CHCF Explainer

JANUARY 2025

by Aurrera Health Group

# California Community Transitions and CalAIM Community Supports

## Understanding Overlaps and Gaps

This explainer describes overlaps and gaps between two Medi-Cal programs: the California Community Transitions program and Community Supports, an initiative of CalAIM (California Advancing and Innovating Medi-Cal). The explainer is part of a series exploring how Community Supports intersect with Medi-Cal home and community-based services (HCBS) waiver and demonstration programs.

The series highlights key issues policymakers and stakeholders should consider if responsibility for some HCBS programs shifts from fee-for-service Medi-Cal to managed care plans. Although California Community Transitions (CCT) is not currently being considered by the state for integration into managed care, it is included in the series given its overlap with Community Supports. Find related explainers on the CHCF website.

### Geographic Reach

The demonstration program is available statewide. Unlike HCBS waiver programs, there is no waitlist or limit in program slots.

### Eligibility

To be eligible for CCT, an individual must:

- Be a Medi-Cal enrollee of any age
- Have continuously resided in a health care facility for a period of 60 consecutive days or longer, with at least one day covered by Medi-Cal
- Need the level of care provided in an inpatient facility to live independently

### Enrollment

There were 4,622 cumulative transitions from 2008 to 2020 and 763 transitions in 2021.

Sources: *Money Follows the Person Rebalancing Demonstration: California Community Transitions Operational Protocol 1.5* (PDF), California Department of Health Care Services (DHCS), February 2017; Victoria Peebles and Johanna Dolle, *Money Follows the Person: Updated State Transitions as of December 31, 2020* (PDF), Mathematica, July 20, 2022; and *California Long Term Services and Supports Dashboard: 2023 Data Release Fact Sheet* (PDF), DHCS, 2023.

## Overview of California Community Transitions

### Description and Goals

CCT, California's HCBS demonstration program, launched in 2007 and is funded through the federal Money Follows the Person (MFP) rebalancing demonstration that provides states with flexibility to support people who require long-term services and supports in moving out of institutional settings and into the community.[1] The goal of the CCT demonstration program is to provide transition coordination services to people who want to move out of a nursing facility and into a home or community setting of their choice.

### Program Operations

Community-based CCT lead organizations are designated by and work with the California Department of Health Care Services (DHCS) to determine whether Medi-Cal enrollees qualify for CCT services. The lead

organization conducts an interview with the enrollee and performs a clinical assessment. After the state approves the enrollee for CCT services, a transition coordinator with the lead organization works directly with the enrollee to develop a comprehensive plan to support them in moving from a facility to the home or community setting of their choice.

The transition coordinator helps enrollees find housing, if needed, and connects them to HCBS based on their needs. Enrollees live in their own homes or in approved community care facilities (e.g., assisted living facilities, congregate living health facilities). CCT lead organizations monitor each enrollee for 365 days following the transition, and at the end of this demonstration period, enrollees who remain eligible for Medi-Cal can continue to receive other HCBS where they reside.[2]

### Included Services

Services provided under CCT include pre- and post-transition coordination and home set-up, home modifications, habilitation, personal care services, family and informal caregiver training, vehicle adaptations, and assistive devices.[3] Transition coordinators also help enrollees find and secure housing if needed. The services are meant to help sustain an enrollee's independence and safety at home. Post-transition services include transitional case management, which involves face-to-face meetings twice per month in the first three months and monthly for the remaining nine months.

Transition coordinators also help refer and connect enrollees to other HCBS for which the enrollee is eligible, including waiver services and/or Community-Based Adult Services (formerly known as Adult Day Health Care), home health agency services, and In-Home Supportive Services. Enrollees can continue using these additional services, if eligible, after the CCT demonstration period of 365 days has come to a close.

### Room and Board

CCT enrollees are required to pay room and board expenses for their home or other community setting of their choice. The CCT lead organization can help with finding and securing housing that the enrollee can afford, and the organization can also pay for non-recurring setup expenses.

## Overlap and Considerations with Community Supports

### CCT Comparison to Community Supports: Community Transition Services/Nursing Facility Transition to a Home; Housing Bundle

The goals and services provided through the CCT program are similar to the Community Transition Services/Nursing Facility (NF) Transition to a Home as well as the "housing bundle" of services offered through Community Supports. The housing bundle includes Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services, and it is meant to ensure members have access to safe housing to address their health-related needs. The Community Transition Services/NF Transition to a Home service is meant to help enrollees moving from a nursing facility to a private residence. It includes assistance with searching for and securing housing; coordinating the move; retaining housing; securing non-medical transportation; and funding environmental modifications for accessibility, if needed. While the person receiving the Community Transition Services/NF Transition to a Home service must pay for room and board expenses themselves, set-up funds are provided to cover utilities and services that are needed for the person's health and safety, including home modifications, medically necessary services, and durable medical equipment coordination.[4]

Unlike CCT services, the Community Transition Services/NF Transition to a Home service under

Community Supports does not include family and informal caregiver training or vehicle adaptations. While CCT services are limited to 365 days, the Community Transition Services/NF Transition to a Home service does not have a time limit but is payable up to a lifetime maximum amount of $7,500. Unlike CCT services, which are provided under a fee-for-service model, Community Supports are optional services provided through managed care.

Appendix A provides additional information comparing CCT to the Community Transition Services/NF Transition to a Home and housing bundle services.

## Challenges and Opportunities

As California considers integrating some HCBS into managed care, it is important to consider the current challenges of Community Supports and CCT implementation and opportunities for improving service delivery. While CCT is not currently among the programs DHCS is considering shifting to managed care, the significant overlap between services provided by CCT and the Community Transition Services/NF Transition to a Home Community Support means that a clearer understanding of both programs is needed to optimize their use. Challenges and opportunities were identified through literature review and interviews with HCBS stakeholders.

**There is variability in Medi-Cal managed care plans (MCPs) offering the Community Transition Services/NF Transition to a Home service, resulting in limitations to access for Medi-Cal enrollees.** While MCPs are strongly encouraged to offer as many Community Supports as possible, they are not required to offer any. Use of the Community Transition Services/NF Transition to a Home service by MCPs has been very low: 318 unique members used this service in the 12 months from July 2023 through June 2024, with nearly all coming from one MCP.[5]

***Opportunity:*** In 2023, institutional long-term care, including NF services, were carved into managed care statewide. As a result, MCPs are incentivized to work with NFs to identify members that may qualify for the Community Transition Services/NF Transition to a Home service to live safely at home. Furthermore, the CCT lead organizations could contract with MCPs to offer Community Supports and could share best practices with MCPs to better coordinate care for this population.

**The CCT program is funded through a time-limited federal demonstration and has low levels of use relative to potential need. While CCT provides invaluable services for the people it serves, it has not operated at scale.** Low use of CCT may be influenced in part by uncertainty and lack of permanent funding for the demonstration program. Stakeholders suggested that the administrative burdens of the CCT program are high and disincentivize its use. By having two programs — CCT and the Community Transition Services/NF Transition to a Home — offering similar transition services to Medi-Cal enrollees, MCPs may be less inclined to offer the Community Support because they assume enrollees can use CCT for transition services.

***Opportunity:*** With the limitations around CCT funding, DHCS could consider mechanisms for making transition services more widespread, reliable, equitable, and consistent. The Community Transition Services/NF Transition to a Home service offered through MCPs could increase opportunities for people to receive the help they need to transition to their own homes. This service could be paired with additional Community Supports, including Personal Care and Homemaker Services, Respite Services, and Day Habilitation Programs, to replicate the services available through CCT. However, this would require coordination with multiple providers and several separate service authorizations, which is more difficult than accessing the services through a bundled package like in CCT. To make the services sustainable, DHCS could also incorporate certain CCT services as required

benefits in MCP contracts, as other states participating in the federal demonstration program have done or plan to do.[6]

**A lack of affordable housing means that Medi-Cal enrollees who cannot afford room and board expenses and/or rent are unable to access HCBS services.** Enrollees who are experiencing homelessness or at risk of homelessness may not be able to afford rent to transition to a home.

***Opportunity:*** MCPs could build upon Community Supports for people experiencing or at risk of homelessness. The Transitional Rent program under the state's new BH-CONNECT initiative could help address some current gaps for this population. There may also be opportunities for MCPs to contract with Public Housing Authorities for people who need HCBS in affordable housing. This could be prioritized for those people transitioning out of a nursing facility who are at risk of homelessness.

## Member Case Study

Jane, a 55-year-old Sacramento resident, faced significant challenges after being diagnosed with early-onset Alzheimer's disease. Her declining health led to a fall, which was followed by a series of hospitalizations and a two-month stay in an NF. As Jane's needs grew more complex, her daughter Alice sought support to ensure her mother could safely return home.

Alice discovered the CCT demonstration program, which offered a comprehensive approach tailored to Jane's unique needs. Because of Jane's Medi-Cal coverage and her prolonged stay in the NF, she met the eligibility criteria for CCT. Alice reached out to their local CCT lead organization, which guided Jane and Alice through the enrollment process.

Once Jane was enrolled, the CCT lead organization assigned her a dedicated transition coordinator. This coordinator became a central figure in Jane's transition back home and worked closely with Alice and Jane's health care providers to create a personalized care plan. The CCT transition coordinator set up Jane's services through a network of organizations, including home care providers and community-based organizations, to ensure Jane received comprehensive care and support. This allowed Jane to receive essential services including assistance with daily tasks, transportation to medical appointments, and specialized counseling.

For Community Support programs to offer the same level of coordinated care or rapid response as the CCT program, it will be key for MCPs to work with providers to understand potential gaps in service provision of the Community Support compared to CCT, such as limited counseling or less intensive care coordination, which could potentially result in fragmented care. MCPs can collaborate with CCT providers to ensure full replication of CCT specialized services in managed care, such as twice-monthly, face-to-face case manager meetings. To ensure a successful transition for members transitioning from an NF to the community under Community Supports, it is crucial that MCPs provide all the specialized services currently available in CCT.

The CCT demonstration, enhanced by the strategic blending and braiding of additional programs, enabled Jane to return home and avoid unnecessary re-institutionalization. The comprehensive, well-coordinated care she received not only improved her overall well-being but also underscored the value of integrated programs for people facing similar challenges.

## Appendix A.
## Comparison of California Community Transitions and Community Supports (Community Transition Services/Nursing Facility Transition to Home, Housing Bundle)

| CHARACTERISTICS | CURRENT HCBS WAIVER/ DEMONSTRATION | COMMUNITY SUPPORTS | |
|---|---|---|---|
| | CALIFORNIA COMMUNITY TRANSITIONS* (CCT) | COMMUNITY TRANSITION SERVICES/ NURSING FACILITY TRANSITION TO HOME | HOUSING BUNDLE† |
| **Eligibility** | **Medi-Cal enrollees of all ages who:**<br>▸ Have continuously resided in inpatient state-licensed health care facilities for a period of 60+ consecutive days (federally funded)‡ or 2-59 days (state funded)§<br>▸ Without HCBS the enrollee would continue to require the LOC provided by an inpatient facility<br>**Enrollee's residence must be one of the following:**<br>▸ A home owned or leased by the enrollee or their family member<br>▸ An apartment with an individual lease that has lockable access and includes living, sleeping, bathing, and cooking areas<br>▸ A licensed community-based residential setting with no more than four unrelated residents | **Medi-Cal enrollees of all ages who:**<br>▸ Are receiving medically necessary NF LOC and choosing to transition home to continue receiving NF LOC services<br>▸ Have lived 60+ days in a nursing home and/or medical respite setting<br>▸ Are interested in moving back to the community<br>▸ Are able to reside safely in the community with appropriate and cost-effective supports and services<br>▸ Need to transition to ensure their health, welfare, and safety; without it, they would require re-institutionalization (no established lease or ownership in enrollee's name required) | **Enrollees of all ages who either:‖**<br>▸ Are prioritized through the local homeless Coordinated Entry System to identify highly vulnerable enrollees with one of the following:<br>  ▸ Disabilities<br>  ▸ One or more serious chronic conditions and/or serious mental illness<br>  ▸ Institutionalization or requiring residential services due to SUD<br>  ▸ Exiting incarceration<br>OR<br>▸ Meet the HUD definition of homelessness, are enrolled in ECM, and meet one of the eligibility criteria above#<br>OR<br>▸ Meet the HUD definition of being at risk of homelessness** |

| CHARACTERISTICS | CURRENT HCBS WAIVER/ DEMONSTRATION | COMMUNITY SUPPORTS | |
|---|---|---|---|
| | CALIFORNIA COMMUNITY TRANSITIONS* (CCT) | COMMUNITY TRANSITION SERVICES/ NURSING FACILITY TRANSITION TO HOME | HOUSING BUNDLE† |
| **Services††** | **Services are available to enrollees for the duration of the demonstration (365 days) with a lifetime expense cap per service that varies depending on the service.**<br>**Demonstration services include:**<br>▸ Home modifications ($7,500 cap)<br>▸ Home set-up (includes rental assistance) ($7,500 cap)<br>▸ Assistive devices ($7,500 cap)<br>▸ Family and informal caregiver training<br>▸ Personal care services pre-IHSS<br>▸ Pre- and post-transition coordination<br>▸ Transitional case management<br>▸ Vehicle adaptations ($12,000 cap)<br>**These optional State Plan services are available based on the enrollee's eligibility determination:**<br>▸ Community-Based Adult Services<br>▸ Home health agency services<br>▸ In-Home Supportive Services<br>**Transition coordinators help participants identify services in care planning, including:**<br>▸ Health care services<br>▸ Supportive services<br>▸ Social services<br>▸ Environmental services<br>▸ Education/training services<br>▸ Financial services<br>▸ Employment services<br>▸ Supplemental services | **Non-recurring set-up expenses** for enrollees transitioning from an NF to a private residence in the community are payable up to a **total lifetime maximum amount of $7,500‡‡**<br>As needed, funding can be coordinated for **services/modifications to establish a basic household, including:**<br>▸ Home modifications (air conditioner or heater and other medically-necessities, such as hospital beds and Hoyer lifts)<br>▸ Set-up fees for utilities or service access<br>▸ Security deposits required to obtain a lease on an apartment or home<br>▸ First month coverage of utilities (phone, electricity, heating, and water)<br>▸ Pest eradication and one-time cleaning prior to occupancy<br>**Optional State Plan services are available based on the enrollee's eligibility determination, including:**<br>▸ Community-Based Adult Services<br>▸ Home health agency services<br>▸ In-Home Supportive Services<br>**Allowable expenses are available to enable a person to establish a basic household, including:**<br>▸ Assessing enrollee housing needs<br>▸ Assisting with the housing search, application completion, and documentation<br>▸ Coordinating move with landlord<br>▸ Securing or funding transportation to assist mobility (non-emergency, non-medical)<br>▸ Identifying need and coordinating funding for home momodifications | **Housing Transition Navigation Services include:§§**<br>▸ Tenant screening and housing assessment<br>▸ Individualized housing support plan<br>▸ Application assistance<br>▸ Benefits advocacy (SSI eligibility, application)<br>▸ Resource identification (HUD Section 8, state and local assistance programs)<br>▸ Communication and advocacy support with landlords<br>**Housing Deposits fund one-time services and modifications, such as:**<br>▸ Medically necessary adaptive aids and services (air conditioning, heaters, hospital beds, Hoyer lifts)<br>▸ Apartment security deposits<br>▸ Utility set-up fees and deposits<br>▸ First and last months' rent for tenancy occupation<br>▸ First month's utilities coverage (phone, gas, electricity, heating, water)<br>▸ Pest eradication and cleaning of premises<br>**Housing Tenancy and Sustaining Services include:**<br>▸ Identification of behavior that risks housing (late payment, hoarding, substance use)<br>▸ Tenants' rights education<br>▸ Coaching for relationships with property managers and landlords<br>▸ Coordination with case manager and landlord<br>▸ Dispute resolution assistance |

| CHARACTERISTICS | CURRENT HCBS WAIVER/ DEMONSTRATION | COMMUNITY SUPPORTS | |
|---|---|---|---|
| | CALIFORNIA COMMUNITY TRANSITIONS* (CCT) | COMMUNITY TRANSITION SERVICES/ NURSING FACILITY TRANSITION TO HOME | HOUSING BUNDLE† |
| **Providers‖ ‖** | **Providers interested in serving CCT participants must apply to be a CCT lead organization.** Interested organizations must:<br>▸ Become a Medi-Cal HCBS waiver provider<br>▸ Agree to terms and conditions in the DHCS CCT lead organization provider contract<br>**List of CCT lead organizations (as of February 2024)** | **Providers listed below are not exhaustive; providers must have experience with the required services.**<br>▸ CCT/Money Follows the Person providers<br>▸ Case management agencies<br>▸ Home health agencies<br>▸ Medi-Cal MCPs<br>▸ County mental health providers<br>▸ 1915(c) HCBA/ALW providers | **Providers listed below are not exhaustive; providers must have experience with the required services.**<br>▸ Vocational service agencies<br>▸ Service providers for enrollees experiencing homelessness<br>▸ County agencies<br>▸ Mental health or SUD treatment providers<br>▸ Public hospital systems<br>▸ Social service agencies<br>▸ Affordable housing providers<br>▸ Supportive housing providers<br>▸ Federally Qualified Health Centers and Rural Health Clinics |

Source: Authors' analysis from multiple sources, including approved state demonstration applications, regulations, and DHCS policy guidance.

Notes: This information is not exhaustive but aims to provide an illustrative and comparative understanding of the potential options available to Medi-Cal members who could benefit from home and community-based services. For a comprehensive explanation of program policy and guidance, please refer to official California Department of Health Care Services (DHCS) documents for detailed program requirements, processes, and procedures. *ALW* is Assisted Living Waiver; *CCT* is California Community Transitions; *DHCS* is California Department of Health Care Services; *ECM* is Enhanced Care Management; *HCBA* is Home and Community-Based Alternatives Waiver; *HCBS* is home and community-based services; *HUD* is Department of Housing and Urban Development (federal); *IHSS* is In-Home Supportive Services; *LOC* is level of care; *MCP* is managed care plan; *NF* is nursing facility; *SSI* is Supplemental Security Income; *SUD* is substance use disorder.

* The California Community Transition (CCT) program is a federal Money Follows the Person (MFP) demonstration. In December 2022, the federal government extended the term of the MFP grant and appropriated additional funding to state grantees. CCT transition services are currently available through 2027.

† The housing bundle refers to the "housing trio" of Community Supports (Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services).

‡ Facility stays for short-term rehabilitation services reimbursed by Medicare are not counted toward the 60-day required period.

§ There is a "state-like" CCT program which uses state dollars, allows enrollment for less than 60 days, and is available to eligible Medi-Cal enrollees until January 1, 2028.

‖ For a comprehensive description of housing bundle eligibility requirements by age, see: *Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide* (PDF), DHCS, July 2023.

# Enrollees who meet the Housing and Urban Development (HUD) definition of homeless or are at risk of homelessness as defined in *Section 91.5 of Title 24 of the Code of Federal Regulations* (PDF).

** "At risk of homelessness" eligibility is available for Housing Transition Navigation Services and Housing Tenancy and Sustaining Services, but not for Housing Deposits.

†† Services provided under Community Supports must supplement not supplant services received through State, local, or federally funded programs.

‡‡ The only exception to the $7,500 maximum is if the member is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond their control.

§§ Housing Transition Navigation Services and Housing Tenancy Sustaining Services are also available to transition-age youth who have significant barriers to housing stability.

‖ ‖ Community Supports availability varies by county and MCP. For information on MCP contracts with Community Supports providers, see: "Chart 4.5.2: Total Number of Community Supports Provider Contracts in Each MCP and County in the Most Recent Reporting Quarter by Service," DHCS, last updated December 2024.

## About the Authors

Mallika Mahalingam, MPH; Brendan Finn, MPH; Kristin Mendoza-Nguyen, MPH; and Kristal Vardaman, PhD, MSPH, are consultants at Aurrera Health Group, a mission-driven national health policy and communications firm based in Sacramento.

## Acknowledgments

We would like to acknowledge Cardea Health, Institute on Aging, and Partners in Care Foundation for sharing their insights, reviewing the explainers, and supporting the member case studies. We would also like to thank the Corporation for Supportive Housing, Disability Rights California, and Justice in Aging for reviewing the explainers.

## About the Foundation

The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

## Endnotes

1. "Consolidated Appropriations Act of 2023," California Department of Health Care Services (DHCS), accessed July 1, 2024.
2. *Money Follows the Person Rebalancing Demonstration: California Community Transitions Operational Protocol 1.5 (PDF), DHCS, February 2017.*
3. *Money Follows the Person*, DHCS.
4. *Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide* (PDF), DHCS, July 2023.
5. "Community Supports Members Data: A Section of the ECM and Community Supports Quarterly Implementation Report," DHCS, updated December 2024.
6. *Tennessee Money Follows the Person Rebalancing Demonstration Summary Report* (PDF), TennCare, February 26, 2021; and *New York State Money Follows the Person Rebalancing Demonstration Sustainability Plan* (PDF), New York Department of Health, October 2017.