and field tested a preference assessment in stage one of a two-stage nursing facility transition assessment protocol. The California Preference Survey Tool (included in Appendix 2) that will be utilized in the California Community Transitions demonstration project is a brief screening interview used to identify nursing facility residents who want to pursue a transition to community living.² One major finding of the California Pathways project is that no one agency or individual is responsible for systematic nursing facility transition services across multiple programs.

² The CA Preference Survey Tool is entitled MFP Preference Data Collection Tool in the Attachment 2: Preference Survey Analysis and Tool.

Additionally, the assessment protocols and tools used in the state are typically focused on one narrow set of services. Individuals wishing to transition to the community typically are assessed by multiple individuals and programs before a successful transition to community living can occur. The California Pathways project is working with various HCBS programs such as ALWPP, MSSP, NF A/H waiver and IHSS, all based on the individual's preference and the primary care physician's recommendations. Finally, the project is developing and testing a core set of duties that would be typical for a successful Transition Coordinator. The outcomes of this work will inform the California Community Transition project proposed in this application.

QUALITY MONITORING

Quality management strategies and processes are critical to ensure programs operate according to approved design, meet statutory and regulatory assurances and requirements, achieve desired outcomes, and identify opportunities for improvement.

In the proposed California Community Transitions demonstration, participants will be enrolled in current Medi-Cal HCBS waivers, which have existing quality assurance and monitoring procedures and processes.

California's Current Quality Management System

In California's recent NF A/H waiver application, the state outlined the existing Quality Management Strategy for the waiver, as required under §1915(c) of the Social Security Act and 42 CFR §441.302. (Appendix 3) The Quality Management Strategy encompasses the following:

- Levels of Care Determination;
- Service Plan Reviews;
- Provider Reviews;
- Oversight of Health & Safety Issues;

- Financial Accountability Issues;
- Quality Management Reports to Appropriate Program Management Team;
- Periodic Evaluation and Revision of Quality Management Strategies.

Quality Management Units (QMUs) are responsible for measuring performance, providing analysis when performance falls below the established levels of compliance, and presenting recommendations for remediation and improvement. QMUs in CDHS include research analysts, waiver analysts, eligibility analysts, information system analysts, and licensed medical professionals. The section chief, managers, nurse evaluator supervisors, and QMUs are responsible for the development, implementation, and evaluation of remediation actions. QMUs collect and analyze data for trends and patterns of populations served and make changes to policy, procedures, and resources based on that analysis.

A QMU under CDHS may span multiple waivers and/or programs. In addition, several state departments may collaborate on quality monitoring activities. For example, CDHS provides quality assurance for the ALWPP, and works with DDS on the DD waiver, and CDA on the MSSP waiver.

PROGRAM COLLABORATION: POLITICAL & STAKEHOLDER SUPPORT

The success of California's Community Transitions demonstration will rely on a collaborative partnership between state and local-level partners. This partnership will be sustained through state-level leadership and ongoing participation from stakeholders throughout the state.

Political Leadership

Administration Leadership. Governor Arnold Schwarzenegger and his Administration remain committed to increasing the availability of home and community-

based services. Kim Belshé, Secretary of CHHSA and a member of the Governor's Cabinet, convenes the state's Olmstead Advisory Committee to identify barriers and develop solutions to provide services to persons with disabilities in the least restrictive and most integrated settings possible. In addition, the Department of Finance (DOF) has supported several budget initiatives that seek to transition consumers into alternative, community-based living situations.

Governor's Legislative Initiatives. This year, the Governor's proposed Fiscal Year (FY) 2006/07 Budget proposed initiatives to maintain and build upon California's commitment to supporting seniors and persons with disabilities in the community by enhancing community-based alternatives to institutionalization, better managing and coordinating consumer needs across the long-term care continuum, and integrating acute and long-term care services. These initiatives included:

- The Coordinated Care Management Demonstration Project. This project seeks to maintain access to medically necessary and appropriate services, improve health outcomes, and provide services for seniors and persons with disabilities who have chronic conditions. The project will target high-end users of the Medi-Cal by offering case management services in order to more efficiently manage service delivery and improve healthcare outcomes. The proposal was included in the 2006-07 Budget and is currently in the beginning phases of implementation.

Additional legislative initiatives are discussed in Appendix 4.

Legislative Leadership. California's Legislature demonstrates a strong commitment to support seniors and persons with disabilities in the community as long as possible, as evidenced by the attached letters of support from members of the legislature.

State-Level Collaboration

State Partners. With the state-level leadership, CDHS will play a key role in convening state partners and stakeholders to address barriers to HCBS waiver

capacity, budget flexibility, systems rebalancing, as well as housing and transportation that will be critical to the success of these efforts. As the single state Medicaid entity, CDHS works closely with other departments administering Medicaid programs including DDS, DMH, CDSS, DOR, and CDA.

Stakeholders. Stakeholders participate in a number of state-level forums, including public meetings regarding proposed initiatives or implementation of HCBS waivers or grant programs, as well as legislative policy and fiscal committee hearings.

Stakeholders will be critical to the success of the California Community Transitions demonstration, and will assist in identifying barriers and solutions to consider for transitions infrastructure development and long-term care systems rebalancing.

Olmstead Advisory Committee. Established by Governor's Executive Order, this group advises the CHHSA Secretary on matters related to the avoidance of institutionalization and the support of seniors and persons with disabilities in their homes/communities. The committee consists of a strong and diverse representation of consumers, as well as members of advocacy groups, provider associations and private organizations. The committee provides a forum to discuss policy issues and create solutions to Olmstead implementation. This committee will play a critical role in implementation of the California Community Transitions demonstration.

CALIFORNIA'S LONG-TERM CARE EXPENDITURES

Expenditures. According to the Kaiser Family Foundation, California spent \$11,354,449,172 on Long-Term Care Services in FY 2005. Appendix 5 provides detailed long-term care expenditures by setting.

Occupancy. OSHPD collects self-reported data on various long-term care facilities in the state, with the exception of IMDs. According to an OSHPD report on Statewide Trends 2001 in Long-Term Care Services, there were 117,000 bed used by 325,000 individuals. The vast majority of these persons were in an institution for less than six months. Appendix 6 provides additional data.

Rebalance of Funding. California is committed to moving towards a rebalanced system focused on home and community-based services, and currently spends over half of all long-term care dollars on community-based services. A recent analysis of California's long-term care program caseloads and costs conducted by the non-partisan Legislative Analyst's Office (LAO) found that while spending in general on long-term care services has grown significantly over the last five years (\$10.3 billion in 2001-02 vs. \$14 billion in 2005-06), an increasing portion of California's long-term care spending is for home and community-based services over institutional care. *Please note, however, that the LAO included community-based non-Medicaid services in the analysis and this data cannot be replicated given the federal definition of state plan and HCBS services under the Maintenance of Effort requirements.*

According to the LAO's 2005-06 report, spending for home and community-based services significantly increased from 55% to 61% over institutional care since it was last examined in 2000-01. Interestingly, over the past decade the number of Medi-Cal paid nursing facility days has stayed virtually the same (a 1.7% increase), despite the fact that the number of persons eligible for Medi-Cal over age 65 has increased almost 25%. The LAO findings demonstrate a clear shift in long-term care services towards home and community-based services. The availability of California's IHSS program, HCBS

waiver programs, home health, ADHC, and other community-based services have helped reduce average utilization from almost 44 days per eligible Medi-Cal person over age 65 in 1991 to just over 36 days in 2001 – a 22% reduction.

ADDRESSING LONG-TERM CARE DELIVERY SYSTEM GAPS

The following represents gaps in the long-term care delivery system for individuals who wish to transition from institutional settings, as well as barriers to long-term care systems rebalancing. The California Community Transitions demonstration seeks to address these gaps and, with stakeholder input, resolve systems, funding, capacity and programmatic issues.

Lack of Transitions Infrastructure. Nursing facility residents who wish to return to the community often lack access to critical transition services, including assistance from a coordinator who can help facilitate connections to home and community-based services, resources to cover one-time emergency needs for return to the community, and access to affordable and accessible housing. Specific barriers include:

- Residents lack awareness of a process that could support their return to community, if that is their preference;
- Lack of a systematic way to accurately identify those who want to transition;
- Lack of trained coordinators to work with residents who wish to return to community living;
- Lack of community organizations and HCBS waiver capacity to provide for residents' temporary and long term needs upon return to community, including ongoing case management if needed.

The California Community Transitions demonstration will provide a mechanism to develop infrastructure at the local level, test models, and develop best practices to help facilitate institutional transitions in various regions of the state.

Lack of Access to Affordable, Accessible Housing. Seniors and persons with disabilities often face high housing costs or live in physically unsupportive environments

that are disconnected from services. For persons who need more services and support provided in their homes and apartments, there is an inadequate supply of affordable housing options. Consequently, seniors and persons with disabilities are often faced with living in inadequate settings or moving to more institutionalized settings. Persons wishing to transition out of an institution into the community often cannot do so due to lack of affordable and accessible housing options. Through the California Community Transitions demonstration, the state is committed to working closely with our housing partners to address these barriers and identify solutions to meet the need for affordable, accessible housing.

Lack of Access to Services. Due to system fragmentation, consumers and caregivers often cannot access the necessary services and supports that promote community living, resulting in premature or unnecessary institutionalization. Specifically, case management is not available on a statewide basis. Medi-Cal does not offer case management as an optional state plan benefit to all populations; some HCBS waivers offer these services, but the availability of services varies throughout the state and eligibility is frequently based on age or specific disability type. While California provides case management through the MSSP and NF A/H waivers, these programs are limited in scope. In addition, the TCM is a county-based Medi-Cal State Plan option that provides short-term case management. However, several counties do not choose to operate TCM programs, and for those that do, most do not offer TCM for persons transitioning from institutions.

The California Community Transitions demonstration will address this barrier by ensuring that the target population is provided access to case management services

through the existing HCBS waivers that offer these services (NF A/H, MSSP, DD waivers).

System Fragmentation. California's acute and long term care system has long been impacted by system fragmentation stemming from a multiplicity of funding streams, assessment procedures, and lack of coordination between the medical and social systems of care. This fragmentation can lead to higher-than-necessary rates of hospitalization and nursing home expenditures, as well as a lack of coordination between primary, acute, long term care systems. The California Community Transitions demonstration will address this barrier by ensuring that the local Community Transitions Teams coordinate services at the local level, connecting consumers and caregivers to the services they need to successfully transition into the community.

Lack of Capacity. Consumers often cannot access the necessary services and supports that promote community living, due to program waiting lists. The California Community Transitions demonstration will address this barrier by ensuring that consumers can access services at the local level, which may require increasing capacity at the state level. The state will seek the necessary programmatic and budgetary approval to increase program capacity. Any increase in program capacity is subject to control agency approval.

Lack of Flexibility in State Budgeting. The State's administrative framework for administering long-term care services is large and complex. Depending upon the department and the origin of program funding, there are different payment methodologies. Due to the various payment methodologies and reimbursement systems, resources for long-term care in general cannot be transferred to the area of

need. In addition, the state lacks a global long-term care budget system, which means the state is unable to address community capacity by simply transferring spending from institutional to home and community-based care. This lack of flexibility in budgeting is a critical component to long-term care systems rebalancing and will be discussed in the context of California's Real Choice Systems Transformation grant (California Community Choices) over the next five years, in partnership with the California Community Transitions demonstration efforts.

Data Constraints. Another barrier to long-term care funding management is a lack of consistent data collection across agencies and programs. Data is critical to understanding population needs, gaps in services and areas of duplication. However, no single department or agency uniformly collects and reports all long-term care data. In some situations, there may be available data but little analytical information, or there may be significant gaps in available information or incomplete data.

LEGISLATIVE/REGULATORY CHANGES

The California Community Transitions demonstration seeks to expand services through existing waivers and programs under Medi-Cal. Since these programs and waivers are currently in operation, CDHS maintains the authority needed to implement the demonstration. Throughout the term of the project and based on target population needs, CDHS may need to increase home and community-based program capacity. Any increase in waiver or program capacity will be subject to control agency approval. CDHS and CHHSA will work with the related departments, DOF and the Legislature to seek budgetary approval for related program capacity needs. In addition, additional legislation may be required to provide additional demonstration and supplemental

services identified during the pre-implementation phase. In partnership with stakeholders, California's Real Choice Systems Transformation grant (California Community Choices) will identify and address other legislative and/or regulatory changes needed to address long-term care systems rebalancing, and will work to achieve this rebalancing in coordination with this proposed California Community Transitions demonstration. CDHS is committed to working closely with the Administration, CHHSA, DOF, and the Legislature on any legislative or regulatory issues that may arise throughout the term of the project.

FUTURE OUTLOOK

The proposed California Community Transitions demonstration provides an important opportunity for California to expand and strengthen its existing continuum of long-term care services by testing local models and developing community-level infrastructure to facilitate the transition of institutional residents (with a stay of six months or longer) to the community.

Despite California's progress in reducing long-term care institutional expenditures and increased home and community-based capacity over the past several years, significant barriers remain to long-term care systems rebalancing and infrastructure development for the transition of individuals from institutions to the community. The California Community Transitions demonstration, together with the California Community Choices Real Choice Systems Transformation grant, affords California an opportunity to begin addressing these challenges.

PART II: Demonstration Design

The proposed California Money Follows the Person (MFP) Demonstration project, California Community Transitions, will focus on developing community-level infrastructure to assist long-stay institutional residents with transitioning to community living, as well as identifying and addressing barriers to long-term care systems rebalancing. The state will work closely with stakeholders to develop the most successful system possible and address broadscale rebalancing issues.

The demonstration will require local entities to establish community-level transition teams comprised of home and community-based services local providers and stakeholders, and to compete for participation in the demonstration. Through a request for proposal (RFP) process that will be designed with stakeholder input, the California Department of Health Services (CDHS) will carefully screen applications to ensure that local teams meet the RFP specifications and demonstrate the ability to work with the target population. These local teams will lead in assisting successful transition of individuals from institutions to the community.

The California Community Transitions demonstration design is founded on the following principles:

- Individuals who reside in nursing facilities and other institutions have the right to self-determination, access to home and community-based services, independence and choice;
- The development of community-level infrastructure is essential for successful institutional-to-community transition and relies on a collaborative partnership between the state, counties, community-based organizations, nursing facilities and consumers.

The goals of the California Community Transitions demonstration are to:

- Build on existing community-based infrastructure to address systemic gaps and test models to facilitate transitions from institutions to the community;
- Develop best practices that could serve as models for successful transitions throughout the state;
- Increase awareness about home and community-based care options for the target population;
- Build local capacity and identify community-based service needs that are critical in ensuring successful transitions;
- Identify barriers that prevent successful transitions from institutions to the community and make recommendations to remove these barriers;
- Identify and address barriers to long-term care systems rebalancing and identify financing options that promote community living options.

PRE-IMPLEMENTATION

Details of the project implementation and operational protocol will be finalized during the federally required pre-implementation phase in collaboration with stakeholders. The following timeline details pre-implementation activities.

Recruit and hire CDHS project staff.	•	•											
Engage in formal planning, with stakeholder involvement, to finalize demonstration design, develop community transition team criteria and standards and local project selection criteria, and develop operational protocol, including data collection and performance measures.			•	•	•	•	•	•	•	•	•		
Conduct competitive process to identify up to 10 regions to participate, based on phased-in implementation.					•	•	•	•					
Identify HCBS Waivers that will require an increase in available slots; prepare waiver amendments.									•	•	•		
Submit Operational Protocol to CMS.													•

Selection Process for Community Transitions Teams

In partnership with stakeholders, the state will develop a Community Transition Team (CTT) RFP selection process, project guidelines and transition protocol during pre-implementation planning.

Community Transition Teams. Each participating local regional area (either a single county or multi-county region) will be required to identify a lead organization responsible for organizing a CTT, comprised of key community-level providers including In Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Linkages, Independent Living Centers (ILC), Regional Centers, Ombudsman programs, IHSS public authorities, nursing facilities, transportation, hospitals, local housing authorities, Area Agencies on Aging (AAAs), California Caregiver Resource Centers, Aging and Disability Resource Centers (ADRCs) and other community-based organizations involved with service planning to seniors and adults with disabilities.

Local CTT Project Management. One of the CTT members will be identified to lead the MFP efforts in the region. The CTT will identify the appropriate lead entity based on local home and community-based services capacity and expertise. For example, in one county, the local ILC may be best suited to head up the MFP CTT efforts, while in another county, the AAA or MSSP program may be best-suited for this role. The CTT would be responsible for working with a Transition Coordinator (defined below) to identify residents of institutions to participate in the project, develop local infrastructure and processes, identify transition barriers, and work with the state throughout implementation of the demonstration. As such, California's demonstration approach provides flexibility to communities in a large, diverse state to propose a range of locally

developed transition models. CDHS will be responsible for monitoring implementation of local projects and project outcomes, and ensuring compliance with all state and federally required demonstration and reporting requirements.

The CTT will also develop a culturally and linguistically-appropriate community education and outreach process, and will consult with the state in determining a process to reach out to and transition nursing facility residents and coordinate supports in the community. All CTTs will utilize claiming and reimbursement mechanisms, e.g. Targeted Case Management (TCM), Home and Community-Based Services (HCBS) Waivers, IHSS, MSSP, and other non-Medi-Cal HCBS programs, to structure most demonstration services. Demonstration participants will be informed of and involved with every aspect of the demonstration decisions, especially direct service decisions.

Transition Coordinator and Transition Process. Each CTT would be staffed by a Transition Coordinator who will act as case manager/service coordinator, participating under the Nursing Facility Acute Hospital (NF A/H) waiver program¹, the MSSP program, or a local qualified organization that claims Medi-Cal TCM funds to cover costs of case management (depending on whether counties choose to fund TCM for deinstitutionalization efforts). The Transition Coordinator will be responsible for one-on-one work with the facility residents and will begin the transition process by administering the California Preference Survey Tool, developed as part of the state's current MFP pilot project, California Pathways. The survey is a brief screening interview that can be used to identify nursing facility residents who want to pursue a transition to community living. The Transition Coordinator will then work with the consumer (or proxy) to

¹ California's NF A/H Waiver allows case management to be provided by certain additional local non-profit organizations, effective January 1, 2007, as well as the traditional nurse or social worker case managers.

determine housing, medical and other service needs, support preferences, availability of informal supports, and potential cost of services in the community. The Transition Coordinator will also work with the consumer to develop a transition plan that includes the most appropriate HCBS waiver and other services; for example, nutrition programs or other Older American's Act (OAA) services available through local AAAs, IHSS, Medi-Cal eligibility, and other community supports. If the resident identified is a Developmentally Disabled consumer, then the Transition Coordinator would refer the resident to the local Regional Center for assessment and follow-up. If the resident has mental health needs, the Transition Coordinator would consult with the Department of Mental Health (DMH) and/or the county specialty mental health programs and services under the Mental Health Services Act. The Transition Coordinator is the consumer's connection to community supports.

Regions/Service Area. The state will select up to 10 regions (either single or multi-county areas) to participate in the California Community Transitions project. Regions in the northern, central, and southern area of the state will be selected based on RFP criteria and demonstrated ability to meet state and federal project specifications. The specific number of regions selected will depend on the local responses to the RFP, the quality of local proposals and CDHS capacity to oversee the demonstration. The project specifications will be identified as part of the stakeholder pre-implementation process.

Selection Criteria. It is the intent of the state to select teams in the Central, Northern and Southern areas of California, thereby representing the spectrum of rural and urban populations. To be selected, CTTs will have to fulfill all MFP demonstration

requirements as developed by the state in partnership with stakeholders, including, but not limited to: CTT team elements, partnership with institutions and affordable housing professionals, cultural and linguistic competency, and diversity in target population. Local CTT projects will be required to develop a proposal identifying elements including coordination between programs, program protocol, identification of target population, and services needed by the local target population. The regions may present various CTT models, enabling the state to test a variety of transition team concepts. For example, one organization may organize four CTTs in two counties. Once the local CTT projects are identified by the state, the first one or two projects will be implemented in year two of the demonstration. The remaining projects will be implemented, using a phased-in approach.

CTTs will be carefully scrutinized for cultural and linguistic competency. CTTs will also be required to provide assurances that privacy of health information is maintained, and that assessments and service planning for these individuals will be provided in a timely manner, before the individual returns to the community. All CTTs and their staff will be required to meet all applicable Health Insurance Portability and Accountability Act (HIPAA) and privacy protection requirements as they apply to Medi-Cal eligible facility residents.

IMPLEMENTATION

The goal of the California Community Transitions demonstration is to assist 2,000 individuals transition from institutions to community living.

Target Population

All demonstration participants must be Medi-Cal eligible and have resided in a facility for six months or longer, which could include a combined six-month period across institutions. The demonstration will target multiple population groups, including:

- Persons with disabilities of all ages (including the developmentally disabled);
- Older adults, including those with cognitive impairments;
- Patients in acute hospital beds;
- Acute hospital/nursing facility patients residing in public or private freestanding or Distinct Part Nursing Facilities with a history of substance abuse;
- Acute hospital/nursing facility patients residing in public or private freestanding or Distinct Part Nursing Facilities with co-occurring chronic medical and mental illness;
- Persons of any age with Traumatic Brain Injury;
- Residents of Institutes for Mental Disease (IMDs) who are under the age of 21 and over the age of 65.

Per federal guidelines, eligible facilities will include Distinct Part and freestanding public and private nursing facilities (including ICF-MRs), IMDs and acute care hospitals.

Target Population Estimate Methodology. Based on data from the Office of Statewide Health Planning and Development² and CDHS, approximately 20 percent of nursing home residents have lengths of stay greater than six months, or roughly 22,000 residents out of the approximate 110,000 nursing home residents (this number includes both private pay and Medi-Cal). In California, the number of Medi-Cal nursing home residents statewide for all lengths-of-stay is 66,322³. Of the total 66,322 Medi-Cal

² State of California, Health Care Quality and Analysis Division: Annual Utilization Reports of Hospitals and LTC Facilities, 1992-2001. The updated nursing facility census information was provided by the Department of Health Services.

³ CDHS Licensing and Certification Division.

nursing home residents, it is estimated that approximately 20 percent have resided in nursing homes for longer than six months; thus, approximately 13,300 Medi-Cal residents would be eligible under the California Community Transitions project. However, this number does not include acute care hospital or eligible IMD residents who have resided for longer than six months, nor does it represent institutional residents with a combined total of six months' residence across institutional settings (e.g., hospital for three months and nursing facility for three months).

Based on experience from the current MFP project, California Pathways⁴, the state estimates that approximately 10 percent of the eligible population, approximately 1,300 residents, prefer community living and could reasonably be candidates for transition under this demonstration, not including acute care hospital or eligible IMD residents. Therefore, including long-term care, acute care Medi-Cal and eligible IMD residents, the state will target up to 2,000 individuals for the demonstration. This estimate does not preclude anyone from participating in the demonstration if he/she is eligible and resides in a participating facility. The Transition Coordinator, responsible for identification of individuals to be served, will conduct a 20 minute face-to-face interview with interested residents using the California Preference Survey Tool.

Although this application estimates a target population to be served under the demonstration, the exact number of individuals (including breakdown of age and disability) who will be served under the California Community Transitions demonstration will be calculated during the pre-implementation phase, and will depend on many factors, including:

⁴ See Appendix 2 for complete report.

- The number of local service areas participating in the demonstration;
- The number of CTT teams staffed within each local demonstration service area;
- The number of facilities participating in the demonstration;
- The census of the partner facilities;
- The percentage of facility residents who are Medi-Cal eligible;
- The percentage of individuals who have resided in a facility six months or more;
- The percentage of individuals who state a stable preference to transition to community living.

Implementation Timeline and Transition Goals

One	Stakeholder process and development of Operational Protocol
Two	Transition up to 100 residents to a qualified residence in the first year (phased-in approach in one to two regions). The first year of implementation will be designed to test the system in one or two specific regions of the state and then modify systems based on barriers encountered and lessons-learned.
Three	Transition implementation in up to six regions of the state with up to 500 residents transitioned in second year.
Four	Transition up to 650 residents in third year with implementation in remaining regions.
Five	Continuation of activities in all participating regions with transition of up to 750 residents. Conclusion of demonstration and federal evaluation.

Demonstration Services

California Community Transitions demonstration participants will have access to a wide range of community-based services and supports.

Qualified Home and Community-Based Services. Qualified HCBS include California’s Medicaid service package that comprises 1915(c) and/or state plan services. Depending on eligibility, demonstration participants may also access California’s non-Medicaid funded home and community-based services: however, these services would not include a federal funding match under the demonstration (unless developed as policy and defined as Supplemental Demonstration Services and approved by state control agencies).

Home and Community-Based Demonstration Services. The state intends to propose additional transition services beyond what is offered through the state's HCBS waivers, which will be identified in collaboration with stakeholders during the pre-implementation phase. Demonstration services that will be considered include: personal care services hours exceeding the state statutory limit of 283 hours, respite for caregivers, and family training.

Supplemental Demonstration Services. The state intends to offer supplemental services that are essential for successful transition. These services will be identified with stakeholder input during the pre-implementation phase and will require state control agency approval. Supplemental Demonstration Services that will be considered include: outreach and education for HCBS service providers, nursing facility staff, hospital discharge planners, consumers and their families, and flexible one-time funding for home set-up.

Self-Directed Services. Demonstration participants will be actively involved in designing a set of services that best meet their needs and selecting their community-based residence. The participant will decide how, when, and in what manner services will be provided, will have the opportunity to control the delivery of his/her services, and will play a critical role in service management, with the assistance of a care manager, if desired. To this end, consumers can choose whether they want to maintain responsibility for hiring, training, and supervising personal care providers as some do in the state's IHSS Program.

Case Management/Service Coordination. Case management/service coordination services are a critical component to ensuring that consumers are connected to the

appropriate services they need to successfully transition to and remain in the community. Assuming it is the consumer's preference, case management/service coordination will be provided as part of the transition process, and on an ongoing basis upon a resident's return to the community. Transitional service planning (provided before) and ongoing case management (provided after transitioning to the community) will be covered either by a HCBS waiver (depending on participant eligibility) or by local TCM funds (counties will be encouraged to modify their TCM plan to use TCM for institutional transitions). If the resident is a developmentally disabled, the DD Waiver would provide the case management through the Regional Center or, if a developmentally disabled resident is eligible for the NF A/H Waiver, the NF A/H Waiver would provide case management in coordination with the Regional Center.

Resident Choice of Qualified Home and Community-Based Services. The majority of residents enrolled in California Community Transitions will most likely chose to transition into the NF A/H waiver program and others may seek transition into the Assisted Living Waiver Pilot Project, the MSSP program, or the Developmentally Disabled (DD) Waiver. Waiver capacity will be analyzed during pre-implementation to ensure adequate waiver "slots" are available to the target population.

Qualified Residence. Per federal guidelines, eligible residences will include a home owned/leased by individual/family; an apartment with an individual lease with lockable access and egress; or a residence in a community-based setting in which no more than four unrelated individuals reside. The competitive process and subsequent state oversight will ensure these demonstration requirements are met.

Recruiting Demonstration Participants

The California Community Transitions project will use a two-pronged strategy to recruit demonstration participants: (1) education and outreach; and (2) preference assessment.

Using existing local home and community-based partnerships and programs (including ILCs, Regional Centers, ADRCs, and AAAs, and California Caregiver Resource Centers), the demonstration will include culturally and linguistically appropriate outreach and education to nursing home and other targeted institutional residents, caregivers, and local community-based programs. The goal of outreach and education component is to inform the community of the California Community Transitions project, home and community-based alternatives to institutional placement, as well as resident's rights to return to the community.

The state will also work with the local participating entities to ensure that the education print or media materials and content disseminated are consumer-friendly and culturally appropriate (modeled after existing community education materials such as those of Regional Centers and other home and community-based programs). Outreach activities will include staff training for home and community-based programs and health facilities involved in MFP demonstration.

Secondly, the California Community Transitions demonstration will use the systematic California Preference Survey Tool to identify eligible individuals who would like to transition to community living. The state will provide local CTTs specific guidance and protocols on implementing the survey during the RFP process. Additional assessment factors that may be considered include functional status, length of time in

facility, and availability of needed supports. Successful transitions will depend on HCBS capacity, affordable and accessible housing options, mobility options, caregiver support, personal care services, availability of transportation, and home modifications.

Increasing HCBS Capacity

Depending on target population projection, additional slots may be needed for the NF A/H and MSSP waivers to accommodate individuals transitioning from institutions in the MFP demonstration (the increase in slots would be based on number of individuals targeted for the demonstration, current capacity of waivers to meet increased demand, and state control agency approval). These additional slots will require the state to submit waiver amendments to the Centers for Medicare and Medicaid Services (CMS). Enhancing capacity of HCBS services to accommodate needs of the target population will require control agency approval. CDHS will work with the appropriate entities, including Administrative and Legislative colleagues, to seek the necessary approvals in time for and throughout program implementation.

Collaboration

The success of the California Community Transitions demonstration will rely on a collaborative partnership between state and local-level partners, which will be led by the CDHS, under the auspices of the California Health and Human Services Agency (CHHSA). See Appendix 7 for stakeholder letters of support.

Cross Agency Collaboration. The CHHSA maintains strong working relationships with the Departments of Housing and Community Development (HCD), Transportation (DOT), and the Housing Finance Agency (CHFA). CHHSA will play a key role in convening these cross-agency partners to address barriers to housing and

transportation that will be critical to the success of California Community Transitions efforts. CHHSA continues to work closely with HCD and CHFA in other efforts to develop affordable and accessible housing stock including implementation of the State's Housing Bond (Proposition 46) and the Governor's Chronic Homelessness Initiative. In addition, DOT is partnering with the CHHSA departments as part of the federal United We Ride Initiative to develop the state's Mobility Action Plan and better connect the health and human service system with transportation alternatives at the local levels. CHHSA is poised to continue to these relationships and address housing and transportation barriers related to implementation of this demonstration.

As the single state Medicaid entity, CDHS works closely with other departments that administer Medicaid programs via Interagency Agreements, including the Department of Developmental Services (DDS), the Department of Social Services (CDSS), the Department of Rehabilitation (DOR), the Department of Aging (CDA) and DMH. Throughout the term of this project, CDHS will convene regular meetings with these state partners to identify barriers, address program implementation issues, and identify policy solutions.

At the local level, the Community Transition Teams will be responsible for addressing local program and policy implementation issues. Representatives of local level partners will be convened at the state level as members of the Transitions Advisory Committee. In this capacity, the local implementation issues and solutions will be addressed at the state level.

Interagency and Public/Private Collaboration. The California Community Transitions demonstration will convene a Transitions Advisory Committee comprised of

community stakeholders representing the target population of consumers, advocates, family members/caregivers, and providers as well as state departments (including DOR, CDA, DDS, DMH, and CDSS) and CHHSA. The purpose of the Transitions Advisory Committee will be to identify barriers and develop solutions to consider in the context of program implementation.

In addition, the California Olmstead Advisory Committee will play an important role in providing feedback and guidance throughout the term of the project. The Olmstead Advisory Committee is established by Governor's Executive Order to advise the Secretary of CHHSA on matters related to the avoidance of institutionalization and the support of seniors and persons with disabilities in their homes/communities. The committee consists of a strong and diverse representation of consumers, as well as members of advocacy groups, provider associations and private organizations. The committee provides a forum to discuss policy issues and create solutions to Olmstead implementation together with the Secretary of CHHSA, Kim Belshé, a member of the governor's cabinet. CHHSA and staff from multiple state departments update the Committee, review data, discuss progress, and receive feedback from this body regarding long-term care issues and will play a critical role in implementation of California Community Transitions.

Consumers. Consumers will continue to play a critical role in pre-implementation planning and project implementation. Letters of support received from numerous consumer organizations including, but not limited to, AARP, California Advocates for Nursing Home Reform, Easter Seals, Californians for Disability Rights, Protection and Advocacy, Inc., and the Gray Panthers of California, testifies to the broad-based support

for California's demonstration. The California Community Transitions demonstration is grounded in the guiding principle that individuals who reside in nursing facilities and other institutions have the right to self-determination, access to home and community-based services, independence and choice. Throughout the project, consumers will play a central role in program design and implementation at the state and local level. At the state level, consumers will play a critical role in the Transitions Advisory Committee and, in turn, will help develop the transition infrastructure to ensure that it represents a consumer-centered system of services. At the local level, Community Transition Teams will be required to partner with consumers and their peers to develop solutions that are responsive to consumer needs.

Institutional Providers. As demonstrated by the support of the California Association of Health Facilities (representing California's nursing home providers), the California Hospital Association, the California Assisted Living Association, SCAN Health Plan, and Contra Costa Health Plan, institutional providers will continue to be key partners at the state and local levels, and will play a central role throughout the term of the project. Representation on the Transitions Advisory Committee will include, among other stakeholders, hospitals, nursing homes, and other long-term care providers. Local level Community Transition Teams will also be required to have the representation of institutional providers. These providers are also represented on the Olmstead Advisory Committee, and in this capacity, will be providing guidance and support throughout the term of the project.

Housing and Transportation

California will build on its partnership with HCD and CHFA to address issues related to the development of affordable, accessible housing options for seniors and persons with disabilities.

If passed by voters in November, the Housing and Emergency Shelter Trust Fund Act of 2006 may help increase the availability of housing by authorizing the state to sell \$2.85 billion of general obligation bonds to fund 13 new and existing housing and development programs. Rental assistance would not be included within the Bond. About one-half of the funds would go to existing state housing programs. The state will use this opportunity to consider various housing options in order to provide affordable, accessible housing for the target population.

In addition to housing, adequate transportation and mobility options are necessary to ensure access to medical care and other community-based services. During the pre-implementation phase, CHHSA, other CHHSA departments, and DOT will continue efforts to implement a mobility action plan to promote better coordination of human services transportation programs, and to provide mobility management programs, including travel training to familiarize riders with transit and para-transit modes, to connect people to a continuum of accessible transportation services.

Quality Management

Since a majority of California's MFP grantees will likely be enrolled in the NFA/H waiver, California's preliminary design of the MFP Quality Management Strategy will mirror the quality management design used in the NF A/H waiver, in that it will include mechanisms to ensure that:

1. The state conducts level of care need determinations;
2. Plans of care are responsive to waiver participant needs;
3. Qualified providers serve waiver participants;
4. The health and welfare of waiver participants is maintained;
5. As the State Medicaid Agency, CDHS retains administrative authority over the waiver program; and
6. The state provides financial accountability for the waiver.

Detail on the NF A/H Waiver Quality Management Strategy was provided in the Systems Assessment and Gap Analysis section. In addition, current waiver protocols will also be modified to accommodate more frequent assessments for demonstration participants to ensure their health and safety in the community. CDHS will also provide additional monitoring and oversight, including measuring quality and outcomes specific to the demonstration and its participants. These additional quality management processes will be determined in the pre-implementation phase and will require a Quality Improvement strategy that feeds back into the existing Quality Assurance program to make adjustments based on measures such as self reported quality of life, level of involvement in the community per individual preferences, caregiver assessments, re-hospitalizations, changes in service plan, and consumer satisfaction.

Information Technology

CDHS has comprehensive Information Technology systems that will be used to identify eligibility for demonstration participants and to respond to federally required programmatic and financial reporting requirements. No modifications to existing systems are proposed in this application.

The CDHS Management Information System/Decision Support System (MIS/DSS) is an integrated data warehouse of Medi-Cal eligibility, provider, service and financial records, including over seven years of both fee-for-service and managed care data.

The system enables managers and staff to query the relational database and generate standardized and ad-hoc reports for analyses and day-to-day management of the Medi-Cal program, including: program monitoring, data analysis, federal reporting, monitoring the quality of care provided to beneficiaries, and anti-fraud activities.

In addition, demonstration participants will be assigned a specific Medi-Cal aid code through the Medi-Cal Eligibility Data System (MEDS) that will allow tracking of demonstration participants' eligibility status and demographic data. MEDS maintains a record for every individual reported as Medi-Cal or (County Medical Services Program (CMSP) eligible since 1981. Each record is maintained under the recipient's Social Security Number (SSN) or under a MEDS assigned pseudo number if the individual does not have an SSN. Each record may contain up to seventeen months of eligibility status information, including future, current and the prior fifteen history months. The primary uses of the information maintained on MEDS are:

- Issuance of Benefit Identification cards for Medi-Cal or CMSP beneficiaries to provide a method of accessing the automated eligibility verification system for state health services;
- Matching of recipient cases to prevent duplicate issuance of benefits;
- Tracking eligibility for and purchasing Medicare Coverage;
- Tracking Medi-Cal contracted Health Care Plan enrollment;
- Responding to provider inquiries regarding Medi-Cal/CMSP eligibility;
- Identifying eligibility for payment of medical claims;
- Providing a statistical database on eligibles for budgeting and federal reporting purposes.

CDHS is now using data from Case Management Information System (CMIS) to establish new quality indicators that will help determine if changes need to be made to the waiver enrollment criteria, services, providers, or any other aspect of waiver administration. The CMIS program can provide data on how potential participants are referred to the waiver, how many referrals are received, document the timeliness of the

referral, evaluation, and enrollment process, captures data on applicants placed on the wait list, and track reasons why active waiver cases are closed. The CMIS system or equivalent manual database will be used to identify demonstration participant data, including dates of preference survey, assessment data, care plan data, and transition dates.

Demonstration Benchmarks

1	Develop community-level infrastructure and test models to facilitate transitions from institutions to the community.	Develop CTT selection criteria and implement RFP process during Pre-Implementation Phase.
		Up to 10 regions selected for participation included in Operational Protocol.
		All transition team models implemented using state-identified transition protocol by 2010.
2	Transition 2,000 individuals from institutions by 2011.	The following number of individuals transitioned each year of the demonstration, for a total of 2,000 by 2011: Year 2 – 100; Year 3 – 500; Year 4 – 650; Year 5 – 750
3	Target multiple populations for participation in demonstration.	Percentage of populations participating in demonstration each year compared as indicated in State Profile and Summary of Project ⁵ : Elderly – 25%, MR/DD – 15%, Physical Disability- 45 %, Mental Illness – 10%, Dual Diagnosis – 10%
4	Increase access to home and community-based services.	Submit HCBS waiver amendments requesting increased waiver slots, as determined during pre-implementation phase and approved by state control agencies, to CMS.
		Local analysis of service provider gaps. State technical assistance to local CTTs during implementation process with regular demonstration guidance, e.g., procedure memos, handbook, on-site visits, teleconferences, etc.
6	Increase in HCBS spending compared to institutional LTC spending.	Statewide increase in percentage of HCBS spending as a total of all long-term care spending each year of the demonstration.
7	Increase awareness about home and community-based options for target populations.	Number of informational materials distributed and outreach activities performed by local CTTs to target groups, e.g. brochures, information and referral listings, media events, participation in community events, etc.

⁵ Target percentages subject to change based on experience gained first year of implementation.

Barriers to Flexibility of Medicaid Funds

In this application, the state has established yearly goals to increase the dollar amount and percentage of expenditures on home and community-based services.

These goals will be met by:

- Ensuring interest and participation of target population with culturally and linguistically appropriate education and outreach on the availability of HCBS waiver and other services.
- Increasing the number of available HCBS waiver slots as appropriate, to ensure waiver access to demonstration participants.

Rebalancing

California recognizes the need to continue efforts to rebalance the long-term care system. It is estimated that the population requiring long-term care services is growing at a rate of three percent per year as evidenced by the last five years. (California Legislative Analysts Office, 2005/06). While California has increased its share of spending for community-based care, the state must effectively manage long-term care funding in order to meet the challenge of the ever-increasing demand for long-term care, and to help financial resources go farther to meet consumers' home and community-based needs.

In an effort to more effectively manage its long-term care funding and rebalance the long-term care system, California was awarded a CMS Real Choice Systems Transformation Grant in October of 2006 (California Community Choices) that provides resources to develop an in-depth understanding of the specific fiscal, legal, structural, and policy measures that will encourage and support community care living options—as well as the specific mechanisms that discourage and prevent individual choice and selection of community care options. Increasing the state's capacity to serve individuals

in the community does not necessarily require *more* resources, but it clearly does require a better understanding of its current resources, how best to spend them, and what steps are needed to bridge the gap from current resource expenditure systems to a new, more flexible budget and reimbursement system of integrated service delivery.

The Real Choices Systems Transformation effort will include recommendations for budget restructuring and funding management reforms—the advantages and disadvantages, and potential venues or modes of realization, (e.g., by Medicaid State Plan Amendment, new or modified HCBS waivers, State legislation, proposed federal legislation, or a combination). Such restructuring may mean amending the Medicaid State Plan, adding a number of slots to an existing waiver, implementing an integrated Medicare and Medicaid delivery system, and/or developing or restructuring waivers that allow money to follow the person. The state will examine its payment methodologies across the long-term care continuum and ensure that incentives are appropriately aligned to increase access to HCBS, which ultimately will lead to a rebalancing of the financing structure. It is anticipated that some recommendations will center on changes to payment methodologies, reimbursement systems, and other measures to allow transfer of funds between HCBS and institutional programs.

At the end of the 5 year Real Choice Systems Transformation grant period (which will be year four of the MFP demonstration), California will have accomplished the following towards long-term care systems rebalancing:

- Conducted a comprehensive study and analysis of funding management reforms that will help increase use of HCBS and encourage rebalancing;
- Disseminated the long-term care financing study findings to all interested parties;

- Involved the Olmstead Advisory Committee, other stakeholder groups, department policy makers, and legislative staff in reform discussions and decisions;
- Formulated a set of realistic, recommended funding system and policy changes likely to receive wide support and accomplish systems change and rebalancing;
- Functioned as a resource for the State Legislature and stakeholders seeking to implement legal and regulatory reform, and changes in policies and practices that negatively impact the use of HCBS.

Part III: Preliminary Budget and Organizational Staffing Plan

ORGANIZATIONAL STRUCTURE

The demonstration will be administered through the CDHS Office of Long Term Care (OLTC). See Appendix 8 for the organizational chart. The OLTC will be responsible for all aspects of reporting to CMS and monitoring local delivery of demonstration services.

STAFFING PLAN

Administration			
5% In-Kind	1	Chief, Office of Long Term Care	CDHS
10% In-Kind	1	Health Program Manager I	CDHS
100% Demonstration	1	Project Director	CDHS
100% Demonstration	1	Project Analyst	CDHS
Service Delivery			
100% Demonstration	# Per Successful RFP	Transition Coordination (HCB Demonstration Services)	Regional Agency(ies)
No contracted positions			

STAFFING NARRATIVE

Assumption: 2 Part-Time Project Oversight (In-Kind) CDHS is the single Medicaid agency in California. Within CDHS, OLTC oversees the Program of All-Inclusive Care for the Elderly (PACE), a Social Health Maintenance Organization (S/HMO), a 2003 Real Choice Systems Change grant and the California Partnership for Long-Term Care. These programs, as well as special initiatives and projects, which places OLTC as the best situated state-level office to administer the MFP demonstration. PACE, the S/HMO and the Real Choice grant all focus on how best to provide long-term care services under Medi-Cal. OLTC interacts daily with multiple Medi-Cal programs and organizations. Providing in-kind management expertise, two managers within OLTC will oversee the federal demonstration in coordination with the Health and Human Services Agency (CHHSA), the Olmstead Advisory Committee, other state departments and

several divisions within CDHS/Medical Care Services, all of which administer aspects of the Medi-Cal program. The two individuals providing in-kind management expertise have, between them, close to 60 years of state service experience and both focused their careers over the past 20 years on long-term care policy innovations in California and in the nation. Resumes are included in Attachment 3. Others dedicated to the project include an Assistant Secretary at CHHSA, the State Medicaid Director, and Division and Section Chiefs in the Medi-Cal Operations Division and Home and Community-Based Services (HCBS) Section. Each will support the project goals and activities.

Assumption: 2 Full-Time Project Staff (50% State funded, 50% Federal Grant

funded). For this demonstration, two project staff to be budgeted as:

- Full-time employees of CDHS, housed in OLTC
- \$90,000 salary, including benefits
- 1 Project Director at the analyst level
- 1 Project Monitor at the analyst level
- 50% State General Fund (GF), 50% Federal Financial Participation (FFP)

Project staff will be dedicated full-time to the federal MFP demonstration and will:

- Work with departments within CHHSA including Aging (MSSP waiver), Developmental Services (DD waiver) and other impacted state departments to address implementation issues.
- Work with departments external to CHHSA including the Department of Housing and Community Development, California Housing Finance Agency, and Department of Transportation to address system barriers related to the demonstration's implementation.
- Interact with and facilitate project goals and deliverables through existing Medi-Cal systems, programs and organizations within CDHS and locally.
- Set project standards and requirements.
- Conduct the competitive selection process for project regions.
- Convene quarterly project advisory committee meetings.
- Provide regular project updates to the CHHSA Olmstead Advisory Committee.
- Provide CDHS management with project updates and progress.
- Provide the required reports to CMS.
- Provide technical assistance to local regions and CTTs.

BUDGET NARRATIVE

Qualified Home and Community-Based Services (25% State GF, 75% FFP)

Assumption: QHCBS services include seven existing HCBS waivers and sets of services that have been approved by CMS and approved through state budget authorities. The demonstration will serve multiple sub-population groups, and each individual will be enrolled in the HCBS waiver that best meets his/her needs. Since nursing facility residents are diverse in their service needs, the transition process may encounter any and all members of sub-population target groups; e.g. elderly, younger physically disabled, developmental disabled, etc. Therefore, the demonstration will be available to any one of the sub-group populations and will utilize any one of the existing HCBS waivers to serve demonstration participants.

Assumption: Current Annual HCBS Waiver Demonstration Enrollee Cost is \$51,804 at 50% state general funds. Each of California's HCBS waivers are budgeted using assumptions for cost neutrality based on each waiver's distinct coverage and the needs of the sub-population it serves. As a proxy for calculating this federal request, California is using \$51,804 annual cost per demonstration participant across all California HCBS waivers. The use of \$51,804 amount is also subject to state control agency approvals. This proxy amount is also used because the case mix of the nursing facility transition population is unknown at this time. As the state gains more experience with nursing facility transition services and protocols, accurate assumptions can be drawn for future budgeting. This proxy amount for annual HCBS waiver enrollee costs includes HCBS waiver services as well as:

- Personal care services under state plan and/or IHSS Plus waiver (sec. 1115 waiver);
- Other Medi-Cal State plan services during enrollment in the waiver.

During the pre-implementation phase, the state will revisit this assumption and make adjustments, as necessary.

Home and Community-Based Demonstration Services (25% State GF, 75% FFP)

Assumption: Transition Coordination is a service that is included in some, but not all, of California’s HCBS waivers. A system for staffing institutional transition coordination is not available statewide. During the demonstration’s competitive selection process, regions will submit their preferred option to fund Transition Coordination either through TCM or through HCBS waivers. Transition Coordinators will be:

- County employees funded through the TCM program under Medi-Cal at the county option; OR
- HCBS waiver providers who conduct transition coordination and are either social workers, nurses or other case management professionals.

The assumptions for HCB Demo services Transition Coordination in the federal budget request calculations are:

- 1 Full-time Transition Coordinator will handle a caseload of 15 active transitions.
- Each transition takes an average of 6 months to successfully plan and execute. The six month average is based on experience in western Los Angeles under the DIAL program pilot and the Community Resources for Independence in Santa Rosa. Additionally, 6 months (180 days) is the amount of time billable for transitional care planning under an approved HCBS waiver.
- 1 Transition Coordinator will turnover a caseload of 15 once in 6 months, for a total of 30 transitions in a year.
- 1 Transition Coordinator is budgeted at \$90,000 (salary and benefits, and eligible for 75% FFP under the HCB Demonstration service category).
- Given the proposed number of demonstration participants, this demonstration projects the following numbers of local Transition Coordinators each year: Year 1: 0 (Pre-Implementation); Year 2: 3; Year 3: 15; Year 4: 19; Year 5: 22.

Assumption: State general funds “saved” due to enhanced FFP opportunity are allocated to other HCB Demo Services (other than Transition Coordination) and Supplemental Demonstration services (yet to be determined) and subject to control agency approvals. These “saved” state dollars, approximately half of the originally budgeted 50% of state general fund waiver costs (without the demonstration), enable the state to identify and offer HCB Demo services and Supplemental demonstration services while at the same time, remain cost neutral to the state for the duration of the demonstration.

California will work during the pre-implementation phase to develop policy standards, rates and criteria for authorizing HCB Demo services, including Transition Coordination. Proposals in this category of services will be subject to state control agency approval and federal approval of the pre-implementation plan. Preliminary planning and stakeholder input have identified some other areas of priority under HCB Demonstration other services, including, but not limited to, the following: excess personal care services beyond state statutory cap of 283 hours; respite for caregivers; family training;

Supplemental Demonstration Services (50% State GF, 50% FFP)

Supplemental Demonstration services will be considered during pre-implementation period and subject to control agency approvals. Preliminary planning and input from stakeholders have suggested the following Supplemental Demonstration Services be including within the demonstration. Any services proposed and implemented in this category are subject to control agency approvals. These services include, but are not limited to: one-time funding for home modifications; assistive technology; substance abuse counseling; and others that may be identified with transitions experience.

Part IV: Assurances

INFORMED CONSENT

In order to fulfill privacy protection requirements, individuals participating in the demonstration will be asked for written permission for the Transition Coordinator to make referrals and information sharing on their behalf necessary to pursue the desired services in the community setting.

California's current Home and Community-Based Services (HCBS) waivers each have informed consent protocols, which document choice of HCBS over institutional care. Demonstration participants will be provided opportunities for choice and adequate information to make those choices. Currently, outreach to HCBS waiver participants is typically through an established network of waiver providers, depending on the waiver's target population; e.g. regional centers, counties, etc. The Money Follows the Person (MFP) demonstration challenges California to conduct outreach and education and informed consent across several HCBS waiver networks and target populations. The state will work during the pre-implementation phase to develop core information that will be used by Community Transition Teams (CTTs) for both outreach and education products (print or media), as well as products that document informed decision-making. CTTs will be required to carry out the state's systematic protocols for:

- MFP Demonstration Eligibility Determination
- MFP Demonstration Enrollment
- MFP Demonstration Assessment and Reassessment
- MFP Conclusion (at the end of 12 months of services) and Enrollment into an existing HCBS Waiver to ensure any needed services are continued.

During pre-implementation, the state will develop core information (likely a form and a required procedure) that will ensure that each CTT will demonstrate that informed

consent of each demonstration participant will be discussed and documented at every decision point. The MFP Informed Consent form will be modeled after the *Medi-Cal HCBS Waiver Informing Notice* (Appendix 9) and will provide adequate information about choices and expectations for available community-based services and supports as well as housing options. Demonstration participants will also receive required information about a Medi-Cal beneficiary's rights to fair hearing under the Social Security Act.

PUBLIC PROCESS

The California Health and Human Services Agency (CHHSA) and California Department of Health Services (CDHS) are committed to working with industry and community stakeholders on the California Community Transitions demonstration.

In developing this application, CDHS and CHHSA drew upon the expertise of the State's Olmstead Advisory Committee, industry and stakeholder groups review of gaps in the State's long-term care continuum and home and community-based services, and to make recommendations on potential target populations and demonstration design. Stakeholders were provided a paper detailing California's concept for the MFP demonstration and encouraged to provide both written and verbal feedback. In addition, several meetings were conducted to gather public feedback.

To ensure ongoing public input, California will conduct a strategic planning process during the pre-implementation phase that is inclusive of all stakeholders by convening a Transitions Advisory Committee, which will be comprised of community stakeholders representing the target population of consumers, advocates, family members/caregivers, and providers as well as state departments (including the

Departments of Rehabilitation, Aging, Developmental Services, Mental Health, Social Services, and the CHHSA). The Transitions Advisory Committee will assist CDHS in developing the Operational Protocol, including performance measures, and developing community transition team criteria and standards and local project selection criteria. The Transitions Advisory Committee will also be convened regularly throughout the lifespan of demonstration to develop solutions to barriers identified during implementation.

The state will also continue to rely on the Olmstead Advisory Committee to offer public input, review data, discuss progress, receive feedback, and make recommendations on demonstration efforts. Comprised of 32 members with diverse consumer representation, as well as members of advocacy groups, provider associations and private organizations, the Olmstead Advisory Committee offers a wealth of knowledge on matters related to the avoidance of institutionalization and the support of seniors and persons with disabilities in their homes/communities.

Finally, a public process will be a key factor in the competitive region selection process. Each region will be required to have a local public process by which demonstration requirements will be met. By definition, local organizations will come together to apply to the state to participate in the demonstration. As such, local organizations and the public will have a direct impact on the how the demonstration will operate in their area.

MAINTENANCE OF EFFORT (MOE)

CDHS has multiple state department partners that are responsible for HCBS waiver oversight and institutional services. Data relative to actual HCBS and institutional

expenditures for 2005 reside in multiple databases and cover multiple time-periods, depending on the waiver effectiveness period. A trend rate for growth must also be applied when establishing an MOE for future years in order to show success beyond that which would happen without the demonstration. Establishing an accurate MOE is critical to how the success of the demonstration will be measured. The time sensitive nature of this demonstration grant application required use of a proxy data set. CDHS has included the required MOE matrices; see Attachment 4: MOE Forms and Certifications.

REPORTING TO CMS

CDHS assures that all federally required reporting requirements will be met including quarterly, semi-annual and final reports, financial reports, and any data requests. In addition, CDHS will fully cooperate with all information requests related to the national MFP demonstration evaluation. A requirement of the competitive selection of regions and CTTs will be the lead organization's ability to meet and report on all MFP demonstration requirements; including number of CTTs in the region, the number of Transition Coordinators, the names and numbers of facility partners, the names and demographic data on demonstration participants and other necessary data elements. One demonstration project staff located at the CDHS is dedicated entirely to fiscal analysis and data gathering and reporting at the state level.

Section VII
Required Attachments

- | | |
|----------------------|---|
| Attachment 1: | Prohibited Use of Grant Funds |
| Attachment 2: | State Profile & Summary of Project |
| Attachment 3: | Resumes of Key Project Staff |
| Attachment 4: | MOE Forms & Certifications |

Attachment 1

Prohibited Uses of Grant Funds

Money Follows the Person Rebalancing Grant funds may not be used for any of the following:

- To match any other Federal funds
- To provide services, equipment or supports that are the legal responsibility of another party under Federal or State law (e.g., vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.
- To provide infrastructure for which Federal Medicaid matching funds are available at the 90/10 matching rate, such as certain information systems projects.
- To supplant existing State, local or private funding of infrastructure or services such as staff salaries, etc.
- To be used for expenses that will not primarily benefit individuals of any age who have a disability or long-term illness

Attachment 2: State Profile & Summary of Project

Name of State: *California*

Primary Contact Name and Title: *Carol Freels (Chief, Office of Long-Term Care) or Paula Acosta (Chief, Long-Term Care Projects Unit)*

Year of Demonstration: *Year 2 – January 1 through December 31, 2008*

Estimated Number of Individuals to be Transitioned*	20	15	45	10	10
Statewide (SW) or Not Statewide (NSW)	NSW	NSW	NSW	NSW	NSW
Qualified Institutional Settings*	NF, ICF or Hospital				
Qualified Community Settings**	Home, Apartment or Assisted Living				
Qualified HCB Services	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care
HCB Demonstration* Services	Transition Coordination Excess Personal Care				
Supplemental Demonstration Services*	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers

- ***Subject to control agency approvals.***
- ***Defined during pre – implementation***
- ***Total number of slots is 100***

Name of State: California

Primary Contact Name and Title: Carol Freels (Chief, Office of Long-Term Care) or Paula Acosta (Chief, Long-Term Care Projects Unit)

Year of Demonstration: Year 3 – January 1 through December 31, 2009

Estimated number of individuals to be transitioned *	100	75	225	50	50
Statewide (SW) or Not Statewide (NSW)	NSW	NSW	NSW	NSW	NSW
Qualified Institutional Settings*	NF, ICF or Hospital				
Qualified Community Settings**	Home, Apartment or Assisted Living				
Qualified HCB Services	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care
HCB Demonstration* Services	Transition Coordination Excess Personal Care				
Supplemental Demonstration Services*	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers

- **Subject to control agency approvals.**
- ***Total Slots 500.**

Name of State: California

Primary Contact Name and Title: Carol Freels (Chief, Office of Long-Term Care) or Paula Acosta (Chief, Long-Term Care Projects Unit)

Year of Demonstration: Year 4 – January 1 through December 31, 2010

Estimated number of individuals to be transitioned *	130	98	292	65	65
Statewide (SW) or Not Statewide (NSW)	NSW	NSW	NSW	NSW	NSW
Qualified Institutional Settings*	NF, ICF or Hospital				
Qualified Community Settings**	Home, Apartment or Assisted Living				
Qualified HCB Services	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care
HCB Demonstration* Services	Transition Coordination Excess Personal Care				
Supplemental Demonstration Services*	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers

- **Subject to control agency approvals.**
- **Total slots 650**

Name of State: California

Primary Contact Name and Title: Carol Freels (Chief, Office of Long-Term Care) or Paula Acosta (Chief, Long-Term Care Projects Unit)

Year of Demonstration: Year 5 – January 1 through December 31, 2011

Estimated number of individuals to be transitioned *	150	143	337	75	75
Statewide (SW) or Not Statewide (NSW)	NSW	NSW	NSW	NSW	NSW
Qualified Institutional Settings*	NF, ICF or Hospital				
Qualified Community Settings**	Home, Apartment or Assisted Living				
Qualified HCB Services	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care	Per Existing HCBS Waivers And Plan of Care
HCB Demonstration* Services	Transition Coordination Excess Personal Care				
Supplemental Demonstration Services*	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers	Flexible one-time services not included in current waivers

- **Subject to control agency approvals.**
- **Total slots 750**

Name of State: *California*

Primary Contact Name and Title: *Carol Freels (Chief, Office of Long-Term Care) or
Paula Acosta (Chief, Long-Term Care Projects Unit)*

2007	0	0	0	\$90,000	0	\$90,000.
2008	3,885,000.	1,773,900	523,800	\$90,000	0	\$6,273,000.
2009	19,426,500.	10,084,500	3,024,000	\$90,000	0	\$32,625,000.
2010	25,254,450.	13,133,475	3,950,325	\$90,000	0	\$42,428,250.
2011	29,139,750.	15,177,375	4,564,125	\$90,000	0	\$48,971,250.
TOTAL:	\$77,706,000.	*\$40,169,250.	\$12,062,250.	\$450,000	\$0	\$130,387,500.

* Transition Coordination and HCB Demo (other) included.

Attachment #3
Resumes of Key Project Staff

Carol A. Freels, Chief
Office of Long-Term Care
California Department of Health Services

Biographical Sketch -- Position Qualifications

Position Title: Career Executive Assignment (CEA II)

Ms. Freels has been with the California Department of Health Services (CDHS) since 1979 during which she has developed, administered or monitored a number of programs. During the last 16 years her focus has been on specialized long-term care projects. She was responsible for creating the In-Home Operations section of DHS that administers three home-and community-based waiver programs; she managed the policy unit for Medi-Cal long-term care; she led the development of the state's Primary Care Case Management program; she provided oversight of numerous programs operating under several federal waivers administered by the Departments of Aging, Mental Health, Drug and Alcohol, and Developmental Services. She was instrumental in facilitating a statewide Medicaid Section 1115 Demonstration waiver (In-Home Supportive Services (IHSS) Plus)) waiver that provides self-directed personal care services to thousands of Californians every year.

CURRENT OFFICE RESPONSIBILITIES:

- California Programs of All-inclusive Care for the Elderly.
- Social Health Maintenance Organization.
- California Partnership for Long Term Care
- Real Choice Systems Change Grant (2003 through 2007) – Money Follows the Person: California Pathways.
- Coordinating Long-Term Care Policy innovations for CDHS.
- Participating as a member of the Work Groups supporting the California Health and Human Services Olmstead Advisory Committee.

ADDITIONAL EXPERTISE/EXPERIENCE

- Responsibility for directly administering multiple 1915(c) Home and Community-Based Services waivers.
- Speaker and subject matter expert on issues related to long-term care in California.
- Established a statewide unit consisting of 40 multidisciplinary state positions that included nurses, a physician, and analysts.
- Worked closely with the information technology and policy staff to complete annual 372 reports to CMS.
- Established the Pediatric Subacute program as a Medi-Cal covered benefit.
- Developed criteria for nursing facilities (NF) including definition of what were included in the NF rate, minimum staffing and initiated several special long-term care projects.

7-24-2003

PAULA ACOSTA
Health Program Manager I
California Department of Health Services/Office of Long Term Care

Provides leaderships and support on multiple long term care innovative projects; such as legislative proposals, budget change proposals, special programs, issue analyses, and new initiatives.

Manages and monitors the current federal Real Choice Systems Change grant and the active partnership with University of California at Los Angeles, the Department of Rehabilitation and the University of Southern California.

Consults with multiple CDHS divisions as a subject matter expert in policy matters related to long term care; for example, Medi-Cal long term care services and supports, integrated long term care state program options, Olmstead issues, and other state program delivery options intended to serve seniors and persons with disabilities.

Conducts state level coordination activities with other state agencies, providers, trade associations, advocates, grantees and stakeholder groups on politically sensitive issues and/or implementation issues.

Provides technical editorial support to OLTC staff on major projects and deliverables; for example, issue analyses, bill analyses, request for applications, written monitoring protocols, waivers, budget proposals, and others.

Represents the Office of Long Term Care at the California Health and Human Services Agency (CHHSA) Olmstead work groups. Track the Department's interests in Olmstead initiatives.

Accomplishments:

- Participated as the CDHS representative for the SB 910 Planning Committee – Strategic Plan for Aging Californians
- Team lead for development of a Long Term Care Integration Request for Applicants (RFA).
- Primary author/editor, Legislative Report – AB 3054 - Alternative to Long Term Care Integration Pilot Project.
- Primary editor and team member for development of the In-Home Supportive Services Plus waiver application.
- Participated as a member or chair various task forces and work groups as a subject matter expert in Medi-Cal Home and Community-Based Services (HCBS) waivers and services statewide generally, and Assisted Living specifically.
- Team lead to develop, negotiate and manage the Assisted Living consultant procurement project.
- Monitored Area Agencies on Aging in 13 counties; including contracts and compliance

Paula Acosta
Biographical Sketch
October 30, 2006

with Older Americans Act and Older Californians Act program standards.

- Participate as staff on loan to represent the Department of Aging (1993) at the Governor's Office's, Commission on Improving Life Through Service (CILTS). Provide staff support to developing CILTS and implementing the federal Community Services Act—Service Learning and Americorps.
- Provide staff support to the California Senior Legislature.
- Managed two-county Long Term Care Ombudsman program; including staff management, volunteer training, budgeting, fund raising and daily operations. Investigated and resolved complaints and problems on behalf of frail and disabled residents of long term care facilities.
- Generated multiple publications, local public appearances and public informational meetings relative to local long-term health care issues.

California Community Transitions Demonstration CDHS Staff Descriptions

CDHS will recruit staff for these positions upon award of the demonstration and approval from state control agencies.

Project Director: CDHS will recruit a Health Program Specialist to serve as project director for the demonstration. The Project Director will be responsible for overall project management, including project planning, coordination with internal and external partners, development of local project selection criteria, and coordination, monitoring, evaluation and reporting functions. The Project Director will be responsible for establishing the Operational Protocol for the demonstration during the pre-implementation phase and ensuring timely submission to CMS, providing technical assistance to local partners and other partner departments, convening regular meetings of the Transitions Advisory Committee, acting as liaison with other state department partners, ensuring important interdepartmental relationships (Medi-Cal Operations and Policy), monitoring implementation of local projects and project outcomes, as well as ensuring compliance with all federally required demonstration and reporting requirements. The Project Director will have skills and knowledge in health program administration and Medi-Cal programs and policy analysis.

Associate Accounting Analyst: The Associate Accounting Analyst will be responsible for ensuring all demonstration requirements for federal funds claiming and reporting on use of federal funds. The Accounting Specialist will establishing and maintain effective working relationships with staff from numerous divisions including Information Technology, Medi-Cal Operations, Budgets, Accounting, and Fiscal Forecasting to ensure access to fiscal and programmatic data for the demonstration and consistency with claiming federal financial participation, and to coordinate and monitor impact to costs under the Medi-Cal program. The Accounting Analyst will provide specialized knowledge on fiscal issues and technical assistance to program staff, and will perform analysis on complex accounting assignments to prevent duplication of payments and consistency of reporting Medi-Cal expenditures under the demonstration's benchmarks.

SARAH SUTRO STEENHAUSEN

108 40th Street Sacramento, CA 95819
(916) 736-9827 sarahsutro@hotmail.com

PROFESSIONAL EXPERIENCE

California Health and Human Services Agency ~ February 2005- Present

Assistant Secretary for Long-Term Care

- Work with Departments of Aging, Social Services, Rehabilitation, Health Services, and Developmental Services in overseeing long-term care program and policy issues that impact the state's implementation of the *Olmstead* decision.
- Principle staff for the Olmstead Advisory Committee and Alzheimer's Advisory Committee.
- Collaborate with Agency departments, community stakeholders, and legislative partners to advance the collective interest of identifying and addressing barriers that stand in the way of more integrated community-based services for state residents.

California State Senate ~ 2002-Jan. 2005

Consultant, Senate Subcommittee on Aging and Long Term Care

- Served as principal policy advisor to Senator John Vasconcellos, Chair, and Subcommittee on aging-related issues
- Staffed Legislation in 2003-2004 legislative sessions pertaining to aging prisoners (SB 549), end-of-life care (SB 549), statewide prevention of elder abuse (SB 1305 and SB 1475) and long term care integration (SB 1671). Staffed legislation in the 2001-2002 legislative sessions that addressed long-term care system fragmentation, training of aging-service professionals, senior employment, and senior volunteerism (SB 953).
- Represented Senator Vasconcellos in various public forums including panel and roundtable discussions and community meetings.
- Organized and managed legislative informational hearings, Subcommittee task forces, and educational forums.

California State Senate Fellows Program ~ 2000-2001

Consultant, Senate Health and Human Services Committee

- Served as policy advisor to Senator Deborah Ortiz, Chair, and Committee.
- Staffed Legislation in 2001-2002 legislative sessions pertaining to the Multipurpose Senior Service Program (SB 337), fall prevention and home modifications for seniors (B 370), elder abuse (SB 502), and disease management (SB 859).
- Analyzed legislation pertaining to nursing homes, assisted living, and prescription drugs.

National Resource Center on Supportive Housing ~ 1999-2000

Research Assistant, State Policy Research Project

- Analyzed state and federal home modification policies and conducted original research.

Southern California Presbyterian Homes for the Aging ~ 1998-2000

Program Evaluator and Research Assistant

- Developed program evaluation system, conducted interviews and wrote reports for a senior financial management program.

AARP, Division of Legislative Affairs ~ 1999

Summer Associate, Washington, D.C.

- Wrote and presented policy briefs to legislative team, and assisted with legislative analysis of medical proposals

The Coro Fellows Program in Public Affairs ~ 1997-1998

Coro Fellow

- Participated in graduate-level training program on leadership in public affairs

Health Insurance Counseling and Advocacy Program ~ 1994-1997

Community Educator and Senior Health Insurance Counselor

- Managed community education, outreach and public relations programs.
- Conducted weekly presentations to seniors and caregivers on Medicare, long-term care, and elder abuse prevention.

EDUCATION

University of Southern California~ 1998-2000

Masters of Science, Gerontology

- Honors: Phi Kappa Phi (All University Honors Society), Sigma Phi Omega (Gerontology Honors Society)

Connecticut College ~ 1990-1994

B.A., History

- Honors: 1994 History Department Prize, Senior Leadership Award, Helen Buttenweiser Scholar

School for International Training: Nairobi, Kenya ~ Fall 1992

- Conducted research on the non-governmental sector's role in health care development

HONORS

California Association of Homes and Services for the Aging

Advocate of the Year, 2003

- Selected as the Association Advocate of the Year for work on behalf of California's seniors.

Older Women's League

Advocate of the Year

- Selected as the Older Women's League Advocate of the Year for leadership in issues affecting California's older women.

COMMUNITY ACTIVITIES

Eskaton's Talking, Listening, and Caring Program

Volunteer

- Provide friendship to a housebound elderly woman.

Attachment #4
MOE Forms & Certifications

**Money Follows the Person Rebalancing Demonstration
Maintenance of Effort**

Table 1: Demonstration Funding Request

Fiscal Year	Medicaid Admin. Costs	Qualified HCB Service Costs (Enhanced FMAP)	HCB Demo Service Costs (Enhanced FMAP)	Supplemental Demo Service Costs (regular FMAP)	Total FY Estimated Funding Request
2007	\$90,000	0	0	0	\$90,000
2008	\$90,000	\$3,885,300	\$1,773,900	\$523,800	\$6,273,000
2009	\$90,000	\$19,426,500	\$10,084,500	\$3,024,000	\$32,625,000
2010	\$90,000	\$25,254,450	\$13,133,475	\$3,950,325	\$42,428,250
2011	\$90,000	\$29,139,750	\$15,177,375	\$4,564,125	\$48,971,250
Total	\$450,000	\$77,706,000	\$40,169,250	\$12,062,250	\$130,387,500

Table 2: Maintenance of Effort - HCBS Expenditures

Fiscal Year	HCBS Expenditures (Statewide Data)	HCBS Expenditures for the Demonstration per Award Year (Demonstration Caseload)
2005	\$1,718,317,220	
2006	\$1,867,810,818	
2007		0
2008		\$6,183,000
2009		\$32,535,000
2010		\$42,338,250
2011		\$48,881,250
Grand Total	\$3,586,128,038	\$129,937,500

Table 3: Maintenance of Effort – Long Term Care Services

Fiscal Year	% LTC Institutional Expenditures	% LTC HCBS Expenditures
2005	63.8%	36.2%
2006	62.5%	37.5%
2007	61.1%	38.9%
2008	59.7%	40.3%
2009	58.3%	41.7%
2010	56.9%	43.1%
2011	55.5%	44.5%
Grand Total	59.4%	40.6%

- The time sensitive nature of this grant application required us to use a proxy data set. DHS analysts utilized actual Medi-Cal Long Term Care (LTC) data as proxy for the Federal categories.
- The annual growth rate percentages are derived from actual Medi-Cal LTC program data, which are based on the assumed 50% Federal Medicaid share.
- Sources: 6 MFP MOE Waiver Forms, Medi-Cal estimates, Medi-Cal Program—Historical LTC Expenditures and Users, FY 2001-02 through FY 2004-05.

**MEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE
FOR THE MEDICAL ASSISTANCE PROGRAM
PRIOR PERIOD ADJUSTMENTS IN THIS QUARTER**

MEDICAL ASSISTANCE PAYMENTS CA January 1, 2004 - December 31, 2004 TYPE OF WAIVER: <u> AIDS </u> WAIVER NUMBER: <u> 0183 90 </u>	TOTAL COMPUTABLE	FEDERAL SHARE			TOTAL FEDERAL SHARE	DEFERRAL OR C.I.N. NUMBER
		FMAP	I.H.S. FACILITY SERVICES	FEDERAL SHARE		
		Jan-Jun: 52.95% Jul-Dec: 50%	100%			
	(a)	(b)	(c)	(d)	(e)	{f}
1a. CASE MANAGEMENT: January - June	2,754,940	1,458,741		0	1,458,741	
1b. CASE MANAGEMENT: July - December	2,754,940	1,377,470		0	1,377,470	
2a. HOMEMAKER SERVICES: January - June	660,741	349,862		0	349,862	
2b. HOMEMAKER SERVICES: July - December	660,741	330,371		0	330,371	
3. HOME HEALTH AIDE SERVICES	0			0		
4. PERSONAL CARE	0			0		
5. ADULT DAY HEALTH	0			0		
6. HABILITATION	0			0		
a. RESIDENTIAL HABILITATION	0			0		
b. DAY HABILITATION	0			0		
7. EXPANDED HABILITATION SERVICES (42 CFR §440.180(c))	0			0		
a. PREVOCATIONAL SERVICES	0			0		
b. SUPPORTED EMPLOYMENT	0			0		
c. EDUCATION	0			0		
8. RESPITE CARE	0			0		
9. DAY TREATMENT	0			0		
10. PARTIAL HOSPITALIZATION	0			0		
11. PSYCHOSOCIAL REHABILITATION	0			0		
12. CLINIC SERVICES	0			0		
13. LIVE-IN CAREGIVER (42 CFR §441.303(f)(8))	0			0		
14. CAPITATED PAYMENTS FOR LONG TERM CARE SERVICES	0			0		
15a. OTHER*: January - June	2,317,274	1,226,997		0	1,226,997	
15b. OTHER*: July - December	2,317,274	1,158,637		0	1,158,637	

NOTE: * Indicates Optional Wavier Services offered by the State as provided under 42 CFR §440.180(b)(9) for long term care services.

Please use the MFP MOE NARRATIVE to explain why the services listed in #14 is not part of services listed in numbers 1 through 13.

Alternate service titles should also be noted in the MFP MOE NARRATIVE.

MFP MOE WAIVER (Based on FORM CMS 64.9P WAIVER)

WAIVER SERVICES ONLY

**MEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE
FOR THE MEDICAL ASSISTANCE PROGRAM
PRIOR PERIOD ADJUSTMENTS IN THIS QUARTER**

MEDICAL ASSISTANCE PAYMENTS CA July 1, 2004 - June 30, 2005 TYPE OF WAIVER: <u> IHMC </u> WAIVER NUMBER: <u> 0348.90 </u>	TOTAL COMPUTABLE	FEDERAL SHARE			TOTAL FEDERAL SHARE	DEFERRAL OR C.I.N. NUMBER
		FMAP 50.00%	I.H.S. FACILITY SERVICES 100%	FEDERAL SHARE		
		(a)	(b)	(c)		
1. CASE MANAGEMENT	93,655	46,828		0	81,858	
2. HOMEMAKER SERVICES	0			0		
3. HOME HEALTH AIDE SERVICES - Shared	168,824	84,412		0	84,412	
4. PERSONAL CARE	0			0		
5. ADULT DAY HEALTH	0			0		
6. HABILITATION	0			0		
a. RESIDENTIAL HABILITATION	0			0		
b. DAY HABILITATION	0			0		
7. EXPANDED HABILITATION SERVICES (42 CFR §440.180(c))	0			0		
a. PREVOCAIONAL SERVICES	0			0		
b. SUPPORTED EMPLOYMENT	0			0		
c. EDUCATION	0			0		
8. RESPITE CARE	0			0		
9. DAY TREATMENT	0			0		
10. PARTIAL HOSPITALIZATION	0			0		
11. PSYCHOSOCIAL REHABILITATION	0			0		
12. CLINIC SERVICES	0			0		
13. LIVE-IN CAREGIVER (42 CFR §441.303(f)(8))	0			0		
14. CAPITATED PAYMENTS FOR LONG TERM CARE SERVICES	0			0		
15. OTHER*	11,372,447	5,686,224		0	5,686,224	

NOTE: * Indicates Optional Wavier Services offered by the State as provided under 42 CFR §440.180(b)(9) for long term care services. Please use the MFP MOE NARRATIVE to explain why the services listed in #14 is not part of services listed in numbers 1 through 13. Alternate service titles should also be noted in the MFP MOE NARRATIVE.

MFP MOE WAIVER (Based on FORM CMS 64.9P WAIVER)

WAIVER SERVICES ONLY
**MEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE
FOR THE MEDICAL ASSISTANCE PROGRAM
PRIOR PERIOD ADJUSTMENTS IN THIS QUARTER**

MEDICAL ASSISTANCE PAYMENTS CA January 1, 2004 - December 31, 2004 TYPE OF WAIVER: ___ NF-A/B _____ WAIVER NUMBER: ___ 0139.90 _____	TOTAL COMPUTABLE	FEDERAL SHARE			TOTAL FEDERAL SHARE	DEFERRAL OR C.I.N. NUMBER
		FMAP	I.H.S. FACILITY SERVICES	FEDERAL SHARE		
		Jan-Jun: 52.95% Jul-Dec: 50%	100%			
(a)	(b)	(c)	(d)	(e)	{f}	
1a. CASE MANAGEMENT: January - June	159,981	84,710		0	84,710	
1b. CASE MANAGEMENT: July - December	159,981	79,991		0	79,991	
2. HOMEMAKER SERVICES	0			0		
3. HOME HEALTH AIDE SERVICES	0			0		
4a. PERSONAL CARE (Personal Care Services): January - June	1,187,981	629,039		0	629,039	
4b. PERSONAL CARE (Personal Care Services): July - December	1,187,981	593,990		0	593,990	
5. ADULT DAY HEALTH	0			0		
6. HABILITATION	0			0		
a. RESIDENTIAL HABILITATION	0			0		
b. DAY HABILITATION	0			0		
7. EXPANDED HABILITATION SERVICES (42 CFR §440.180(c))	0			0		
a. PREVOCATIONAL SERVICES	0			0		
b. SUPPORTED EMPLOYMENT	0			0		
c. EDUCATION	0			0		
8. RESPITE CARE	0			0		
9. DAY TREATMENT	0			0		
10. PARTIAL HOSPITALIZATION	0			0		
11. PSYCHOSOCIAL REHABILITATION	0			0		
12. CLINIC SERVICES	0			0		
13. LIVE-IN CAREGIVER (42 CFR §441.303(f)(8))	0			0		
14. CAPITATED PAYMENTS FOR LONG TERM CARE SERVICES	0			0		
15a. OTHER*: January - June	6,212,975	3,289,770		0	3,289,770	
15b. OTHER*: July - December	6,212,975	3,106,488		0	3,106,488	

NOTE: * Indicates Optional Wavier Services offered by the State as provided under 42 CFR §440.180(b)(9) for long term care services.

Please use the MFP MOE NARRATIVE to explain why the services listed in #14 is not part of services listed in numbers 1 through 13.

Alternate service titles should also be noted in the MFP MOE NARRATIVE.

MFP MOE WAIVER (Based on FORM CMS 64.9P WAIVER)

WAIVER SERVICES ONLY

CENTERS FOR MEDICARE & MEDICAID SERVICES

**MEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE
FOR THE MEDICAL ASSISTANCE PROGRAM
PRIOR PERIOD ADJUSTMENTS IN THIS QUARTER**

MEDICAL ASSISTANCE PAYMENTS CA April 1, 2004 - March 31, 2005 TYPE OF WAIVER: ___NF-S/A___ WAIVER NUMBER: ___384___	TOTAL COMPUTABLE	FEDERAL SHARE			TOTAL FEDERAL SHARE	DEFERRAL OR C.I.N. NUMBER
		FMAP	I.H.S. FACILITY SERVICES	FEDERAL SHARE		
		Apr-Jun: 52.95% Jul-Mar: 50%	100%			
	(a)	(b)	(c)	(d)	(e)	{f}
1a. CASE MANAGEMENT: April 04 - June 04	75,640	40,051		0	40,051	
1b. CASE MANAGEMENT: July 04 - March 05	226,921	113,460		0	113,460	
2. HOMEMAKER SERVICES	0			0		
3. HOME HEALTH AIDE SERVICES	0			0		
4. PERSONAL CARE	0			0		
5. ADULT DAY HEALTH	0			0		
6. HABILITATION	0			0		
a. RESIDENTIAL HABILITATION	0			0		
b. DAY HABILITATION	0			0		
7. EXPANDED HABILITATION SERVICES (42 CFR §440.180(c))	0			0		
a. PREVOCATIONAL SERVICES	0			0		
b. SUPPORTED EMPLOYMENT	0			0		
c. EDUCATION	0			0		
8. RESPITE CARE	0			0		
9. DAY TREATMENT	0			0		
10. PARTIAL HOSPITALIZATION	0			0		
11. PSYCHOSOCIAL REHABILITATION	0			0		
12. CLINIC SERVICES	0			0		
13. LIVE-IN CAREGIVER (42 CFR §441.303(f)(8))	0			0		
14. CAPITATED PAYMENTS FOR LONG TERM CARE SERVICES	0			0		
15a. OTHER*: April 04 - June 04	8,501,076	4,501,320		0	4,501,320	
15b. OTHER*: July 04 - March 05	25,503,228	12,751,614		0	12,751,614	

NOTE: * Indicates Optional Waiver Services offered by the State as provided under 42 CFR §440.180(b)(9) for long term care services.

Please use the MFP MOE NARRATIVE to explain why the services listed in #14 is not part of services listed in numbers 1 through 13.

Alternate service titles should also be noted in the MFP MOE NARRATIVE.

MFP MOE WAIVER (Based on FORM CMS 64.9P WAIVER)

WAIVER SERVICES ONLY

**MEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE
FOR THE MEDICAL ASSISTANCE PROGRAM
PRIOR PERIOD ADJUSTMENTS IN THIS QUARTER**

MEDICAL ASSISTANCE PAYMENTS CA July 1, 2003 - June 30, 2004 TYPE OF WAIVER: ___MSSP___ WAIVER NUMBER: ___0141.90.01___	TOTAL COMPUTABLE	FEDERAL SHARE			TOTAL FEDERAL SHARE	DEFERRAL OR C.I.N. NUMBER
		FMAP Jul-Sep:54.35% Oct-Jun:52.95%	I.H.S. FACILITY SERVICES 100%	FEDERAL SHARE		
		(a)	(b)	(c)		
1a. CASE MANAGEMENT: July 03 - September 03	7,807,483	4,243,367		0	4,243,367	
1b. CASE MANAGEMENT: October 03 - June 04	23,422,450	12,402,187		0	12,402,187	
2. HOMEMAKER SERVICES	0			0		
3. HOME HEALTH AIDE SERVICES	0			0		
4. PERSONAL CARE	0			0		
5. ADULT DAY HEALTH	0			0		
6. HABILITATION	0			0		
a. RESIDENTIAL HABILITATION	0			0		
b. DAY HABILITATION	0			0		
7. EXPANDED HABILITATION SERVICES (42 CFR §440.180(c))	0			0		
a. PREVOCATIONAL SERVICES	0			0		
b. SUPPORTED EMPLOYMENT	0			0		
c. EDUCATION	0			0		
8a. RESPITE CARE: July 03 - September 03	498,659	271,021		0	271,021	
8b. RESPITE CARE: October 03 - June 04	1,495,976	792,119		0	792,119	
10. PARTIAL HOSPITALIZATION	0			0		
11. PSYCHOSOCIAL REHABILITATION	0			0		
12. CLINIC SERVICES	0			0		
13. LIVE-IN CAREGIVER (42 CFR §441.303(f)(8))	0			0		
14. CAPITATED PAYMENTS FOR LONG TERM CARE SERVICES	0			0		
15a. OTHER*: July 03 - September 03	1,882,860	1,023,334		0	1,023,334	
15b. OTHER*: October 03 - June 04	5,648,580	2,990,923		0	2,990,923	

NOTE: * Indicates Optional Wavier Services offered by the State as provided under 42 CFR §440.180(b)(9) for long term care services.
Please use the MFP MOE NARRATIVE to explain why the services listed in #14 is not part of services listed in numbers 1 through 13.
Alternate service titles should also be noted in the MFP MOE NARRATIVE.

MFP MOE WAIVER (Based on FORM CMS 64.9P WAIVER)

**MEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE
FOR THE MEDICAL ASSISTANCE PROGRAM
PRIOR PERIOD ADJUSTMENTS IN THIS QUARTER**

MEDICAL ASSISTANCE PAYMENTS CA October 1, 2004 - September 30, 2005 TYPE OF WAIVER: <u>DD</u> WAIVER NUMBER: <u>0336.90.01</u>	TOTAL COMPUTABLE	FEDERAL SHARE			TOTAL FEDERAL SHARE	DEFERRAL OR C.I.N. NUMBER
		FMAP 50.00%	I.H.S. FACILITY SERVICES 100%	FEDERAL SHARE		
	(a)	(b)	(c)	(d)	(e)	{f}
1. CASE MANAGEMENT	0				0	
2. HOMEMAKER SERVICES	4,218,411	2,109,206			2,109,206	
3. HOME HEALTH AIDE SERVICES	15,121,255	7,560,628			7,560,628	
4. PERSONAL CARE	0				0	
5. ADULT DAY HEALTH	0				0	
6. HABILITATION	0				0	
a. RESIDENTIAL HABILITATION for Children	51,153,099	25,576,550			25,576,550	
b. DAY HABILITATION	386,260,897	193,130,449			193,130,449	
7. EXPANDED HABILITATION SERVICES (42 CFR §440.180(c))	0				0	
a. PREVOCATIONAL SERVICES	39,131,003	19,565,502			19,565,502	
b. SUPPORTED EMPLOYMENT	18,357,042	9,178,521			9,178,521	
c. EDUCATION	0				0	
8. RESPITE CARE	50,570,771	25,285,386			25,285,386	
9. DAY TREATMENT	0				0	
10. PARTIAL HOSPITALIZATION	0				0	
11. PSYCHOSOCIAL REHABILITATION	0				0	
12. CLINIC SERVICES	0				0	
13. LIVE-IN CAREGIVER (42 CFR §441.303(f)(8))	0				0	
14. CAPITATED PAYMENTS FOR LONG TERM CARE SERVICES	0				0	
15. OTHER*	689,161,367	344,580,684			344,580,684	

NOTE: * Indicates Optional Waiver Services offered by the State as provided under 42 CFR §440.180(b)(9) for long term care services.

Please use the MFP MOE NARRATIVE to explain why the services listed in #14 is not part of services listed in numbers 1 through 13.

Alternate service titles should also be noted in the MFP MOE NARRATIVE.

MFP MOE WAIVER (Based on FORM CMS 64.9P WAIVER)

CERTIFICATION REGARDING MAINTENANCE OF EFFORT

In accordance with the applicable program statute(s) and regulation(s), the undersigned certifies that financial assistance provided by the Centers for Medicare and Medicaid Services, for the specified activities to be performed under the California Community Transitions Program by California Department of Health Services (Applicant Organization), will be in addition to, and not in substitution for, comparable activities previously carried on without Federal assistance.



Signature of Authorized Certifying Official

Chief Deputy Director

Title

11/1/06

Date

Section VIII

Additional Appendices

- Appendix 1: HCBS Services Across State Departments (Matrix)**
- Appendix 2: Preference Survey Analysis and Tool**
- Appendix 3: Quality Management Strategy from NF A/H Waiver**
- Appendix 4: Additional State Long-Term Care Legislative Initiatives**
- Appendix 5: Distribution of Medi-Cal Spending on Long-Term Care**
- Appendix 6: California Office of Statewide Health Planning and Development (OSHPD): Long-Term Care Services, Statewide Trends**
- Appendix 7: Letters of Support from Stakeholders**
- Appendix 8: Organizational Charts**
- Appendix 9: Home and Community-Based Services (HCBS) Informing Notice**
- Appendix: 10: Acronyms**

Appendix 1: HCBS Services Across State Departments

CA Dept of Aging (CDA)					
<p>Medi-Cal Adult Day Health Care – State Plan Benefit (also CDHS)</p> <p><i>Multipurpose Senior Services Program Waiver (also CDHS)</i></p> <p>Older Californians Act Programs: Linkages Alzheimer's Day Care Brown Bag Program Senior Companion Program Health Insurance Counseling & Advocacy Program</p> <p>Older Americans Act Programs (OAA): Area Agencies on Aging Home Delivered Meals Services Congregate Nutrition Services Legal Services Projects National Family Caregiver Support Program Senior Community Service and Employment Foster Grandparent Program Senior Centers</p> <p>Grants/Initiatives: Aging with Dignity Initiatives 2000 California Aging and Disability Resource Center Initiative Real Choice Systems Change Grant ***</p>	<p>Medi-Cal <i>Developmentally Disabled Waiver (also CDHS)</i></p> <p>California Developmental Disabilities Information System Project Developmental Centers Regional Centers Self-Directed Services Program</p> <p>Grants/Initiatives: Real Choice Systems Change Grants ***</p>	<p>Medi-Cal <i>Developmentally Disabled Waiver (also DDS)</i> <i>Multipurpose Senior Services Program Waiver (also CDA)</i> <i>In-Home Medical Care Waiver</i> <i>Nursing Facility A/B (A/H) Waiver</i> <i>Nursing Facility Subacute Waiver</i></p> <p>State Plan Benefits Adult Day Health Care (also CDA) <i>In-Home Supportive Services Plus Waiver (also CDSS)</i> Target Case Management</p> <p>Alzheimer's Disease Research Centers of California</p> <p>Office of Long Term Care California Partnership for Long-Term Care Program for All-Inclusive Care for the Elderly Social Health Maintenance Organization Program (S/HMO)</p> <p>Grants/Initiatives: Real Choice Systems Change Grants***, CA Pathways Medicaid Infrastructure</p>	<p>Medi-Cal Specialty Mental Health Health Services Act</p> <p>Adult and Older Adult Program Policy Older Adult Systems of Care Demonstration Projects Caregiver Resources Centers Mental Health Services Act (Proposition 63)</p> <p>Grants/Initiatives: Real Choice Systems Change Grants ***</p>	<p>Independent Living Centers Specialized Services for the Blind and Visually Impaired and Deaf and Hard of Hearing Title VII Chapter 2-- Independent Living Services for Older Individuals Who are Blind</p> <p>Grants/Initiatives: Real Choice Systems Change Grants***, CA Pathways partner</p> <p>*Discretionary Funding Projects: Independent Living Center Services Program Transition Funds DIAL Program</p>	<p>Medi-Cal <i>In-Home Supportive Services Plus Waiver (also CDHS)</i> Personal Care Services Program –State Plan Benefit</p> <p>Adult Protective Services Assistance Dog Special Allowance Program Blind Services Continuing Care Disability Benefits Office of Deaf Access Supplemental Security Income/State Supplementary Payment</p> <p>Grants/Initiatives: Real Choice Systems Change Grants ***</p>

** Italics indicates HCBS waiver programs.

*** Please refer to subsequent pages for a detailed discussion on the Real Choice Systems Change Grants.

Real Choice Systems Change (RCSC) Grants

1. Community Choices/Systems Transformation Grant

Award: \$3,000,000 over 5 years

Goal: Create two new one-stops called CommunityLink Resource Centers and provide technical assistance, particularly in IT, to California's two existing ADRCs. Pilot and field test CalCareNet, California's aging and long-term care web portal. Pilot and field test California's anticipated coordinated assessment tool for long-term care. Conduct a systemic analysis of the laws, regulations, policies and procedures that effect long-term care financing resulting in recommendations for a more effective funding management.

Progress: Grant was recently awarded and work will commence November 2006.

2. DMH – California Study on New Medi-Cal Respite Benefit for Caregivers of Adults with Cognitive Impairment

Award: \$100,000 per year since 2003

Goal: Develop plan to expand respite services to caregivers of persons with adult-onset cognitive impairments. Provide recommendations on ways California can implement and evaluate a new respite benefit under Medi-Cal. An advisory committee will identify the target population, project service use, analyze potential impact of expanding respite services with current infrastructure, identify protocols and procedures in existing state programs and outcome methodology currently in use in California and elsewhere, and establish procedures for data collection and evaluation to measure satisfaction, outcomes, cost, and utilization.

Progress: Project work is completed and a draft final report has been compiled.

3. Community Resources for Independence – Santa Rosa Nursing Home Transition Project -Transitions Independent Living Partnership Grant

Award: \$337,500 for three years

Goal: To transition Native Americans and Hispanic individuals with cognitive, mental/emotional, physical, hearing, vision and multiple disabilities, families from nursing homes to the community.

Progress: Working with 27 NFs, 35 persons were transitioned, three persons were diverted, and 38 individuals developed Independent Living Plans. Developed an outreach brochure and conducted presentations to 38 NFs and three hospitals. Matched consumers with peer support members. Project Director Nancy Hall was appointed to the California Olmstead Advisory Committee in March 2005, and is a member of the Assessments Subcommittee monitoring issues including "Money Follows the Person" (MFP).

4. California Pathways/MFP

Award: \$750,000 federal funding over three years

Goal: To develop and field test a model for a uniform assessment and transition protocol that would enable NF consumers to exercise informed choice of HCBS.

Provide case encounter and cost data that supplies the basis for policy recommendations for MFP initiatives in California.

Progress: Field-tested a preference assessment tool for nursing consumers on their preference to return to community living in 8 facilities (analysis of data is in progress). Identified existing Medi-Cal programs and HCBS waivers that support transition from NFs. Required stakeholder input, including program experts, potential consumers, advocacy group representatives, and the CHHSA Olmstead Committee. In addition, the University of California Los Angeles/Borun Center, the University of Southern California and the project team will make recommendations on a: transition assessment tool; a small pilot project for a transition protocol that can be used in various facilities; data set to demonstrate that the money follows the person; and a uniform transition care planning protocol that enables NF consumers to exercise interest and informed choice of care options and services in a community setting.

5. **Aging and Disability Resource Center (ADRCs)**

Award: \$800,000 over three years

Goal: To develop effective RCs providing the public with easily accessible information, counseling and/or assistance, and program linkage on the following areas: aging and long term support options; benefits counseling; long-term care services planning; health promotion; and HCBS supports. This initiative involves a “one-stop” approach to the services provided at the RCs, simplifying not only the number of places, but also eligibility and assessment processes.

Progress: San Diego and Del Norte are the two counties developing RCs. Both have secured lead staff, formed local advisory groups including consumers, and identified baseline assessments and activities to address the problems noted. San Diego has contracted with a developer to work with Center staff to design and install website fixes; developed a second targeted community survey; conducted formal survey sessions with care management and Call Center staff of the principle service providers; held stakeholder advisory group meetings; developed a continuous quality improvement model focused on Web support tool development; and held focus groups with physicians re: their needs for Web support tools. Del Norte progress includes upgrading their Management Information System to improve capability for reporting, supervision and client intake management; began work on a Web-based resource directory for consumers, caregivers and providers; met with hospital discharge staff and local NFs regarding ADRC development; plans for co-location with a health clinic serving most community consumers; held Medicare Part D and ADRC outreach and education sessions at a multitude of public events and through radio and flyer distribution.

6. **DSS IHSS Enhancement Initiative RCSC**

Award: \$1,385,000 for three years, serves 360,000 individuals under IHSS, and roughly 280,000 care providers

Goals: (1) Develop training, educational materials, and other methods of support to aid IHSS program consumers to better understand IHSS and to develop the skills required to self-direct their care; and (2) identify training and other support needs of

IHSS providers and create materials, tools, and work aids to enable providers to improve the quality of care and services.

Progress: DSS has contracted with California State University, Sacramento (CSUS). CSUS completed all data collection activities, including telephone interviews with consumers and providers in 18 counties and focus groups in three counties. Focus groups were conducted with IHSS program staff, IHSS public authority staff, elderly and disabled consumers, family care providers, non-family care providers, and Service Employees International Union and United Domestic Workers staff. CSUS completed an inventory of existing training material available through the counties, public authorities, unions, and other agencies; assessment report; and inventory of existing educational material. Topics were prioritized for material development. Drafted the final training material, which is currently under review by DSS. After this material is approved, CSUS will present training to county IHSS and public authority staff. Activities are scheduled to end 9-29-05.

7. **DDS – Bay Area Quality Enhancement Initiative**

Award: \$499,844 per year

Goals: Design a model and corresponding plans to implement a Quality Services Network to provide person-centered and person-directed quality services and supports to persons served within the Bay Area; adopt a systematic approach to measure consumers' satisfaction in meaningful ways at important intervals to guide system improvement efforts; apply the "lessons learned" from the project activities to make statewide system reforms.

Progress: Developed model for the Quality Services Network, renamed the "Bay Area Quality Management System (QMS)" and implementation plans. Interviewed approximately 220 consumers - 770 still in process. QMS is working in collaboration with closure of Agnews Developmental Center (individuals who transitioned into the community from Agnews Center

Appendix #2

Preference Survey Analysis and Tool

Running head: DEVELOPING AND TESTING TRANSITION SCREEN

Assessing the Role of Preference, Ability, and Feasibility in Transition Decisions: Developing
and Testing the California Nursing Facility Transition Screen

Christy M. Nishita, Ph.D. (CORRESPONDING AUTHOR)
University of Southern California
Andrus Gerontology Center
3715 McClintock Ave.
Los Angeles, CA 90089-0191
Ph- 213.821.4242
cnishita@usc.edu

Kathleen H. Wilber, Ph.D.
University of Southern California
Andrus Gerontology Center
3715 McClintock Ave.
Los Angeles, CA 90089-0191
Ph- 213.740.1736
wilber@usc.edu

Saki Matsumoto, B.A.
UCLA Borun Center for Gerontological Research
7150 Tampa Avenue
Reseda, CA 91335
Ph- 818.774.3234
saki.matsumoto@jha.org

John F. Schnelle, Ph.D.
UCLA Borun Center for Gerontological Research
7150 Tampa Avenue
Reseda, CA 91335
Ph- 818.774.3234
jschnell@ucla.edu

Acknowledgements:

From the Center for Medicare and Medicaid Services (Real Systems Change Grant for Community Living (11-P-92077)), California Department of Health Services, and the California Department of Rehabilitation to the UCLA/Borun Center for Gerontological Research and the USC Andrus Gerontology Center. The views expressed in this article are those of the authors and may not reflect those of the supporting agencies.

We thank Barbara Bates-Jensen, Ph.D., Lisa Howell, and Kelly Hickey for their assistance in the development of the screening tool, help with data collection, and insight during the research process. We also appreciate Paula Acosta, Gretchen Alkema, Dawn Alley, Ph.D., Richard Devylder, Carol Freels, and George Shannon, Ph.D. for their helpful comments on earlier versions of the paper.

Abstract

Purpose: Little is known about the preferred living arrangement of custodial nursing facility residents. This study describes the development and application of an instrument designed to systematically assess preference toward transition and to explore their ability and feasibility of transitioning.

Design and Methods: We targeted all Medicaid-funded, long-stay residents in eight nursing facilities in southern California (n=218). Of these, 121 (56%) self-consenting residents or their legally designated proxy decision-maker were interviewed using the California Nursing Facility Transition Screen. No presumptions were made as to which residents were good or bad candidates for transition based on their health or functional capacity.

Results: Results indicated that 46% of those interviewed preferred to transition whereas a smaller proportion believed in his/her own ability to transition (23%) and the feasibility of transitioning after discussing potential living arrangements and services (33%). Most who indicated that transitioning was feasible remained stable in their transition decision (79%). In 46% of cases, the screen found a preference to transition whereas the MDS did not indicate such a preference. A higher proportion of residents who were responsible for their own decision-making (65%) thought it was feasible to relocate than residents with designated proxies (35%).

Implications: Transition decisions are complex and include preference as well as one's own (resident or his/her proxy) assessment of the resident's ability and feasibility of transitioning. Compared to the MDS, we identified a higher proportion of residents who want to transition, suggesting that a systematic approach to assessing residents' preference is needed.

Key Words: custodial care, nursing facility residents, living arrangements, relocation

Assessing the Role of Preference, Ability, and Feasibility in Transition Decisions: Developing and Testing the California Nursing Facility Transition Screen

For over two decades, long-term care policy efforts have focused on developing home and community-based alternatives to institutionalization. In 1999, these efforts became a federal imperative with the Olmstead Decision, in which the Supreme Court determined that unnecessary institutionalization violates the ADA [Americans with Disabilities Act of 1990] (Williams, 2000). In response, public entities must administer programs and activities in the most integrated setting appropriate for persons with disabilities (Rosenbaum, 2000). Some states have responded by using health and social supports to: 1) divert persons at risk of nursing facility placement, 2) delay entry into the nursing facility, and 3) identify and transition nursing facility residents into community settings. Although an extensive body of literature has developed that focuses on strategies to divert and delay nursing facility placement, comparable information about transitioning long-stay residents out of nursing facilities is lacking. The purpose of the present study was to develop and test a comprehensive instrument that identifies nursing facility residents with the potential to transition by assessing their preference and self-reported ability to leave the facility.

Understanding the Preferences of Nursing Facility Residents

Although it is clear that prior to placement the vast majority of older adults wish to remain in their own homes (AARP, 2000), little is known about the extent to which long-stay nursing facility residents of any age prefer to transition to community settings or to remain in an institutional setting. Both the admission and annual assessment of the Minimum Dataset 2.0 (MDS), completed for all residents in state and federally certified nursing facilities, include one question about the resident's preference to return to the community. However, the MDS

measure, which is based on a single screening question about the resident's potential interest in returning to the community, may not be uniformly and regularly asked of every resident and does not explore the reasons and circumstances surrounding the preference. Furthermore, the MDS manual instructs assessors to use indirect questions with long-stay residents to avoid creating unrealistic expectations.

The lack of a more direct approach is defensible if those being interviewed are clear and spontaneous in expressing their intent. For example, residents admitted to the nursing facility for rehabilitation and still have housing will likely express a strong preference to return home, even if not asked directly. However, long-stay residents may not make their preference known because they may not consider transition to the community as an option. Barriers, which make transition less likely to be considered, include losing prior housing, unquestioning acceptance of life in the facility, and lack of awareness of home and community-based alternatives.

In addition to the MDS, several states and localities have developed tools to assess preference of residents to transition out of nursing facilities. The Michigan Department of Community Health developed planning tools, including open-ended interview questions that explore potential barriers, availability of friends and family to provide support, and previous experience with personal care assistants. In some states, questions about preferences are built into uniform assessments as part of an integrated system. For example, Washington's Comprehensive Assessment Reporting Evaluation (CARE) tool has an open-ended, broad assessment of client goals, which can include a nursing facility resident's preference to return to the community. The uniform assessments in both Oregon (Client Assessment and Planning System tool) and Wisconsin (Long-term Care Functional Screen) have a section in the assessment that asks about current and preferred living situations.

Some Independent Living Centers (ILC) have also developed instruments to determine the health and social service needs of persons who want to transition from the nursing facility to the community. Community Resources for Independence in Santa Rosa, California and the Austin Resource Center for Independent Living in Texas have assessments that contain several items that evaluate community living preference. In these localities, however, potential candidates have already been referred to the ILC by family members or health professionals because the resident has indicated a wish to transition home. Therefore, the focus of these assessments is on housing and service needs.

These examples demonstrate that approaches to assessing the preference of nursing facility residents have been developed. However, we are not aware of instruments that systematically assess all nursing facility residents or gather comprehensive information on both preference and self-perceived ability to relocate using standardized protocols. Rather, most measure preference to return home before an individual is admitted to the long-stay portion of the nursing facility or after the resident is identified by caregivers or family members as wanting to transition. Where instructions are included in the protocols (e.g., MDS), they allow interviewers wide flexibility in how or even if preference questions are asked. In addition, few instruments include training for interviewers, which could lead to inconsistency in obtaining responses.

Studies on the nursing facility population must distinguish between residents who enter for long-stay custodial care, many of whom are funded by Medicaid, and those admitted for short-stay Medicare-funded rehabilitation (Keeler, Kane, & Soloman, 1981, Liu & Palesch, 1981). This distinction is important because those most likely to be discharged are short-stay residents receiving Medicare-covered rehabilitation. For example, one study found that residents

with Medicare-covered stays were nearly three times more likely to be discharged than residents not covered by Medicare, whereas those relying on Medicaid were almost four times more likely to remain in the nursing facility than those whose stay was not covered by Medicaid (Chapin, Wilkinson, Rachlin, Levy, & Lindbloom, 1998). Long-stay residents are more likely to utilize Medicaid funding for custodial care and to have higher levels of impairment. Gillen, Spore, More, & Freiburger (1996) found that the longer a resident remained in the facility, the less likely he/she was to be discharged to the community. In addition, older residents and those with high levels of functional and cognitive impairment were least likely to return home.

In addition to assessing preference to leave or to remain in the facility, it is important to help residents weigh the implications of their choice. In this regard, there is some evidence that lack of awareness of what options are available influences residents' statements about preferences. For example, a study of residents in three nursing facilities who were identified by nurses as having light care needs indicated that 70% (n=20) did not want to remain in the facility but all but one believed that they had no other option (Grando, Mehr, Popejoy, Maas, Rantz, Wipketevis, et al., 2002). Lack of resources or inability to identify and access resources may present a significant barrier for long-stay residents to consider returning home (Mehr, Williams, & Fries, 1997). Related factors that may impact preference and residents' perceived ability to transition successfully include: 1) concerns about safety and the perceived risk of living in the community without 24-hour care; 2) lack of affordable and accessible housing, 3) lack of transportation needed to access services; and 4) concerns about retaining the resident's primary care physician.

To comply with the Olmstead Decision, a comprehensive transition screen is needed that can systematically assess the preferences of all long-stay nursing facility residents receiving

custodial care. The protocol should tap residents' core preference about remaining or leaving the facility. In addition to soliciting preference, the screen should evaluate the consumers' perceived ability to transition and include information to help the resident and/or the resident's family examine the feasibility of transitioning to the community. To address the lack of systematic research in this area, we report the findings from using the California Nursing Facility Transition Screen in eight nursing facilities to address the following questions: 1) What is the proportion of long-stay residents who indicate a preference and self-perceived ability to transition from the nursing facility to a community-based setting? 2) Do residents believe that transition is feasible after discussing the available community services and supports? 3) Are residents' transition decisions stable over time? 4) Does interviewing all Medi-Cal-funded (California's Medicaid program), custodial residents within the nursing facility using a comprehensive interview protocol identify a different rate of preference to return home than the MDS?

Design and Methods

The Development of the California Nursing Facility Transition Screen

The screening tool was developed by building on lessons learned from reviewing other instruments such as the MDS and preference instruments from other states and localities. We also sought input from key stakeholder groups who represented those in facility-based care such as consumer groups and groups representing persons with disabilities and older adults. Previous efforts in California to design a transition assessment protocol had been criticized by some of these key stakeholder groups for failing to adequately measure resident preferences, according to initial conversations with the California Department of Rehabilitation and Department of Health Services, who were co-sponsors of the project. Representatives argued that many people with a strong preference to live outside of the nursing facility have the ability to do so despite the

presence of objective medical problems that would appear to make community living difficult. Advocates were concerned that residents' medical characteristics were the primary or only factor that influenced transition decisions.

As a result, efforts were made to solicit extensive feedback and to pilot test the instrument. The initial screening protocol was placed on a website and representatives of a variety of stakeholder groups, identified by the California Department of Health Services, provided comments. To further solicit feedback on the instrument, an in-person meeting was held with representatives from advocacy groups, provider groups, and community agencies with interests in transition activities. Preliminary drafts of the interview were revised based on pilot tests in two southern California nursing facilities. Criteria for the screening tool were that it assessed preference from all Medi-Cal residents, included information on community supports to help the resident determine the feasibility of transitioning, was not taxing to complete, and did not create unrealistic expectations about opportunities to live outside the facility. The University of California Los Angeles Institutional Review Board approved all facets of the project.

The interview, which can be completed in about ten minutes, begins with a brief description of the project and the purpose of the interview. Participants are informed that they will be asked questions about their preferred living arrangements, but there is no guarantee that transition will result. The interview includes 27 open- and closed-ended questions that examine reasons for entering the nursing facility, preference to transition, and ability to return to the community. Finally, to ensure that respondents are aware of housing and community options before assessing the feasibility of transition, the instrument explores potential living arrangements and services needed.

Sample

The project targeted all English-speaking residents alive and residing in the nursing facility at the time of the interview. These eligible residents were receiving custodial (long-term) nursing facility care covered by Medi-Cal in eight nursing facilities in Southern California (n=178). Residents paying privately and those receiving Medicare-funded rehabilitation were excluded. Non-English speaking residents (n=4) were excluded from this pilot phase but plans are being made to accurately translate the screening tool and the protocol to accommodate other languages.

Seven facilities were affiliated with for-profit nursing facility chains and one was an independent for-profit facility. Facility inclusion criteria were 99 or more beds, freestanding facility, and a high proportion of Medi-Cal residents (75% or more). Exclusion criteria included nursing facilities that were primarily locked psychiatric facilities, those that were exclusively rehabilitation or sub-acute facilities, or facilities that served only the developmentally disabled.

Procedure

With privacy safeguards in place, each nursing facility identified residents whose stay at the nursing facility was funded by Medi-Cal and whose stay at the nursing facility was expected to be long-term. Information from each resident's face sheet was used to indicate those who could provide self-consent and those who required a proxy for health care decisions. For those who could not provide consent due to dementia or other impairments, the face sheet in the resident chart identified the legally designated proxy. It is important to note that because we did not exclude residents based on cognitive status criteria, a significant number of residents had a designated proxy for medical decisions. We were thus required to contact these proxies

telephonically since it was not known when or if the proxy would be visiting the facility in person.

Interviewers were graduate students who received four hours of training to administer the interview. Interviewers contacted residents in the facility who had the capacity to provide self-consent (n=44). Using an interview script, they notified residents of the potential option to transition to a community setting and asked if they were willing to be interviewed about their preferences regarding transition. Thirty-three residents (75.0%) agreed to participate.

For residents who had a legally designated decision-maker and could not consent to the interview themselves (n=174), a total of three attempts were made to contact the proxy via the telephone. Trained researchers used a structured telephone script to leave messages, to introduce the study to the proxies, and to obtain consent to conduct the interview. Seventy seven percent (n=134) of proxies were contacted and eighty-eight proxies (65.7%) agreed to participate. Both nursing facility residents and proxies who consented to the interview were asked to sign a Health Insurance Portability and Accountability Act of 1996 (HIPAA) consent to access the resident's MDS records. Preference information contained in the most recent full MDS (item Q1.a) were compared with the responses to the California Nursing Facility Transition Screen. Residents who preferred to transition to the community were asked to sign a release consent to share their information with the community agencies who would assist them. Twelve inter-rater reliability interviews were conducted, in which two interviewers coded participants' responses. Agreement was 100% on participants' preference to relocate. In addition, to assess stability of the transition decision, all participants who indicated that transition was feasible were re-interviewed approximately three weeks later.

Results

Securing Participation in the Study

Figure 1 illustrates the flow of residents through the study. A total of 218 Medi-Cal residents were eligible for the study in eight nursing facilities, 44 were self-consenting residents and 174 had proxies for health care decisions. Researchers were able to contact 82% of Medi-Cal residents or their proxies (n=178). Forty proxies (18.3%) could not be contacted after three attempts; some did not return researchers' messages and others did not have an answering machine. Sixty eight percent of all those contacted (n=121) consented to the interview, 33 were self-consenting residents (75.0% of all self consenters) and 88 were proxies (50.6% of all eligible proxies). Seventy-two percent of the 57 participants who did not consent to the interview provided explanations. Most cited the resident's excessive health problems as reasons for declining the interview (36.6%, n=15). Twenty nine percent (n=12) were clear that the resident was incapable of leaving the nursing facility. Other participants were not interested in the study (24.4%, n=10), were satisfied with the nursing facility (7.3%, n=3), and one was unwilling to provide personal information. The final analytic sample consisted of 33 residents and 88 proxies or 56% the original sample.

(PLACE FIGURE 1 ABOUT HERE)

Reasons for Entering the Nursing Facility

Participants were first asked: "What changes occurred in your (your relative's) life that led you (your relative) to move to the nursing facility?" All provided responses (n=154) were collapsed into categories. Fifty six percent (n=86) cited a change in medical health status as the reason for entering the nursing facility. Another 27% (n=42) indicated a change in physical

ability. A smaller number indicated the need for therapy to recover from surgery (n=8) and the need for 24-hour assistance (n=4).

Ability and Preference to Leave the Nursing Facility

Participants were first asked about their *ability* to transition with the question: “Do you think you (your relative) would be able to leave the nursing facility and live somewhere else now?” Twenty three percent (n=28) said that the resident was able to leave the nursing facility, 69% (n=84) indicated the resident was not able, and 7% (n=9) were unsure. Although there were more than two times more proxy interviews than resident interviews, only 25% (n=7) of proxies stated that the resident was able to leave the nursing facility whereas 75% (n=21) of residents responded in the affirmative ($\chi^2= 8.72, p=.013$). Most participants provided a response when asked why the resident was unable to leave the nursing facility (81.0%, n=68). The majority cited the need for a high level of care (50.0%, n=34), the inability to perform basic activities such as walking or eating (33.8%, n=23), and the risk involved with leaving the nursing facility (5.9%, n=4, e.g., risk of falling).

Participants were then asked about the resident’s *preference* to leave the nursing facility with the following question: “Would you (your relative) want to live somewhere other than the nursing facility?” Almost half of the participants (n=56, 46.3%) indicated that the resident wanted to leave the nursing facility. Forty-two participants (34.7%) said the resident did not want to leave the nursing facility, and 19% (n=23) stated that they didn’t know. A greater percentage of proxies (85.7%, n=36) than residents (14.3%, n=6) indicated that the resident did not want to leave the nursing facility ($\chi^2= 16.09, p<.0001$). To determine why participants did not want to transition, they were asked “What are some reasons you/your relative want to continue living in the nursing facility?” Thirty-four of the 42 participants who did not want to leave the nursing

facility provided responses that could be easily collapsed into three categories: 1) need for a high level of care (56%); 2) like nursing facility or staff (29% of comments); and 3) the nursing facility is the most appropriate placement (15% of comments). Twenty percent (n=24) indicated that residents both preferred to leave and were able to transition from the nursing facility.

In the third part of the interview, interviewers briefly described various community-based living arrangements and the types of support that can be provided in each setting. Participants were asked if they thought these housing and services were good options for the resident. Among those who responded “no” or “don’t know”, the interviewer asked a second question in which he/she listed specific Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) and said that assistance with these tasks could be provided to the resident. The interviewer asked if the respondent could get this help, would the respondent change his/her mind about transitioning. If the participant said “yes” or “don’t know”, the interviewer proceeded with the next section of the interview. If the respondent again said “no”, the interview was stopped. If the respondent said “yes” to the former question about living arrangements and types of support, the interviewer again listed the ADLs and IADLs, but asked if this type of assistance sounded important for the resident. The interview was stopped for respondents who said “no”. If the respondent says either “yes” or “don’t know” to this question, the interviewer proceeded with the next section of the interview (n=52).

Living Arrangements and Assistance

In the next section, interviewers further explored potential living arrangements and assistance needed with the 52 participants who indicated an interest in transitioning if needed support were available. Respondents were able to express an interest in more than one living arrangement. Thirty percent of these respondents (n=17) said that the resident had no place to go

if he/she left the nursing facility. Another 25% (n=14) said that the resident would live alone in an apartment or home. Twelve respondents said that the resident could live with other family members (21.1%) or with a partner/spouse (5.3%, n= 3). Several respondents said that the resident would be interested in an assisted living facility (7.0%, n=4) or group home (12.3%, n=7). It is important to note that the above data reflects self-reports and may not reflect what happens at the point that relocation is attempted.

To further examine the need for support and the capacity for residents to transition, interviewers asked the respondents to evaluate the resident's need for assistance with activities of daily living (ADL) and instrumental activities of daily living (IADLs). Residents or proxies reported a mean of six IADL difficulties (M = 5.6, SD=1.6). Most problematic were housework (96.1%, n=49), cooking or preparing meals (91.8%, n=45), shopping (90.4%, n=47), and transportation (90.4%, n=47). Residents had a mean of three ADLs (M=3.02, SD=1.7), with the majority needing help with bathing or showering (86.3%, n=44). The next most prevalent ADL difficulties were dressing (69.4%, n=34) and toileting (56.0%, n=28).

Feasibility of Transitioning

The interview concluded by asking the question, "If you had help available for any of these services, would you or your relative be able to leave the nursing facility?" This question is identical to the earlier question asking about the ability to transition, but after discussing the preferred living arrangements and services needed, the goal of the question was to assess whether respondents believed transitioning continued to be a *feasible* option.

Seventy-seven percent (n=40) of those who completed the entire interview believed that transitioning was a feasible option, 13% said "no" (n=7), and 10% (n=5) were unsure. Of the 40 respondents who responded that leaving the nursing facility was a feasible option, the majority

were self-consenting residents (65%) rather than proxies (35%) ($\chi^2= 8.72, p=.013$). In short, 40 respondents out of the 121 who were initially interviewed (33%) believe that transitioning was a feasible option after hearing about service and community living options.

Clarity and Motivation to Transition

After completing the interview, interviewers rated the resident's or proxy's understanding of the transition process. Among participants who indicated that transitioning was feasible (n=40), the majority of interviewers stated that residents and proxies were very clear in understanding what services were needed (77.5%), 15% were somewhat clear, 5% were neither clear or unclear, 3% were rated as "somewhat unclear", and none of the respondents were "not at all clear". Interviewers also rated the level of motivation that the resident or proxy had toward transition. Most participants (60.0%) were "very motivated" toward the transition process, 23% were "somewhat motivated", but 10% were "neither motivated nor unmotivated", and 8% were "somewhat unmotivated". None of the respondents were "not at all motivated" to transition.

Feasibility of Transitioning: Stability Over Time

Interviewers approached the 40 participants who said that transitioning was feasible approximately three weeks later. Most participants consented to a second interview (85.0%, n=34). Of the 34 who provided consent, 23 were residents and 11 were proxies. Overall, 27 participants (79.4%) responded with a stable response to transition to the community. In comparing residents and proxy responses, 74% (n= 17) of residents demonstrated stability in their transition decision versus 91% (n=10) of proxies. Among these 27 participants, 81% (16 residents, 6 proxies) completed a release form to enable researchers to refer their case to a community-based agency.

Comparison of Preference Findings with MDS Preference Question

Among the 121 residents who consented to the interview, permission was obtained to secure MDS data on 41 residents. The preference data from the California Nursing Facility Transition Screen were compared to MDS question Q1a “Resident expresses or indicates a preference to return to the community.” In 46% of cases (n=19), our interview indicated that the resident preferred to move, but the MDS indicated that the resident did not want to leave ($\chi^2 = 4.67, p = .097$). In one case, the MDS indicated that the resident had a preference to leave whereas our interview found the opposite. Twelve percent of residents (n=5) were unsure if they wanted to leave according to our interview, but the MDS was recorded as “no”. There was agreement in the remaining cases (39.0%, n=16).

Comparing Resident Characteristics

Table 1 illustrates the characteristics of residents who indicated that transitioning was feasible and those who said moving was not feasible. Although the small proportion of the sample who agreed to sign a HIPAA consent reduced the power to identify differences, it is clear that participants who thought that transitioning was feasible were less cognitively impaired and younger.

(PLACE TABLE 1 ABOUT HERE)

Discussion

This article’s main research question was: How many long-stay residents express a preference and ability to relocate if attempts are made to interview all Medi-Cal residents or their proxies using no cognitive or physical functioning exclusion criteria? Forty six percent (n=56) of respondents indicated that the resident preferred to return home. However, the question on self-

reported ability to move reduced the percentage of affirmative responses by half (23%, n=28). Many respondents may prefer transition, but at the same time, indicate reasons that transition is or may not be possible. Qualitative analyses on the reasons given by participants demonstrate that the need for a high level of care was the most prominent reason for not preferring or not being able to move. These findings suggest that residents and their proxies are sensitive to what care setting is most appropriate. Transition is a complicated decision in which the individual must weigh both the desire and capacity to relocate. Despite the preference to return to the community, the person may also have concern and anxiety over the transition home, residing in the community, and potential need to return to the nursing facility in the future.

The second research question explored the capacity of residents and proxies to assess the feasibility of transitioning after discussing potential living arrangements and service needs. This section of the interview was designed to encourage residents and proxies to think about the need for assistance with daily tasks. Forty participants stated that transitioning was feasible, a number higher than the 28 who indicated that the resident was able to move. It can be argued that these residents and proxies, who believed that transition was feasible, were most serious about transition. They may be more likely to work closely with community agencies throughout the transition process, which can involve many tasks, including securing housing and arranging for services. Some respondents may want to move and believe that they are able to leave, but a discussion of potential living arrangements and service needs was necessary to determine whether community living was possible. It helped participants to understand what assistance could be available to them before answering the final question about feasibility of transitioning.

The third research question investigated whether the respondent's perception of the feasibility of transitioning was stable over time. The majority of participants who consented to a

second interview continued to believe that transition to the community was feasible (79.4%, n=27). The instability of the remaining 20% reflects the gravity of the transition decision. This subset could be targeted for further educational or supportive efforts to understand their fears or concerns. In practice, a secondary interview may be necessary to enable residents and families to reflect on this important decision. Furthermore, the 22 of 27 participants, who completed the release form to be referred to a community agency, took a proactive step that demonstrated their commitment to transition.

The study's fourth goal was to determine whether the California Nursing Facility Transition Screen identified a different proportion of preference to transition than the MDS. The MDS assesses preference with a single item on the admission and annual assessment that is based largely on the assessor's judgment and cautions assessors against creating unrealistic expectations. With the systematic approach of interviewing all custodial residents and proxies regardless of their health condition, the screen identified a large proportion of residents who wanted to transition even though the MDS indicated a lack of preference to leave (46.3%, n=19). Although only a small proportion of participants allowed access to their medical records, this finding suggests that a direct questioning approach should be employed when ascertaining a custodial resident's preference to return home. Furthermore, it does not appear that the California Nursing Facility Transition Screen created unrealistic expectations. The responses of participants indicated that they were aware that some residents needed a high level of care or that the nursing facility setting was most appropriate.

The conclusions made in this paper are limited in several ways. First, relatively few people who did not want to relocate were willing to allow access to their medical record data. This prevented better comparison of the California Nursing Facility Transition Screen and the

MDS approach to assessing preference. Secondly, we did not conduct stability interviews with residents or proxies who said “no” to the move and there is a chance that some of these participants would later believe that transitioning was feasible. We did not repeat interviews with these participants at least partially because many proxies appeared definite in their opinion that the resident could not move and did not want further contact. Thirdly, we do not know how successful the people who were referred to community agencies will be in the transition process or the cost of this process. There is a chance the nursing facility staff are not identifying more people on the MDS for transition because of low expectations about the feasibility of this transition process. Finally, only English-speaking residents were interviewed during this pilot phase.

Despite these limitations, this pilot study represents an important first step in an area with no previous systematic research. We approached and enabled all eligible nursing facility residents to express their preferences and beliefs toward their ability to and feasibility of returning home. In addition, no presumptions were made as to which residents were good or bad candidates for transition based on their health or functional capacity. In supporting the philosophy of consumer direction and choice, the California Nursing Facility Transition Screen presents both the opportunity and means for nursing facility residents to create a different future for themselves and receive the needed resources to meet this goal. The interview identified a significant proportion of people expressing a preference to relocate, an important population according to the Olmstead principles. Despite the instability of some interview responses toward the feasibility of transitioning, the screen should be conducted with all long-stay residents independent of the MDS.

The fact that residents who were able to self-consent and who were less cognitively impaired were more likely to express a stable belief that they could transition than proxies who were answering for more impaired residents also has important policy implications. Specifically immediate efforts should be made to interview this important but relatively small group of self-consenting residents since they appear to be excellent candidates for transition. MDS item 'A9', which records the legal proxy decision-maker, could potentially be used to identify this group. The number of interviews would be smaller and it is likely that a high number of transition candidates would be identified with this effort.

The next stage of the pilot project in California is to document the transition process and to determine if the resident's or proxies' perceived feasibility of transitioning predicts their success in the community. Further research with the nursing facility MDS may determine whether there are certain conditions or levels of impairment that are more difficult to maintain in a community setting. A profile could be developed of residents who prefer to transition home versus those who do not want to transition. Policy research will determine the extent to which there are barriers that interfere with the ability to honor a resident's preference. For example, long waiting lists for services and a lack of supply make it difficult to secure affordable senior housing units. Future evaluation of processes and outcomes of the transitioning process will guide policy makers and inform advocates as states strive to facilitate consumer direction and comply with the principles of the Olmstead Decision.

References

- AARP (2000). *Fixing to Stay: A National Survey of Housing and Home Modification Issues*. Washington, D.C.: AARP.
- Chapin, R., Wilkinson, D.S., Rachlin, R., Levy, M., & Lindbloom, R. (1998). Going home: Community reentry of light care nursing facility residents age 65 and over. *Journal of Health Care Finance*, 25(2), 35-48.
- Gillen, P., Spore, D., Mor, V., & Freiburger, W. (1996). Functional and residential status transitions among nursing home residents. *Journal of Gerontology*, 51A(1), M29-M36.
- Grando, V.T., Mehr, D., Popejoy, L., Maas, M., Rantz, M., Wipketevis, D.D., & Westhoff, R. (2002). Why older adults with light care needs enter and remain in nursing homes. *Journal of Gerontological Nursing*, 28(7), 47-53.
- Keeler, E.B., Kane, R.L., & Solomon, D.H. (1981). Short- and long-term residents of nursing homes. *Medical Care*, 19(3), 363-369.
- Liu, K. & Palesch, Y. (1981). The nursing home population: Different perspectives and implications for policy. *Health Care Financing Review*, 3(2), 15-23.
- Mehr, D.R., Williams, B.C., & Fries, B.E. (1997). Predicting discharge outcomes of VA nursing home residents. *Journal of Aging and Health*, 9(2), 244-265.
- Rosenbaum, S. (2000). The Olmstead decision: Implications for state health policy. *Health Affairs*, 19(5), 228-232.
- Williams, L. (2000). Long-term care after Olmstead v. L.C.: will the potential of the ADA's integration mandate be achieved? *Journal of Contemporary Health Law Policy*, 17(1), 205-239.

Figure 1. Flow of Participants Through the Study

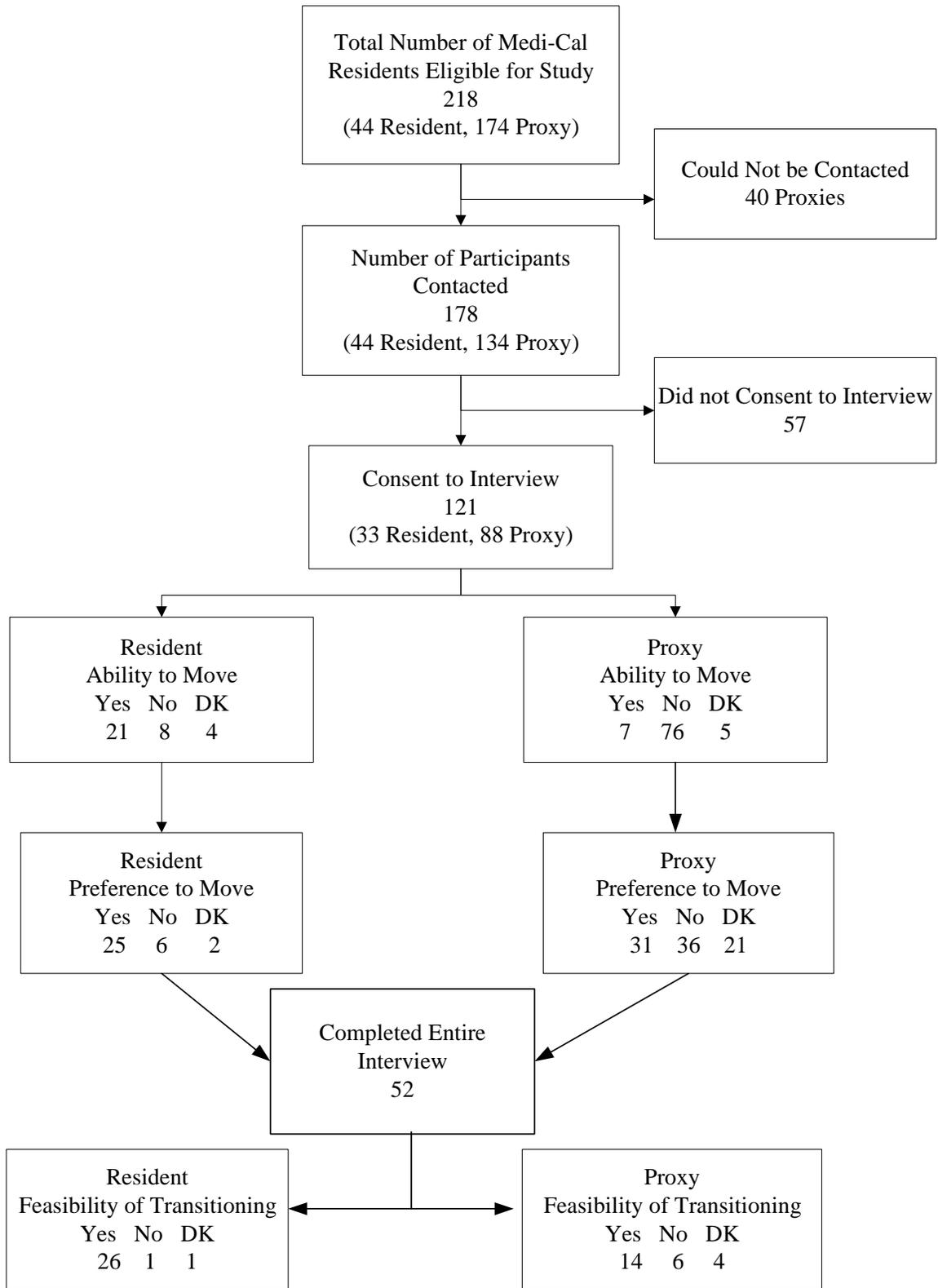


Table 1. Comparison of Participants Who Believed That Transitioning Was Feasible Versus Those Who Indicated That Transition Was Not Possible (Total N = 40)^a

	Transition is Feasible (n=30)		Transition is Not Feasible (n=10)	
	N	%	N	%
Gender				
Male	14	46.7%	2	20.0%
Female	16	53.3%	8	80.0%
Total	30	100.0%	10	100.0%
Ethnicity				
White, Not Hispanic	14	46.7%	6	60.0%
Hispanic	1	3.3%	1	10.0%
Black	10	33.3%	3	30.0%
Asian/Pacific Islander	4	13.3%	0	0.0%
American Indian/Alaskan Native	1	3.3%	0	0.0%
Total	30	100.0%	10	100.0%
Marital Status^{*b}				
Never Married	13	43.3%	1	10.0%
Married	5	16.7%	1	10.0%
Widowed	8	26.7%	2	20.0%
Divorced	4	13.3%	6	60.0%
Total	30	100.0%	10	100.0%
Cognitive Skills for Decision Making^{**}				
Independent- Decisions Consistent/Reasonable	17	56.7%	2	20.0%
Modified Independence- Some Difficulty in New Situations Only	5	16.7%	1	10.0%
Moderately Impaired- Decisions Poor, Cues or Supervision Required	8	26.7%	4	40.0%
Severely Impaired- Never/Rarely Made Decisions	0	0.0%	3	30.0%
Total	30	100.0%	10	100.0%
Memory				
Short-term Memory Problem	14	46.7%	7	70.0%
No Short-term Memory Problem	16	53.3%	3	30.0%
Total	30	100.0%	10	100.0%
Long-term Memory Problem ^{**}	8	26.7%	7	70.0%
No Long-term Memory Problem ^{**}	22	73.3%	3	30.0%
Total	30	100.0%	10	100.0%
	M	SD	M	SD
Age ^{**}	70.57	16.10	82.20	6.34
Number of Diseases/Conditions	4.67	2.71	6.00	3.33
Number of ADL Tasks in Which the Resident Needs Extensive to Total Assistance	4.60	3.27	5.20	3.08
Number of Days in the Nursing Facility	600.77	623.90	824.80	539.31

^a One person, who provided access to his/her MDS information, was excluded from this table because the participant was unsure whether transitioning was feasible or not feasible.

^b ** p<.05, *p<.10

INTERVIEWER NOTE: The purpose of this interview is to determine an individual's preference for leaving the nursing home and to begin to identify services that might be needed to live in the community. However, many nursing home residents are not aware of living alternatives or the services that may be available to assist individuals living in the community. Thus, it is essential to ensure that individuals who respond that they do not want to leave the nursing home are fully informed when making this decision. In this regard, questions 4 and 5 are designed to educate people about housing alternatives and services that might be available. All people including those that expressed an initial preference to not leave the nursing home are asked these questions. The more specific questions about housing and services (questions 6-26) are also not designed to screen people from further consideration for relocation. These questions are designed to educate people about what services and housing options might be available.

MFP Preference Interview Data Collection Tool

Subject ID #: _____ Date: ____/____/____

Interviewer ID #: _____ Start Time: _____

Hi I'm _____ from UCLA. We are doing research with the California State Department of Health and Rehabilitation. This research involves helping people who live in nursing homes move into the community to live in other places such as an assisted living facility or a group housing arrangement using the same money from MediCal that is spent for nursing home care. We are trying to determine which nursing home residents receiving MediCal would prefer to live in the community and might be able to be moved into the community. We would like to ask you some questions about where you (your relative) might want to live. The information you give us may help us determine which nursing home residents would prefer to live in the community.

Answering these questions is voluntary and refusing to answer the questions will not change the care you (your relative) receive at the nursing home. This interview will take 10 minutes. After the interview we may give (mail) you a form asking for written permission to gather some information from your medical record. The medical record information is necessary to help determine the services that might be needed by nursing home residents who might be moved into the community and to describe people who want to move out of the nursing home.

I want to be clear that the program has not started and that even if you answer these questions you (your relative) might not be able to receive the new benefit. Thinking about being able to live in the community may make you feel disappointed if you are not able to receive the new benefit.

We will not provide information to any person describing your responses to the interview that can be linked to your (your relative's) name unless you want to relocate from the nursing home and give us separate written consent to provide your contact information to the state agency responsible for helping people move from the nursing home. All information is stored by a code number in locked files.

After the interview is finished, if you have questions about any part of the interview you may contact John F. Schnelle, PhD or Barbara Bates-Jensen PhD from the UCLA Borun Center for Gerontological Research at 7150 Tampa Ave in Reseda, 91335 in writing or by phone at 818-774-3032 or 3234. If you have questions regarding your (your relatives) rights as a research subject, you may contact the Office for the Protection of Research Subjects, UCLA, Box 951694, Los Angeles, CA 90095-1694 or 310-825-8714.

Is now a good time and can I ask you some questions?

_____ NO, **STOP INTERVIEW**
_____ YES, **CONTINUE**

1. What changes occurred in your (your relative's) life that led you (your relative) to move to the nursing home?(PROMPT WITH EXAMPLES BELOW IF RESIDENT IS UNCERTAIN OR CONFUSED)

_____ 1. A change in medical health,

_____ 2. A need for therapy to recover from surgery,

_____ 3. A change in physical ability,

_____ 4. A long illness,

_____ 5. A need for help 24 hours a day,

_____ 6. Money problems,

_____ 7. Don't know, Not sure

_____ Other (LIST): _____

2. Do you think you (your relative) **would be able to** leave the nursing home and live somewhere else, now?

_____ 1. NO (GO TO Q2a),

2a. What are some reasons you (your relative) couldn't leave the nursing home?

(LIST)

1. _____

2. _____

3. _____

4. _____

(GO TO Q3)

Comments: _____

_____ 3. Don't know, Not sure (GO TO Q3)

Comments: _____

_____ 2. YES (GO TO Q3)

3. Would you (your relative) **want** to live somewhere other than the nursing home?

_____ 1. NO (Go to Q3a)

3a. What are some reasons you (your relative) want to continue living in the nursing home? (LIST)

1. _____

2. _____

3. _____

4. _____

(GO TO Q4)

_____ 3. Don't know, Not sure (GO TO Q4)

Comments: _____

_____ 2. YES (GO TO Q4)

4. There are options for living outside the nursing home. You (your relative) could live in your (their) own home or (a senior) apartment with help from in home supportive services, personal care assistants, community meals, and special activities; you (your relative) could live in an assisted living facility, which provides meals, housekeeping, some light personal assistance, and special activities; or you (your

relative) could live with 3 to 6 other people in a group home which provides meals, housekeeping, and in home supportive services and personal care assistants. Do you think any of these would be good for your relative?

- NO, (Go to Q5)
- YES, (Go to Q5)
- Don't Know, Not Sure, (Go to Q5)

5. I am going to list some services that you (your relative) might be able to get. You (your relative) could get help with: getting out of bed, bathing, eating, toileting, getting dressed, walking, using the phone, shopping, preparing meals, housekeeping, taking medications, transportation, managing money. Would it be feasible for you (your relative) to live outside the nursing home with these services?

NO,

STOP INTERVIEW, GET HIPAA CONSENT SIGNED (TELL FAMILY MEMBERS THIS WILL BE MAILED TO THEM). Would you allow us to talk with your relative? NO YES

Thank you for taking the time to answer these questions

- YES, (Go to Q6)
- Don't Know, Not Sure, (Go to Q6)

6. Where would you (your relative) live and with whom?

- Apartment or home alone
- Apartment or home with family
- Apartment or home with spouse or partner
- Assisted living facility
- Group home
- No place to go

- a. Are you willing to live in a group home with 3 to 6 other people?
- b. Are you willing to live in an assisted living facility?
- c. Are you willing to live in a senior apartment?

Now I'm going to list the services that might help you (your relative) live outside the nursing home. Listen to them and tell me if you need the service.

- 7. Help getting out of bed and into a chair? NO (7),
 YES (7),
- 8. Help getting started to eat? For example, cutting up your food, or getting your silverware at meal times?
 NO (8),
 YES (8),
- 9. Help eating? For example, someone to feed you? NO (9),

- _____ YES (9),
 _____ NO (10),
 _____ YES (10),
10. Help turning or moving in bed?
- _____ NO (11),
 _____ YES (11),
11. Help getting to the toilet?
- a. _____ Wears adult briefs or pads
 _____ NO (11a),
 _____ YES (11a),
12. About how many times during the day do you think you need help getting to the toilet OR changing your adult brief/pad? _____
13. Help with morning care like brushing your teeth, washing your face, brushing your hair, or putting on your deodorant?
 _____ NO (13),
 _____ YES (13),
14. Help with bathing or taking a shower?
 _____ NO (14),
 _____ YES (14),
15. Help walking inside?
 _____ NO (15),
 _____ YES (15),
16. Help walking outside?
 _____ NO (16),
 _____ YES (16),
17. What kind of help do you need?
 _____ Cane
 _____ Walker
 _____ Safety rails on walls
 _____ Wheelchair
- a. If Wheelchair, do you need help getting around in your wheelchair **inside**?
 _____ NO (17a),
 _____ YES (17a),
- b. If Wheelchair, do you need help getting around in your wheelchair **outside**?
 _____ NO (17b),
 _____ YES (17b),
18. Help getting dressed in the morning?
 _____ NO (18),
 _____ YES (18),
- a. If YES, what do you need help with
 _____ Shoes/socks
 _____ Shirt/dress
 _____ Pants

19. Help getting undressed at night? _____ NO (19),
_____ YES (19),

a. If YES, what do you need help with

_____Shoes/socks

_____Shirt/dress

_____Pants

20. Help using the telephone? _____ NO (20),
_____ YES (20),

a. YES, Do you need

_____Volume increased, can't hear

_____Large numbers, can't see to dial

_____Dialing assistance, can't dial

21. Help cooking or preparing your meals? _____ NO (21),
_____ YES (21),

22. Help with medications? _____ NO (22),
_____ YES (22),

23. Help with housework? _____ NO (23),
_____ YES (23),

a. If YES, what do you need help with

_____Laundry

_____Washing dishes

_____Cleaning house

24. Help shopping? _____ NO (24),
_____ YES (24),

25. Help with transportation? _____ NO (25),
_____ YES (25),

26. Help managing your money or finances? _____ NO (26),
_____ YES (26),

a. If YES, do you need help with

_____Paying your bills

_____Balancing your check book

_____Tracking your bank accounts

27. If you had help available for any of these services, would you (your relative) **be able to** leave the nursing home?

_____ NO (27)

_____ YES (27)

STOP INTERVIEW, GET HIPAA CONSENT SIGNED (TELL FAMILY MEMBERS THIS WILL BE MAILED TO THEM). Would you allow us to talk with your relative? _____NO _____YES

Thank you so much for taking the time to answer these questions. We want to be sure you understand that answering these questions does NOT mean that you will be relocated out of the nursing home. We don't want to create false hope about moving. We are only getting information on nursing home residents who would prefer to live some place other than the nursing home.

OFFER FOLLOW UP WITH OMBUDSMAN, INDEPENDENT LIVING CENTER, AND/OR RESEARCHER.

For interviewee to fill out:

28. How clear is the person in terms of what services are needed?

_____ 1-Not at all clear

_____ 2-Somewhat clear

_____ 3-Neither clear nor unclear

_____ 4-Somewhat clear

_____ 5-Very clear

29. How motivated is the person to relocate?

_____ 1-Not at all motivated

_____ 2-Somewhat unmotivated

_____ 3-Neither motivated nor unmotivated

_____ 4-Somewhat motivated

_____ 5-Very motivated

End Tim: _____

Appendix #3
Quality Management Strategy from
NF A/H Waiver

Appendix H: Quality Management Strategy
 HCBS Waiver Application Version 3.3 – October 2005

H4: Compilation and Communication of Quality Management Strategy

CDHS/IHO' quality management reports are designed as Administrative Management Reports. The following identify the major reports, the topic, frequency, and the recipient(s) of the report.

Name of Report	Topic	Frequency	Recipient(s) of Report
Waiting List	List of applicants awaiting a slot on the NF/AH Waiver.	Monthly	CDHS/IHO Management
Waiver Summary	Number of participants enrolled in the waiver and number of applicants assigned to the IHO Intake Unit and being assessed for enrollment.	Monthly	CDHS/IHO Management
Intake greater than 6 months	List of applicants who have been assigned to the IHO Intake Unit for more than 6 months	Monthly	CDHS/IHO Management
Home Visit Overdue	List of participants whose re-evaluation visit is over due by 30 days or more	Monthly, Quarterly, Annually	Supervisors, CDHS/IHO Management
Provider Visit Overdue	Annual Provider visit is overdue by 30 days or more	Monthly, Quarterly, Annually	Supervisors, CDHS/IHO Management
Event/Issue Report	By issue, amount of time to resolve, and participant satisfaction	Bi-annual, Annually	CDHS/IHO Management
State Fair Hearing Report	By issue and outcomes	Annually	CDHS/IHO Management
Outreach Activities	List of outreach activities, who attended, and average evaluation scores.	Annually	CDHS/IHO Management

In 2008, CDHS/IHO will evaluate the ability to post the results and remediation actions from the Annual Case Record and Provider Visits Reviews on the CDHS website. In 2009, CDHS/IHO will have the ability to post the results and remediation actions from the Participant and Provider Surveys on the website.

H5: Periodic Evaluation and Revision of Quality Management Strategy

The QMU and participants of the Case Record and Provider Visit Review conduct a post-review evaluation of the review process and evaluation tools. Based upon the evaluation, the Case Record, Provider Visit Review Tools and instructions may be revised to remove items that have a history of significant compliance and add new items which have been identified as a potential issue or problem, and modify policies and procedures for how a specific issue is reviewed. CDHS/IHO will conduct a post-review of the implementation of the Provider Satisfaction Survey in the third quarter of 2009, the Participant Satisfaction Survey in the fourth quarter of 2008 and the Claims Quality Management Strategy in the first quarter of 2008. Changes to any of the above processes will be described in the annual CMS 373 Q report.

In-Home Operations' (IHO) Quality Management Strategy is to develop and implement discovery tools and methods to evaluate California Department of Health Services (CDHS)/IHO' effectiveness in compliance with the waiver assurances and CDHS/IHO policies and procedures. As a result of discovery activities, CDHS/IHO will develop, implement, and evaluate remediation actions to enhance, correct, and/or improve CDHS/IHO' compliance. The CDHS/IHO Quality Management Unit (QMU)

State:	California
Effective Date:	January 1, 2007

Attachment #1 to Appendix H: 11

is responsible for developing discovery activities, collecting, and analyzing the data from the discovery activities. The staff of the QMU includes: a research analyst, waiver analysts, an eligibility analyst, an information system analyst, and licensed medical professionals. The CDHS/IHO Section Chief, Managers, Nurse Evaluator (NE) Supervisors, and QMU are responsible for the development, implementation, and evaluation of remediation actions. The QMU utilizes the following tools for discovery:

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

The CMIS is a new database developed and implemented in 2005. During 2006, CDHS/IHO will begin using information from CMIS to establish new quality indicators that will help determine if changes need to be made to the waiver enrollment criteria, services, providers, or any other aspect of waiver administration. CMIS program can provide data on how potential participants are referred to the waiver, how many referrals are received, document the timeliness of the referral, evaluation, and enrollment process, captures data on applicants who are placed on the wait list, and track the reasons active waiver cases are closed. CMIS will also allow CDHS/IHO to document the utilization and cost of Home and Community-Based Services Personal Care (HCBSPC) benefit as well as track Notice of Action (NOA) and capture the number of requests for state hearings along with the outcomes of those hearings.

The QMU and the CDHS/IHO Medical Consultant, who is 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 QMU will randomly select a sample of case records with a 95% level of confidence with a 5% interval for the entire waiver population. The waiver population includes all waiver participants that were open to the waiver anytime during the selected waiver year. Using the identified sample size indicated by the Sample Size Calculator, the QMU will select the cases for review based upon the corresponding percentage of participants at each level of care (LOC) by CDHS/IHO field office location and will ensure that all CDHS/ IHO NE staff are represented in the cases selected for review. The Case Record Review uses a Record Review Tool designed to document the following:

Evidence of the accuracy of LOC evaluation;

- The participant, and/or his/her legal representative(s), and/or circle of support, which includes individuals identified by the participant, and their involvement in the development of the Plan of Treatment (POT);
- The POT appropriately addresses all of the participant's identified needs' and assures participant's health and welfare;
- The participant, and/or his/her legal representative(s), and circle of support's knowledge of issues concerning abuse, neglect, and exploitation and how to report them;
- The POT reflects that all the participant's services are planned and implemented in accordance with their unique needs, expressed preferences and decisions, personal goals, abilities, and health status in mind;
- Information and support is available to help the participant, and/or his/her legal

State:	California
Effective Date:	January 1, 2007

representative(s) and/or circle of support to make selections among service options and providers;

- The design of the participant’s home and community-based program is cost neutral;
- POT addresses the need for HCBS healthcare and other services; and
- The CDHS/IHO NEs level of compliance with CDHS/IHO’ policies and procedures in the completion and maintenance of the waiver participant’s case report.

The annual Case Record Review also uses the Record Review Tool to document compliance with the assurances provided in the NF/AH Waiver and CDHS/IHO’ policies and procedures for annual provider visits conducted by the CDHS/IHO NEs. The Provider Visit Review is conducted on each provider for those participants selected for the annual Case Record Review. The Provider Visit Overdue report is used to track annual provider visits that are 30 days overdue. The Provider Visit Review discovers if the CDHS/IHO staff conducts timely provider visits, ensures providers meet the waiver licensing and certification requirements, provides written feedback to the provider following a provider visit, notifies appropriate agencies of provider issues that effect the health and safety of the waiver participant, and documents that the provider has received HCBS waiver training.

CDHS/IHO Event/Issue database captures the type and number of events and issues that affect or can affect the health and safety of the waiver participant, the timeliness of the reporting, and the participant’s and/or his/her legal representative(s), and circle of support’s satisfaction with the outcome of the action plan for the reported issue or event. Reports are developed bi-annually and annually and evaluated for possible remediation actions.

The CA-MMIS and CMIPS databases are used to run utilization and expenditure reports to document that CDHS/IHO is meeting the waiver’s cost assurances. CDHS/IHO annually submits a list of participants who were active on the waiver for the reporting year to the CDHS claims data-reporting contractor, Thomson/MedStat. Thomson/MedStat is responsible for running utilization and expenditure reports for waiver participants and peer groups and providing this data to the CDHS Medi-Cal Policy Division (MCPD), Waiver Analysis Section (WAS), and CDHS/IHO for analysis.

Using these tools, CDHS/IHO will be able to collect and analyze data for trends and patterns of populations served and make changes to policy, procedures, and resources based on that analysis. This information will be used to plan for future outreach activities. CDHS/IHO can then develop any needed remedial actions deemed necessary to provide the best service to the HCBS waiver population while assuring compliance with waiver assurances as well as CDHS/IHO polices and procedures.

H.1.a: Level of Care (LOC) Determination

LOC determinations are conducted for all applicants and enrolled participants utilizing the tools, procedures, and processes described in Appendix B-6. The QMU utilizes the CMIS and the Case Record Review to monitor the timeliness and accuracy of the LOC initial and re-evaluations determinations. The CMIS captures the data documenting:

- CDHS/IHO *received* the HCBS Waiver Application;
- CDHS/IHO *reviewed* the HCBS Waiver Application;
- The applicant was referred to the IHO Intake Unit for an initial visit and evaluation;
- The applicant was enrolled in the NF/AH Waiver; and
- When the next re-evaluation visit is due, based upon the level of case management.

The annual Quality Assurance Case Record Review conducted by the QMU staff and the CDHS/IHO Medical Consultant evaluates the accuracy of the LOC determination based on the information documented in the participant’s case report.

State:	California
Effective Date:	January 1, 2007

In 2006, the QMU will use CMIS to conduct discovery activities on 100% of case records to establish time frame standards for initiation of HCBS waiver services. The number of days between receipt and review of the HBCS Application, the number of days between review and assignment to the Intake Unit, and the number of days from assignment to the Intake Unit and the initial visit by the Intake Unit CDHS/IHO NE will be captured and analyzed. The data from 2006 will be presented to the CDHS/IHO management team in the first quarter of 2007 to be used to establish time frame standards for these activities. In the second quarter of 2007, a written policy and procedure document will be developed by the QMU, distributed to the Intake Unit by the Intake Supervisors along with training on the standards. The QMU will develop monthly reports monitoring the timeliness of these activities and provide quarterly analysis to the CDHS/IHO Section Chief and Managers beginning the third quarter of 2007. The CDHS/IHO Section Chief, Managers, and QMU will use these reports to develop remediation activities as needed. Results of the discovery and remediation activities will be reported in the Centers for Medicare & Medicaid Services (CMS) 373 Q report.

Initial LOC evaluations are conducted as described in Appendix B. The IHO Intake Unit is responsible for the initial LOC evaluation and determination. The IHO Intake Unit staff consists of registered nurses (RN), identified as CDHS/IHO NEs and their Supervisor who is also a RN. The CDHS/IHO NE must submit evidence of the evaluation visit and documentation of the LOC determination to the IHO Intake Supervisor for the applicant to be enrolled in the waiver. Only the IHO Intake Supervisor and the QMU has permissions to enter the enrollment information in CMIS. The CMIS has an edit that will not allow the applicant to be enrolled in the waiver unless the date of the evaluation visit has been entered. Enrollment is documented by entering the date the applicant was determined to be eligible for the waiver and their LOC is selected.

The QMU will run monthly reports identifying the home visit date, enrollment date and LOC determinations for all cases opened for that month. A quarterly and annual report and analyses will be provided to the CDHS/IHO Section Chief, Managers and Supervisors, here after referred to, as CDHS/IHO Management Team. Based upon the report, remediation actions will be developed by the CDHS/IHO Management Team and QMU. The QMU and Supervisors will provide training to the CDHS/IHO NEs on the remediation activities. The QMU will conduct monthly follow-up discovery activities to determine the effectiveness of the remediation actions and ensure understandability and user-friendly assistance is available.

Re-evaluations of LOC determinations are conducted as described in Appendix B. The Case Management Units are responsible for conducting timely LOC re-evaluations. The Case Management Units consist of RNs, identified as CMs, and their Supervisors who are also RNs. QMU uses the CMIS to discover the timeliness of the reevaluation LOC determinations using the Home Visit Over Due Report. This report calculates the date of the next LOC re-evaluation based upon the date of the last LOC evaluation and the participant's level of case management. The QMU runs a monthly report that identifies participants who have not had their LOC re-evaluation completed within 30 days of the calculated date. These reports are provided to the CDHS/IHO Management Team for the development of remediation activities to ensure regular, systematic, and objective methods are used to monitor a participant's well being and health status. The QMU provides a quarterly and annual report and analysis of the timeliness of the re-evaluation visits to the CDHS/IHO Management Team. Remediation actions will be developed based upon the level of compliance. The QMU and Supervisors will provide training to CMs. The QMU will conduct monthly follow-up discovery activities to determine the effectiveness of the remediation actions.

The QMU and CDHS/IHO Medical Consultant conduct the annual Case Record Review on a sample of participants who were enrolled in the waiver during the reporting waiver year. The QMU uses the Sample Size Calculator as previously described to determine the number cases for review. The cases selected for review will reflect the percentage of cases for each LOC in the waiver, percentage of cases

State:	California
Effective Date:	January 1, 2007

per CDHS/IHO field office and ensure cases from all CDHS/IHO NEs are represented. The CDHS/IHO NE use a case report form to document their observations, actions, and information obtained during the participant's initial and re-evaluation visit. The CDHS/IHO NE document the participant's medical care needs and the justification of the LOC determination in the case report and use the criteria and regulations cited in the waiver in making the LOC determinations. It is CDHS/IHO' policy that the Supervisor reviews all case reports. Once the Supervisor has determined the case report is complete and is in agreement with the LOC determination, the Supervisor signs and dates the case report. If the Supervisor and CDHS/IHO NE are not in agreement with the LOC determination, the case report is reviewed by the CDHS/IHO Medical Consultant. The CDHS/IHO Medical Consultant's LOC determination is final and documented in the case report.

The annual Case Record Review is used to discover the CDHS/IHO NE level of compliance with completing the case report and if the LOC determinations are in compliance with the NF/AH waiver facility alternatives. Within 90 days of the review, the QMU will present an analysis of the findings to the CDHS/IHO Management Team. Based upon the findings and level of compliance, remediation actions will be developed and implemented by the CDHS/IHO Managers, CDHS/IHO Medical Consultant, Supervisors, and QMU within 90 days to develop procedures to ensure participant safeguards. Effectiveness of the remediation actions will be monitored by the CDHS/IHO Medical Consultant and Supervisors and re-evaluated at the next year's annual Case Record Review.

H.1.b: Service Plan

During the annual Case Record Review, the QMU uses the Record Review Tool to discover if the participant has a service plan, hereafter referred to as the POT, which is current in accordance with the standards described in Appendix B-7.

At the annual Case Record Review, the case report is evaluated for documentation by the CDHS/IHO NE to show that:

- The participant and/or his/her legal representative(s) and/or their circle of support exercise a high degree of involvement in the identification, development, and management of services and supports that meets the participant's needs;
- The services are delivered as described in the POT;
- The POT is modified to meet changing circumstances;
- The participant and/or his/her legal representative(s), and/or circle of support was informed of all the services and provider types available, and,
- If the POT did not reflect the participant's needs or was not observed to be successful, what corrective actions were taken and the result of the actions.

The annual Case Record Review looks for evidence in the case record for:

- Freedom of Choice document signed by the participant and/or his/her legal representative(s) stating they were informed of the choice of receiving care in their home and community in lieu of facility care;
- Copies of Informing Notices sent to the participant and/or his/her legal representative(s), current provider(s) and the current physician overseeing the home program;
- Current Menu of Health Services (MOHS), which lists all waiver services and provider types and identifies the services and providers the participant or legal representative has selected; and
- All the services identified on the MOHS are described on the participant's POT.
- Within 90 days of the review, the QMU will present an analysis of the findings to the CDHS/IHO Management Team. The analysis will include an evaluation of the waiver's impact to the participant's health and welfare and identify any risks to the participant and how

State:	California
Effective Date:	January 1, 2007

those risks will be managed. Based upon these findings and level of compliance, remediation actions will be developed and implemented by the CDHS/IHO Managers, Supervisors, and QMU within 90 days. Effectiveness of the remediation actions are measured during the following year's annual Case Record Review.

H.1.c: Qualified Providers

The annual Case Record Review, conducted by the QMU, uses the Record Review Tool to discover evidence in the case record that the waiver providers were licensed and/or certified at the start of service, continue to have a current and active license and/or certification, and that they initially and continue to meet the waiver provider requirements as described in Appendix C-3. The evidence includes copies of professional licenses, State and Medi-Cal certification, copies of current basic life support certification, and documentation of education and work experience as described in the NF/AH Waiver's Standards of Participation (SOP). The Record Review Tool is designed to determine if the provider received an annual visit by CDHS/IHO staff, if the participant's chart maintained by the provider is current, if the provider is rendering the care as described on the participant's POT, and if the CM has evaluated the provider for any training needs and actions rendered as a result of the evaluation.

The Record Review Tool is used to document evidence the HCBSPC benefit provider, who is a non-licensed/non-certified individual who initially and continues to meet the CDHS/IHO NF/AH Waiver personal care provider requirements. Evidence includes documentation for each provider of enrollment in the county's In-Home Supportive Services (IHSS) Personal Care Services program, and a copy of each provider's Driver's License, Social Security Card, and signature.

During the annual Case Record Review, the QMU runs a report from CMIS identifying all the participant's HCBS Waiver providers to ensure providers are available and have the skills, competencies, and qualifications to support the participant effectively. This report is used to discover if the CDHS/IHO NE have obtained the required documentation for all of the participant's HCBS waiver providers.

Within 90 days of the review, the QMU will present an analysis of the findings to the CDHS/IHO Management Team. Based upon the findings and level of compliance, remediation actions will be developed and implemented by the CDHS/IHO Managers, Supervisors, and QMU within 90 days. Effectiveness of the remediation actions will be re-evaluated at the next year's annual Case Record Review.

In 2008, CDHS/IHO will begin development of a Provider Satisfaction Survey. The survey is a mechanism to secure feedback from providers, to evaluate the provider's satisfaction of being a NF/AH Waiver provider, the effectiveness of the NF/AH Waiver services in supporting the participant's choice to receive care in his/her home and community in lieu of care in a facility, and solicit suggestions for improving the NF/AH Waiver and/or processes. The goal will be to conduct a survey in 2009.

The timeline for this action is as follows:

- 01/01/08-04/30/08 Conduct research on the Provider Satisfaction Surveys and select a model.
- 05/01/08-07/31/08 Develop a survey, instructions and evaluation criteria. Have the appropriate Branch managers review and approve the survey and instructions.
- 08/01/08-10/30/08 Ask a small sample number of providers to review the survey and provide feedback.
- 11/01/08-12/31/08 Make changes to the survey and instructions based upon the provider's feedback.
- 02/01/09-03/15/09 Issue and collect the survey by mail with possible follow-up by CDHS/IHO NE staff to help ensure a reasonable percentage of input by providers.
- 03/16/09-04/30/09 Analyze and evaluate the results of the survey by provider type and present

State:	California
Effective Date:	January 1, 2007

05/01/09 recommendations to CDHS/IHO Management Team. Provide results and recommendations to the providers and solicit their input.
 Develop and implement a remediation plan based upon all input. Determine frequency of future Provider Satisfaction Surveys.

H.1.d: Health and Safety

CDHS/IHO' staff is responsible for completion of an Event/Issue Report when they either discover or receive information of an event or issue that affects or can affect the health and safety of a participant. The Event/Issue Reports are sent to the QMU. The following information is entered into the Event/Issue Database:

- Date the event/issue was discovered or reported;
- Date the event/issue occurred;
- Type of event/issues (i.e. staffing, medication, equipment, abuse, neglect, exploitation);
- Date the event/issue was resolved; and
- Participant, legal representative, and/or circle of support 's satisfaction with the outcome.

The data is analyzed and monitored for ongoing concerns of affected participants, documentation of the interventions, timeliness of the actions, and participant, legal representative, and/or circle of support's satisfaction. The results of the analysis are presented semi-annually, annually or as needed to the CDHS/IHO Management Team. The CDHS/IHO Management Team will determine what changes in training, education, policies and/or procedures need to be made to protect the health and safety of the waiver's participants. Evidence of the effectiveness of the changes will be discovered through the annual Case Record Review.

The annual Case Record Review conducted by the QMU uses the Record Review Tool to document the evidence in the case record and the Provider Visit Report of the CDHS/IHO NEs evaluation of the participant's health and safety. The case record and Provider Visit Report prompt the CDHS/IHO NE to interview the participant, legal representative, and/or circle of support about any occurrence of unscheduled hospitalizations, emergency room visits, issues with medications, or any situation that could endanger the participant and document the outcome of these events. The annual Case Record Review looks for evidence that the CDHS/IHO NE have documented their observations of any issues concerning the participant's health care needs such as the need for medications to be managed efficiently and appropriately and notes that safeguards are in place to protect the participant from life endangering situations or conditions of abuse, neglect and/or exploitation. The annual report identifies risk factors and monitors the completion and submission to the QMU of an Event/Issue Report when issues concerning health and safety are identified in the case record or Provider Visit Report so modifications can be offered to promote participant independence and safety.

Within 90 days of the review, the QMU will present an analysis of the findings from the Case Record Review to the CDHS/IHO Management Team. Based upon the findings and level of compliance, remediation actions will be developed and implemented by the CDHS/IHO Managers, Supervisors, and QMU within 90 days. Effectiveness of the remediation actions will be re-evaluated at the next annual Case Record Review to assess health risk and safety safeguards.

In 2007, CDHS/IHO will begin development of a Participant Satisfaction Survey. The goal is to improve access to services and reduce unmet needs while allowing more person centered participation. The survey will allow the participant and/or legal representative to provide feedback to CDHS/IHO anonymously on his/her satisfaction with the services and providers available through the waiver, identify issues that effect their health and safety, inform CDHS/IHO of his/her satisfaction or dissatisfaction with the CDHS/IHO staff, and solicit suggestions for improving the waiver and/or

State:	California
Effective Date:	January 1, 2007

processes. The goal will be to conduct a survey in 2008.

The timeline for this action is as follows:

- 01/01/07-04/30/07 Conduct research on the Participant Satisfaction Surveys and select a model.
- 05/01/07-07/31/07 Develop a survey, instructions and evaluation criteria. Test the survey readability and have it reviewed and approved by the appropriate CDHS/IHO Management Team.
- 08/01/07-10/30/07 Ask a small sample number of participants and legal representatives to review the survey and provide feedback.
- 11/01/07-12/31/07 Make changes to the survey and instructions based upon the participants and legal representatives' feedback. Develop a policy and procedures to ensure anonymity of participant.
- 02/01/08-03/15/08 Conduct survey and compile responses.
- 03/16/08-04/30/08 Analyze and evaluate the results of the survey regarding the level of participant satisfaction in how the waiver is administered. Present recommendations to CDHS/IHO Management Team. Provide results and recommendations to the participants and solicit their input.
- 05/01/08 Develop and implement a remediation plan based upon all input. Determine frequency of future participant surveys.

H.1.e: Administrative Authority

CDHS/IHO has sole responsibility for the administration and oversight of who is eligible for the NF/AH Waiver, the effectiveness of the participant's POT, the authorization of waiver services, the enrollment of waiver providers, and the monitoring of the participant's health and safety. The effectiveness of administration and oversight activities is discovered through the quality management strategy previously described in this Appendix.

The annual Case Record Review looks for evidence of issuance of a NOA to the participant or legal representative when the participant has lost Medi-Cal eligibility, CDHS/IHO has determined the participant no longer meets the waiver's LOC, there is a change in the participant's LOC resulting in a reduction in waiver services, or the participant does not meet the enrollment requirements as described in this waiver. The NOA provides the participant and legal representative with information as to their right to appeal CDHS/IHO' decision.

CDHS/IHO has developed a database that tracks State Fair Hearing requests, the basis of the hearing, and the outcome. The QMU will annually perform an analysis of the data. The analysis will look for trends and outcomes of the hearings that may indicate a need for changes within program policy and procedures. The information will be presented to the CDHS/IHO Management Team. Based upon the need, remediation actions will be developed and implemented by the QMU and Supervisors. Effectiveness of the remediation actions will be re-evaluated at the next Annual Review.

H.1.f: Financial Accountability

The QMU currently conducts ad hoc discovery activities based upon a provider's complaint of non-payment and the suspicion of fraud. The QMU will access either the Surveillance or Utilization Review Subsystem (SURS) or the CMIPS to obtain evidence that a claim was submitted by an NF/AH waiver provider for prior authorization of NF/AH Waiver services and was reimbursed at the established rate for the service. The evidence is submitted to the CDHS/IHO Management Team to determine what, if any, further action maybe required. For issues concerning fraud, the QMU will notify the CDHS' Audit and Investigations (A&I) Branch. For issues concerning non-payment for all

State:	California
Effective Date:	January 1, 2007

Attachment #1 to Appendix H: 18

but waiver personal care services, the QMU, CDHS/IHO NE, Supervisors or Managers will assist the provider in resolving the issues concerning the authorization of services. For issues beyond CDHS/IHO' ability to remedy, the provider will be referred to the Electronic Data System (EDS) Help Desk, and/or CDHS' Med-Cal Payment Systems Division. For non-payment of CDHS/IHO authorized HCBSPC benefit services, the provider will be referred to the Department of Social Services' IHSS program.

In 2007, CDHS/IHO will begin development of a Claims Quality Management strategy for reviewing NF/AH Waiver claims. The quality management strategy will include the following elements:

- Determining the sample size of claims to be reviewed;
- Establish processes for accessing the claims data in SURS and CMIPS;
- Determine if the provider submitting the claim is a qualified NF/AH Waiver provider.
- Determine if the reimbursement rate matches the established rate for the service, as noted in the Medi-Cal Provider Manual or CMIPS; and
- Determine if the services were prior authorized in:
 - CA-MMIS,
 - Service Utilization Review Guidance and Evaluation (SURGE), or
 - CMIPS

The QMU will conduct the review annually and provide the CDHS/IHO Management Team with the results within 90 days of the completion of the review. Based upon the results and the level of compliance, the CDHS/IHO Managers and Supervisors will develop and implement remediation activities within 90 days. Effectiveness of the remediation actions will be measured at the next year's annual review.

The timeline for this action is as follows:

- 01/01/07-03/31/07 Conduct research on other claims discovery processes.
- 04/01/07-06/30/07 Develop a Claims Review Tool. Conduct a test of the review tool to determine if the tool captures the information needed to determine if the claims are paid accurately and to an approved HCBS Waiver provider.
- 07/01/07-09/30/07 Make changes to the Claims Review Tool based upon the test.
 Determine the average number of NF/AH Waiver claims processed over 2 years and determine a sample size of claims to be reviewed.
- 10/01/07-10/30/07 Conduct a review on the representative sample of claims.
- 11/01/07-12/15/07 Complete an analysis of the review and present recommendations to the CDHS/IHO Management Team.
- 01/02/08-03/01/08 Develop and implement remediation actions as needed based upon the results of the review.
- 09/2008 Implement the annual Claims Review.

H2: Roles and Responsibilities

The QMU is responsible for the measurement of performance, providing analysis when performance falls below the established Levels of Compliance, as described below, and the presentation of recommendations for remediation and improvement to CDHS/IHO' Management Team. In evaluating performance that falls below the established standards, the QMU will determine the cause of the problem or lack of documentation through interviews with the CDHS/IHO NE who are responsible for evaluating the participant's LOC, overseeing the POT to ensure it meets the participant's medical care

State:	California
Effective Date:	January 1, 2007

Appendix H: Quality Management Strategy
 HCBS Waiver Application Version 3.3 – October 2005

needs, reporting issues that affect the health and safety of the participants, and ensuring the waiver providers meet the NF/AH Waiver's requirement. The Supervisors are also interviewed, as they are responsible for approving the LOC determinations and evaluating the documentation on the Case Report and Provider Visit Reports for completeness. The results of the interviews will be provided to the CDHS/IHO Management Team for the development of remedial actions. Based upon the need, remediation actions will be developed and implemented by the QMU and Management Team.

The QMU Nurse Consultant conducts weekly meetings to review State Fair Hearings requests that have been filed. The purpose of the meeting is to discuss the cases to ensure all efforts have been made to resolve the issue prior to going to the hearing, to ensure the participant and/or legal representative are aware of the fair hearing process and their rights, and review any decisions rendered by the Administrative Law Judge (ALJ) at previous hearings. Attendees include the QMU Nurse Consultant, the CDHS/IHO Medical Consultant, Nursing Supervisors, and the CDHS/IHO NE who will be representing the CDHS at the State Fair Hearing. Lessons learned are shared with staff at the weekly CDHS/IHO Managers and Supervisors meeting and the weekly CDHS/IHO NE meetings. Information from these meetings can lead to process and procedure changes and/or updates to CDHS/IHO policies.

The Managers and Supervisors are responsible for conducting CDHS/IHO NE staff meetings. These meetings occur weekly or bi-monthly depending on workload. The purpose of these meeting is to share information and provide training to the CDHS/IHO NEs. Some of the topics include: new or updated policies and procedures, a discussion of issues that affect the health and safety of waiver participants, presentation of case studies, new CMS and CDHS policies, legislation that can affect the waiver or our participants, and results of QMU activities.

CDHS/IHO conducts annual statewide meetings, as the budget permits, to provide training and updates to all CDHS/IHO staff. Based on areas of need identified by QMU reviews and requests by CDHS/IHO staff, CDHS/IHO locates speakers, identified by CDHS as leaders in their field of expertise, to provide training during these meetings. These training sessions could include such varied subjects as dealing with provider billing issues, elder and dependent abuse in the home setting, or communication issues. Evaluations are collected to determine if the training goals and objectives have been met. The meeting's minutes will also be reviewed annually by the QMU and a summary of identified issues, remedial actions and follow-up activities will be described in the annual CMS 373 Q report.

The QMU works with Thomson/MedStat, CDHS contractor for cost reports. The QMU provides Thomson/MedStat with the participant's identification number and service identifiers for cost reports for HCBS and State Plan services. Thomson/MedStat will also run cost reports on Medi-Cal beneficiaries who are receiving long term care in a NF/AH Waiver's facility alternative. The results of these reports are analyzed by the QMU for trends and patterns across populations and reported to CDHS/IHO Section Chief, Managers, Supervisors and the Medi-Cal Policy Division, Waiver Analysis Section. Evidence of remedial actions will be described in the annual CMS 373 Q report.

State:	California
Effective Date:	January 1, 2007

H3: Process to Establish Priorities and Develop Strategies for Remediation and Improvement

The CDHS/IHO Management Team is responsible for establishing priorities, remediation, and improvement actions. CDHS/IHO has established the following Levels of Compliance that are used to determine when remediation and improvement actions will occur. These levels of compliance are applied to the reports and reviews described in H1.

<u>Levels of Compliance</u>	
80-100%	<u>Substantial compliance with NF/AH Waiver assurances and/or CDHS/IHO Policy & Procedures.</u> No significant remediation actions required.
70-80%	<u>Compliant with NF/AH Waiver assurances and/or CDHS/IHO Policy & Procedures,</u> but raises concerns, additional investigation is needed. Remediation action and follow-up focus review as needed.
60-70%	<u>Marginally compliant with NF/AH Waiver assurances and/or CDHS/IHO Policy & Procedures,</u> remediation action and follow-up focus review required.
Less than 60%	<u>Non-compliant with NF/AH Waiver assurance and/or CDHS/IHO Policy & Procedures,</u> remediation action and follow-up focus review is required.

Regardless of the level of compliance, program issues that affect the immediate health and safety of the participants will receive priority. The issue will be brought to the attention of the Management Team and a remediation plan will be developed and implemented. The remediation plan may include contacting other agencies and State Departments for assistance, changes to CDHS/IHO' policies and procedures and/or requesting assistance from the CMS.

The Level of Compliance score is used to determine the priority in the development and implantation of remediation activities. Level of Compliance scores of less than 60% will require immediate action. A remediation plan will be developed and implemented within 90 days. A follow-up focus review will be conducted 90 and 180 days after implantation of the remediation plan to determine the effectiveness of the plan. Results of the review will be presented to the Management Team for future planning.

Compliance scores of 60-70% will have the next priority and will also require a remediation plan and follow-up focus review. Areas with a compliance review of 70-80% will be further investigated and the CDHS/IHO Management Team will determine if there is a need for a remediation plan. When CDHS/IHO is unable to address all areas of concern, CDHS/IHO will give priority to areas that directly affect the waiver participant. Follow-up focus review will only be conducted on participant related issues. Effectiveness of remedial actions related to CDHS/IHO compliance with internal polices and procedures will be measured at the annual review. Results of all reviews will be presented to the Management Team for future planning.

State:	California
Effective Date:	January 1, 2007

Appendix H: Quality Management Strategy
 HCBS Waiver Application Version 3.3 – October 2005

H4: Compilation and Communication of Quality Management Strategy

CDHS/IHO' quality management reports are designed as Administrative Management Reports. The following identify the major reports, the topic, frequency, and the recipient(s) of the report.

Name of Report	Topic	Frequency	Recipient(s) of Report
Waiting List	List of applicants awaiting a slot on the NF/AH Waiver.	Monthly	CDHS/IHO Management
Waiver Summary	Number of participants enrolled in the waiver and number of applicants assigned to the IHO Intake Unit and being assessed for enrollment.	Monthly	CDHS/IHO Management
Intake greater than 6 months	List of applicants who have been assigned to the IHO Intake Unit for more than 6 months	Monthly	CDHS/IHO Management
Home Visit Overdue	List of participants whose re-evaluation visit is over due by 30 days or more	Monthly, Quarterly, Annually	Supervisors, CDHS/IHO Management
Provider Visit Overdue	Annual Provider visit is overdue by 30 days or more	Monthly, Quarterly, Annually	Supervisors, CDHS/IHO Management
Event/Issue Report	By issue, amount of time to resolve, and participant satisfaction	Bi-annual, Annually	CDHS/IHO Management
State Fair Hearing Report	By issue and outcomes	Annually	CDHS/IHO Management
Outreach Activities	List of outreach activities, who attended, and average evaluation scores.	Annually	CDHS/IHO Management

In 2008, CDHS/IHO will evaluate the ability to post the results and remediation actions from the Annual Case Record and Provider Visits Reviews on the CDHS website. In 2009, CDHS/IHO will have the ability to post the results and remediation actions from the Participant and Provider Surveys on the website.

H5: Periodic Evaluation and Revision of Quality Management Strategy

The QMU and participants of the Case Record and Provider Visit Review conduct a post-review evaluation of the review process and evaluation tools. Based upon the evaluation, the Case Record, Provider Visit Review Tools and instructions may be revised to remove items that have a history of significant compliance and add new items which have been identified as a potential issue or problem, and modify policies and procedures for how a specific issue is reviewed. CDHS/IHO will conduct a post-review of the implementation of the Provider Satisfaction Survey in the third quarter of 2009, the Participant Satisfaction Survey in the fourth quarter of 2008 and the Claims Quality Management Strategy in the first quarter of 2008. Changes to any of the above processes will be described in the annual CMS 373 Q report.

State:	California
Effective Date:	January 1, 2007

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In-Home Operations (IHO) Home and Community-Based Services (HCBS) Nursing Facility/Acute Hospital (NF/AH) Waiver providers are not subject to the requirement of the Single Audit Act (31 U.S.C. 7501-7507) as amended by the Single Audit Act Amendments of 1996 (P.L. 104-146). IHO does not grant federal or state awards to participating waiver providers.

Payments for most, but not all, NF/AH Waiver and State Plan services are made through the approved California Medi-Cal Management Information System (CA-MMIS). The California Department of Health Services (CDHS) Payment Systems Division (PSD) administers the Medi-Cal claiming system and manages the State's third party fiscal intermediary contract with Electronic Data Systems (EDS).

All claims processed through EDS 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.

The CDHS Audits and Investigations (A&I) Division is responsible for ensuring the fiscal integrity and medical necessity of Medi-Cal program services, including the NF/AH Waiver program.

All claims submitted by waiver and State Plan providers are subject to random review regardless of provider type, specialty, or service rendered. A&I verifies 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 Code (W & I Code), Section 14124.2.

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

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-checkwrite 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 more comprehensive review will receive an on-site visit by A&I staff. Many of these reviews result in program removal, monetary penalties, or less intrusive sanctions and utilization controls.

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

State:	California
Effective Date:	January 1, 2007

Appendix I-1: 1

Appendix #4

Additional State Long-Term Care Legislative Initiatives

1. **MSSP Augmentation**: The Multipurpose Senior Service Program (MSSP) program provides critical social and health care management for frail elderly clients who are at risk of placement in a nursing facility but who choose to live at home with MSSP support. Recognizing the importance of the program in helping frail seniors remain at home and avoid institutionalization, Governor Schwarzenegger sustained the \$3 million augmentation for MSSP.
2. **Supplemental Security Income/State Supplementary Payment (SSI/SSP)**: The budget reverses last year's decision to delay the annual cost-of-living adjustment for SSI/SSP recipients. The 2005-06 Budget Act had called for the increase to be delayed from January 1, 2007, to April 1, 2007. This year's budget includes a \$43 million increase to provide the 2.1 percent benefits increase on January 1, 2007.
3. **Supporting Community-Based Services for People with Developmental Disabilities**: The budget includes \$68.4 million to support a 3 percent rate increase for community-based providers serving people with developmental disabilities. This increase will benefit providers who have been subject to past rate freezes, including community care facilities, community-based day programs and transportation providers, and support improvements in the quality of care.
4. **Enhancing Employment Services**: The budget provides an increase of more than \$199 million to support employment programs and other services for persons with disabilities. This includes \$180 million for the Supported Employment Program (SEP) and Work Activity Program (WAP), representing a 24% increase in support. It also includes \$19.1 million for wage increases for WAP and day program providers.
5. **Augmenting the Program for All Inclusive Care for the Elderly**: The Program for All Inclusive Care for the Elderly (PACE) is a model of acute and long term care integration offering a comprehensive service package to frail seniors who are at risk of institutionalization, permitting them to continue living at home while receiving services rather than be institutionalized. The budget includes \$2.2 million (\$1.1 million General Fund) to increase reimbursement to the PACE program.
6. **Expanding Alzheimer's Research and Treatment**: California is a national leader in research into Alzheimer's disease and related disorders. The budget provides an additional \$2 million to increase grants to the Alzheimer's Disease Research Centers of California (ARCC). This increase, the first since 1998-99, will enhance the program's ability to provide state-of-the art diagnostic and treatment services, caregiver training and support services, and evaluate the most complex cases of dementia of Alzheimer's-related disorders.

7. **Expanding Access to Community-Based Nursing Services:** Consistent with the Governor's January budget, this item provides \$1.15 million (\$355,000 General Fund) to implement legislation (SB 643, Chesbro, Chapter 551, Statutes of 2005) that requires the Department of Health Services to add 500 more slots to the Nursing Facility A/B waiver that provides nursing facility services to people who would otherwise live in an institution.
8. **Supporting Assisted Living Options for Medi-Cal Beneficiaries:** Consistent with the Governor's January budget, this item will provide \$880,000 (\$364,000 General Fund) to implement a pilot project that requires the Department of Health Services to seek a federal Medicaid waiver to test assisted living as a Medi-Cal benefit.
9. **Nursing Home Transitions to the Community through Money Follows the Person (MFTP):** The budget includes Budget Bill Language that will, under specified circumstances, allow individuals in nursing homes to voluntarily move into a community setting and still receive the same amount of funding for services. This language is important because it clears the way for the state/Department of Health Services (DHS) to move forward with a MFTP proposal for California. Please note, DHS is awaiting more information from the federal Centers for Medicare and Medicaid (CMS) to further inform the Administration's understanding of the prospects of an application. DHS anticipates formal notice from CMS will be issued later this summer/early fall.
10. **Ending Chronic Homelessness:** The budget supports the Governor's Initiative to End Chronic Homelessness, which will provide supportive housing to chronically homeless people with mental illness. Under the plan, up to \$75 million in Proposition 63 funding will be allocated each year for 20 years, leveraging \$1.5 billion in Proposition 63 funds to secure \$4.5 billion to build more than 10,000 housing units for this population. The budget includes \$1.2 million for the Department of Mental Health to coordinate implementation of the initiative.
11. **Advancing Community Options through Integration:** This initiative included \$1.1 million to establish Medicare/Medi-Cal pilot projects that would coordinate services to improve continuity of care across acute and long-term care service settings and simplify access to home and community-based services for consumers. The Legislature did not include this proposal in the final 2007-08 budget, but the Administration remains committed to exploring alternatives for an integrated service delivery system.
12. **Coordinated Assessment Tool:** This initiative sought to develop a coordinated assessment tool (Community Options and Assessment Protocol) for use across long-term care programs to better coordinate services for consumers. The Legislature did not include this proposal in the final 2007-08 budget, but the Administration remains committed to exploring alternatives for a coordinated assessment system.

Appendix #5
Distribution of Medi-Cal Spending
on Long-Term Care



California: Distribution of Medicaid Spending on Long Term Care, FY2005

Distribution of Medicaid Spending on Long Term Care, FY2005 Compare 				
	CA \$	CA %	US \$	US %
ICF-MR	760,244,403	6.7	12,683,264,171	12.0
Mental Health Facilities	1,852,618,708	16.3	4,735,443,438	4.5
Nursing Facilities	3,094,800,549	27.3	46,948,545,285	44.4
Home Health & Personal Care	5,646,785,512	49.7	41,276,618,446	39.1
Total	11,354,449,172	100.0	105,643,871,340	100.0

Notes and Sources: Show | Hide

Notes: All spending includes state and federal expenditures.

Definitions: **ICF-MR** stands for intermediate care facility for the mentally retarded.

Mental Health Facilities include inpatient psychiatric services for individuals age 21 and under, and other mental health facilities for people age 65 and older.

Home Health & Personal Care includes standard home health services, personal care, targeted case management, hospice, home and community-based care for the functionally disabled elderly, and services provided under home and community-based services waivers.

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Centers for Medicare and Medicaid Services-64 reports, October 2006.

Download these data Other download options [Help](#)

Appendix #6

**Office of Statewide Health Planning &
Development (OSHDP) Report: Long-Term
Care Services, Statewide Trends**

CALIFORNIA LONG TERM CARE SERVICES
STATEWIDE TRENDS, 1992 - 2001

LONG TERM CARE FACILITIES AND SERVICES BY OWNERSHIP TYPE - DECEMBER 31

	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>
FREESTANDING FACILITIES:										
Profit	1,030	1,039	1,047	1,052	1,044	1,053	1,050	1,065	1,051	1,041
Nonprofit	206	204	190	189	190	188	180	179	178	183
Government	2	3	4	4	5	6	6	7	6	6
Unknown				7	10	13	7	6	4	3
Subtotal	1,238	1,246	1,241	1,252	1,249	1,260	1,243	1,257	1,239	1,233
HOSPITAL-BASED LTC SERVICES:										
Profit	29	36	42	53	63	70	66	64	59	55
Nonprofit	106	113	125	141	149	148	153	159	152	141
Government	44	48	51	68	56	55	47	53	53	53
Unknown				0	0	0	0	1	0	0
Subtotal	179	197	218	262	268	273	266	277	264	249
FREESTANDING AND HOSPITAL-BASED:										
Profit	1,059	1,075	1,089	1,105	1,107	1,123	1,116	1,129	1,110	1,096
Nonprofit	312	317	315	330	339	336	333	338	330	324
Government	46	51	55	72	61	61	53	60	59	58
Unknown				7	10	13	7	7	4	3
TOTAL	1,417	1,443	1,459	1,514	1,517	1,533	1,509	1,534	1,503	1,481

LICENSED BEDS BY LICENSED BED CLASSIFICATION - DECEMBER 31

	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>
FREESTANDING:										
Skilled Nursing - General	109,282	110,585	109,933	110,492	110,998	111,631	111,431	112,065	112,347	111,835
Skilled Nursing - Mentally Disordered	4,470	4,378	4,378	4,376	4,349	4,223	4,240	4,124	4,124	4,124
Intermediate Care - General	2,563	2,412	2,329	2,213	2,172	2,103	1,964	1,749	1,632	1,541
Intermediate Care - Developmentally Disabled	2,154	1,861	1,715	1,851	1,804	1,782	1,643	1,273	1,205	1,205
Congregate Living	174	190	207	221	254	324	306	269	232	238
Subtotal	118,643	119,426	118,562	119,153	119,577	120,063	119,584	119,480	119,540	118,943
HOSPITAL-BASED:										
Skilled Nursing - General	10,086	10,790	12,091	12,666	13,119	13,513	13,388	12,806	12,698	12,296
Skilled Nursing - Mentally Disordered	94	94	34	21	21	21	21	21	21	21
Intermediate Care - General	3	3	3	3	3	3	3	3	3	3
Intermediate Care - Developmentally Disabled	0	0	0	0	0	0	0	0	0	0
Subtotal	10,183	10,887	12,128	12,690	13,143	13,537	13,412	12,830	12,722	12,320
SWING BEDS (GAC Beds used for LTC Care)	215	315	306	327	442	442	440	440	450	433
FREESTANDING AND HOSPITAL-BASED:										
Skilled Nursing - General	119,368	121,375	122,024	123,158	124,117	125,144	124,819	124,871	125,045	124,131
Skilled Nursing - Mentally Disordered	4,564	4,472	4,412	4,397	4,370	4,244	4,261	4,145	4,145	4,145
Intermediate Care - General	2,566	2,415	2,332	2,216	2,175	2,106	1,967	1,752	1,635	1,544
Intermediate Care - Developmentally Disabled	2,154	1,861	1,715	1,851	1,804	1,782	1,643	1,273	1,205	1,205
Congregate Living	174	190	207	221	254	324	324	269	232	238
TOTAL	128,826	130,313	130,690	131,843	132,720	133,600	133,014	132,310	132,262	131,263

**CALIFORNIA LONG TERM CARE SERVICES
 STATEWIDE TRENDS, 1992 - 2001**

PATIENTS ADMITTED BY SOURCE

	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>
FREESTANDING:										
Home	17,754	18,749	19,921	19,204	20,121	19,985	19,860	19,804	18,289	17,127
Hospital	129,850	139,299	147,203	152,031	161,320	172,029	183,421	185,416	192,283	199,958
Other Long Term Care Facilities	9,712	10,191	10,941	10,669	10,703	11,496	12,025	11,324	11,235	10,446
Residential Care Facilities	7,120	7,117	6,954	7,052	7,047	7,142	7,403	7,413	6,825	6,421
Other	2,855	3,036	3,479	3,235	3,871	3,739	3,953	4,313	4,244	3,419
Subtotal	167,291	178,392	188,498	192,191	203,062	214,391	226,662	228,270	232,876	237,371
HOSPITAL-BASED:										
Home	3,747	4,079	6,450	7,013	7,683	8,081	9,485	10,191	10,608	8,262
Hospital	53,276	64,801	77,168	97,298	111,221	119,248	116,787	104,520	89,214	76,723
Other Long Term Care Facilities	1,493	1,579	3,164	1,617	1,547	2,094	1,921	1,907	1,317	1,724
Residential Care Facilities	244	195	388	344	298	404	402	447	384	481
Other	768	1,503	1,701	1,164	2,444	2,570	2,954	3,517	1,344	1,326
Subtotal	59,528	72,157	88,871	107,436	123,193	132,397	131,549	120,582	102,867	88,516
FREESTANDING AND HOSPITAL-BASED:										
Home	21,501	22,828	26,371	26,217	27,804	28,066	29,345	29,995	28,897	25,389
Hospital	183,126	204,100	224,371	249,329	272,541	291,277	300,208	289,936	281,497	276,681
Other Long Term Care Facilities	11,205	11,770	14,105	12,286	12,250	13,590	13,946	13,231	12,552	12,170
Residential Care Facilities	7,364	7,312	7,342	7,396	7,345	7,546	7,805	7,860	7,209	6,902
Other	3,623	4,539	5,180	4,399	6,315	6,309	6,907	7,830	5,588	4,745
TOTAL	226,819	250,549	277,369	299,627	326,255	346,788	358,211	348,852	335,743	325,887

**CALIFORNIA LONG TERM CARE SERVICES
 STATEWIDE TRENDS, 1992 - 2001**

PATIENTS DISCHARGED BY DISPOSITION

	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>
FREESTANDING:										
Home	46,146	51,700	57,664	61,183	67,073	71,984	78,083	77,527	79,643	80,280
Hospital	59,087	61,132	60,748	62,397	63,260	68,409	72,571	76,616	78,020	83,183
Long Term Care Facilities	8,646	9,505	9,959	9,977	9,884	10,218	11,351	11,211	10,625	10,571
Residential Care Facilities	11,208	11,808	12,863	13,017	14,370	15,573	16,206	15,520	16,101	15,832
Other	1,357	1,208	1,915	1,410	2,021	2,259	2,175	2,087	1,900	2,156
AWOL	2,076	2,111	1,729	1,764	1,996	1,644	1,739	1,722	2,027	1,878
Death	37,665	40,462	42,250	42,985	45,065	44,312	44,281	44,482	43,788	43,077
Subtotal	166,185	177,926	187,128	192,733	203,669	214,399	226,406	229,165	232,104	236,977
HOSPITAL-BASED:										
Home	32,886	41,095	51,009	64,795	75,664	82,727	81,515	73,374	63,054	50,002
Hospital	8,287	9,362	9,940	12,878	13,433	14,682	15,272	14,445	12,895	11,989
Long Term Care Facilities	8,164	9,550	13,613	14,414	17,370	18,385	17,883	15,627	12,829	11,252
Residential Care Facilities	1,869	2,169	2,739	2,893	3,321	3,926	4,028	4,298	3,840	4,613
Other	931	1,865	2,202	3,150	3,663	3,382	3,878	3,900	2,952	3,392
AWOL	261	444	549	345	334	383	631	442	572	436
Death	6,498	7,047	8,076	8,757	8,997	8,916	8,826	8,624	7,260	6,957
Subtotal	58,896	71,532	88,128	107,232	122,782	132,401	132,033	120,710	103,402	88,641
FREESTANDING AND HOSPITAL-BASED:										
Home	79,032	92,795	108,673	125,978	142,737	154,711	159,598	150,901	142,697	130,282
Hospital	67,374	70,494	70,688	75,275	76,693	83,091	87,843	91,061	90,915	95,172
Long Term Care Facilities	16,810	19,055	23,572	24,391	27,254	28,603	29,234	26,838	23,454	21,823
Residential Care Facilities	13,077	13,977	15,602	15,910	17,691	19,499	20,234	19,818	19,941	20,445
Other	2,288	3,073	4,117	4,560	5,684	5,641	6,053	5,987	4,852	5,548
AWOL	2,337	2,555	2,278	2,109	2,330	2,027	2,370	2,164	2,599	2,314
Death	44,163	47,509	50,326	51,742	54,062	53,228	53,107	53,106	51,048	50,034
TOTAL	225,081	249,458	275,256	299,965	326,451	346,800	358,439	349,875	335,506	325,618

CALIFORNIA LONG TERM CARE SERVICES
STATEWIDE TRENDS, 1992 - 2001

PATIENTS BY LENGTH OF STAY PRIOR TO DISCHARGE

	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>
FREESTANDING:										
Less Than 3 Months	107,119	118,483	129,715	133,199	144,579	154,591	166,958	167,916	170,015	176,026
3 To 6 Months	18,915	19,149	19,153	19,892	19,637	20,383	21,045	21,812	22,375	22,192
7 To 12 Months	13,203	13,214	12,853	13,127	12,965	13,652	12,637	12,646	12,766	13,211
1 Year But Less Than 2 Years	11,233	11,161	10,205	10,879	10,764	10,603	10,835	11,445	11,270	11,266
2 Year But Less Than 3 Years	6,361	6,274	5,815	6,091	6,054	5,969	5,747	5,990	6,136	5,771
3 Year But Less Than 5 Years	5,317	5,590	5,477	5,358	5,333	5,034	4,933	5,158	5,353	4,613
5 Year But Less Than 7 Years	2,254	2,416	2,189	2,409	2,537	2,434	2,324	2,339	2,192	2,105
7 Years Or More	1,783	1,639	1,614	1,778	1,800	1,733	1,927	1,859	1,243	1,793
Subtotal	166,185	177,926	187,021	192,733	203,669	214,399	226,406	229,165	231,350	236,977
HOSPITAL-BASED:										
Less Than 3 Months	55,426	67,450	84,426	103,411	120,590	128,992	128,844	117,182	96,974	85,149
3 To 6 Months	1,423	1,656	1,470	1,686	2,236	1,288	1,309	1,427	1,781	1,487
7 To 12 Months	793	1,016	713	744	1,521	748	648	678	835	612
1 Year But Less Than 2 Years	534	691	674	577	1,201	555	527	605	1,089	571
2 Year But Less Than 3 Years	280	301	324	299	646	309	248	324	1,177	264
3 Year But Less Than 5 Years	229	258	291	286	526	239	216	250	445	257
5 Year But Less Than 7 Years	105	84	128	96	215	152	114	113	189	155
7 Years Or More	106	76	102	133	177	118	127	131	217	146
Subtotal	58,896	71,532	88,128	107,232	127,112	132,401	132,033	120,710	102,707	88,641
FREESTANDING AND HOSPITAL-BASED:										
Less Than 3 Months	162,545	185,933	214,141	236,610	265,169	283,583	295,802	285,098	266,989	261,175
3 To 6 Months	20,338	20,805	20,623	21,578	21,873	21,671	22,354	23,239	24,156	23,679
7 To 12 Months	13,996	14,230	13,566	13,871	14,486	14,400	13,285	13,324	13,601	13,823
1 Year But Less Than 2 Years	11,767	11,852	10,879	11,456	11,965	11,158	11,362	12,050	12,359	11,837
2 Year But Less Than 3 Years	6,641	6,575	6,139	6,390	6,700	6,278	5,995	6,314	7,313	6,035
3 Year But Less Than 5 Years	5,546	5,848	5,768	5,644	5,859	5,273	5,149	5,408	5,798	4,870
5 Year But Less Than 7 Years	2,359	2,500	2,317	2,505	2,752	2,586	2,438	2,452	2,381	2,260
7 Years Or More	1,889	1,715	1,716	1,911	1,977	1,851	2,054	1,990	1,460	1,939
TOTAL	225,081	249,458	275,149	299,965	330,781	346,800	358,439	349,875	334,057	325,618

CALIFORNIA LONG TERM CARE SERVICES
 STATEWIDE TRENDS, 1992 - 2001

PATIENTS BY AGE GROUPING - DECEMBER 31 CENSUS

	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>
FREESTANDING:										
Less Than 45 Years Of Age	6,140	5,749	5,620	5,693	5,487	5,064	4,707	4,446	4,522	4,251
45 To 54 Years Of Age	3,067	3,357	3,521	3,611	3,929	3,923	4,072	4,240	4,428	4,663
55 To 64 Years Of Age	5,075	5,108	5,201	5,331	5,406	5,710	6,005	6,012	6,420	6,841
65 To 74 Years Of Age	14,674	15,031	14,624	14,349	14,430	14,073	13,678	13,595	13,563	13,462
75 To 84 Years Of Age	32,601	32,354	32,395	32,073	31,502	31,338	31,556	31,398	31,491	31,086
85 To 94 Years Of Age	33,927	34,081	33,349	33,311	33,481	33,327	33,522	32,808	32,252	31,428
95 Years Of Age And Older	7,283	7,200	7,146	7,332	7,369	7,117	7,293	7,061	6,907	6,548
Subtotal	102,767	102,880	101,856	101,700	101,604	100,552	100,833	99,560	99,583	98,279
HOSPITAL-BASED:										
Less Than 45 Years Of Age	820	863	934	864	903	908	940	877	959	974
45 To 54 Years Of Age	405	423	453	463	615	644	640	685	667	709
55 To 64 Years Of Age	531	626	718	793	718	743	781	779	734	780
65 To 74 Years Of Age	1,415	1,567	1,656	1,689	1,733	1,624	1,521	1,446	1,350	1,218
75 To 84 Years Of Age	2,466	2,724	2,903	3,077	3,150	3,126	2,970	2,853	2,490	2,346
85 To 94 Years Of Age	2,122	2,101	2,258	2,329	2,457	2,523	2,232	2,308	1,965	1,955
95 Years Of Age And Older	346	368	422	385	398	423	357	367	324	299
Subtotal	8,105	8,672	9,344	9,600	9,974	9,991	9,441	9,315	8,489	8,281
FREESTANDING AND HOSPITAL-BASED:										
Less Than 45 Years Of Age	6,960	6,612	6,554	6,557	6,390	5,972	5,647	5,323	5,481	5,225
45 To 54 Years Of Age	3,472	3,780	3,974	4,074	4,544	4,567	4,712	4,925	5,095	5,372
55 To 64 Years Of Age	5,606	5,734	5,919	6,124	6,124	6,453	6,786	6,791	7,154	7,621
65 To 74 Years Of Age	16,089	16,598	16,280	16,038	16,163	15,697	15,199	15,041	14,913	14,680
75 To 84 Years Of Age	35,067	35,078	35,298	35,150	34,652	34,464	34,526	34,251	33,981	33,432
85 To 94 Years Of Age	36,049	36,182	35,607	35,640	35,938	35,850	35,754	35,116	34,217	33,383
95 Years Of Age And Older	7,629	7,568	7,568	7,717	7,767	7,540	7,650	7,428	7,231	6,847
SUBTOTAL	110,872	111,552	111,200	111,300	111,578	110,543	110,274	108,875	108,072	106,560

CALIFORNIA LONG TERM CARE SERVICES
 STATEWIDE TRENDS, 1992 - 2001

PATIENT (CENSUS) DAYS BY LICENSED BED CLASSIFICATION

	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>
FREESTANDING:										
Skilled Nursing - General	34,593,752	34,827,523	34,188,125	34,491,340	34,730,876	34,145,608	34,308,621	33,859,746	34,122,268	33,707,341
Skilled Nursing - Mentally Disordered	1,124,451	1,174,945	1,409,438	1,340,731	1,092,282	1,036,257	873,884	851,940	819,391	757,993
Intermediate Care - General	728,551	611,152	629,427	688,466	532,295	878,807	426,046	389,536	467,085	364,948
Intermediate Care - Developmentally Disabled	676,989	633,331	603,908	609,789	546,467	525,720	484,085	423,801	340,540	379,335
Congregate Living	35,815	48,101	35,805	48,679	58,470	61,095	52,959	77,023	49,668	54,547
Subtotal	37,159,558	37,295,052	36,866,703	37,179,005	36,960,390	36,647,487	36,145,595	35,602,046	35,798,952	35,264,164
HOSPITAL-BASED:										
Skilled Nursing - General	2,771,528	2,902,623	3,254,794	3,474,634	3,528,831	3,570,794	3,540,420	3,410,304	3,216,515	3,073,416
Skilled Nursing - Mentally Disordered	49,806	25,915	24,564	30	0	0	0	18,625	19,757	18,250
Intermediate Care - General	7,257	85	0	552	2,445	573	0	0	0	12,976
Intermediate Care - Developmentally Disabled	0	0	0	0	0	0	0	0	0	0
Subtotal	2,828,591	2,928,623	3,279,358	3,475,216	3,531,276	3,571,367	3,540,420	3,428,929	3,236,272	3,104,642
FREESTANDING AND HOSPITAL-BASED:										
Skilled Nursing - General	37,365,280	37,730,146	37,442,919	37,965,974	38,259,707	37,716,402	37,849,041	37,270,050	37,338,783	36,780,757
Skilled Nursing - Mentally Disordered	1,174,257	1,200,860	1,434,002	1,340,761	1,092,282	1,036,257	873,884	870,565	839,148	776,243
Intermediate Care - General	735,808	611,237	629,427	689,018	534,740	879,380	426,046	389,536	467,085	377,924
Intermediate Care - Developmentally Disabled	676,989	633,331	603,908	609,789	546,467	525,720	484,085	423,801	340,540	379,335
Congregate Living	35,815	48,101	35,805	48,679	58,470	61,095	52,959	77,023	49,668	54,547
TOTAL	39,988,149	40,223,675	40,146,061	40,654,221	40,491,666	40,218,854	39,686,015	39,030,975	39,035,224	38,368,806

BED OCCUPANCY RATES BY LICENSED BED CLASSIFICATION

	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>
FREESTANDING:										
Skilled Nursing - General	86.6%	86.6%	85.1%	85.6%	85.7%	84.0%	84.4%	83.0%	83.0%	82.4%
Skilled Nursing - Mentally Disordered	68.3%	71.6%	88.2%	84.5%	68.7%	66.8%	56.5%	61.0%	54.3%	23.8%
Intermediate Care - General	74.6%	67.8%	72.5%	82.6%	67.0%	112.3%	122.6%	56.6%	76.0%	132.5%
Intermediate Care - Developmentally Disabled	82.6%	90.4%	93.4%	92.8%	82.8%	78.8%	78.4%	84.7%	74.9%	86.2%
Congregate Living	76.0%	73.7%	52.4%	65.5%	64.3%	57.2%	47.0%	72.8%	56.7%	63.6%
Subtotal	85.5%	85.7%	85.1%	85.6%	84.6%	83.7%	82.9%	81.7%	81.8%	82.2%
HOSPITAL-BASED:										
Skilled Nursing - General	78.5%	76.9%	77.8%	76.4%	74.7%	73.1%	72.3%	72.2%	69.3%	68.0%
Skilled Nursing - Mentally Disordered	144.8%	75.5%	172.1%	0.4%	0.0%	0.0%	0.0%	243.0%	257.1%	238.1%
Intermediate Care - General	660.9%	7.8%	0.0%	50.4%	222.7%	52.3%	0.0%	0.0%	0.0%	1185.0%
Intermediate Care - Developmentally Disabled	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Subtotal	79.3%	76.8%	78.1%	76.2%	74.6%	73.0%	73.0%	72.4%	69.6%	68.5%
FREESTANDING AND HOSPITAL-BASED:										
Skilled Nursing - General	85.9%	85.7%	84.4%	84.7%	84.5%	82.8%	83.1%	81.9%	81.6%	80.9%
Skilled Nursing - Mentally Disordered	70.3%	71.6%	88.9%	84.0%	68.4%	66.4%	56.2%	57.5%	55.3%	24.9%
Intermediate Care - General	75.2%	67.8%	72.4%	82.6%	67.2%	112.3%	59.7%	60.9%	75.9%	134.5%
Intermediate Care - Developmentally Disabled	82.6%	90.4%	93.4%	92.8%	82.8%	78.8%	78.4%	84.7%	74.9%	86.2%
Congregate Living	76.0%	73.7%	52.4%	65.5%	64.3%	57.2%	47.0%	72.8%	56.7%	63.6%
TOTAL	85.1%	85.0%	84.4%	84.7%	83.7%	82.6%	81.8%	80.8%	80.6%	80.9%

**CALIFORNIA LONG TERM CARE SERVICES
 STATEWIDE TRENDS, 1992 - 2001**

PATIENTS BY PAYMENT SOURCE - DECEMBER 31 CENSUS

	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>
FREESTANDING:										
Medi-Cal	64,716	65,368	65,739	66,287	65,458	64,550	65,491	64,009	64,678	64,548
Medicare	6,631	7,665	7,218	7,226	7,391	7,684	6,979	7,630	7,814	7,987
Insurance, HMO And Self Pay	27,605	25,931	26,053	25,065	25,496	25,617	25,579	25,309	24,194	22,784
Other	3,815	3,916	2,846	3,122	3,259	2,701	2,784	2,612	2,897	2,960
Subtotal	102,767	102,880	101,856	101,700	101,604	100,552	100,833	99,560	99,583	98,279
HOSPITAL-BASED:										
Medi-Cal	4,563	4,738	4,968	4,758	4,750	4,848	4,709	4,709	4,578	4,785
Medicare	2,230	2,562	2,945	3,165	3,257	3,145	2,657	2,518	2,037	1,860
Insurance, HMO And Self Pay	1,123	1,185	1,358	1,607	1,852	1,882	1,832	1,842	1,681	1,411
Other	189	187	73	70	115	116	243	246	193	225
Subtotal	8,105	8,672	9,344	9,600	9,974	9,991	9,441	9,315	8,489	8,281
FREESTANDING AND HOSPITAL-BASED:										
Medi-Cal	69,279	70,106	70,707	71,045	70,208	67,695	68,148	68,718	69,256	69,333
Medicare	8,861	10,227	10,163	10,391	10,648	12,532	11,688	10,148	9,851	9,847
Insurance, HMO And Self Pay	28,728	27,116	27,411	26,672	27,348	27,499	27,411	27,151	25,875	24,195
Other	4,004	4,103	2,919	3,192	3,374	2,817	3,027	2,858	3,090	3,185
TOTAL	110,872	111,552	111,200	111,300	111,578	110,543	110,274	108,875	108,072	106,560

CALIFORNIA LONG TERM CARE SERVICES
STATEWIDE TRENDS, 1992 - 2001

PATIENTS BY GENDER - DECEMBER 31 CENSUS

	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>
FREESTANDING:										
Male	29,407	29,632	30,161	30,543	30,987	31,123	30,972	31,247	31,664	31,988
Female	73,360	73,248	71,695	71,157	70,617	69,429	69,861	68,313	67,919	66,291
Subtotal	102,767	102,880	101,856	101,700	101,604	100,552	100,833	99,560	99,583	98,279
HOSPITAL-BASED:										
Male	3,010	3,224	3,528	3,591	3,804	3863	3,705	3,613	3,431	3,343
Female	5,095	5,448	5,816	6,009	6,170	6128	5,736	5,702	5,058	4,938
Subtotal	8,105	8,672	9,344	9,600	9,974	9,991	9,441	9,315	8,489	8,281
FREESTANDING AND HOSPITAL-BASED:										
Male	32,417	32,856	33,689	34,134	34,791	34,986	34,677	34,860	35,095	35,331
Female	78,455	78,696	77,511	77,166	76,787	75,557	75,597	74,015	72,977	71,229
TOTAL	110,872	111,552	111,200	111,300	111,578	110,543	110,274	108,875	108,072	106,560

PATIENTS BY WHITE AND NONWHITE - DECEMBER 31 CENSUS

	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>
FREESTANDING:										
White	81,841	81,138	79,432	78,652	77,899	76,467	75,800	73,353	71,977	69,733
Nonwhite	20,973	21,742	22,424	23,048	23,705	24,085	25,033	26,207	27,606	28,546
Subtotal	102,814	102,880	101,856	101,700	101,604	100,552	100,833	99,560	99,583	98,279
HOSPITAL-BASED:										
White	6,880	7,288	6,934	7,245	7,452	7393	6,859	6,689	5,880	5,681
Nonwhite	10,610	1,384	2,410	2,729	2,522	2,598	2,582	2,626	2,609	2,600
Subtotal	17,490	8,672	9,344	9,974	9,974	9,991	9,441	9,315	8,489	8,281
FREESTANDING AND HOSPITAL-BASED:										
White	88,721	88,426	86,366	85,897	85,351	83,860	82,659	80,042	77,857	75,414
Nonwhite	31,583	23,126	24,834	25,777	26,227	26,683	27,615	28,833	30,215	31,146
TOTAL	120,304	111,552	111,200	111,674	111,578	110,543	110,274	108,875	108,072	106,560

FACILITIES CERTIFIED FOR MEDI-CAL SKILLED NURSING BY OWNERSHIP TYPE

	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>
FREESTANDING:										
Profit	918	931	920	941	920	921	906	895	919	896
Nonprofit	160	160	158	151	150	145	141	160	137	143
Government	2	3	4	3	4	5	4	5	4	4
Subtotal	1,080	1,094	1,082	1,095	1,074	1,071	1,051	1,060	1,060	1,043
HOSPITAL-BASED:										
Profit	10	17	20	25	28	37	34	32	29	28
Nonprofit	83	84	93	96	90	97	97	95	100	94
Government	53	54	58	63	52	50	44	46	44	43
Subtotal	146	155	171	184	170	184	175	173	173	165
FREESTANDING AND HOSPITAL-BASED:										
Profit	928	948	940	966	948	958	940	927	948	896
Nonprofit	243	244	251	247	240	242	238	255	237	228
Government	55	57	62	66	56	55	48	51	48	82
TOTAL	1,226	1,249	1,253	1,279	1,244	1,255	1,226	1,233	1,233	1,206

MEDI-CAL CERTIFIED BEDS BY LICENSED BED CLASSIFICATION - DECEMBER 31

	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>
FREESTANDING:										
Skilled Nursing - General	100,217	101,378	100,008	100,892	102,889	102,674	103,601	103,820	103,957	102,103
Skilled Nursing - Mentally Disordered	4,214	4,242	4,242	4,376	4,066	3,916	3,045	3,566	3,321	3,059
Intermediate Care - General	2,385	2,221	2,176	1,760	1,816	1,680	1,269	1,534	1,229	1,177
Intermediate Care - Developmentally Disabled	2,026	1,590	1,587	1,618	1,617	1,536	1,420	1,163	1,153	1,096
Congregate Living	90	105	85	130	105	113	98	74	51	51
Subtotal	108,932	109,536	108,098	108,776	110,493	109,919	109,433	110,157	109,711	107,486
HOSPITAL-BASED:										
Skilled Nursing - General	8,694	8,975	9,974	10,413	10,144	10,387	10,435	10,165	10,017	10,050
Skilled Nursing - Mentally Disordered	94	94	34	0	0	21	0	0	0	0
Intermediate Care - General	3	3	3	3	3	0	3	5	0	0
Intermediate Care - Developmentally Disabled	0	0	0	0	0	0	0	3	0	0
Subtotal	8,791	9,072	10,011	10,416	10,147	10,408	10,438	10,173	10,017	10,050
FREESTANDING AND HOSPITAL-BASED:										
Skilled Nursing - General	108,911	110,353	109,982	111,305	113,033	113,061	114,036	113,985	113,974	112,153
Skilled Nursing - Mentally Disordered	4,308	4,336	4,276	4,376	4,066	3,937	3,045	3,566	3,321	3,059
Intermediate Care - General	2,388	2,224	2,179	1,763	1,816	1,680	1,272	1,539	1,229	1,177
Intermediate Care - Developmentally Disabled	2,026	1,590	1,587	1,618	1,617	1,536	1,420	1,166	1,153	1,096
Congregate Living	90	105	85	130	105	113	98	74	51	51
TOTAL	117,723	118,608	118,109	119,192	118,394	120,327	119,871	120,330	119,728	117,536

LONG TERM CARE DEFINITIONS:

Census Counts	Census counts taken on December 31st for each year.
Licensed Bed Counts	Licensed bed counts reflect beds licensed on December 31st for each year; includes licensed beds in-suspense.
LTC	Long Term Care services , licensed as Skilled Nursing, Skilled Nursing - Mentally Disordered, Intermediate Care, or Intermediate Care - Developmentally Disabled.
LTC - Freestanding	Long Term Care Facilities , licensed as Skilled Nursing Facilities, and Intermediate Care Facilities; also know as, Nursing Homes, Convalescent Hospitals, etc.
LTC - Hospital Based	Distinct Parts , licensed Long Term Care services of General Acute Care Hospitals or Acute Psychiatric Hospitals; excludes State Hospitals and State Correctional Facilities.
Swing Beds	Those licensed General Acute Care hospital beds "approved" for providing LTC services; not included in "licensed" LTC bed counts.
ICF Occupancy Rate note:	A significant amount of ICF level care is provided in LICENSED Skilled Nursng beds (approved for ICF level of service). Because occupancy rates are calculated by dividing Patient (Census) Days by Licensed Bed Days, the ICF occupancy rates can be exaggerated.

Appendix #7
Letters of Support from Stakeholders

DRA Money Follows The Person
Letters of Support

#	ORGANIZATION	NAME	ADDRESS	PHONE NUMBERS
1	AARP	Casey L. Young, Advocacy Manager	1415 L Street Suite 960 Sacramento CA. 95814	(916) 886- 3641 Fax (916) 446-2223
2	Alameda County Network of Mental Health Clients (ACNMHC)	Kathie Zatzkin, System Liaison	3238 Adeline Avenue Berkley CA. 94705	(510) 652-5891 Fax (510) 652-4557
3	Aging Services of California	Rick Taylor, Associate Director of Public Policy	1315 "I" Street Suite 100 Sacramento, CA. 95814	(916) 392-5111 Fax (916)428-4250
4	AltaMed Health Services Corporation	Castulo De La Rocha, J.D.	500 Citadel Drive Suite 490 Los Angeles, CA 90040	(323) 889-7328 Fax 323 889-7855
5	Alzheimer's Association	Jackie Wynne McGrath, Public Policy Director	921 11th Street Suite 601 Sacramento, CA 95814	(916) 447-2731 Fax (916) 447-2741
6	Assembly Committee Chair, Senate Committee on Transportation	Alan Lowenthal, Chair, Senate Committee on Transportation	State Capitol, Room 3048 Sacramento, CA. 95814	(916) 651-4027 Fax (916) 327-9113
7	Assembly California Legislature Assembly Committee on aging and Long Term Care	Patty Berg, Chair	State Capitol P.O. Box 942849 District Office 455 Golden Gate Ave Suite 14300 San Francisco CA. 94102	(916) 319-3990
8	Assembly California Legislature	Mark Leno, 13th District	State Capitol P.O. Box 942849 Sacramento CA. 924849	(415) 557-3013 Fax (415) 557-3015
9	Association of California Caregiver Resource Centers	Donna Benton, President	5664 Chaney Lane Paradise, Ca. 95969	(503) 872-2609 Fax-(same)
10	California Advocates For Nursing Home Reform (CANHR)	Patricia McGinnis	650 Harrison Street 2n Floor San Francisco, CA 94107	(415) 974-5171 800 474-1116 Fax (415) 777-2904
11	California Assisted Living Association (CALA)	Heather S. Harrison Vice President of Public Policy	455 Capitol Mall Sacramento, CA. 95814-4405	(916) 448-1900 Fax (916) 448-1659

DRA Money Follows The Person
Letters of Support

12	California Association of Area Agencies on Aging	Derrell Kelch, Executive Director	980 Ninth Street Suite 2200 Sacramento, Ca. 95814	(916) 443-2800 Fax (916) 554-0111
13	CA Association of Health Facilities (CAHF)	James H. Gomez, CEO President	2201 K Street P.O. Box 537001 Sacramento, CA 95853-7004	(916) 441 6400 ext 201 Fax (916) 441-6441
14	CAPA California Association of Public Authorities for In-Home supportive Services	Donna Calame, President, CAPA	1100 N Street Suite Sacramento CA. 95814	(916) 448-5049
15	California Commission on Aging	Jorge Lambrinos, Chair	1300 National Drive Suite 173 Sacramento, Ca, 95834	(916) 419-7591 Fax(916)419-7596
16	California For Disability Rights	Laura Williams, President	909 12th Street Suite 200 Sacramento, CA. 95814	(916) 447-2237 or (800) 838 9237
17	California Foundation for Independent Living Centers	Teresa Favuzzi, Executive Director	1029 "J" Street Sacramento CA. 95814	(916) 325 - 1695 (916) 325 -1699
18	California Hospital Association	Patricia Blaisdell, vice President, Hospital Services for Continuing Care	1215 K Street Suite 800 Sacramento, CA. 95814	(916) 443-7401 Fax (916) 552-7585
19	Congress of California Seniors	Gary Passmore, Executive Director	1230 N Street Suite 201, Sacramento, Ca. 95814	(916) 442-4474 Fax(916) 442-1877
20	Contra Costa Health Plan (CCHP)	Patricia Tanquary, MSW, PhD, Chief Operating Officer and Acting Chief Executive	Contra Costa, CA.	(925) 313-6009 Fax (925) 313-6002
21	Council on Aging Orange County	Pamala McGovern	1971 East 4th Street Suite 200 Santa Ana CA. 92705-3917	(714) 479-0107 Fax (714) 497-0234
22	County of San Diego Health and Human Services Agency Aging and Independence Services	Pamela B. Smith, Director	9335 Hazard Way San Diego CA 92123 -1222	(858) 495-5858 Fax (858) 495-5080

DRA Money Follows The Person
Letters of Support

23	Dayle McIntosh Center (DMC)	W.D. Chrisner III, CRC/LPC, Executive Director	13272 Garden Grove Blvd Ste 210 Garden Grove, CA. 92842	(714) 621-
24	Easter Seals	Carlene S. Holden, Easter Seals California	16946 Sherman Way Suite 100 Van Nuys CA. 91406	(818) 996-9902 Fax (818)995-1605
25	Family Caregiver Alliance, National Center on Caregiving	Kathleen Kelly, Executive Director	180 Montgomery Street Suite 1100, San Francisco CA. 94104	(415) 434-3388 Fax (415) 434-3408
26	Gray Panthers	Joan B. Lee, Legislative Liaison	5313 Fernwood Way. Sacramento, CA. 95841	(916) 332-5980
27	Huntington Hospital	Eileen Koons, MSW Director of Government Programs	837 S. Fair Oaks Avenue, Ste 100 Pasadena, CA. 91105	(626) 397-3110
28	IN SPIRIT In Support of Paralytics In Really Intense Times	Aneice Taylor, Executive Director	P.O. Box 383 Woodacre, CA 94973	(415) 488-0477 Fax (415) 488-4870
29	Multipurpose Senior Services Program Site Association	James A. Cook, MSA President	921 11th Street Suite 701 Sacramento, CA. 95814	(916) 552-7400 Fax (916) 552-7404
30	ON LOC Senior Health Services	Robert Edmondson, Executive Director/CEO	1333 Bush Street San Francisco, CA. 94109-5611	(415) 292-8888 Fax (415) 292-8745
31	Partners in Care Foundation	W. June Simmons, CEO	732 Mott Street Suite 150 San Fernando, CA. 91340	(818) 837-3775 Fax (818) 837-3799
32	PASC Personal Assistance Services Council	Ronald L.G. Osterhout	4730 woodman Avenue Ste 405 Sherman Oaks, CA. 91423	(818) 206-7006 Fax (818) 206-8000
33	Protection & Advocacy, Inc.	Deborah Doctor, Legislative Advocate	Legislation and Public Information Unit	(916) 497-0331 Fax (916) 497-0813

DRA Money Follows The Person
Letters of Support

34	San Francisco Senior Center	Kathleen Mauyeda, Director of Social Services	Aquatic Park Branch, 890 Beach Street San Francisco, CA. 94109	(415) 775-1888 Fax(415) 775-4020
35	SCAN Health Plan	Timothy Schwab, MD Chief Medical/Information Officer Health Pland	3800 Kilroy Airport Way Ste. 100 P.O. Box 22616 Long Beach CA. 90801-5616	(562) 989-5100 Fax (562-989-5200)
36	State Independent Living Council (SILC)	Michael C. Collins, Executive Director	1600 K Street Suite 100 Sacramento, CA 95814	(916) 445-0142 Fax (916) 445-5973
37	The Access Center of San Diego, Inc (AC)	Louis Frick, Executive Director	1295 University Avenue #10 San Diego, CA. 92103	(619) 293-3500 Fax (619) 293-3508
38	The ARC of California	Tony Anderson, Executive Director	Advocates for Persons with Developmental Disabilities and Their Families 1225 "O" Street Suite 210 Sacramento, CA 95814	(916) 552-6619 Fax (916) 441-3494
39	UC Davis Care Management	Janet Heath, MA	UC Davis Care Management MSSP/Linkages/Caregiver Supt. 3700 Business Dr, Ste 130 Sacramento, CA. 95820	(916) 734-5432 Fax (916) 454-3070
40	Western University Of Health Sciences, Center for Disability Issues and Health Professionals (CDIHP)	Brenda Premo, Director	309 E. Second Street Pamon, CA. 91766-1854	(909) 469-5380 Fax (909) 469-5503
41	Westside Center for Independent Living	Mary Ann Jones, Executive Director	12901 Venice Boulevard Los Angeles, CA. 90056	(310) 390-3611 Fax (310) 390-4906
42	WID World Institute Disability	Kathy Martinez, Executive Director by Byron MacDonald	510 Sixteenth Street, Suite 100 Oakland CA. 94612-1500	(510) 763-4109 Fax (510) 763-4109



October 19, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

On behalf of AARP California's over 3 million members, we support the California Department of Health's application for the "*Money Follows the Person Rebalancing Demonstration.*" These funds will help older and disabled persons move out of an institutional setting and back into their homes and community settings appropriate to their individual support requirements and preferences.

AARP is a nonprofit, nonpartisan membership organization that works to help people 50+ have independence, choice and control in ways that are beneficial and affordable to them and society as a whole.

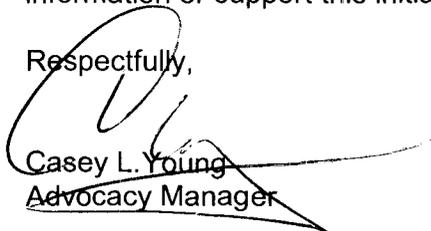
California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. We feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project. The demonstration project supports AARP principles of independence, choice and control.

AARP members overwhelmingly want to live in their own communities. They want a system that is consumer-directed and that gives them more choices in types of services and in the settings in which they are offered. Through this initiative, consumers of long-term care services will be able to make informed decisions about their care through a self-directed option. This option will allow consumers to make personal choices and more easily access their preferred settings.

AARP California strongly supports the state in applying for these new funds. AARP California is firmly committed to providing our support and expertise throughout the term of this demonstration project. We urge you to look favorably upon California's proposal.

Please contact Nina Weiler-Harwell at 916-556-3027 if we can provide you with further information or support this initiative in other ways.

Respectfully,


Casey L. Young
Advocacy Manager

cc: Tom Porter
Nina Weiler-Harwell



October 16, 2006
 S. Kimberly Belshé, Secretary
 California Health and Human Services Agency
 1600 9th Street, Suite 460
 Sacramento, CA 95819

Dear Ms. Belshé:

The Alameda County Network of Mental Health Clients, the administrative and programmatic umbrella for 5 client-run self-help groups, submits this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration." We are persons labeled with psychiatric disabilities. Our mission is to provide the services and supports clients choose in order to bring about true community integration. We want to live in our communities without having to forego our basic civil rights.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. We feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

With any proposal, program, demonstration, and/or pilot, we want to ensure that any services delivered be chosen by the persons receiving those services and that all services be **free of any coercion**—this is particularly important when persons with psychiatric disabilities are receiving services in the community. We strongly hope that, with the above caveat in mind, you will look favorably upon California's proposal.

Sincerely,


 Kathie Zatzkin, System Liaison
 Alameda County Network of Mental Health Clients; Olmstead Advisory Committee member

**Alameda County Network of Mental Health Clients 3238 Adeline Avenue
 Berkeley CA 94705 (510) 652-5891/Main 510 655-8007/Direct**



aging services of californiaSM

Advocating Quality Senior Living and Care

October 18th, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

Aging Services of California is pleased to be submitting this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

Aging Services of California (formerly the California Association of Homes and Services for the Aging) is the primary statewide organization representing the full spectrum of senior living services. Aging Services' members have ties to their local communities through volunteer boards of directors and have a long-term commitment to providing housing, health care and community services to older adults. We have been the leader in the field of senior living services since our founding in 1961, and today our members provide affordable housing, health care and community services to more than 80,000 seniors throughout the state.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. We feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

Aging Services of California is firmly committed to providing support and expertise throughout the term of this demonstration project, and strongly hope that you will look favorably upon the state's proposal.

Respectfully,

Rick Taylor
Associate Director of Public Policy

AltaMed

October 16, 2006

The Honorable Kimberly Belshe, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshe:

On behalf of AltaMed Health Services, I am pleased to submit this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

Founded in 1969 as the East Los Angeles Barrio Free Clinic, AltaMed's mission is to help Latino and multiethnic medically underserved communities access comprehensive health and human services. AltaMed is deeply concerned about long term care issues and initiated services to the elderly by opening one of the first Adult Day Health Care Centers in the state in 1982. Currently, we provide a vast array of programs designed to keep the elderly out of nursing homes: Senior BuenaCare PACE, MSSP, ICMP and ADHCs. AltaMed is also a Federally Qualified Health Center (FQHC) that provides primary medical care, prenatal care, dental care, HIV treatment and prevention, health education, youth services programs and specialized programs to assist persons with substance abuse. More than 70,000 persons receive services annually through our various programs.

California's Money Follows the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. This community approach and the engagement of a broad range of stakeholders representing ethnically diverse communities is integral to the success of the project.

Many families in our community have expressed a dire need for more resources that will help their loved ones transition from a nursing home to an independent setting. Frequently, safe and affordable housing options are not available leaving families with the difficult decision of nursing home placement.

I am firmly committed to provide our support and the expertise of our staff throughout the term of this demonstration project. We hope that CMS will look favorably upon California's proposal.

Sincerely,



Castulo de la Rocha, J.D.
President & CEO

CALIFORNIA COUNCIL



the compassion to care, the leadership to conquer

Officers

Jack Farr
President
Aptos

Robb Fanno
Vice President
Chico

Carvette McCalib
Secretary
Salinas

Herb Hirsh
Treasurer
Woodland Hills

October 19, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

On behalf of the Alzheimer's Association and the 500,000 California families living with dementia, I am writing in support of the California Department of Health Services' (DHS) application for the *Money Follows the Person Rebalancing Demonstration*.

The Association is dedicated to protecting and expanding community-based services that enable people with Alzheimer's to remain at home. We are also committed to reducing barriers to accessing these services, which is a primary focus of DHS' application.

California's *Money Follow the Person Demonstration* proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. We feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

We are particularly supportive of the component of the application that will evaluate the barriers to rebalancing the funds currently spent throughout California's long term care delivery system, including nursing homes. Continuing fiscal realities dictate that we must be resourceful and creative in shifting resources to enable people to remain in the community.

The Alzheimer's Association is firmly committed to providing our support and expertise throughout the term of this demonstration project. We urge your support of California's proposal.

Sincerely,

Jackie Wynne McGrath
Executive Director

IB CAPITOL OFFICE
STATE CAPITOL, ROOM 3048
SACRAMENTO, CA 95814
TEL (916) 651-4027
FAX (916) 327-9113

LONG BEACH OFFICE
115 PINE AVENUE, SUITE 430
LONG BEACH, CA 90802
TEL (562) 495-4766
FAX (562) 495-1876

PARAMOUNT OFFICE
16401 PARAMOUNT BLVD.
PARAMOUNT, CA 90723
TEL (562) 529-6659
FAX (562) 529-6662

SENATOR.LOWENTHAL@SEN.CA.GOV

WWW.SEN.CA.GOV/LOWENTHAL

October 18, 2006

California State Senate

SENATOR
ALAN LOWENTHAL
TWENTY-SEVENTH SENATE DISTRICT



TRANSPORTATION
AND HOUSING
CHAIR
SUBCOMMITTEE ON
CALIFORNIA PORTS AND
GOODS MOVEMENT
CHAIR
BANKING, FINANCE
AND INSURANCE
BUDGET AND FISCAL
REVIEW
EDUCATION
LABOR AND INDUSTRIAL
RELATIONS
NATURAL RESOURCES
AND WATER
ENVIRONMENTAL QUALITY

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Secretary Belshé:

As a former member of the Assembly Committee on Aging and Long-Term Care, I am writing in support of the California Department of Health Services' application to the Center for Medicare & Medicaid Services for the Money Follows the Person Rebalancing Demonstration Project proposal.

I am deeply concerned about California's lack of preparation to meet the needs of the fastest growing segment of our population – the elderly. By supporting the right of self-determination for individuals who reside in institutions, California moves toward the goal of empowering older Californians to live long and healthy lives with dignity. In addition, it is extremely critical for the wellbeing of these individuals to live in an environment of their own choosing.

California's Money Follows the Person Demonstration Project proposal focuses on supporting community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. Specifically, the project will enable us to learn about the experiences of local communities who have developed and coordinated transition programs that identify best practices and reflect the needs of California's diversity.

I hope the Centers for Medicare & Medicaid Services look favorably upon California's comprehensive proposal, which reflects the input of the California Department of Health Services, Department of Mental Health Services, and the many stakeholders representing the needs of our diverse communities.

Sincerely,

Alan Lowenthal
Senator, 27th District

REPRESENTING THE CITIES OF THE 27TH SENATE DISTRICT
ARTESIA, AVALON, BELLFLOWER, CERRITOS, DOWNEY, HAWAIIAN GARDENS, LAKEWOOD, LONG BEACH,
LYNWOOD, PARAMOUNT, SIGNAL HILL, SOUTH GATE, FLORENCE-GRAHAM AND WILLOWROCK

PRINCIPAL CONSULTANT
Allison Ruff

COMMITTEE SECRETARY
Sarah Loftin

STATE CAPITOL
P.O. BOX 942849
Sacramento, CA 94249-0087
(916) 319-3990

Assembly California Legislature

ASSEMBLY COMMITTEE ON AGING AND LONG-TERM CARE

PATTY BERG, CHAIR

MEMBERS:
LYNN DAUCHER, VICE CHAIR
RUDY BERMÚDEZ
JOE CANCIAMILLA
MIMI WALTERS

October 16, 2006



2073

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Secretary Belshé:

As Chair of the Assembly Committee on Aging and Long-Term Care, I am writing in strong support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

As you are well aware, California faces a number of challenges and opportunities with respect to the aging of our population. By supporting the right of self-determination for individuals who reside in institutions, we can further our goals of empowering all Californians and ensure that older adults and adults with disabilities are able to live long, healthy and dignified lives, and do so in the environment of their choosing. California's Money Follows the Person Demonstration proposal is a key step in moving towards a brighter future for all of our residents.

California's proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. I believe that this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

Through this demonstration, we can build upon the experiences of local communities who have developed coordinated transition programs. We can identify and learn from the best practices, and we can identify the barriers that prevent successful transitions from institutions to the community. California is a large and diverse state, by piloting this program in a range of areas; we can build a network of services and supports for all Californians, whether they live in Weaverville, or Los Angeles.

I am firmly committed to providing my support and expertise throughout the term of this demonstration project. I strongly hope that you will look favorably upon California's proposal.

Sincerely,

A handwritten signature in cursive script that reads "Patty Berg".

PATTY BERG, Chair

PB: ar

STATE CAPITOL
P.O. BOX 942849
SACRAMENTO, CA 94249-0013
(916) 319-2013
FAX (916) 319-2113
DISTRICT OFFICE
455 GOLDEN GATE AVE., SUITE 14300
SAN FRANCISCO, CA 94102
(415) 557-3013
FAX (415) 557-3015
assemblymember.leno@assembly.ca.gov
www.asm.ca.gov/leno

Assembly California Legislature



MARK LENO
ASSEMBLYMAN, THIRTEENTH DISTRICT

COMMITTEES

- PUBLIC SAFETY, Chair
- APPROPRIATIONS
- ELECTIONS AND REDISTRICTING
- LABOR AND EMPLOYMENT

October 18, 2006

2112

Ms. Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Secretary Belshé:

I am writing in strong support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration."

California faces a number of challenges and opportunities with respect to the aging of our population. By supporting the right of self-determination for individuals who reside in institutions, we can further our goals of empowering all Californians and ensure that older adults and adults with disabilities are able to live long, healthy and dignified lives, and do so in the environment of their choosing. California's Money Follows the Person Demonstration proposal is a key step in moving towards a brighter future for all of our residents.

California's proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. This community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

Through this demonstration, we can build upon the experiences of local communities who have developed coordinated transition programs. We can identify and learn from the best practices, and we can identify the barriers that prevent successful transitions from institutions to the community. California is a large and diverse state, by piloting this program in a range of areas; we can build a network of services and support for all Californians, wherever they live.

I strongly hope that you will look favorably upon California's proposal, and thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "Mark Leno".

Mark Leno,
13th District

Association of California Caregiver Resource Centers

October 11, 2006

Secretary Kim Belshé
California Health & Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95814

Dear Ms. Belshé:

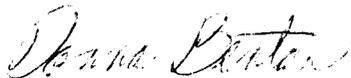
The Association of California Caregiver Resource Centers is in full support of California's application for Medicare and Medicaid Services "Money Follows the Person Rebalancing Demonstration".

We are excited that California is proposing a "Money Follow the Person Demonstration" that focuses on a community level infrastructure that will assist those in institutions moving into their community and will need to use community-based services. We agree that this community level approach is integral to the success of the project.

This demonstration is consistent with our mission to ensure that family caregivers needs are addressed through access to long-term support should their family member return home after being institutionalized.

Be assured that the Association of California Caregiver Resource Centers offers our commitment and support throughout the term of this demonstration project. We hope that you will look favorably upon California's proposal.

Sincerely,



Donna Benton
President

CALIFORNIA ADVOCATES FOR NURSING HOME REFORM

650 Harrison Street • 2nd Floor • San Francisco, CA 94107 • 415-974-5171 • 800-474-1116 • Fax 415-777-2904

October 20, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

RE: Money Follows the Person Rebalancing Demonstration

Dear Ms. Belshé:

California Advocates for Nursing Home Reform (CANHR) strongly supports the establishment of a Money Follows the Person Demonstration project in California.

Founded in 1983, CANHR is a non-profit advocacy and service organization dedicated to improving the quality of care and quality of life for long-term care residents in California.

Many thousands of Californians who need long term care are unnecessarily institutionalized in nursing homes due to lack of available and affordable home and community based services. Home and community based services should be the foundation of our long-term care system.

CANHR lacks sufficient information to endorse the details of the CDHS application. We are encouraged, however, that the Department has engaged a broad range of stakeholders to provide initial feedback on its plans. CANHR encourages CHHSA and CDHS to develop an ambitious proposal to expand and improve home and community based services and to maximize the number of nursing home residents who will be able to participate in this demonstration project.

CANHR is committed to providing support and expertise to help reform California's long term care system.

Sincerely,



Pat McGinnis
(M.C.)

Patricia McGinnis
Executive Director

California Assisted Living

CALA

Association

October 20, 2006

455 Capitol Mall

Suite 604

Sacramento

California

95814-4405

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

The California Assisted Living Association (CALA) is pleased to support the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

(916) 448-1900

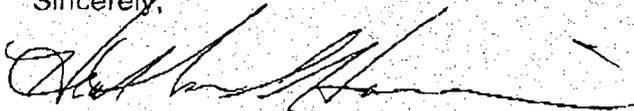
CALA members serve elderly Californian's who need 24-hour care and supervision, including assistance with activities of daily living and some health related services. Many of our 400+ members are well equipped to care for people who have been inappropriately placed in a skilled nursing facility.

Fax: (916) 448-1659

Consistent with the assisted living philosophy, CALA has a record of supporting efforts that empower individuals to make decisions regarding their own care and that encourage individuals to live as independently as possible in the setting of their choice. CALA supported the effort to create a Medicaid waiver for assisted living and supports the State's continued efforts to promote access to assisted care. While the MFP program doesn't specifically address access to assisted living, it does have the potential to help identify individuals who could benefit from the services and direct them to the Medicaid waiver for assisted living program.

CALA is committed to work with the department throughout the term of this demonstration project.

Sincerely,



Heather S. Harrison
Vice President of Public Policy

The Voice of
Assisted
Living



CALIFORNIA ASSOCIATION OF AREA AGENCIES ON AGING

October 24, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

The California Association of Area Agencies on Aging (C4A) supports the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

C4A is the statewide organization representing the 33 area agencies on aging in California.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. I/we feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

C4A is firmly committed to providing our support and expertise throughout the term of this demonstration project. We strongly hope that you will look favorably upon California's proposal.

Sincerely,

Derrell Kelch,
Executive Director

Oct-31-2006 17:19

From-

T-627 P.002/002 F-743

CALIFORNIA
ASSOCIATION OF
HEALTH FACILITIES



October 31, 2006

*Supporting People,
Health and
Quality of Life*

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

2201 K Street
P.O. Box 53700-1
Sacramento, CA
(95816) 95853-7004
fax (916) 441-6441
(916) 441-6400

Dear Ms. Belshé: *Kim*

1125 West Sixth Street
Suite 304
Los Angeles, CA
90017
fax (213) 627-6106
(213) 627-3000

I am submitting this letter on behalf of the California Association of Health Facilities (CAHF), a not-for-profit organization representing the majority of California's skilled nursing facilities (SNFs), in support of the concepts outlined in the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

P.O. Box 370
La Jolla, CA
92038
fax (760) 944-1049
(760) 944-1666

CAHF has long-held that people should have the choice to remain in the community as long as possible and, based on individual preferences and abilities, should also have the opportunity to transition from SNFs to the community. Consistent with this belief, as the continuum of care has shifted in California, SNFs increasingly care for people who, several years ago, would have been served only in acute hospitals. In addition to serving a population that is sicker, The Office of Statewide Health Planning and Development Utilization Reports show that, while some people remain in SNFs or are referred to other more appropriate medical settings, over half of all people receiving SNF services will be discharged within 30 days. Less than 12% will be there longer than 1 year and it is this latter group who will be the major focus of the Department's demonstration. CAHF also understands that the scope of this project will encompass all SNFs throughout California whether they are operated by public or private entities. Further, CAHF believes a coordinated, community-level approach and collaboration among a broad range of stakeholders is integral to the success of this project.

www.cahf.org

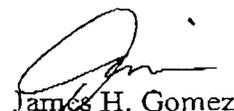
Floyd Rhoades
Chairman of the Board

CAHF wishes to affirm our commitment to providing support and expertise as the demonstration project develops and we strongly hope CMS will look favorably upon California's proposal.

Frances Foy
Vice Chairman of the Board

Sincerely,

Debby Friedman
Secretary/Treasurer


James H. Gomez
CEO/President

Richard Mendlen
Immediate Past Chairman

James H. Gomez
CEO/President

October 16, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

On behalf of the California Association of Public Authorities for In-Home Supportive Services (CAPA), I am submitting this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

Among the purposes of CAPA is to develop and support public policy to improve personal assistance services and to prevent inappropriate, premature placement of consumers in institutions.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. The CAPA board feels this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

We are pleased to be listed as one of the organizations that could participate in the Community Transition Team. One of the specific roles of IHSS Public Authorities is to provide a registry of screened independent provider home care workers from which IHSS consumers can hire their own worker. In some counties, our registry services are used to assist people either in delaying institutionalization or in transitioning from a hospital or nursing facility to home. In addition to promoting a policy that supports the expansion of home and community-based programs, our agencies may be able to assist in implementation of a Money Follows the Person Demonstration.

CAPA is committed to providing support and expertise throughout the term of this demonstration project. We urge you to look favorably on California's proposal.

Sincerely,


Donna Calame
President, CAPA

1300 National Drive, Suite 173
Sacramento, CA 95834

Telephone: 916-419-7591
Fax: 916-419-7596
E-Mail: CCoA@cco.ca.gov
Web Site: www.CCoA.ca.gov



Executive Director
Sandra Fitzpatrick

October 12, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Secretary Belshé:

The California Commission on Aging (CCoA) is pleased to submit this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

The CCoA functions as the principal advocate and advisor to the Governor and California State Department on Aging (CDA), to the State, Federal, and Local departments and agencies to ensure a high quality of life for older Californians. A high quality of life means that older persons are an integral part of society as they age, that they have every opportunity to function as a part of that society, and that if they become disabled, aid is available to help them age with dignity in the environment of their choice. In addition, the CCoA has monitoring responsibilities for the *Long Range Strategic Plan for an Aging California Population; Preparing for the Baby Boomers (LRSPA)*.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. We feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

The CCoA is firmly committed to providing its support and expertise throughout the term of this demonstration project. We strongly hope that you will look favorably upon California's proposal.

Sincerely,

A handwritten signature in black ink, appearing to read "Jorge Lambrinos".

Jorge Lambrinos, Chair

⋮
Californians for Disability Rights

**909 12th Street, Suite 200
Sacramento, Ca., 95814
916 447-2237 or 1-800-838-9237**

October 13, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

Californians for Disability Rights, Incorporated [CDR] is pleased to submit this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration". CDR is a statewide grassroots membership organization serving Chapters and members since 1970. We are committed to preserving the rights and independence achieved through advocacy, and constantly strives to improve the opportunities for all Californians to live rich and full lives in their communities. We work to fulfill our mission:

***To Improve the Quality of Life for All Persons
with any Disability Through Education and Training
— By Working to Remove Barriers
Through Advocacy and Change in Public Policy***

and have been active participants in stakeholder workgroups to help bring about the promise of the Americans with Disabilities Act, and the subsequent Supreme Court ruling referred to as "Olmstead" as well as providing input to the state funded Medicaid programs.

California's Money Follows the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. We feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

Californians for Disability Rights remains committed to the rights of individuals of any age, of any earnings or assets or any level of disability to have the right to choose the setting for receiving service from any provider. This demonstration project will increase the state resource capacity to meet the rights of all Californians. CDR is firmly committed to providing our support and expertise throughout the term of this demonstration project. We strongly hope that you will look favorably upon California's proposal.

Sincerely,



Laura Williams, President
Californians for Disability Rights

CDR – A Force for Change

10/18/2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

The California Foundation for Independent Living Centers (CFILC) is pleased to submit this letter of support on the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration Proposal".

Over 140,000 people with disabilities live more independently as a direct result of the services provided by the 26 Independent Living Centers represented by CFILC. The implementation of the Olmstead Decision is a major priority for CFILC and this project has the potential to re-balance long-term care in our state, to focus on community options and to allow over 2,000 individuals an opportunity to live in the community.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. We feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

CFILC is firmly committed to providing support and expertise throughout the term of this demonstration project and beyond.

Sincerely,


Teresa Favuzzi
Executive Director

California
Foundation
for Independent
Living Centers

1029 J Street, Suite 120
Sacramento, CA 95814
(916) 325-1690
TDD (916) 325-1695
Fax (916) 325-1699
www.cfilc.org

- Access Center of San Diego, Inc. - San Diego
- Center for Independence of the Disabled - Belmont
- Center for Independent Living - Fresno
- Central Coast Center for Independent Living - Salinas
- Communities Actively Living Independent & Free - Central LA
- Community Access Center - Riverside
- Community Rehabilitation Services - Los Angeles
- Community Resources for Independence - Santa Rosa
- Community Resources for Independent Living - Hayward
- Dayle McIntosh Center for the Disabled - Anaheim
- Disability Resources Agency for Independent Living - Modesto
- Disabled Resources Center - Long Beach
- FREED Center for Independent Living - Grass Valley/Marysville
- Independent Living Center of Kern County - Bakersfield
- Independent Living Resource Center San Francisco - San Francisco
- Independent Living Resource Center of Contra Costa & Solano Counties - Concord
- Independent Living Resource Center - Santa Barbara/Ventura/S.L.O.
- Marin Center for Independent Living - San Rafael
- Placer Independent Resource Services - Auburn
- Rolling Start, Inc. - San Bernardino/Inyo/Mono
- Independent Living Center - East San Gabriel Valley
- Silicon Valley Independent Living Center - San Jose
- Southern California Rehabilitation Services - Downey
- Tri-County Independent Living, Inc. - Eureka
- Westside Center for Independent Living - Los Angeles



12000th Street
Sacramento, CA 95814

October 27, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

The California Hospital Association Hospital Services for Continuing Care (CHA HSCC) is submitting this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

The California Healthcare Association is a nonprofit organization dedicated to representing the interests of hospitals and health systems in California. CHA has nearly 500 hospital and health system members, including general acute care hospitals, hospital-based skilled nursing facilities, inpatient rehabilitation hospitals, psychiatric hospitals, academic medical centers, county hospitals, investor-owned hospitals, and multi-hospital health systems. These members furnish vital health care services to millions of our states' citizens. CHA provides its members with state and federal representation in the legislative, judicial, and regulatory arenas, in an effort to improve health care quality, access and coverage; promote health care reform and integration; achieve adequate health care funding; improve and update laws and regulations; and maintain public trust in health care.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. We feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

CHA HSCC is committed to providing our support and expertise throughout the term of this demonstration project. We strongly hope that you will look favorably upon California's proposal.

Sincerely,

A handwritten signature in black ink, appearing to read "Patricia Blaisdell".

Patricia Blaisdell
Vice President, Hospital Services for Continuing Care
(916) 552-7553
pblaisdell@calhospital.org



CONGRESS OF CALIFORNIA SENIORS

1230 "N" STREET, SUITE 201, SACRAMENTO, CA 95814 • (916) 442-4474 • (800) 543-3352 • FAX (916) 442-1877 • www.seniors.org

October 11, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95814

Dear Secretary Belshé:

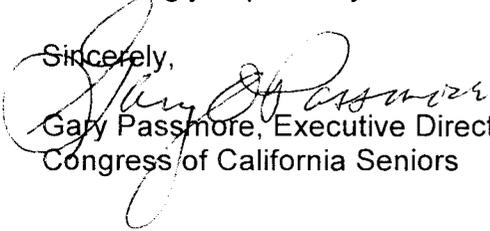
I am submitting this letter on behalf of the Congress of California Seniors to express our support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

The Congress of California Seniors (CCS), founded in 1977, is a statewide nonprofit advocacy organization registered as a 501(c)(4) California corporation. As a public advocacy organization we focus on health, housing, and consumer issues that impact older adults. In recent years, we have broadened our efforts by developing and conducting public education and outreach programs for seniors, minorities, and the community at large. We have a diverse membership and active volunteers. We have been actively engaged in securing reforms and sufficient funding for long term care for California seniors and persons with disabilities, and have participated in the stakeholder review process that contributed to the development of this proposal.

California's Money Follow the Person Demonstration proposal will focus on community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. We feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

In recent years we have worked closely with the associations representing California's long term care facilities as well as organizations representing their care giving employees. This work has allowed us to build a positive partnership to bring about change and a dialogue to examine future actions needed in California. This proposal is certainly consistent with those actions and we are firmly committed to providing support and expertise throughout the term of this demonstration project. We strongly hope that you will look favorably upon California's proposal.

Sincerely,


Gary Passmore, Executive Director
Congress of California Seniors



October 19, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

On behalf of the Contra Costa Health Plan (CCHP) I am pleased to submit this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

Contra Costa County has long been involved in working to build a system that will support county residents' ability to remain independent in the community. To this end, CCHP has had a collaborative relationship with the County Aging & Adult Services for over ten years, working to build a system of long term care integration.

California's Money Follow the Person Demonstration proposal will focus on supporting the community-level infrastructure that facilitates transitions from institutions to the community by using existing home and community-based systems. We know from experience that this community-level approach, coming from the grass-roots, is what makes a project like this successful.

Over the past four years, Aging & Adult Services PACT program has been proof that individuals and their families can succeed in returning to the community. We would welcome a chance to expand that pilot program further in the state and in Contra Costa County.

The Contra Costa Health Plan is firmly committed to providing our support and expertise throughout the term of this demonstration project. We are hopeful that you will look with favor upon California's proposal.

If I can provide any further information, please do not hesitate to call me at (925) 313-6009.

Sincerely,


Patricia Tanquary, MSW, PhD
Chief Operating Officer and Acting Chief Executive

2111

Oct. 18, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

Council on Aging-Orange County is submitting this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration" [MFP].

The Council on Aging-Orange County is a 501 (c) (3) nonprofit corporation, serving older and dependent adults and their families throughout Orange County. Council on Aging provides services to older adults, frail elderly, and disabled persons 18 years and older through out Orange County. Our mission is to promote adult empowerment, prevent abuse and advocate for the rights and dignity of those experiencing health and aging challenges.

Research shows that persons with disabilities and their families overwhelmingly prefer home and community based care over institutional care. However, low-income individuals who are eligible for publicly funded services have no choice in long-term care options. There are very limited services available for them in the community.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. We feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

Once the MFP program is in place, low-income elderly and individuals with disabilities will have more options to receive services in their own homes and communities. They will obtain greater control over their lives, which will result in improved quality of life. Council on Aging-Orange County has two programs directly related to transition from facilities to the community. Ombudsman staff and volunteers and Linkages case managers will play an important role in the process.

Council on Aging-Orange County is firmly committed to providing our support and expertise throughout the term of this demonstration project. We strongly hope that you will look favorably upon California's proposal.

Sincerely,


Pamala McGovern
Executive Director



1971 East 4th Street
Suite 200
Santa Ana
California
92705-3917

TEL 714.479.0107
FAX 714.479.0234

HICAP
TEL 714.560.0424
FAX 714.560.0319

www.coaoc.org



County of San Diego

JEAN M. SHEPARD
DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY
1700 PACIFIC HIGHWAY, SAN DIEGO, CALIFORNIA 92101-2417

PAMELA B. SMITH
DIRECTOR

AGING & INDEPENDENCE SERVICES
9335 HAZARD WAY, SAN DIEGO, CALIFORNIA 92123-1222
(858) 495-5858 FAX (858) 495-5080

October 18, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

I am submitting this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration" on behalf of Aging & Independence Services and all our community partners. Our programs in San Diego strive to improve health and social services for the elderly and disabled so that choices for independence are expanded.

Aging & Independence Services (AIS) is a division within the County of San Diego's Health and Human Services Agency. It is the local Area Agency on Aging combined with all County-related aging and disability services, including the distinct part nursing facility. AIS has over 700 employees, and an annual budget of \$255 M. AIS is the hub of the aging network and partners with the local Independent Living Center (the Access Center) as one of the California Aging and Disability Resource Center sites. The Access Center has a foundation grant for a deinstitutionalization project, which AIS supports with several staff participating in Steering Committee meetings to plan future collaboration and teamwork. AIS has also held State contracts for Medicaid waivers for over 20 years.

Over the last seven years, AIS's Long Term Care Integration Project (LTCIP) has worked with 750 stakeholders to assess local need and willingness to change the culture of local care. Much work has been completed, including actuarial analysis, contract language recommendations, and care management standards for a fully integrated Medicare and Medi-Cal pilot. The products, process and history are available to the public on the project web site at www.sdltcip.org.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. I/we feel this

Kimberly Belshé, Secretary
October 18, 2006
Page 2

community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

AIS is firmly committed to providing support and expertise throughout the term of this demonstration project and see the opportunity for a local demonstration site as a natural transition for the deinstitutionalization project at the Access Center which will give this community a “running start”! We strongly hope that you will look favorably upon California’s proposal.

Sincerely,

A handwritten signature in black ink that reads "Pamela B. Smith". The signature is written in a cursive style with a large initial "P" and "S".

PAMELA B. SMITH
Director

PBS:egg

FROM :Dayle McIntosh Center

FAX NO. :714-663-2094

Oct. 30 2006 12:37PM P1



*Our Mission is:
To advance the empowerment, equality,
integration and full participation of people
with disabilities in the community.*

October 30, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Secretary Belshe:

The Dayle McIntosh Center (DMC) is the independent living center for Orange County; our mission is to advance the empowerment, equality, integration and full participation of people with disabilities in the community. As the Executive Director of DMC, we are submitting this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration", being submitted to the Centers for Medicare and Medicaid Services (CMMS).

We are very involved with the prevention of unnecessary institutionalization of people with disabilities and assuring individuals return to the community who have been so incarcerated.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. We feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

Although there have been significance barriers with the transition process of returning those in institutions to a life of independence in the community, DMC has assisted dozen of people to do so in our over 29 years of inservice. Unfortunately, however, we know there were 1,000 of individuals who we were unable to assist because of these barriers, who have died in facility or are still waiting to leave.

FROM :Dayle McIntosh Center

FAX NO. :714-663-2094

Oct. 30 2006 12:38PM P2

DMC is firmly committed to providing **our** support and expertise throughout the term of this demonstration project. **We** strongly hope that CMMS will look favorably upon California's proposal.

Sincerely,

A handwritten signature in black ink, appearing to read "W.D. Chrisner III". The signature is written in a cursive style with a prominent flourish at the end.

W.D. Chrisner III, CRC/LPC
Executive Director

Oct 17 06 02:27p



Creating solutions, changing lives.

Services for children and adults with disabilities in Southern California

Easter Seals

Southern California

16946 Sherman Way, Suite 100
Van Nuys, California
91406
818.996.9902 phone
818.996.1606 fax
www.essc.org

October 17, 2006

Kimberly Belshe, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, Ca 95819

Re: Money Follows the Person

Dear Ms. Belshe:

Easter Seals is in fully support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

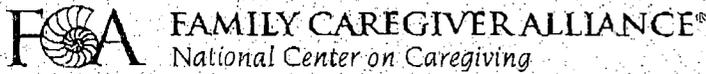
It is the mission of Easter Seals to provide local services that promote equality, dignity and independence for individuals with a disability. The focus of Easter Seals has always been to offer community based services and supports to help people live with dignity and independence. Services offered include an array of individualized supports, Independent Living, Supported Living, Senior Day Programs, Adult Day, and group homes with fewer than four (4) residents per home. Easter Seals currently assists adults in long term care institutions routinely return to their home community and it is our strong hope that this demonstration project will help even more adults achieve the successes they desire.

California's Money Follows the Person Demonstration proposal will focus on the system and supports necessary for individuals to be able to successfully transition from institutions to community living. Our mission and service model are fully aligned with the goals of this application. Easter Seals is committed to providing support and expertise throughout the term of this demonstration project.

Sincerely,

Carlene S. Holden
Easter Seals California

CC: Carol Treels
440-7540



180 Montgomery Street
Suite 1100
San Francisco, CA 94104

800-445-8106
415-434-3388
415-434-3508 Fax
info@caregiver.org
www.caregiver.org

- Programs
- National Center on Caregiving
- Statewide Resources Consultant
- Bay Area Caregiver Resource Center
- Research, Policy & Program Development
- Consumer & Professional Publications
- Education & Training
- Corporate Eldercare Programs
- Online Services/ Link2Care

A nonprofit, tax-exempt organization

October 23, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

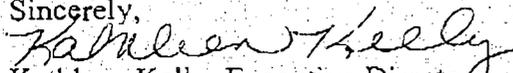
Family Caregiver Alliance is submitting this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

Family Caregiver Alliance (FCA) is a nonprofit organization with a mission to improve the quality of life for family caregivers through services, education, research and advocacy. For over thirty years, the agency has been working directly with caregivers on their own needs and that of their family, building the capacity of the statewide system of Caregiver Resource Centers and advocating policies and practices on a national level to ensure development of caregiver support services and programs in every state.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. FCA feels this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

Rebalancing may often involve family and friends during and after a transition from nursing home to a community setting. For some families, this may mean that a family member takes on the role of primary caregiver -- a role that needs practical support. FCA has extensive experience in working with families to provide the education, counseling, respite and planning required to take care of the caregiver as well as maintain the individual in a home setting. We would welcome to the opportunity to provide any assistance about these issues during the planning and implementation of this pro

FCA is firmly committed to providing our support and expertise throughout the term of this demonstration project. We strongly hope that you will look favorably upon California's proposal.

Sincerely,

Kathleen Kelly, Executive Director

FROM :GP

FAX NO. :9163325980

Oct. 11 2006 09:23AM P2



P.O. Box 19538
Sacramento, CA 95819
916.332.5980
www.graypanthersacramento.org

October 11, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

Gray Panthers California is pleased to offer our total support for the submission of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

Gray Panthers California is a statewide organization, a part of the National Gray Panthers non-profit organization, with 2,000 official members of networks and approximately 1,000 at large members in California. Gray Panthers are mainly seniors, often in the mid to low income bracket, with both a personal and organizational investment in the future of long term care for seniors and disabled persons. We have worked for years to improve the quality of nursing care, in and out of facilities and are active on the Olmstead Advisory Committee through the appointment to that body of Joan Lee. Our members are strong representatives and many times workers in the In-Home-Supportive-Services (IHSS) system, and have striven to see the provision of quality care by homecare workers.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. We strongly feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

Having carefully reviewed the various aspects of the proposal, we feel it has real potential for achieving the success long sought for by Californians, to finally assure the best in care for those in need. We will offer any assistance we can in support of the projects if funded, and will assure information and education about the project offerings are widely distributed in the state through our outreach.

READY FOR ACTION



TO TAKE ON THE FUTURE



FROM :GP

FAX NO. :9163325980

Oct. 11 2006 09:22AM P1

Page 2, Gray Panthers, Oct 11, 2006

efforts, and providing support and expertise throughout the term of this demonstration project. Gray Panthers strongly urge you to give favorably consideration to California's proposal.

Sincerely,



Joan B. Lee
Legislative Liaison
Gray Panthers California
5313 Fernwood Way
Sacramento, CA 95841
916-332-5980
Joanblee78@lanset.com

FAXED to: Carol Freels, Chief Office of Long-Term Care
Department of Health Services
ATTN: DRA MFP Support
PO Box 942732, MS 0018
Sacramento, CA 94234-7320
FAX (916) 440-7540 (preferred)



California Association of Public Authorities
for In-Home Supportive Services

Legislative Advocate: Karen Keeslar
1100 N Street, Suite 5C
Sacramento, CA 95814
(916) 448-5049
kreeslar@sbcglobal.net

October 16, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

On behalf of the California Association of Public Authorities for In-Home Supportive Services (CAPA), I am submitting this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

Among the purposes of CAPA is to develop and support public policy to improve personal assistance services and to prevent inappropriate, premature placement of consumers in institutions.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. The CAPA board feels this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

We are pleased to be listed as one of the organizations that could participate in the Community Transition Team. One of the specific roles of IHSS Public Authorities is to provide a registry of screened independent provider home care workers from which IHSS consumers can hire their own worker. In some counties, our registry services are used to assist people either in delaying institutionalization or in transitioning from a hospital or nursing facility to home. In addition to promoting a policy that supports the expansion of home and community-based programs, our agencies may be able to assist in implementation of a Money Follows the Person Demonstration.

CAPA is committed to providing support and expertise throughout the term of this demonstration project. We urge you to look favorably on California's proposal.

Sincerely,

A handwritten signature in cursive script that reads "Donna Calame".

Donna Calame
President, CAPA

IB CAPITOL OFFICE
STATE CAPITOL, ROOM 3048
SACRAMENTO, CA 95814
TEL (916) 651-4027
FAX (916) 327-8113

LONG BEACH OFFICE
115 PINE AVENUE, SUITE 430
LONG BEACH, CA 90802
TEL (562) 495-4768
FAX (562) 495-1876

PARAMOUNT OFFICE
16401 PARAMOUNT BLVD.
PARAMOUNT, CA 90723
TEL (562) 529-6659
FAX (562) 529-6662

SENATOR.LOWENTHAL@SEN.CA.GOV

WWW.SEN.CA.GOV/LOWENTHAL

October 18, 2006

California State Senate

SENATOR
ALAN LOWENTHAL
TWENTY-SEVENTH SENATE DISTRICT



TRANSPORTATION
AND HOUSING
CHAIR
SUBCOMMITTEE ON
CALIFORNIA PORTS AND
GOODS MOVEMENT
CHAIR
BANKING, FINANCE
AND INSURANCE
BUDGET AND FISCAL
REVIEW
EDUCATION
LABOR AND INDUSTRIAL
RELATIONS
NATURAL RESOURCES
AND WATER
ENVIRONMENTAL QUALITY

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Secretary Belshé:

As a former member of the Assembly Committee on Aging and Long-Term Care, I am writing in support of the California Department of Health Services' application to the Center for Medicare & Medicaid Services for the Money Follows the Person Rebalancing Demonstration Project proposal.

I am deeply concerned about California's lack of preparation to meet the needs of the fastest growing segment of our population – the elderly. By supporting the right of self-determination for individuals who reside in institutions, California moves toward the goal of empowering older Californians to live long and healthy lives with dignity. In addition, it is extremely critical for the wellbeing of these individuals to live in an environment of their own choosing.

California's Money Follows the Person Demonstration Project proposal focuses on supporting community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. Specifically, the project will enable us to learn about the experiences of local communities who have developed and coordinated transition programs that identify best practices and reflect the needs of California's diversity.

I hope the Centers for Medicare & Medicaid Services look favorably upon California's comprehensive proposal, which reflects the input of the California Department of Health Services, Department of Mental Health Services, and the many stakeholders representing the needs of our diverse communities.

Sincerely,

Alan Lowenthal
Senator, 27th District

REPRESENTING THE CITIES OF THE 27TH SENATE DISTRICT
ARTESIA, AVALON, BELLFLOWER, CERRITOS, DOWNEY, HAWAIIAN GARDENS, LAKEWOOD, LONG BEACH,
LYNWOOD, PARAMOUNT, SIGNAL HILL, SOUTH GATE, FLORENCE-GRAHAM AND WILLOWBROOK

STATE CAPITOL
P.O. BOX 942849
SACRAMENTO, CA 94249-0013
(916) 319-2013
FAX (916) 319-2113
DISTRICT OFFICE
GOLDEN GATE AVE., SUITE 14300
SAN FRANCISCO, CA 94102
(415) 557-3013
FAX (415) 557-3015
assemblymember.leno@assembly.ca.gov
www.assemblymember.leno.com

Assembly California Legislature



MARK LENO
ASSEMBLYMAN, THIRTEENTH DISTRICT

COMMITTEES

- PUBLIC SAFETY, Chair
- APPROPRIATIONS
- ELECTIONS AND REDISTRICTING
- LABOR AND EMPLOYMENT

October 18, 2006

2112

Ms. Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Secretary Belshé:

I am writing in strong support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration."

California faces a number of challenges and opportunities with respect to the aging of our population. By supporting the right of self-determination for individuals who reside in institutions, we can further our goals of empowering all Californians and ensure that older adults and adults with disabilities are able to live long, healthy and dignified lives, and do so in the environment of their choosing. California's Money Follows the Person Demonstration proposal is a key step in moving towards a brighter future for all of our residents.

California's proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. This community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

Through this demonstration, we can build upon the experiences of local communities who have developed coordinated transition programs. We can identify and learn from the best practices, and we can identify the barriers that prevent successful transitions from institutions to the community. California is a large and diverse state, by piloting this program in a range of areas; we can build a network of services and support for all Californians, wherever they live.

I strongly hope that you will look favorably upon California's proposal, and thank you for your consideration.

Sincerely,

Mark Leno,
13th District

Huntington Memorial Hospital
The Senior Care Network
837 S. Fair Oaks Avenue, Suite 100
Pasadena, California 91105
Telephone (626) 397-3110

2125

October 20, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

This is to express my agency's strong support for California's proposal to the Centers for Medicare and Medicaid Services for the Money Follows the Person Rebalancing Demonstration.

Huntington Hospital's Senior Care Network, founded in 1984, has a rich history of providing home and community-based alternatives to institutionalization. Our mission is to maximize the wellness and independence of adults in our community. As a community-based arm of Huntington Hospital, Senior Care Network fully supports making high quality, effective home and community-based services widely available to California residents.

I understand that California's Money Follow the Person Demonstration proposal will focus on supporting community-level infrastructure to facilitate transitioning individuals from institutions to the community through the use of existing home and community-based systems. This community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

We look forward to participating as a stakeholder in the development and implementation of California's rebalancing demonstration. Please do not hesitate to contact me with any questions. I can be reached at (626) 397-2011.

Sincerely,



EILEEN KOONS, MSW
Director of Government Programs

cc: Sarah S. Steenhausen, California Health and Human Services Agency

In Spirit

IN SUPPORT OF PARALYTIKS IN REALLY INTENSE TIMES

A NONPROFIT ORGANIZATION

October 18, 2006

Kimberly Belshe, Secretary
California Health and Human Services Agency
1600 9th St., Suite 460
Sacramento, CA 95819

Dear Ms. Belshe:

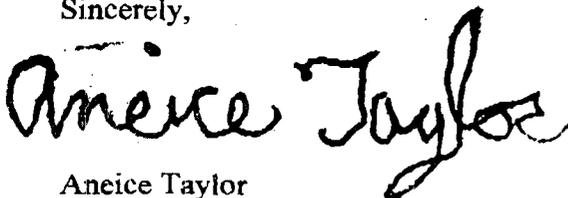
I am submitting this letter in support of the California Department of Health and Human Services' application for the "Money Follows the Person Rebalancing Demonstration".

IN SPIRIT has been providing services to quadriplegics since 1987, and we are aware of the many obstacles that can prevent them from living successfully in the community. In addition, we have repeatedly witnessed the inadequacy of care provided to quadriplegics who are living in nursing homes. Money invested in homecare yields a happier, healthier and more productive person.

We understand California's Money Followed the Person Demonstration proposal focuses on support of community-level infrastructure to facilitate transitions from nursing homes to the community. It is important that you engage stakeholders and disability advocacy groups in your planning.

I hope you will take this opportunity to further efforts to help people move into the community and that you will continue to maximize services for the disabled and elderly population who are endeavoring to stay in their homes and communities.

Sincerely,



Aneice Taylor
Executive Director



Multipurpose Senior Services Program Site Association

921 11th Street, Suite 701, Sacramento, CA 95814 Phone: 916. 552. 7400 Fax: 916. 552. 7404

October 18, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

The Multipurpose Senior Services Program Site Association is submitting this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

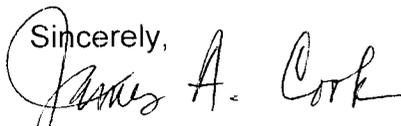
The Multipurpose Senior Services Program (MSSP), authorized as a Federal Medicaid 1915(c) home and community-based services waiver, serves frail, nursing home certifiable older adults in the home in lieu of institutional placement consistent with the Olmstead decision. Forty-one sites provide interdisciplinary care management and support services to more than 11,000 frail elderly clients over age 65. MSSP is a cost-effective alternative to nursing homes – data shows the clients are 25% less costly to the State than nursing home care.

MSSP is widely regarded as one of California's most cost-effective models for individuals in need of alternatives to nursing home care. Consequently, MSSP is in a position to advocate for continued expansion of MSSP or similar models of care as the state continues to pursue Money Follows the Person initiatives and implements elements of the Olmstead decision.

MSA recognizes the important work occurring through California's Olmstead Advisory Committee and the Federal Money Follows the Person initiatives. MSA will continue to play a vital role in designing, developing, and implementing a comprehensive solution for home and community based long term care in California.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems such as MSSP and MSSP's Deinstitutionalized Care Program. We feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

We are firmly committed to providing our support and expertise throughout the term of this demonstration project and strongly hope that you will look favorably upon California's proposal.

Sincerely,

James A. Cook, MSA President



On Lok Senior Health Services

1333 Bush Street

San Francisco, CA 94109-5611

tel: (415) 292-8888

fax: (415) 292-8745

web: www.onlok.org

October 13, 2006

Kim Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

On behalf of On Lok, I am submitting this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

For 35 years, On Lok has assisted seniors to live with dignity by helping them to stay in their homes and neighborhoods for as long as possible. On Lok Senior Health Services is the prototype for the PACE (Program of All-Inclusive Care for the Elderly) model of care for seniors in need of nursing home care. On Lok's PACE program, On Lok SeniorHealth, currently brings comprehensive social and medical services to over 1,025 seniors throughout San Francisco and in southern Alameda County. These services include everything from day health care, home care, social services, transportation and meals to primary medical care and, when necessary, hospitalization and nursing home placement. An interdisciplinary team that includes physicians, nurses, rehabilitative and recreational therapists, and social workers coordinates services and is able to respond quickly to participants' needs, thereby preventing problems when possible. The broad range and intense coordination of services provided by PACE enables seniors to remain at home and in their communities, enjoying a higher quality of life.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. We feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

On Lok is firmly committed to providing our support and expertise throughout the term of this demonstration project. We strongly hope that California's proposal is looked upon favorably.

Sincerely,

A handwritten signature in black ink, appearing to read "RE Edmondson", written over a horizontal line.

Robert Edmondson
Executive Director/ CEO



October 27, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Our guiding principles:

Collaboration · Innovation · Impact

We believe that today's
healthcare and social services
need to change in
fundamental ways.

This requires new strategies and
high-impact innovations.

We seek to design, develop, manage
and pilot new programs that will
serve as replicable models of care.

Together with community-based
organizations and public
and private funders
we work to create these
fundamental changes.

Dear Ms. Belshé:

Partners in Care Foundation is pleased to express our support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration."

Partners in Care is a unique and dynamic organization that is both care provider and innovator with a strong orientation toward creating and testing new models that will form the basis for evidence-based practice. As part of an array of services aimed at helping elders retain their independence, we operate two 1915-C waiver programs under the motto, "Life is Better at Home." The Money Follows the Person Demonstration is an excellent extension of that work – to help institutionalized people *regain* their ability to enjoy life at home.

To realistically enable transitions back into the community for individuals who have been institutionalized for six months or more, it is absolutely essential to build community-level infrastructure and communication protocols that will connect people with existing home and community-based services. California's Money Follow the Person Demonstration proposal will engage a broad range of stakeholders whose participation and collaboration will be integral to the success of the project. The creation of local Community Transition Teams and the use of Relocation Specialists are important and innovative ways to achieve the difficult but laudable goal of connecting frail and disabled people with the housing and services necessary to support them outside of the institutions they have been living in. The plan to involve the nursing facility residents plus their families or personal support systems in the effort to transition back to a home in the community will help ensure that the array of services designed for the person reflect their true desires and choices.

Partners in Care Foundation is firmly committed to California's Money Follows the Person Demonstration and will actively support the effort with our participation and expertise. This is an important step in our society's ongoing effort to ensure that increasing frailty and disability will no longer exile individuals to institutions that separate them from their communities.

Sincerely,

W. June Simmons, CEO

www.pict.org

Ronald L.G. Osterhout

*Executive Director
Chief Operating Officer*

www.pascla.org
rosterhout@pascla.org



*Personal Assistance
Services Council
of
Los Angeles County*

October 17, 2006

Ms. Kim Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

On behalf of the Personal Assistance Services Council of Los Angeles County (PASC), I am writing in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration" grant, which would expand access to home- and community-based services for seniors and individuals with disabilities.

PASC, as you are aware, is the public authority charged by state statute and county ordinance with enhancing the IHSS program by representing the interests of the 155,000 consumers and 124,000 providers of services within LA County. This function allows us to easily see the value of this grant, which augments the community focus of PASC, as it works to improve services within the IHSS program, helping its constituents to live in the safety and dignity of their own homes.

PASC is vigorous in support of efforts that have a favorable impact upon the IHSS program. PASC believes individuals who reside in nursing facilities and other institutions have the right to self-determination, access to home- and community-based services, independence and choice. California's grant proposal will facilitate transitions from institutions to the community through the use of existing home- and community-based systems, as well as the engagement of a broad range of stakeholders, which is integral to the success of the project.

The goals of the grant with respect to assisting nursing facility residents and their family/support circles to transition to the community are integral to PASC's mission, and have been highlighted as concurrent priorities by the PASC Governing Board in supporting the work of the California Olmstead Advisory Committee. PASC joins with the California Association of Public Authorities in a firm commitment to providing our support and expertise throughout the term of this demonstration project.

PASC strongly hopes for a favorable response to California's proposal.

Sincerely,

cc: PASC Governing Board

Protection & Advocacy, Inc.

LEGISLATION & PUBLIC INFORMATION UNIT
1029 J Street, Suite 150, Sacramento CA 95814
Telephone: (916) 497-0331 Fax: (916) 497-0813
www.pai-ca.org

October 25, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

RE: "Money Follows the Person" Application

Dear Ms. Belshé:

Protection and Advocacy Inc., (PAI) a non-profit advocacy agency mandated to advance the human and legal rights of persons who have disabilities, supports the California Department of Health Services' application for the "Money Follows the Person (MFP) Rebalancing Demonstration".

Founded in 1978, PAI is the largest disability rights organization in the United States. We dedicate considerable resources to advocacy on long term care issues, from assisting individual consumers and representing classes of institutionalized persons, to promoting the implementation of the *Olmstead* decision in California.

We believe that rebalancing of long term care expenditures, away from institutions and toward the preferred alternatives of home and community-based services, is long overdue in the state and in the nation.

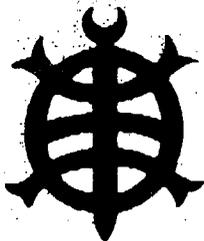
We see the MFP Demonstration as an opportunity to move people and money from institutions, to increase the variety and capacity of community services, and to rethink how long term care is delivered in California into the future. People with a wide range of disabilities of all ages, living in many kinds of institutions, can and should benefit from the demonstration. Participation of the widest possibly array of stakeholders, including institutionalized persons, their caregivers and advocates, will be crucial to the success of the demonstration.

PAI commits to providing our expertise throughout the term of this demonstration project. We look forward to the proposal being funded and to working with you.

Sincerely,

A handwritten signature in black ink that reads "Deborah Doctor". The signature is written in a cursive style with a large, sweeping initial "D".

Deborah Doctor
Legislative Advocate



SAN FRANCISCO SENIOR CENTER

AQUATIC PARK BRANCH, 890 BEACH STREET, SAN FRANCISCO, CA 94109 (415) 775-1868, Fax: (415) 775-4020
DOWNTOWN BRANCH, 481 O'FARRELL STREET, SAN FRANCISCO, CA 94102 (415) 771-7950, Fax: (415) 771-1135

October 20, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

I, *Kathleen Mayeda*, am submitting this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

The Homecoming Service Program here at the Senior Francisco Senior Center is a community-based program, which supports this effort. We are already providing transitional care and work in partnership with hospitals, community-based organizations, and public and private agencies to provide needed services. We would really like to see this effort move along.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. *I/we* feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

I am firmly committed to providing my support and expertise throughout the term of this demonstration project. I strongly hope that you will look favorably upon California's proposal.

Sincerely,

Kathleen Mayeda, Director of Social Services
415-923-4490



3800 Kilroy Airport Way
Suite 100, P.O. Box 22616
Long Beach, CA 90801-5616

October 20, 2006

TEL 562 989.5100
FAX 562 989.5200

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

SCAN Health Plan is submitting this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

Founded in 1977 as the Senior Care Action Network, SCAN Health Plan is a Medicare Advantage organization currently serving over 90,000 Medicare beneficiaries in Southern California, including persons enrolled in Medicare and Medi-Cal. SCAN's mission is to continue to find innovative ways to enhance seniors' ability to manage their health and to control where and how they live.

Over the past 20 years, SCAN has helped to keep over 50,000 seniors out of nursing homes and in their own homes. SCAN has achieved this success by offering home- and community-based services through a client-centered care management approach, in addition to acute medical services.

California's "Money Follow the Person Rebalancing Demonstration" proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. SCAN believes that this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

Recognizing the rapidly growing number of older and frailer Americans and the pressure to comply with the demands of the Oimstead decision, there is currently a major opportunity to encourage the growth of programs that offer alternatives to institutionalization. Because this demonstration project will promote the dignity and independence of seniors and persons with disabilities, SCAN is offering its' support.

SCAN strongly hopes that you will look favorably upon California's proposal.

Sincerely,

A handwritten signature in black ink, appearing to read "Timothy Schwab MD". The signature is fluid and cursive, with a long horizontal line extending to the left.

Timothy Schwab, MD
Chief Medical/Information Officer
SCAN Health Plan

State Independent Living Council (SILC)

1600 "K" Street, Suite 100
Sacramento, CA 95814
Voice: (916) 445-0142
Fax: (916) 445-5973
TTY/TDD: (916) 445-5627



October 17, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

I am writing on behalf of the State Independent Living Council (SILC), a small independent California State government agency, in support of the California Department of Health Services' application for the Money Follows the Person (MFP) Rebalancing Demonstration.

As you know, the mission of the SILC is to enable people with disabilities to live independently. We accomplish this through the state's network of independent living centers and services, as well as a number of grants that support independent living activities each year. SILC members and staff are committed to the principle of independence for people with disabilities as embodied in the Americans with Disabilities Act (ADA), and as reiterated by the Supreme Court in the 1999 *Olmstead* decision. We feel that the State's successful application for financial support for the MFP grant will enhance California's ability to provide additional independent living options outside the walls of our state's long-term care facilities or institutions.

The California MFP Demonstration proposal focuses on the support of the community-level infrastructure that is a critical component for people transitioning from institutions to the community. While we have over 70 different services and programs available in California to support such community living for people with differing types of disabilities, a missing component has been the short- and mid-term support needed during the transition and relocation stages. The draft of the state's MFP Demonstration proposal which I have reviewed appears to fill in this gap in those areas where the demonstrations will occur. One of the strong points of this proposal is the support of a diverse and dedicated group of stakeholders from throughout California who are looking forward to the implementation phase of the MFP project.

Kimberley Belshé

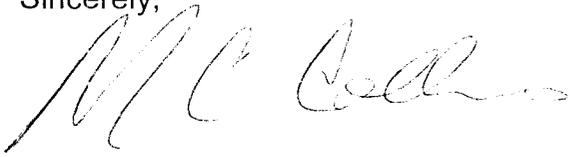
October 18, 2006

Page 2

The SILC and its partner agency, the Department of Rehabilitation, have demonstrated our commitment toward community transition through grant activities for several years. We intend to stay actively involved during the term of the MFP grant, if received, and look forward to a continuation of our positive relationship with the California Health and Human Services Agency in meeting the needs of all Californians with disabilities.

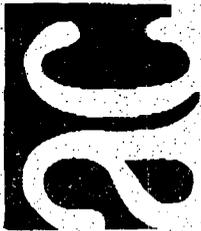
Good luck with the grant proposal, and please call me at (916) 445-0142 if you need any additional information from the SILC.

Sincerely,

A handwritten signature in black ink, appearing to read "M.C. Collins". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

Michael C. Collins
Executive Director

CC: Carol Frick
440-7540



Empowering People
with Disabilities

The **ACCESS CENTER** of San Diego, Inc.

www.accesscentersd.org

1295 University Avenue #10 • San Diego, CA 92103 • (619) 293-3500 • TDD 293-7757 • FAX 293-3508

October 20, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

I, Louis Frick Executive Director of the Access Center of San Diego Inc., am submitting this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

The Access Center is an independent living center and, as such, supports the Supreme Court's 1999 Olmstead decision, which gives people with disabilities the option of living in a community-based setting in the least restricted setting possible.

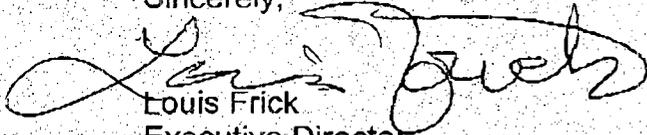
Our mission is to promote full inclusion by empowering and challenging people with disabilities to achieve their greatest potential.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. I/we feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

The Access Center has been assisting people with disabilities as they transition from institutions into community-based living arrangements for the past three years. In August of 2006 we received a generous grant from the California Endowment to significantly expand our deinstitutionalization services, which fits hand in glove with this demonstration project. Through this grant we are working directly with staff at various nursing facilities as we assist residents and their families throughout the transitional process.

As an individual with a disability and as the Executive Director of the Access Center I am firmly committed to providing our support and expertise throughout the term of this demonstration project. We strongly hope that you will look favorably upon California's proposal.

Sincerely,

A handwritten signature in black ink, appearing to read "Louis Frick", written in a cursive style. The signature is positioned above the printed name and title.

Louis Frick
Executive Director



advocacy • respect • commitment

1225 9th Street, Suite 210
Sacramento, CA 95814

October 27, 2006

Kim Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95814

Subject: Endorsement and Commitment to the "Money Follows the Person Rebalancing Demonstration"

Dear Ms. Belshé:

On behalf of The Arc of California, the state's oldest and largest association for people with intellectual and other developmental disabilities and their families, I am writing in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration". The Arc of California, the state chapter of The Arc of the United States an organizational plaintiff on the Olmstead v. L.C. case, is fully committed to the principles as put forth in the Olmstead decision and views the state's application for the Money Follows the Person demonstration as advancing these principles by supporting a community-level infrastructure to ease transitions from institutions to the community through the use of existing home and community-based systems. We agree that this community-level approach, as well as the engagement of a broad range of stakeholders, is integral to the success of the project.

The Arc of California is pleased to note that this demonstration proposal includes helping people with intellectual and other developmental disabilities who are living in institutionalized hospital settings to self determine their lives and lifestyles in the community as do most other people with the same disabilities throughout our state and country.

We are firmly committed to providing our support and expertise throughout the term of this demonstration project. We strongly hope that you will look favorably upon California's proposal.

Sincerely,

A handwritten signature in black ink, appearing to read "Tony Anderson", written over a horizontal line.

Tony Anderson
Executive Director
The Arc of California
(916) 552-6619

Advocates for Persons with Developmental Disabilities and Their Families



UC Davis Care Management
MSSP/Linkages/Caregiver Support
3700 Business Dr., Suite 130
SACRAMENTO, CA 95820
PHONE (916) 734-5432
FAX (916) 454-3070

October 19, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

I am submitting this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration" on behalf of UC Davis Care Management. We have been providing long term care coordination services to the community through the Multipurpose Senior Services Program for over 23 years, the Linkages Program for over seven years, and most recently the Assisted Living Waiver Pilot Project. The mission of UC Davis Care Management is to offer an alternative to institutional care through long term care coordination for those that desire to remain in the community.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. I feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

The Assisted Living Waiver Pilot Project has given us valuable experience in the complexities of transitioning from the nursing home into assisted living facilities. However, the need for deinstitutionalization is real and the public is demanding this option. Every week in Sacramento County we receive about 10 calls from nursing home residents or their families asking to be part of this project because of their desire to be in a home-like environment. Additionally we receive many calls from nursing home administrators that recognize that many of their residents do not need the level of care provided in nursing homes.

UC Davis Care Management is firmly committed to providing support and expertise throughout the term of this demonstration project. I strongly hope that you will look favorably upon California's proposal.

Sincerely,

Janet Heath, MA
Director
916-734-5432



Western University
OF HEALTH SCIENCES

2168

Center for Disability Issues and the Health Professions

Brenda Premo, MBA
Founding Director

(909) 469-5380 • TTY (909) 469-5520 • FAX (909) 469-5503
Information V/TTY (800) 832-0524 • bpremo@westernu.edu

October 27, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

The Center for Disability Issues and the Health Professions (CDIHP) is submitting this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration".

The mission of the Center for Disability Issues and the Health Professions at Western University of Health Sciences is to enhance health professions education, and to improve access for people with disabilities to health, health education and health care services.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. I/we feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

As chairperson of the Olmstead committee and Director of the CDIHP I am fully committed to any opportunities which can improve the ability of people to live independent and productive lives in their community of choice.

The Center for Disability Issues and the Health Professions (CDIHP) is firmly committed to providing *my (our)* support and expertise throughout the term of this demonstration project. *I (we)* strongly hope that you will look favorably upon California's proposal.

Sincerely,

Brenda Premo, Director





Westside Center for Independent Living

October 26, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

The Westside Center for Independent Living is submitting this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration."

The mission of the Westside Center for Independent Living is to empower people with disabilities to reach their independent living goals through a variety of non-residential programs and services. WCIL advocates, educates, and provides primarily peer-conducted services to its consumers and the community. Our primary long-term care concerns include state and federal policies that continue to favor expensive institutionalization at the expense of home- and community-based services favored by people with disabilities and seniors as well as the need to restructure federal, state and local long-term care services to both effectiveness and efficiency.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. We feel this community-level approach, as well as engagement of a broad range of stakeholders, is integral to the success of the project.

As an Independent Living Center who has been involved in a demonstration project transitioning consumers out of skilled nursing facilities for the past two years in Southern California, it is imperative that the state be able to fully implement systems changes that facilitate these efforts. Our State Departments have built collaborations which uniquely position them, with this support, to effect enormous changes for people with disabilities and seniors that allow them to become fully integrated and involved community members and at a significant cost savings to the state and the Medicaid system.

WCIL is firmly committed to providing its support and expertise throughout the term of this demonstration project. We strongly hope that you will look favorably upon California's proposal.

Sincerely,


Mary Ann Jones
Executive Director, maryann@wcil.org (310)390-3611, ext. 2016

MAR VISTA OFFICE

Executive Offices
Programs & Services
12901
Venice
Boulevard
Los Angeles
California
90066

310 390 3611
TTY 310 398 9204
FAX 310 390 4906
888 851 9245
WEB www.wcil.org

SATELLITE OFFICES

Program & Services
Santa Monica
Redondo Beach
Torrance

BUSINESS OFFICE

Resource Development
Finance Department
11201
South
LaCienega
Boulevard
Los Angeles
California
90045

310 568 0107
TTY 310 568 0756
FAX 310 568 1015

WCIL is a member of the California Foundation for Independent Living Centers and the National Council for Independent Living



WORLD INSTITUTE ON DISABILITY

510 Sixteenth Street • Suite 100 • Oakland CA 94612-1500 • <http://www.wid.org>

October 20, 2006

Kimberly Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95819

Dear Ms. Belshé:

The World Institute on Disability is submitting this letter in support of the California Department of Health Services' application for the "Money Follows the Person Rebalancing Demonstration."

WID is a nonprofit research, training and public policy center promoting the civil rights and the full societal inclusion of people with disabilities.

California's Money Follow the Person Demonstration proposal will focus on support of community-level infrastructure to facilitate transitions from institutions to the community through the use of existing home and community-based systems. The community-level approach and the engagement of a broad range of stakeholders is integral to success of the Demonstration.

WID has over a twenty three year history focused on long term care, personal assistance services, health care coverage and employment of people with disabilities. When one of WID's founder's Ed Roberts stated decades ago, "I am going to live off campus in an apartment," he started an international independent living movement. All of us deserve the choice and the outcomes we choose when deciding where we live. This California Demonstration will bring us closer to the goal.

WID is proud to have staff appointed to California's Olmstead Advisory Committee within the Health and Human Services Agency. WID is committed to providing support and expertise throughout the term of this demonstration project.

We trust and hope that you will look favorably upon California's proposal.

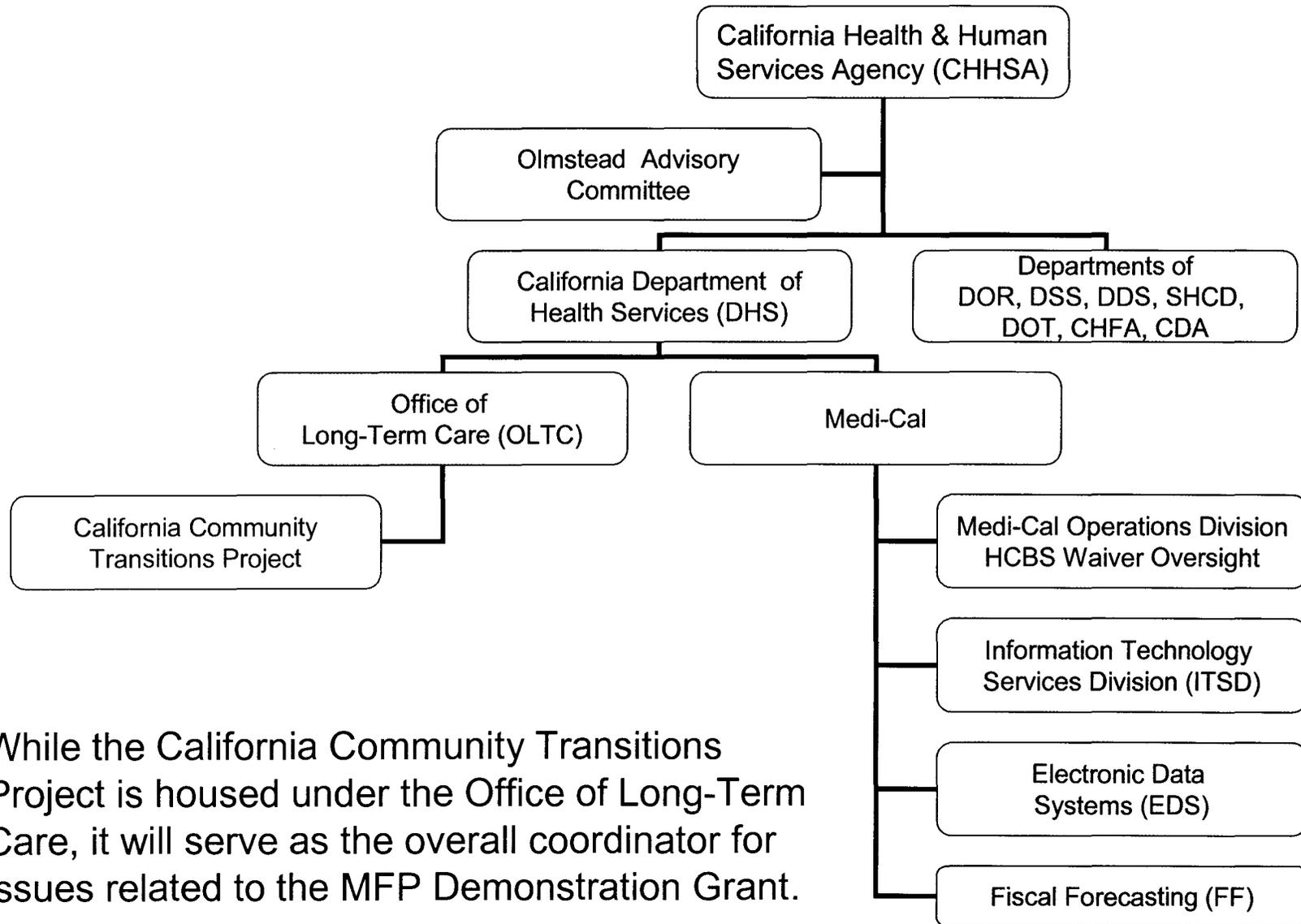
Sincerely,

Bryon MacDonald, for Kathy Martinez, Executive Director (in travel status)
California Work Incentives Initiative
Program, Policy and Development Manager
Phone 510-251-4304, Fax 510- 763-4109
TTY 510-208-9493



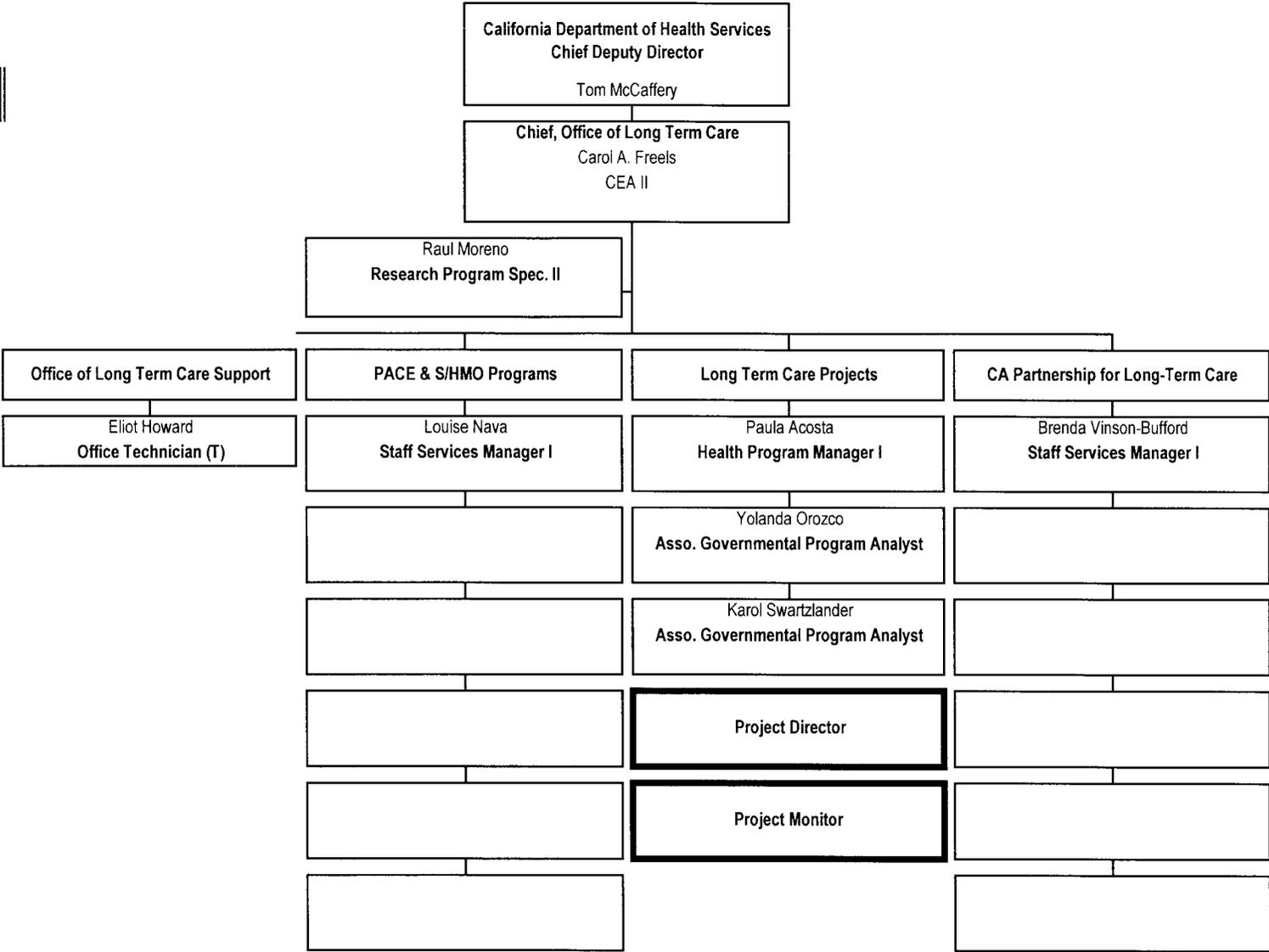
Appendix #8
Organizational Charts

MFP Organizational Chart: The California Community Transitions Project Reports to the Office of Long-Term Care



While the California Community Transitions Project is housed under the Office of Long-Term Care, it will serve as the overall coordinator for issues related to the MFP Demonstration Grant.

CALIFORNIA DEPARTMENT OF HEALTH SERVICES OFFICE OF LONG TERM CARE



DRA MFP Demonstration Operations

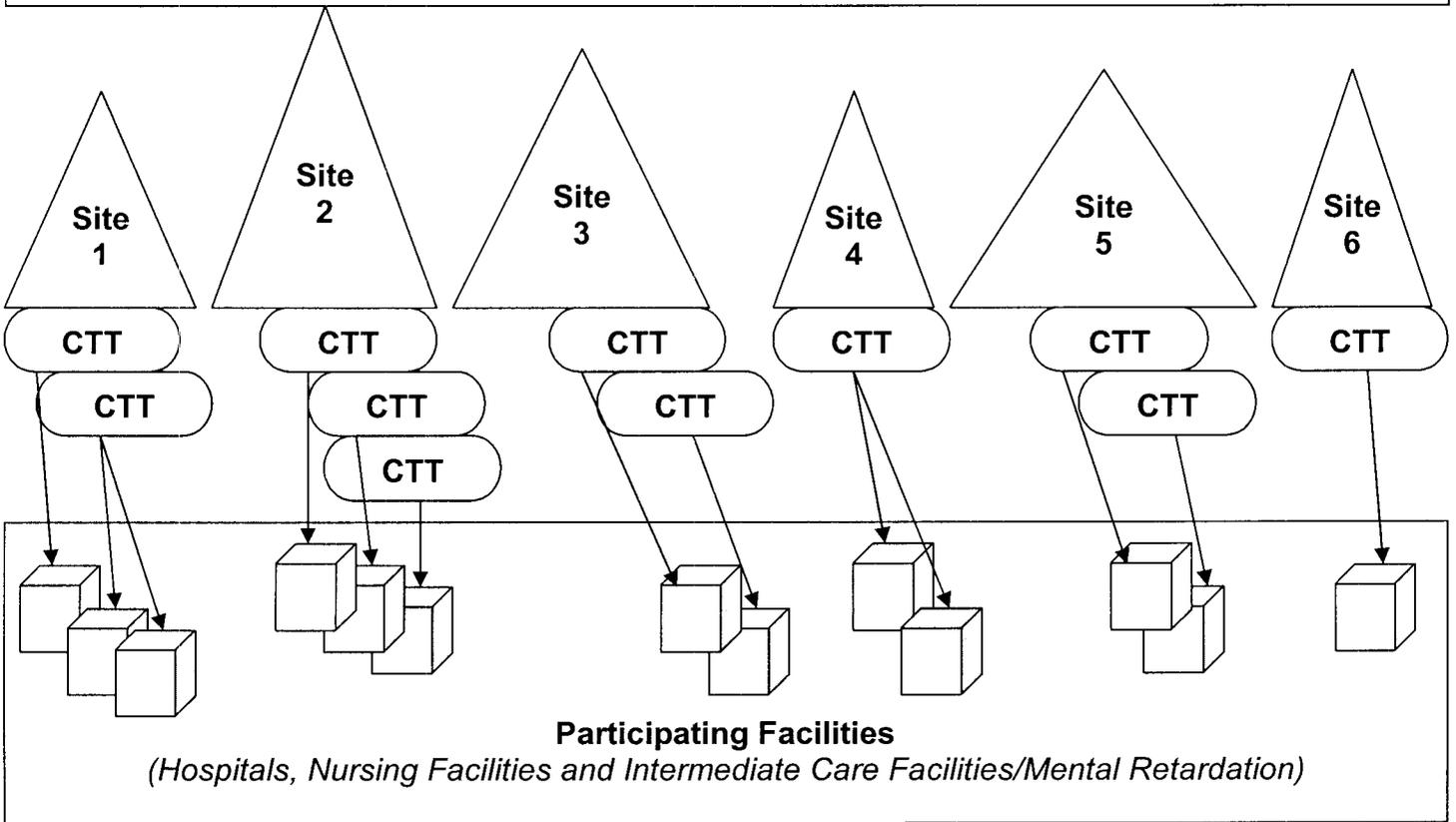
California Department of Health Services
The Single Medicaid Agency in California

**CHHSA Olmstead
Advisory
Committee and
Stakeholders**

CDHS Office of Long Term Care
*Statewide Coordination and
Project Direction*

**Participating State
Departments**
*Technical
Assistance &
Support*

Competitive Application for Site Selection
Select Up to 10 Participating Sites Throughout California



**Transitions from Facilities to
Community Living & HCBS Waiver
Enrollment**

Appendix #9
Home and Community-Based Services
(HCBS) Informing Notice



State of California - Health and Human Services Agency
Department of Health Services



Arnold Schwarzenegger
Governor

October 12, 2006

Jane Doe
1501 Capitol Ave
Sacramento, CA 95814

Dear Mr. /Ms. Doe:

**MEDI-CAL HOME-AND COMMUNITY-BASED SERVICES (HCBS) WAIVER
INFORMING NOTICE FOR Jane Doe**

The Department of Health Services, Medi-Cal In-Home Operations (IHO) has received a request for HCBS waiver services for Jane Doe under the NF A/B Waiver.

The purpose of this HCBS Informing Notice is to describe the waiver program and to outline the roles and responsibilities of the beneficiary and primary caregiver, the primary care physician, the HCBS waiver service provider(s), and IHO. Ultimately, our goal is to inform all interested individuals regarding what is needed from them in order to ensure the successful development and implementation of a safe home program under the NF A/B Waiver.

The HCBS waivers are sets of services designed for Medi-Cal beneficiaries to assist them in remaining in their homes as an alternative to care in a licensed health care facility, also known as the "institutional alternative ". In order for IHO to authorize these services, there must be a medical need for the services. Additionally, the cost of the requested service(s) shall not exceed the costs Medi-Cal would have paid to the health care facility alternative should the service(s) not have been provided in the home setting. The licensed health care facility alternative is determined by IHO and is based upon criteria outlined in regulations, as well as in the requested waiver program. The services available under the NF A/B Waiver include case management, private duty nursing, personal care services, and respite.

In order for IHO to authorize initial or ongoing NF A/B waiver services, the following information is needed:

- 1 . A Treatment Authorization Request (TAR), which is the primary way to request HCBS waiver services. TARs are submitted to IHO by the selected HCBS primary waiver service provider. This formal request may also be submitted in a different written format, as required by IHO, when the HCBS primary provider is an unlicensed individual or a nontraditional Medi-Cal provider;
- 2 . A plan of treatment (POT), which is the physician's order for the HCBS waiver services. The POT outlines the needs of the beneficiary and must include all waiver and nonwaiver services needed by the individual in order to be maintained safely in the home setting. This would include services provided by the identified HCBS waiver service provider and any other provider type; and,
- 3 . Medical justification for the HCBS waiver services. This information should support the medical need for the services and assist IHO in determining the appropriate health care facility alternative.

NOTE:

Initial and ongoing requests for HCBS waiver services must demonstrate a medical need for the services and be cost-effective in order to be authorized or reauthorized. Changes in medical needs may impact the future level of care and amount of services that may be authorized by IHO. Should IHO determine a change in the authorization of services is necessary, the beneficiary will be notified in writing about the change and why it was made. This notification will include appeal rights for the beneficiary, as required by law.

ROLES AND RESPONSIBILITIES FOR:

1. The Beneficiary and Primary Caregivers

- The beneficiary must identify a support network system, such as a primary caregiver, to support him or her in the event the HCBS waiver service provider is not able to provide the total number of authorized services.
- The beneficiary must be Medi-Cal eligible with no restrictions on the amount of services he or she is eligible to receive. The physician must document that the beneficiary has medical needs that can be safely provided for in the home.

- ▶ A home must be maintained that ensures the health and safety of the beneficiary, as well as the HCBS waiver services provider(s). This would include: an area to accommodate the medical equipment and supplies, an appropriate area for cleaning the supplies, adequate lighting and temperature control, an area free from pest infestations, working utilities, a functional telephone, an adequate entrance into the home, and an emergency plan in the event of a home evacuation.
- ▶ The beneficiary and/or primary caregiver must assist the HCBS waiver service provider(s) and the primary care physician in the development of the POT that outlines the home program and the needs of the individual.
- ▶ The beneficiary and/or the primary caregiver must comply with the developed POT in order to ensure a successful home program.
- ▶ The beneficiary and/or the primary caregiver must work cooperatively with IHO in identifying services to assist in maintaining the individual in the home. This would include needed services from the NF A/B waiver within program cost limits, Medi-Cal, and other community or government funded programs.
- ▶ The beneficiary and/or the primary caregiver must participate actively in the home care program. For the primary caregiver, this would include being trained in the care needs of the beneficiary, being present in the event the HCBS waiver service provider is not available, and following any additional physician's orders, if applicable, to ensure the health, safety, and welfare of the beneficiary.
- ▶ The beneficiary and/or the primary caregiver must contact the HCBS waiver service provider(s) or the IHO nurse case manager regarding any issues or concerns with the home program that may impact the delivery of services.
- ▶ The beneficiary and/or the primary caregiver must contact the HCBS waiver services provider(s) and IHO as soon as possible, in the event there are changes with the availability of the primary caregiver. This notification is necessary in the event the changes in the availability of the caregiver impact the safety, health, and welfare of the beneficiary.
- ▶ The beneficiary and/or the primary caregiver must notify the HCBS waiver service provider(s) and IHO as soon as possible when changing residences. This is necessary so that IHO can assist as needed in linking the beneficiary with other potential providers of services in the new community. The IHO nurse case manager may also request a home visit of the new residence for evaluation of health and safety, as appropriate.

- ▶ The beneficiary and/or the primary caregiver must seek out a new HCBS waiver service provider in the event the current HCBS waiver service provider is not able to meet the needs of the beneficiary. Depending upon the availability of a new HCBS waiver service provider, there may be a waiting period of 30 days or more before the change is effective. The beneficiary may contact the IHO nurse case manager for assistance in locating a new HCBS waiver service provider.

2. The Primary Care Physician must:

- ▶ Provide the following information to the HCBS waiver service provider in a timely manner: written beneficiary-specific orders, a complete and accurate written medical record that includes current medical diagnoses, a history and physical assessment with a systems review, and other medical documentation as requested.
- ▶ Participate actively with the beneficiary and the HCBS waiver service provider in developing and/or writing a POT that is individualized for the needs of the beneficiary, and includes all needed services under the NF A/B waiver, Medi-Cal, and other services provided by public or private programs.
- ▶ Actively assist the HCBS waiver service provider and the beneficiary with any needed revisions to the POT.
- ▶ Provide written documentation that the beneficiary's medical condition is stable and that the provision of services under the NF A/B waiver can be provided safely in the home.
- ▶ Provide written documentation that the medical needs of the beneficiary are of such a nature that the beneficiary would require care in a licensed health care facility, if the beneficiary cannot be safely maintained in the home.
- ▶ Work cooperatively with the HCBS waiver service provider and IHO in providing updated medical information as requested to substantiate both initial and ongoing medical necessity for the services requested.
- ▶ Accept full responsibility for providing and coordinating the beneficiary's medical needs for the home care program, as documented in a written statement to be provided in a format satisfactory to IHO.

3. The HCBS Waiver Services Provider must:

- ▶ Sign and have on file with IHO an HCBS Waiver Provider Agreement. This agreement

must be signed, dated, and returned to IHO before HCBS waiver services can be authorized.

- ▶ Assess for the availability of a support network system for the beneficiary with the onset of services and periodically thereafter and no less than twice a year. In the event the beneficiary does not have this support network system or if changes are needed the HCBS provider of services will assist the beneficiary in developing and/or maintaining this system.
- ▶ Be licensed and/or certified and appropriately trained as outlined in the NF A/B Waiver. The provider may be a current Medi-Cal provider or a provider under the HCBS waiver. In the event the provider is identified to provide only HCBS waiver services, the provider must meet all applicable Medi-Cal criteria. The HCBS waiver service provider must maintain compliance with all applicable state and federal requirements, including but not limited to:
 - Development of a POT, based upon the primary care physician's written orders for the home program. The POT is to include that the beneficiary is on the NF A/B waiver, all waiver services authorized by the Department and all other services being provided to the beneficiary while under the NF A/B waiver. These services may also include Medi-Cal related services, such as equipment, supplies, transportation, and Adult Day Health Care; services through California Children's Services, such as therapies; regional center services, such as respite; services provided through other public entities, such as In-Home Supportive Services (IHSS), and private entities.
- ▶ Maintain documentation, subject to the Department's review and approval, acknowledging compliance with the developed POT.
- ▶ Evaluate and document that the beneficiary's residence is appropriate and adequate for the delivery of waiver services, which will ensure both the health and safety of the beneficiary and the provider of service(s). This documentation shall be in a format acceptable to the Department and will include the following:
 - Assessment of the area in which the beneficiary will be cared for and the area(s) to be used for the maintenance, cleaning, and storing of supplies and equipment;
 - Assessment of primary and back-up utility services, communication systems, fire safety systems and devices, such as grounded electrical outlets, smoke detectors, a fire extinguisher, and a

functional telephone;

- Development of an emergency back-up plan appropriate to the area of residence and the types of emergencies that are known to occur in the area. This plan requires that a party be designated to notify the local utility companies, the emergency response systems, the fire department, and any local rescue organizations that the beneficiary has special medical needs that may require assistance in case of an emergency.
- ▶ Notify the Department in a timely manner of any changes reported to the Department of Licensing and Certification (California Code of Regulations, Title 22, Division 3, Section 74667). This notification is required by all HCBS providers who are licensed and certified home health agencies, and applies to changes that impact the health, safety, or welfare of the beneficiary.

4. The Department (IHO) will:

- ▶ Work cooperatively with the beneficiary and/or the primary caregiver, the HCBS waiver service provider(s), the primary care physician, and all other providers of Medi-Cal services to help ensure a successful home program. This would also include collaboration on linking the beneficiary with other programs and supports, and problem resolution, as warranted.
- ▶ Assist as warranted in the identification of supports needed to ensure the health and safety of this individual while under this waiver.
- ▶ Conduct home visits that may or may not be announced to assess the home program and any issues related to the home program. Unannounced visits shall be conducted, as deemed necessary by the Department, to assess the health and safety of the beneficiary.
- ▶ Modify, reduce, deny, or terminate NF A/B Waiver services should any one of the following occur:
- The cost of the requested service(s) exceeds the cost of the identified institutional alternative and the beneficiary and/or the primary caregiver does not agree to a reduction in the requested services in order to maintain program cost-neutrality;
 - The beneficiary loses Medi-Cal eligibility;

- The beneficiary dies;
- The beneficiary or his/her authorized representative elects in writing to terminate NF A/B waiver services;
- The beneficiary moves from the geographical area in which the NF A/B waiver services were being authorized, and in the new area there are providers of services but no provider has agreed to render waiver services to the beneficiary;
- The beneficiary's condition is unstable as demonstrated by repeated, unplanned hospitalizations;
- The beneficiary's condition improves to the point that he/she no longer meets the medical eligibility criteria for the NF A/B waiver services, i.e., the level of care has changed;
- The beneficiary or the primary caregiver refuses to comply with the primary care physician's orders on the POT and the Department determines that such compliance is necessary to assure the health and safety of the beneficiary;
- The beneficiary or the primary caregiver does not cooperate in attaining or maintaining the plan of treatment goals;
- The identified support network system or the primary caregiver can not be identified, is not able, or is no longer willing or available to assume the responsibility to act as a back-up for the beneficiary;
- The home assessment fails to demonstrate an environment that supports the beneficiary's health and safety or is otherwise not conducive to the provision of HCBS waiver services. The home safety assessment will be determined through a home safety evaluation completed by the HCBS provider;
- The beneficiary or the primary caregiver declines the case management

services when electing to receive "waiver personal care services" as the sole waiver service;

- The HCBS waiver service provider is unwilling or unable to provide the amount of authorized services as required by the beneficiary's treatment plan and/or physician's order. This inability to provide services may impact the quality of the service(s) provided. Therefore, if requested to do so by the beneficiary and/or the authorized representative, the Department shall assist with the authorization process for the beneficiary at the otherwise appropriate licensed health care facility, until another HCBS waiver service provider accepts the responsibility for providing services in the home setting; and,
- Any documented incidence of noncompliance by any party with the requirements of this agreement that poses a threat to the health or safety of the beneficiary, and/or any failure to comply with all regulatory requirements.

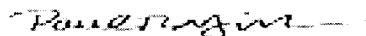
Questions regarding this notice should be directed in writing to the following address:

Department of Health Services
Home- and Community-Based Services Branch
In-Home Operations Section
1501 Capitol Avenue, MS 4502
P.O. Box 997419
Sacramento, CA 95899-7419

Telephone inquiries should be directed to the following number: (916) 552-9105.

Your interest as a participant in the NF A/B Waiver is appreciated.

Sincerely,



Paul Miller, Chief
In-Home Operations Section
Home and Community-Based Services Branch

Appendix 10: Acronyms

A

AAA	Area Agenc (ies) on Aging
ADHC	Adult Day Health Care
ADRC	Aging and Disability Resource Centers
AIDS	Acquired Immune Deficiency Syndrome
ALWPP	Assisted Living Waiver Pilot Project

C

CDA	California Department of Aging
CDHS	California Department of Health Services
CHFA	California Housing and Finance Agency
CHHSA	California Health and Human Services Agency
CHIIP	California Health Incentives Improvement Project
CMIS	Case Management Information System
CMS	(Federal) Centers for Medicare and Medicaid Services
CTT	Community Transition Team
CY	Calendar Year
CFR	Code of Federal Regulations
CDHS	California Department of Health Services
CDSS	California Department of Social Services
CMSP	County Medical Services Program

D

HCD	California Department of Housing and Community Development
DDS	California Department of Developmental Services
DMH	California Department of Mental Health
DOF	California Department of Finance
DOR	California Department of Rehabilitation
DOT	California Department of Transportation (CalTrans)

F

FY	Fiscal Year
FFP	Federal Financial Participation

G
GF

General Fund

H

HCBS Home and Community Based Services (Wavier)
HIPAA Health Insurance Portability and Accountability Act
HIV Human immune deficiency virus
HHA Home Health Agency

I

ICF Intermediate Care Facility
ICF/DD Intermediate Care Facility for the Developmentally Disabled
ICF/DD-CN Intermediate Care Facility for the Developmentally Disabled –
Continuous Nursing
ICF/DD-H Intermediate Care Facility for the Developmentally Disabled –
Habilitative
ICF/DD-N Intermediate Care Facility for the Developmentally Disabled –
Nursing
ICF/MR Intermediate Care Facility for Mental Retardation
IHMC In-Home Medical Care (Waiver)
IHO In-Home Operations (Section under CDHS)
IHSS In-Home Supportive Services
ILC Independent Living Center
IMD Institution(s) for Mental Disease

L

LAO Legislative Analyst's Office

M

MEDS Medi-Cal Eligibility Data System
MFP Money Follows the Person
MIS/DSS CDHS Management Information System/Decision Support System
MSSP Multipurpose Senior Services Program

N

NF Nursing Facility
NF A/H Nursing Facility (Waiver) for Acute Hospital
NF A/B Nursing Facility Level A and B

O

OAA Older Americans Act
OLTC Office of LongTerm Care (under the California Department of Health Services)
OSHPD Office of Statewide Health Planning and Development

P

PACE Program of All-Inclusive Care for the Elderly

Q

QA Quality Assurance
QMU Quality Management Unit

R

RFP Request for Proposal

S

SSN Social Security Number
S/HMO Social Health Management Organization

T

TCM Targeted Case Management

W

WY Waiver Year