CALIFORNIA

Money Follows the Person/California Community Transitions Operational Protocol

OPERATIONAL PROTOCOL VERSION **#1**

GRANT **1LICMS300149-01-26**

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HOW TO USE THE MONEY FOLLOWS THE PERSON OPERATIONAL PROTOCOL

Purpose

The Operational Protocol (OP) is the operational guide that outlines the Demonstration and addresses how the state or territory will meet the objectives of the Money Follows the Person (MFP) Demonstration. The OP describes how the state or territory will operationalize processes to ensure that the state or territory's Demonstration is equipped with the tools, infrastructure, systems, and policies to make MFP Demonstration goals and initiatives successful.

The state or territory must review and amend the OP every three years, or more frequently as needed, in response to changes in (1) federal, state, or territory law, regulation, or policy impacting MFP eligibility, enrollment, or program operations; and (2) MFP operations, inclusive of changes to any of the required MFP OP elements. Refer to MFP Program Terms and Conditions (PTC) 36 for specific requirements around amending the OP.

While the OP describes "how" the state or territory operates the MFP program, "what" the state or territory plans to do to advance MFP and Medicaid home and community-based services (HCBS) is included in the state or territory's unique MFP Work Plan. Reporting on progress is included in the state or territory's Semi-Annual Progress Report (SAR).

Change log

If amending or updating the OP, complete the change log by inserting entries into Table 1.

Table 1. Change log

Section	Prompt	Date of OP submission	Changes made since last revision of OP
All Sections	1	5/2/2025	Initial submission of OP (Draft Version #1)
All Sections	2	10/24/2025	Re-submission of OP (Draft Version #2)
Sections B, E F, and I.	3	3/19/2026	Re-submission of OP (Draft Version #3) ***Approved by CMS on April 8, 2026 (Approved Version #1)***

SECTION A. MFP PROGRAM OVERVIEW

This section briefly describes how the state or territory's MFP Demonstration is designed to meet unique state or territory long-term services and supports (LTSS) system reform efforts to increase the use of HCBS, rather than institutional LTSS. Use the prompts in this section to report on the state or territory's LTSS system assessment and gap analysis and to identify the state or territory's MFP Demonstration target population and geographic area(s) of service.

A.1. State or territory system and gap analysis

A.1.1. Summary of state or territory LTSS system and gap analysis

The summary must address these components:

- Identify LTSS population needs
- Identify geographic area(s) of need

Identify ways the state or territory can test new approaches and flexibilities in its Medicaid programs to strengthen HCBS through the MFP Demonstration

Identify and determine measurable, attainable, and timely MFP Demonstration goals and outcomes

To achieve California's LTSS system reform efforts, several HCBS programs have been established. The MFP grant is one of the state's initiatives striving to reduce the number of individuals requiring services within an institutional long-term care setting. In California, the MFP Demonstration is known as the California Community Transitions (CCT) Project and is administrated by the Department of Health Care Services (DHCS). The synopsis of programmatic information below is based on California's grant implementation activities, as well as the state's observations of collected service data, since 2007.

In California, the program population needs are vast. Specifically, the needs vary due to the eligibility criteria for CCT. The enrollment criteria are: (1.) Being (at the time of application submission) currently enrolled/eligible for Medi-Cal/Medicaid; (2.) Having a skilled nursing level of care; (3.) Residing in a long-term care facility for at least 60 days (e.g., with at least one day paid for by Medicaid); and (4.) Desiring to return to live and receive services in a community-based setting. In addition, the needs are drastically different due to the population's wide range of characteristics, such as but not limited to, health history, socioeconomic status, accessibility needs, and demographic differences.

The CCT Project is implemented in community settings across the state of California by Lead Organizations (LOs).

To become an LO, an interested entity must complete and submit an application package to DHCS. The package includes the LO form, proposal, and provider enrollment waiver. When seeking approval, the LO notates the California area/region where services will be provided. Currently, there are 20 approved CCT LOs within 56

counties (e.g., all counties except Napa and Marin) of the state. However, DHCS has observed that there are regions within California with a disproportionate share of LOs. For instance, Los Angeles County has approximately eight of the 20 LOs in the state. Meanwhile, the northern region of the state (which is more rural), and the Bay Area (with a higher cost of living) do not have a large number of enrolled LOs. DHCS is in the process of exploring opportunities to identify and collaborate with new LOs in the central and northern regions of the state with the intention of expanding the number of LOs in the applicable regions.

Currently, the CCT project is implementing and testing a new programmatic approach. For instance, the CCT project is streamlining the clinical assessment and service reimbursement activities by developing and requiring the use of an online portal known as MedCompass. The MedCompass portal allows CCT LOs to confidentially and securely submit reports, assessments, and case notes associated with beneficiaries who are enrolled in and/or receiving MFP services. DHCS then uses the portal to review and approve these submitted items. MedCompass is also used for data tracking and reporting purposes. MedCompass is also the assessment tool used in several of the state's HCBS programs, allowing for more streamlined data tracking for CCT participants who transition to HCBS programs.

Another new programmatic approach is ensuring LOs support CCT participants in transitioning to other HCBS waivers and/or managed care plans (MCPs) at the 165-day marker of the program's 365-day timeframe. This enhancement ensures continuous and consistent programmatic HCBS support for all participants.

Based on lessons learned gathered from decades of grant implementation, DHCS has identified the following time bound CCT goals and outcomes:

- By October 31, 2025, DHCS will have designed, recorded, and disseminated MedCompass training sessions for CCT LOs to ensure proper data entry practices are being implemented
    - To measure this goal, program administrators developed, finalized, and implemented training modules, as well as provided technical assistance (TA) services.
    - Similar quality measurement and improvement initiatives will be explored and developed for 2026.
- Throughout 2026, DHCS will leverage the support and expertise of a newly hired Housing Specialist (Health Program Specialist I) to explore the development of an MFP/CCT supplemental services project plan that could be submitted to CMS for final approval, specifically a project plan that is aligned with housing-related supports.
    - The project plan is anticipated to include internal brainstorming sessions, strategic planning and forecasting, information gathering from other critical

stakeholders (such as CCT LOs and other sister departments), reviewing MFP supplemental services resources (i.e., Stand-Alone Services Description Requirements and MFP Best Practices), and formal documentation for providing updates to department leadership and to CMS.

- Throughout 2026, the CCT program administrators will monitor the percentage of participants who have remained transitioned/living in a community-based setting.
    - To measure this goal, CCT program administrators will calculate the number of participants (for each calendar year (CY)) who did not return to an institutional setting after being transitioned to a community-dwelling.

These activities will be monitored to determine if programmatic goals are achieved.

A.2. Service areas and target groups of the MFP program

A.2.1. Service areas

Specify the service area(s) in which the MFP Demonstration operates.

☒ State or territory-wide

☐ If not state or territory-wide, indicate specific jurisdictions:

Not Applicable

A.2.2. Target groups

Complete Table A.2.2 to indicate the MFP target population(s) included in the state or territory's Demonstration and indicate the corresponding state or territory operating agency administering Medicaid HCBS. Please note that target groups falling into the "Other" category must be defined here and throughout the OP.

Table A.2.2. MFP target population groups

Select all that apply	Target group of eligible individuals	State or territory operating agency
☒	Older adults	DHCS
☒	Individuals with physical disabilities (PD)	DHCS
☒	Individuals with intellectual and developmental disabilities (I/DD)	DHCS
☒	Individuals with mental health and substance use disorders (MH/SUD)	DHCS
☒	Other, please specify (e.g., HIV/AIDS, brain injury) HIV/AIDS, traumatic brain injury	DHCS

Describe reasons for targeting certain MFP populations. Include geographic strategies, considerations specific to rural areas, provider network considerations, and alignment with state or territory Olmstead plans and rebalancing strategies.

Medi-Cal members who are inpatients beyond a short visit in MFP qualified inpatient facilities remain in this type of setting for a variety of reasons. There is no single consumer profile that represents the ideal candidate for the Demonstration. For this reason, the state requires CCT transition services be offered to eligible individuals who prefer to live in a community setting.

The target populations for CCT were proposed in the state's application dated November 2006 and are described below.

- **Elders Who Have One or More Medical, Functional or Cognitive Disabilities**: Includes Medi-Cal members who are age 65 and older who have one or more functional, medical or chronic conditions. Other terms used for this group are older adults and seniors. This group also includes elders who have Alzheimer's disease or other dementias.
- **Persons with I/DD**: This group includes Medi-Cal members of any age who have I/DD that manifested before their 18th birthday.
- **Persons Who Have One or More PDs**: Includes Medi-Cal members under the age of 65 years who have at least one PD. People who are HIV positive or have AIDS are included in this group.
- **Persons Who Have Mental Illness**: This group includes Medi-Cal members who have been diagnosed with chronic mental illness.
- **Persons Who Have Experienced an Acquired Brain Injury/Traumatic Brain Injury (TBI)**: This group includes Medi-Cal members who do not have a mental illness but have experienced brain trauma resulting in functional challenges, such as physical, cognitive, and psychosocial, behavioral, or emotional impairments. Stakeholders requested that these Medi-Cal members be included in the demonstration. Medi-Cal members in this category will be included and reported to CMS under the "other" federal category.
- **Adults and Children Who Are Hard-to-Place:** This group of Medi-Cal members includes children and adults who are residents of MFP qualified inpatient facilities with few or no care options outside of the institution because of their medical or behavioral conditions. Stakeholders requested that these Medi-Cal members be included in the demonstration. Medi-Cal members in this category will be included and reported to CMS under the most-applicable federal category.

A.3. Other information

If needed, provide other information regarding the state or territory's service area(s), target populations, or reporting that is not addressed elsewhere in the template.

Not applicable.

SECTION B. PROJECT ADMINISTRATION

B.1. Administrative structure

B.1.1. Organizational chart

Include an organizational chart as an external link.

A DHCS Organizational Chart link can be found here: DHCS-Exec-Staff-Org-Chart.pdf.

B.1.2. Administrative structure

Describe how the state or territory will structure the administration of the MFP program, including how roles and responsibilities will be coordinated across state or territory operating agencies and managed care plans (MCP) (if applicable). Clearly indicate how the organizational and structural administration will function to implement, operate, and monitor the OP elements of the Demonstration.

Example Table B.1.2. Administrative structure

Administrative entity (state/territory, other government entity, MCP or contractor/consultant)	OP element(s)	MFP role and key responsibilities (how the entity will implement, operate, or monitor the OP element)	Formal commitments (for example, Memorandum of Understanding)
DHCS	All OP elements	The Authorized Organizational Representative (AOR), Project Director (PD), and other key staff (refer to section B.2.2. for a complete list) oversee the administrative aspects of the MFP grant and ensure federal reporting requirements are completed.	N/A; DHCS employee
California Housing Finance Agency (CalHFA), California Department of Housing and Community Development (HCD), and California Tax Credit Allocation Committee (CTCAC)	Sections E and F	Contribute to the implementation of the housing initiative activities as CCT participants prepare to transition from a facility to a community-based setting.	Interagency Agreement (IA)
California Department of Social Services (CDSS)	Sections C, D, and F	CDSS contributes to assisting individuals with transitioning from facility settings to community/home-based settings. The CDSS staff support and implement the MFP transition requirements.	IA
California Department of Developmental Services (DDS)	Sections E and F	Contribute to the implementation of the housing initiative activities as CCT participants prepare to transition from a facility to a community-based setting.	IA

Administrative entity (state/territory, other government entity, MCP or contractor/consultant)	OP element(s)	MFP role and key responsibilities (how the entity will implement, operate, or monitor the OP element)	Formal commitments (for example, Memorandum of Understanding)
California Department of Aging (CDA)	Sections C & D	Contribute towards the Medicaid administration claiming process to fund the No Wrong Door (NWD) system are the activities associated with the NWD system.	IA
AssureCare	Sections F and H	Develop and update the MedCompass system to collect MFP/HCBS Access Rule and Quality Measures requirements. AssureCare assists with updating the necessary systems and processes to ensure compliance with CMS requirements.	Contract
Mathematica	Sections F and I	Develop and assist with the implementation of the MFP Quality Measures requirements. Mathematica identifies transition enhancement opportunities to ensure compliance with CMS requirements	Contract

As the single-state agency for the administration of the state's Medicaid program, DHCS has administrative and fiscal monitoring, as well as oversight responsibilities for the CCT program. All required CCT administrative activities are completed by DHCS team members. The various divisions, as well as CCT roles/tasks are listed below:

- Integrated Systems of Care Division (ISCD)/HCBS Policy Branch (HPB)
    - AOR, PD and Program Management
- ISCD/HCBS Operations Branch (HOB)
    - Data entry, data systems management, Treatment Authorization Request (TAR) review/approval, contract initiators, LO points of contact
- ISCD/Division Support Branch (DSB)
    - Fiscal Forecasting & Data Management
    - Financial Management
    - Budget Monitoring
    - Contract Management
- ISCD/Quality and Monitoring Branch (QMB)
    - Enrolls new LOs
- Financial Management Division (FMD)
    - Internal review and approval of budgets
    - Budgetary monitoring and reporting
- Enterprise Data and Information Management (EDIM)

    - Data reporting
- CA-Medicaid Management Information Systems (CA-MMIS)
    - Rate codes/updates/adjustments
- Clinical Assurance Division (CAD)
    - Assists with the review and approval of TARs
- Procurement and Contracting Division (PCD)
    - Contract development
- Quality Population Health Management Division
    - Assisting with driving quality improvement efforts
- Information Technology Services
    - Computer security/updates
- Office of Administrative Hearings & Appeals
    - Monitors participant access/rights
- Office of HIPAA Compliance
    - Monitors participant access/rights
- Office of Legal Services
    - Provides legal advice/support
- Office of Legislative & Governmental Affairs
    - Monitors and manages State legislation – associated with CCT policies/implications
- Office of the Medical Director
    - Monitors assessment forms and templates
- Office of Public Affairs
    - Monitors and manages public communication/messaging

B.2. Staffing

B.2.1. Other project staff

Complete Example Table B.2.2 for all non-contract positions. Describe the MFP role, responsibilities, and relevant OP element(s) for each position in the last column on the table.

Example Table B.2.2. MFP Demonstration staff

Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/ consultant position	MFP role, responsibilities, and relevant OP element(s)
PD/Health Program Specialist I	100%	Administrative	Non-contract	Responsible for the development and/or oversight of all grant deliverables. Reviews reports, uploads documents to GrantSolutions, serves as the liaison for ISCD and CMS communications, reviews expenditure reports, facilitates internal and external stakeholder meetings, and alerts the AOR of any potential project challenges.

Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/ consultant position	MFP role, responsibilities, and relevant OP element(s)
DQA/Research Data Specialist II	100%	Administrative	Non-contract	Responsible for federal and state reporting, updating databases for all CCT and sustainability statistics, providing TA on policy guidance to staff, and generating cost analysis. Also, conducts scheduled and ad hoc queries for state and federal reports.
Co-PD/Health Program Specialist I	100%	Administrative	Non-contract	Work collaboratively with the PD and AOR to complete grant deliverables. Contributes to the development of internal and external stakeholder meeting materials, reviews draft reports, contributes to data extraction/review activities, uploads documents to GrantSolutions, and manages the correspondence with LOs and program participants.
Housing Specialist/Health Program Specialist I	100%	Administrative	Non-contract	Manage the LOs housing referral activities and serve all LOs collectively. The individual will be responsible for leading and facilitating internal and external stakeholder meetings, developing referral reports, and ensuring that CCT participants receive housing information if needed. They will establish supplemental policy guidance required by CMS to support housing options for MFP program participants and support the LOs by identifying opportunities for service improvement and measuring progress toward achieving program goals related to the provision of housing services. Lead planning and implementation of TA (i.e., surveys, trainings, etc.) for the LOs as it relates to housing. Develop and provide TA training components and corresponding materials. Additionally, identify and develop MFP/CCT sustainability opportunities and plans related to housing, and research multiple avenues to determine program success and ongoing needs in areas such as community transitions. Address program issues and/or gaps in housing support services and oversee changes to the housing regulations and standards.

Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/ consultant position	MFP role, responsibilities, and relevant OP element(s)
Financial Analyst/Analyst II	100%	Administrative	Non-contract	Responsible for fiscal oversight and budget development and monitoring for the MFP/CCT Project. This position strengthens program-side financial management and ensures compliance. Activities include analyzing expenditures and reconciliation. The analyst's role is focused on maintaining fiscal integrity and supporting budget development.
Program Analyst/Analyst I	100%	Administrative	Non-contract	Validate enrollment and eligibility documentation, review and ensure completeness of enrollment information and case documentation, update the case management system, provide TA and support work for LOs and program applicants/enrollees for the CCT Project.
Research Data Specialist II	100%	Administrative	Non-contract	Assists with federal and state reporting, updating databases for all CCT and sustainability statistics, providing tech assistance on policy guidance to staff, and generating cost analysis. Conduct scheduled and ad hoc queries for state and federal reports. Oversee ongoing maintenance of quality metrics requirements.
Nurse Evaluator II (3)	100%	Administrative	Non-contract	Work with the LOs and Waiver Agencies to review documentation for all CCT transitions, provide TA, and clinical review of TARs, and as part of sustaining CCT beyond the end date of the MFP grant (e.g., including newly required programmatic quality measures).
Health Program Specialist I	100%	Administrative	Non-contract	Work with CDA to review their Medicaid Administrative Claiming (MAC) Operational Plan for the State's Aging and Disability NWD. The specialist will also coordinate and manage the DHCS MAC review and approval activities to prepare documents for CMS submission.
Policy Analyst/ Analyst II	100%	Administrative	Non-contract	The Analyst II will contribute to the required grant reporting and monitoring activities, assist with housing support, provide community resources to LOs, and support CMS' processes. The Analyst II will collect, analyze, and report on the development of

Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/ consultant position	MFP role, responsibilities, and relevant OP element(s)
				compliance audits of LOs to ensure programmatic compliance standards are being met. This position would acknowledge receipt, commence investigation/research, develop action plans, and track MFP/CCT deliverables. Additionally, the Analyst II will determine the appropriate course of action and recommend next steps to the PD and/or Housing Lead.

B.2.2. In-kind support

Describe positions providing in-kind support (that is, support from non-MFP staff) to the MFP Demonstration. Indicate the percentage of time each individual or position is dedicated to the grant and the roles and responsibilities of each position. Indicate the OP element(s) the positions will support. If a large number of staff provide in-kind support to the MFP Demonstration, describe the staff in general or aggregate terms, such as contracting specialists, fiscal staff, etc.

The following positions provide in-kind support (being less than 100%) for the MFP/CCT Project Demonstration:

- AOR (10%): This position is associated with all OP elements, with some of the most important roles associated with approval of the budget, as detailed in Section B.3.1. Budget development process. Other important roles are associated with Section H.1. Reporting plans and procedures.
- Manager II (10%): This position is associated with all OP elements, per ensuring CCT and HCBS sustainability efforts at state and local levels and overseeing grant implementation. Important roles are associated with specific OP elements, such as Section B.3.1. Budget development process, Section D. Community Engagement, Section E.5. Service providers, Section F. Transition and housing services, and Section I. Quality measurement, assurance, and monitoring.
- Supervisor I (25%): This position is associated with all OP elements, per ensuring CCT and HCBS sustainability efforts at state and local levels, overseeing grant implementation, and overseeing HCBS policies. Important roles are associated with specific OP elements, such as Section B.3.1. Budget development process, Section C.2.2. Participant recruitment and enrollment process, Section E.5. Service providers and Section F. Transition and housing services.

- Finance Manager/Supervisor I (10%): Provides strategic oversight for contract execution and invoice processing through the development and monitoring of the annual MFP/CCT budget. This role ensures fiscal integrity and alignment with broader departmental goals. The manager's limited allocation reflects a targeted focus on high-level review and coordination, not daily processing. While the Finance Manager does not directly process contracts or invoices, this role ensures fiscal alignment and compliance during budget planning and approval phases.

- Budget Analyst/Analyst II (10%): Supports budget validation and assists with new contracts and amendments. This includes verifying program codes and participating in routine and ad hoc budget drills. The analyst's role complements the Financial Analyst by focusing on budget-side compliance and planning.

- Research Data Supervisor II (20%): This position supports the OP elements associated with Section H.1. Reporting plans and procedures. The position's roles are specifically associated with updating databases for all CCT and sustainability statistics, providing tech assistance on policy guidance to staff, generating cost analysis, conducting scheduled and ad hoc queries for state and federal reports.

- Research Data Supervisor I (20%): This position supports the OP elements associated with Section H.1. Reporting plans and procedures. The position's roles are specifically associated with updating databases for all CCT and sustainability statistics, providing tech assistance on policy guidance to staff, generating cost analysis, conducting scheduled and ad hoc queries for state and federal reports.

B.2.3. Staffing and contract execution timeline

Provide a hiring timeline (start and end date) for non-contract staff. For contract, consultant, or subrecipient positions, provide the contract execution date and expected expiration/end date.

The hiring timeline for non-contract staff varies per position. For instance, the Analyst and Specialist positions usually require a four-to-seven-month timeframe to fill a vacant position. However, Nursing positions can require up to one year to fill due to the health care shortage for this occupation experienced across the nation. The contract with AssureCare was executed on 08/01/2024 and is expected to expire on 01/31/2029. The contract with Mathematica was executed on 10/03/2022 and is expected to expire on 06/30/2028.

B.3. Billing and reimbursement

B.3.1. Billing and reimbursement procedures

Describe how the state or territory will establish billing and reimbursement procedures to link Medicaid claims to MFP individuals. Include the following:

- Description of MFP identifier codes in the Medicaid Management Information System (MMIS) and if applicable in the state or territory accounting system
- Description of procedures for ensuring against duplication of payment for the Demonstration and Medicaid programs
- If the state or territory operates a managed long-term services and supports (MLTSS) program, description of your state or territory's managed care claiming methodology to determine the portion of the capitation rate that is attributable to qualified HCBS listed in Attachment A of the MFP PTC
- Procedures for fraud control and monitoring

All CCT services offered to enrollees and participants comply with DHCS' existing guidelines to prevent duplication of services, fraud, and/or financial abuse. The CCT program operates within guidelines and procedures established for Medi-Cal programs in the State of California, unless specifically stated otherwise, utilizing the state's current systems. A TAR will be submitted by the CCT LOs for every CCT service. Once approved, the CCT LO submits a claim for payment to the contracted fiscal intermediary (FI). The state's FI for CCT services is known as Service Utilization Review, Guidance, & Evaluation (SURGE). The newly developed and implemented MedCompass database, allows CCT project staff complete/submit assessments forms, monitor and track service utilization, and support LOs in submitting claims. Any egregious billing errors are referred to DHCS' CA-MMIS and ISCD/HPB.

DHCS' CA-MMIS Division administers the Medi-Cal claiming system and manages the state's contract with the FI. All claims processed through the FI 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 have been established and measurements against these criteria occur weekly before the release of payments. All CCT LOs are required to receive training from the state FI to submit claims for CCT services rendered.

California's MFP program operates through fee-for-service (FFS) delivery systems rather than managed care. The MFP-qualified HCBS listed in Attachment A of the MFP Program Terms and Conditions (PTCs) are also excluded from the managed care capitation rates and operate on an FFS basis. These services are typically carved out of managed care contracts and reimbursed directly on an FFS basis. As a result, California does not allocate a portion of the managed care capitation payments to MFP-qualified HCBS because these services are billed and paid separately

through the FFS system. This approach allows the state to track and claim Medicaid expenditures for MFP-eligible HCBS more precisely, using direct claims data from FFS providers, which simplifies the linkage of services to MFP participants.

ISCD is responsible for reviewing the FI and medical necessity for CCT services. All claims submitted by HCBS waiver and state plan providers are subject to random review regardless of provider type, specialty, or service rendered. Ultimately, ISCD verifies submitted claims have sufficient documentation to approve the claim for payment. CCT LOs 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 Section 14124.2.

B.4. Budget process

B.4.1. Budget development process

Describe how the state or territory will prepare the MFP budget. Include the following:

- Process for projecting annual expenditures
- Cross-agency roles and responsibilities for developing, reviewing, and approving the budget
- Procedures for adjusting or reconciling the budget

The State develops the grant budget utilizing the CMS provided Microsoft Excel Budget Template. This template serves as the primary tool for tracking and projecting financial requirements. The budget preparation process is a collaborative DHCS effort which includes input from various divisions and specialists that support the CCT program.

Step-by-Step Budget Development Process

1. **Review of Actuals vs. Projected Costs:**
   The DHCS team conducts a detailed analysis of historical expenditures and compares them with prior budget projections to identify variances.
   Insights from this analysis inform adjustments to ensure accuracy in future projections.

2. **Service Utilization Analysis:**
   Program staff collaborate with budgetary specialists to examine service utilization trends, including participant enrollment data, service delivery patterns, and associated costs.

   Any significant shifts in service demand are factored into the budget to address evolving program needs.

3. **Claims Review and Data Forecasting:**
ISCD reviews claims submitted by LOs to identify patterns and anomalies. Data specialists develop a financial trajectory for the program, typically covering the next 2–3 years, using statistical models and trend analyses.

4. **Cross-Division Collaboration:**
Input is gathered from various stakeholders, including fiscal analysts, program managers, and external partners, to ensure a comprehensive understanding of funding needs. This collaboration ensures alignment with both state and federal requirements.

5. **Template Completion and Justification:**
The collected data, analyses, and projections are incorporated into the CMS budget template. Each line item is supported by detailed programmatic justifications, outlining the necessity of funds and their intended impact on program outcomes.

6. **Final Review and Submission:**
The completed budget undergoes a multi-level review process to validate the accuracy and consistency of data.

Once approved internally, the budget is submitted to CMS for consideration through GrantSolutions. This structured and thorough approach ensures that the budget reflects the program's financial needs while adhering to state and federal guidelines. The process not only guarantees transparency but also strengthens the program's ability to secure and effectively manage grant funding.

DHCS has several cross-agency roles and responsibilities for the development, review, and approval of the MFP/CCT Budget. These are within the following areas of the department:

- ISCD
    - AOR: Approve the budget on GrantSolutions
- ISCD/HPB
    - Manager II
    - Supervisor I
    - MFP/CCT PD: Review and submit the budget on GrantSolutions
- ISCD/DSB

    - Supervisor II
    - Supervisor I
    - Financial Analyst Analyst/Analyst II: Assist with budget development
- FMD
    - Division Chief: Internal approval of the budget

The Fiscal team monitors the personnel and contract expenditures monthly using contract logs and labor detail reports. The team verifies expenditures using the Financial Information System for California, which is also known as Fi$Cal, to adjust or reconcile the MFP grant application. The MFP Demonstration Financial Reporting Forms report adjustment memo for services, which accounts for most of the MFP budget, is processed nine to ten months in arrears due to the delay in accessing the expenditure data. The delay in processing these adjustments reflects lower expenditure data in the Payment Management System (PMS). DHCS must use the data in the PMS to adjust the budget lower.

B.5. Other information

If needed, provide other information regarding the state or territory's MFP Demonstration administration that is not addressed elsewhere in the template,

Not applicable.

SECTION C. RECRUITMENT, ENROLLMENT, OUTREACH, AND EDUCATION

C.1. MFP-qualified inpatient facility recruitment

C.1.1. MFP-qualified inpatient facility types

In Table C.1.1, describe how the state or territory will collect and verify that MFP participants are transitioning to the community from an MFP-qualified inpatient facility. Describe the process for each target population and inpatient facility type. If there are multiple "other" populations to note, illustrate the type(s) of inpatient facilities separately for each "other" population with a new row.

able C.1.1. MFP-qualified inpatient facility type by target group

Target population(s)	MFP-qualified inpatient facility types from which the target population will transition	Description of data collection and verification procedures
Older adults	☒ Nursing facility ☐ ICF/IID ☒ Hospital ☐ IMD	The LO completes assessments in the MedCompass program which are used for data collection. The LO is required to upload documents into the MedCompass document center. An ISCD Analyst verifies the listed dates meet eligibility requirements. A Nurse Adjudicator verifies the applicant meets the clinical requirements for the program. The data collection and verification procedures are the same for all CCT target populations.
Individuals with PD	☒ Nursing facility ☐ ICF/IID ☒ Hospital ☐ IMD	Refer to the section above.
Individuals with I/DD	☒ Nursing facility ☐ ICF/IID ☒ Hospital ☐ IMD	Refer to the section above.
Individuals with MH/SUD	☒ Nursing facility ☐ ICF/IID ☒ Hospital ☐ IMD	Refer to the section above.
Other, please specify in text box below (e.g., HIV/AIDS, brain injury) HIV/AIDS, traumatic brain injury	☒ Nursing facility ☐ ICF/IID ☒ Hospital ☐ IMD	Refer to the section above.

Note: MFP programs transitioning MFP participants from an IMD (see PTC 14) must provide a description in section C.1.2 of the OP of how the state or territory will verify certain requirements, such as that the individual meets MFP individual eligibility criteria.

ICF/IID = Intermediate Care Facility for Individuals with Intellectual Disabilities; IMD = Institution for Mental Diseases.

C.1.2. Institution for mental diseases (IMD) exclusion

For MFP programs transitioning MFP participants from an IMD (see PTC 14), provide a description of how the state or territory will verify that the:

- Individual meets the MFP individual eligibility criteria
- Individual is receiving one of these benefits:
  - Services for individuals ages 65 and older in an IMD, referred to as "IMD over 65"
  - Inpatient psychiatric services for individuals younger than 21, referred to as "psych under 21"
  - Medicaid beneficiaries ages 21 through 64 residing in an IMD who are receiving services that are covered under a Substance Use Disorder or Serious Mental Illness section 1115 demonstration

Not applicable.

C.1.3. Strategies for recruiting MFP-qualified inpatient facilities

Describe strategies for recruiting MFP-qualified inpatient facilities to engage in the development and implementation of person-centered transition programs that offer residents the choice of leaving the facility to return to the community. Include geographic strategies, considerations specific to rural areas, alignment with state or territory Olmstead plans and rebalancing strategies, and facility access and engagement approaches.

CCT LOs engage in outreach, providing brochures and flyers and developing relationships with the administration and social workers at the MFP qualified inpatient facilities in the counties they serve. This approach serves as the LOs recruitment strategy to identify clients who are interested and eligible in transitioning into a community setting. The LO explains the process, goals, and criteria. If the applicant is still interested the LO enrolls them in the CCT program.

Additionally, LOs are designated as Local Contact Agencies (LCAs) with the State Medicaid Agency (SMA) and respond to the Minimum Data Set (MDS), Section Q referrals on behalf of residents, regardless of the residents' insurance coverage. The MDS 3.0 Section Q allows individuals to express interest in learning more about possibilities for living outside of the nursing facility. Nursing facilities are required to notify designated LCAs when a resident expresses a desire to learn more about options for living in the community. DHCS has designated one or more LCA in each county. The LCAs are responsible for keeping data on nursing facility referrals and providing information/education to individuals who have indicated the desire to speak with someone about HCBS living options. LCAs may be one of several agency types: Aging and Disability Resource Connection (ADRC) programs, CCT LOs, Independent Living Centers (ILCs), or Area Agencies on Aging.

LCAs provide information/education to all interested individuals in nursing facilities regardless of payer source.

Currently, there are 20 approved CCT LOs within 56 counties (e.g., all counties except Napa and Marin) of the state. However, DHCS has observed there are regions within California with a disproportionate share of LOs. For instance, Los Angeles has approximately 8 of the 20 LOs in the state. Meanwhile, the northern region of the state (which is more rural), and the Bay Area (with a higher cost of living) do not have a large number of enrolled LOs. DHCS has begun a process of exploring opportunities to identify and collaborate with new LOs in the central and northern regions of the state, which are regions with higher amounts of ruralized areas.

California is committed to providing health care services and supports to Medi-Cal beneficiaries in the least restrictive and most integrated setting of their choice. This is in alignment with what was envisioned by the 1999 U.S. Supreme Court's Olmstead decision. The CCT Project is closely connected to initiatives of California's Olmstead Plan and Disability and Aging Community Living Advisory Committee (DACLAC), allowing for beneficiaries to live in their own homes or community-based settings, instead of residing in institutional settings. This promotes improved quality of life for beneficiaries that have long-term service and support needs.

C.2. MFP participant recruitment and enrollment

C.2.1. Eligibility criteria for participation in MFP

Describe any state or territory-specific MFP eligibility criteria. For example, describe your state or territory's requirements for individuals' length of stay in an MFP-qualified inpatient facility if more than 60 consecutive days. See section IV of the MFP PTC for a description of MFP eligibility criteria.

DHCS works with designated CCT LOs to identify eligible Medi-Cal beneficiaries who have continuously resided in MFP qualified inpatient facilities for a period of 60 consecutive days or longer with at least one day of Medi-Cal coverage. Days that a beneficiary received short-term rehabilitative services can be counted towards the minimum stay requirement.

C.2.2. Participant recruitment and enrollment process

Describe the MFP participant recruitment and enrollment process, indicating differences as applicable for each target group and inpatient facility type identified in C.1.1. Include the following:

- Describe the process to identify eligible individuals interested in transitioning from an inpatient facility to a qualified residence.
- Describe the role of No Wrong Door (NWD) systems to recruit and enroll MFP participants.
- Describe how the state or territory will verify MFP individual eligibility criteria.
- Describe the provider(s) rendering services to recruit and enroll individuals into MFP.

- Describe how the state or territory will ensure a person-centered planning process during the MFP recruitment and enrollment process. The person-centered planning process must include a person-centered service plan that identifies the individual's needs and individualized strategies and interventions for meeting those needs, and be led by the individual and the individual's legally authorized representative if applicable.

The LOs work with MFP qualified inpatient facilities in the counties they serve to identify clients who are interested in transitioning into a community setting, as being potential CCT enrollees. The LO explains the process, goals, and criteria. If the applicant is still interested the LO begins the CCT enrollment process by reviewing with the applicant or their representative the CCT Enrollee and Participant Rights and Responsibilities / Consent Form. Once the form is signed, the process moves forward to include the development of an Initial Transition and Care Plan (ITCP). The ITCP includes: a preferred and qualified housing option, necessary medical services, MCPs, supervision of and/or assistance with activities and instrumental activities of daily living (ADLs) provided by care providers and other non-Medi-Cal community resources, plans for managing identified risks and challenges that may be experienced upon returning to the community, and a targeted transition date.

Upon becoming a CCT Enrollee, a Final Transition and Care Plan (FTCP) is developed, which minimally includes: the actual transition date, a current status of a Supplemental Security Income (SSI) reinstatement request, lease agreement (if applicable), household setup (if applicable), home modifications (as appropriate), enrollment into MCPs and/or HCBS Waivers (as appropriate), all arrangements for HCB LTSS, and post-transition care coordination and follow-up plans.

CDA and DHCS collaborate on the MAC process to fund the NWD system and/or the activities associated with the NWD system, including but not limited to training, program planning, and quality improvement. CDA will assist in conducting outreach, creating partnerships with local and state agencies and departments, providing ongoing TA to local organizations, coordinating with key referral sources, developing a person-centered counseling process, and developing follow-up procedures to ensure individuals receive needed services. The main goal is to strengthen California's LTSS for older adults, individuals with disabilities, and their families by developing, implementing, and administering an expanded NWD system in California utilizing the ADRC Program.

CCT LOs initially verify Medi-Cal eligibility through the Medi-Cal Eligibility Database System (MEDS), being a state database of record that has eligibility information inputted from local counties throughout California. A beneficiary is required to have one of the full scope aid codes to be eligible for the CCT Project. MEDS has the capability to provide data to the DHCS MedCompass database.

DHCS clinical staff also verify a beneficiary's eligibility for Medi-Cal and the CCT Project when reviewing and adjudicating TARs.

The following processes are involved with provider's rendering services:

- Working with inpatient facility personnel to identify Medi-Cal beneficiaries who have either expressed interest in returning to the community through MDS 3.0, Section Q, or are identified (by DHCS or the facilities) as beneficiaries who meet MFP eligibility criteria.
- Conducting exploratory interviews with potential enrollees and/or legal representatives, guardians, conservators, or anyone else legally authorized in writing by the potential enrollee to speak with the Contractor about the potential enrollee returning home or to the community. Documentation to verify conservator must be submitted to DHCS' CCT inbox during the enrollment process, at California.CommunityTransitions@dhcs.ca.gov.
- Obtaining consent from the potential enrollee or their legal representative, to access the potential enrollee's medical records to review prior and current medical conditions and current treatments, functional impairments, cognitive and behavioral status, ability to perform activities and instrumental ADLs, and family support.

The CCT LO Transition Coordinators works with applicants, or their legally authorized representatives, and nurses to formulate and review an ITCP, CCT Assessment Tool, FTCP, as well as the Health Care Service Plan to use as guidance for the transition and long-term success living in the community. In addition, the information collected via the assessment tool is utilized to assist participants in transitioning to the Assisted Living Waiver (ALW)/applicable tier level.

C.2.3. Data sources for recruiting MFP participants

Describe how the state or territory will process and organize data sources to identify and recruit MFP participants. The description must include the use of the Minimum Data Set (MDS) Section Q and must describe any variability among MFP target populations, MFP-qualified inpatient facilities, and state or territory operating agencies.

California partners with LOs to recruit all CCT participants. The LOs gather and manage the applicable recruitment data, which is shared with DHCS via the MedCompass database.

Each CCT LO is designated as a LCA with the SMA and responds to MDS, Section Q referrals received from qualified inpatient facilities on behalf of residents who have indicated they would like additional information on returning to live and receiving services in the community, regardless of the residents' insurance coverage. This

includes working with inpatient facility personnel to identify Medi-Cal beneficiaries who have either expressed interest in returning to the community through MDS 3.0, Section Q, or are identified (by DHCS or the facilities) as beneficiaries who meet MFP eligibility criteria.

The tracking of MDS referrals received from inpatient facilities is documented through the Enrollee Information Form (EIF) every time a CCT enrollment is completed, which is submitted through MedCompass.

C.3. Outreach and marketing to participants, providers, and the community

C.3.1. Marketing plan

Describe how the state or territory will develop and implement a marketing plan to recruit and enroll MFP participants. Include a description of the following:

- Strategy or strategies to provide cultural, linguistic, and disability competency in the production and dissemination of marketing materials
- Types of marketing materials and tools
- Types of media approaches (print, radio, television, direct mail, social media, search engine, and so on)

As previously described, LO providers work directly with MFP qualified inpatient facilities to identify clients who are interested in transitioning to a community setting. LOs develop materials, websites, and informational sheets to distribute information on the CCT program, which are person-centered in their approaches that takes into consideration an individual's cultural, linguistic, and/or disability considerations.

Examples of LO websites are accessible via the following hyperlinks:

- Choice in Aging: Transition & Case Management Services
- Independent Living Center of Kern County: Transition Program - Independent Living Center of Kern County
- Libertana: CCT - Libertana
- Silicon Valley Independent Living Center: Community Transition Program – Silicon Valley Independent Living Center

Additionally, MCPs are included in the CCT Enrollment Process, as LOs are expected to collaborate with MCPs on the development and updates to a potential enrollee's Initial CCT Transition and Care Plan.

C.3.2. Outreach and education plan

Describe how the state or territory will develop and implement an outreach and education plan to recruit MFP-inpatient facility providers, service providers, affordable and accessible housing providers, community-based organizations, and other relevant entities. Include a description of the following:

- Methods and tools
- Collaboration opportunities
- Types of events and trainings

LOs are recruited from entities that participate in other 1915(c) Waivers, referrals from Medi-Cal, MCPs, and HCBS provider associations, and stakeholders. DHCS provides information on its website at https://www.dhcs.ca.gov/services/ltc/Pages/CCT.aspx. DHCS makes available an inbox for interested applicants to raise questions.

DHCS is available via a public facing mailbox to provide information, TA, and resource information upon request. The hyperlinks below serve as examples of the educational resources/materials available for providers.

- The CCT Mailbox: California.CommunityTransitions@dhcs.ca.gov
- ABCs of Nursing Home Transition: An Orientation Manual for New Transition Facilitators: ABCs of Nursing Home Transition: An Orientation Manual for New… | ILRU
- CCT Overview: https://www.dhcs.ca.gov/services/ltc/Documents/Module-2-CCT-Overview.pdf
- CCT Transition Process: https://www.dhcs.ca.gov/services/ltc/Documents/REVISED_Mod3-CCT%20Transition%20Process-.pdf
- Person Centered Planning: https://www.dhcs.ca.gov/services/ltc/Documents/Module-4-Person-Centered-Planning.pdf
- LCA Services: https://www.dhcs.ca.gov/services/ltc/Documents/Module-5-Local-Contact-Agency-Services.pdf
- CCT Reimbursement Structure: https://www.dhcs.ca.gov/services/ltc/Documents/Module-6-CCT-Reimbursement-Structure.pdf
- Reporting Requirements: https://www.dhcs.ca.gov/services/ltc/Documents/REVISED_Mod7-Reporting%20Requirements.pdf

Additionally, on the first Tuesday of every other month, the CCT PD hosts a Roundtable Conference Call Meeting to facilitate communications between DHCS staff and CCT LOs. The purpose of the Roundtable meetings is to share new CCT Project information and to provide a forum in which CCT LOs can provide feedback to the state. Meeting minutes are recorded at each meeting. Upon approval of the meeting minutes, they are distributed to the public. Entities and organizations, also interested in enrolling as LO providers have the opportunity to attend, participate, and ask questions.

C.3.3. Stevens Amendment and accessibility requirements

Select the boxes below to confirm the state or territory adheres to the requirements regarding the Stevens Amendment and complies with accessibility laws.

☒ The state or territory affirms that it has established procedures for complying with the requirement in Section 26.G and 26.H of the CMS Standard Terms and Conditions (STC) regarding the Stevens Amendment, which describes actions federal award recipients must take when engaging in public reporting and acknowledgement of sponsors.

☒ The state or territory acknowledges responsibility for complying with federal laws regarding accessibility (Attachment B of CMS STC).

C.4. Informed consent

C.4.1. Informed consent criteria

Describe how the state or territory will implement procedures for obtaining informed consent. Include the following:

- Process for ensuring that each eligible individual or the individual's legally authorized representative will be provided the opportunity to make an informed choice regarding whether to participate in the MFP Demonstration

Prior to

- Process for ensuring that each eligible individual or the individual's legally authorized representative will have input into, and approve the selection of, the qualified residence in which the individual will reside and the setting in which the individual will receive HCBS
- Process for ensuring individuals are informed about all aspects of the transition process; have full knowledge of the services and supports that will be provided both during and after the program year; and are informed of their rights and responsibilities as a participant, including the right to file reports or complaints regarding violation of their rights or other critical incidents
- Method(s) for obtaining informed consent (written, verbal, digital, and so on)

The CCT LO reviews the Rights, Responsibility and Consent form with the applicant and/or their legal representative. All parties sign the form, which is uploaded into the MedCompass document center. An ISCD Analyst verifies that the document is included and signed before verifying the enrollment. The TARs are not reviewed until there is a case note in MedCompass noting the EIF has been verified.

CCT Enrollee and Participant Rights and Responsibilities/Consent Form: CCT Consent Form.

The CCT LO reviews the CCT Enrollee and Participant Rights and Responsibilities/Consent Form with the applicant and or their legal representative. All parties sign the form, and it is uploaded into the MedCompass document center before DHCS approves the initial TAR from the LO. The rights and responsibilities outlined in the document are comprehensive, explaining not only what the program can offer (i.e., rights) but also the responsibilities of the applicant/and or legal representative if they choose to participate in the program. Upon review of the rights and responsibilities, the applicant and/or legal representative will be fully informed on what the program can offer and requires of them. Furthermore, the Consent section lists important representations that the applicant and/or legal representative must acknowledge by providing a signature. For example, "#2.) I have read the CCT Enrollee and Participant Rights and Responsibilities included in this document, or they have been read to me as written. #3.) I understand the content and purpose of the CCT Enrollee and Participant Rights and Responsibilities included in this document. #4.) I understand that failure to adhere to the responsibilities described in this document and/or in my signed TCP may result in termination from CCT".

CCT LOs develop an ITCP and FTCP with full participation of the applicant and/or legal representative in the process. The ITCP must include the applicant's and/or legal representative's "Preferred, qualified housing option: home, independent living, or a home-like assisted living facility."

The CCT LO reviews the CCT Enrollee and Participant Rights and Responsibilities / Consent Form with the applicant and/or their legal representative. All parties sign the form, and it is uploaded into the MedCompass document center before DHCS approves the initial TAR request from the LO. The rights and responsibilities outlined in the document are comprehensive, explaining not only what the program can offer (i.e., rights) but also the responsibilities of the applicant/and or legal representative if they choose to participate in the program. It also contains a provision related to the right to submit complaints regarding any violation of their rights or the provision of services. Upon review of the rights and responsibilities, the applicant and/or legal representative will be fully informed on what the program can offer and requires of them.

The LO must conduct an assessment of potential enrollees, utilizing DHCS' CCT Assessment Tool, to ascertain their functional ability and identify associated risks that must be addressed to ensure their health and welfare in the community. DHCS will only

accept CCT Assessment Tools completed and signed by a case manager and a RN. The results of the comprehensive assessment must be sufficient to provide clinical staff with information to determine:

> *The level of medical supervision and nursing care that the potential enrollee will require to maintain their health and welfare in the community, the amount of habilitation the potential enrollee will require to regain and maintain independence in the community, the level of assistance with activities (and instrumental activities) of daily living that the potential enrollee will require to maintain their health, welfare, and independence in the community, the level of supervision by paid or unpaid care providers that the potential enrollee will require to maintain their safety in the community, and the preferences that the potential enrollee will pursue in returning to the community.*

Discuss options with the potential enrollee, their legal representatives, anyone legally authorized in writing to access and discuss the potential enrollee's information, guardian, or conservator, to develop an ITCP to support the potential enrollee in the community. The ITCP shall include, but is not limited to:

> *Preferred, qualified housing option: home, independent living, or a home-like assisted living facility, necessary medical services, including: primary care, specialty care, mental health care, substance abuse services, durable medical equipment, pharmacy services, and other services required to maintain the continuation of care in the community, MCPs, as applicable, supervision of and/or assistance with activities and instrumental ADLs provided by paid or unpaid care providers, including but not limited to Medi-Cal providers, through the STP or an HCBS Waiver, as well as other non-Medi-Cal community resources, and plans for managing identified risks and challenges the potential enrollee may experience upon returning to the community; and a targeted transition date.*

Ensure the person-centeredness of the ITCP, as defined in the HCBS final rule, by including the potential enrollee, and/or their legal representative, in the development of the ITCP based on the potential enrollee's preferences and informed decision-making. Prepare a FTCP based on the services and supports available and appropriate to meet CCT Enrollees' needs and preferences, and to comply with the HCBS settings requirements of the Medi-Cal STP. The FTCP must include:

> *The actual transition date, current status of SSI reinstatement request to ensure payments are reestablished in a timely fashion, lease Agreements (if applicable), household setup (if applicable), home modifications (as appropriate), Enrollment into Medi-Cal MCPs and/or HCBS Waivers (as appropriate), all arrangements for HCB LTSS, including but not limited to, requests for Medi-Cal STP services and/or*

HCBS Waiver programs that provide the services required to meet the CCT Enrollee's specific needs outside of a facility, and post-transition care coordination and follow-up plans to monitor the health and welfare of the beneficiary.

The CCT LO reviews the CCT Enrollee and Participant Rights and Responsibilities/Consent Form with the applicant and/or their legal representative. All parties sign the form, and it is uploaded into the MedCompass document center. This document comprehensively outlines the rights, responsibilities, and representations/acknowledgements required for participation in the CCT Project, as discussed above.

C.5. Legally authorized representative

C.5.1. Procedures for MFP engagement with a legally authorized representative

Describe how the MFP Demonstration will engage with a legally authorized representative and how the process aligns with state or territory policy. Include the following:

- Procedures for engaging with a legally authorized representative as part of an individual's person-centered planning process during the transition period and the 365-day MFP enrollment period
- Specific strategies and approaches when working with inpatient facility administrators who are serving as a legally authorized representative, particularly around identifying and eliminating conflict of interest concerns
- Process for verifying that an MFP participant's legally authorized representative has (1) a known relationship with the individual; (2) ongoing interaction with the individual; and (3) recent knowledge of the individual's welfare

The CCT LO verifies with the applicant and the facility if the applicant has a legally authorized representative. The conservator's information is entered on the enrollment assessment, and the documents are uploaded into the MedCompass document center. An ISCD/HOB analyst verifies that the document is included and signed before verifying the enrollment. The TARs are not reviewed unless there is a case note in MedCompass noting EIF verification. The clinical team reviews the power of attorney and/or conservator document(s) for validation and authenticity.

CCT LOs discuss options on an ongoing basis with an applicant's legally authorized representative, if one is established and authorized in writing. This can also include anyone who is authorized to access and discuss the applicant's information, guardian, or conservator, to develop an ITCP to support the potential enrollee in the community. The ITCP relies upon person-centeredness, as defined by the HCBS final rule and California's HCBS STP. This is achieved by including the applicant and/or legal representative, so the ITCP is based upon a potential enrollee's preferences and informed decision-making.

Equivalent parameters are also required for the preparation of an enrollee's FTCP.

The CCT LOs obtain written proof that an individual is legally authorized to represent the MFP participant and upload the document to MedCompass. In addition, the LOs follow up monthly after a participant transitions, and will confirm on each call the continued interaction between the legal representative and participant, as well as inquire as to the participant's welfare with the legal representative in each monthly contact.

C.5.2. Re-enrollment

Describe the state or territory's MFP re-enrollment policy (1) for individuals who have been re-institutionalized or hospitalized prior to completing their 365-day MFP enrollment period, and (2) for individuals who have been re-institutionalized after completing their 365-day MFP enrollment period. Include actions that occur at 30- and 60-day intervals during an individual's institutional or hospital stay.

Re-enrollment requirements for CCT participants who are temporarily re-admitted to inpatient facilities during the 365-day demonstration period are determined by the length of their stay in the facility.

- When a CCT participant is re-admitted to an inpatient facility for a period of less than 30 days, the individual remains enrolled, and the 365-day demonstration period resumes upon the date of discharge, where it was on the day the individual was admitted to the inpatient facility. No disenrollment process is involved.
- When a CCT participant is re-admitted to an inpatient facility for a period of more than 30 days, a new clinical assessment must be completed, and a new Transition Care Plan (TCP) must be developed to ensure the individual's needs and preferences will be met in the community. Upon approval of the new TCP, the individual may re-enroll in the CCT Project without re-establishing the 60-day institutional residence requirement. If a person is again institutionalized for more than 30 days after re-enrollment, the individual's participation is discontinued effective the 31st day of consecutive institutionalization post-re-enrollment.

Participants who have completed the CCT Project with a successful 365-day transition are eligible for a one-time re-enrollment if they have been re-institutionalized and need assistance transitioning back to a community setting.

C.6. Other information

If needed, provide other information regarding the state or territory's approach to recruitment, enrollment, outreach, and education that is not addressed elsewhere in the template.

Not applicable.

SECTION D. COMMUNITY ENGAGEMENT

Describe how the state or territory will engage the broad community, including but not limited to, Medicaid agency leadership, participants in HCBS programs, residents in long-term care facilities, long-term care facility staff, family members and other caregivers, HCBS providers, the aging and disability network, MCPs, housing providers, and the direct care workforce, to inform the state or territory's approach to the design of the MFP Demonstration and how the state or territory can leverage the MFP Demonstration to expand and enhance the HCBS system. Include a description of the state or territory's strategy(s), structure of the engagement process, engagement tools, communication process, and how the process will be strengthened throughout the MFP program period of performance.

DHCS is committed to Medi-Cal members and their caregivers. Since the original grant award, the composition of the stakeholder group has gone through several iterations based on the evolution of the program. For instance, in June 2015, DHCS convened the first of five HCBS Stakeholder Advisory Workgroups to engage experts to provide recommendations on building the longevity of institutional transitions to HCBS, the future of HCBS under a managed care delivery system and establishing an adequate HCBS provider network.

Additionally, in 2021, DHCS developed and began to implement the Gap Analysis and Multi-Year Roadmap. The purpose of this engagement activity was to identify and analyze opportunities to expand HCBS access, to improve health outcomes, and patient satisfaction for Medicaid beneficiaries in California. Beneficiaries, their families and caregivers, and providers were invited to participate. To complete this work, DHCS conducted a series of stakeholder meetings, which included public forums, listening sessions, and website and email updates. Since January 2023, more than 1,600 stakeholders have been involved through multiple forums, including five public stakeholder meetings, quarterly engagement with existing stakeholder groups, small group consultation, and a series of sixteen consumer listening sessions with members with different HCBS needs, ages, geographies, races, and languages. The stakeholder activities gave DHCS an opportunity to engage stakeholders and consumers with lived experience using and accessing HCBS. Key themes derived from the stakeholder engagement efforts include:

A. Benefits of HCBS:
    a. Improved mobility, independence, and quality of life
    b. Waiver and non-waiver services help HCBS users live safely in their homes and are connected to their communities by providing care coordination, transportation, home care, and other services

B. HCBS Challenges:
    a. Confusion regarding eligibility for and availability of services
    b. Difficulty finding and retaining home care providers

c. Identifying and securing affordable housing

C. HCBS Recommendations:
   a. Improve communication about and promotion of HCBS
   b. Expand access to and improve the continuity of HCBS
   c. Create a more centralized location for information regarding HCBS
   d.

The qualitative data collected from these efforts, coupled with quantitative data, helped inform the final Gap Analysis report (https://www.dhcs.ca.gov/services/ltc/Documents/CA-HCBS-Gap-Analysis-Final-Report.pdf).

D.1. Community engagement process

States or territories may use Example Table D.1 to list those engaged in the design and implementation of the MFP Demonstration; to indicate the related OP element(s); and a brief description of the engagement structure, including the type and frequency of engagement and role(s) in the engagement process.

Table D.1. Description and frequency of community engagement

Entities (examples)	OP elements	Description of the engagement process
MFP participants	D	Invited to participate in stakeholder meetings and review of proposed HCBS integration plans
Family members and caregivers	D	Invited to participate in stakeholder meetings and review of proposed HCBS integration plans
Centers for Independent Living	D	Invited to participate in stakeholder meetings and review of proposed HCBS integration plans
Long-term care facilities	D	Invited to participate in stakeholder meetings and review of proposed HCBS integration plans
HCBS providers	D	Invited to participate in stakeholder meetings and review of proposed HCBS integration plans
Housing partners	D	Invited to participate in stakeholder meetings and review of proposed HCBS integration plans
Managed care plans	D	Invited to participate in stakeholder meetings and review of proposed HCBS integration plans
Aging and disability networks	D	Invited to participate in stakeholder meetings and review of proposed HCBS integration plans
Direct care workforce	D	Invited to participate in stakeholder meetings and review of proposed HCBS integration plans
Aging and Disability Advocacy Organizations	D	Invited to participate in stakeholder meetings and review of proposed HCBS integration plans

D.2. Other information

If needed, provide other information regarding the state or territory's approach to engagement that is not addressed elsewhere in the template.

Not applicable.

SECTION E. BENEFITS AND SERVICES

Describe how the MFP Demonstration will provide opportunities for MFP participants to receive high-quality services in their own homes or community rather than institutions. The state or territory must describe qualified HCBS (PTC 16 and Attachment A in the PTC), Demonstration services (PTC 17), and supplemental services (PTC 24) that it will provide under the MFP Demonstration.

E.1. Qualified HCBS

The qualified HCBS program is the Medicaid service package(s) that the state or territory will make available to an MFP participant when they move to a community-based residence. This program can be comprised of any Medicaid home and community-based state plan services and HCBS waiver program services. MFP-qualified HCBS are listed and described in Attachment A to the MFP PTC.

The state or territory must describe:

- Qualified HCBS available to MFP participants
- Target population
- Any proposed Medicaid coverage strategy to amend and implement changes to the state plan or HCBS waiver program(s) to carry out the Demonstration; these descriptions must indicate:
  - The specific HCBS program that will be changed or amended
  - Which authority the HCBS program operates under
  - When the change or amendment will occur

The state or territory may insert information using (1) Example Table E.1, (2) a description in the text response box below, or (3) a combination of both a table and a separate text description.

Table E.1. MFP-qualified HCBS

MFP-qualified HCBS	Qualified HCBS description	MFP target population(s)
HCBS under section 1905(a) state plan services	In-Home Supportive Services (IHSS) • Housecleaning • Meal Preparation • Laundry • Grocery Shopping • Personal Care Services (such as bowel and bladder care, bathing, grooming, and paramedical services) • Accompaniment to Medical Appointments • Protective Supervision for the Mentally Impaired • Personal care services to complete ADL and independent activities of daily living	Individuals who are generally aged, disabled, and blind.

HCBS under sections 1915(c), 1915(i), 1915(j) and 1915(k)	1915(c): ALW Assisted Living Services – Homemaker; Home health Aide; Personal Care • Care Coordination • Residential Habilitation • Augmented Plan of Care Development and Follow-Up • NF Transition Care Coordination • 1915(c): HCBS Alternatives (HCBA) Waiver Habilitation Services • Home Respite • Waiver Personal Care Services (WPCS) • Paramedical Service • Assistive Technology • Community Transition Services • Comprehensive Care Management • Continuous Nursing and Supportive Services Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services • Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services • Environmental Accessibility Adaptations • Facility Respite • Family/Caregiver Training • Medical Equipment Operating Expense • Personal Emergency Response (PERS) Installation and Testing • Private Duty Nursing - Including Home Health Aide and Shared Services • Transitional Case Management (TCM) 1915(c): HCBS Waiver for the Developmentally Disabled Behavioral Intervention Services • Community Living Arrangement Services • Day Service • Homemaker • Prevocational Services • Respite Care • Supported Employment • Dental Services • Home Health Aide	Individuals with PDs, individuals with I/DD, individuals with MH/SUDuse disorder, and individuals diagnosed with HIV/AIDS or a TBI Individuals who are general aged, disabled, and blind.

	• Occupational Therapy • Optometric/Optician Services • Physical Therapy • Prescription Lens and Frames • Psychology Services • Speech, Hearing and Language Services • Financial Management Service • Chore Services • Communication Aides • • Community Based Training Service • Coordinated Family Supports • Environmental Accessibility Adaptations • Family Support Services • Family / Consumer Training • Housing Access Services • Intensive Transition Services • Non-Medical Transportation • Nutritional Consultation • Participant-Directed Services • Personal Emergency Response Systems (PERS) • Self-Directed Support Services • Skilled Nursing • Specialized Medical Equipment and Supplies • Transition / Set Up Expenses • Vehicle Modifications and Adaptations 1915(c):Multipurpose Senior Services Program(MSSP) • Case Management • Personal Care Services • Respite Care (in-home and out-of-home) • Environmental Accessibility Adaptations • Minor Home Repair, etc. • Transportation • Chore Services • PERS/ Communication Device • Adult Day Care • Protective Supervision • Meal Services - Congregate / Home Delivered	

	• Social Reassurance / Therapeutic Counseling • Money Management • Communication Services: Translation / Interpretation 1915(c): Self-Determination Program (SDP) • Community Living Supports • Employment Supports • Homemaker • Live-In Caregiver • Prevocational Supports • Respite, Acupuncture • Chiropractic Services, Dental Services • Home Health Aide • Lenses and Frames • Occupational Therapy • Optometric/Optician Services • Physical Therapy • Psychology Services • Speech/Hearing/Language Services • Financial Management • Independent Facilitator • Behavioral Intervention • Communication Support • Community Integration Supports • Crisis Intervention and Supports • Environmental Accessibility Adaptations • Family Support Services • Family/Consumer Training • Housing Access Supports • Individual Training and Education • Massage Therapy • Non-Medical Transportation • Nutritional Consultation • Participant Directed Goods and Services • PERS • Skilled Nursing • Specialized Medical Equipment and Supplies • Technology • Training and Counseling for Unpaid Caregivers	

	• Transition/Set Up Expenses • Vehicle Modifications and Adaptations 1915(i): State Plan HCBS Services • Habilitation- Community Living Arrangement Services • Habilitation- Day Services • Habilitation Behavioral Intervention Services • Respite Care • Enhanced Habilitation- Supported Employment Individual • Enhanced Habilitation- Prevocational Services • Homemaker Services • Home Health Aide Services • Community Based Adult Services • PERS • Vehicle Modification and Adaptation • Speech, Hearing and Language Services • Dental Services • Optometric/Optician Services • Prescription Lenses and Frames • Psychology Services • Chore Services • Communication Aides • Environmental Accessibility Adaptations • Non-Medical Transportation • Nutritional Consultation • Skilled Nursing • Specialized Medical Equipment and Supplies • Transition/Set-Up Expenses • Community-Based Training Services • Financial Management Services • Family Support Services • Housing Access Services • Occupational Therapy • Self-Directed Supports Service • Technology Services • Coordinated Family Supports • Physical Therapy • Intensive Transition Services • Family/Consumer Training • Person-Centered Future Planning • Participant-Directed Services	

	1915(j): IHSS Self-Directed Personal Assistant Services • Provides framework and allows individuals to have more control over their care, such as selecting their providers (e.g. family, friends, other individuals) and managing their care plan with support. 1915(k): IHSS Community First Choice (CFC) Option Provides HCBS attendant services and supports, including help with household chores, personal care services, paramedical services, and protective supervision.	

Other HCBS options (describe) Optional HCBS Under as Sections 1915(b) and 1115	Enhanced Care Management (ECM) – Section 1915(b): • Outreach and Engagement • Comprehensive Assessment and Care Management Planning • Enhanced Coordination of Care • Health Promotion • Comprehensive Transitional Care • Member and Family Supports • Coordination of and Referral to Community and Social Support Services	ECM is intended for the highest risk, highest-cost Medi-Cal MCP members with the most complex medical and social needs. ECM will provide these members with long-term help coordinating their services across delivery systems to address their needs. To be eligible for ECM, members must be enrolled in a Medi-Cal MCP health plan and meet criteria for at least one of the Populations of Focus. Populations of focus include: • Individuals and Families Experiencing Homelessness • Adult High Utilizers • Adults with Serious Mental Illness (SMI) / Substance Use Disorder (SUD) • Incarcerated and Transitioning to the Community • At Risk for Institutionalization and Eligible for Long Term Care • Nursing Facility Residents Transitioning to the Community • Children/Youth Populations of Focus

	Community Supports – Section 1115: • Transitional Rent • Housing Transition Navigation Services • Housing Deposits • Housing Tenancy and Sustaining Services • Short-Term Post- Hospitalization Housing • Recuperative Care (Medical Respite) • Respite Services • Day Habilitation Programs • Nursing Facility Transition/Diversion to Assisted Living Facilities • Community Transition Services/Nursing Facility Transition to a Home • Personal Care and Homemaker Services • Environmental Accessibility Adaptations (Home Modifications) • Medically-Supportive Food/Medically Tailored Meals • Sobering Centers • Asthma Remediation	Community Supports are available to a wide range of members, including people with high needs and who are enrolled in ECM. However, members do not need to be enrolled in ECM to access Community Supports. Community Supports are medically appropriate and cost-effective substitute services provided by Medi-Cal MCPs to help members address their health-related social needs, such as having access to safe housing or healthy meals to aid in their recovery from illness, living healthier lives, and avoiding higher, costlier levels of care.

E.2. MFP Demonstration services

E.2.1. Demonstration service description

MFP Demonstration services are qualified HCBS that could be provided, but are not currently provided, under the state or territory's Medicaid program. Demonstration services must be reasonable and necessary, not available to the participant through other means, and clearly specified in the participant's service plan. The state or territory is expected to test and evaluate Demonstration services. Demonstration services are not required to continue after the conclusion of the MFP Demonstration or for the participant at the end of the 365-day enrollment period. Demonstration service descriptions must include:

- The qualified HCBS Medicaid authority under which the service could be covered
- The target population(s) receiving the service
- For a new Demonstration service not currently covered under the state or territory's HCBS program, a description of the scope of the service including a definition of the discrete service; a complete list and description of any goods and services that will be provided; any conditions that apply to the provision of the service; and eligibility criteria

- For a Demonstration service currently authorized under the state or territory's Medicaid program, a description of how the service complements or supplements the authorized HCBS in an amount, frequency, scope, or duration greater than allowed under the state or territory's Medicaid program
- A description of how the state or territory will test and evaluate the service to determine whether the service contributes to the successful transition and community functioning of an MFP participant

The state or territory may insert information using (1) Example Table E.2.1, (2) a description in the text response box, or (3) a combination of both a table and a separate text description.

Table E.2.1. Demonstration services

Demonstration service title	HCBS Medicaid authority	MFP target population(s)	Amount, duration, and scope of service	Service testing and evaluation
Pre to post-transition coordination	Optional HCBS Under Sections 1915(b) (ECM) and/or 1115 (Community Supports)	Older adults, individuals with PD, individuals with I/DD, individuals with MH/SUD, individuals diagnosed with HIV/AIDS, brain injury	Currently, this service is offered by non-mandatory, optional-based services from ECM and/or Community Supports, being potentially available to beneficiaries enrolled in MCP services. Under the MFP/CCT Project, this is a service offered to any eligible beneficiary, to include three stages of transitioning, being pre-enrollment services once enrolled as a CCT Enrollee, transition and care planning services, where a CCT Enrollee becomes a CCT Participant upon successfully transitioning, and post-transition services of up to 365 days. It also must be a service that is not currently being provided by another waiver program and/or entity. Please refer to the linked resources associated with the DHCS CCT LO TAR Submission Resource and the CCT Service Code Overview.	National Core Indicators – Aging and Disabilities (NCI-AD) Survey, especially in relation to LTSS-1 and LTSS-2.

Home Set-Up	Optional HCBS Under Sections 1915(b) (ECM) and/or 1115 (Community Supports) HCBS Section 1915(c)	Older adults, individuals with PD, individuals with I/DD, individuals with MH/SUD, individuals diagnosed with HIV/AIDS, brain injury	Currently, this service is offered by non-mandatory optional-based services from ECM and/or Community Supports, being potentially available to beneficiaries enrolled in MCP services. It's also an optional service offered by Section 1915(c). Under the MFP/CCT Project this is allowed for a maximum of $7500 per the 365-day Demonstration period, being a service offered to any eligible beneficiary. It also must be a service that is not currently being provided by another waiver program and/or entity.	NCI-AD Survey, especially in relation to LTSS-1 and LTSS-2.

Home Modification	Optional HCBS Under Sections 1915(b) (ECM) and/or 1115 (Community Supports) HCBS Section 1915(c)	Older adults, individuals with PD, individuals with I/DD, individuals with MH/SUD, individuals diagnosed with HIV/AIDS, brain injury	Currently, this service is offered by non-mandatory optional-based services from ECM and/or Community Supports, being potentially available to beneficiaries enrolled in MCP services. It's also an optional service offered by Section 1915(c). Under the MFP/CCT Project this is allowed for a maximum of $7500 per the 365-day Demonstration period, being a service offered to any eligible beneficiary. It also must be a service that is not currently being provided by another waiver program and/or entity.	NCI-AD Survey, especially in relation to LTSS-1 and LTSS-2.

Habilitation	Optional HCBS Under Sections 1915(b) (ECM) and/or 1115 (Community Supports) HCBS Section 1915(c) HCBS Section 1915(i)	Older adults, individuals with PD, individuals with I/DD, individuals with MH/SUD, individuals diagnosed with HIV/AIDS, brain injury	Currently, this service is offered by non-mandatory optional-based services from ECM and/or Community Supports, being potentially available to beneficiaries enrolled in MCP services. It's also an optional service offered by Sections 1915(c) and 1915(i). Under the MFP/CCT Project, this is a service offered to any eligible beneficiary. It also must be a service that is not currently being provided by another waiver program and/or entity. Additionally, the maximum amount for transition-related services is 60 15 minute increments during the 365-day Demonstration period. Although requests for more than 60 15 minute increments may be approved for additional hours.	NCI-AD Survey, especially in relation to LTSS-1 and LTSS-2.

Personal Care Services	HCBS Section 1905(a), 1915(c), 1915(i), 1915(J), and 1915(k)	Older adults, individuals with PD, individuals with I/DD, individuals with MH/SUD, individuals diagnosed with HIV/AIDS, brain injury	Currently, this service is offered as an optional service as IHSS under Sections 1905(a), 1915(c), 1915(i), 1915(J), and 1915(k). Under the MFP/CCT Project, this is a service offered to any eligible beneficiary who is awaiting for IHSS services to be in place. It's a service that is provided in 15 minute increments.	NCI-AD Survey, especially in relation to LTSS-1 and LTSS-2.
Family and Informal Caregiver Training	Optional HCBS Under Sections 1915(b) (ECM) and/or 1115 (Community Supports) HCBS Section 1915(c) HCBS Section 1915(i)	Older adults, individuals with PD, individuals with I/DD, individuals with MH/SUD, individuals diagnosed with HIV/AIDS, brain injury	Currently, this service is offered by non-mandatory optional-based services from ECM and/or Community Supports, being potentially available to beneficiaries enrolled in MCP services. It's also an optional service offered by Sections 1915(c) and 1915(i). Under the MFP/CCT Project, this is a service that must be provided by an RN and is not being provided by another waiver program and/or entity. It's a service that is provided in 15 minute increments.	NCI-AD Survey, especially in relation to LTSS-1 and LTSS-2.

Vehicle Adaptations	HCBS Section 1915(c) HCBS Section 1915(i)	Older adults, individuals with PD, individuals with I/DD, individuals with MH/SUD, individuals diagnosed with HIV/AIDS, brain injury	Currently, this service is offered as an optional service as environmental adaptations under Sections 1915(c) and 1915(i). Under the MFP/CCT Project, this is a service that must be provided to a vehicle that belongs to the MFP/CCT eligible beneficiary or a parent/legal guardian for the express purpose of meeting the transportation needs of the eligible beneficiary. Additionally, this is allowed for a maximum of $12,000 per the 365-day Demonstration period. In the event there is partial coverage from a waiver program and/or entity, the MFP/CCT Project covers the difference between what is authorized.	NCI-AD Survey, especially in relation to LTSS-1 and LTSS-2.

Assistive Devices	Optional HCBS Under Sections 1915(b) (ECM) and/or 1115 (Community Supports) HCBS Section 1915(c) HCBS 1915(i) State Plan Amendment (SPA)	Older adults, individuals with PD, individuals with I/DD, individuals with MH/SUD, individuals diagnosed with HIV/AIDS, brain injury	Currently, this service is offered by non-mandatory optional-based services from ECM and/or Community Supports, being potentially available to beneficiaries enrolled in MCP services. It's also an optional service offered by Sections 1915(c) and 1915(i) SPA. Under the MFP/CCT Project, this is a service that must be provided per a medical justification signed by a licensed medical professional. Additionally, this is allowed for a maximum of $7500 per the 365-day Demonstration period. In the event there is partial coverage from a waiver program and/or entity, the MFP/CCT Project covers the difference between what is authorized.	NCI-AD Survey, especially in relation to LTSS-1 and LTSS-2.

For additional details for MFP/CCT Project Demonstration Services, please refer to the DHCS CCT LO TAR Submission Resource and the CCT Service Code Overview.

E.3. MFP supplemental services

E.3.1. Supplemental service descriptions

Supplemental services are one-time services to support an MFP participant's transition that are otherwise not allowable under the Medicaid program. Supplemental services must be reasonable and necessary,

not available to the participant through other means, and clearly specified in the participant's service plan. Supplemental services are not required to continue after the conclusion of the MFP Demonstration or for the participant at the end of the 365-day enrollment period. The state or territory is expected to test and evaluate supplemental services.

DHCS is currently in the process of brainstorming Supplemental MFP/CCT services for potential development. Upon receiving TA and approval from CMS, the OP will be revised to include the applicable information.

E.3.2. Supplemental services housing plan and food security plan

DHCS is currently in the process of brainstorming Supplemental MFP/CCT services. Upon receiving TA and approval from CMS, the OP will be revised to include applicable information.

E.4. Managed long-term services and supports

Select the box below to indicate whether your state or territory operates an MLTSS program.

☐ Yes, the state or territory operates an MLTSS program that includes providing HCBS to these populations: (select all that apply).

- ☐ Older adults
- ☐ Adults with PD
- ☐ Individuals with I/DD
- ☐ Individuals with MH/SUD
- ☐ Other, please specify (e.g., HIV/AIDS, brain injury)

For states or territories that selected "Yes", describe how the state or territory implements the MFP Demonstration under managed care programs. Clearly indicate the qualified HCBS, Demonstration, and supplemental services that are delivered under managed care. Additionally, describe how the MFP Demonstration supports or complements the state or territory's MLTSS strategy for expanding HCBS, promoting community integration, ensuring quality, and increasing efficiency.

DHCS MCPs/MLTSS do not currently implement HCBS provisions. DHCS may explore possible HCBS integration (for some services) into MCPs in the future.

Related to the demonstration supporting/complimenting the state's MLTSS strategies, the LOs are liaisons who encourage connections between CCT enrollees and/or participants and MCPs. The overall intention is to develop a more fully integrated system, which would include connections between the LOs, CCT enrollees and/or participants, MCPs, and other available services, such as waiver programs.

For example, CCT participants have the opportunity to be involved in the DHCS 811 Housing Program through associated Tenant Referral Organizations (TROs). TROs are contracted with DHCS to implement MFP case management services/transitions support services. In this case, the TROs would partner with the applicable CCT participants approximately 120 days before their CCT program participation concludes to recommend participants for other case management services, such as, but not limited to, services via their Medi-Cal MCP, ECM and/or Community Supports, or other applicable waivers/community programs.

E.5. Service providers

E.5.1. Qualified HCBS, MFP Demonstration, and supplemental service providers

For each qualified HCBS, MFP Demonstration, and supplemental service, include the following:

- Describe how the state or territory will ensure that providers have sufficient experience and training in the provision of their applicable supplemental services.
- Describe how the state or territory provides access to needed services or manages a waiting list when provider shortages or other barriers prevent timely provision of HCBS, MFP Demonstration, and supplemental services.
- Describe how the MFP program will ensure that MFP participants are offered the choice of a Medicaid-qualified provider under a person-centered planning process or the Medicaid authority limiting participants' choice of provider.

The state or territory may insert information using (1) Example Table E.5.1, (2) a description in the text response box, or (3) a combination of both a table and separate text description.

Example Table E.5.1. Describe HCBS, MFP Demonstration, and supplemental service provider qualifications

Training and Experience

Service	Provider qualifications
MFP/CCT Services	To administer HCBS services, providers must: (1) be eligible to enroll as an HCBS and Medi-Cal provider; and (2) possess the infrastructure to implement the program.

DHCS ensures that the providers participating in the CCT Project as LOs are supported with oversight, training, and structured support systems. If an entity is interested in becoming a CCT LO, they must meet specific criteria to participate, which include submitting an inquiry email to DHCS to express interest via the CCT Mailbox. Specific instructions are accessible on the DHCS CCT webpage regarding the application process for enrolling as a CCT LO. Additionally, interested entities are welcome to attend the Roundtable conference call meeting that is hosted by the CCT Project PD, which is on the first Tuesday of every other month. If it is determined that an applicant does not sufficiently meet the standards to provide CCT LO services, a formal notice of denial is provided by DHCS.

Upon the completion of an initial pre-screening process from ISCD/HPB, an applicant is provided with the following application forms:

- CCT LO Information Form (DHCS 1315)
- CCT LO Narrative Proposal Form (DHCS 1317)

Additional application materials to be provided by the applicant may include:

- Banking statements
    - A best practice on behalf of applicants is the demonstration of the fiscal capacity to cover a minimum of three months of encumbered costs to ensure against a disruption in reimbursement and services
- Evidence of current office location
- Evidence of staffing levels and staff experience

Upon the completion of the application review process, ISCD/HPB collaborates with the Provider Enrollment Unit (PEU) within ISCD/QMB. PEU then begins the process of reviewing the applicant for eligibility for enrollment as a Medi-Cal Provider. When an applicant becomes enrolled as a Medi-Cal Provider, an appropriate Category of Service is assigned, which allows the provider to bill for relevant DHCS services.

Upon being enrolled as a Medi-Cal Provider, ISCD/HOB begins collaborating with ISCD/DSB, PCD, and the entity to develop a DHCS CCT LO contract.

Upon a CCT LO contract being developed and executed, training is provided from ISCD/HOB to CCT LO staff, including transition coordinators, RNs, program managers/supervisors, and support staff. Additionally, staff from the CCT LO are included as attendees at the Roundtable conference call meeting as MFP/CCT providers. ISCD/HOB monitor the CCT Mailbox and provides responses to inquiries or questions that CCT LOs have.

The MedCompass database also has a Help Manual that CCT LOs can reference at any time. Notifications are sent through MedCompass to CCT LOs when program updates or modifications are made.

DHCS has not identified any waitlist or provider shortages specific to the CCT Project. However, DHCS does face provider shortages and waitlist issues post 365-day

transition, as some of our 1915(c) Waivers have waitlists. In addition to increasing the number of slots in our most impacted 1915(c) Waivers (ALW and HCBA Waiver), DHCS has taken significant steps since the COVID-19 Public Health Emergency (PHE) to help alleviate these issues at a broader level. This includes a substantial injection of funds through the American Rescue Plan Act of 2021. Key initiatives funded by this plan covered a wide range of needs, for example:

- Workforce: Investments in the direct care workforce, including IHSS Career Pathways training programs and one-time $500 hazard payments to IHSS providers who served clients during the pandemic.
- Service Expansion: Increasing slots and capacity for HCBS waiver programs (such as expanding enrollment in the ALW and DDS waivers) to reduce waitlists and serve more individuals in the community.
- Provider Infrastructure: Grants for adult day programs, independent living centers, and home care agencies to recover and enhance services post-pandemic.
- Technology and Access: Funding for telehealth capabilities, caregiver respite, affordable housing supports for HCBS participants, and NWD system improvements to help people locate and access HCBS resources.

As the demand for HCBS continues to rise across California, DHCS will continue to actively assess and reassess a variety of strategies to address ongoing challenges related to waitlist management and provider shortages.

A core principle of California's MFP/CCT program is ensuring that participants have access to high-quality, Medicaid-qualified providers and that their preferences, needs, and goals guide the care they receive. The person-centered planning (PCP) process is at the heart of the MFP program, and it emphasizes the individual's active involvement in the development of their care plan. This means that MFP participants are given the opportunity to identify their own goals, preferences, and needs in terms of both care and providers. During the transition from an institutional setting to a home or community-based environment, a care coordinator or case manager works with the participant to design a care plan that reflects their choices and desired outcomes. The participant and/or their representative is encouraged to consider a range of providers, ensuring that the selected services align with their personal preferences and values. Additionally, based on the needs of the participant and their eligibility status, case managers provide participants with information on California's diverse 1915(c) waivers and the various services offered to determine which waiver would best suit the participant's needs.

E.6. Other information

If needed, provide other information regarding the state or territory's benefits and services that is not addressed elsewhere in the template.

Not applicable.

SECTION F. TRANSITION AND HOUSING SERVICES

F.1. Transition services

F.1.1. Comprehensive transition coordination services

Describe how the state or territory's MFP Demonstration will implement comprehensive transition coordination services during these three phases: (1) pre-transition, (2) transition, and (3) during an MFP participant's 365-day enrollment period. Include the following:

- Description of transition coordination activities
- Description of person-centered planning in the transition coordination process, including:
  - How the state or territory's MFP Demonstration will ensure that each MFP participant's service plan is individualized to provide the services and supports needed to live in the community
  - How MFP participants and their legally authorized representative (if applicable) will lead the development of their service plan
- Steps in the transition coordination process
- Communication process between MFP transition coordination and Medicaid HCBS programs
- How transition coordination services advance health for all people served
- How transition coordination services promote community integration

Use discrete descriptions for each target population.

MFP transition coordination activities in California are provided by CCT LOs in designated service areas. These service areas are based upon counties throughout the state, being a total of 58 counties. CCT LOs conduct outreach efforts at MFP qualified inpatient facilities in their designated service areas. These outreach efforts allow for beneficiaries who are residing in MFP qualified inpatient facilities to be identified as being interested in transitioning into a community setting of their choice. CCT LOs are also LCAs with the SMA and respond to the MDS, Section Q referrals on behalf of residents of MFP qualified inpatient facilities, regardless of residents' insurance coverages.

Upon a beneficiary being determined as eligible for MFP services with the assistance of CCT LO providers, they are identified as an enrollee upon completing the ITCP. Additional forms completed, with the assistance of CCT LO providers, include the CCT Assessment Form, FTCP, the Day of Transition Report Form (DTRF), and an MFP Participant 24-Hour Special Incident Plan and Contact Resources. Specific CCT LO staff who assist with the completion of these forms include Transition Coordinators and Registered Nurses (RNs). These forms are submitted by CCT LO staff on the MedCompass database, where they are reviewed and approved by DHCS staff. Upon an enrollee transitioning from a qualified inpatient facility to their community for the 365-day MFP Program, they are then designated as an MFP participant.

In the process of being initially enrolled as an enrollee to transitioning to the community as a participant for the 365-day MFP Program, the principles of PCP are embedded throughout. This also includes conducting a rigorous verification process with beneficiaries and facility staff to determine if a legally authorized representative is present, such as a legal conservator. If a legally authorized representative is determined as being present, they are included for the duration of MFP services being provided.

Additionally, CCT LOs submit TARs for every service that is provided on behalf of an MFP enrollee or participant, which is monitored through the DHCS Service Utilization Review, Guidance, & Evaluation (SURGE) and MedCompass databases. Once a TAR is approved by DHCS, a CCT LO is reimbursed for services that have been provided to the participant.

The CCT LO provides pre and post-transition services under procedure code G9012, which includes coordination services provided to transition an eligible individual from a health facility to a home and community-based (HCB) setting: Other specified case management service not elsewhere classified through TCM, which are categorized as Demonstration Services. This includes up to twenty hours for the initial enrollment of the individual in the program while residing in the facility, and up to 100 hours of pre-transition services. Upon successful transition to the community the CCT LO may provide up to an additional 50 hours of post-transition services.

The pre and post transition services include: Coordinated care fee, risk adjusted maintenance, other specified care management, and coordination services provided to transition an eligible individual from a health facility to a (HCB) setting. This includes the assessment of the individual's medical and nonmedical needs, supports in the home and funding. TCM services may be provided up to 180 days before discharge from an institution. Providers may claim a maximum of 24 hours per day.

Additional services that may be provided include: family and informal caregiver training, home modification, personal care services, habilitation, assisting devices, and home set-up. A resource on the DHCS CCT Webpage that can be referred to is the LO TAR Submission Resource or the CCT Service Code Overview.

The PCP process is at the heart of the MFP program, and it emphasizes the individual's active involvement in the development of their care plan. This means that MFP enrollees and participants are given the opportunity to identify their own goals, preferences, and needs in terms of both care and providers. During the transition from a

qualified inpatient facility setting to a home or community-based environment, a care coordinator or case manager works with the participant to design a personalized care plan that reflects their choices and desired outcomes.

The enrollee/participant and/or their representative are encouraged to consider a range of providers, ensuring that the selected services align with their personal preferences and values. Additionally, based on the participants' needs and eligibility status, case managers provide information on California's diverse 1915(c) waivers and the various services offered to determine which waiver would best suit their needs.

The contracted CCT LO has primary responsibility for enrolling individuals into the CCT program, transitioning individuals from the health facility to the community, and for monitoring the status of the transitioned individual for 365 days post-transition.

The steps in the transition coordination process include conducting an assessment and consulting with a care coordinator/case manager who works with the individual and/or legally authorized representative to create a care plan around their desired outcomes. Additionally, the CCT LO case manager facilitates the individual's transition while ensuring continuity of care and monitors the individual's transition to community living while adjusting support services as seen necessary.

Phase 1: Outreach and Targeting Phase:

- Develop relationships with area long-term care inpatient facilities.
- Respond to inpatient facility referrals of people who want more information about community integration (identified in MDS, Section Q).
- Work closely with facility discharge planners to identify potential candidates for CCT.

Phase 2: Information Gathering & Enrollment:

- CCT LO staff conduct an initial interview with the beneficiary to gauge their interest in transitioning to the community. If interested in transitioning, the beneficiary must agree to the terms of the demonstration and sign the following CCT forms: the CCT Enrollee and Participant Rights and Responsibilities/Consent and the Authorization for Release of Protected Health Information (PHI).
- CCT LO Transition Coordinators collect records necessary to conduct local level reviews of patient history, eligibility, durable power of attorney (DPA), etc. Transition Coordinators begin the assessment tool and CCT LO RNs complete

the clinical portion of the assessment tool to identify the health and safety needs to be addressed in the ITCP.

- Transition Coordinators meet with the beneficiary to gather information on their preferences, and service and care needs for community living. It is determined if transition to community living is possible based on the services available to meet the beneficiary's identified preferences and needs of their chosen location.

Phase 3: Implementation:

- DHCS reviews the beneficiary's record prior to adjudicating the pre-transition TARs to determine if the individual's needs and preferences are addressed, and whether the services the individual will receive in the community are sufficient to meet the beneficiary's health and safety needs.
- Upon DHCS approval, the CCT LO transition team collaborates with the beneficiary, now referred to as an enrollee, and their identified transition team, to develop a FTCP that addresses the member's unique preferences, and their medical and social needs in the community, including the development of their 24-Hour Backup Plan. This includes securing appropriate and available HCBS, housing, in-home support worker(s), etc. to meet the enrollee's identified needs and preferences. Additionally, an intake appointment is scheduled with the enrollee's identified community physician.
- Two weeks prior to transition, the CCT LO submits an FTCP and 24-Hour Backup Plan on MedCompass documenting the LTSS that have been put in place prior to enrollee's transition. DHCS then reviews the FTCP and 24-Hour Backup Plan and approves post-transition hours.

Phase 4: Transition to Community Living:

- Services must be in place on the day of transition, including, but not limited to: home/household set-up, home modifications, delivery and set-up of equipment, financial arrangements, personal care services/nursing care services, and/or other HCBS. Upon an enrollee successfully transitioning to the community, they are now known as a participant.
- CCT LO Transition Coordinators must be with the participant at their residence on the day of transition and completes the DTRF, which also includes that their 24-hour-Backup Plan is secured in an accessible location in their residence.
- The first day of participation in the 365-day demonstration period then begins.

Phase 5: Follow-Up:

- CCT LO Transition Coordinators collaborate with other service providers associated with the participant to ensure a smooth community transition is maintained. Potential service providers may include IHSS social workers, MCP case managers, HCBS case managers, etc.

- CCT LO Transition Coordinators review the FTCP with the participant at regularly scheduled intervals during the post-transition period and address any needs or concerns.
- CCT LO Transition Coordinators remind the participant that the MFP/CCT demonstration period ends on day 365, and that existing services will continue as long as the person remains eligible for Medi-Cal, CalAIM, and/or HCBS Waiver programs.
- It is strongly recommended for CCT LO Transition Coordinators to perform a final review of the FTCP with the participant in the eleventh month of their MFP/CCT demonstration period to ensure that all of their needs and preferences have been met.

Transition Coordinators, via CCT LOs, are in regular communications with California's various HCBS programs, such as programs listed under sections 1905(a), 1915(b), 1915(c), 1915(i), 1915(j), 1915(k), and 1115. Specific programs include IHSS, ALW, HCBA Waiver, HCBS Waiver for the Developmentally Disabled, MSSP, SDP, ECM, and Community Supports.

CCT LOs communicate, engage, and liaise with these programs at any point during the MFP process, which may include when a beneficiary is an enrollee at a qualified inpatient facility or as a participant when residing in the community during the 365-day enrollment period. The main intent and purpose of these case management efforts on behalf of the CCT LOs are to ensure that the HCBS programs are able to remain intact and accessible for beneficiaries upon the completion of MFP services, which acts as a supportive capacity in reducing the likelihood of re-institutionalization while they continue to reside in their communities.

When focused on advancing health for all people served, transition coordination services focus on the individual by tailoring specific care plans to meet the needs and preferences of each individual. These services also focus on empowering patients and their families by providing support and resources to promote informed decision making. Alongside empowering and focusing on the individual, transition coordination services foster collaboration among healthcare providers by bridging the gap between different healthcare settings and levels of care.

Similarly to how transition coordination services advance health for all people served, these services are also able to promote community integration by providing tailored support to individuals who transition from healthcare or institute settings into community living spaces. These services can focus on individuals being empowered to participate

in their communities, to develop essential life skills, while also building social connections within their communities.

F.1.2. Transitions under managed care plans

If MFP participants are required to enroll in a managed long-term care or comprehensive managed care plan, clearly describe how the MFP Demonstration will coordinate the delivery of comprehensive transition coordination services with the MCP. Include the following:

- Describe the roles and responsibilities for the MCP during each transition phase: (1) pre-transition, (2) transition phase, and (3) during an MFP participant's 365-day enrollment period
- Describe how the MFP program will ensure that MCPs provide all data and related documentation necessary to monitor and evaluate MFP transition coordination services, including identifying MFP managed care encounters through the Transformed Medicaid Statistical Information System (T-MSIS).

Although CCT services are carved out of Managed Care and provided via FFS, the vast majority of California's Medi-Cal beneficiaries are enrolled in MCPs. With this distinction, MCPs do have the opportunity to be included in the CCT Enrollment Process, as they are able to collaborate with CCT LOs on the development and updates to a potential enrollee's ITCP. CCT LOs also collaborate with potential enrollees to assess for enrollment in MCPs with the ITCP, if appropriate. Upon becoming an official enrollee, beneficiaries can be confirmed as being enrolled in MCPs, if appropriate, which is monitored with the FTCP.

Upon being transitioned and in the 365-day enrollment period, MCPs have the opportunity to play a supportive role with MFP participants. MCPs monitor the transition process to ensure continuity of care. For example, MCPs are identified in California's Individualized 24 Hour/7 Days a Week Backup Plan. They are able to provide high-quality, accessible, and cost-effective health care services, which emphasize primary and preventative care. MCPs are required to ensure that any beneficiary requiring urgent care is seen within 24 hours. Additionally, MCPs are required to have a physician (or an appropriate licensed professional under their supervision) be available for after-hours calls. MCPs also have the opportunity to assess MFP participants to determine their need for additional services and supports as deemed appropriate, which may include ECM and Community Supports services. ECM and Community Supports are optional Section 1915(b) and 1115 services an MCP may provide, which could include a potential of twenty-two different services, such as Medically-Supportive Food/Medically Tailored Meals and Personal Care and Homemaker Services. Additional services may be assessed for during the 365-day enrollment period and provided once the enrollment period ends, such as Community Supports and ECM services. Please refer to Table E.1. MFP-qualified HCBS for additional information for Community Supports and ECM services.

DHCS collaborates with the MCPs, as has been indicated above. DHCS coordinates through the T-MSIS to ensure timely and accurate submission of MFP-related data. This includes encounter data, service utilization, and transition outcomes. The data submitted through T-MSIS supports both state and federal oversight. Also, the T-MSIS report allows DHCS to track the effectiveness of transition coordination services, identify trends and ensure compliance with program goals.

F.1.3. Housing-related services and supports

Describe how the state or territory will structure, organize, and implement housing-related supports and services to increase affordable and accessible housing opportunities for MFP participants. Account for any differences between target population groups and geographic service areas, specifically in rural service areas.

DHCS, through its HCBS and MFP program, aims to help individuals transition from institutional settings into community living. The CCT LOs assist participants in navigating housing options, including help with applications, identifying available lease-up properties, and connecting with property owners. CCT LOs are trained to connect participants with HCBS and housing supports such as the 811 PRA.

DHCS contracts with a range of community-based providers to serve as CCT LOs, including Home and Health Care Management, Libertana Home Health, and Star Nursing. These providers may also serve as TROs and Care Coordination Agencies (CCAs) under programs like ALW. TROs implement a wide array of support services, including: Whole-person care planning, Case management, Habilitation, Skilled nursing and personal care, Medical equipment and assistive technology, Home accessibility modifications, Furnishings, First-month’s rent assistance, and housing deposits.

As MFP participants transition to community settings, TROs continue to provide case management and assist with enrollment in waiver or Community Supports/ECM services to ensure continuity of services beyond the 365-day MFP eligibility period. CCT LOs are directly connected to housing opportunities through 811 PRA, Medi-Cal MCPs for housing subsidies and units, and CalAIM (section 1115 and 1915(b) waivers, which includes Community Supports, such as housing transition navigation and tenancy-sustaining services.

CCT LOs coordinate these services by contracting with providers, ensuring compliance with DHCS policies, and facilitating data sharing and billing. They serve as the bridge between Medi-Cal MCPs, service providers, and the individuals receiving support. In rural communities, DHCS recognizes unique challenges, including limited provider networks, transportation barriers, and a scarcity of affordable and accessible housing.

DHCS prioritizes LO applications from providers committed to serving rural and underserved areas and invests in infrastructure, including housing specialist positions, electronic referral systems, housing registries, shared data platforms, and screening tools, as well as workforce development and cultural competency training. DHCS has interagency agreements to expand access to housing subsidies, including the 811 PRA program. These strategies help mitigate rural service gaps and ensure that MFP participants in these areas receive equitable support.

DHCS supports individuals who require institutional care, whose target population includes:

- Older adults who need assistance to remain in their homes or communities.
- Individuals with (I/DD).
- Individuals with PDs who require help with daily activities.
- Individuals with mental health conditions or substance use disorder who benefit from community-based support systems.

These populations often face different barriers to transition, such as behavioral health needs, lack of informal supports, or housing discrimination. The rural areas have challenging geographic service areas. Urban areas tend to have more CCT LOs, housing options, and community-based services. Rural areas often have fewer CCT LOs and limited provider capacity, a lack of affordable and accessible housing, transportation barriers for site visits and service coordination, and limited access to HCBS, such as home health and adult day services. DHCS prioritizes LO applications from providers interested in serving underserved and rural areas.

F.2. Partnerships with state or territory and local housing entities

Describe how the state or territory will develop and sustain partnerships with state or territory and local housing agencies to increase access to affordable and accessible housing for MFP participants. Include the following:

- How the state or territory will put in place partnership arrangements with state or territory and local housing entities
- How the state or territory will work with those entities to assist MFP participants to obtain affordable and accessible housing
- Description of the proposed infrastructure expenditures to support housing partnerships; examples of infrastructure expenditures include:
  - Housing specialist position(s)—responsible for developing/maintaining system-level partnerships with state or territory and local housing entities

- Technology—for example, electronic referral systems, shared data platforms, screening tool, case management systems, databases/data warehouses, housing registry
- Workforce development—for example, training, housing coordination certification, cultural competency training
- Outreach, education, and convenings—for example, design and production of outreach and education materials, translation, investments in community convenings

DHCS currently has effectuated IAs with four state departments to implement the 811 PRA housing program, which is supported via the state's MFP program. The four departments include DDS, CalHFA, HCD, and CTCAC. The intent of 811 PRA is to proactively implement system changes for Medi-Cal beneficiaries with disabilities, ages 18-61, who have resided in a long-term health care facility for at least 60 days and desire to return to community living. To ensure the implementation of a collaborative partnership, DHCS representatives meet on a weekly basis to review project successes and areas for enhancement. Additionally, the IAs are reviewed on an annual basis to determine if revisions are needed to continue the project's effectiveness.

Through the 811 PRA program, DHCS works with the previously listed departments to complete numerous activities to assist MFP participants in obtaining affordable and accessible housing. CalHFA plays an important supportive role in the success of the CCT Project under the MFP initiative. CalHFA helps develop affordable housing by providing loans and tax credits to developers building housing for low and moderate-income individuals. They support projects that include accessible units for people with disabilities, which are often used by CCT participants. CalHFA works with the TROs that help place CCT participants into these housing units. CalHFA ensures that the housing options are safe, accessible, and sustainable for people with complex medical and behavioral needs. DHCS also internally tracks in MedCompass the MFP qualified residents that MFP/CCT participants have transitioned, including into 811 PRA housing.

To implement the 811 PRA program to assist MFP participants in obtaining accessible and affordable housing, several infrastructure expenditures are needed. These expenses include funding to support a total of two full-time MFP housing specialist staff. These positions include one housing specialist and one housing analyst. The specialist would be responsible for managing the CCT LOs housing referral activities. In addition, this team member would lead and facilitate internal and external stakeholder meetings, develop referral reports, and ensure MFP participants are provided with housing information. The analyst would support the specialist by conducting assessments of applicable regulatory requirements, organizing meetings, and monitoring the housing mailboxes and phone lines.

Another infrastructure expenditure is workforce development. As the 811 PRA program is implemented, there have been areas for enhancement identified to assist the project

in being more efficient. This includes training for the TRO case managers, DHCS staff members, and online resources (e.g., asynchronous training modules). Examples of training topics include, but are not limited to, data entry, recruitment and marketing, cross-agency collaboration, and report development.

DHCS continues to integrate services across health care and housing systems, including collaboration with CalHFA and housing developers to expand the supply of affordable and accessible housing, and engaging TROs to connect individuals with the 811 PRA housing units and other housing options. Also, DHCS does have data sharing agreements in place to support its infrastructure activities, especially those involving housing partnerships. The agreements enable secure and compliant exchange of participant data between DHCS, CCT LOs, and housing authorities. This allows the health and housing systems to work together to identify housing needs, match services, and monitor outcomes. CCT LOs use these agreements to coordinate transitions from institutional care to community housing, share data needed for housing navigation, tenancy support, and service referrals, and track outcomes and ensure continuity of care.

F.3. MFP-qualified residence

Describe how the state or territory will verify and document the type of MFP-qualified residence (see PTC 15) an MFP participant resides in during the 365-day enrollment period. Use discrete descriptions for each target population if applicable. Include the following:

- Description of the process for identifying MFP-qualified residences
- Description of the provider(s) responsible for verifying and documenting the type of MFP-qualified residence
- Assessments or tools for screening MFP-qualified residences, including:
  - Name and description of the assessments of tools

Despite the MFP target population/grouping, CCT LOs work with enrollees and their support network to promote a smooth transition of participants into MFP-qualified residences, per the parameters of PTC #15 and the Deficit Reduction Act of 2005 (DRA), section 6071 (b)(6). Potential categories of MFP-qualified residences consist of:

- A home owned or leased by the MFP participant or the MFP participant’s family member
- An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the MFP participant or the MFP Participant's family has domain and control; and, that is regulated by a lease with a landlord, county and/or city guidelines, or a public housing agency
- A licensed community-based residential setting, in which no more than 4 unrelated individuals reside

To identify an MFP-qualified residence, CCT LO Transition Coordinators conduct assessments to determine whether the settings are safe and appropriate. A specific housing assessment used is the CCT Independent Housing Disclosure, which is completed by the CCT LO Transition Coordinator in coordination with a CCT Enrollee and their legal representative, if applicable. The CCT Home Set Up resource is also provided to the CCT Enrollee. In addition, if an MFP-qualified residence is categorized as a licensed community-based residential setting the CDSS and/or DHCS ensures all licensure and certification requirements are achieved and maintained. A tool used from DHCS to ensure residential providers comply with the Federal HCB Setting final Rule, 42 CFR §441.301(c)(4)(5), is the Residential Provider Verification.

Additionally, all housing options for MFP participants who receive waiver services must comply with CMS' 2014 Final Rule on HCB Settings Requirements, CMS 2249-F and CMS 2296-F. More information on the Final Rule, including California's compliance efforts, can be found on the DHCS HCBS Statewide Transition Plan website.

The CCT LO Transition Coordinator also documents the MFP-qualified residence options for enrollees and participants with the use of the ITCP, FTCP, and DTRF.

As previously described CCT LOs conduct the assessments to verify qualified residence. CCT LO Transition Coordinators are responsible for completing the assessments. Moreover, CDSS staff complete the licensure assessments and issuances for community-based residential settings.

Various assessment processes/forms are utilized to screen MFP-qualified residences, which are able to be submitted and processed via the MedCompass database. For instance, some of the forms used include:

- ITCP: CCT ITCP
- FTCP: CCT FTCP
- Home Set-Up Resource: CCT Home Set Up
- Independent Housing Disclosure: CCT Independent Housing Disclosure
- DTRF: CCT DTRF
- Residential Provider Verification (42 CFR § 441.301(c)(4)): Residential Provider Verification

F.4. Other information

If needed, provide other information regarding the state or territory's transition coordination and housing processes and services that is not addressed elsewhere in the template.

Not applicable.

SECTION G. SELF-DIRECTION AND INFORMAL CAREGIVING

G.1. Self-direction

Describe any opportunities for MFP participants to receive HCBS as self-directed services.

Opportunities include State Plan programs, such as IHSS and the SDP, as well as WPCS, offered through the HCBA waiver.

G.1.1. Termination of self-direction

Describe how the state or territory accommodates a participant who voluntarily terminates self-direction to receive services through an alternate service delivery method, including how the state or territory assures continuity of services and participant health and welfare during the transition from self-direction to the alternative service delivery method. Describe the circumstances under which the state or territory will involuntarily terminate the use of self-direction and thus require the participant to receive provider-managed services instead. Specify procedures for switches from self-direction to provider-managed or other service delivery systems.

CCT LOs in designated service areas provide transition coordination activities. The Transition Coordinators conduct person-centered assessments to determine the participants' needs and preferences. They also help develop a comprehensive transition plan that includes housing, health services, and community supports. If a participant chooses to exit self-direction, the coordinator ensures a seamless shift to managed care or other HCBS waiver services.

Programs and/or waivers associated with self-direction are involuntarily terminated if it is determined that an individual no longer meets the eligibility criteria. When an involuntary termination is necessary, every effort is made to ensure that there are the least amount of gaps as possible in the event there is a transition to other services.

G.2. Other information

If needed, provide other information regarding self-direction and informal caregiving that is not addressed elsewhere in the template.

Not applicable.

SECTION H. REPORTING

H.1. Reporting plans and procedures

Describe how the state or territory will develop and implement a reporting plan and procedure for data collection, reporting, and participation in the MFP evaluation effort. The reporting plan must include data collection plans and procedures that demonstrate the state or territory's capacity to collect and share data for reporting the required program, expenditure, and financial information. States or territories must include a description of their T-MSIS data submission status and must address how identified T-MSIS data quality issues are being addressed.

Describe the reporting procedures for ensuring timely and complete data submissions to CMS, including quarterly, semi-annual, and annual reporting requirements; performance indicators and program outcome metrics; and continuous quality improvement and quality measures reporting.

Describe the strategies for ensuring that all partners and participants—including all affiliated departments, agencies, and providers—will participate in the project's evaluation.

The T-MSIS was developed with EDIM and is submitted to CMS by April 1 on an annual basis. T-MSIS files remedy issues related to data accuracy and completeness, data submission timeliness, and other issues identified in the state's monthly production data submission related to MFP enrollees.

The MFP Demonstration Financial Reporting Forms report, due to CMS quarterly, provides an expenditure summary by service category of all CCT expenditures that occurred during the reporting period. At the end of each quarter, a Specialist II in EDIM, being the California's CCT Project DQA, utilizes a CCT Quarterly template and sends it to the FMD/Fiscal Support Unit (FSU). FMD/FSU will compile the report document with additional quarterly expenditures as reported by CCT LOs and submit the report to CMS for review/approval.

The CCT Quarterly template is used to ensure consistent and accurate data across the MFP Demonstration Financial Reporting Forms Report, quarterly accounting memos, and CMS 64 feeder forms. The MFP Demonstration Financial Reporting Forms Report, quarterly accounting memos, and feeder forms report nearly the same totals; however, only the MFP Demonstration Financial Reporting Forms Report includes Administrative Costs (Personnel, equipment, and invoice totals for contracts with CDA.

The CCT Project DQA is a member of the EDIM team, whose responsibilities include coordinating the submission of the MFP Demonstration Financial Reporting Forms reports and T-MSIS to CMS.

SECTION I. QUALITY MEASUREMENT, ASSURANCE, AND MONITORING

I.1. Quality assurance and improvement

I.1.1. Quality management strategy

Provide as an appendix a comprehensive and integrated quality management strategy. Describe how the state or territory assures quality and continuously improves the quality of HCBS under the state or territory Medicaid program, and assures the health and welfare of individuals participating in the MFP Demonstration. In the Work Plan, include state or territory initiatives to improve the quality of services received by individuals receiving HCBS through the MFP Demonstration and the systems that serve them. Include how the state or territory monitors and evaluates the quality of services provided to MFP participants (including supplemental services), the roles and responsibilities of all agencies involved, and remediation and improvement processes.

Describe the program's targeted system performance requirements, including that (1) the state conducts level-of-care need determinations consistent with the need for institutionalization, (2) plans of care are responsive to participants' needs, (3) qualified providers serve participants, (4) health and welfare of participants is protected, (5) state or territory Medicaid agency retains administrative authority over the program, and (6) the state or territory provides financial accountability of the program.

If the state or territory plans to integrate the MFP program into a new or existing section 1915(c) HCBS waiver program, section 1915(i) state plan HCBS, section 1915(j) self-directed personal care services, section 1915(k) Community First Choice, or a section 1115 demonstration, provide a link to the approved quality improvement system (QIS), for example as found in:

- Appendix H of the section 1915(c) HCBS waiver application
- QIS information provided in the section 1915(i) state plan application
- The quality assurance and improvement plan used to monitor and evaluate the section 1915(j) self-directed option
- The quality assurance and improvement strategy used to monitor the section 1915(k) Community First Choice State Plan option
- Section IV of the section 1115 demonstration application, describing how delivery system reforms will impact quality, access, cost of care, and health status of the covered populations

Describe how the HCBS state plan, section 1115 demonstration, or waiver program's existing QIS is or will be modified to ensure adequate oversight and monitoring of the MFP program.

Please refer to the Quality Management Strategy Appendix for additional details.

I.1.2. Quality assurance attestation

☒ Select this box to indicate the state or territory will cooperate in carrying out activities to develop and implement continuous quality assurance and quality improvement systems for HCBS and LTSS.

I.1.3. HCBS quality measures

Describe how your state or territory plans to select an experience of care survey or surveys for each of the major population groups included in the state or territory's HCBS program from the HCBS Quality Measures and report on the survey data.

To comply with the new MFP reporting requirements identified in the Center for Medicaid and Chip Services (CMCS) Informational Bulletin released on April 11, 2024, and MFP PTC #43, DHCS launched the NCI-AD Adult Consumer Survey for the 2024-2025 cycle. Prior to selecting the NCI-AD survey, DHCS compared multiple survey instruments based on several factors, including survey mode, frequency, topics included, and cost to administer, among other considerations. DHCS also met with its sister department, DDS, which administers the National Core Indicators – Intellectual and Developmental Disabilities (NCI-IDD) survey for the I/DD HCBS population. Based on research and information collected, DHCS determined that the NCI-AD survey would be the most appropriate experience of care survey to administer to meet the requirements of PTC #43. The NCI-AD instrument was consistent with some of the guiding values utilized in choosing measures for California's Medi-Cal LTSS Data Dashboard, including being person-centered and broadly meaningful to the public, advocates, and policymakers. Additionally, it offered several implementation advantages, including the following:

- Ability to collect consistent information in a reliable manner across LTSS programs both within and outside the Medi-Cal program.
- Complementing the existing NCI-IDD efforts while also ensuring that the population of people with I/DD are not overly burdened with multiple surveys.
- Significant TA providing by ADvancing States and the Human Services Research Institute (HSRI) to administer the survey, conduct analysis, and report on the results.

In accordance with MFP PTC #43, the NCI-AD survey included all Medicaid-funded HCBS under section 1915(c), (i), (j), and (k) authorities. For the NCI-AD survey, this included populations from the following Waivers/Programs: ALW, HCBA Waiver, MSSP, Medi-Cal Waiver Program (MCWP), IHSS, and Community-Based Adult Services (CBAS). The NCI-IDD surveyed I/DD populations receiving services through the HCBS Waiver for Californians with Developmental Disabilities, the SDP Waiver for Individuals with Developmental Disabilities, and the 1915(i) State Plan Option.

DHCS' contractor collects and stores the data through the Online Data Entry Survey Administration system. Per the CMCS Informational Bulletin released on April 11, 2024, CMS plans to work with ADvancing States and HSRI to set up a process to obtain the survey results and avoid separate reporting to CMS.

Describe any limitations in the data sources, sampling strategy, or calculations used to report the HCBS Quality Measure Set, as well as any other anticipated challenges for reporting.

For LTSS-1 and LTSS-2, DHCS collaborated with other California state operating agencies in 2024 to assess what LTSS-1 and LTSS-2 core, and supplemental elements were currently in care plans and assessments for their Section 1915(c), 1915(i), 1915(j), and 1915(k) programs and any section 1115 demonstrations that include HCBS. DHCS is in the process of reviewing, updating, and amending data collection fields in the assessments and case management records. Other state operating agencies use separate case management systems from DHCS that may not collect consistent data elements.

In particular, in order to meet the reporting requirements for LTSS-1 and LTSS-2, MedCompass (the case management system used for CCT, HCBA, and ALW) requires updates to ensure that DHCS has the ability to collect, aggregate, and report on these measures. The updates to the case management system include new data fields to collect necessary data for the core and supplemental elements needed to develop reporting measures. These enhancements are vital for demonstrating MFP program compliance, ensuring high-quality, person-centered care, and driving continuous quality improvement. To this end DHCS is working on two new assessments (still in development) in MedCompass for HCBA which will be adapted for ALW: the RN Level of Care assessment and the Plan of Treatment assessment.

- LTSS-1 Core Measures: All captured in RN Level of Care Assessment
- LTSS-1 Supplementary Measures: All 18 measures captured in RN Level of Care Assessment
- LTSS-2 Core Measures: All captured in the Plan of Treatment Assessment
- LTSS-2 Supplementary Measures – All but supplementary measure 2 are captured in the Plan of Treatment Assessment.

For LTSS-6, LTSS-7, and LTSS-8, DHCS is reviewing all available claims/encounter data and expects to move forward with draft measure calculations over the next year to identify any barriers or data quality considerations to prepare for the mandatory reporting of these measures. Because of known data quality issues with California's HCBS data in the T-MSIS files, DHCS will report these measures using its own data rather than having CMS calculate the measures on the states' behalf with incomplete data. Further, because of limitations in California's data systems, calculating these measures requires merging data from multiple departments in the state, extensive data cleaning and quality checks, and merging Medicare data for the state's dually-eligible beneficiaries to report LTSS-6, LTSS-7, and LTSS-8. DHCS will review the LTSS-6,

LTSS-7, and LTSS-8 results that were shared by CMS reflecting the CY 2021 to help benchmark internal assessments. California is assessing the data output and determining where there might be barriers to reporting or data quality considerations. Updates to the data systems will be made in the next year to facilitate reporting in 2026.

Describe how HCBS Quality Measure Set data will be used to support MFP program monitoring and improvement.

The HCBS Quality Measure Set (QMS) includes a variety of metrics related to service delivery, such as individual choice, satisfaction, health outcomes, and the availability of services. By monitoring these measures, DHCS can assess whether individuals transitioning out of institutions are receiving the appropriate and high-quality community-based services they need. The data can highlight where gaps exist in service delivery, which could be hindering successful community transitions. Additionally, the HCBS QMS, especially through the statewide consumer survey, can help track whether individuals are satisfied with the choices available to them, whether they have access to the services they need, and if their personal goals are being met. Post data collection and aggregation, DHCS will conduct an analysis to identify service gaps and/or geographic disparities. Based on data findings and analyses, DHCS will adjust policies, procedures, and practices to better meet the needs of MFP participants. For instance, if certain service types are underperforming or not meeting participant needs, new training, additional resources, or service modifications may be implemented.

DHCS plans to conduct regular analysis of HCBS QMS datasets to inform ongoing program adjustments and improvements. To support that work, DHCS will be building a data dashboard for the NCI-AD data. Currently, the state only receives static data reports from the NCI-AD measure steward which have limited usefulness for state decision makers in their current form. By building a data dashboard with the NCI-AD data, the state will further its MFP goals by incorporating the NCI-AD data into the state's existing LTSS Dashboard which will allow the state better insight into the functioning and quality of the HCBS infrastructure as a whole. The dashboard will also support the state in fulfilling CMS' recommendation that states develop a HCBS Quality Improvement Strategy that includes ongoing measurement, data use, and public engagement. This investment will not only improve our compliance posture but also elevate transparency, promote equity, and drive meaningful quality improvement in our MFP program and potentially across all our HCBS programs. DHCS also plans to publicly report on LTSS-6, LTSS-7, and LTSS-8 on the state's existing LTSS Data Dashboard. By assessing areas where performance is lacking, states can develop new strategies to enhance the quality of services and improve the overall CCT Project. This supports a cycle of continuous quality improvement, ultimately benefiting participants in the program.

Please list the responsible party and any key partners for reporting on the HCBS Quality Measure Set and driving improvement.

DHCS is the SMA responsible for assessing data quality, constructing measures, and reporting measure rates to CMS. It will be receiving support from EDIM and the Quality Population Health Management Division within the Department, the contractor Mathematica, and the other state operating agencies who oversee other HCBS programs, including CDA, DDS, and CDSS.

I.2. Additional MFP quality assurance requirements

Describe how the state or territory will address the three additional MFP quality assurance requirements for (1) 24-hour backup systems for crucial services, (2) risk assessment and mitigation, and (3) incident management. For each requirement, describe how the state or territory will monitor its use and effectiveness and explain any variations by target population, geography, or any other factor. Describe the protocol for the reporting of incidents to the state or territory's critical incident systems for the state or territory's HCBS program(s).

I.2.1. 24-hour backup systems for critical services

Using the table shell below, describe any 24-hour backup systems accessible by Demonstration participants, as well as how participants can access the systems (for example, toll-free telephone number or website). The state or territory should describe, at a minimum, the backup systems related to (1) critical services, (2) transportation, (3) direct care workers, (4) repair and replacement for durable medical equipment (DME) and other equipment (including provision of loaning equipment while repairs are being made), and (5) access to medical care (including how participants are assisted with initial appointments, how to make appointments, and how to deal with appointment or care issues). Add as many rows as needed to capture all backup systems available to Demonstration participants.

Table I.2.1. 24-hour backup systems

Backup system	Description of system	Participant access
Critical services	Emergency Medical Services (911)	Access by phone or telecommunications devices for the deaf (TDDs)
	Suicide and Crisis Lifeline (988)	Access by phone or TDDs
	211 California	Access by phone or TDDs
Transportation	Local government transportation services	Access by Internet or phone/TDDs
	Ridesharing services	Access by Internet
	Nonmedical transportation (NMT) and nonemergency medical transportation (NEMT)	NMT/NEMT can be accessed by Internet or phone/TDDS
Direct care workers	IHSS	Access through local government county office
Repair and replacement for DME and other equipment	Medi-Cal FFS and MCP DME providers	Access by contacting after-hours phone/TDDs of DME providers

Backup system	Description of system	Participant access
Access to medical care	Medi-Cal FFS and MCP medical services providers	Access by contacting after-hours phone/TDDs of medical services providers
Other (describe):		

Describe the organization of 24-hour backup systems. Explain which state, territory, or local agencies are responsible for providing 24-hour, seven day per week emergency backup in all geographical areas in which the MFP Demonstration will operate and for each target group if it varies.

DHCS has worked closely with CMS to develop parameters to ensure CCT participants have access to a 24/7 backup. CCT Policy Letter (PL) #15-001, lists the quality requirements for an individualized 24/7 backup plan for individuals receiving CCT services.

Additionally, DHCS is currently in the process of developing an updated individualized 24 hour/7 days a week backup plan PL. Upon being available for distribution, an updated PL link will be provided in the OP.

Describe the process for receiving and resolving participant complaints when the backup systems and supports do not work.

If a participant would like to report a complaint, they may submit an email to the CCT Administrative Team at California.CommunityTransitions@dhcs.ca.gov. In addition, the Long-Term Care Ombudsman can be reached at: 1-800-231-4024.

I.2.2. Risk assessment and mitigation

Describe the organization of risk assessment and mitigation processes for all program participants, including monitoring.

Risk Assessment and Mitigation is an ongoing, proactive program to provide a safe transition and service provision for the CCT participants as they move from the inpatient facility to living and receiving LTSS in the community. Using specific techniques, the enrollee, the CCT transition team, and the CCT Nurse Evaluator work to identify the following prior to transition:

- Identify initial risks (potential problems) in transition to community living.
- Outline how those risks will be addressed (mitigated).

Risk assessment/mitigation information is included on both the ITCP and FTCP to ensure the risk areas are evaluated and addressed prior to transition. Transition teams are required to develop plans for addressing/mitigating identified risks. TCPs that do not identify and develop plans for addressing potential risks that could arise in a community setting, will not be accepted by the CCT Project clinical staff, and if the risk of transition to community living is too high, such that the individual's health and welfare are jeopardized, then his/her transition will not be approved, and a Notice of Adverse Action

will be issued. The LOs follow-up visits to demonstration participants after transition occur on a preset schedule to review the participant's skilled care needs, current LTSS being provided, and the participant's living situation. A participant's Transition Coordinator is required to meet the participant at their home on the day of transition, to ensure needed LTSS are in place as planned. Any last-minute concerns will be addressed at that time. After the initial day of the transition visit, the CCT has set a transition coordinator visitation schedule based on the type of housing the participant chose. Additional visits may be added, as needed to ensure the participant's health and safety.

One of the goals of each post-transition contact/visit is to ensure LTSS needs continue to be met in the participant's new home. Any new concerns or issues with the original LTSS set-up will be addressed, with changes made to the TCP, as needed. The overall goal of the CCT Project is to assist in providing the individual with a transition that benefits their health and welfare and allows them to remain in the community for as long as possible.

Monitoring activities include desk-based and/or on-site Program Compliance Reviews (PCR), provider quality improvement/quality management evaluations, and financial audits. DHCS staff shall conduct a one two-day PCR for each CCT provider annually. The purpose of the PCR activities are to assure compliance with the CCT Project requirements and provide TA as needed. The PCR consists of the review of:

- Staff qualifications
- Transition and Care Plans
- Policies and procedures
- Medical records
- Billing records
- Case notes
- Subcontracts
- Purchase Receipts

The PCR client's chart reviews will confirm compliance with eligibility, enrollments, dis-enrollments, service plan updates, and the delivery of service pre-transition and post-transition. DHCS conducts an exit interview with CCT providers and sends a written report identifying PCR findings and areas requiring corrective action to the provider, and the LO is required to submit a Corrective Action Plan (CAP) to DHCS after reviewing the report.

I.2.3. Incident management system

Assure that MFP critical incidents are reported through the state or territory's incident management systems for Medicaid HCBS. Describe the organization of the incident management system used to monitor the health and welfare of MFP participants. Identify the state or territory entity responsible for receiving, reviewing, and responding to MFP critical incident reports and investigating consumer complaints regarding violation of their rights. If applicable, clearly describe how the policy differs by situation (for instance, by participant population group, qualified institutional setting, or operating division).

The CCT Project's "critical incident" reporting management system/program goes by another name. As not all events tracked in the system are "critical," California chose to name their program the "Event/Issue System." The event/issue system uses the same structure as that of DHCS' HCBS waivers. Some of the activities included in this existing system include monitoring services activities, investigating reported service issues, and working with the California Department of Public Health's (CDPH's) Licensing & Certification program and other state agencies as required by regulation and law.

In addition, the LO is responsible for monitoring the participant's health and /or welfare. The LO reviews and evaluates all event/issue reports during the participant's demonstration period. The LO will review the participant's health and /or welfare to determine if any measures can be taken to provide a different outcome that may have prevented the occurrence or reduced the risk of occurrence to the participant. Modification(s) will be made to reflect needed changes.

The CCT Project clinical staff members will be available to LOs for consultation on enrollee/participant health.

CCT uses the MedCompass Issue Management module to track Participant Issues. Reports are being developed to gather data to determine what measures can be taken to avoid further incidents. The data will be provided to CMS.

I.3. Other information

If needed, provide other information regarding the state or territory's approach to quality that is not addressed elsewhere in the template.

Not applicable.

SECTION J. CONTINUITY OF CARE POST-DEMONSTRATION

In accordance with section 6071(c)(2) of the Deficit Reduction Act of 2005, the MFP Demonstration must operate in connection with a qualified HCBS program to assure continuity of services for eligible individuals.

Select this box.

☒ The state or territory affirms that it has established procedures and processes for ensuring that the provision of HCBS will continue for an MFP participant at the conclusion of the 365-day enrollment period for as long as an individual remains eligible for medical assistance.

SECTION K. TRIBAL INITIATIVE

If your state or territory has or is planning a Tribal Initiative, please describe the Tribal Initiative.

K.1. Tribal Initiative project director

Name the project director of the Tribal Initiative, describe the percentage of time the project director spends on this initiative, and offer a brief description of the roles and responsibilities of the position.

Not applicable.

K.2. Capacity building and planning

K.2.1. Federally recognized Tribal nations

Name each of the federally recognized Tribal nations within the state or territory.

Not applicable.

K.2.2. Engagement with Tribal nations

Describe which tribes are MFP Tribal partners and how the state or territory engages with these partners. Describe how the state or territory engages with tribes that are not MFP Tribal partners. Include strategies and efforts to date and any anticipated or planned engagement efforts.

Not applicable.

K.3. Operations

Describe the operating details of your state or territory's Tribal Initiative. Describe any operational activities that differ from the state or territory's MFP Demonstration in terms of benefits and services available to participants through the Tribal Initiative, quality assurance, self-direction options, housing options for participants, and how continuity of care is maintained after the end of the 365-day Demonstration period.

Include in the MFP Work Plan specific Tribal Initiative objectives including transition benchmarks, outreach to Tribes and Tribal providers, recruitment and enrollment efforts, and workforce development objectives including the amount of services delivered Tribally.

Not applicable.

K.4. Other information

If needed, provide other information regarding the state or territory's approach to Tribal Initiatives that is not addressed elsewhere in the template.

Not applicable.

SECTION L. PUBLIC HEALTH EMERGENCIES

L.1. Program adaptations in response to Public Health Emergencies

L.1.1. Program adaptations

Describe adaptations your state or territory's MFP Demonstration made in response to a Public Health Emergency (PHE), such as the COVID-19 PHE, declared at either the state, territory, or federal level. For instance, these could include protocols for MFP participants living in the community who test positive for COVID-19, plans to prevent COVID-19 spread among participants, modifying recommendations related to infection control or immunizations (such as the COVID-19, flu, and shingles vaccines), or ways the MFP Demonstration has expanded access to or incorporated services delivered through telehealth technology. Identify adaptations that have ended and those that are ongoing. Describe how any MFP Demonstration adaptations in response to PHEs align with and use policies and procedures from the state or territory's HCBS program(s).

In the case of a PHE, DHCS works in collaboration with CMS, as well as partnering agencies to update waiver services via Appendix Ks. Per CMS guidance, *"…Appendix [K's] may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) HCBS waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities. [The] appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.*" DHCS also issued policy guidance (CCT PL: 23-001) which permitted the use of telehealth service delivery during and post-PHE.

L.2. Future PHEs

Describe if and how your state or territory is planning for future PHEs in its HCBS systems and MFP Demonstration. For instance, this may include permanent adoption of measures implemented for the COVID-19 PHE.

As previously noted, DHCS also issued policy guidance (CCT PL: 23-001) which permitted the use of telehealth service delivery during and post-PHE.

L.3. Other information

If needed, provide other information regarding the state or territory's approach to PHEs that is not addressed elsewhere in the template.

Not applicable.

SECTION M. SUMMARY OF HYPERLINKS & APPENDIX

States or territories may include additional information and documents that do not fit in the other template sections in the Appendix. The template provides default appendix section and subsection headings that states or territories may rename, delete, or otherwise modify as needed. States or territories may also modify the appendix section titles to meet their needs. States or territories that include hyperlinks in the OP must collect all links in the reference table below.

M.1. Summary of Hyperlinks

Copy all hyperlinks used in the OP into the table below, by OP section. For each link, provide a brief description (for example, “educational materials provided to participants”).

Appendix Table A.1. Summary of Hyperlinks

OP section	CMS Provided Links	Brief description
A. MFP program overview	N/A	N/A
B. Project administration	DHCS-Exec-Staff-Org-Chart.pdf	DHCS Organizational Chart

C. Recruitment, enrollment, outreach, and education	California's HCBS STP	DHCS' STP webpage
	1999 U.S. Supreme Court's Olmstead decision	U.S. Supreme Court's ruling on the Olmstead decision
	DACLAC	DACLAC's webpage
	CCT Consent Form	Link to the CCT Enrollee & Participant Rights and Responsibilities/Consent Form
	Choice in Aging Services	Choice in Aging is a LO that offers CCT Services
	Independent Living Center of Kern County Services	Independent Living Center of Kern County is a LO that offers CCT Services
	Libertana Services	Libertana is a LO that offers CCT Services
	Silicon Valley Independent Living Center Services	Silicon Valley Independent Living Center is a LO that offers CCT Services
	California.CommunityTransitions@dhcs.ca.gov	California's CCT Program Mailbox
	ABCs of Nursing Home Transition: An Orientation Manual for New Transition Facilitators | Independent Living Research Utilization	Independent Living Research Utilization manual which contains tools and strategies the transition facilitator can use to conduct the fundamental tasks of the institutional transition process.
	Module 2 - CCT Overview	An Overview of the MFP/CCT Program
	CCT_TrainingMod3	An overview of the MFP/CCT Transition Process
	TM4_PCP	An overview of the MFP/CCT Person Centered Planning process

OP section	CMS Provided Links	Brief description
	TM5_CCT_LCA	An overview of the MFP/CCT for LCAs and MDS 3.0, Section Q Referrals
	Module 6 - CCT Reimbursement Structure.pdf	An overview of the MFP/CCT Reimbursement Structure
	Rev C C T Train Mod 7	An overview of the MFP/CCT Reporting Requirements
D. Community engagement	California HCBS Gap Analysis Report	California HCBS Gap Analysis Report, being a final report from January 31, 2025
E. Benefits and services	DHCS CCT LO TAR Submission Resource	This is a resource that provides information required to complete TARs for the reimbursement for providing CCT Demonstration Services
	CCT Service Code Overview	This is an additional resource that provides information required to complete TARs for the reimbursement for providing CCT Demonstration Services

OP section	CMS Provided Links	Brief description
F. Transition and housing services	811_PRA_Stakeholder_Engagement	Description of California's 811 PRA pertaining to award stakeholder outreach and engagement
	Residential Provider Verification (42 CFR § 441.301(c)(4))	Residential licensure form
	CCT ITCP	The CCT form that is completed for an individual to initially document their transition plan.
	CCT FTCP	A CCT form that is completed to further plan and develop transitioning planning efforts upon a participant has transitioned to a MFP-qualified residence.
	CCT Home Set Up	A pre-authorization of maximum thresholds for allowable household set-up costs based on the type of CCT-qualified housing option selected by the individual.
	CCT Independent Housing Disclosure	A CCT form that is used as a tool to identify and secure qualified housing in an individual's community of choice.
	CCT DTRF	A CCT form that is completed the day that an individual is transitioned from an MFP qualified inpatient facility to an MFP qualified residence.
G. Self-direction and informal caregiving	N/A	N/A
H. Reporting	N/A	N/A
I. Quality measurement, assurance, and monitoring	HCBS Quality Measure Set	Information about the HCBS Quality Measure Set
	PL 15-001 24-7 Backup	Lists the quality requirements for an individualized 24/7 backup plan for individuals receiving CCT services.
	California.CommunityTransitions@dhcs.ca.gov	California's CCT Program Mailbox
	NMT/NEMT	Provides resources for accessing NMT/NEMT

OP section	CMS Provided Links	Brief description
J. Continuity of care post-Demonstration	Section 6071(c)(2) of the Deficit Reduction Act	Requirement that the MFP project must operate in conjunction with a qualified and operational HCBS program
K. Tribal Initiative	N/A	N/A
L. Public health emergencies	CCT PL 23-001	DHCS' issued policy permitting the use of telehealth service delivery during and post-PHE.

Appendix	**Appendix A:** Quality Management Strategy

M.2. Appendix A: Quality Management Strategy

Table of Contents

A. Introduction
B. Targeted System Performance Requirements
C. MFP-Specific Quality Management Strategy
D. HCBS Quality Management Strategy for 1915(c) Waivers
E. HCBS Quality Management Strategy for 1915(j) and 1915(k)
F. Continuous Quality Improvement

A. Introduction

DHCS administers Medicaid HCBS programs under multiple authorities, including 1915(c) waivers, state plan amendments, and Section 1115 demonstrations. This Quality Management Strategy documents California's framework to monitor, evaluate, and improve the quality of HCBS, including integration of the MFP demonstration program, known as the CCT Project in California, to support transitions from institutional to community-based settings.

B. Targeted System Performance Requirements

The purpose of establishing this Quality Management Strategy is to ensure the provision of effective and quality HCBS, and assures the health and welfare of demonstration participants. CMS requires the state to provide assurances that six HCBS system performance areas are in place for demonstration participants:

(1) the state conducts level-of-care need determinations consistent with the need for institutionalization
(2) plans of care are responsive to participants' needs
(3) qualified providers serve participants
(4) health and welfare of participants is protected
(5) state or territory Medicaid agency retains administrative authority over the program
(6) the state or territory provides financial accountability of the program.

Collectively, these areas provide checks and balances to ensure that demonstration participants receive safe, competent care to support good health and wellbeing. Besides collecting data on all of these areas. Specific Quality Management Strategy information for each waiver, program, and/or state plan service is listed under its specific area at the end of this section.

C. HCBS Comprehensive and Integrated Quality Management Strategy

To support California's comprehensive and integrated quality management strategy, DHCS contracted with Mathematica in 2022 to complete and submit to DHCS a statewide Gap Analysis of California's HCBS and MLTSS programs and networks. The

final Gap Analysis Report and report appendices were published in February 2025. Mathematica will also complete and submit to DHCS a Multiyear Roadmap addressing the identified gaps. The purpose of the Gap Analysis and Multiyear Roadmap is to identify and make recommendations for gap closures within California's HCBS and MLTSS programs and provider networks. Mathematica will analyze available data to assess California's HCBS/MLTSS current capabilities to reach the following objectives:

- Objective 1: Reducing Inequalities in Access and Services
- Objective 2: Meeting Client Needs
- Objective 3: Program Integration and Increased Coordination
- Objective 4: Quality Improvement
- Objective 5: Streamlined Access

The populations of focus for the Gap Analysis and Multiyear Roadmap include beneficiaries currently served by LTSS programs authorized through the Medi-Cal State Plan or current waivers. This includes:

- IHSS Program (including the Medi-Cal 1915(k) Community First Choice state plan option); the CBAS program; the MSSP Waiver; the HCBA Waiver; the ALW; the MFP grant, known as CCT; and Long-term Care (LTC), or skilled nursing facility care;
- Medi-Cal beneficiaries at risk of or needing LTSS, including beneficiaries receiving LTSS or HCBS, through programs funded under the Older Americans Act and administered locally by Area Agencies on Aging, ADRC services, ILC programs, or Caregiver Resource Centers;
- Individuals with developmental disabilities, and individuals with HIV/AIDS who are served by California's waiver and state plan programs; and,
- Certain Medi-Cal Managed Care members.

Understanding the current gaps in California's HCBS and MLTSS programs is a critical preliminary step to ensure the health and welfare of individuals receiving HCBS in California and helps DHCS understand where to focus future quality improvement activities. For example, using the findings from the Gap Analysis Report in combination with the measure results of the HCBS Quality Measure Set, Mathematica will support DHCS in implementing the required performance improvement projects (PIPs). This includes helping the state choose measures to focus on for PIPs, identifying appropriate interventions to improve performance, developing training and other TA materials for CCT LOs and other stakeholders to implement those interventions, and support the state in monitoring progress of the PIPs.

D. MFP Specific Quality Management Strategy

Quality management is an integral part of the CCT Project on several levels. The DHCS CCT Project Team will perform routine fiscal and service oversight, as well as a review of event/issue occurrence information submitted monthly by each LO. This information will be included in the required CMS reports. In addition, the CCT Project Team staff will perform semi- annual reviews of each LO to ensure compliance with CMS requirements and DHCS contracts.

1. Eligibility Checks

The CCT LO verifies in the MEDs database the applicant's Med-Cal eligibility. When a DHCS Nurse is adjudicating the TAR, the nurse also verifies Med-Cal eligibility. The ISCD/HOB Team verifies the necessary documentation is included in the file before a case note is entered, notating the case as EIF verified. Each week, the list of Client Identification Numbers of the enrollments that have been verified is sent to the Nurse Supervisor. The ISCD/HOB Team verifies the enrollment date is at least 60 days later than the facility intake date, to ensure federal eligibility.

With the launch of MedCompass, DHCS has the ability to run reports showing active cases for each LO. Once the reports are run, they are able to be distributed for the LOs to respond and update the files. DHCS plans to request an additional CCT analyst to follow up with the LOs to complete the file updates each month. Finally, a nurse reviews the clinical aspects of the case for Medi-Cal adjudication purposes.

2. Risk Assessment & Mitigation

Risk Assessment and Mitigation is a proactive program to provide a safe transition and service provision for the CCT participant as they move from the inpatient facility to living and receiving LTSS in the community. Using specific techniques, the enrollee, the CCT transition team, and the CCT Nurse Evaluator work to identify the following prior to transition:

- Identify initial risks (potential problems) in transition to community living.
- Outline how those risks will be addressed (mitigated).

Risk assessment/mitigation information is included on both the ITCP and the FTCP to ensure the risk areas are evaluated and addressed prior to transition. Transition teams are required to develop plans for addressing/mitigating identified risks. TCPs that do not identify and develop plans for addressing potential risks that could arise in a community setting, will not be accepted by the CCT Project Nurse Evaluators, and if the risk of transition to community living is too high, such that the individual's health and welfare are jeopardized, then his/her transition will not be approved, and a Notice of Adverse Action will be issued.

The LOs conduct follow-up visits to demonstration participants after transition occurs on a preset schedule to review the participant's skilled care needs, current LTSS being provided, and the participant's living situation. A participant's Transition Coordinator is

required to meet the participant at their home on the day of transition, to ensure needed LTSS are in place as planned. Any last-minute concerns will be addressed at that time. After the initial day of transition visit, the CCT has set a TC visitation schedule based on the type of housing the participant chose. Additional visits may be added, as needed, to ensure the participant's health and safety.

One of the goals of each post-transition contact/visit is to ensure LTSS needs continue to be met in their new home. Any new concerns or issues with the original LTSS set-up will be addressed, with changes made to the TCP as needed. The overall goal of the CCT Project is to assist in providing the individual with a transition that benefits their health and welfare and allows them to remain in the community for as long as possible.

Monitoring activities include PCR, provider quality improvement/quality management evaluations, and financial audits. DHCS staff shall conduct a one two-day PCR for each CCT provider annually. The purpose of the PCR activities are to ensure compliance with the CCT Project requirements and provide TA as needed. The PCR consists of the review of:

- Staff qualifications
- Transition and Care Plans
- Policies and procedures
- Medical records
- Billing records
- Case notes
- Subcontracts
- Purchase Receipts

The PCR client's chart reviews will confirm compliance with eligibility, enrollments, dis-enrollments, service plan updates, and the delivery of service pre-transition and post-transition. DHCS conducts an exit interview with CCT LO providers and sends a written report identifying PCR findings and areas requiring corrective action to the LO, and the LO is required to submit a CAP to DHCS after reviewing the report.

E. HCBS Quality Management Strategy for 1915(c) Waivers

The six Quality Management Strategy assurance areas that apply to the 1915(c) waivers are the same as for the CCT Project. All areas together provide a checks and balances system to ensure that demonstration participants receive safe and competent care to meet their health and welfare needs. Below is listed information on each specific waiver to which participants might be enrolled after transitioning from an institution. Once participants' time in the demonstration is completed, they will continue in the chosen waiver so long as they continue to meet clinical and Medi-Cal eligibility requirements.

1. ALW

DHCS is responsible for administration and oversight of the ALW. The ALW Quality Improvement Strategy (QIS) is designed to provide meaningful performance measures through the review of participant Individual Service Plans (ISPs) to identify all health

care needs and develop prevention strategies through trend analysis, prioritization of assessed participant risks, and development of specific goals and objectives resulting in the implementation of system improvements.

California assures quality of participant health and welfare by setting proactive quality improvement strategies with participation and collaboration of the CCA in tandem with participants and/or their families, providers, consumer/participant advocates, and local and state agencies. Agreed upon quality improvement goals are set on an annual basis with specified objectives. California uses reported data to set ad hoc improvement goals as the data and circumstances suggest.

This approach is focused on the expectation that through comprehensive development of a participant's ISP each ALW participant will have a greater likelihood of improved health status and quality of life, which includes all measures of the ALW Assessment Tool - assistance with ADLs and IADLs as they relate to coordinated physical health and community-based supports and services, as well as the seven functional categories of cognitive patterns, behavioral symptoms, continence, communications, medications, skin conditions and other treatments. Concurrently, this process allows early identification and prevention of deterioration of the participant's intake health status while supporting the assurances of 42 CFR §441.301 and §441.302. The ALW uses the participant's ISP as a gauge to measure all health care needs and develop prevention strategies through qualitative analysis of the services delivered. The ISP focused preventions allow the ALW participants and providers to have a direct role in the quality assessment and quality improvement processes, allowing timely interventions to assure early identification of health and welfare needs.

The DHCS biennial Quality Assurance audits provides the data for TA to all ALW provider(s). Identified ISP and Special Incident Reports trends are closely monitored by the DHCS to support the assurances of 42 CFR §441.301 and §441.302. For all assurance problems with providers, DHCS reviews the nature and severity of the problem and, if needed, develops a CAP as indicated for the provider in question. DHCS continues to monitor and follow up with the provider to ensure that the conditions of the CAP are met and the health and safety needs of the participant are met. If the conditions of the CAP are not addressed, then probationary action is initiated. This process allows DHCS to identify, quickly and reliably, positive or undesirable trends that will allow for necessary adjustments to enhance the overall performance of the system, and act on opportunities for improvement.

2. Developmental Disability (DD) Waiver

The Quality Management Strategy model for California's 1915(c) HCBS for the Developmentally Disabled (HCBS-DD Waiver) is built upon the premise that quality assurance is an essential component of the manner in which the work is accomplished. According to the renewal DD waiver application, "It embodies the notion that discovery is a by-product of the work at hand and does not require participants in the system to

generate special reports to satisfy the need to understand how the system is performing. Within this context, remediation and improvement will not only benefit the system but will make the day-to-day work of the participants in the system more meaningful and effective." All levels of the system will be involved in Quality Management Strategy, to include the entire developmental disability service delivery system.

In California, all HCBS for individuals with developmental disabilities are provided through a statewide system of 21 regional centers, which are funded by DDS. Within this structure, and under the oversight of the DHCS, DDS ensures that the HCBS Waiver is implemented in accordance with Medicaid law and California's approved Waiver application. It is through this same service delivery system that California also provides services under the 1915(i) SPA, 21-0002. As a result, the overall QIS described in this appendix applies to services provided under both programs. For federal reporting, California will collect and report information specific to each program for the performance measures under the federal assurances, with the exception of Administrative Authority, Qualified Providers, and Financial Accountability, which are reported in a consolidated format.

DDS employs a comprehensive QIS to monitor, evaluate, and enhance the health, safety, and service quality of individuals receiving HCBS through regional centers. This includes targeted TA to regional centers showing increases in critical incidents, collaboration with risk management personnel, and a variety of monitoring activities—such as reviews of individual records, service providers, facilities, and participant interviews—to ensure services are delivered safely and appropriately. Findings from these activities are compiled into biennial reports and shared with stakeholders, including DDS, DHCS, and regional center boards.

Oversight is coordinated through multiple structures, including performance contracts, independent risk management contractors, and standing committees composed of regional center personnel, risk managers, and HCBS waiver staff. The Quality Management Executive Committee plays a central role in system-wide assessment, using data to identify trends, set priorities, and guide improvement efforts. It reviews outcome data; delegates focused work to subcommittees and incorporates findings into policy or programmatic changes. The QIS is built on continuous discovery and reporting, stakeholder engagement, and ongoing analysis to ensure alignment with waiver assurances and inform waiver renewals and system enhancements.

3. 1915(i) State Plan Option

Established as part of the DRA, section 1915(i) of the Social Security Act gives states the option to provide HCBS without a waiver. One of the key provisions of Section 1915(i) is that eligibility criteria for these services must be less stringent than the institutional level of care criteria required under waivers. DHCS conducted oversight as DDS renewed the 1915(i) SPA, which allows DDS to access federal funding for

community services provided to individuals who do not meet the eligibility criteria of the current HCBS Waiver.

Under California's 1915(i) State Plan, relatives and legal guardians may provide services if they meet all required provider qualifications and are selected through the PCP process in accordance with applicable laws. Legally responsible individuals (such as parents or spouses) may also be paid to provide community living arrangement services, but only when the individual's needs exceed what is typical for someone of the same age without developmental disabilities (i.e., requiring extraordinary care). Oversight is provided through regular service coordinator follow-ups, Financial Management Services verification of payments, regional center audits, and state program and fiscal reviews to ensure services are appropriate, documented, and effectively delivered.

Additionally, the state has launched a Quality Incentive Program beginning January 1, 2025, to lay the groundwork for future quality measures and data-driven improvements. In this initial phase, providers can earn supplemental payments by contributing to a statewide provider service directory, which will centralize and standardize data on provider services, access, capacity, and language availability. This directory will be a foundational tool for evaluating provider networks, improving transparency, and supporting individual and family access to care options. Providers earning less than 100 percent of the modeled rate can qualify for supplemental payments by submitting and verifying required information, which will be reviewed by regional centers before payment is authorized.

4. MSSP

CDA and DHCS monitor the quality control measures described in the waiver and MSSP Site Manual in order to ensure that the quality of services provided under the waiver and the state plan to persons served under the waiver, are based on the monitoring activities of both departments pursuant to the CDA and DHCS Monitoring and Oversight Protocol(s).

CDA conducts ongoing Utilization Reviews (URs) of MSSP participant records to ensure timely, appropriate documentation and service delivery. These reviews assess areas such as level of care, care plans, service provision, and participant health and welfare. When deficiencies are found, CDA issues a CAP request to the site, which must detail remediation steps and timelines. CDA monitors implementation and may conduct follow-ups to verify correction before approving the CAP. Results from these reviews are aggregated to guide statewide remediation strategies, training, and policy updates, which are shared through MSSP Site Association meetings, newsletters, and TA.

Oversight is further supported by DHCS, which reviews CDA's findings and may issue its own Corrective Action Reports (CARs). CDA has 60 days to respond, and DHCS may conduct independent reviews if necessary. CDA and DHCS meet regularly—monthly and quarterly—to review UR findings, waiver compliance, policy updates, and

trends, using these insights to coordinate system changes and updates to monitoring tools like the UR and CAR. These meetings ensure alignment between both agencies and help drive ongoing quality improvement. Additionally, CDA gathers participant feedback during URs and public forums, and incorporates this into program evaluations and the broader HCBSettings Transition Plan. Every 18 months, CDA and DHCS review and update quality assurance systems based on CMS requirements and collaborative input from the MSSP Site Association.

5. CBAS

CDA and DHCS' Quality Assessment and Performance Improvement (QAPI) Plan encompass LTSS measures set forth in the federal managed care rule as specified in CalAIM Section 1115 Demonstration special terms and conditions (STCs).

The CBAS QAPI Strategy Advisory Committee, which includes members of the CDA Executive Team, CBAS staff, CDA providers, DHCS, MCPs, and other stakeholders, began the development of the drafted performance measures (PM) in December 2023. California worked on establishing the PM with CMS to ensure there is no duplication of effort and will report on the initial series within one year of finalization, and from that point will report annually. The committee's approach has been to discuss and finalize PM for the six required components (i.e., administrative authority, level of care/eligibility, qualified providers, service plan, health and welfare, and financial accountability) on a rolling basis as agreed by California and CMS. CDA continues to facilitate the Quality Strategy Advisory Committee meetings on a quarterly basis. Upon receiving the final PM approval from CMS, implementation, data collection, and compliance will be put in motion. CDA and DHCS will proceed with fulfilling Special Term and Condition 5.9, which includes reporting the findings and status of the HCBS quality assurances and measures.

6. HCBA Waiver

DHCS is responsible for monitoring quality control measures described in the HCBA Waiver; as described in the waiver language and special terms and conditions approved by CMS.

DHCS maintains continuous oversight of Waiver Agencies through two main quality assurance processes: Quarterly Performance Reports (QPRs) and annual Quality Assurance Reviews (QARs). QPRs provide data on enrollment activities, provider qualifications, incident reporting, and participant health and welfare. DHCS analyzes these reports to identify trends, provide TA, and require corrective action when needed. If deficiencies are found, DHCS issues a formal request for a CAP, which must outline specific actions, responsible personnel, and timelines for remediation. DHCS monitors implementation and may conduct site visits to ensure resolution.

The QARs involve in-depth annual reviews—either onsite, virtual, or desk-based—of Waiver Agency performance, including case file audits and participant/provider interviews. Findings from QARs may also result in required CAPs. DHCS uses

aggregate data from QPRs and QARs to inform system-wide remediation strategies, develop training initiatives, and update policies. TA is provided throughout the review and remediation process to support agency compliance and performance improvement.

In addition to addressing critical incidents, DHCS also handles non-critical incidents and grievances through analysis and corrective action as needed. DHCS evaluates the effectiveness of remediation strategies and incorporates lessons learned into updates of monitoring tools, policies, and training. Every 18 months, DHCS reviews the overall QIS to ensure ongoing efficacy and incorporates necessary updates into the QPR and QAR processes, with input from Waiver Agencies gathered during regular meetings.

7. MCWP

CDPH, Office of AIDS (CDPH/OA) conducts ongoing oversight of the MCWP through PCRs. These reviews evaluate participant records, assessments, care plans, and provider documentation to ensure timely and appropriate service delivery. When deficiencies are identified, CDPH/OA issues a formal request for a CAP. The MCWP agency must respond within 30 days with specific remediation actions, responsible staff, and completion timelines. CDPH/OA monitors the CAP's implementation and provides TA as needed until the issue is resolved.

Aggregate findings from PCRs—including trends in enrollment, care planning, and service deficiencies—are reviewed quarterly with DHCS and related divisions. These insights inform policy updates, which are shared through protocols, manuals, and policy letters. CDPH/OA uses this data to identify training needs and organizes multi-site training sessions, followed by post-training follow-up to evaluate impact. CDPH/OA continuously refines its tools, TA methods, and system processes based on the effectiveness of remediation efforts and input from agency interactions.

F. HCBS Quality Management Strategy for 1915(j) and 1915(k)

1. IHSS

In California, IHSS is administered by CDSS through the 1915(j) Self-Directed Option (known as the IHSS Plus Option (IPO)) and 1915(k) Community First Choice State Plan Option (known as the IHSS Community First Choice Option). California's has implemented a comprehensive quality assurance and improvement plan to enhance service delivery, ensure program integrity, and support both recipients and providers. The quality assurance and improvement plan includes:

- Quality Assurance Monitoring: Established through Senate Bill 1104 (2004), the IHSS Quality Assurance (QA) program mandates routine desk reviews, home visits, and targeted assessments to ensure compliance with statutes and regulations. CDSS conducts annual monitoring reviews across all 58 counties, providing technical support to county QA staff to uphold program integrity and access to quality care.
- Program Integrity and Fraud Prevention: The IHSS Fraud Prevention and Program Integrity initiative, established via Senate Bill 1104, includes activities such as routine desk reviews, home visits, and targeted reviews to verify service

receipt and prevent fraud. CDSS collaborates with counties to implement these protocols, emphasizing transparency, recipient well-being, and dignity.

- Quality Improvement Action Plans: Counties are required to submit Quality Improvement Action Plans (QIAPs) if they fail to meet specific performance standards, such as timely application processing, reassessments, and adherence to Hourly Task Guidelines. These plans outline corrective actions and are part of the state's commitment to continuous improvement in service delivery.
- IHSS Career Pathways Program: The IHSS Career Pathways program offers specialized training for IHSS providers to enhance their skills and improve care quality. Providers receive compensation for training time and may qualify for incentive payments upon completion. The program, which began in October 2022, aims to bolster the workforce and ensure high-quality care for recipients.

G. Continuous Quality Improvement

1. Experience of Care Survey

To comply with CMS requirements of MFP participating states to report the HCBS Quality Measure Set, DHCS implemented the NCI-AD survey beginning with the 2024-2025 survey cycle and plans to continue fielding the survey every other year going forward (pending available funding). DHCS sampled from all HCBS programs in which CCT participants would be enrolled to conduct the survey. Results of the survey will be used for continuous quality monitoring and to identify opportunities to develop performance improvement projects. Data collection for the 2024-2025 survey cycle wrapped up in June 2025, and DHCS expects to receive survey results in late 2025 from ADvancing States to select specific measures for performance improvement plans.

Contingent on additional MFP funding, DHCS also plans to build a public facing interactive dashboard for the NCI-AD survey data. This dashboard would allow DHCS to manipulate and export data visualizations of the survey data, similar to how DDS makes the NCI-IDD survey data available to the public and policymakers. The dashboard will enable internal teams, stakeholders, providers, and advocates to engage with quality data and identify areas for improvement. It supports CMS' recommendation that states develop an HCBS QIS that includes ongoing measurement, data use, and public engagement. The development of a public-facing dashboard is critical to implementing the HCBS QMS effectively and fulfilling both current and anticipated federal MFP expectations. This investment will not only improve our compliance posture but also elevate transparency, promote equity, and drive meaningful quality improvement in our MFP program and potentially across all our HCBS programs.

2. Quality Metrics – Case Management Records (LTSS-1 and LTSS-2)

In addition to reporting on the measures included in the NCI-AD, to comply with the new MFP reporting requirements identified in the CMCS Informational Bulletin released on April 11, 2024, several key systems and processes within MedCompass (the State's case management system for select waivers) are being updated starting in CY 2025. In particular, in order to meet the reporting requirements for LTSS-1 (Comprehensive Assessment and Update) and LTSS-2 (Comprehensive Person-Centered Plan and Update), DHCS is updating MedCompass to ensure that DHCS has the ability to collect,

aggregate, and report on these measures. The updates to the case management system include new data fields to collect necessary data for the core and supplemental elements needed to develop reporting measures. These enhancements are vital for demonstrating MFP program compliance, ensuring high-quality, person-centered care, and driving continuous quality improvement. DHCS is also working on improving the ability to extract data from MedCompass to use this data in reporting LTSS-1 and LTSS-2.

3. Quality Metrics – Administrative Data (LTSS-6, LTSS-7, and LTSS-8)

As part of California's ongoing commitment to improving the quality and accountability of LTSS, DHCS is currently conducting data exploration and analysis of existing administrative data sources. This work is focused on developing a process to bring together multiple administrative data sources for reporting on nationally recognized quality measures LTSS-6 (Admission to a Facility from the Community), LTSS-7 (Minimizing Facility Length of Stay), and LTSS-8 (Successful Transition After Long-Term Facility Stay). Because of known data quality issues with California's HCBS data in the T-MSIS files, California's preference is to report these measures using its own data. DHCS' data exploration includes detailed analysis of claims, encounter data, and care plan documentation to align with CMS' technical specifications. It also requires the use of Medicare data for all dually eligible members for the purposes of identifying facility stays and transitions from facilities. These measures will inform system-level performance monitoring and quality improvement initiatives. As the state's approach to calculating the measures are finalized, California intends to incorporate LTSS-6 through LTSS-8 into the public LTSS Dashboard, enhancing transparency and driving targeted improvements across programs. These measures are key to tracking the effectiveness of care transitions, promoting HCBS, and supporting rebalancing efforts within California's Medi-Cal system.

4. Performance Targets

Utilizing data gathered from the statewide NCI-AD consumer survey, the case management data aligned with LTSS-1 and LTSS-2 (Service Plan Implementation) and the administrative data through LTSS-6, LTSS-7, and LTSS-8 (Successful Transition After Long-Term Facility Stay), DHCS is in the process of developing performance targets for each of the MFP mandatory measures within the HCBS Quality Management Strategy. These targets are being designed to reflect achievable yet ambitious benchmarks that are grounded in both historical data trends and desired system improvements. The final targets will be submitted to CMS for review and approval and will be included in California's updated MFP Integrated Quality Management Strategy and Plan.

To support the achievement of these performance targets, California will pursue a multi-faceted set of strategies focused on care quality, system integration, and beneficiary-centered outcomes. For LTSS-1 and LTSS-2, efforts could include enhanced training and TA for assessors and care coordinators to improve the timeliness, accuracy, and person-centeredness of service plans. This may also involve the deployment of standardized tools to complete various elements of the assessment and the

incorporation of real-time tracking systems to ensure that service plans are not only developed promptly but also implemented fully and consistently across counties and delivery systems.

For the transition-related measures—LTSS-6, LTSS-7, and LTSS-8—California plans to strengthen partnerships between Medi-Cal MCPs, county agencies, IHSS providers, and facility-based providers to improve communication and care coordination during transitions. Key strategies may include developing early identification protocols for individuals at risk of institutionalization, expanding access to transition navigation and tenancy support services, and leveraging data analytics to target high-risk populations for proactive intervention. California will also continue to expand the availability of community-based services through initiatives such as California Advancing and Innovating Medi-Cal's (CalAIM's) ECM and Community Supports, which are designed to help individuals remain in or return to home settings. CalAIM specifically targets Medi-Cal members who are at risk of institutionalization, and those recently transitioned to the community from nursing facilities, as populations of focus for the Medi-Cal MCPs use of ECM and Community Supports (which are in lieu of service offerings). These combined efforts will contribute to a more integrated, accountable, and equitable system of long-term care, ensuring better outcomes for HCBS participants statewide.