Home and Community-Based Long-Term Care: Recommendations to Improve Access for Californians

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Prepared for:

California Community Choices
California Health and Human Services Agency

Submitted by:

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Acknowledgements and About the Authors

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About the Authors

Robert Mollica, Ed.D., is one of the nation's leading authorities on state long-term care policy and program development. As Senior Program Director with the National Academy for State Health Policy for 18 years, he conducted health policy and long-term care research; provided technical assistance to state policy leaders on long-term care and assisted living; conducted nine national studies on state assisted living policy; and co-authored studies of Medicaid managed care programs for elders, dual eligibles, and community care systems. As Assistant Secretary for Policy and Program Development in the Massachusetts Executive Office of Elder Affairs for eight years, he managed policy and program development for long-term care, housing, health, transportation, agency research, and state and federal legislation. Recently retired, Dr. Mollica works as an independent consultant. He currently serves on a team of experts providing technical assistance to states under the federal Money Follows the Person Demonstration Program and is conducting a study of state reimbursement practices in assisted living residences.

Leslie C. Hendrickson, Ph.D., has over 25 years of Medicaid, Medicare and related experience in reimbursement and cost analysis, administration, regulatory analysis of federal and state laws, and market analysis of senior living programs. He spent eleven years with Oregon Medicaid, as the Senior Budget Analyst in the Medicaid Budget Office and as Principal Executive Manager, Medicaid. As an Assistant Commissioner in the New Jersey Department of Health and Senior Services for five years, he managed 250 staff and a $1.5 billion nursing home reimbursement program and Medicaid waiver programs. Most recently, Dr. Hendrickson has consulted on state long-term care programs and Medicaid financial issues, and authored 14 reports on financial and policy issues in nursing facility and home and community-based care.

November 2, 2009

Kim Belshé, Secretary
California Health and Human Services Agency
1600 9th Street, Room 460
Sacramento, CA 95814

Dear Secretary Belshé:

The California Community Choices Advisory Committee is pleased to present a federally funded long-term care financing study, *Home and Community-Based Long-Term Care: Recommendations to Improve Access for Californians*. The report offers 28 recommendations for redesigning California's long-term care service system, based on a thorough analysis of long-term programs in California and best practices across other states.

The authors, Robert Mollica, Ed.D., and Leslie Hendrickson, Ph.D., are nationally known for their expertise in Medicaid, state long-term care policy, and analysis of data and long-term care financing. They present a thorough and powerful analysis that demonstrates home and community-based services can be financially sustainable as they result in savings over institutional care.

The Advisory Committee worked with the authors to divide the 28 recommendations into three categories representing three main domains for change: Financing, Access and Delivery System and State-level Organization. See page xiii for "Recommendations by Category." As you consider the recommendations, the Committee would like to call your attention to the following:

1. California needs both a strong statement of legislative intent and a statewide strategic plan in order to achieve a meaningful system redesign since our current delivery system is fragmented among multiple provider networks and state departments;

2. The authors' recommendations are based on sound financial analysis and are framed to promote informed consumer decision-making, choice and quality of life;

3. Implementation of the recommendations would level the playing field so consumers can have full choice between home and community-based services and nursing facility care options; and

4. The recommendations are complex, multi-faceted and interdependent.

The Advisory Committee thanks the authors for a comprehensive and action-oriented report, particularly in this time of budget crisis. We are confident that this report will generate dialogue among administration leaders, legislative partners, state departments, service providers, consumers and other stakeholders. We also expect it to create a platform for long-lasting systems change that will benefit Californians for years to come.

We ask you to read carefully and join to promote positive change.

Respectfully submitted on behalf of the California Community Choices Advisory Committee,

June Simmons
Chair

cc: Choices Advisory Committee Members

Denika Boardman, Central Coast Center for Independent Living
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Vicki Farrell, Association of California Caregiver Resource Centers
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California Community Choices
Long-Term Care Financing Study

Executive Summary

California faces enormous challenges maximizing opportunities for seniors and persons with disabilities of all ages to live independently in the setting of their choice. The challenges are fiscal, geographic and structural. Even when the state does not face unprecedented budget deficits, investments are needed in the services and delivery system to promote informed choice, access to preferred services and adequate financial support. The sheer size of the state makes statewide implementation of a major initiative far more complex, yet "pilot" programs that operate in limited areas of the state add to the fragmentation that hampers consumer access.

The California Community Choices (Choices) project is a five-year grant funded by the Centers for Medicare & Medicaid Services to increase consumer access to home and community-based long-term care services by establishing one-stop resource centers, Aging and Disability Resource Connection (ADRC) programs, in cooperation with the California Department of Aging. ADRCs provide information, referral, and assistance for persons with disabilities, caregivers, family and friends who seek information about long-term care services. The Choices project also developed the California Care Network (CalCareNet), a website guide to long-term care services in California. CalCareNet is being piloted with ADRCs in Orange and Riverside counties to provide complementary information and assistance in person or by phone to persons seeking services.

The Choices project also includes a financing study to examine the laws, regulations, policies and payment methodologies related to long-term care financing in California. The study was initiated to improve the state's understanding of the financial and structural barriers to increasing consumer access to home and community-based services, and to provide recommendations that enable the state to more effectively manage funding for long-term care in ways that promote community living options.

California spends more than $10 billion annually on long-term care, and the majority of the funds pay for services in the community. The programs that cover the services for adults with physical disabilities and older adults appear to function independently with separate delivery systems and management structures. Consumers must contact different organizations for each program. Only persons with developmental disabilities are able to contact a single entity, receive information about their options, assess their service needs and access the appropriate service.

The Choices project and the Department of Aging are developing Aging and Disability Resource Connection (ADRC) programs to provide additional centralized sources of information and referral. ADRCs provide information about programs, services and eligibility requirements to

help consumers make informed decisions. Where an ADRC also administers long-term care programs, access to community services can be expedited.

The report recommends that California develop a strategic plan that describes which populations, services and programs will be addressed by the strategic plan, and describes the mission, values and goals for its long-term living services and supports programs. The plan should include a mission and vision statement and short, medium and long-term goals that include objectives, tasks that will be undertaken to achieve the objectives and the entity and staff that will be responsible for implementing each one.

This report includes findings from interviews with state officials, state staff and stakeholders, data obtained from the state and other sources as well as reviews of statutes, regulations and previous reports. Appendix A contains a nine-page bibliography that includes these previous reports.

General Findings

- Approximately 2.4 million persons in California report having two or more disabilities and an estimated 400,000 plus have intellectual or developmental disabilities.

- California has more persons age 65 and older than other states and the population is growing. In 2007, California was home to 4.0 million persons age 65 and older or 11.0% of the total population. By 2010, the number of Californians age 65 and older will increase to 4.4 million or 14.7%, and will increase to 8.3 million or 17.8% of all Californians in 2030.

- The system is organized by program rather than by person. California's services for older adults and individuals with disabilities are covered through programs managed by multiple state agencies and organizations. However, the programs provide a core of similar services that include support with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health and social needs. Tens of thousands of persons receive services from multiple programs, while others shift between programs in complex passages resulting in costs and consumer outcomes that are rarely studied since no one department is responsible for the entirety of a person's care and services.

- In 2009, California's DD programs ranked seventh in the nation for the best performing state Medicaid programs in a national study by United Cerebral Palsy which measured 20 factors.

- California ranks 1st in the nation on the number of personal care participants per 1,000 population, 19th on home health participants per 1,000 population, and 42nd on Home and Community-Based Services (HCBS) Waiver participants per 1,000 population. California ranks 6th in total HCBS participants per 1,000 population and 17th on total HCBS expenditures per capita in 2005.

- For older adults and adults with physical disabilities, California was ranked 5th nationally in the percentage of HCBS spending with 48% on institutional care and 52% on HCBS in 2007.

  Note: The annual table of the percentage of spending on HCBS prepared by Thomson Reuters reports all Medicaid State Plan personal care expenditures (IHSS) in the data for aged and disabled beneficiaries. Medicaid service expenditures reported on CMS Form 64 are frequently used to rank states on long-term care spending. However, the Form 64 data under-report spending for community services in California and other states.

- In 2007, California was 48th in the nation on per capita spending for waiver expenditures, 4th on personal care and 18th overall on total HCBS.

  Note: Comparing California's rank for per capita HCBS spending to other states may be misleading since state expenditures on related Medi-Cal state plan services and services under the Lanterman Developmental Disabilities Services Act (Lanterman Act) funded by state general revenues are not captured in HCBS data reported on the CMS Form 64.

- In 2007, HCBS accounted for 62% of developmentally disabled (DD) spending and 38% for institutional care, which placed California 32nd among states. When spending for targeted case management and clinical services is included, the ratio is 66% HCBS and 34% institutional.

  Note: Comparing California's rank for waiver spending for persons with developmental disabilities to other states may be misleading since the state spends such a large amount on IHSS, other Medi-Cal state plan services and services under the Lanterman Act funded by state general revenues. Data on these expenditures are not captured in the CMS Form 64, which is frequently used to rank states on long-term care spending.

- Annual per capita spending presents a different perspective on spending. In FY 2007, California exceeded the national average for spending on state plan personal care services (referred to as IHSS in California)—$101.51 versus $34.47. California's spending for HCBS Waivers for aged and disabled beneficiaries is $3.00 per capita per year compared to $21.02 nationally, and for individuals with Mental Retardation/Developmental Disabilities (MR/DD), per capita spending was $35.12 in California compared to $68.04 nationally. The inclusion of targeted case management spending would increase per capita spending.

- California spent less annually per capita than the national FY 2007 average on nursing facility care—$100.04 per day compared to $155.76 per day nationally, and spending for Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) was $21.27 per day in California compared to $39.83 per day nationally.

- Nursing facility spending increased 40.7% between 2001 and 2007 while waiver spending for older adults and individuals with disabilities increased 20.6% during the same period. Nationally, nursing facility spending increased 10% and waiver spending for older adults and individuals with physical disabilities rose 85% during the same period.

- Medi-Cal spending for all nursing facility and ICF/MR institutional services rose 46.9% between 2001 and 2007 while spending for community services—In-Home Supportive Services (IHSS), MR/DD and other waiver services—rose 88.4%.

- The state does not take full advantage of Medicaid provider fees.

System Design

- California lacks a strategic plan that would set priorities for services for the future to maximize the use of finite resources. The Olmstead Plan offers a framework for developing a strategic plan.

- New programs often require a new delivery system because there is no logical infrastructure or single entry point to administer new programs. Consumers admitted to a nursing facility do not have access to a central source of information, preadmission screening, or assistance and support to access community service options. Consumers living in the community who need assistance do not have access to options counseling to understand what services might be available to them as better alternatives to admission to an institution.

- While there is no statewide entry point for older adults and individuals with disabilities, ADRCs are being designed to provide information about the multiple services and access points.

- The state's budget deficit makes consideration of changes that require investment in services or the delivery system more difficult in the short term. However, investments in HCBS programs would likely improve the effectiveness of the overall delivery system and reduce the rate of growth by shifting more resources to community services.

- Collaboration between community service organizations and hospital discharge planners to divert admissions to nursing facilities is not well developed.

- Previous reports recommended consolidation of agencies and programs serving individuals with disabilities and older adults. However, each program and agency has a long and rich tradition with a strong network of providers, advocates and consumers that seem more comfortable with the system they know, than a new, untested structure that is not clearly defined.

In-Home Supportive Services (IHSS)

- Opinions about the reasons for IHSS caseload growth differed. Persons interviewed attributed the growth to the:
    - Low functional eligibility requirements
    - Widespread awareness of the program
    - Use of family and friends as caregivers
    - Statewide availability of services
    - Difficulty accessing HCBS Waivers
    - The program's well-established history and its administrative support structure
    - Aging of the population

- Persons interviewed stated that the low IHSS functional eligibility requirements help prevent further functional decline and that allowing family and friends to be reimbursed (which is becoming more common in state programs) addresses tight labor pools and supports family caregiving.

- New IHSS participants have higher assessed levels of impairment than persons who entered the program eight years ago.

- The IHSS limit on the maximum number of hours of service that may be authorized, 283 hours per month, is higher than almost all other states. However, persons interviewed said exceptions to the cap are warranted for participants with more intensive needs, to reduce the need for supplemental services through HCBS Waivers.

- Studies about the impact of wage and benefit increases to personal care workers report that increases have predictable positive impacts on their willingness to work and job turnover.

Home and Community-Based Services (HCBS) Waiver Programs

- Recent research found that states with well-established HCBS programs had less overall long-term care (LTC) spending growth. In contrast, states with low levels of HCBS expenditures had an increase in overall costs, as their institutional costs increased. California was rated an expanding HCBS state for non-MR/DD services and a low HCBS state for DD Waiver services.

- The Medi-Cal level of care criteria used to determine eligibility for each HCBS program seems appropriate given the intended populations served and the program services provided.

- Multipurpose Senior Services Program (MSSP) enrollment is limited by funding but experienced periods of growth. The program primarily provides case management to persons age 65 and older who also receive IHSS services. Stakeholders noted that

expanding MSSP services to provide more transition assistance to persons wishing to leave institutions would be a useful program development.

- The Assisted Living Waiver (ALW) expands long-term care settings by providing residential service choices but serves persons in a limited number of counties and is not available statewide.

- California does not use the special income level eligibility option, which would streamline access for individuals with income below 300% of the federal Supplemental Security Income (SSI) benefit.

- The cost differences between waiver expenses and institutional costs totaled $3 billion in FY 2006, which suggests that HCBS programs are cost-effective, and delay or substitute for hospital, nursing facility and ICF/MR care even if only a modest percentage of persons would have been served in institutions in the absence of the programs.

- The state has not studied the cost effectiveness of its waiver programs.

- Stakeholders commented that the number of waiver slots is low relative to most other states, and expanding the waiver capacity would be important to address in a strategic plan for long-term care.

Department of Developmental Services

- The Regional Center delivery system for individuals with developmental disabilities is well developed. It is California's only long-term care system that operates as a single entry point that provides access to comprehensive services.

- The growth in the number of persons served in Department of Developmental Services (DDS) programs has been steady throughout the last decade. The caseload has grown from just over 180,000 in 2001 to over 247,001 in July 2009.

- The state has made significant progress in helping persons with intellectual and developmental disabilities leave state-operated institutions. DDS stated that the effort to transition individuals out of private facilities focused on relocating persons with developmental disabilities from large facilities to small home-like settings. While the number of persons in private facilities has increased, the number of persons in large ICF-MRs has declined and the number of persons in smaller facilities has increased.

- Prior to July 1, 2008, regional centers negotiated rates for nonresidential services. The extent and depth of negotiated rates, and the degree to which negotiations are used in the cost-based approaches, is not reported by DDS. The uniformity of rate payments across regional centers is not known.

- When implemented, the April 2009 settlement of the class action lawsuit (Capitol People First v. DDS) will provide more information and choices to live in small community

settings to individuals with developmental disabilities who currently live in government or privately operated facilities.

- The two main drivers of DD Waiver costs are sustained increases in enrollment and utilization. Once a person enrolls in the waiver, they tend to remain, although DDS staff indicated that between 5,000-6,000 persons disenroll from the waiver each year.

Adult Day Health Care (ADHC)

- A study of programs in six states (California, Maryland, New Jersey, New York, Texas and Washington) found that ADHC can save the Medicaid program significant resources by delaying or avoiding inappropriate entry into more costly institutional care.

- A review of Treatment Authorization Requests (TARs) estimated that between 30–40% of all participants would need nursing facility care in the absence of ADHC services. The specific level of nursing facility care—Level A, Level B or Subacute—was not indicated.

- Over 80% of ADHC participants are age 65 and older and fewer than half are age 80 and older, which is comparable to recipients who receive services in a nursing facility.

- ADHC often serves beneficiaries who receive other services. A review of paid Medi-Cal claims found that 60% also received IHSS services. A state official suggested that ADHC may supplement IHSS for participants who need more hours than can be authorized under IHSS. ADHC also provides skilled services that are not available through IHSS, and the combined services meet a broader range of health and functional needs.

- Legislation passed in 2006 made significant changes in the ADHC program and reduced expenditures.

- ADHCs serve two distinct populations—one receives temporary rehabilitative services and the other receives longer-term support and medical services.

Mental Health

- California does not operate an HCBS program that is designed specifically for persons with mental illness. A package of services for nursing facility residents with a mental illness could be designed under a §1915(c) Waiver or a §1915(i) state plan HCBS amendment.

Nursing Facilities

- California ranks 43rd among states in the supply of nursing facility beds per capita, and 31st with an occupancy rate of 86%. The Medi-Cal nursing facility resident census has declined slightly, 1.4%, over the past eight years. However, between December 2001 and December 2008, the number of Medicaid residents in nursing facilities dropped 8% nationally and 22 states experienced a reduction of 10% or greater, which suggests that further reductions are possible through diversion and transition/relocation initiatives. Although other factors may contribute to California's modest decline, effective diversion and transition programs along with fiscal incentives for counties would continue the trend.

- From December 2002 to December 2008, the number of nursing facilities in California declined approximately 6%, slightly above the national average. The numbers of nursing facility residents and nursing facility beds have also declined modestly, although less than the national decline, while the occupancy rate has increased slightly.

- While there is a perception among persons interviewed that California has a history of low nursing facility reimbursement rates, a review of national rates from 1998 to 2005 shows that California ranks in the midrange compared to other states in nominal dollar terms.

- California has a higher proportion of residential care and a lower supply of nursing facility beds per 1,000 persons age 65 and older than the other large states.

- Medicare nursing facility use increased 26% in California and 34% nationally between 2001 and 2008. Nursing facilities have a financial incentive to expand their Medicare and managed care subacute business by its profitable ancillary revenue.

- Increases in nursing facility Medi-Cal per diems in California have been greater than general inflation over the period 2001–2008 and have kept up with medical inflation.

- Operating margins of nursing facilities have increased substantially in California since 2000.

- Only about 55–60 nursing facilities report any caregiver training expenses although it is a 100% pass-through cost.

- California's nursing facility cost reimbursement methodology does not control for low occupancy. In per diem reimbursement systems, costs are divided by days of service. As the number of days becomes smaller, the cost per day goes up. Unless low occupancy rates are controlled for, the entities receiving the per diem reimbursement will get more money per person as they serve fewer persons.

- California also uses prospective cost-based rates that are not adjusted for the acuity of the residents.

- If California had the same nursing facility usage as the national average, about 42,600 more persons would have their nursing facility stay paid for by Medi-Cal. At 2007 costs, if these 42,600 persons had been receiving nursing facility Level B services for 219 days each at a cost of $139.70 (the average number of days and costs in 2007 in California paid by Medi-Cal), the state would have spent an additional $1.4 billion per year.

Transition Programs

- The state currently operates nursing facility transition initiatives through the Department of Rehabilitation, Centers for Independent Living, 1915(c) Waivers, a program in San Francisco, and the new Money Follows the Person (MFP) Rebalancing Demonstration.

- MFP offers an opportunity to develop and refine strategies that provide transition coordination to nursing facility residents who are interested in moving to the community. The fragmented delivery system poses additional challenges to transition coordination. The program's success will depend on the ability of the service network to provide access to the level of service needed by individuals who are interested in moving to the community.

- Access to affordable housing is a barrier to transitioning for persons who want to return to the community but lack a source of housing.

This report's recommendations support five primary goals:

- Define goals for balancing the long-term care system

- Reduce the rate of growth in spending on institutional care

- Expand HCBS programs over time as the economy recovers and state revenues increase

- Invest savings from a lower rate of institutional growth in home and community-based services for individuals who are at risk of entering an institution

- Improve the management of home and community services programs

The recommendations are grouped by the length of time it might take to implement them and then by category: Financing, Access and Service Delivery and State-level Organization.

Summary of the Recommendations

Recommendation	Brief Description	Action
General Recommendations		
1. Establish the Philosophy and Legislative Intent	The statutes describe the role and purpose of California's different long-term care programs but, taken together, they do not establish a framework for making decisions about new programs or services nor do they address the "system" as a whole.	Statute
2. Develop a Strategic Plan	California should prepare a strategic plan that describes which populations, services and programs will be addressed by the plan and describes the mission, values and goals for its long-term services and supports system. The goals should include measurable targets to improve balance between HCBS and institutional services for all populations.	Administrative/ Statute
Short-Term Recommendations—One Year to Implement		
3. Add a Special Income Level Eligibility Group	This option enables individuals with income below 300% of SSI in the community to become Medi-Cal eligible who would otherwise have to incur expenses equal to the share of cost under the Medically Needy Option. Meeting the spend-down creates a barrier for persons who readily meet the share of cost in a nursing facility but cannot afford the share of cost in the community and retain enough income to meet their expenses.	Administrative
4. Increase the Home Maintenance Income Exemption	Maintaining or establishing a home in the community is a major obstacle for Medicaid beneficiaries who want to return home after admission to an institution. Medicaid eligibility rules give states the flexibility to support this goal and allow states to exempt income to maintain a home. The existing exemption is $209 per month, which is too low to maintain a home in California.	Statute
5. Maintain the SSI/SSP Medi-Cal Eligibility Status	This option allows beneficiaries to retain their full SSI/SSP during the first 90 days of an institutional stay for beneficiaries who are able to return home.	Administrative
6. Adopt a Case-Mix Reimbursement System for Nursing Facilities	This option creates incentives to serve high acuity residents and facilitates community transition for lower acuity residents. The case-mix system would be "zero sum" and not result in additional payments to nursing facilities.	Statute
7. Establish a Nursing Facility Occupancy Provision	This option creates an incentive for facilities to reduce their licensed capacity, which ensures that beds will not be back-filled as residents relocate or as new admissions are diverted through preadmission screening/options counseling.	Statute
8. Convert the Labor-Driven Operating Allocation to an Incentive to Promote Discharge Planning or Increased Quality of Care	Given the magnitude of the per diem and the fact that the offset does not reimburse an actual cost, we suggest that the state rethink this incentive and exercise policy-related control over it.	Statute
9. Review Department of Developmental Services (DDS) Regional Centers Rates for Nonresidential Services	Should budget conditions improve and the rate freeze be lifted, before restoring previous rate methodologies DDS should review the use of negotiated rates to avoid concerns about compliance with CMS policy.	Administrative

Recommendation	Brief Description	
10. Conduct a Study of Need for Waiver Expansion	Waivers are cost effective and their use should be expanded.	Administrative
Medium Range Recommendations—One to Two Years to Implement		
11. Establish a Statewide Institutional Transition Program	Ideally, the transition program would be part of the single entry point entities and reflect the experience from the California Community Transitions program. Until single entry point entities are established, the State should establish a statewide institutional transition program and current MFP programs should continue and be expanded.	Administrative
12. Reinvest Savings from Institutional Care in HCBS	Savings from beneficiaries who transition can be transferred to home and community-based services program accounts. A reserve fund can be created for savings that may be used for investments in a subsequent fiscal year. The nursing facility appropriation can be used to pay for services in the community for individuals who relocate from an institution when waiver programs have reached their maximum capacity and wait lists are established.	Administrative
13. Provide Diversion through Preadmission Screening (PAS)/Options Counseling about Community Alternatives through Single Entry Points and Aging and Disability Resource Connections (ADRCs) and by Working with Hospitals	PAS/options counseling is a strategy to inform individuals and family members who apply for admission to an institution about the community services that are available to help them remain at home. Options counseling is often mandatory for Medicaid beneficiaries seeking admission to a nursing facility. It may be advisory for individuals who are not eligible for Medicaid but are likely to spend down within six months of admission.	Administrative
14. Expand Coverage of Residential Options Statewide to Offer More Service Alternatives for Older Adults	California currently offers limited coverage of services in Residential Care Facilities for the Elderly (RCFE) through the Assisted Living Waiver Program. Offering a full array of services gives consumers additional residential options besides a nursing facility bed. Residential settings are particularly useful for consumers who do not have a caregiver at night and on weekends, need 24-hour supervision or need access to assistance that cannot be scheduled.	Administrative
15. Increase the Use of Provider Fees for HCBS Providers	Federal regulations require that the fees: be broad based; be uniformly imposed throughout a jurisdiction; and not violate the hold harmless provisions of the regulations. The state should benefit from the financial advantages that are permitted under federal regulations.	Statute
16. Explore Converting a Portion of State Supplement Program (SSP) Payments to Provide Services in Residential Settings	Federal law allows states that increased the SSI State Supplement Program payment since 1983 to reduce the supplement to 1983 levels. General revenues saved by lowering the payment could be used to expand Medi-Cal supportive services in RCFEs without reducing the personal needs payment to residents. *Update: The 2009 budget agreement reduced the SSP payment to 1983 levels. This recommendation is retained as a reference.*	Statute
17. Create a Temporary Rental Assistance Housing Subsidy	This option converts a portion of the state share of the savings from Medi-Cal payments for individuals who transition from an institution to a housing subsidy while they wait for a housing voucher or other federal housing subsidy.	Administrative

Recommendation	Brief Description	
18. Allow Presumptive Medi-Cal Eligibility for HCBS Waiver Applicants	This option allows case managers in a comprehensive entry point system to fast track or presume Medi-Cal eligibility to enroll applicants in a waiver program and avoid admission to a nursing facility. This recommendation should be considered in relation to the recommendation for co-locating eligibility workers	Administrative
19. Develop HCBS That Address Individuals with Mental Illness	A package of services for nursing facility residents with a mental illness could be designed under a §1915(c) Waiver or a §1915(i) state plan HCBS amendment. MFP includes demonstration services that address the needs of persons with mental illness living in nursing facilities. The services should be defined and implemented to improve the project's ability to meet the benchmarks for this population.	Administrative
20. Create Rate and Other Incentives to Reduce Nursing Facility Capacity	This recommendation would create rate incentives, perhaps using funds from the labor-driven operating allocation for nursing facility providers, to downsize nursing facilities, and the resulting savings can be used for pay-for-performance or to expand affordable housing, adult day health care, and in-home services.	Statute
Long-Term Recommendations—Two Years or Longer to Implement		
21. Create a Department of Long-Term Services and Supports	Individuals with developmental disabilities for the most part access services managed by one state agency and a strong comprehensive entry point system operated by 21 regional centers. While some consumers receive IHSS services, the majority of home and community-based services are accessed through regional centers. No similar structure is available to serve older adults and individuals with physical disabilities. As a result, new initiatives are often built through new structures and administrative arrangements.	Statute
22. Create Single Entry Points (SEPs) to Access Services for Aged/Disabled Beneficiaries	Without a visible entity that offers seamless entry to the system, consumers contact multiple agencies and organizations, complete multiple application forms and apply for programs that have different financial and functional eligibility criteria.	Administrative
23. Co-Locate Medi-Cal Financial Eligibility Workers in Single Entry Points/ADRCs	Determining financial eligibility quickly can mean the difference between entering a nursing facility and returning home.	Administrative
24. Create a Unified Long-Term Care Budget	This option creates a unified long-term care budget at the county/regional level that includes nursing facility spending, IHSS and selected HCBS Waiver programs.	Statute
25. Create a Standardized Rate Structure for HCBS Based on the Acuity of Persons Receiving Services	Long-term care services should be managed as if they are a single program. Persons with physical impairments and disabilities use multiple programs both over time and at the same time. Eligibility and service delivery changes in one program impact the utilization of other programs.	Administrative
26. Create Incentives for HCBS through Managed Long-Term Care and Capitation	Expand capitated managed long-term care options. A review of managed long-term care programs prepared in 2006 found that managed long-term care programs reduce the use of institutional services and increase the use of home and community-based services relative to fee-for-service programs, and that consumer satisfaction is high.	Administrative

Recommendation	Brief Description	
27. Create Financing Strategies That Improve the Balance Between Community and Institutional Services	Examples of possible strategies from Washington and Vermont are described.	Statute
28. Develop a Long-Term Care Data Base	Develop a long-term care data base that contains information on the physical and mental characteristics and service utilization history of persons using long-term care services. The purpose of the database is to enable the state to manage long-term care services as though it were one program. The data base will permit the comparison of persons across programs so the state can understand who uses programs, what services they receive, and what the total costs are. Currently, data are organized by program; what is needed is data organization at the individual level.	Administrative

Recommendation by Category

Recommendation	Financing	Access and Delivery System	State-level Organization
1. Establish the Philosophy and Legislative Intent	●	●	●
2. Develop a Strategic Plan	●	●	●
3. Add a Special Income Level Eligibility Group		●	
4. Increase the Home Maintenance Income Exemption		●	
5. Maintain the SSI/SSP Medi-Cal Eligibility Status		●	
6. Adopt a Case-Mix Reimbursement System for Nursing Facilities	●		
7. Establish a Nursing Facility Occupancy Provision	●		
8. Convert the Labor-Driven Operating Allocation to an Incentive to Promote Discharge Planning or Increased Quality of Care	●		
9. Review Department of Developmental Services (DDS) Regional Centers Rates for Nonresidential Services	●		
10. Conduct a Study of Need for Waiver Expansion		●	
11. Establish a Statewide Institutional Transition Program		●	●
12. Reinvest Savings from Institutional Care in HCBS	●		
13. Provide Diversion through Preadmission Screening (PAS)/Options Counseling about Community Alternatives through Single Entry Points and Aging and Disability Resource Connections (ADRCs) and by Working with Hospitals		●	
14. Expand Coverage of Residential Options Statewide to Offer More Service Alternatives for Older Adults		●	
15. Increase the Use of Provider Fees for HCBS Providers	●		

Recommendation	Financing	Access and Delivery System	State-level Organization
16. Explore Converting a Portion of State Supplement Program (SSP) Payments to Provide Services in Residential Settings	●		
17. Create a Temporary Rental Assistance Housing Subsidy	●		
18. Allow Presumptive Medi-Cal Eligibility for HCBS Waiver Applicants		●	
19. Develop HCBS That Address Individuals with Mental Illness		●	
20. Create Rate and Other Incentives to Reduce Nursing Facility Capacity	●		
21. Create a Department of Long-Term Services and Supports			●
22. Create Single Entry Points (SEPs) to Access Services for Aged/Disabled Beneficiaries		●	
23. Co-Locate Medi-Cal Financial Eligibility Workers in Single Entry Points/ADRCs		●	
24. Create a Unified Long-Term Care Budget	●		
25. Create a Standardized Rate Structure for HCBS Based on the Acuity of Persons Receiving Services	●		
26. Create Incentives for HCBS through Managed Long-Term Care and Capitation	●	●	
27. Create Financing Strategies That Improve the Balance Between Community and Institutional Services	●		
28. Develop a Long-Term Care Data Base			●

Introduction, Purpose and Scope

California has been dealing with a large structural fiscal deficit. The dimensions of the revenue decline grew during the course of the study. The Governor's January 9, 2009 budget message on the 2009–2010 budget stated that California faces the most challenging budget in its history. The combined effect of the structural deficit and the dramatic decline in revenues due to the international economic crisis have produced a two-year deficit of $65 billion—over half of the state's projected 2009–2010 revenues.

This report was prepared based on information obtained primarily in 2008. Continuing revenue shortfalls and increasing program caseloads significantly alter the environment on which the report and recommendations were developed. Since the report was submitted for review to state agency staff and members of the Finance Subcommittee of the Project's Advisory Committee, multiple spending reductions were proposed by the Administration and enacted by the Legislature.

The Amended Budget for FY 2009–2010 eliminates or reduces IHSS services to individuals with the lowest needs. Domestic and related services including housekeeping, meal preparation, food shopping and errands are eliminated for individuals whose needs are assessed at a functional index (FI) rank of 1, 2 or 3. The neediest individuals (with scores of 4 and 5) will continue to receive domestic and related services. This reduction will affect an estimated 97,000 IHSS participants.

The enacted budget for FY 2009–2010 eliminates all IHSS services to an estimated 36,000 recipients with functional index (FI) scores of 1.99 or below. The budget also reduces the State Supplementary Payment (SSP) payment standards to the levels that were in effect in 1983, which is the minimum level permitted by federal law.

Because of the ongoing nature of California's budget-balancing efforts and reduction implementation, it was not possible to update the program descriptions and expenditures. When the impact of the budget changes is known, we suggest that state officials and stakeholders review the recommendations in the context of the current programs and establish a strategic planning process to guide future policy and funding decisions.

It is clear that California's revenue outlook will not sustain the level of services currently offered to its residents. The long-term care system needs to change. The institutional bias and complex administrative structure limit opportunities to reduce the growth rate for long-term care spending. While recommendations included in the report require an initial investment, we believe that they will reduce the rate of long-term care spending growth over time. A recent study by Kaye et al. (2009)[1] found that states with well-established HCBS programs had much lower rates of spending growth compared to those with low HCBS spending. High rates of HCBS reduced spending for institutional care. The authors reported a lag of several years before

[1] Kaye, H., LaPlante, M. & Harrington, C. (January, 2009), *Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?* Health Affairs, Vol. 28, No. 1 pp. 262-272. An abstract of the article can be found at, retrieved on 1-11-09: http://content.healthaffairs.org/cgi/content/abstract/28/1/262.

institutional spending appeared to decline. California is considered an "expanding HCBS state" for services to older adults and individuals with disabilities and must continue to invest in HCBS to become a well-established HCBS state for individuals with developmental disabilities. The data used for the study do not include spending for targeted case management and personal care services covered by the In-Home Supportive Services Program for individuals with developmental disabilities.

California Community Choices

The California Health and Human Services Agency (CHHS) received a Systems Transformation Grant from the Centers for Medicare & Medicaid Services (CMS) in 2006. The grant supports the California Community Choices project (http://communitychoices.info), which is dedicated to increasing consumer access to home and community-based long-term care services and diverting persons with disabilities and older adults from unnecessary institutionalization through development of California's long-term care services and supports infrastructure. The Choices project includes a financing study of the state's long-term services and supports that examines the laws, regulations, policies and payment methodologies related to long-term care financing in California. The study was initiated to improve the state's understanding of the financial and structural barriers to increasing consumer access to home and community-based services and to provide recommendations that enable the state to more effectively manage the funding for long-term care supports that promote community living options.

The study was conducted by Robert Mollica, Senior Program Director at the National Academy for State Health Policy, and Leslie Hendrickson, Hendrickson Development.

Methodology

The project team obtained information about long-term care services and programs from interviews with state officials and stakeholders, public forums and a review of statutes, regulations, documents and data provided by state officials. During three site visits, we interviewed staff from CHHS, the Departments of Health Care Services, Aging, Social Services, Developmental Disabilities and Mental Health, as well as staff in the Department of Finance and the Legislative Analyst's Office.

The Community Choices Project has an advisory committee and three subcommittees. The Financing Subcommittee provided guidance and feedback on the study during discussions at quarterly meetings and regular conference calls.

The study focused primarily on state and federal funding sources of long-term care services including IHSS, Medi-Cal home and community-based services waiver programs, ADHC, developmental services and nursing facilities. The report does not include services funded by the Older Americans Act and briefly describes services from the Department of Mental Health.

We reviewed multiple studies and materials. The reports are included in Appendix A. For example, the reports included studies such as the May 2004 *Planning for an Aging California Population: Preparing for the "Aging Baby Boomers,*" which was prepared by a Strategic

Planning Advisory Committee formed by Assemblywoman Patty Berg. The focus of this report was broader than long-term care and identified a range of issues in health care, housing, transportation, employment, finance and retirement, wellness, workforce, financial abuse and long-term supports. Concerning long-term supports, the report concluded that California needed "policies and funding streams that promote non-institutional caregiving and creative community-based long-term care arrangements."[2] The report identified guiding principles and a series of key questions that need to be addressed but did not describe a plan for addressing them.

Organization of the Report

The report is organized by section.

- Section 1 presents an overview of long-term care services in California.
- Section 2 provides demographic data and estimates of the number of persons with disabilities in California.
- Section 3 describes program trends and includes descriptions of each home and community-based services program, caseload trends, expenditure data and other information.
- Section 4 describes services for persons with developmental disabilities.
- Section 5 discusses mental health services.
- Section 6 presents nursing facility supply and utilization information. It also compares historical spending for institutional care and home and community-based services.
- Section 7 describes nursing facility reimbursement and rate setting issues.
- Section 8 analyzes HCBS rate setting issues, cost avoidance and cost-effectiveness.
- Section 9 reviews fiscal incentives.
- Section 10 discusses community transition initiatives.
- Section 11 presents stakeholder feedback obtained through forums and an electronic survey.
- Section 12 presents the findings from the report.
- Section 13 describes the recommendations.

[2] *Planning for an Aging California Population: Preparing for the "Aging Baby Boomers."* (May 2004), Available at: http://www.nbrc.net/Links-pictures/AgingBabyBoomers.pdf.

Section 1: Overview

Long-term care covers institutional, residential, community and in-home services for persons of all ages with functional, cognitive or developmental disabilities. Medicaid is the primary payer for long-term care. Over 10 million persons in the U.S., about 5% of the total adult population, need assistance with activities of daily living (ADLs) such as bathing, dressing, eating, toileting and mobility and instrumental activities of daily living (IADLs) such as meal preparation, housekeeping, laundry, shopping, money management and transportation. 58% of those who receive services are age 65 or older and 42% are age 64 and younger.[3] Medicaid paid for 40% of all long-term care expenditures in 2006. In 2007, Medicaid spent $101 billion on long-term care for institutional and community services[4] and spending for Home and Community-Based Services (HCBS) to older adults by programs funded totally by state general revenues added another $1.2 billion.[5]

California has an array of programs and services for individuals with disabilities. The programs are located in multiple agencies, use different delivery systems and challenge consumers, family members, advocates and providers seeking to access and coordinate services. Previous reports on long-term care programs consistently concluded that programs operate in separate "silos" which create "fragmentation" and barriers to obtaining information and access to services, and that needed program services are not available statewide.

California spends more than $10 billion annually on long-term care and the majority of the funds pay for services in the community. The state provides extensive funding for home and community-based services. Over half of Medi-Cal long-term services spending pays for home and community-based services compared to the national average of 39%.[6] Beneficiaries that receive long-term care services incur high costs. Persons with disabilities and older adults comprise 24% of all Medicaid enrollees, yet they account for 70% of Medicaid expenditures.[7] Nationally, long-term care services account for 75% of the total expenditures and acute care services—physician, lab, x-ray, inpatient care and therapies—account for 25% of the total expenditures for persons using long-term care.[8] Yet the programs that cover the services for adults with physical disabilities and older adults appear to function independently, with separate delivery systems and management structures. Responsibilities for setting policy and managing programs are spread across multiple agencies.

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[3] *Medicaid and Long-Term Care Services and Supports.* Medicaid Facts. Kaiser Commission on Medicaid and the Uninsured. (February 2009), Access at: http://www.kff.org/medicaid/upload/2186_06.pdf.

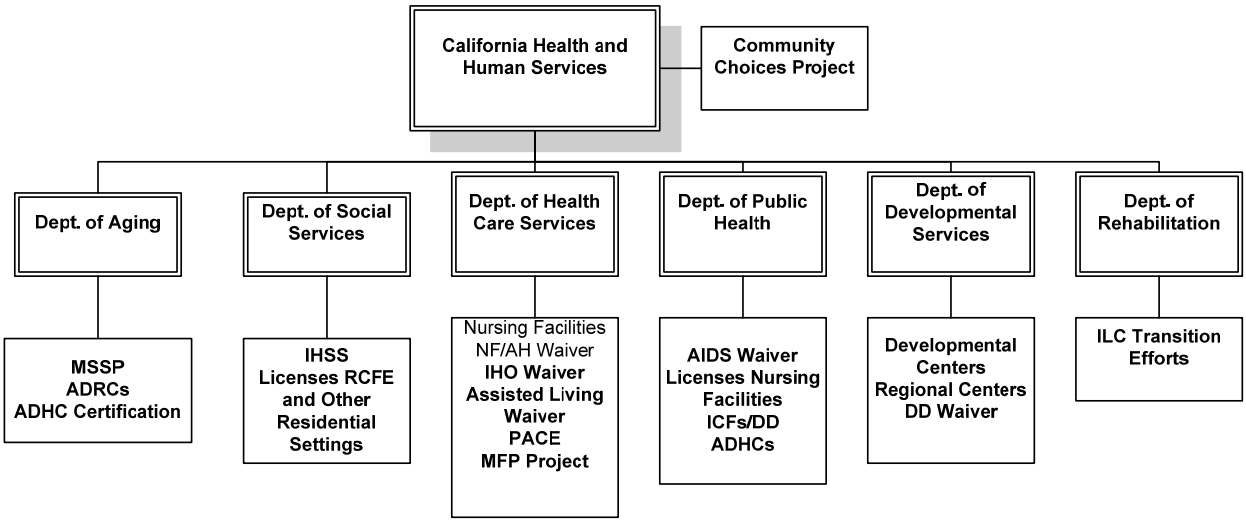
[4] Burwell, B., Sredl, K. & Eiken, S. (September 26, 2008), *Medicaid Long-Term Care Expenditures in FY 2007.* Report prepared under contract to the Centers for Medicare & Medicaid Services, Baltimore, MD retrieved on 12-11-2008: http://www.hcbs.org/files/145/7235/HCBSWaivers2007--Table1&Figures.xls.

[5] Mollica, R., Kassner, E., & Sims-Kastelein. (2009), State-Funded Home and Community-Based Services Programs for Older Adults (2007). AARP, Public Policy Institute. http://www.aarp.org/research/ppi/ltc/hcbs/articles/2009_06_hcbs.html.

[6] The comparison of California institutional vs. home and community spending is presented later in the report. See the section titled Nursing Home Trends.

[7] *The Medicaid Program at A Glance.* Medicaid Facts. Kaiser Commission on Medicaid and the Uninsured. (November, 2008), Available at: http://www.kff.org/medicaid/upload/7235_03-2.pdf.

[8] *Medicaid and Long-Term Care Services and Supports.* Medicaid Facts. Kaiser Commission on Medicaid and the Uninsured. (February, 2009), Available at: http://www.kff.org/medicaid/upload/2186_06.pdf.



- The California Department of Aging (CDA) manages the Multipurpose Senior Services Program (MSSP), certifies Adult Day Health Care (ADHC) providers, contracts for Aging and Disability Resource Connection (ADRC) programs and manages the Older Americans Act and the Older Californians Act programs.

- The Department of Social Services (DSS) manages the In-Home Supportive Services (IHSS) Program, the nation's largest program providing supportive personal care services in residential settings.

- The Department of Health Care Services (DHCS) manages nursing facility policy, three 1915(c) Waiver programs: nursing facility/acute hospital (NF/AH), In-Home Operations (IHO) and Assisted Living Waiver (ALW), plus the ADHC Program, the Program of All-Inclusive Care for the Elderly (PACE) and the Money Follows the Person (MFP) Rebalancing Demonstration.

- The Department of Public Health manages the Acquired Immune Deficiency Syndrome (AIDS) Waiver program and licenses nursing facilities, intermediate care facility services for the developmentally disabled (ICF-DD) and ADHC Centers.

- The Department of Rehabilitation (DOR) contracts with Independent Living Centers (ILCs) for nursing facility transition, and The Department of Developmental Services (DDS) manages institutional and community services for persons with developmental disabilities.

Unlike services for persons with developmental disabilities, programs for older adults and individuals with physical disabilities are administered by multiple organizations at the local or regional level. The absence of a consolidated organization (or single entry point), a unified database, and management structure means that consumers often cannot contact a single entity to receive information about their options, assess their service needs and access the appropriate service(s). Instead, consumers must contact different organizations for each program.

The California Community Choices project and the CDA are developing ADRCs to address the fragmentation. ADRCs provide information about the range of programs, services and eligibility requirements to help consumers make informed decisions. Where an ADRC also administers long-term care programs, access to community services is expedited.

Based in local communities, ADRCs will develop and implement consumer-centered, coordinated entry points to the long-term care support system for older adults, persons with disabilities and caregivers. They will support health and long-term care professionals and service providers who need information about available services and supports.

Four new regional ADRCs were operational in 2008. The first two, in Orange and Riverside counties, were awarded contracts under the Community Choices Project. Two additional ADRCs (one serving five north central rural counties and the other serving San Francisco County) were launched in Spring 2008 with funding from CDA. The two original ADRCs are located in San Diego and Del Norte counties, funded by CDA.

Strategic Plan

California does not have a strategic plan for long-term care that crosses state agencies. The DHCS developed a department-wide strategic and implementation plan in 2008 that includes long-term care components.[9] The plan describes the following California Health and Human Services Agency (CHHS) goal that guides DHCS' role: "disabled and aged Californians will have the opportunity to live in their own homes and communities (rather than institutional settings) in the most integrated setting possible." The plan describes DHCS core values that include:

> We provide community-based care alternatives to promote choice. We develop and implement care options to address the continuum of care needs from home care through hospital and skilled nursing care and adult day health care. We respect individuals' autonomy and self-determination.

The plan's goals and objectives are broad and apply to the full range of DHCS services and activities. The implementation plan includes seven actions designed to provide care in settings that promote community integration. The actions cover programs for which DHCS is responsible.

The plan proposed to:

- Provide HCBS through waivers and demonstration projects, allowing individuals to remain in their homes and promoting community integration
    - Establish additional sites for PACE

[9] Available at: http://www.dhcs.ca.gov/Pages/DHCSStrategicPlanandImplementationPlan.aspx.

- Maintain and evaluate operations for the AIDS Waiver

- Maximize the effectiveness of the NF/AH Waiver by ensuring ongoing state budget neutrality requirements are met and federal flexibilities (i.e. the Deficit Reduction Act HCBS State Plan Option) are maximized

- Develop a 1915(c) Self-Directed Services Waiver for individuals with developmental disabilities

- Maintain waiver operations for the MSSP

- Maintain waiver operations for the IHSS Plus Program and assess the feasibility of converting the waiver to a 1915(j) HCBS State Plan Option

- Fully implement the Assisted Living Waiver Pilot Project in the three selected counties

- Restructure the ADHC Benefit to comply with federal policy

    - Ensure provision of health care services to former consumers of Agnews Developmental Center who have moved into community homes (in collaboration with DDS, Bay Area regional centers and three Medi-Cal managed care health plans)

- In collaboration with the City and County of San Francisco, develop a program to provide community-living support benefits to Medi-Cal beneficiaries who reside in San Francisco

- Implement the MFP Rebalancing Demonstration

- Develop and implement the California Pathways Real Choice Systems Change Grant to develop and field test an assessment and transition protocol (known as the Preference Interview Tool) for nursing facility residents who choose to transition to community placement

- Provide oversight, monitoring and technical assistance to schools that provide assessments and direct health services to special education students

Section 2: Demographics

In 2007, California was home to 4.0 million persons age 65 and older, which was 11.0% of the total population. By 2010, the number of Californians age 65 and older will increase to 4.4 million and by 2030 to 8.3 million or 17.8% of all Californians. By comparison in 2007, Florida had 3.1 million persons age 65 and older, New York 2.5 million, Texas had 2.4 million and Pennsylvania had 1.9 million.

Nationally, one study states that about 5.3% of older persons in the 1990's used some form of long-term care residential services.[10] In California, persons age 75 and older make up a substantial proportion, 5.2%, of the total population and sixty-one percent of persons age 75 and older are female. Table 1 shows California-specific statistics.

Table 1: Numbers of Males and Females Age 75 and Older in California: 2006

California	Male	Female	Total	% of Total Population
Age 75-79	331,539	446,102	777,641	2.1%
Age 80-84	248,683	374,125	622,808	1.7%
Age 85 and over	173,810	350,634	524,444	1.4%
Subtotal	754,032	1,170,861	1,924,893	5.2%
Total Population	18,225,275	18,232,274	36,457,549	100%

Data Source: 2006 American Community Survey Table BO1001 Sex by Age

While California has more persons age 65 and older than other states, California ranked 46th in the percentage of the population over 65 in 2007 and 45th in the percentages of persons age 75 and older and age 85 and older. While relatively low compared to other states, California's population will age considerably. The percentage of persons age 65 and older will rise to 14.7% by 2020 and 17.8% by 2030. Nationally, 19.7% of the population will be age 65 and older. The age 85 and older group will increase from 1.3% in 2000 to 2.0% in 2020 and 2.5% in 2030, just under the national average of 2.5%. Florida ranked first in the percentage of its population age 65 and older, Pennsylvania ranked 3rd, New York ranked 21st, and Texas ranked 48th. See Appendix C for 2006 data by county.[11]

Projected population data for older age cohorts by county for the year 2010 and the percentage increases in these age cohorts between 2010 and 2020, and 2010 and 2030, are presented in Appendix C. The counties in the table are ranked by the percentage increases for persons age 85 and older between 2010 and 2030 as shown in the far right column.

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[10] Spillman, B. and Black, K., (January 4, 2006), *The Size of the Long-Term Care Population in Residential Care: A Review of Estimates and Methodology*, The Urban Institute, Health Policy Center, Washington, D.C. Retrieved on 12-31-08:http://aspe.hhs.gov/daltcp/reports/ltcpopsz.pdf.

[11] The table was constructed from the 2006 U.S. Census's American Community Survey. It presents county level data for all counties with more than 65,000 persons in them. Data for counties with fewer than 65,000 persons was obtained from: http://www.dof.ca.gov/HTML/DEMOGRAP/Data/RaceEthnic/Population-00-50/RaceData_2000-2050.php. The percentage of older persons was then calculated by the authors based on this data.

The demographic data predict a significant aging of California's population in the coming years. The number of persons age 85 and older will double in 19 counties from 2010 to 2030. The population of Californians age 75 and older will increase from approximately 2 million in 2010 to 4 million by 2030. The percentage of persons between age 75 and 79 will increase 119% between 2010 and 2030, while the percentage of persons between age 80 and 84 will increase 96%, and the percentage of persons age 85 and older will increase 72% over the 20-year period. In comparison, as the population age 75 and older doubles, the population age 74 years of age and younger will only increase 22%, from approximately 37.1 million in 2010 to 54.2 million in 2030.

Disability Prevalence in California

Disability and low income predict potential demand for long-term care services. The U.S. Census' American Community Survey collects annual data on disability prevalence, and its data for 2007 for California shows that approximately 1.87 million persons age six and older have one type of disability and 2.4 million persons have two or more types of disability.[12] A summary table of the number of persons with a disability by county is not available from the U.S. Census; however, county level tables are available.[13] Summary tables of the percentage of persons with a disability by county and age can be found at the 2007 American Community Survey site.[14]

The census data does not report the number of persons age four and younger with disabilities. This can be a large number, and some states have specialized programs for taking care of these younger persons, such as Florida's Blind Babies Program.[15]

Table 2: Percent and Number of Persons Age Five and Older in California with a Disability: 2007

2007 California Disability Populations	Total
Age five and older	33,321,461
Without any disability	87.2%
Number with one type of disability	1,866,002
With one type of disability	5.6%
Number with two or more types of disability	2,399,145
With two or more types of disabilities	7.2%

Data Source: 2007 U.S. Census, American Community Survey

[12] See 2007 American Community Survey statistics for California at: http://factfinder.census.gov/servlet/STTable?_bm=y&-qr_name=ACS_2007_1YR_G00_S1801&-geo_id=04000US06&-context=st&-ds_name=ACS_2007_1YR_G00_&-tree_id=307&-_lang=en&-format=&-CONTEXT=st.

[13] To find county-level statistics on the number of persons with a disability go to: http://factfinder.census.gov/servlet/AFFAdvSearchGeneralServlet?_lang=en&_sse=on and in the search box type: "California disability county".

[14] For example, the percentage of persons age 21-64 by county with a disability can be found at: http://factfinder.census.gov/servlet/GCTTable?_bm=y&-geo_id=04000US06&-_box_head_nbr=GCT1802&-ds_name=ACS_2006_EST_G00_&-_lang=en&-mt_name=ACS_2006_EST_G00_GCT1802_ST2&-format=ST-2

[15] See http://dbs.myflorida.com/cs/babies.shtml

Persons with disabilities are more likely to have low income. As shown in Table 3, the prevalence across all types of disability for persons below the poverty level is much higher: 15.2% have a sensory disability, 16.5% have a physical disability, 21.7% have a mental disability and 19% have a self-care disability. Just over 11% of the total California population is at or below the Federal Poverty Level (FPL).

Table 3: Disability Prevalence for Persons Age Five and Older below Poverty Level: 2007

2007 California Disability Populations	Total
Age five and older for whom a poverty status is determined	33,077,163
With any disability	4,253,321
Below poverty level	17.3%
With a sensory disability	1,195,648
Below poverty level	15.2%
With a physical disability	2,673,372
Below poverty level	16.5%
With a mental disability	1,683,865
Below poverty level	21.7%
With a self-care disability	935,335
Below poverty level	19.0%
No disability	28,823,842
Below poverty level	11.10%

Date Source: 2008 U.S. Census, American Community Survey

Disability increases with age. Table 4 highlights how large the differences are. The data shows potentially extensive demand for long-term care services. Excluding children, approximately 2.3 million Californians report some kind of disability. Another 3.9 million persons are age 65 and older, and 40.6% of the persons in this group report a disability.

Table 4: California Disability Prevalence by Age: 2007

2007 California Disability Populations	Population Age 16-64	Population Age 65 and Over
Number of persons	23,813,857	3,896,341
With any disability	10.20%	40.60%
With a sensory disability	2.20%	16.10%
With a physical disability	5.90%	31.10%
With a mental disability	4.00%	13.70%
With a self-care disability	1.80%	11.70%
With a go-outside-home disability	2.70%	19.20%
With an employment disability	5.90%	n/a

Data Source: 2007 U.S. Census, American Community Survey

Disability Prevalence in California as Limitations in Activities of Daily Living (ADLs)

Activities of Daily Living (ADLs) are defined as basic tasks performed during daily living such as bathing, dressing and grooming, eating, transferring in and out of bed, toileting and

mobility/walking. Most states collect information on these activities as part of a preadmission assessment screening for nursing facility admission and Medicaid home and community-based programs.[16] Information on these activities is also collected in Section G of the Federal Minimum Data Set (MDS) for nursing facility residents.[17]

All but three states use ADLs to determine Medicaid eligibility for nursing facility and home and community-based services.[18] Given that there are states that require two or more ADL limitations for Medicaid Waiver functional eligibility, this report assumes that anyone that needs assistance with two or more ADLs has a disability and consequently a need for long-term care services.

The Lewin Group uses "The HCBS Population Tool" to project ADL disability prevalence by age and income.[19] Applying this tool to California for persons age six and older at all income levels produces the following results. In the tables below, the calculations for 2010–2020 are made using the HCBS Population Tool, and the calculations for 2020 and 2025 are added by the authors. The intent of the HCBS Population Tool is to estimate the number of individuals living in the community who might use home and community-based services, and the tool excludes institutionalized individuals. Table 5 shows all persons regardless of income that are age six and older who have either a mental retardation or developmental disability or who have two or more ADL limitations.[20]

Table 5: Number of Persons Age Six and Older in California

Year	MR/DD	2+ ADLs	MR/DD or ADL Limitation	Total CA Population
2010	425,599	279,714	705,313	33,389,066
2015	441,332	312,645	753,976	35,155,705
2020	459,448	349,856	809,304	37,065,401
2025	475,975	384,214	860,189	38,879,726
2030	492,900	419,285	912,184	40,717,893

Data Source: The Lewin Group: The HCBS Population Tool[21]

[16] See Hendrickson, L. and Kyzr-Sheeley, G. (March, 2008), *Determining Medicaid Nursing Home Eligibility: A Survey of State Level of Care Assessment*, Rutgers University, Center for State Health Policy, New Brunswick, NJ. Retrieved on 1-3-08: http://www.cshp.rutgers.edu/cle/Products/Nursing%20Facility%20Level%20of%20Care%20FINAL.pdf.

[17] For a draft look at Section G of the new MDS 3.0 see: http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30FinalReport.pdf

[18] Hendrickson, L. and Kyzr-Sheeley ibid. Table 1.

[19] Available at: http://lewingroup.liquidweb.com/cgi-bin/woodwork.pl.

[20] The 425,599 persons in 2010 that are projected to have MR/DD may also include persons who have two or more ADL limitations. The 279,714 persons in 2010 with two or more ADL limitations exclude persons who also have MR/DD.

[21] Later in this report, data is presented showing the number of persons served by DDS which is lower than the estimated number of persons with developmental disabilities from Lewin's Population Tool which is based on U.S. Census data.

Table 6 shows the prevalence of individuals with mental retardation and developmental disabilities (MR/DD) and other individuals with two or more ADLs by age and income. The data below are for persons age six and older in households with income less than 100% of the Federal Poverty Level (FPL).

Table 6: Number of Persons Age Six and Older and with Incomes Less Than 100% of FPL in California with MR/DD and Two or More ADLs: 2010–2030

Year	MR/DD	2+ ADLs	MR/DD or ADL Limitation	Population Age Six and Older, Less Than 100% FPL	Total California Population
2010	73,801	50,870	124,671	4,681,504	33,389,066
2015	76,702	55,417	132,119	4,844,018	35,155,705
2020	80,456	60,300	140,756	5,052,203	37,065,401
2025	83,641	64,959	148,600	5,229,941	38,879,726
2030	86,969	69,674	156,643	5,415,290	40,717,893

Data Source: The Lewin Group: The HCBS Population Tool

Table 7 estimates the number of persons with impairments in one or more ADLs, which is more than double the number of persons with two or more ADLs. For example, in 2010 the number of non-institutionalized persons age six and older with income below 100% of the FPL and one or more limitations in ADLs is estimated to be 119,664 persons, 135% more than the number of individuals with two or more ADL limitations.

Table 7: Number of Persons Age Six and Older and with Incomes Less Than 100% of Federal Poverty Level in California with MR/DD and One or More ADLs: 2010–2030

Year	MR/DD	1+ ADL	MR/DD or ADL Limitation	Population Age Six or Older, Less Than 100% FPL	Total California Population
2010	73,801	119,664	193,465	4,681,504	33,389,066
2015	76,701	127,924	204,625	4,844,019	35,155,705
2020	80,456	137,420	217,876	5,052,203	37,065,401
2025	83,641	146,092	229,733	5,229,941	38,879,726
2030	86,969	154,970	241,939	5,415,291	40,717,893

Data Source: The Lewin Group, The HCBS Population Tool

Disability rates among older populations have declined and have been studied extensively in the last 20 years.[22] Table 8 shows national percentages of persons who have no disability and those who have ADL or Instrumental Activities of Daily Living (IADL) limitations.

[22] See the archived files of the Center for Demographic Studies at Duke University for a sample of this literature. Retrieved on 1-3-09: http://www.nltcs.aas.duke.edu/publications/search/search.htm.

Table 8: Percentages of Persons With and Without IADL and ADL Limitation: 1982–2004

Impairment Level	1982	1984	1989	1994	1999	2004/2005
No disability	73.5%	73.8%	75.2%	76.8%	78.8%	81.0%
IADL only	5.7%	6.0%	4.5%	4.4%	3.3%	2.4%
One or two ADLs	6.8%	6.9%	6.6%	6.1%	6.3%	5.6%
Three or four ADLs	2.9%	3.0%	3.7%	3.4%	3.7%	3.8%
Five or six ADLs	3.5%	3.3%	3.1%	2.9%	3.0%	3.2%
Institution	7.5%	7%	6.9%	6.3%	4.9%	4.0%
Per year declines		-0.6%	-1.1%	-1.3%	-1.8%	-2.2%

Data Source: National Long-Term Care Survey (NLTCS)

Declining disability rates have been attributed to the increased use of home and community-based services, expanded health insurance coverage, technological and pharmaceutical advances, and improved medical practices.[23] The impact of these changes has been taken into account in studies of nursing facility use and home and community-based service use.[24]

Estimating when or if the declining disability rate will slow down or cease poses a challenge to policy makers. A full discussion of the causality of declining disability is beyond the scope of this report. However, the significant questions are how low the disability prevalence will fall and how long the trend will continue.

Level of Care Criteria Considerations

Estimating potential demand or need for specific long-term care programs in California is difficult because the available data on the prevalence of functional impairments is not consistent with the level of care criteria required to enroll in a Medi-Cal Home and Community-Based Service (HCBS) Waiver. Disability data is not a good proxy for functional eligibility for waiver services. Figure 1 summarizes and compares the functional eligibility criteria for the Multipurpose Senior Services Program (MSSP), assisted living, nursing facility/acute hospital (NF/AH), In-Home Operations (IHO) and developmental disabilities 1915(c) Waivers, In-Home Supportive Services (IHSS) and Adult Day Health Care (ADHC). HCBS 1915(c) Waivers must, at a minimum, use the institutional level of care (nursing facility, hospital or Intermediate Care Facility for the Mentally Retarded (ICF/MR). The Deficit Reduction Act of 2005 creates a new HCBS option under the state plan, §1915(i), that allows states to set the level of care below institutional levels of care. A summary of §1915(i) is included in Appendix D.

Level of care criteria vary by program. Two waivers—MSSP and the Assisted Living Waiver (ALW)—serve participants who meet the nursing facility A and B criteria. Two other waivers serve persons with disabilities with more intensive medical conditions, and the level of care

[23] Manton, K., Gu, X. & Lamb, V. (2006), *Change in Chronic Disability from 1982 to 2004/2005 as Measured by Long-Term Changes in Function and Health in the Elderly Population*. Proceedings of the National Academy of Sciences. 103, no. 48, 18734-9.

[24] For example, see retrieved on 1-5-08: http://www.lewin.com/content/publications/NursingHomeUseTrendsPaperRev.pdf.

criteria are significantly different for these participants. The IHO Waiver services persons of any age that in the absence of the waiver, and as a matter of medical necessity, would require care in a nursing facility providing the following types of care: nursing facility distinct part, Nursing Facility (NF) Level B pediatric services, NF Subacute (NF/SA) services or NF Pediatric Subacute services.

The NF/AH Waiver also serves persons with physical disabilities without an age limit that meet the acute hospital, adult or pediatric subacute, nursing facility, distinct-part nursing facility, adult or pediatric Level B (skilled) nursing facility or Level A (intermediate) nursing facility level of care with the option of returning to and/or remaining in his/her home or home-like setting in the community in lieu of institutionalization.

The Developmentally Disabled (DD) Waiver serves persons with two or more developmental deficits that require predictable and scheduled skilled nursing needs. Although eligible for the DD Waiver, individuals at the Intermediate Care Facility Services for the Developmentally Disabled-Habilitation (ICF/DD-H) level of care seldom meet the medical criteria for enrollment on the NF/AH Waiver. On a medical acuity level, the ICF/DD-H level of care is generally lower than the NF/AH level of care. Persons also qualify if they meet the Intermediate Care Facility Services for the Developmentally Disabled-Nursing (ICF/DD-N) level of care, which requires the presence of two or more developmental deficits and the need for active nursing treatments and intermittent nursing services. Generally, individuals at the ICF/DD-N level of care will meet the medical criteria for enrollment on the NF/AH Waiver. On a medical acuity level, the ICF/DD-N level of care is generally higher than the NF/A level of care and may meet the criteria for NF/B level of care.

ADHC serves beneficiaries with one or more chronic or post-acute medical, mental health or cognitive conditions who are likely to deteriorate without monitoring, treatment or intervention; conditions that result in two ADL or IADL limitations, or require ongoing or intermittent protective supervision, skilled observation, assessment or intervention by a skilled health or mental health professional to improve, stabilize, maintain or minimize deterioration of the medical, cognitive or mental health condition.

IHSS serves participants with impairments in one or more ADLs and IADLs.

The level-of-care criterions used to determine eligibility for each program seem appropriate given the intended populations to be served and the program services to be provided.

Figure 1 provides brief descriptions of the levels of care used and comments from persons interviewed about differences in the levels. Readers who want a full description of each level are referred to Appendix F.

Figure 1: Comparison of Level of Care Criteria for Selected Programs

MSSP, ALW Waivers

NF-A: medical condition which needs an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration.

NF-B: medical condition which needs 24-hour skilled nursing care to render treatment for unpredictable, unscheduled and/or unmet nursing needs. Bedridden patients, quadriplegics and full-assist patients with excess ADL and IADL needs that exceed the capacity of the ICF and qualify for NF-B.

ADHC

One or more chronic or post-acute medical, mental health or cognitive conditions that are likely to deteriorate without monitoring, treatment or intervention; conditions resulting in two ADL or IADL limitations or require ongoing or intermittent protective supervision, skilled observation, assessment or intervention by a skilled health or mental health professional to improve, stabilize, maintain or minimize deterioration of the medical, cognitive or mental health condition.

IHO, NF/AH Waivers

Physically disabled (no age limit) requiring care in a nursing facility providing the following types of care: nursing facility distinct part; NF Level B pediatric services; NF subacute services; or NF pediatric subacute services.

DD Waiver

ICF-DD: need for specialized developmental and training services, the extent to which provisions of specialized developmental and training services can be expected to result in a higher level of functioning and a lessening dependence on others for ADLs; and has a qualifying developmental deficit in either a self-help area or social-emotional area.

ICF-DDH: presence of two or more developmental deficits and ***only*** predictable and scheduled skilled nursing needs. Although eligible for the DD Waiver, individuals at the ICF-DDH level of care (LOC) seldom meet the medical criteria for enrollment on the NF/AH Waiver. On a medical acuity level, the ICF-DDH Level of Care (LOC) is generally lower than NF-A LOC.

ICF-DDN: presence of two or more developmental deficits ***and*** recurring but intermittent nursing services. Examples include but are not limited to apnea monitoring, colostomy care, GT feedings and care and wound irrigation and dressing. Generally, individuals at the ICF-DDN LOC will meet the medical criteria for enrollment on the NF/AH Waiver. On a medical acuity level, the ICF-DDN LOC is generally higher than the NF-A LOC and may meet the criteria for NF-B LOC.

Section 3: Program Trends

The next section describes each program, the services covered, caseloads and spending trends.

In-Home Supportive Services (IHSS)

Personal care services are an optional Medi-Cal benefit, provided in California as the IHSS program. In 2005, 30 states reported personal care services expenditures. The Centers for Medicare & Medicaid Services (CMS) reimburses the state at the Federal Medical Assistance Percentage (FMAP) rate for expenditures, while the state of California pays 65% of the nonfederal share of costs through State General Funds, and counties pay the remaining 35% of the nonfederal share. The American Recovery and Reinvestment Act increases California's FMAP from 50% to 61.59% through December 31, 2010, which temporarily reduces the state and county shares.

IHSS is the largest personal care program in the country.

California's IHSS program is the largest personal care program in the nation. IHSS operates under two authorities—the Medi-Cal state plan and §1115 demonstration authority. A Medicaid State Plan Amendment that will cover services under §1915(j) was submitted to CMS. The IHSS program originally began in the late 1970s with state, county and federal Title IV-A (later the Social Services Block Grant program) funds.[25] The program, and most of the expenditures, converted to the Medi-Cal personal care option in 1993. Three components of the original program were not eligible for federal matching and were continued as a state and county funded IHSS residual program. The residual program was converted to the IHSS Plus program under §1115 demonstration authority in 2004.[26]

IHSS Eligibility

Any California resident living in his/her own home who meets functional eligibility requirements and one of the following income eligibility conditions is eligible for IHSS services:

- Currently receives Supplemental Security Income/State Supplement Program (SSI/SSP) benefits and Medi-Cal linked to SSI or 1619(b) Medi-Cal (the SSI working disabled category)
- Receives Medi-Cal with no share of cost including through institutional deeming, or the Continuous Eligibility for Children Program, or the Aged and Disabled Federal Poverty Level Program or the 250% Working Disabled Program[27]
- Receives Medi-Cal with a share of cost

[25] Newcomer, R. & Kang, T. (July, 2008), Analysis *of the California In-Home Supportive Services (IHSS) Plus Waiver Demonstration Program.* A report prepared under sub contract 5-312-208826 from the Research Triangle Institute, Research Triangle Park, NC. Retrieved on 3-09-19: http://aspe.hhs.gov/daltcp/reports/2008/ihssplus

[26] Ibid.

[27] http://www.disabilitybenefits101.org/ca/programs/health_coverage/medi_cal/ihss/faqs.htm#_q702.

The IHSS program is administered by counties with state oversight. IHSS serves individuals who need assistance with instrumental activities of daily living (meal preparation, housework, laundry and shopping) and activities of daily living (bathing, dressing, mobility, eating, using the toilet and transferring). Services covered by the IHSS program include domestic and related services (housework, shopping for food, meal preparation and laundry); nonmedical personal care services; transportation (such as accompaniment to medical appointments); paramedical services (necessary health care activities that recipients would normally perform for themselves were it not for their functional limitations) and protective supervision (for persons whose cognitive or mental functioning poses a risk to themselves). County social workers assess functional capacity and authorize services, but do not provide ongoing case management and do not have regular contact with participants.

As described by other researchers, the IHSS Plus Waiver covers activities which could not be covered under the state plan at the time: payments to parents and spouses for personal care, protective supervision, domestic and related services, restaurant meal vouchers and advance payments (funds paid in advance to support timely payments to providers who serve severely impaired participants).[28]

A detailed look at the characteristics and expenditures of the IHSS participants for 2005 and 2006 has been published, and readers are referred to this July 2008 study for comprehensive data on participant characteristics and expenditures.[29]

The IHSS caseload has expanded rapidly, growing 100% between January 2000 (220,816 persons served) and March 2009 (440,000 persons served).

Comparative national data from 30 states on the number of persons using personal care services is available for 1999–2005.[30] The data shows that the number of IHSS participants increased 78% (137,071 participants) compared to 50% nationally. Ten other states had higher percentage increases. California's program participation increased more than 78% compared to Alaska (121% - 1,500 participants), Massachusetts (270% - 10,049 participants), Maine (620% - 6,769 participants), New Mexico (989% - 9,614 participants), North Carolina (459% - 441,733 participants), Nevada (315% - 1,547 participants), Oregon (302% - 3,821 participants), Utah (870% - 1,574) and Washington (142% - 10,804 participants). Although these programs grew from a lower base, the growth rates were substantially greater than the growth rate in California. Michigan, a program with comparable functional eligibility criteria, had a caseload growth of 27% (79,180 participants) during the same period.[31]

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[28] Ibid. One reviewer said, "During the course of negotiating the IHSS Plus Waiver for parent/spouse providers, advance pay and meal allowance, the state also negotiated coverage of protective supervision and domestic and related services-only cases to be covered under the state plan."

[29] Newcomer, R. & Kang, T. (July, 2008), Op. cit.

[30] Ng, T., Harrington, C., and O'Malley, M. (2008, December), *Medicaid Home and Community-Based Services Programs: Data Update.* Kaiser Commission on Medicaid and the Uninsured. Washington, DC. http://www.kff.org/medicaid/7720.cfm

[31] Comparisons of persons using Medicaid State Plan personal care services in different states are difficult since some states provide personal care through 1915(c) waivers. Some researchers prefer to combine personal care and waiver statistics and make comparisons based on the combined totals. Data comparing state eligibility definitions and growth rates is not available.

The maximum number of service hours is capped at 283 per month. A 2008 study showed that in 2005 the average IHSS participant used substantially fewer than the maximum hours allowed by policy, ranging from approximately 60 hours to 115 hours, depending on the age, caregiver, and the physical and cognitive limitations of the IHSS participant.[32] These limits require that participants with higher functional needs that qualify for a home and community-based services (HCBS) Waiver receive services from two programs if their needs exceed the amount of services available through IHSS. Other participants who need the additional services offered by a waiver program may not be served due to limited funding. Stakeholders noted that an exceptions process is not available that would allow individuals with complex or very high service needs to receive additional services in lieu of seeking other services, perhaps through a waiver program.

IHSS Expenditure Analysis

The three cost components in the IHSS program are the number of persons receiving services, the cost per hour to provide the services and the number of hours of service provided.

Number of Persons Receiving IHSS

From July 2001-2008, the characteristics of IHSS participants have been quite stable. The age distribution of persons receiving services has not changed much: roughly 1% are age 6 and younger, 4% are age 7-18, 12% are age 19-44, 25% are age 45-64, 32% are age 65-79, and 26% are age 80 and older. The proportion of males and females was also stable. Roughly one-third of the persons receiving IHSS services are male and two-thirds are female.

The percentage of IHSS participants who also receive federal SSI payments decreased from 92% in 2001 to 88% in 2008. The percentages of aged, blind and disabled SSI recipients have been generally stable over the period 2001 through 2008. The percentage of IHSS SSI persons who are disabled increased modestly, from 51% in January 2001 to 55% by the end of 2008. This shift was gradual over the years. About 30,000 IHSS participants are developmentally disabled as of 2008.

A February 2000 report on IHSS caseloads from FY 1996–1997 through FY 1998–1999 also found that during the late 1990s the percentage of individuals with a disability rose gradually and the percentage of older persons declined.[33] The pattern observed during the previous decade appears to continue in this decade.

[32] Newcomer & Kang (July, 2008), Table 6.
[33] California Department of Social Services, (February, 2000), *In-Home Supportive Services: Examining Caseload and Costs during State Fiscal Year 1996-97 through 1998-99.* Research and Development Division, Sacramento, CA. p. 12.

IHSS participants are primarily older adults and women with disabilities living in poverty. Table 9 shows the average monthly caseload has steadily increased over the decade, growing 6.9% an average per year for a cumulative 48% growth over a seven-year period.[34]

Table 9: IHSS Caseload Growth: 2002–2008

Year	Caseload Average Month	Caseload % Change
2002	277,603	-
2003	306,542	10.42%
2004	326,127	6.39%
2005	344,569	5.65%
2006	360,759	4.70%
2007	384,674	6.63%
2008	411,706	7.03%
Seven-Year Total		48.31%
Average Per Year		6.90%

Data Source: California Department of Social Services

Regarding reasons for the caseload growth, persons interviewed cited the low functional eligibility required for services, the widespread knowledge about the program, the program's use of family and friends as caregivers, the statewide availability of services, the difficulty accessing HCBS Waivers, the program's well-established history and the administrative support provided for the program.[35]

The Cost per Hour for IHSS

Table 10 shows the cost per hour has grown an average 4.16% per year for a cumulative total growth of about 29% over the seven-year period 2002-2008.

[34] Data on average caseload for all months of 2000 and 2001 was not available, but the cumulative percentage growth would have been higher had average data for earlier years been available.
[35] A Google search for "IHSS California" yields 63,700 items.

Table 10: Growth in the Cost Per Hour: 2002–2008

Year	Cost Per Hour Average Month	Cost Per Hour % Change	California Inflation[36]
2002	$8.02		
2003	$8.63	7.60%	2.20%
2004	$8.84	2.37%	2.20%
2005	$9.29	5.07%	3.20%
2006	$9.62	3.58%	3.70%
2007	$10.03	4.26%	3.20%
2008	$10.36	3.30%	3.40%
Seven-Year Total		29.11%	
Average Per Year		4.16%	

Data Source: California Department of Social Services

Number of Hours of IHSS Services Provided

County social workers can authorize up to a maximum 283 hours of service per month per person based on the assessment. At 283 hours, California has a higher service authorization cap than almost all other states.[37] An exceptions process that would allow individuals with complex or very high service needs to receive additional services is not available. The average number of hours actually used in 2008 was 86 per month or 21.4 per week. The national average hours of assistance with ADLs and IADLs per week is about 31.4 hours, but this statistic includes both paid and unpaid hours of care (LaPlante et al., 2002). Average IHSS hours only include paid services. IHSS data provided by DSS found that 6% of IHSS participants received 200 or more hours of service in December 2008.[38] Table 11 shows that the average number of hours of IHSS service provided grew only 3.27% over the seven-year period.

[36]Sacramento Forecast Project, California State University at Sacramento. (January, 2009), See: http://www.csus.edu/indiv/j/jensena/sfp/ca/CALIF.htm.

[37] See Table 9 of Summer, L & Ihara, E (August, 2005), *The Medicaid Personal Care Services Benefit: Practices in States that Offer the Optional State Plan Benefit.* Georgetown University Health Policy Institute, Report prepared for AARP Public Policy Institute, Washington, D.C. Retrieved on 3-1-09: http://www.aarp.org/research/. The only state with a higher maximum number of authorized hours is the state of Washington which allows 420 hours per month.

[38] Interviews with key staffs about the IHSS program indicated that data is not available to determine whether those with severe disabilities receive an adequate amount of services in terms of hours to prevent or reduce institutionalization. Individuals with severe disabilities may receive HCBS Waiver services that supplement the IHSS program.

Table 11: Growth in the Average Number of Utilized Hours per Person: 2002–2008

Year	Hours Per Person Average Month	Hours Per Person % Change
2002	83.29	-
2003	83.51	0.27%
2004	83.32	-0.24%
2005	83.46	0.18%
2006	84.62	1.39%
2007	85.36	0.87%
2008	86.01	0.76%
Seven-Year Total		3.27%
Average Per Year		0.47%

Data Source: California Department of Social Services

IHSS Expenditures

Table 12 shows average monthly total fund expenditures by year. The expenditures incorporate the impact of the three cost components—the number of persons receiving services, the number of hours of service received and the average cost per hour. As shown in the tables above, the largest single factor is the caseload growth followed by the cost per case. Changes in the number of hours are not a significant factor in the expenditure growth rate. This pattern has been consistent since the 1990s.[39] Table 12 shows average monthly total fund expenditures by year. Expenditures almost doubled over the seven-year period, growing an average 14% each year.

Table 12: Growth in the Average Monthly Expenditures: 2002–2008

Year	Average Expenditures Per Month	Expenditures % Change
2002	$ 185,671,299	
2003	$ 221,126,365	19.10%
2004	$ 240,160,716	8.61%
2005	$ 267,007,463	11.18%
2006	$ 293,674,404	9.99%
2007	$ 329,416,442	12.17%
2008	$ 367,635,271	11.60%
Seven-Year Total		98.00%
Average Per Year		14.00%

Data Source: California Department of Social Services

[39] Ibid. The IHSS February 2000 report also found that both caseload and cost per hour went up in the late 1990s and utilization had small increases.

IHSS Functional Index

The IHSS program assigns each person served a "functional index" (FI) score, which is a measure of the amount of assistance the person needs in performing ADLs. The person's capabilities to perform these functions are ranked and a cumulative score is determined. Fourteen functions are listed in the Department of Social Services (DSS) manual:[40]

- Housework
- Laundry
- Shopping and errands
- Meal preparation and cleanup
- Mobility inside
- Bathing and grooming
- Dressing
- Bowel, bladder and menstrual
- Transfer
- Eating
- Respiration
- Memory
- Orientation
- Judgment

Social workers assess the person's functional capacity on the first 10 functions listed above using the following hierarchical five-point scale:

- Rank 1: Able to function independently without human assistance although the recipient may have difficulty in performing the function, but the completion of the function, with or without a device or mobility aid, poses no substantial risk to his/her safety. A recipient who ranks a "1" in any function shall not be authorized the correlated service activity.

- Rank 2: Able to perform a function, but needs verbal assistance, such as reminders, guidance or encouragement.

- Rank 3: Able to perform the function with some human assistance including, but not limited to, direct physical assistance from a provider.

[40] See California Department of Social Services. (July 1, 2008), *Social Services Standards: Service Program No. 7: In-Home Support Services,* Division 30, Section 30-756. Retrieved on 12-24-08 from: http://www.dss.cahwnet.gov/ord/PG310.htm.

- Rank 4: Able to perform a function but only with substantial human assistance.
- Rank 5: Unable to perform the function, with or without human assistance.[41]

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The five-point scale is not used for all functions. Only ranks 1, 2 and 5 are used with functions of memory, orientation and judgment, and only ranks 1 and 5 are used with the respiration function.

The ranks for the first 11 activities are weighted by hours of service and used to arrive at a total score for the person that varies from 1 to 5. Data from 2006 shows the IHSS population had the following distribution by FI score, which is a weighted average of the rank for each activity.[42]

Table 13: Distribution of IHSS Participants by Total Congregate Weighted Functional Index Score: May 2006

Total Congregate Weighted Functional Index Scores	Number	Percent
1–1.99	34,048	9.51%
2–2.99	167,717	46.86%
3–3.99	130,413	36.44%
4–4.99	24,947	6.97%
5	776	0.22%
Total Participants	357,901	100.00%

Data Source: California Assembly Budget Subcommittee, May 2006

The FI score is combined with the individual's needs, the number of persons living in the home and the home environment to determine the hours of service that are authorized. Two individuals with the same score may have different hours of service allocated based on their environment and the number of persons in the home. For example, someone living in a two-story house vs. a one-story house will probably receive more hours if they need assistance with transitioning from bed to chair, walking, ambulation, and so forth.

FI scores have changed over time. Table 14 shows the FI scores of persons who were new to the program during the month of June for the years 2000-2008. The data show the change in the program during the decade as new persons enrolling in the program have higher assessed impairment levels.

[41] Ibid. The functional index score is referred to by Department of Social Services staff as the "Total Congregate Weighted Score" to indicate it is the weighted average of all the ranks for each activity, as distinct from a rank on one of the activities. The description of the ranks is also taken from Section 30-756.
[42] See California Assembly Budget Subcommittee No. 1 on Health and Human Services Agenda on May 11, 2006. Retrieved on 12-24-08: www.assembly.ca.gov/acs/committee/c1/hearing/2006/may%2011%20butte.doc.

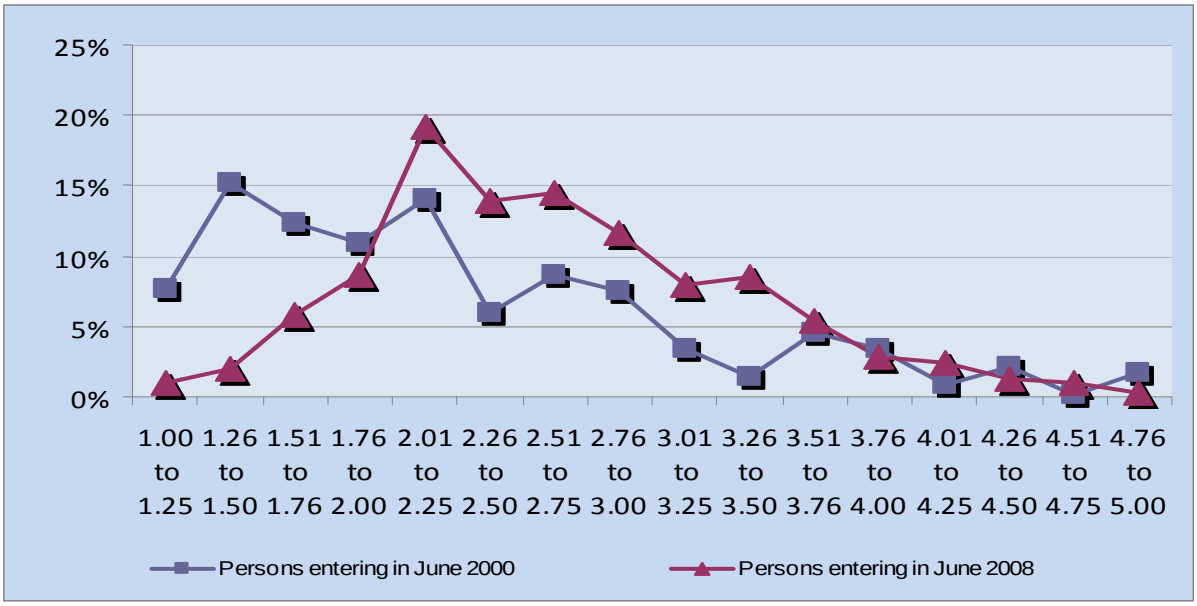
Table 14: Distribution of Functional Index Scores for IHSS Opened in June of Each Year: 2000–2008

% of Persons in FI Interval	Cases Open in June 2000	Cases Open in June 2001	Cases Open in June 2002	Cases Open in June 2003	Cases Open in June 2004	Cases Open in June 2005	Cases Open in June 2006	Cases Open in June 2007	Cases Open in June 2008
1.00 to 1.25	7.60%	1.20%	0.98%	0.76%	0.79%	0.85%	0.82%	1.19%	0.93%
1.26 to 1.50	15.20%	2.97%	2.79%	2.18%	1.71%	2.58%	2.28%	2.38%	1.98%
1.51 to 1.76	12.39%	6.04%	6.04%	6.17%	5.75%	5.14%	5.15%	5.20%	5.81%
1.76 to 2.00	10.96%	8.77%	9.47%	9.29%	7.92%	8.52%	8.01%	9.22%	8.65%
2.01 to 2.25	13.99%	12.29%	14.21%	15.13%	14.97%	14.63%	15.22%	18.60%	19.21%
2.26 to 2.50	5.93%	14.68%	14.01%	13.52%	13.75%	14.93%	14.40%	15.38%	13.99%
2.51 to 2.75	8.73%	14.09%	14.66%	15.08%	16.15%	15.85%	15.49%	14.17%	14.50%
2.76 to 3.00	7.46%	10.70%	11.00%	11.74%	13.03%	12.38%	12.04%	11.34%	11.62%
3.01 to 3.25	3.37%	8.11%	7.81%	7.87%	7.98%	7.88%	7.84%	7.62%	8.01%
3.26 to 3.50	1.41%	8.50%	8.31%	8.53%	8.67%	8.51%	9.27%	7.45%	8.52%
3.51 to 3.76	4.51%	4.85%	4.58%	4.94%	5.18%	5.05%	5.30%	5.10%	5.44%
3.76 to 4.00	3.45%	2.74%	2.58%	2.76%	2.48%	2.58%	2.72%	2.91%	2.77%
4.01 to 4.25	0.89%	2.39%	1.92%	1.98%	1.71%	1.52%	2.12%	2.26%	2.45%
4.26 to 4.50	2.18%	1.26%	1.38%	1.09%	0.99%	1.05%	1.07%	1.25%	1.26%
4.51 to 4.75	0.14%	1.48%	1.05%	1.11%	1.02%	0.79%	1.16%	1.14%	0.97%
4.76 to 5.00	1.77%	0.19%	0.20%	0.38%	0.20%	0.31%	0.30%	0.22%	0.24%
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Number	5,038	5,151	5,417	6,049	5,962	6,114	6,353	7,115	7,536

Source: Department of Social Services

Over time, the assessed impairment level of new participants increased. The figure below shows that the percentage of new participants with midrange FI scores was higher in 2008 than 2000. The percentage of persons at the upper end is about the same.

Figure 2: Percentage of Persons by Congregate Weighted Functional Index Score Level Entering IHSS: June 2000 vs. June 2008



Data Source: Department of Social Services

Medi-Cal Home and Community-Based Services (HCBS) Waiver Programs

Overview

Section 1915(c) of the Social Security Act, as amended by §2176 of the Omnibus Budget and Reconciliation Act of 1981, gave the Centers for Medicare & Medicaid Services (CMS) the authority to allow states to provide services that are not covered by a state's Medicaid program, such as personal care not covered by the state plan, home-delivered meals, adult day care, personal emergency response systems, respite care, environmental accessibility adaptations and other services approved by the Secretary of Health and Human Services (HHS) that are required to keep a person from being institutionalized.

Waivers allow states to limit the availability of services geographically, target specific populations or conditions, control the number of individuals served and cap overall expenditures which are not allowed under the Medicaid statute.[43] CMS may waive the following requirements:

[43] For a discussion of Section 2176, see Miller, N. (1992), Medicaid *2176 Home and Community-Based Care Waivers: The First Ten Years*. Health Affairs. Winter 1992. PP. 162-171 retrieved on 12-12-06: http://content.healthaffairs.org/cgi/reprint/11/4/162.pdf. Note: §2176 refers to the section of the law passed by Congress in 1981 that established the waiver authority.

- Statewideness—allows states to target waivers to particular areas of the state where the need is greatest, or perhaps where certain types of providers are available.

- Comparability of services—allows states to make waiver services available to persons at risk of institutionalization, without being required to make waiver services available to the Medicaid population at large. States use this authority to target services to particular groups, such as elderly individuals, technology-dependent children or persons with mental retardation or developmental disabilities. States may also target services on the basis of disease or condition, such as Acquired Immune Deficiency Syndrome (AIDS).

- Income and resource rules applicable in the community—allows states to provide Medicaid to persons who would otherwise be eligible only in an institutional setting, often due to the income and resources of a spouse or parent.

In December 1981, Oregon became the first state to implement an HCBS Waiver. Since then the use of HCBS Waivers has increased substantially, and by FFY 2007 there were approximately 331 HCBS Waivers with a total spending of about $27.5 billion.[44] As of October 2009, California had 25 Waivers, including 15 §1915(b) Freedom of Choice Waivers, three §1115 Demonstration Waivers, and seven 1915(c) HCBS Waivers.

The CMS 372 report is the standard federal reporting form for 1915(c) Waiver data. Unlike the CMS 64 form, the CMS 372 reports data on the unduplicated number of persons who use waiver services, the number of days of services provided and program expenditures.[45] The CMS 372 form also has a cost-neutrality test that compares the Medicaid expenditures for persons on the waiver with Medicaid expenditures for persons in an institution. The eligibility and cost-neutrality provisions assume that only persons who meet the eligibility requirements for being admitted to an institution can receive waiver services, i.e., receiving waiver services prevents institutionalization. Cost neutrality is also used to ensure that state Medicaid spending will not be higher under a §1915(c) waiver than it would in the absence of the waiver.

Data on each waiver follows.

[44] Burwell, B., Sredl, K. & Eiken, S. (September 26, 2008), *Medicaid Long-Term Care Expenditures in FY 2007.* Report prepared under contract to the Centers for Medicare & Medicaid Services, Baltimore, MD retrieved on 12-11-2008: http://www.hcbs.org/files/145/7235/HCBSWaivers2007--Table1&Figures.xls.

[45] Waiver staffs in the Department of Health Care Services keep excellent data on the persons, costs and utilization of waiver services and the authors are appreciative of the help these staffs provided. Data on the 372 reports was obtained from the file copies, supplemented by data from Excel spreadsheets. States send CMS an "initial" 372 six months after the end of the reporting period and a "lag" report 12 months after the end of the reporting period. California's historical records, like other states, contain a mix of initial, lag and combined data where combined means only one report was issued for the year. Where possible, data from the lag or combined reports was used to construct the tables.

Acquired Immune Deficiency Syndrome (AIDS) Waiver

Background

Since reporting AIDS data began in California in March 1983, approximately 153,232 persons have been reported as having AIDS, of whom 67,236 are still alive.[46] Approximately 2,500 persons have been served each year through the AIDS Waiver.

The state's 2006 HIV/AIDS Plan indicates how the waiver fits into the services the state uses to prevent and treat HIV and AIDS.[47] The state has a Case Management Program (CMP) that supports the provision of home and community-based services to persons with AIDS or symptomatic HIV infection that would otherwise go to hospitals, emergency rooms and nursing facilities. The CMP program is paid for with state general funds and Part B federal funding. The AIDS Medi-Cal Waiver Program (MCWP) provides comprehensive case management and direct care services to persons with HIV Disease or AIDS with current symptoms related to HIV Disease, AIDS or HIV Disease/AIDS treatment to allow these individuals to remain in their homes, stabilize their health, improve their quality of life and avoid costly institutional care.

In general, MCWP clients have more cognitive and functional impairments than those in the AIDS CMP. The co-existence of CMP and MCWP in the same agency allows CMP clients who become eligible for MCWP services to continue receiving home care without an interruption of services and care providers.

Population Served

The AIDS Waiver serves persons that meet clinical qualifications for nursing facility admission, meet income eligibility qualifications for Medi-Cal, have a diagnosis of HIV disease or AIDS and live in a setting where in-home services can be provided. The AIDS Waiver serves both children and adults.[48] (See Table 15.) The waiver is administered by the Department of Public Health/Office of AIDS through an inter-agency agreement with the Department of Health Care Services (DHCS).

Services

The waiver covers case management, homemaker services, home health aide services, attendant care, psychotherapy, Medi-Cal supplements for infants and children in foster care, non-emergency medical transportation, nutritional counseling, nutritional supplements, home-delivered meals, skilled nursing (registered nurse/licensed vocational nurse), specialized medical equipment/supplies and minor physical adaptations to the home.

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[46] California Department of Public Health, Office of AIDS, HIV/AIDS Case Registry Section, data as of April 30, 2009. See April 2009 *HIV/AIDS Surveillance in California* report retrieved on 9-27-09: http://www.cdph.ca.gov/data/statistics/Pages/OA2009MonthlyStatistics.aspx

[47] California Health and Human Services Agency, (2006, February), *California Comprehensive Plan Update for HIV/AIDS Care and Treatment Services*. Sacramento, CA. Retrieved on 12-12-08: http://choicehiv.org/community_planning/comp_hiv_prev_plan.pdf.

[48] A list of eligibility requirements is available at: http://www.dhcs.ca.gov/SERVICES/MEDI-CAL/Pages/AIDSMedi-CalWaiver.aspx.

Program Trends

As shown in Table 15, the number of persons served peaked at 3,021 in 1996 and dropped to 2,495 in 2006. The cost per person rose 29.5% between 1994 and 2006 and the average waiver days per person increased 75.6%.

Table 15: CMS 372 Data for Unduplicated Persons, Expenditures and Waiver Days for the Acquired Immune Deficiency (AIDS) Waiver: CY 1994–2006

Reporting Period	Unduplicated Persons	Cost Per Person	Expenditures	Waiver Days	Days Per Person
CY 1994	2,538	$ 3,217	$ 8,165,377	372,924	147
CY 1995	2,962	$ 3,226	$ 9,556,858	459,788	155
CY 1996	3,021	$ 3,377	$ 10,202,811	573,095	190
CY 1997	2,669	$ 3,380	$ 9,020,616	584,748	219
CY 1998	2,497	$ 3,623	$ 9,046,551	571,537	229
CY 1999	2,619	$ 3,572	$ 9,355,068	616,061	235
CY 2000	2,518	$ 3,694	$ 9,301,567	612,352	243
CY 2001	2,453	$ 3,375	$ 8,278,705	627,670	256
CY 2002	2,852	$ 3,907	$ 11,143,320	870,441	305
CY 2003	2,846	$ 3,935	$ 11,198,013	906,897	319
CY 2004	2,830	$ 4,052	$ 11,465,910	875,675	309
CY 2005	2,882	$ 4,136	$ 11,918,560	748,495	260
CY 2006	2,495	$ 4,050	$ 10,103,726	643,624	258

Data Source: Department of Health Care Services

Table 16 presents the data in year-to-year percentage changes. Table 17 shows that from 1994 to 2006 the number of unduplicated persons served has only increased 1.7%. Enrollment in this waiver has been flat. However, the absence of change in the number of persons enrolled is misleading. The average person is now using 75% more days of service and the cost per average person is up 25%. The program appears to have gradually evolved into taking care of persons with more serious medical needs.

Table 16: Annual Percentage Changes in the Acquired Immune Deficiency (AIDS) Waiver Participants, Costs and Waiver Days: 1994–2006

Reporting Period	Unduplicated Persons	Cost Per Person	Expenditures	Waiver Days	Days Per Person
1994–1995	16.7%	0.3%	17.0%	23.3%	5.6%
1995–1996	2.0%	4.7%	6.8%	24.6%	22.2%
1996–1997	-11.7%	0.1%	-11.6%	2.0%	15.5%
1997–1998	-6.4%	7.2%	0.3%	-2.3%	4.5%
1998–1999	4.9%	-1.4%	3.4%	7.8%	2.8%
1999–2000	-3.9%	3.4%	-0.6%	-0.6%	3.4%
2000–2001	-2.6%	-8.6%	-11.0%	2.5%	5.2%
2001–2002	16.3%	15.8%	34.6%	38.7%	19.3%
2002–2003	-0.2%	0.7%	0.5%	4.2%	4.4%

Reporting Period	Unduplicated Persons	Cost Per Person	Expenditures	Waiver Days	Days Per Person
2003–2004	-0.6%	3.0%	2.4%	-3.4%	-2.9%
2004–2005	1.8%	2.1%	3.9%	-14.5%	-16.1%
2005–2006	-13.4%	-2.1%	-15.2%	-14.0%	-0.7%
% Change 1994-2006	-1.7%	25.9%	23.7%	72.6%	75.6%

Data Source: Department of Health Care Services, percentages calculated by authors

Table 17 shows the services, persons and expenditures provided under the AIDS Waiver during CY 2006. Everyone received case management services, 44% received non-emergency medical transportation, 35% received nutritional supplements or home-delivered meals, and 30% received attendant care. About 87% of the money was spent on three services: 50% on case management, 26% on attendant care and 11% on homemaker services.

Table 17: CMS 372 Data for Services, Unduplicated Persons and Expenditures for the Acquired Immune Deficiency (AIDS) Waiver: CY 2006

Services Categories	Unduplicated Persons	% of Unduplicated Persons	Expenditures	% of Total Expenditures
Case Management	2,488	99.72%	$ 5,163,001	51.10%
Skilled Nursing	83	3.33%	$ 103,618	1.03%
Attendant Care	732	29.34%	$ 2,631,202	26.04%
Psychosocial Counseling	275	11.02%	$ 315,582	3.12%
Homemaker Services	394	15.79%	$ 1,131,575	11.20%
Minor Physical Adaptations to the Home	85	3.41%	$ 10,584	0.10%
Medi-Cal Supplement for Infants and Children in Foster Care	4	0.16%	$ 4,946	0.05%
Non-Emergency Medical Transportation	1,096	43.93%	$ 215,294	2.13%
Nutritional Counseling	94	3.77%	$ 7,039	0.07%
Nutritional Supplements/Home-Delivered Meals	873	34.99%	$ 520,885	5.16%
Total Expenditures			$ 10,103,726	100%
Total Unduplicated Persons	2,495			
Average Per Capita Expenditures			$ 4,050	

Data Source: Department of Health Care Services

CMS requires that waivers prove their cost neutrality and the CMS 372 form also reports on cost neutrality. The 2006 combined CMS 372 for the AIDS Waiver showed a savings of $51,000 per person.

Multipurpose Senior Services Program (MSSP) Waiver

Background

The MSSP provides care management, adult day care, housing assistance, chore and personal care services (if they have used the allocated IHSS service hours), protective supervision, respite, transportation, meal services, social services and communication services.

Services are administered by the California Department of Aging (CDA) through 41 regional contractors. MSSP services are not available in eight counties. The approved waiver allows up to 16,335 participants to be served. Care managers assist clients in gaining access to waiver and other Medi-Cal State Plan services, as well as medical, social and other services, regardless of the funding source. Care managers are responsible for ongoing monitoring of services included in the client's care plan. Additionally, care managers initiate and oversee the process of assessment and reassessment of client level of care and the monthly review of care plans.

The program converted from a state-funded demonstration to a §1915(c) Waiver in 1983. Table 19 presents 12 years of data for the MSSP Waiver.

Population Served

The MSSP Waiver serves persons who meet clinical qualifications for nursing facility admission, meet income eligibility qualifications for Medi-Cal, are age 65 and older and reside in a county with an MSSP provider.[49] Beneficiaries are eligible if they receive SSI, SSP, are Medically Needy or have income below 100% of the FPL. The waiver allows care managers to assist beneficiaries in a hospital or nursing facility, and who are not enrolled in MSSP, to relocate to the community. However, this service is not widely used. Case managers do continue to serve MSSP participants who are admitted to a hospital or nursing facility to return home.

Program Trends

Enrollment in MSSP peaked in FY 2003 with 14,182 participants and declined slightly to 13,840 in FY 2006. The average cost per person rose 22.7% between FY 1995 and FY 2006 due primarily to the increase in case management costs. The average cost was $3,085 in FY 2006 compared to $2,513 in FY 1995. The average number of waiver days in FY 2006 was 281, down from the peak of 325 in FY 2003.

[49] A list of eligibility requirements is available at http://www.dhcs.ca.gov/services/medi-cal/Pages/MSSPMedi-CalWaiver.aspx#eligibility.

Table 18: CMS 372 Data for Unduplicated Persons, Expenditures and Waiver Days for the Multipurpose Senior Services Program (MSSP) Waiver: FY 1995–2006

Reporting Period	Unduplicated Persons	Cost Per Person	Expenditures	Waiver Days	Days Per Person
FY 1995	8,022	$2,513	$20,155,838	2,010,559	251
FY 1996	8,076	$2,506	$20,237,372	2,040,399	253
FY 1997	8,004	$2,583	$20,670,930	1,994,869	249
FY 1998	7,890	$2,627	$20,725,898	1,988,106	252
FY 1999	8,489	$2,496	$21,189,029	2,183,784	257
FY 2000	10,781	$2,650	$28,574,637	2,742,449	254
FY 2001	12,070	$2,728	$32,926,380	3,446,569	286
FY 2002	14,042	$2,732	$38,362,112	4,236,309	302
FY 2003	14,182	$2,967	$42,074,566	4,611,665	325
FY 2004	13,889	$2,962	$41,136,375	4,438,928	320
FY 2005	13,911	$2,974	$41,373,584	4,448,074	320
FY 2006	13,840	$3,085	$42,699,627	3,885,988	281

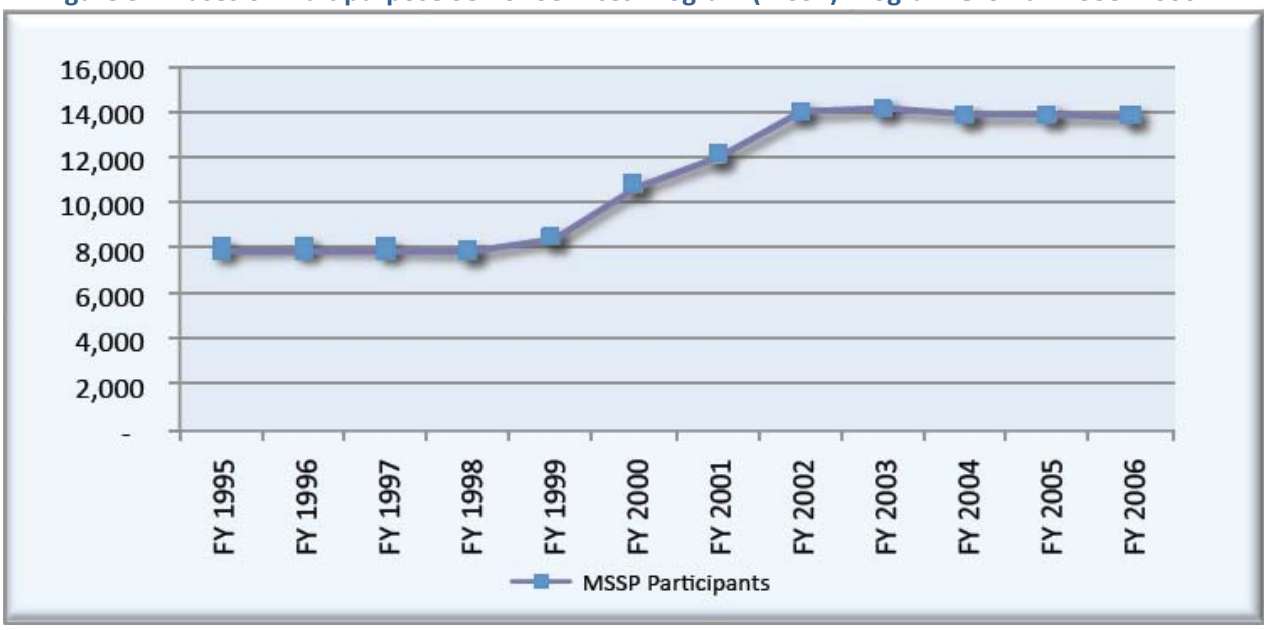
Data Source: Department of Health Care Services

The expenditures do not include funds contributed by local program operators, many of whom contribute significant additional cash and in-kind resources to meet the MSSP staffing and program requirements.

Figure 3 tracks the number of participants over time in the MSSP Waiver. The program's growth is driven by three components. As shown in Table 19, from 1996 to 2006 the number of participants increased by over 72%, the cost per person rose 22.8% and the days per person increased 12%. However, the growth has been uneven. As shown in Figure 3, the number of participants served went through three phases. It was level from 1995 to 1999, substantially increased from 1999 to 2002 and has remained level since 2003. The MSSP Waiver received additional funding in 2000 to add 22 sites to support expansion to cover those who are most in need in each region of the state.

In 2008, seven county MSSP sites submitted notice to the CDA of their intent to cancel their contracts. The counties cited rising costs, stagnant or decreasing program funding and increased need for county financial support as reasons for their decisions to terminate their contracts. In response, the department procured new contracts to serve all but one of these counties.

Figure 3: Phases of Multipurpose Senior Services Program (MSSP) Program Growth: 1995–2006



Data Source: Department of Health Care Services

One indicator of a flat-funded program is the existence of waiting lists.[50] For example, in 2006 the Assessment/Transition Work Group of the Olmstead Advisory Committee reported that both the Nursing Facility (NF) A/B and MSSP Waiver programs were operating at full capacity with waiting lists and said that "providing ongoing case management to current waiver enrollees consumes most allocated resources allowing few, if any, resources to be available for new caseload for transitional care planning. [51]" The report noted that even if additional resources were made available, additional training on transition coordination is needed. As a result, the current waivers do not have the capacity to provide transitional care planning services to residents of nursing facilities.

Another indicator of a level-funded program is the application of cost-of-living increases. The agencies providing the case management receive an amount per person served. These amounts were held constant from about 1988 to 1998, when an increase was granted. The next increase did not occur until 2006, when the amount was raised 13.5% from $3,776 per person to $4,285.

[50] Some data exists about waiting lists in California. See Table 11 in Ng, T., Harrington, C., and O'Malley, M. (2008), *Medicaid Home and Community-Based Service Programs: Data Update.* Report prepared for the Kaiser Commission on Medicaid and the Uninsured,. December. Washington, DC. http://www.kff.org/medicaid/upload/7720_02.pdf.

[51] Assessment/Transition Work Group (September 15, 2006), *Assessment/Transition Work Group Policy Priorities. Olmstead Advisory Committee Meeting Presentation to Full Committee*, Sacramento, CA. Retrieved on 12-12-08: http://www.chhs.ca.gov/initiatives/Olmstead/Documents/Assessment%20Transition%20Work%20Group%20Policy%20Priorities-%209-15-06.pdf.

Table 19: Year-to-Year Percentage Changes in the Multipurpose Senior Services Program (MSSP) Waiver Persons, Costs and Waiver Days: 1995–2006

Reporting Period	Unduplicated Persons	Cost Per person	Expenditures	Waiver Days	Days Per Person
1995–1996	0.7%	-0.3%	0.4%	1.5%	0.8%
1996–1997	-0.9%	3.1%	2.1%	-2.2%	-1.4%
1997–1998	-1.4%	1.7%	0.3%	-0.3%	1.1%
1998–1999	7.6%	-5.0%	2.2%	9.8%	2.1%
1999–2000	27.0%	6.2%	34.9%	25.6%	-1.1%
2000–2001	12.0%	2.9%	15.2%	25.7%	12.3%
2001–2002	16.3%	0.1%	16.5%	22.9%	5.7%
2002–2003	1.0%	8.6%	9.7%	8.9%	7.8%
2003–2004	-2.1%	-0.2%	-2.2%	-3.7%	-1.7%
2004–2005	0.2%	0.4%	0.6%	0.2%	0.0%
2005–2006	-0.5%	3.7%	3.2%	-12.6%	-12.2%
% Change 1995-2006	72.5%	22.8%	111.8%	93.3%	12.0%

Data Source: Department of Health Care Services, percentages calculated by authors

The 2005-2006 data show a decline of 12% in the average number of days a person stays on the waiver and a drop of about 562,000 days of service from 4,448,074 in 2005 to 3,885,988 in 2006.

Table 20 shows MSSP Waiver services utilization data for FFY 2006. In 2006, approximately 77% of all expenditures paid for care management. A review of care management spending since 1994 shows that the percentage of funds spent on care management has grown from 72% in 1994 to 77% in 2006. In a program that is level funded, this suggests that the contractors may have gradually reduced services in order to maintain labor-intensive care management.

Almost all of the MSSP Waiver participants also receive personal care services through the state's IHSS program. When considered in conjunction with IHSS, the MSSP program provides monthly case management, which is not available from IHSS, additional hours of in-home service, respite care hours beyond those authorized by IHSS, housing assistance and Personal Emergency Response Systems (PERS) that IHSS does not provide. A true expenditure mix would include IHSS; however, IHSS expenditures for MSSP participants were not available. If IHSS personal care expenditures were included, the percentage of funds spent on care management would likely decline.

The other 23% of expenditures were spread over the remaining services. Four other services are used by more than 25% of the unduplicated persons: 54% use special communications, 40% receive housing assistance, 28% use transportation and 26% use waiver funded in-home supportive services in addition to personal care provided through IHSS.

Table 20: CMS 372 Multipurpose Senior Services Program (MSSP) Data for Services, Unduplicated Persons and Expenditures: FFY 2006

Services Categories	Unduplicated Persons	% of Unduplicated Persons	Expenditures	% of Total Expenditures
Adult Social Day Care/Adult Day Support Center	154	1.11%	$ 377,866	0.88%
Care/Case Management	13,827	99.91%	$ 32,910,453	77.07%
Health Care				
Housing Assistance	5,593	40.41%	$ 1,664,463	3.90%
In-Home Supportive Services	3,580	25.87%	$ 2,302,902	5.39%
Meal Service	1,828	13.21%	$ 752,117	1.76%
Money Management				
Professional Care Assistance				
Protective Services/Supervision	481	3.48%	$ 258,020	0.60%
Respite Care	929	6.71%	$ 1,220,664	2.86%
Social Assurance				
Special Communications	7,526	54.38%	$ 1,715,019	4.02%
Therapeutic Counseling				
Transitional Care/Case Management (aka, Transitional Deinstitutional Care)	7	0.0%	$ 25,544	0.06%
Transportation	3,829	27.66%	$ 1,472,579	3.45%
Total Expenditures			$ 42,699,627	100%
Total Unduplicated Persons	13,840			
Average Per Capita Expenditures			$ 3,085	

Data Source: Department of Health Care Services

Housing assistance includes minor home modifications, home equipment such as microwaves, emergency utility assistance and temporary moving and relocation assistance. The other large category is special communications. The majority of expenditures under special communications are for PERS and for interpretation and translation expenses.

CMS requires that waivers demonstrate that they are cost neutral and the CMS 372 form also reports on cost neutrality. The CMS 372 FY 2006 Lag Report for the MSSP Waiver showed a savings of approximately $18,500 per person.

Developmentally Disabled (DD) Waiver

Background

Services for individuals with developmental disabilities are delivered through contracts between the Department of Developmental Services (DDS) and 21 regional centers.

The first two regional centers, in Los Angeles and San Francisco, were established in 1966 as regional pilots. In 1969, the Lanterman Mental Retardation Services Act extended regional center services throughout California. In 1973, eligibility for regional center services was expanded beyond mental retardation to include individuals with cerebral palsy, epilepsy, autism

and other neurological handicapping conditions closely related to mental retardation. In 1983, the state obtained CMS approval for a §1915(c) Waiver for individuals with a developmental disability.

The centers are responsible for the provision of outreach, intake, assessment, evaluation and diagnostic services, preventive services and case management/service coordination for persons with developmental disabilities. The waiver covers homemaker services, home health aide services, respite care, habilitation (residential habilitation for children's services, day habilitation, prevocational services, supported employment services), environmental accessibility adaptations, skilled nursing, transportation, specialized medical equipment/supplies, chore services, personal emergency response systems (PERS), family training, adult residential care (adult foster care, assisted living, supported living services), vehicle adaptations, communication aides, crisis intervention (crisis intervention facility services, mobile crisis intervention), nutritional consultation, behavior intervention services, specialized therapeutic services, transition/set-up expenses and habilitation.

For example, Supported Living Services (SLS) are services to adults with developmental disabilities who, through the Individual Program Plan (IPP) process, choose to live in homes they themselves own or lease in the community. SLS may include assistance with:

- Selecting and moving into a home
- Choosing personal attendants and housemates
- Acquiring household furnishings
- Performing common daily living activities and handling emergencies
- Becoming a participating member in community life
- Managing personal financial affairs

Population Served

- As described in the HCBS application, to be eligible for the DD Waiver, applicants must meet the clinical qualifications for admission to an intermediate care facility for the mentally retarded (ICF/MR), which in California can consist of three levels of care:

    - Intermediate care facility services for the developmentally disabled (ICF/DD), pursuant to Title 22, California Code of Regulations (CCR), §51343

    - Intermediate care facility services for the developmentally disabled-habilitation (ICF/DD-H), pursuant to Title 22, California Code of Regulations (CCR), §51343.1

    - Intermediate care facility services for the developmentally disabled-nursing (ICF/DD-N), pursuant to Title 22, California Code of Regulations (CCR), §51343.2

Applicants must also meet income eligibility qualifications for Medi-Cal, receive services from a regional center and have a diagnosis of a developmental disability that originates before age 18. The DD Waiver is the largest of the state's waivers.

Program Trends

In 2007, California spent more on community services for persons with developmental disabilities, 62%, including waiver and IHSS, than on institutional care, 38%. The figures do not include approximately $292 million for targeted case management and $14 million for clinical services, which shifts the percentages to 34% for institutional care and 66% for HCBS. Additional HCBS expenditures from the general fund for services that are not covered by the HCBS Waiver or for persons who are not eligible for Medi-Cal shift the balance further.

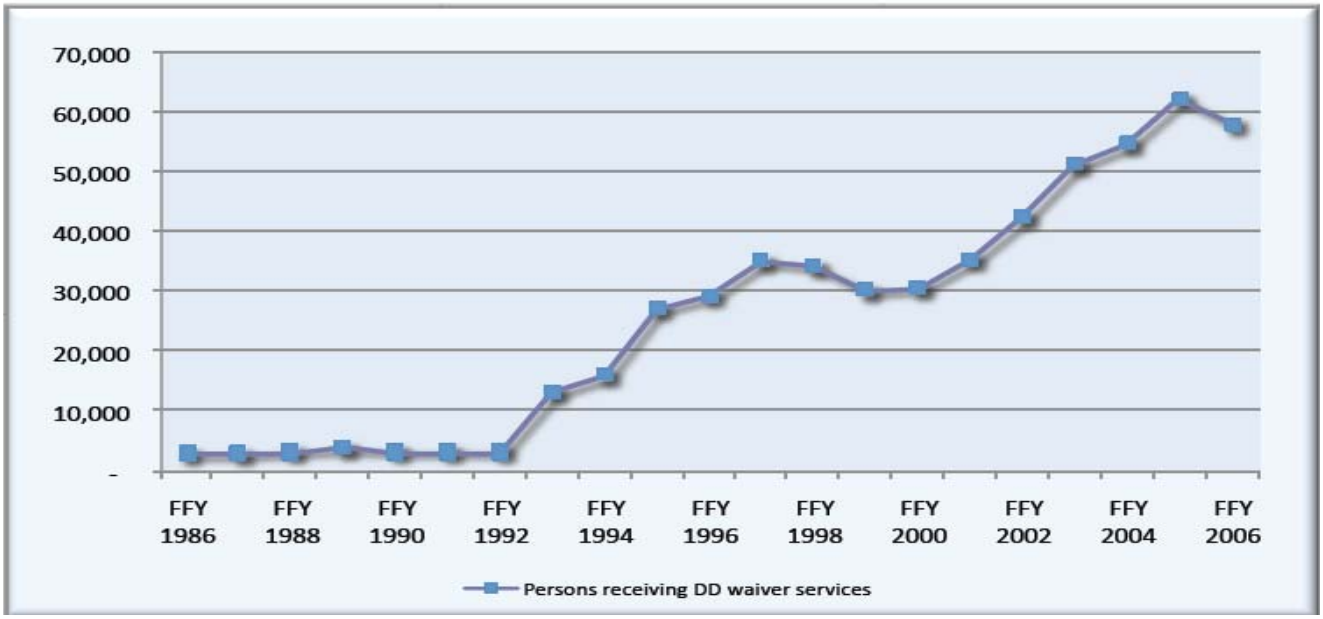
The national average for HCBS spending is 63%. Oregon spends 100% on HCBS and seven other states (Alaska, New Hampshire, Rhode Island, New Mexico, Hawaii, Colorado and Michigan) spend more than 90% of their funds on HCBS. A total of 14 states spend 80% of their funds on HCBS. California ranks 44th nationally in per capita waiver spending for persons with developmental disabilities and 33rd in per capita spending for intermediate care facilities for the mentally retarded (ICF/MRs).[52]

From FFY 1987 to FFY 2006 the number of participants rose about 2,000%, from roughly 3,000 to 58,000. The growth has been uneven. Enrollment was stable between 1986 and 1992. In 1992 the caseload was 3,344. Enrollment expanded between 1993 and 1997 when the caseload reached 35,000. The caseload went flat in 1997 because of the federal Medicaid agency's concern with quality and administration of the waiver. CMS froze waiver enrollment in December 1997 and did not lift the freeze until October 2000.[53] The caseload was again level until 2002 when it expanded to 42,000 and grew to 62,000 by 2005. In 2006 the caseload declined to 58,000. Enrollment at January 31, 2009 was approximately 77,000.The waiver currently has an enrollment cap of 85,000, effective October 1, 2008, which increases annually and reaches 95,000 in FY 2010–2011.

[52] Burwell, B., et al.

[53] The events of this period are described in the report, Department of Developmental Services, (December, 2007), *Controlling Regional Center Costs: Report to the Legislature Submitted to fulfill the requirements of Section 102.5, Chapter 188, Statutes of 2007.* Sacramento, CA. Retrieved on 3-4-09: http://www.dds.ca.gov/Publications/docs/ControllingRCCosts2007.pdf. p. 28.

Figure 4: Trends in Developmentally Disabled (DD) Waiver Participants: 1986–2006



Data Source: Department of Health Care Services, CMS 372 reports

Table 21: CMS 372 Data for Unduplicated Persons, Expenditures and Waiver Days for the Developmentally Disabled (DD) Waiver: FFY 1986–2006[54]

Reporting Period	Unduplicated Persons	Cost Per Person	Expenditures	Waiver Days	Days Per Person
FFY 1986	2,976	$ 8,874	$ 26,408,681	858,552	288
FFY 1987	2,951	$ 10,255	$ 30,263,750	859,093	291
FFY 1988	3,353	$ 10,327	$ 34,627,694	923,496	275
FFY 1989	3,897	$ 13,448	$ 52,406,848	1,111,378	285
FFY 1990	3,388	$ 15,829	$ 53,630,301	1,146,465	338
FFY 1991	3,349	$ 16,770	$ 56,163,213	1,112,481	332
FFY 1992	3,344	$ 17,443	$ 58,330,686	1,126,675	337
FFY 1993	13,200	$ 13,261	$ 175,043,959	3,914,052	297
FFY 1994	16,006	$ 14,375	$ 230,092,379	4,946,695	309
FFY 1995	27,194	$ 11,220	$ 305,116,906	8,109,636	298
FFY 1996	29,314	$ 12,179	$ 357,004,168	10,469,521	357
FFY 1997	35,105	$ 10,994	$ 385,934,451	11,703,189	333
FFY 1998	34,212	$ 12,941	$ 442,726,898	11,625,424	340
FFY 1999	30,205	$ 15,991	$ 482,995,527	9,167,277	304
FFY 2000	30,602	$ 16,267	$ 497,807,589	10,297,824	337
FFY 2001	35,372	$ 19,192	$ 678,852,401	11,883,323	336
FFY 2002	42,377	$ 20,627	$ 874,089,949	14,190,817	335
FFY 2003	51,203	$ 20,244	$ 1,036,562,479	15,878,356	310

[54] The phrase "unduplicated persons" means a unique person is only counted once in the count of persons.

Reporting Period	Unduplicated Persons	Cost Per Person	Expenditures	Waiver Days	Days Per Person
FFY 2004	54,682	$ 21,016	$ 1,149,204,698	17,860,501	327
FFY 2005	62,224	$ 20,601	$ 1,281,896,642	21,689,683	349
FFY 2006	57,973	$ 22,657	$ 1,313,519,501	20,582,586	355

Data Source: Department of Health Care Services.

Table 22 expresses the same data as a percentage change from year-to-year.

Table 22: Year-to-Year Percentage Changes in Developmentally Disabled (DD) Waiver Persons, Costs and Waiver Days: 1986–2006

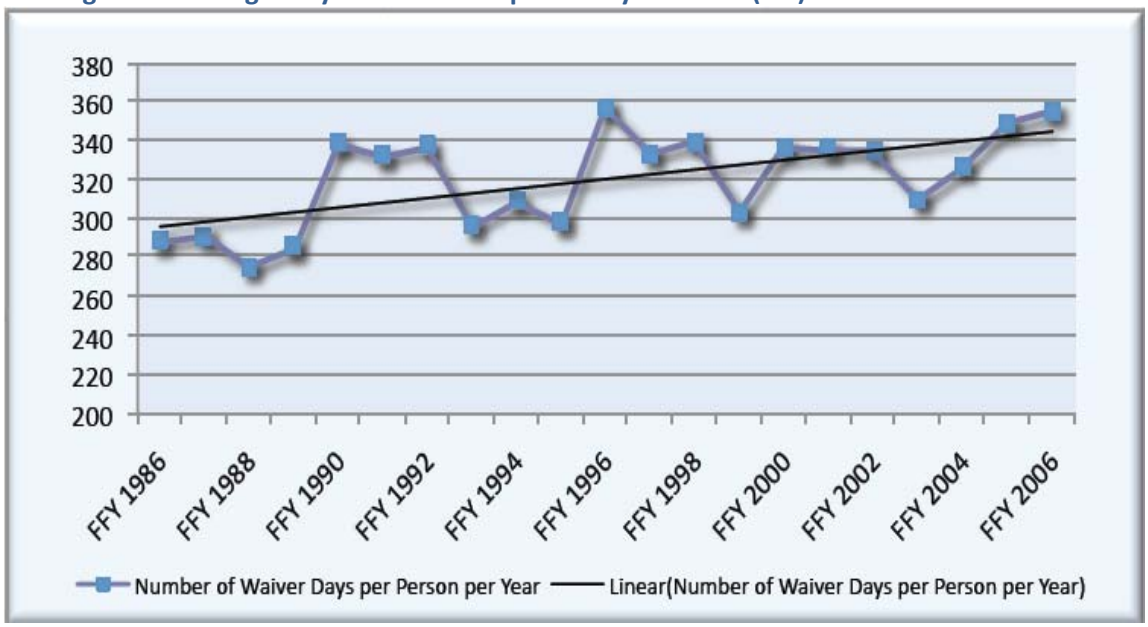
Reporting Period	Unduplicated Persons	Cost Per Person	Expenditures	Waiver Days	Days Per Person
1986–1987	-0.8%	15.6%	14.6%	0.1%	0.9%
1987–1988	13.6%	0.7%	14.4%	7.5%	-5.4%
1988–1989	16.2%	30.2%	51.3%	20.3%	3.5%
1989–1990	-13.1%	17.7%	2.3%	3.2%	18.7%
1990–1991	-1.2%	5.9%	4.7%	-3.0%	-1.8%
1991–1992	-0.1%	4.0%	3.9%	1.3%	1.4%
1992–1993	294.7%	-24.0%	200.1%	247.4%	-12.0%
1993–1994	21.3%	8.4%	31.4%	26.4%	4.2%
1994–1995	69.9%	-21.9%	32.6%	63.9%	-3.5%
1995–1996	7.8%	8.5%	17.0%	29.1%	19.8%
1996–1997	19.8%	-9.7%	8.1%	11.8%	-6.7%
1997–1998	-2.5%	17.7%	14.7%	-0.7%	1.9%
1998–1999	-11.7%	23.6%	9.1%	-21.1%	-10.7%
1999–2000	1.3%	1.7%	3.1%	12.3%	10.9%
2000–2001	15.6%	18.0%	36.4%	15.4%	-0.2%
2001–2002	19.8%	7.5%	28.8%	19.4%	-0.3%
2002–2003	20.8%	-1.9%	18.6%	11.9%	-7.4%
2003–2004	6.8%	3.8%	10.9%	12.5%	5.3%
2004–2005	13.8%	-2.0%	11.5%	21.4%	6.7%
2005–2006	-6.8%	10.0%	2.5%	-5.1%	1.9%
% Change 1986–2006	1990.9%	132.2%	4754.1%	2426.3%	20.8%

Data Source: Department of Health Care Services, percentages calculated by authors.

The two significant drivers of waiver costs are the steady increases in enrollment and utilization. During the initial years of the DD Waiver, the average participant received services for fewer than 300 days. The linear trend line below shows a gradual increase in the number of waiver days used by the average person. By 2006, the average number of days was 355,

indicating low turnover. Once a person enrolls in the waiver they tend to remain, although DDS staff indicated that between 5,000-6,000 persons disenroll from the waiver each year.[55]

Figure 5: Average Stay on the Developmentally Disabled (DD) Waiver: FFY1986-2006



Data Source: Department of Health Care Services

Table 23 shows the services, unduplicated participants and expenditures for the DD Waiver participants during FFY 2005. Over 100 procedure codes are "rolled up" to comprise the services shown in the waiver documents. The most frequent services used by waiver participants are: day habilitation, 59%; transportation, 58%; adult residential care, 39%; respite care, 31% and prevocational programs, 12%. About 46% of the funding was spent on adult residential care, 30% on day habilitation, 7% on transportation, and the remaining 17% was spread across the other services. Case management is provided by the regional centers under the "targeted case management" state plan option. The number of participants who also received IHSS was not reported.

[55] The authors recognize that the reported number of persons who disenroll each year does not mesh smoothly with the reported length of stay but have not attempted to reconcile this difference.

Table 23: CMS 372 Data for Services, Unduplicated Persons and Expenditures for the Developmentally Disabled (DD) Waiver: FFY 2006

Services Categories	Unduplicated Persons	% of Unduplicated Persons	Expenditures	% of Total Expenditures
Adult Day Services				
Adult Foster Care				
Adult Residential Care	22,378	38.60%	$599,324,167	45.63%
Adult Supported Living				
Behavior Intervention Services	3,981	6.87%	$22,415,608	1.71%
Chore Services	7	0.01%	$18,453	0.00%
Communication Aides	425	0.73%	$242,233	0.02%
Crisis Intervention Facility	44	0.08%	$2,710,674	0.21%
Day Habilitation	34,203	59.00%	$395,513,352	30.11%
Day Treatment and Partial Hospitalization				
Environmental Modifications	63	0.11%	$ 621,422	0.05%
Family Training	2,933	5.06%	$5,614,230	0.43%
Habilitation				
Homemaker Services	752	1.30%	$4,609,938	0.35%
Home Health Aide	1,622	2.80%	$14,827,147	1.13%
Mobile Crisis Intervention	698	1.20%	$ 1,706,198	0.13%
Nonmedical Equipment and Supplies				
Nutritional Consultation	374	0.65%	$147,391	0.01%
Occupational Therapy				
Personal Care Services				
Personal Emergency Response Systems	345	0.60%	$ 74,646	0.01%
Physical Therapy				
Physician Services				
Prevocational Services	6,927	11.95%	$38,604,536	2.94%
Psychological Services				
Regional Center Direct Client Support Services				
Residential Care				
Residential Habilitation				
Residential Habilitation for Children	1,370	2.36%	$49,467,427	3.77%
Respiratory Therapy				
Respite Care	18,077	31.18%	$ 61,107,287	4.65%
Skilled Nursing	863	1.49%	$ 2,573,139	0.20%

Services Categories	Unduplicated Persons	% of Unduplicated Persons	Expenditures	% of Total Expenditures
Specialized Medical Equipment and Supplies	827	1.43%	$ 1,470,654	0.11%
Specialized Therapeutic Services	91	0.16%	$ 58,365	0.00%
Speech, Hearing and Language Services		0.00%		0.00%
Supported Employment	3,244	5.60%	$19,738,570	1.50%
Transition/Set Up Expenses				
Transportation, Nonmedical	33,725	58.17%	$92,106,690	7.01%
Vehicle Modification	82	0.14%	$567,374	0.04%
Total Expenditures			$1,313,519,501	100%
Total Unduplicated Persons	57,973	100.00%		
Average Per Capita Expenditures			$22,657	

Data Source: Department of Health Care Services

CMS requires that waivers demonstrate their cost neutrality and the CMS 372 form also reports on cost neutrality. The CMS 372 FFY 2006 combined report for the DD Waiver showed a savings of approximately $43,700 per person compared to the cost of care in a developmental center.

Stakeholders questioned whether regional centers were enrolling all eligible participants into the HCBS Waiver. DDS provided the following response:

- The last fiscal year caseload data (June 30, 2008) shows the following: Approximately 241,000 persons are receiving services in the California DDS system.

- Approximately 44,000 persons are in the categories of intake, at-risk infants, prevention and developmental centers, all of which are not eligible for the waiver because they either do not have a diagnosis of DD or they live in a Developmental Center. California DD staff say they actively pursue outplacement of persons living in the Developmental Centers into the community, where the person may be enrolled on the waiver. In response to a comment that at-risk infants are eligible if they clearly meet eligibility criteria, DDS noted that infants at risk of a developmental disability are not eligible to receive waiver services until they have a definitive diagnosis of developmental disability.

- Approximately 197,000 persons have a diagnosis of developmental disability.

Of the 197,000 active clients:

- Approximately 10,000 are not waiver eligible because they live in facilities deemed "institutions" by CMS (ICF/MR or Community Care Facilities with greater than 15 beds). As with persons living in developmental centers, DD staff say the regional centers actively pursue placement of persons living in ICF/MRs or Community Care Facilities with greater than 15 beds into smaller community care facilities, which may be billed to the waiver, as appropriate.

- Approximately 36,000 are not waiver eligible because they are ineligible for Medi-Cal.

- Approximately 63,000 are not waiver eligible because they do not meet the waiver level of care requirements**.** To be eligible for the DD Waiver, a person must be enrolled in a full-scope Medi-Cal program and therefore meet the Medi-Cal income requirements. The majority of persons not enrolled in Medi-Cal have income that exceeds the maximums. Persons who meet waiver eligibility criteria may be institutionally deemed and enrolled in the waiver. All consumers, as part of the intake and Individual Program Plan (IPP) process, are informed about the waiver. However, there are no additional services, either in type or quantity, provided through the waiver which are not provided through the State's entitlement, the Lanterman Developmental Disabilities Services Act.

- Approximately 11,000 are waiver eligible but, in accordance with their IPPs, they do not receive CMS services covered by the waiver. DDS staff say they actively pursue new services to add to the waiver. As a result, some of these 11,000 persons may have future waiver billable services. California provides services to persons with developmental disabilities through the Lanterman Developmental Disabilities Services Act based on the needs of the consumers that are identified in the IPPs. Certain services provided under the Lanterman Act are not covered by the waiver such as day care services. In addition, there are waiver billable services that cannot be billed to the waiver because the persons are living in institutions and, therefore, do not meet the criteria for participation in a home and community-based waiver such as day programs (active treatment) for persons living in ICF/MRs or community care facilities with greater than 15 beds.

  Furthermore, because there are no additional services, either in type or quantity, provided through the waiver that are not provided through the State's Lanterman Act, there are persons receiving waiver/Lanterman Act services that do not meet waiver eligibility criteria.

- Approximately 76,000 are enrolled on the waiver.

- As of June 30, 2008, approximately 1,000 persons eligible for the waiver were not yet enrolled. The majority of these have been enrolled since then.

Assisted Living Waiver Pilot Project (ALWPP)

Background

The ALWPP HCBS Waiver, originally approved in 2005, was renewed by CMS effective March 1, 2009. The waiver allows California to offer services in residential settings to older adults and adults with physical disabilities. It provided services in two residential settings: Residential Care Facilities for the Elderly (RCFEs) and publicly subsidized housing in which services are delivered by a home health agency. The services include environmental accessibility adaptations, nursing facility transition care coordination, community transition services, translation and interpretation services, care coordination and consumer education services. This waiver went into effect January 2006 as a pilot program in three counties and was renewed in 2009. Under the renewal, the ALWPP was renamed the Assisted Living Waiver (ALW).

The major differences between the ALWPP and the new waiver are the addition of two counties per year, the addition of 60 slots per county per year and an increase in provider reimbursement rates.

The waiver covers assisted living services which include 24-hour awake staff to provide oversight and meet the scheduled and unscheduled needs of residents; provision and oversight of personal and supportive services (assistance with ADLs and IADLs); health-related services (e.g., medication management services); social services; recreational activities; meals, housekeeping and laundry; and transportation. Room and board costs are paid by the beneficiary.

Population Served

To be eligible for the ALW, applicants must meet the clinical qualifications for admission to a nursing facility, meet income eligibility qualifications for Medi-Cal, may have a physical disability and be age 21 or over.

Program Trends

In 2008, a policy decision was made to briefly limit participation in the ALWPP program to persons who transition from a nursing facility to a community residential setting. This limitation was included in the new ALW and one goal is that one-third of new participants will relocate from nursing facilities.[56]

In addition to limiting the program to persons currently residing in a nursing facility, provider participation was also limited to the approximately 50 residential providers in the three counties. While California provides a state supplement to the SSI program for residents of RCFEs, it is not sufficient to cover services needed by beneficiaries who meet the nursing facility level of care. The waiver covers services in residential settings for individuals with physical disabilities and older adults. Nationally about 36 states cover services in assisted living settings under

[56] See ALW application. Appendix B-3e. A link to the waiver document is contained on the ALW website at http://www.dhcs.ca.gov/services/ltc/Pages/ALWPP.aspx

HCBS Waivers. Alternative residential settings provide options for Medi-Cal beneficiaries in the community who require access to unscheduled services and supervision nights and weekends and for nursing facility residents.

Table 24: CMS 372 Assisted Living Waiver Pilot Project (ALWPP) Data for Unduplicated Persons, Expenditures and Waiver Days: CY 2006

Reporting Period	Unduplicated Persons	Cost Per Person	Expenditures	Waiver Days	Days Per Person
CY 2006	186	$ 7,093	$ 1,319,352	22,236	120

Data Source: Department of Health Care Services

In 2006, all participants received care coordination and assisted living services. About one out of six received assistance to transition from a nursing facility and the average amount of care coordination for transition assistance was $1,000.

Table 25: CMS 372 Data for Services, Unduplicated Persons and Expenditures for the Assisted Living Waiver Pilot Project (ALWPP): CY 2006

Services	Unduplicated Persons	% of Unduplicated Persons	Expenditures	% of Total Expenditures
Care Coordination	182	97.85%	$142,253	10.78%
NF Transition Care Coordination	28	15.05%	$28,000	2.12%
Community Transition Services				
Translation and Interpretation				
Consumer Education Services				
Environmental Accessibility Adaptations				
Assisted Living Bundled Service Array (RCFE)	173	93.01%	$1,149,099	87.10%
Assisted Care Benefit in Public Housing (HHA provider)				
Total Expenditures			$ 1,319,352	100.00%
Total Unduplicated Persons	186			
Average Per Capita Expenditures			$ 7,093	

Data Source: Department of Health Care Services

CMS requires that waivers demonstrate cost neutrality and the CMS 372 form also reports on cost neutrality. The CMS 372 CY 2006 "Lag" report for the ALWPP Waiver showed a savings of approximately $16,000 per person.

Discontinued Waivers

The In-Home Medical Care (IHMC) Waiver

Background

The IHMC and two of the waivers that are reported on below were consolidated. The Nursing Facility A/B (NF/AB) Waiver was renamed the Nursing Facility Acute Hospital (NF/AH) Waiver effective January 1, 2007. The new NF/AH Waiver combines the following three prior HCBS Waivers: The In-Home Medical Care (IHMC) Waiver, the Nursing Facility Subacute (NF/ SA) Waiver and the NF A/B Waiver.

Table 27 shows data for the IHMC Waiver. The waiver was intended to provide home and community-based services to severely disabled individuals who had a catastrophic illness, might be technology dependent, had a risk for life-threatening incidents, and who would otherwise require care in an acute care hospital for a minimum of 90 days. It was intended to provide services to persons who would otherwise have received inpatient services from an acute or mental health hospital. This was a small waiver with a high cost per case.

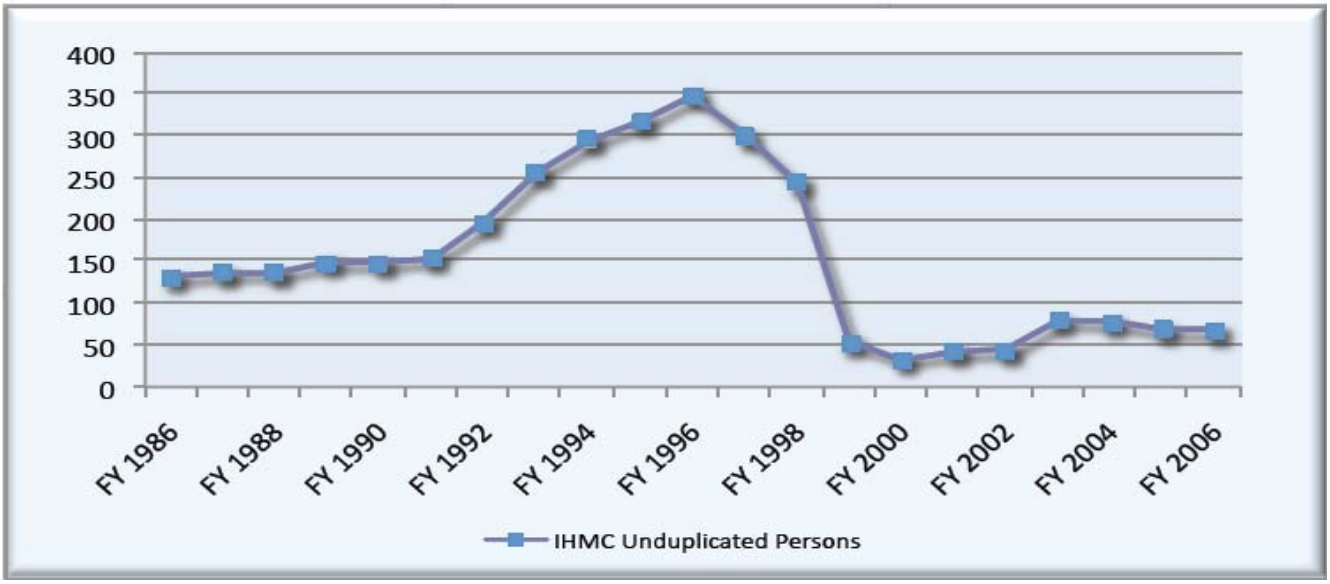
Table 26: CMS 372 Data for Unduplicated Persons, Expenditures and Waiver Days for the In-Home Medical Care (IHMC) Waiver: FY 1986–2005

Reporting Period	Unduplicated Persons	Cost Per Person	Expenditures	Waiver Days	Days Per Person
FY 1986	130	$ 63,077	$ 8,199,998	33,015	254
FY 1987	135	$ 69,153	$ 9,335,657	38,161	283
FY 1988	135	$ 61,595	$ 8,315,381	37,049	274
FY 1989	148	$ 70,765	$ 10,473,288	40,918	276
FY 1990	147	$ 79,487	$ 11,684,553	40,341	274
FY 1991	153	$ 97,088	$ 14,854,530	49,651	325
FY 1992	195	$ 99,403	$ 19,383,622	58,401	299
FY 1993	255	$ 90,753	$ 23,141,965	76,873	301
FY 1994	294	$ 93,045	$ 27,355,257	90,505	308
FY 1995	316	$ 94,666	$ 29,914,319	97,971	310
FY 1996	348	$104,977	$ 36,531,932	113,366	326
FY 1997	299	$106,032	$ 31,703,454	95,036	318
FY 1998	243	$100,739	$ 24,479,647	69,535	286
FY 1999	52	$ 77,052	$ 4,006,722	2,869	55
FY 2000	32	$ 84,832	$ 2,714,638	7,358	230
FY 2001	41	$123,036	$ 5,044,494	12,928	315
FY 2002	42	$127,323	$ 5,347,549	14,446	344
FY 2003	78	$111,241	$ 8,676,836	25,246	324
FY 2004	76	$179,869	$ 13,670,058	27,358	360
FY 2005	67	$171,345	$ 11,480,118	22,694	339
FY 2006	65	$179,617	$ 11,675,109	23,156	356

Data Source: Department of Health Care Services

Figure 6 graphs enrollment in the program, which changed dramatically over the years. Enrollment in the waiver grew modestly the first six years, from 1986 to 1991, rose rapidly to 348 persons in 1996, and declined to 52 persons in 1999. This pattern reflects changing policy decisions about the program. The rapid growth in the mid-1990s was reversed due to a significant change in the program in 1999. Over time the program served a small number of high-cost persons who stayed on the waiver the entire year, an average of 356 days in FY 2006.

Figure 6: IHMC Enrollment Trend



Data Source: Department of Health Care Services

Table 27 presents the annual percentage changes in the IHMC Waiver.

Table 27: Year-to-Year Percentage Changes in In-Home Medical Care (IHMC) Waiver Persons, Costs and Waiver Days: 1986–2006

Reporting Period	Unduplicated Persons	Cost Per Person	Expenditures	Waiver Days	Days Per Person
1986–1987	3.8%	9.6%	13.8%	15.6%	11.3%
1987–1988	0.0%	-10.9%	-10.9%	-2.9%	-2.9%
1988–1989	9.6%	14.9%	26.0%	10.4%	0.7%
1989–1990	-0.7%	12.3%	11.6%	-1.4%	-0.7%
1990–1991	4.1%	22.1%	27.1%	23.1%	18.3%
1991–1992	27.5%	2.4%	30.5%	17.6%	-7.7%
1992–1993	30.8%	-8.7%	19.4%	31.6%	0.7%
1993–1994	15.3%	2.5%	18.2%	17.7%	2.1%
1994–1995	7.5%	1.7%	9.4%	8.2%	0.7%
1995–1996	10.1%	10.9%	22.1%	15.7%	5.1%
1996–1997	-14.1%	1.0%	-13.2%	-16.2%	-2.4%
1997–1998	-18.7%	-5.0%	-22.8%	-26.8%	-10.0%
1998–1999	-78.6%	-23.5%	-83.6%	-95.9%	-80.7%

Reporting Period	Unduplicated Persons	Cost Per Person	Expenditures	Waiver Days	Days Per Person
1999–2000	-38.5%	10.1%	-32.2%	156.5%	316.8%
2000–2001	28.1%	45.0%	85.8%	75.7%	37.1%
2001–2002	2.4%	3.5%	6.0%	11.7%	9.1%
2002–2003	85.7%	-12.6%	62.3%	74.8%	-5.9%
2003–2004	-2.6%	61.7%	57.5%	8.4%	11.2%
2004–2005	-11.8%	-4.7%	-16.0%	-17.0%	-5.9%
2005–2006	-3.0%	4.8%	1.7%	2.0%	5.2%
% Change 1986–2006	-48.5%	171.6%	40.0%	-31.3%	33.4%

Data Source: Department of Health Care Services, percentages calculated by authors

The data shows that the number of participants declined but the cost per person and days per person grew, suggesting that service needs increased over time.

Table 28 shows the services, participants and expenditures of the IHMC Waiver during FY 2006. Although it offered several services, the primary service was private-duty nursing. In FY 2006, case management costs were about $92,000 per year, and the remaining $11.6 million was spent on private-duty nursing. Almost all participants received private-duty nursing either at home or in a congregate living health facility, comprising about 85% of all expenditures. On January 1, 2007 this waiver was combined into the NF/AH Waiver.

Table 28: CMS 372 Data for Services, Unduplicated Persons and Expenditures for the In-Home Medical Care (IHMC) Waiver: FY 2006

IHMC Services Categories	IHMC Unduplicated Persons	IHMC % of Unduplicated Persons	IHMC Expenditures	IHMC % of Total Expenditures
Audiology Therapy				
Case Management	55	84.62%	$ 91,718	0.79%
Congregate Living Health Facility (CLHF) - Private-Duty Nursing	11	16.92%	$ 1,328,598	11.38%
Environmental Adaptations Accessibility				
Family Training				
Home Health Aide Services - Certified Home Health Aide (CHHA)				
Home Health Aide Services - CHHA - Shared				
Personal Emergency Response System				
Private-Duty Nursing - Shared	4	6.15%	$ 345,439	2.96%
Private-Duty Nursing - Supervision				
Private-Duty Nursing Services	52	80.00%	$ 9,909,354	84.88%

IHMC Services Categories	IHMC Unduplicated Persons	IHMC % of Unduplicated Persons	IHMC Expenditures	IHMC % of Total Expenditures
Respite				
Transitional Case Management				
Waiver Service Coordination				
Total Expenditures			$ 11,675,109	100%
Total Unduplicated Persons	65			
Average Per Capita Expenditures			$ 179,617	

Data Source: Department of Health Care Services

CMS requires that waivers prove their cost neutrality and the CMS 372 form also reports on cost neutrality. The CMS 372 FY 2006 annual report for the IHMC Waiver showed a savings of approximately $170,000 per person.

Nursing Facility Subacute (NF/SA) Waiver

Table 29 shows four years of data for the NF/SA Waiver. This waiver was intended to provide services to persons who would otherwise have received adult or pediatric nursing facility services at a subacute level of care for 180 days or more. The waiver supported the relocation of persons from nursing facilities to the community or diverted persons from entering a nursing facility. This was the second of the two waivers combined into the NF/AH Waiver. Like the IHMC Waiver, this waiver also served seriously ill, high-cost cases although this waiver served substantially more participants, and the cost per case was less than half the cost per participant on the IHMC Waiver. When this waiver was discontinued, the participants were reviewed individually, and about 236 were transferred to the NF/AH Waiver while about 210 persons were enrolled in the In-Home Operations (IHO) Waiver.

Table 29: CMS 372 Data for Unduplicated Persons, Expenditures and Waiver Days for Nursing Facility Subacute (NF/SA) Waiver: June 2000–March 2006

Reporting Period	Unduplicated Persons	Cost Per Person	Expenditures	Waiver Days	Days Per Person
6//12002–3/31/2003	364	$ 75,836	$ 27,604,453	94,521	260
4/1/2003–3/31/2004	386	$ 73,755	$ 28,469,546	122,160	316
4/1/2004–3/31/2005	477	$ 71,292	$ 34,006,061	150,634	316
4//12005–3/31/2006	562	$ 64,189	$ 36,074,208	168,257	299

Data Source: Department of Health Care Services

Table 30 presents the percentage change from year-to-year in the NF/SA Waiver. Enrollment increased 54% over the NF/SA Waiver reporting periods. The cost per person steadily dropped although total costs rose due to enrollment growth.

Table 30: Year-to-Year Percentage Changes in Nursing Facility Subacute (NF/SA) Waiver Participants, Costs and Waiver Days: 1986–2006

Reporting Period	Unduplicated Persons	Cost Per Person	Expenditures	Waiver Days	Days Per Person
6/2002–3/2003 to 4/2003–3/2004	6.0%	-2.7%	3.1%	29.2%	21.9%
4/2003–3/2004 to 4/2004–3/2005	23.6%	-3.3%	19.4%	23.3%	0.0%
4/2004–3/2005 to 4/2005–3/2006	17.8%	-10.0%	6.1%	11.7%	-5.2%
6/2002–3/2000 to 4/2005–3/2006	54.4%	-15.4%	30.7%	78.0%	15.3%

Data Source: Department of Health Care Services, percentages calculated by authors

Table 31 presents the services, participants and expenditures of the NF/SA Waiver during the period April 1, 2005 to March 31, 2006. Like the IHMC Waiver, most but not all participants received case management and the majority of expenditures were for private-duty nursing. Approximately 72% of persons received private-duty nursing and 33% received personal care services. Approximately 87% of the funds were spent on private-duty nursing and 12% on personal care services.

Table 31: Services, Unduplicated Persons and Expenditures for the Nursing Facility Subacute (NF/SA) Waiver: April 1, 2005–March 31, 2006

Services Categories	Unduplicated Persons	% of Unduplicated Persons	Expenditures	% of Total Expenditures
Case Management	380	67.62%	$ 334,017	0.93%
Environmental Accessibility Adaptations	2	0.36%	$ 10,000	0.03%
Family Training	41		$ 5,648	0.02%
Home and Community-Based Services Personal Care Benefit	187	33.27%	$ 4,485,791	12.43%
Home Health Aide				
Home Health Aide - Shared				
Personal Emergency Response Systems	3	0.53%	$ 776	0.00%
Private-Duty Nursing	396	70.46%	$ 30,529,307	84.63%

Services Categories	Unduplicated Persons	% of Unduplicated Persons	Expenditures	% of Total Expenditures
Private-Duty Nursing - Shared	8	1.42%	$ 684,360	1.90%
Respite				
Transitional Case Management				
Utility Coverage	53	9.43%	$ 24,309	0.07%
Waiver Services Coordination				
Total Expenditures			$ 36,074,208	100%
Total Unduplicated Persons	562			
Average Per Capita Expenditures			$ 64,189	

Data Source: Department of Health Care Services

CMS requires that waivers demonstrate cost neutrality and the CMS 372 form also reports on cost neutrality. The CMS 372 2005–2006 Annual Report for the NF/SA Waiver showed a savings of approximately $124,800 per person.

Nursing Facility A/B (NF/AB) Waiver

The third waiver that was replaced by the NF/AH Waiver was the NF/AB Waiver. The NF/AB Waiver was named after California's two types of nursing facilities: Level A, intermediate nursing facility care, and Level B, skilled nursing care. This waiver served persons who would otherwise have been in a nursing facility at a non-subacute level for a minimum of 365 days who needed assistance with personal care and/or needed skilled nursing care. In October 2006 there was a waiting list of 649 individuals.[57] Table 32 shows seven years of data for the NF/AB Waiver.

Table 32: CMS 372 Data for Unduplicated Persons, Expenditures and Waiver Days for the Nursing Facility A/B Waiver (NF/AB): FY 2001–CY 2006

Reporting Period	Unduplicated Persons	Cost Per Person	Expenditures	Waiver Days	Days Per Person
FY 2001	538	$ 93,893	$ 50,514,451	179,839	334
7/2001 to 5/2002	501	$ 86,416	$ 43,294,248	179,839	359
CY 2002	316	$ 27,800	$ 8,784,937	60,069	190
CY 2003	427	$ 34,675	$ 14,806,190	132,607	311
CY 2004	556	$ 27,198	$ 15,121,873	164,533	296
CY 2005	663	$ 24,372	$ 16,158,519	209,285	316
CY 2006	645	$ 22,081	$ 14,242,420	205,293	318

Data Source: Department of Health Care Services

[57] California Department of Health Services (October, 2006), *Money Follows the Person Rebalancing Demonstration: California Community Transitions.* Sacramento, CA. p. 8. Retrieved on 12-12-08: http://www.dhcs.ca.gov/services/ltc/Documents/MFP_Demo_CCT_Application.pdf.

Table 33 presents the percentage change from year-to-year in the NF/AB Waiver. The time periods reported on are awkward to display because reporting periods were irregular. During the first two years, over 500 participants enrolled and the cost per case was high. By 2002, enrollment declined by 36.9% and the cost per case dropped 67.8%. For the next four years the growth rate was quite high until 2006, when it leveled off.

Table 33: Year-to-Year Percentage Changes in Nursing Facility (NF/AB) Waiver Participants, Costs and Waiver Days: 2001–2006

Reporting Period	Unduplicated Persons	Cost Per person	Expenditures	Waiver Days	Days Per Person
FY 2001 to 7/2001–5/2002	-6.9%	-8.0%	-14.3%	0.0%	7.4%
7/2001–5/2002 to CY 2002	-36.9%	-67.8%	-79.7%	-66.6%	-47.0%
CY 2002 to CY 2003	35.1%	24.7%	68.5%	120.8%	63.4%
CY 2003 to CY 2004	30.2%	-21.6%	2.1%	24.1%	-4.7%
CY 2004 to CY 2005	19.2%	-10.4%	6.9%	27.2%	6.7%
CY 2005 to CY 2006	-2.7%	-9.4%	-11.9%	-1.9%	0.8%
FY 2001 to CY 2006	19.9%	-76.5%	-71.8%	14.2%	-4.8%

Data Source: Department of Health Care Services, percentages calculated by authors.

Table 34 shows the services, participants and expenditures of the NF/AB Waiver during CY 2006. Like the IHMC Waiver and NF/SA Waiver, most but not all participants received case management. Unlike the IHMC Waiver and NF/SA Waiver, the service used by the highest percentage of persons was personal care, received by about 54% of the participants. Approximately 21% received private-duty nursing and 15.81% received home health aide services. Approximately 40% of the funds were spent on private-duty nursing, 34% on personal care services and 23% on home health aides.

Table 34: CMS 372 Data for Services, Unduplicated Persons and Expenditures for the Nursing Facility A/B Waiver: CY 2006

Services Categories	Unduplicated Persons	% of Unduplicated Persons	Expenditures	% of Total Expenditures
Case Management	384	59.53%	$ 299,778	2.10%
Environmental Accessibility Adaptations	1	0.16%	$ 2,500	0.02%
Family Training	23	3.57%	$ 2,611	0.02%
Home Health Aide	102	15.81%	$ 3,258,636	22.88%
Personal Care Services	350	54.26%	$ 4,929,891	34.61%
Personal Emergency Response Systems	2	0.31%	$ 272	0.00%
Private-Duty Nursing	133	20.62%	$ 5,717,412	40.14%
Private-Duty Nursing - Shared	2	0.31%	$ 30,680	0.22%
Private-Duty Nursing - Supervision				
Respite				
Utility Coverage	5	0.78%	$ 640	0.00%
Waiver Services Coordination				
Total Expenditures			$ 14,242,420	100%
Total Unduplicated Persons	645			
Average Per Capita Expenditures			$ 22,081	

Data Source: Department of Health Care Services

CMS requires that waivers demonstrate cost neutrality and the CMS 372 form also reports on cost neutrality. The CMS 372 2006 annual report for the NF/AB Waiver showed a savings of approximately $9,700 per person. Unlike all other waivers of the state, this waiver was not cost neutral until 2005 and 2006. In the early part of the decade the per capita expenditures were greater than the projected expenditures that might have been incurred in the absence of the waiver.

New Waivers

On January 1, 2007, the previous Nursing Facility Level A/B, Nursing Facility Subacute and In-Home Medical Care Waivers were merged into two new HCBS Waivers—the NF/AH Waiver and the IHO Waiver. This change resulted from negotiations with CMS to implement revisions requested by CMS, to consolidate mandated reporting and to resolve ongoing cost-neutrality issues. Both waivers were amended to increase the individual cost limit for NF A and B level of care, add a new waiver service provider type, change the billing cycle for Waiver Personal Care Service provider payments and clarify various Standards of Participation.

In-Home Operations (IHO) Waiver

Background

The IHO Waiver offers the same services to Medi-Cal beneficiaries who were previously enrolled in an IHO HCBS Waiver since June 1, 2002, and have physician-ordered direct care services in excess of NF/AH Waiver individual cost-neutrality limit requirements. In accordance with CMS directives, cost-neutrality requirements are applied in the aggregate for all IHO Waiver participants.

The services include environmental accessibility adaptations, case management, respite care (home and facility), PERS, PERS installation and testing, community transition services, home health aide services, habilitation services, family training, waiver personal care services, transitional case management, medical equipment operating expenses and private-duty nursing, including shared services. Access to IHO Waiver services is managed through the DHCS. Registered nurses complete an assessment, determine the level of care and review the plan of treatment or service plan as well as the Treatment Authorization Request (TAR). In February 2009, there were 360 persons on the waiting list for the waiver, and they had been waiting an average of 187 days.[58]

Population Served

The DHCS website describes the IHO Waiver as "a new waiver established to serve either participants previously enrolled in the NF A/B Level of Care Waiver who have continuously been enrolled in a DHS In-Home Operations-administered HCBS Waiver prior to January 1, 2002, and require direct care services provided primarily by a licensed nurse, or who have been receiving continuous care in a hospital for 36 months or longer and have physician-ordered direct care services that are greater than those available in the Nursing Facility/Acute Hospital Waiver for the participant's assessed level of care."[59] DHCS staff report that approximately 79% of the IHO participants also receive IHSS services. In April 2009 this represented 131 persons.

Individuals eligible for this IHO Waiver would otherwise receive services in a "distinct-part" nursing facility located within a hospital, NF Level B Pediatric Services, NF Subacute Services or NF Pediatric Subacute Services.

[58] See: www.chhs.ca.gov/initiatives/CAChildWelfareCouncil/Documents/Item6NF**Waiver**Chart**Feb**09doc.doc.
[59] See: http://www.dhcs.ca.gov/SERVICES/MEDI-CAL/Pages/IHOMedi-CalWaiver.aspx#eligibility.

Program Trends

Table 35 presents projected expenditures and utilization from the state's application to CMS.

Table 35: Projected Expenses for the First Year of the In-Home Operations (IHO) Waiver: CY 2007

Services	Unit	Number of Users	Average Units Per User	Average Cost Per Unit	Total Cost
Case Management	Hours	210	18	$ 40.60	$ 153,468
Community Transition Services	Event	1	1	$ 5,000.00	$ 5,000.00
Environmental Accessibility Adaptations	Event	10	1	$ 5,000.00	$ 5,000.00
Family Training	Hours	24	7	$ 40.60	$ 6,821
Habilitation	Hours	18	389	$ 30.68	$ 214,821
Medical Equipment Operating Expenses	Months	10	9	$ 25.00	$ 2,250
Personal Emergency Response Systems	Months	2	12	$ 32.51	$ 780
Personal Emergency Response Systems - Installation and Testing	Event	2	1	$ 35.00	$ 70.00
Private-Duty Nursing, Including Shared Services	Hours	171	2,325	$ 30.25	$ 12,026,644
Facility Respite	Days	5	5	$ 238.57	$ 5,964
Home Respite	Hours	14	40	$ 23.62	$ 3,227
Transitional Case Management	Hours	1	12	$ 40.60	$ 487
Waiver Personal Care Services	Hours	70	1,491	$ 12.02	$ 1,254,527

Data Source: Department of Health Care Services

The waiver assumes that all participants receive case management. The two primary services are private-duty nursing and personal care. Modest amounts of family training and respite are provided. The waiver includes transitional case management. Eighteen consumers who have intellectual or developmental disabilities are projected to receive habilitation services.

Federal waiver applications require a cost-neutrality demonstration. The IHO projected costs were found by taking a weighted average of nursing facility costs for Level B homes that were a distinct part of a larger institution and subacute costs. The resulting weighted average for the first year of the waiver, CY 2007, was projected to be $104,296. Given the size of this average difference, it is possible that the state is not realizing the full savings from waiver services because of the waiting list.

Nursing Facility/Acute Hospital (NF/AH) Waiver

Background

The NF/AH Waiver combined the Nursing Facility Level A/B, Nursing Facility Subacute and In-Home Medical Care Waivers into one larger waiver. This waiver offers services in the home to Medi-Cal beneficiaries who, in the absence of this waiver, would otherwise receive care for at least 90 days in an intermediate care facility, a skilled nursing facility, a subacute facility or an acute care hospital. To maintain cost neutrality, the overall total costs for waiver and Medi-Cal state plan services cannot exceed the costs of facilities offering equivalent levels of care. In accordance with CMS directives, cost-neutrality limit requirements are applied individually to each NF/AH Waiver participant.

Access to NF/AH Waiver services are managed through DHCS. Registered nurses complete each assessment, determine the level of care and review the plan of treatment or service plan as well as the TAR. The services include private-duty nursing, including shared nursing, home health aide services, case management, transitional case management, environmental accessibility adaptations, PERS, PERS installation and training, medical equipment operating expenses, waiver personal care services, community transition, habilitation services and respite care (home and facility). The February 2009 IHO Operations Summary showed that the NF/AH Waiver had 532 available slots out of 2,180 authorized.[60]

Population Served

The goals of the waiver are to facilitate a safe and timely transition of Medi-Cal eligible beneficiaries from a medical facility to his/her home and community utilizing NF/AH Waiver services and to offer eligible Medi-Cal beneficiaries, who reside in the community but are at risk of being institutionalized within the next 30 days, the option of utilizing the NF/AH Waiver services to develop a home program that will safely meet his/her medical care needs."[61]

Program Trends

As shown in Table 36, the NF/AH Waiver has the same services as the IHO Waiver. All participants receive case management. Approximately half the persons are expected to use private-duty nursing and one-third of the persons are projected to use personal care services. The expected enrollment in the NF/AH Waiver is ten times the previous three waivers. The waiver reserves capacity for 250 individuals transitioning from a nursing facility. This waiver supports the department's nursing facility transition efforts by providing transition assistance, transition case management and home modification services. In 2008, 90 nursing facility residents were able to transition to the community through the waiver. DHCS staff report that approximately 79% of the NF/AH participants also receive IHSS services or 1,216 participants in April 2009.

[60] See: www.chhs.ca.gov/initiatives/CAChildWelfareCouncil/Documents/Item6NF**Waiver**Chart**Feb**09doc.doc.
[61] See: http://www.dhcs.ca.gov/services/medi-cal/Pages/NFAHMedi-CalWaiver.aspx.

Table 36: Projected Expenses for the First Year of the Nursing Facility/Acute Hospital (NF/AH) Waiver: CY 2007

Services Categories	Unit	Number of Users	Average Units Per User	Average Cost Per Unit	Total Cost
Case Management	Hour	2,392	29	$ 40.60	$ 2,816,341
Community Transition Services	Event	56	1	$ 5,000.00	$ 280,000
Environmental Accessibility Adaptations	Event	14	1	$ 5,000.00	$ 70,000
Family Training	Hour	68	21	$ 40.60	$ 57,977
Habilitation	Hour	8	416	$ 30.68	$ 102,103
Medical Equipment Operating Expenses	Month	68	12	$ 25.00	$ 20,400
Personal Emergency Response Systems	Month	5	12	$ 32.51	$ 1,951
Personal Emergency Response Systems - Installation and Testing	Event	5	1	$ 35.00	$ 175
Private-Duty Nursing, Including Shared Services	Hour	1,163	3,383	$ 30.25	$ 119,016,477
Facility Respite	Days	13	5	$ 313.57	$ 20,382
Home Respite	Hours	25	40	$ 23.62	$ 23,620
Transitional Case Management	Hours	29	20	$ 40.60	$ 23,548
Waiver Personal Care Services	Hours	721	2,588	$ 12.02	$ 22,428,695

Data Source: Department of Health Care Services

For purposes of the federal cost-neutrality demonstration, three levels of care are used in the NF/AH Waiver. The NF/AH projected costs were calculated based on the weighted average of nursing facility costs from the previous NF A/B Waiver and NF Subacute Waiver plus the average cost of hospital costs. The resulting weighted average for the first year of the waiver, CY 2007, was $97,492. Given the size of this average difference, it is possible that the state is not realizing the full savings from waiver services because of the unused capacity.

Table 37 compares the services covered by the three previous waivers and the two replacement waivers.

Table 37: Comparison of Services Covered by Previous and Replacement Waivers

Services Categories	Previous Waivers			Consolidated Waiver	
	NF AB	NF Subacute	IHMC	IHO	NF/AH
Audiology Therapy			●		
Case Management	●	●	●	●	●
Community Transition Services	●		●	●	●
Congregate Living Health Facility - Private-Duty Nursing			●		
Environmental Accessibility Modifications	●	●	●	●	●
Facility Respite				●	●
Family Training	●	●	●	●	●
Habilitation				●	●
HCBS Personal Care		●			
Home Health Aide	●	●			
Home Health Aide - Shared		●	●		
Certified Home Health Aide - Shared			●		
Home Respite				●	●
Medical Equipment Operating Expenses				●	●
Personal Care Services	●				
Personal Emergency Response Systems	●	●	●	●	●
Personal Emergency Response Systems - Installation and Testing				●	●
Private-Duty Nursing	●	●			
Private-Duty Nursing - Shared	●	●	●		
Private-Duty Nursing Services			●		
PDN Including Shared Services				●	●
PDN Supervision	●		●		
Respite	●	●	●		
Transitional Case Management		●	●	●	●
Utility Coverage	●	●			
Waiver Personal Care Services				●	●
Waiver Service Coordination	●	●			
Number of Services in Each Waiver	13	13	14	13	13

Persons with Traumatic Brain Injuries

Waiver spending and enrollment is low relative to other states and the state may benefit from an expansion of its waiver programs. For example, the state funds a modest Traumatic Brain Injury (TBI) program out of general funds. The program is authorized by Section 4353 of the Welfare and Institutions Code and administered by the Department of Mental Health (DMH). The program pays seven centers to provide services and the average center in FY 2006–2007 received about $173,000, financed by a percentage of fines collected from violations of the seat belt law. The TBI program was evaluated by the DMH.[62] The Governor signed into law AB 1410 on October 14, 2007, requiring the DMH Care Services to apply for a 1915(c) Waiver to put on a program for 100 persons. The legislative history of AB 1410 suggests that legislators considered serving 200 persons.

A national review of state-operated TBI Waivers found they were highly cost-effective.[63] It would be more cost-effective to create a TBI Waiver rather than continue to fund TBI services with 100% state funds. However, enrolling only 100 persons limits potential savings and creates a disproportionate administration burden to manage and report on such a small waiver. Rather the size of the waiver should be determined by its cost-effectiveness. The size of the waiver should be increased as long as it is cost-effective to do so. The 2005 evaluation of the program found that approximately 600 persons with TBI received services at the seven centers, and the persons were generally eligible for SSI and should therefore be Medi-Cal eligible.

Adult Day Health Care

Background

Adult Day Health Care (ADHC) began as a §1115 demonstration program in 1977. The service was initially intended to serve Medi-Cal beneficiaries who were at risk of entering a nursing facility. The Legislature determined that ADHC "is a necessary component in achieving an integrated home and community-based long-term care system consistent with the principles of the decision of the United States Supreme Court in Olmstead."[64] A study of ADHC programs in six states (California, Maryland, New Jersey, New York, Texas and Washington) found:

> In both the short and long-term, ADHC can save the Medicaid program significant resources by delaying or avoiding inappropriate entry into more costly institutional care, and at the same time, create an environment where individuals receive

[62] See Berkeley Policy Associates, (January 30, 2005). *Independent Evaluation of the Traumatic Brain Injury Services of California.* Legislative report prepared for the Department of Mental Health, Sacramento, CA. Retrieved on 3-1-09: http://www.dmh.ca.gov/Services_and_Programs/Adults/docs/TBI_docs/TBI_Eval_Leg_Rep_0106.pdf

[63] Hendrickson, L. & Blume, R. (2008*), Issue Brief: A Survey of Medicaid Brain Injury Programs*. Rutgers University, Rutgers Center for State Health Policy. New Brunswick, N.J. See: http://www.cshp.rutgers.edu/cle/Products/Brain%20Injury%20Waivers.pdf.

[64] SB 1755. Available at: http://www.leginfo.ca.gov/pub/05-06/bill/sen/sb_1751-1800/sb_1755_bill_20060929_chaptered.html.

> supports and therapies that make their transition to a nursing home (if and when it happens) less traumatic and less vulnerable to abrupt declines in mental and physical conditions.[65]

ADHC has a medical component and a social component. It serves a mix of short-term, post-acute clients and longer-term clients. Over time, ADHC served a broader population consisting of persons with chronic conditions with frequent hospital and psychiatric admissions. On average, between 45,000–50,000 beneficiaries annually attend ADHC centers. A review of TARs estimated that 30–40% of all participants would need nursing facility care in the absence of ADHC services.

Population Served

ADHC serves Medi-Cal beneficiaries who:

- Are age 18 or older.
- Have one or more chronic or post-acute medical, cognitive or mental health conditions that are identified by the participant's personal health care provider as requiring monitoring, treatment or intervention, without which the participant's condition will likely deteriorate and require emergency department visits, hospitalization or other institutionalization—monitoring, treatment or intervention.
- Have a condition or conditions resulting in limitations in the performance of two or more ADLs and a need for assistance or supervision in performing the activities, in addition to any other support the participant receives.
- Are in a situation where the participant network of non-adult day health care center supports is insufficient to maintain the individual in the community, demonstrated by at least one of the following:
    - The participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision.
    - The participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the participant.
    - The participant has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the participant.
    - A high potential exists for the deterioration of the participant's medical, cognitive or mental health condition or conditions in a manner likely to result

[65] Alteras, T. (July 23, 2007), *Adult Day Health Care Services: Serving the Chronic Health Care Needs for Frail Elderly through Cost-Effective, Non-Institutional Care*. Health Management Associates.

in emergency room visits, hospitalization or other institutionalization if adult day health care services are not provided.

- The participant's condition or conditions require adult day health care services on each day of attendance that are individualized and designed to maintain the ability of the participant to remain in the community and avoid emergency room visits, hospitalizations or other institutionalization.

ADHCs receive referrals from physicians, other medical professionals, family members, friends and prospective participants. Participants receive an assessment from a multidisciplinary health care team that includes the participant's physician or a staff physician, or both, a registered nurse and a social worker. The assessment may include other members—physical therapist, occupational therapist and other qualified consultants with skills in recreational therapy, speech language pathology or dietary assessment if needed. The assessment team determines the medical, psychosocial and functional status and needs and then develops an individual plan of care based on the findings. Plans of care and the Treatment Authorization Request (TAR) are submitted to DHCS field offices, where they are reviewed and adjudicated by a nurse evaluator. TARs must be renewed every six months. Nurse evaluators process about 70,000 TARs each year.

ADHC often serves beneficiaries who receive other services. A review of paid Medi-Cal claims found that 60% also received IHSS services. A state official suggested that ADHC may supplement IHSS for participants who need more hours than can be authorized under IHSS. ADHC also provides skilled services that are not available through IHSS and the combined services meet a broader range of health and functional needs.

Centers are required to provide a minimum of four hours of service in order to bill for one day, but they must be open a minimum of six hours per day, five days per week. Centers that have sufficient staffing are open six or seven days per week, and several specialize in serving beneficiaries with cognitive impairments or mental illness. The number of centers grew by 10 to 15 per year until a moratorium was imposed in 2004. An audit of claims found instances of inappropriate billings. Combined with a rate reduction, the number of ADHCs declined after 2004. As of February 23, 2009, there were 320 ADHCs with a capacity to serve 45,427 persons.

The Legislature passed a bill (SB 1755) that was chaptered in 2006 that changes the reimbursement methodology. Beginning in 2010, centers will receive a flat rate for core services and other mostly skilled services will be billed separately. Core services are one or more of the following services:

A new reimbursement system for ADHC providers will be implemented in 2010.

- One or more of the following professional nursing services:
    - Observation, assessment and monitoring of the participant's general health status and changes in his/her condition, risk factors and specific medical, cognitive or mental health condition or conditions
    - Monitoring and assessment of the participant's medication regimen, administration and recording of the participant's prescribed medications and intervention, as needed, based upon the assessment and the participant's reactions to his/her medications
    - Oral or written communication with the participant's personal health care provider, other qualified health care or social service provider, or the participant's family or other caregiver, regarding changes in the participant's condition, signs or symptoms
    - Supervision of the provision of personal care services for the participant and assistance
    - Provision of skilled nursing care and intervention
- One or both of the following core services:
    - One or both of the following personal care services: supervision of, or assistance with, ADLs or IADLs; protective group supervision and interventions to assure participant safety and to minimize the risk of injury, accident, inappropriate behavior or wandering
    - One or more of the following social services: observation, assessment and monitoring of the participant's psychosocial status; group work to address psychosocial issues; care coordination
- At least one of the following therapeutic activities provided by the ADHC activity coordinator or other trained ADHC center personnel:
    - Group or individual activities to enhance the social, physical or cognitive functioning of the participant
    - Facilitated participation in group or individual activities for those participants whose frailty or cognitive functioning level precludes them from active participation in scheduled activities
- One meal per day of attendance

SB 1755 designated separately billed services as physical therapy services, occupational therapy services, speech and language pathology services, mental health services, registered dietician services and transportation services.

Program Trends

Table 38 shows the yearly cost of ADHC. This table has been prepared from three different DHCS data sources. Data for FY 2002, FY 2003, FY 2004 and FY 2006 were taken from Excel spreadsheets prepared by the Department, FY 2005 was taken from a January 2008 study and FY 2007 and FY 2008 were provided by staffs that work with the ADHC.

Table 38: Yearly Cost of the Adult Day Health Care Program: FY 2000–2007

Fiscal year	Expenditures
FY 2000	$ 100,884,944
FY 2001	$ 148,377,780
FY 2002	$ 205,046,453
FY 2003	$ 278,078,823
FY 2004	$ 348,263,135
FY 2005	$ 375,238,230
FY 2006	$ 381,916,438
FY 2007	$ 417,820,000
FY 2008	$ 387,500,000

Data Source: Department of Health Care Services

Detailed data about the program is available for FY 2005.[66] Providers are reimbursed using two procedure codes: Z8500 for ADHC Regular Day of Service and Z8502 Initial Assessment with Sub. For both procedure codes combined in FY 2005, there were 57,195 unduplicated beneficiaries. In other words, in FY 2005 about 57,000 unique persons used ADHC. Procedure code Z8502 was billed for 17,031 persons meaning there were approximately 17,000 assessments of new persons to the program. Procedure code Z8500 was billed for 54,486 unique persons and 5,324,018 days of service were billed at an average cost of $69.78 per day. The average person used ADHC for 98 days per year.

Participant data for ADHC for later years is also available; however, unduplicated yearly counts are not available. Rather, data on the number of persons who used ADHC each month is available. If we combine the monthly count of persons who received ADHC each month, then in FY 2006–2007 the program served 527,231 beneficiaries and in FY 2007–2008 the program served 402,120 beneficiaries at a cost of $964 per participant per month, and it will serve a projected 403,056 participants in FY 2008-2009 at a cost of $388.9 million or $1,024 per participant per month. Over 80% of the participants are age 65 and older and fewer than half are age 80 and older, which is comparable to recipients receiving services in a nursing facility.

ADHC spending is not included in national per capita HCBS spending reports because it is not reported separately.

[66] Scourtes, D. (2008), *Cost of Care and Length of Stay of Medi-Cal Long-term Care Recipients, State of California*. Department of Health Care Services, Medical Care Statistics Section, Sacramento, CA. January 2008.

In 2006, SB 1755 also established new eligibility criteria, new medical necessity criteria, new provisions for the participant's personal health care provider, changes in the minimum required ADHC services, unbundling of the current procedure code and a new rate methodology. The bill was effective February 1, 2008 and resulted in a drop in ADHC expenditures as shown in the preceding table.

ADHC serves two distinct populations—one receives temporary rehabilitative services and the other receives longer-term support and medical services. The service spans the health and long-term care systems. ADHC has its own referral and access process. Ideally, all long-term care services would be accessed through single or comprehensive entry points. Designing procedures to determine which participants might access ADHC through a single entry point and which participants might access through referrals from health professionals is complex. We defer making a recommendation to include ADHC in a single entry point system until such a system is created and functional coordination between ADHC and other programs will continue for beneficiaries who receive services from multiple programs.

ADHC is covered as a state plan service in at least eight states (California, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Texas and Washington). CMS has advised California officials that it risks denial of reimbursements because ADHC is not considered by CMS as a rehabilitation service and the provision of ADHC services in the state plan does not follow federal regulations regarding state plan services. CMS suggests that states consider two options—a §1915(c) HCBS Waiver or a §1915(i) HCBS state plan service. See Appendix D for a description of this option.

Converting to a §1915(c) Waiver would limit participants to beneficiaries who meet the institutional level of care criteria. An estimated 20% of the current participants would not meet the criteria and would lose service. ADHC is an eligible service under the §1915(i) HCBS state plan option; however, according to the department, they lack the infrastructure to conduct an independent assessment that is required by the statute and would have to contract with independent entities to conduct the assessment. The options have different impacts. Developing a §1915(i) state plan amendment may incur additional administrative costs to determine eligibility and complete an assessment, depending on how existing resources may be deployed, yet it would allow current participants to continue receiving services. The §1915(c) option would eliminate a substantial number of current participants. DHCS could potentially use the existing assessment and the TAR process to administer ADHC as a waiver service.

In reviewing the multi-year history of the waivers, each waiver experienced cycles in which high enrollment and high costs per person were followed by reduced enrollment or slower rates of growth. The cycles are attributed to the state's budget situation, which worsened in 2006. All of the waivers except one had a lower enrollment in 2006. On the one hand, with the exception of the NF/AB Waiver prior to 2005, the state has assured CMS that all the waivers are cost neutral and that it measures their cost neutrality and includes transition-related services as part of waiver services. On the other hand, the reductions reflect an institutional bias and the perception that waiver services expand aggregate spending.

National Comparisons

California ranks 1st in the nation in the number of personal care participants per 1,000 population and 42nd in HCBS Waiver participants per 1,000. California spends more per capita on personal care, ranking 4th nationally compared to other states, and much less on waiver spending.[67] The state ranks 48th in total waiver spending per capita; 44th for persons with developmental disabilities and 45th for aged and disabled beneficiaries.

Per capita spending from Form 64 is reported for nursing facilities, ICF/MR, personal care services, home health services, HCBS Waivers serving individuals with developmental disabilities and HCBS Waivers serving older adults and individuals with physical disabilities. However, expenditures reported on CMS Form 64 under-report spending for community services in California and other states. Comparing California's waiver spending for older adults and persons with physical disabilities to other states is misleading since the state spends such a large amount on IHSS, which is a state plan service.

California ranks 18th among all states based on available data for waiver and state plan services. The actual ranking might be higher if ADHC and other spending were included. ADHC state plan spending, managed long-term care spending in some states and other state plan services are not reported separately to CMS on Form 64 and are not included in the calculations prepared by Burwell et al. See Table 39.

Table 39: California National Ranking for Per Capita Expenditures: 2007

Measure	Rank
Total long-term care spending	37
Total home care spending	18
Total 1915(c) Waiver spending	48
DD Waiver spending	44
A/D Waiver spending	45
Personal care spending	4

Source: Burwell, B., et al.

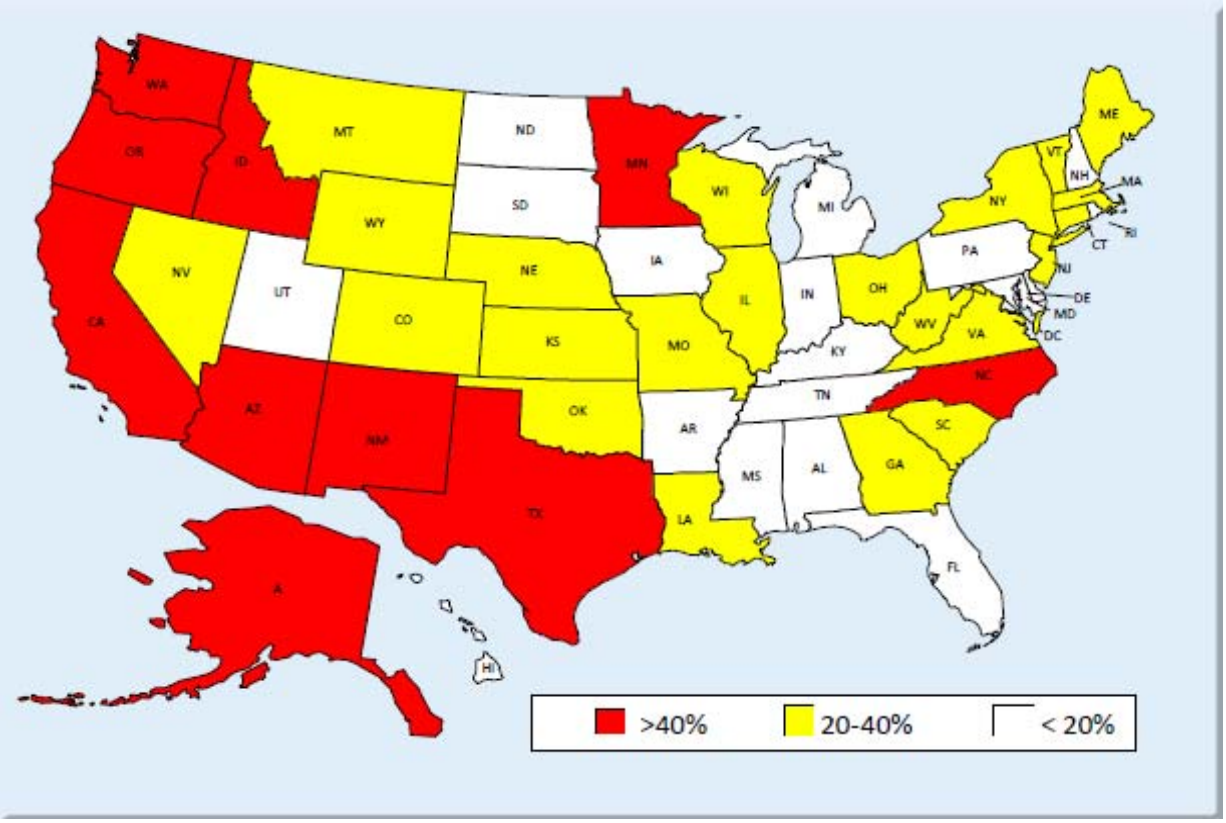
California trails only four states (Arizona, New Mexico, Oregon and Washington) in the percentage of Medi-Cal (Medicaid) funds spent on HCBS for older adults and individuals with physical disabilities. Figure 7 groups states according to the percentage of spending for HCBS: more than 40%, 20–40% and less than 20%. Ten states spend more than 40% of Medicaid long-term care funds on HCBS. As noted elsewhere, the data underreport spending in states like California that cover adult day health care under the Medi-Cal state plan.

The data also does not account for states that operate HCBS programs funded by general revenues. Forty states and the District of Columbia operate multi-service HCBS programs with general revenues. Including these funds increases the percentage spent on HCBS by 2.0 or more percentage points in 16 states and the District of Columbia. Indiana's state-funded CHOICE (Community and Home Options to Institutional Care for Elderly and Disabled) program nearly doubles the state's HCBS effort, from 5.5% to 10.7%. The funds spent on HCBS programs

[67] Burwell, B., Sredl, K. & Eiken, S. Op. cit.

increase by 6.2 percentage points in Illinois and 5.7 percentage points in Massachusetts when state-funded programs are included. Other notable increases were found in the District of Columbia and South Dakota (4 percentage points), North Dakota (3.7 percentage points), Pennsylvania (3.6 percentage points), Wyoming (3.3 percentage points), and Kentucky (3.2 percentage points).[68]

Figure 7: Percentage of Medicaid Long-Term Care Spending Going to Services for Older Persons: 2007

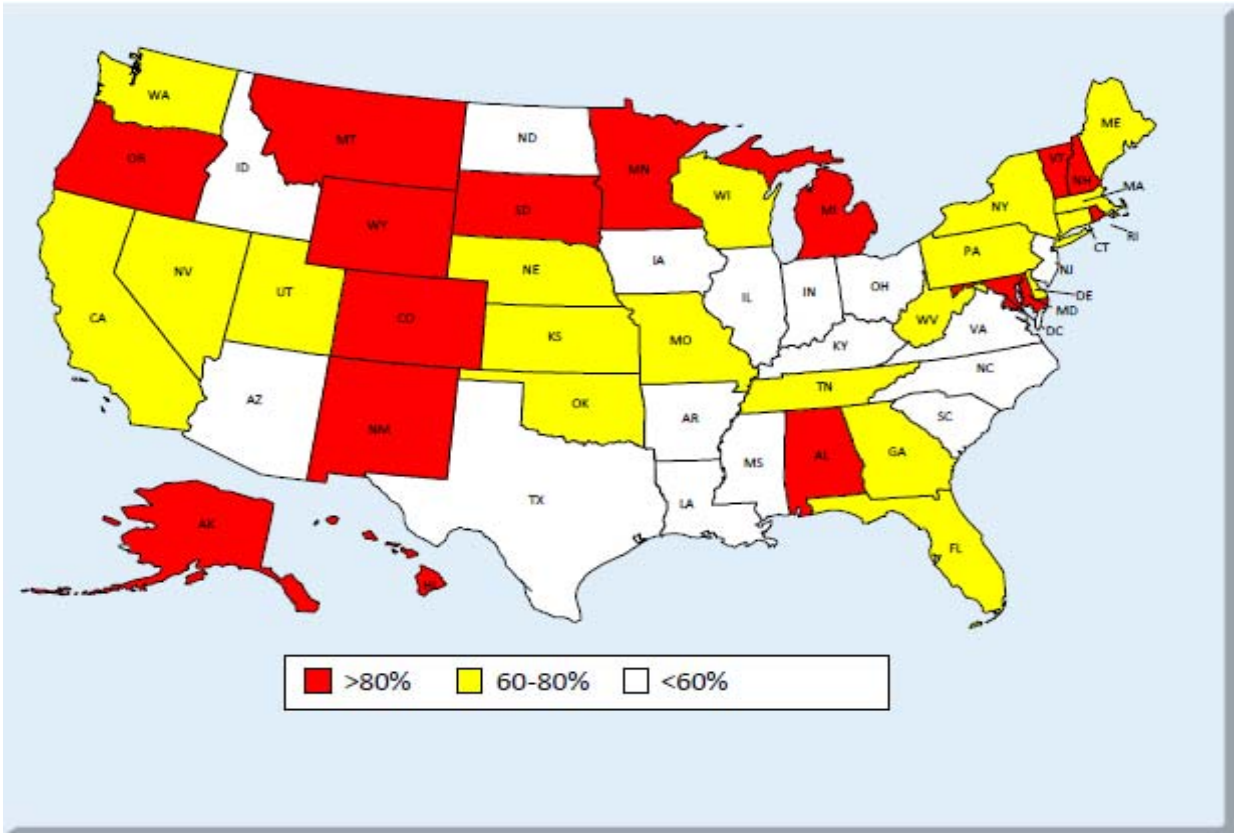


Source: Burwell, B, et al. Note: includes HCBS Waivers, personal care and home health expenditures.

Figure 8 groups states according to the percentage of funds spent on HCBS for persons with developmental disabilities. Fourteen states spend 80% or more on HCBS for this population. As noted earlier, spending on targeted case management HCBS from state general funds is not included. DDS stated that small ICF-MRs are home-like and should be considered community settings. ICF-MRs of all size are licensed as institutional and expenditures for small ICF-MRs are not included as HCBS spending.

[68] Mollica, R., Sims-Kastelein, K., and Kassner, E. (2009), *State-Funded Home and Community-Based Services Programs for Older Adults, 2007*. AARP Public Policy Institute. Washington, DC. Available at: http://www.aarp.org/research/ppi/ltc/hcbs/articles/2009_06_hcbs.html.

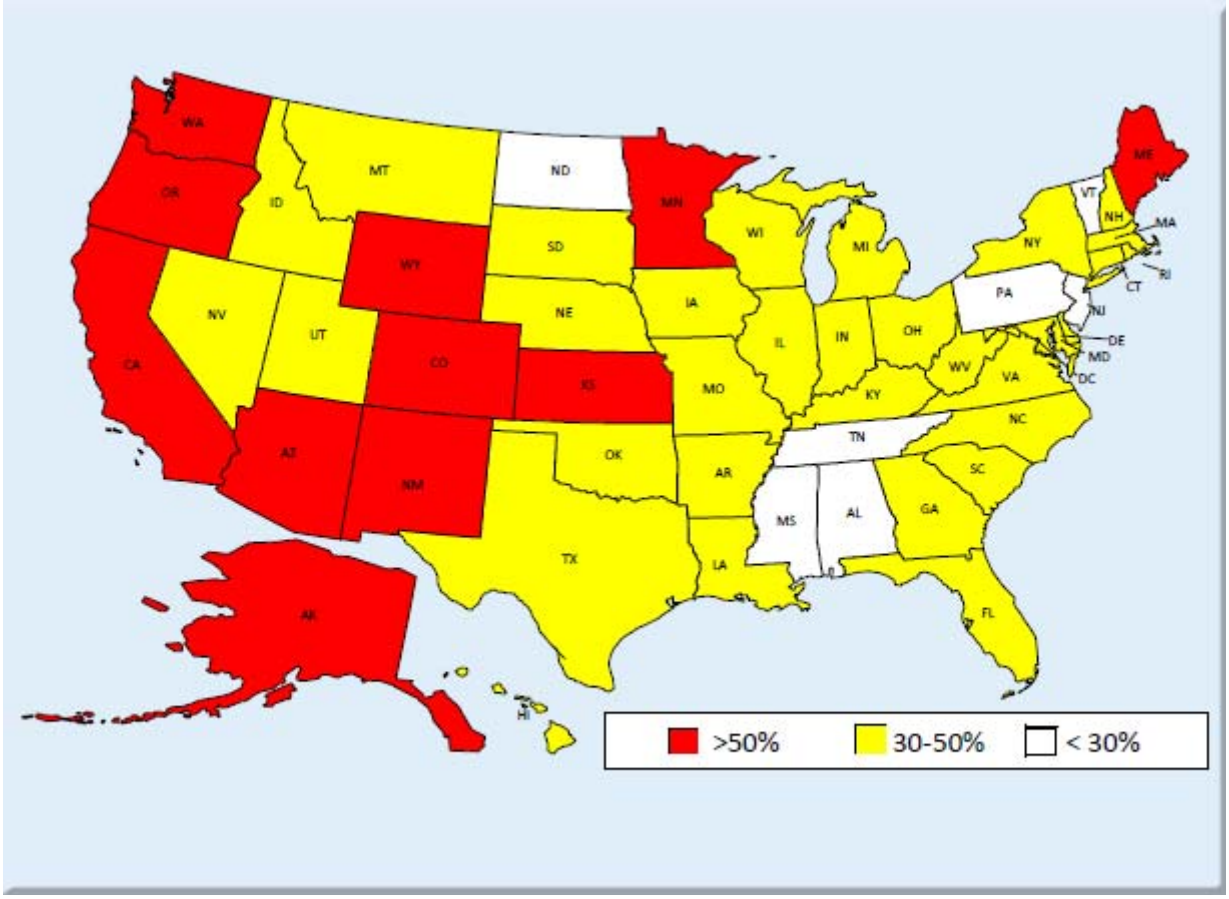
Figure 8: Percentage of Medicaid Long-Term Care HCBS Spending Going to Persons with Developmental Disabilities: 2007



Source: Burwell, B., et al.

California is 8th in the percentage of HCBS spending for all populations. Eleven states spend more than 50% of their Medicaid funds on HCBS for all populations: Alaska, Arizona, California, Colorado, Kansas, Maine, Minnesota, New Mexico, Oregon, Washington and Wyoming.

Figure 9: Percentage of Medicaid Long-Term Care HCBS Spending Going to All Populations: 2007



Data Source: Burwell, B., et al.
Note: Spending under Vermont's two §1115 demonstration programs are not included.

States typically spend a higher percentage on HCBS for persons with developmental disabilities than they spend on other populations. Table 40 shows that approximately 92% of the expenditures for all waivers in California are spent on the DD Waiver due to the much higher cost per person and the large numbers of individuals enrolled in the waiver.

Table 40: Expenditures for All Waivers: 2006

Waiver	2006 Period Expenditures	% of Total
AIDS	$ 10,103,726	0.71%
IHMC	$ 11,675,109	0.82%
Assisted Living	$ 1,319,352	0.09%
MSSP	$ 42,699,627	2.99%
NF/SA	$ 36,074,208	2.52%
DD	$ 1,313,519,501	91.88%
NF A/B	$ 14,242,420	1.00%
Total	$ 1,429,633,943	100.00%

Data Source: Department of Health Care Services

To meet the financial eligibility criteria for §1915(c) Waivers, applicants must receive SSI, SSP, meet the Medically Needy Medi-Cal standards or have income below 100% of the FPL. Individuals who are eligible for Medicaid in an institution may not be eligible in the community. States may cover institutionalized beneficiaries whose income is less than 300% of the Federal SSI benefit ($2,022 per month in 2009) but are not required to cover the same person in the community, although many states do. Individuals in states with a Medically Needy program are more likely to be eligible in an institution than in the community. The high cost of nursing facility care quickly depletes the income and resources of low-income individuals. In the community, low-income individuals need their income and resources to maintain their homes. The cost of HCBS is less likely to meet the "spend down" requirement and they may not have enough resources to meet their expenses and for services until they are eligible for Medicaid. This bias can be addressed by adding the 300% special income group eligibility category to nursing facility and waiver programs.

The relatively low nursing facility bed supply and the high supply of RCFEs would be expected to increase demand for waiver programs. A portion of the demand appears to be met by the IHSS program. Because of its size and coverage as a state plan option, IHSS helps to minimize the institutional bias.

Table 41 compares features of selected programs.

Table 41: Comparison of Selected HCBS Services and Programs: 2009

Waiver	Population Served	Services	Functional Eligibility	Enrollment Cap
IHSS	Medi-Cal beneficiaries with functional impairments	Domestic, meal preparation/clean up, routine laundry, personal care, food shopping and errands, transportation to medical appointments, heavy cleaning, yard hazard abatement, protective supervision, paramedical, restaurant meal allowance and advance pay.	County social services staff conduct assessments utilizing a uniform process that includes the following four elements: Uniform definitions of functions which are clearly correlated to tasks authorized for IHSS programs; A ranking scale, defining each function and behavior a participant would exhibit to rank at each level; A Functional Index score, which is a weighted average, that measures the participant's relative dependence on human assistance for performance of basic tasks; and A method of correlating a participant's discrete rankings and the tasks with which the recipient needs help.	No cap
AIDS	HIV/AIDS	Case management, homemaker, home health aide/attendant care, psychotherapy, supplements for infants and children in foster care, non-emergency medical transportation, nutritional supplements, home-delivered meals, skilled nursing, special medical equipment and supplies and minor physical adaptations.	Those whose health status qualifies them for nursing facility care or hospitalization; Individuals with a written diagnosis by an attending physician of HIV disease or AIDS with current signs, symptoms or disabilities related to HIV disease or treatment; Those who meet the nursing facility level-of-care and score 60 or less using the Cognitive and Functional Ability Scale assessment tool; and Those who have a health status that is consistent with in-home services and have a home setting that is safe for both the client and service providers (e.g. structurally sound, clear exits during emergencies).	3,890
Assisted Living Waiver	Aged/disabled	Environmental accessibility adaptations, transition coordination, transition, translation and interpretation, care coordination, assisted living (in RCFEs), consumer education and assisted care benefits (public housing).	Meet NF level of care and other criteria	1,000
Developmental Disabilities	Developmentally disabled	Homemaker, home health aide, respite care, habilitation (residential habilitation for children services, day habilitation, prevocational, supported employment), environmental accessibility adaptations, skilled nursing, transportation, chores, PERS, family training, adult residential	Must have a formal diagnosis of a developmental disability that originates before an individual attains the age of 18, as defined in the California Lanterman Developmental Disabilities Services Act; Must be a regional center consumer; Must meet the level of care of the Federal ICF/MR, or in California, the ICF/DD-type facilities.	85,000

Waiver	Population Served	Services	Functional Eligibility	Enrollment Cap
		care, vehicle adaptations, communication aides, crisis intervention, nutritional consultation, behavior intervention, specialized therapeutic, transition/set up expenses and habilitation.		
In-Home Operations	Physically disabled	Environmental accessibility adaptations, case management, respite care (home and facility), PERS, PERS installation and testing, community transition, home health aide, habilitation, family training, waiver personal care, transitional case management, medical equipment operating expenses, private-duty nursing and including shared services.	Physically Disabled (no age limit); Beneficiaries, who in the absence of the waiver, and as a matter of medical necessity, would require care in an inpatient nursing facility (NF) providing the following types of care: Nursing Facility (NF) Distinct Part; NF Level B Pediatric Services; NF Subacute Services; NF Pediatric Subacute Services;	210
Multipurpose Senior Services Program	Aged	Case management, personal care, respite care (in-home and out-of-home), environmental accessibility adaptations, housing assistance/minor home repair, transportation, chores, PERS/ communication devices, adult day care/support center/health care, protective supervision, congregate/home-delivered meal, social reassurance/therapeutic counseling, money management and communication services (translation/interpretation).	Receiving nursing facility level of care.	16,035
Nursing Facility/Acute Hospital	Physically disabled	Private-duty nursing, including shared nursing, home health aide services, case management, transitional case management, environmental accessibility adaptations, PERS, PERS installation and training, medical equipment operating expenses, waiver personal care services, community transition, habilitation services, respite care (home and facility)	Physically Disabled (no age limit). Must meet the acute hospital, adult or pediatric subacute, nursing facility, distinct-part nursing facility, adult, or pediatric Level B (skilled) nursing facility or Level A (intermediate) nursing facility (NF) Level of Care with the option of returning to and/or remaining in his/her home or home-like setting in the community in lieu of institutionalization. Must meet other criteria and requirements listed in the waiver.	2,712

Section 4: Developmental Services

National Comparisons

The authors reviewed reports whose data presents different perspectives of California's services for persons with developmental disabilities. One report is based on expenditures data. Based on data reported to CMS by state Medicaid agencies, on a total spending basis, 62% of Medicaid long-term care funding for persons with developmental disabilities in California is spent on home and community-based services, slightly below the national average of 63%, and 38% pays for institutional care. California ranks 44th nationally in per capita waiver spending for persons with developmental disabilities and 33rd in per capita spending for intermediate care facility services for the developmentally disabled (ICF-DDs).

The reported percentage of HCBS spending does not include In-Home Supportive Services (IHSS) delivered to about 16,000 individuals with developmental disabilities, Adult Day Health Care and targeted care management. As noted earlier, including spending for targeted case management and other non-waiver services shifts the percentage of spending for HCBS. Similar to services for adults with disabilities, waiver spending alone does not present a complete picture of services for persons with developmental disabilities. The expenditure data that are reported on CMS Form 64 under-reports spending for community services in California and several other states.

Another report comparing states uses multiple measures. United Cerebral Palsy ranked states on 20 measures and California ranked seventh highest in the country.[69] These 20 measures include factors such as:

- the existence of waiting lists for ID/DD service and California is one of only seven states that does not have waiting lists
- keeping families together through family support and California ranked 9th in the nation on this measure, and
- the percent of persons living in places with 1-3 residents and California ranked 7th in the nation.

These reports provide different perspectives on services for persons with developmental disabilities. Federal financial data is useful because it is collected in a uniform manner across all states. However, spending on persons with ID/DD is included in multiple reporting categories which limit comparisons across states.

[69] United Cerebral Palsy, (2009), *The Case for Inclusion: An Analysis of Medicaid for Americans with Intellectual and Developmental Disabilities*, Washington, D. C. p. 8 Retrieved on 9-29-2009 from http://www.ucp.org/medicaid/main.cfm

Regional Centers

The regional center delivery system for individuals with developmental disabilities is well developed.[70] It is California's only single entry point system that provides access to comprehensive services. While programs for other populations offer valuable services, they operate independently of one another.

The Lanterman Developmental Disabilities Services Act, also known as the Lanterman Act, which passed in 1969,[71] creates the foundation for California's developmental disabilities service delivery system. The Lanterman Act describes the state's commitment to service persons with developmental disabilities in the community and states:

> The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge. Affecting hundreds of thousands of children and adults directly, and having an important impact on the lives of their families, neighbors and whole communities, developmental disabilities present social, medical, economic and legal problems of extreme importance. (Welfare & Institutions Code, §4501)

The Lanterman Act specifies the policies that define and guide the system. Regional centers coordinate and/or provide community-based services to eligible individuals. Regional center services became an entitlement following a California Supreme Court decision in 1985.[72] Budgets are based on historical costs and the number of individuals served. The regional centers are community-based nonprofit corporations governed by volunteer Boards of Directors that include individuals with developmental disabilities, families, a representative of the vendor community and other community representatives.

Regional centers serve as single entry points for HCBS for individuals with developmental disabilities.

Regional centers are funded through contracts with Department of Developmental Services (DDS). They are responsible for the direct provision of outreach, intake and assessment, evaluation and diagnostic services, preventive services and case management/service coordination for persons with developmental disabilities and persons who are at risk of becoming developmentally disabled. In addition, regional centers are responsible for developing, maintaining, monitoring and funding a wide range of services and supports for consumers they serve. Regional centers also conduct quality assurance activities in the community, and they maintain and monitor a wide array of qualified service providers.

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[70] The regional center program was begun by the Legislature through Assembly Bill 691, Chapter 1242, Statutes of 1965. Beginning with two regional centers in Los Angeles and San Francisco, all 21 regional centers were operating by 1976.

[71] Further information about the Lanterman Act and Regional Centers is available at: http://www.dds.ca.gov/ConsumerCorner/docs/LA_Guide.pdf and http://www.dds.ca.gov/RC/Home.cfm.

[72] Association for Retarded Citizens v. Department of Developmental Services (1985), 38 Cal.3d 384, 696 P.2d 150 [March 1985]; 211 Cal. Rptr. 758.

Regional centers operate the Home and Community-Based Services (HCBS) Medi-Cal Waiver, complete individualized assessments to establish functional eligibility, develop, monitor and update Individual Program Plans (IPPs) in response to changing needs, monitor the delivery of services, and ensure the health and safety of waiver participants.

National information is available that includes summaries and data about state programs for persons with developmental disabilities.[73] Data from the DDS Facts Book indicates that the number of individuals served in the community increased 59.6% between January 1997 and December 2007 to over 220,000.[74] 58% were age 21 and younger. 74% of participants lived in their own homes or their family's homes while 3.9% lived in a nursing facility and 1.2% lived in a developmental center.

In 2008, two research studies suggested that there were variations in the type of services received based on age and acuity. Areas of the state that have a greater supply of intermediate care facilities (ICFs) seemed to correlate with lower receipt of regional center services. Clients with higher needs were more likely to receive higher levels of service. Controlling for client needs and other factors, males were more likely to receive out-of-home services. Individuals age 3-21 were less likely to receive services, but were more likely to receive in-home and out-of-home respite services than those age 62 and older were. The supply of nursing facilities, community care facilities, area population characteristics and regional centers was associated with variations in service use and expenditure patterns.[75,76]

The regional center contract with DDS includes annual performance objectives. These contracts require annual performance reports that include two sets of measures—public policy measures and DDS compliance standards. In addition, regional centers may also develop local measures in collaboration with their local community. A regional center is considered to have successfully achieved an item upon demonstrating one of the following:

- The outcome has improved over the prior year's baseline;
- The performance exceeds the statewide average; or
- The performance equals a standard that has been defined by the Department.

DDS guidelines state that local indicators are met when the outcome reflects progress over the prior year's performance (baseline) and is related to a positive impact on consumers and/or families and is not included in the statewide measures listed above, e.g., increased presence of natural supports, persons with foster grandparents, etc. Performance reports were not obtained as part of this study.

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[73] See for example, The Coleman Institute. *The State of the States in Developmental Disabilities 2008.* Department of Psychiatry, University of Colorado, Boulder, CO. (2008), See California and other state data at, retrieved on 1-23-09: https://www.cu.edu/ColemanInstitute/stateofthestates/index.html and Lakin, C., Larson, S., Coucouvanis, K. and Soo-Young, B. *Residential Services for Persons with Developmental Disabilities: Status and Trends through 2007.* University of Minnesota, Research and Training Center on Community Living. Available at: http://rtc.umn.edu/docs/risp2007.pdf.

[74] DDS Fact Book 11th Edition (2008) Department of Developmental Disabilities, Sacramenton, CA Retrieved on 9-28-09 from http://www.dds.ca.gov/FactsStats/docs/factbook_11th.pdf

[75] Harrington, C. & Kang, T (2008), *Disparities in service utilization and expenditures for individuals with developmental disabilities.* Disability and Health Journal. 1 (2008), pp. 184-195. Elsevier Press.

[76] Harrington, C. & Kang, T (2008). *Variation in types of service use and expenditures for individuals with developmental disabilities*. Disability and Health Journal. 1 (2008), pp. 30-41. Elsevier Press.

Individual Program Plans (IPP)

The Lanterman Act requires meetings with consumers and their family members, legal guardians or conservators to discuss the consumer's quality of life and to observe the services and supports available to the consumer and to develop an IPP. The IPP is a planning process that assists persons with developmental disabilities and their families to build their capacities and capabilities. This planning process is described as ongoing and includes a series of discussions or interactions among a team of people including the person with a developmental disability, his/her family (when appropriate), regional center staff and others. DDS staffs reported that IPPs are prepared for all individuals served by regional centers, including HCBS Waiver and non-waiver participants. IPPs based on person-centered planning principles were added to the Lanterman Act in 1992.

The statute states that:

- IPPs will be centered on the person and family.
- DDS will prepare a standard format for IPPs with instructions. The format and instructions will embody an approach centered on the person and family.
- DDS will prepare training materials to implement a person-centered approach.
- To ensure a person-centered approach to IPPs, each regional center shall use the standard format, instructions and training materials prepared by DDS.
- All public or private agencies receiving state funds for the purpose of providing the services and supports selected through the IPP process shall respect choices made by consumers.
- Information needed by consumers and families to exercise their right to make the choices necessary for person-centered IPPs will be provided in an understandable form.
- The activities of employees of the regional centers and service providers related to person-centered IPPs shall reflect awareness of, and sensitivity to, the lifestyle and cultural background of the consumer and family.
- Individuals receiving regional center services have an IPP or individual family services plan (IFSP) in the case of children from birth to age two. The IPP is a tool for ensuring the health and welfare of the persons receiving HCBS Waiver supports, and services funded under the HCBS Waiver are addressed.
- Decisions concerning the consumer's goals, objectives, and services and supports that will be included in the IPP and purchased by the regional center, or obtained from generic agencies, shall be made jointly by the planning team at the program plan meeting.

As part of the planning process, DDS staff say that the team assists the individual in developing a description that includes: a preferred place to live, favorite people with whom to socialize and preferred types of daily activities, including preferred jobs. This description is called a preferred

future and is based on the individual's strengths, capabilities, preferences, lifestyle and cultural background. The planning team decides what needs to be done, by whom, when and how, if the individual is to begin (or continue) working toward the preferred future. The IPP is a record of the decisions made by the planning team. [77]

CMS requires that states have policies and procedures to develop and approve plans of care for waiver participants (synonymous with IPPs) and review mechanisms to assure that services are delivered as specified in the plan of care that meet the consumer's needs. The IPP requirements apply to all IPPs; however, federal rules require annual reviews of plans of care for HCBS Waiver participants, and changes must be made that reflect the person's changing needs. California law specifies that IPPs shall be reviewed and revised by the consumer's planning team as necessary, in response to the person's achievement or changing needs, no less than once every three years.

The authors are not aware of any independent study of the IPP process and the degree to which the planning requirements are complied with by regional center staff.

Community Placement Plan (CPP)

In 2002, the Legislature established the Community Placement Plan (CPP) process to transition individuals who want to relocate from an institution to the community. Regional centers prepare and submit a plan to DDS in January each year. Once reviewed and negotiated with regional centers, DDS includes the resulting costs in the Governor's May Budget Revision.

The statute states:

> The legislature has a special obligation to ensure the well-being of persons with developmental disabilities who are moved from state hospitals to the community. To ensure that persons with developmental disabilities who are moved from state hospitals to the community are receiving necessary services and supports, the department shall contract with an independent agency or organization for the tracking and monitoring of those persons. (Welfare & Institutions Code, §4418.1)

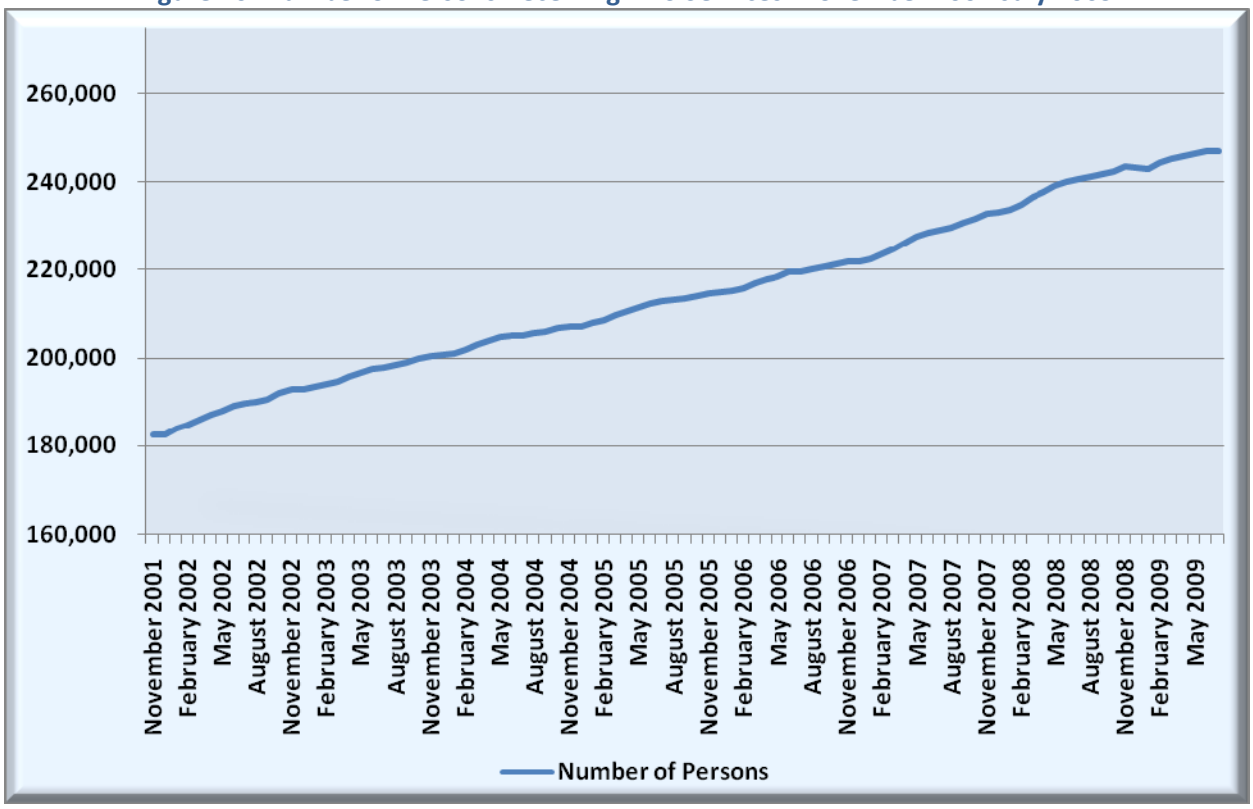
The CPP must be approved by DDS and provides dedicated funding for comprehensive assessments of Developmental Center residents, the cost to transition selected individuals from Developmental Centers to the community and diversion of individuals from admission to a Developmental Center. The plans, where appropriate, include budget requests for regional center operations, assessments, resource development and ongoing placement costs. Regional center service coordinators complete assessments, determine eligibility for services, develop an individual program plan that describes services that will be purchased and implement a service plan. All participants are visited at least quarterly. Service coordinators are required to make at least two unscheduled visits per year to participants who live in licensed settings.

[77] DDS description of the Individual Program Plan. Available at: http://www.dds.ca.gov/RC/RCipp.cfm.

Growth in the Developmental Services Population

The growth in the number of persons served in DDS regional center programs has been steady throughout the last decade. The caseload has grown from just over 180,000 in 2001 to over 247,001 in July 2009.[78] See Figure 10. From November 2001 to July 2009, the population served increased an average of one third of 1% each month, adding some 64,000 persons during this period.

Figure 10: Number of Persons Receiving DDS Services: November 2001-July 2009



Data Source: Department of Developmental Services

Controlling Growth

Policy makers and legislators are concerned about the high rate of growth in regional center expenditures. Significant cost controls were implemented at the beginning of FY 2002–2003 and FY 2003–2004. These included a review of new regional center programs effective July 1, 2002 and rate freezes and eligibility changes on July 1, 2003. These are discussed at length in existing reports.[79] The Acumen report stated that the Community Placement Plan was not subject to budget reductions in 2002–2004. [80] Budget reductions and cost controls are a continuing feature

[78] See DDS Monthly Consumer Caseload Reports retrieved on 9-3-09 from http://www.dds.ca.gov/FactsStats/Caseload_2008.cfm Data shown are for all persons in all "status codes."
[79] For a detailed look at DDS costs, caseloads and utilization during this decade and fiscal impacts of the 2002 and 2003 budget actions, see Acumen. *Trends in DDS Expenditures: Impact of Cost Containment Measures.* Report Submitted to the California Department of Developmental Services (DDS), Burlingame, CA. (April 2008). Retrieved on 1-21-09: http://www.cdcan.us/budget/2008-2009/DDS_expenditures-v28.pdf.
[80] Ibid. Acumen (2008), p. 2.

of the program's history. Even the operational component of the Community Placement Plan experienced 10% reductions in FY 2007–2008 and FY 2008–2009.

The Legislative Analyst's Office (LAO) has a long history of describing and analyzing the operations of the DDS regional centers, and readers are referred to its website at http://www.lao.ca.gov/ for these documents. The LAO also makes yearly suggestions for controlling growth. For example, the following table is taken from the LAO discussion of the FY 2009–2010 budget and is used to document the LAO recommendation that the substantial percentage growth in smaller services needs greater legislative oversight. The LAO on two occasions questioned the accuracy of the data reported by the regional centers and recommended that the State Auditor evaluate the accuracy and the consistency of the purchase of services data now reported by the Centers.[81]

Table 42: LAO Budget Figures for Regional Center Operations: 2008-2010

Regional Center Purchase of Services by Service Category (millions of dollars)				
Service category	2008-2009 [a,b]	2009-2010[a]	Difference	Percentage
Community care facilities	$787.0	$806.1	$19.1	2.4%
Day programs	$782.6	$864.9	$82.3	10.5%
Support services	$629.0	$722.4	$93.4	14.8%
Miscellaneous	**$338.3**	**$452.2**	**$113.9**	**33.7%**
In-home respite	$233.0	$264.4	$31.4	13.5%
Transportation	$208.7	$239.3	$30.6	14.7%
Habilitation services	$148.9	$146.6	($2.3)	-1.5%
Health care	$100.6	$112.9	$12.3	12.2%
Medical facilities	$57.7	$63.4	$5.7	9.9%
Out-of-home respite	$22.5	$22.9	$0.4	1.7%
Subtotals	($2,521.4)	($2,889.1)	($367.7)	(14.6%)
Other adjustments	$30.0	($35.9)	($66.0)	—
Total with Adjustments	$2,551.4	$2,853.1	$301.7	11.8%
[a] Reflects Governor's midyear proposal for 2008–09 and the budget proposal for 2009–2010, excluding the Governor's General Fund reduction of $334 million in 200910 as a savings target.				
[b] Excludes 2008–2009 re-appropriation of $18.7 million for Agnews Developmental Center.				

Data Source: Legislative Analyst's Office[82]

In 2007, the Legislature required that DDS develop options for controlling costs. The report was submitted in December 2007.[83] The report traces the history of regional centers and the factors that contribute to growth such as: the addition of 7,500 new consumers per year, the transition of consumers from Developmental Centers to the community, rate and minimum wage increases, parents who are aging and are no longer able to care for a family member at home and the

[81] See: http://www.lao.ca.gov/analysis_2007/health_ss/hss_06_4300_anl07.aspx The authors did not obtain information from DDS about the utilization of services provided by the Regional Centers and thus this report does not include a detailed analysis of Regional Center services and cannot comment on the accuracy and consistency of service data reported by the Centers.

[82] Retrieved on 3-1-09: http://www.lao.ca.gov/analysis_2009/health/health_anl09003010.aspx#zzee_link_1_1233889516.

[83] Department of Developmental Services. *Controlling Regional Center Costs*. Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007. Sacramento, CA. (December 2006), Retrieved on 1-21-09: http://www.dds.ca.gov/Publications/docs/ControllingRCCosts2007.pdf
See also blogs on the report at: http://arribails.blogspot.com/2008/04/whats-not-in-dds-report-controlling.html.

transition of consumers who leave programs funded by the school system due to age and other factors. Previous options for controlling costs include changing eligibility, reducing the scope of services, payment rates and the process for authorizing services.

The Controlling Regional Centers Costs report also contains detailed descriptions of DDS rate setting procedures and a close look at the multiple rate setting controls that have been instituted throughout this decade. With some exceptions and a limited 3% Consumer Price Index (CPI) increase in July 2006, most providers' rates were frozen in FY 2003-2004 and continue into FY 2008-2009. The controls are broad—encompassing new programs, attempts by providers to shift their reimbursement by changing their programs, i.e. "re-vendorizations," and the gradual narrowing of exceptions since the initial FY 2003-2004 year. In addition to rate controls, eligibility for services was changed by establishing that three "significant functional limitations" had to be present to quality for regional center services.

A DDS report lists 21 options to control spending.

The report listed 21 new cost-control options that included consolidation of regional centers, different quality assurance evaluation processes, increasing caseload ratios, downsizing large residential facilities, applying means testing to all consumers for all services, capping enrollment, and creating waiting lists. Longer-term options were presented that would increase employment opportunities, expand affordable and accessible housing opportunities, leverage Developmental Center land for community housing and expand access to preventive medical and dental services.

Stakeholders expressed concerns about reductions in reimbursement rates, growth in the caseloads and savings obtained by increasing the caseload of workers. Some stakeholders suggested there is an incentive for regional centers to allow individuals with developmental disabilities to enter a Development Center since the state would then pay the cost, whereas if the consumer received home and community waiver services, the costs would be paid from the regional center contracts. DDS staff report that regional centers do not have an incentive to allow individuals to enter a Development Center. The budget process provides regional centers funding based on the number of persons served, and population and utilization growth. Regional centers do not retain any funds that are "saved" if a participant enters an institution, and regional centers do not have any incentive to support admissions to a Developmental Center. Moreover, admissions to a Developmental Center must be reviewed by the court system. The CPP statute creates a process for assuring that individuals are served in the least restrictive setting. The CPP process funds regional centers for the services needed to relocate individuals from developmental centers and to divert individuals from admission to a developmental center.

The current CPP policy and process do not appear to create an incentive for regional centers to place individuals in a developmental center. While a unified or global budget for regional centers that covers both public and private institutional services as well as HCBS programs would consolidate programs, the structure and management of such a budget would be complex. The structure of the current CPP process and the successful closing of the Agnews Center which could be extended to other developmental centers, are effective in serving individuals in the community. The authors do not find that further incentives through a global budget are needed to serve individuals with developmental disabilities in community settings. Further reductions in the populations served in Developmental Centers and large ICF/MRs are possible if there are sufficient supportive housing options and adequate services.

Closing Developmental Centers

Developmental Centers are state-owned and operated institutions for persons with developmental disabilities. In 1991, New Hampshire became the first state to close all of its public institutions. By 2007, eight states (Alaska, Hawaii, Maine, New Hampshire, New Mexico, Rhode Island, Vermont and West Virginia) and the District of Columbia had closed all of their large (16+ beds) public institutions. Another 11 states operate one state institution.[84]

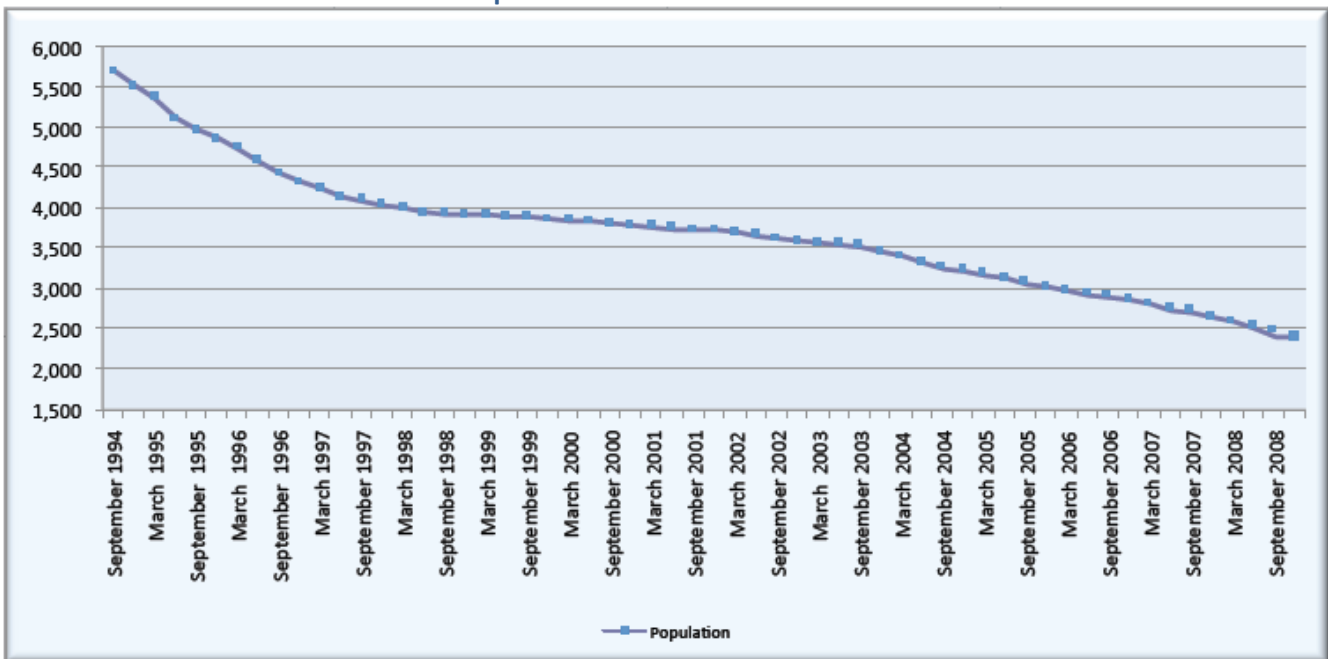
DDS operates five Developmental Centers (four with the closure of Agnews in 2009) that served 2,259 individuals in June 2009, less than half the number served in September 1994. The following figure shows the quarterly population in the Developmental Centers in the period 1994-2008. The rate of change in the population decline was higher in the period 1994-1997, when 2% or more of the persons left the Developmental Centers each quarter.

Developmental Centers are expensive to operate. The November 2008 estimate for the 2009-2010 budget year estimated that it would require $719,485,000 to operate the Developmental Centers. Operations would require 6,438 staff, and the 2,404 persons cared for would cost $299,000 per person per year.[85]

[84]Prouty, R., Alaba, K, and Lakin, C. (2008), *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2007. Status of Institutional Closure Efforts in 2005*. Research and Training Center on Community Living, Institute of Community Integration, University of Minnesota. Accessed 4-10-09: http://rtc.umn.edu/docs/risp2007.pdf.

[85] Department of Developmental Services, (January 9, 2009), *November Estimate: Developmental Centers 2009-10 Governor's Budget*, Sacramento, CA. retrieved on 4-19-09: http://www.dds.ca.gov/Budget/Docs/200910_DCNovemberEstimate.pdf.

Figure 11: Population of the State's Five Developmental Centers and Two Community Facilities: September 1994-December 2008



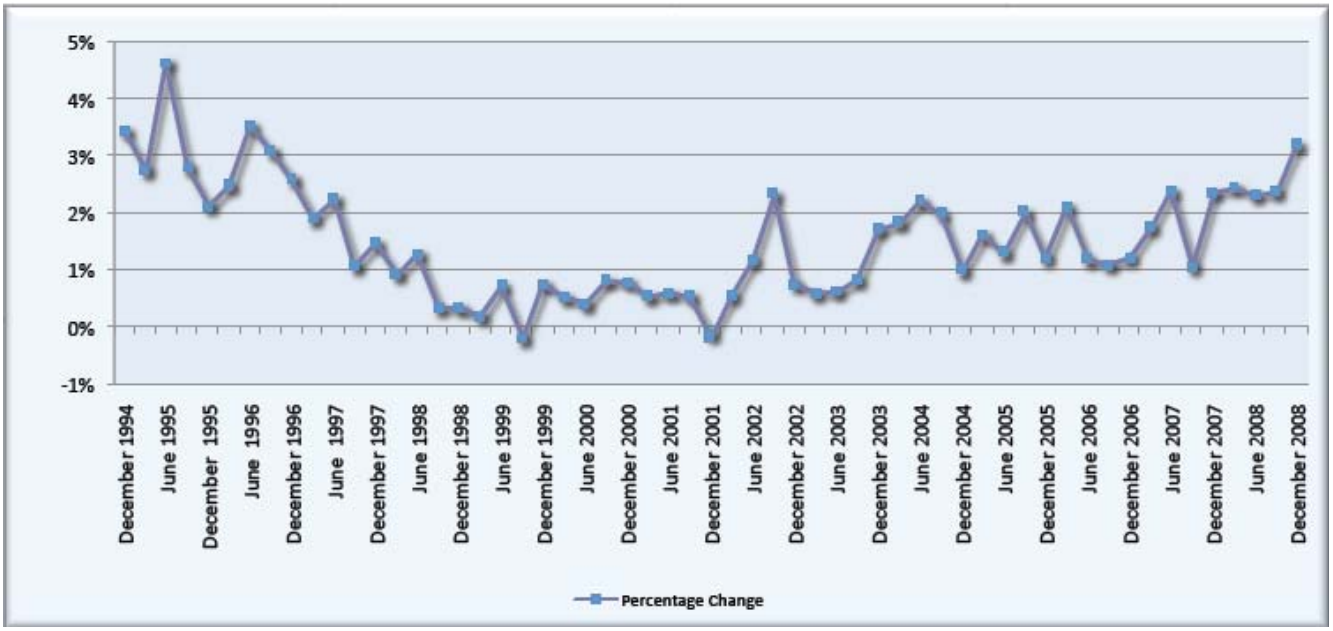
Data Source: Department of Developmental Services

The next figure shows the quarterly change in the percentage of persons leaving the Developmental Centers and other institutions. Each percentage change is the percentage of the previous quarter's population that is no longer there in the next quarter. This figure expresses the drop in population as a rate of change. What is the rate of decline occurring each quarter? For example, if there were 6,000 persons in the population the previous quarter and the next quarter there were 5,910, then 1.5% of the 6,000 persons were no longer there, since 90/6000 = 1.5%.

Figure 12 highlights three phases. In the period 1994-1998, the net quarterly change in the number of persons at the Developmental Centers and institutions dropped by greater than 1% of the population each quarter. From June 1998 to June 2002 the rate of change was less than 1% per quarter, indicating that the transition rate of the mid-1990s did not continue. From 2002 to 2007 the rate of change was between 1% and 2% per quarter, indicating a greater emphasis was placed on helping persons transition from the Developmental Centers beginning in mid-2002.[86] The declines were due to the closing of facilities at certain times and agreements reached between DDS and the plaintiffs in two lawsuits. For example, approximately 2,450 persons left the Centers as a result of the Coffelt decision.[87]

[86] Data points for two missing quarters, June 2000 and June 2002 were interpolated by the authors.
[87] Protection and Advocacy, (2004), *Update on Community Living in California 2004*, Oakland, CA. Retrieved on 4-19-09: http://www.disabilityrightsca.org/PUBS/2004SupportedLifeMasterPacket.pdf

Figure 12: Quarterly Percentage Change in Net Number of Persons Leaving Developmental Centers and Facilities: 1994–2008



Data Source: Calculated by the Authors from data of the Department of Developmental Services

After an extensive process, the last resident moved from the Agnews Center, a complex of some 46 buildings located in San Jose, CA, in March 2009. The closing was made possible by an innovative financing plan to create small group homes that serve five to six residents. The homes are owned by nonprofit housing corporations. The regional centers contract with community organizations to hire caregivers.

The innovative approach to creating housing options was authorized by AB 2100 (Chapter 831, Statutes of 2004). The law authorized DDS to approve a proposal, or proposals, from the Bay Area regional centers to provide for, secure and assure the payment of leases for housing for persons with developmental disabilities to support closure of the Agnews Developmental Center.[88] The plan, called the Bay Area Housing Plan (BAHP), is a joint venture between the Bay Area regional centers and the housing developer. The Bay Area regional centers and the housing developer entered into loan agreements with Bank of America and California Housing Finance Agency (CalHFA).

> Under the BAHP, the Bay Area regional centers contract with a developer to acquire, design and develop housing for persons leaving Agnews. The property is owned by a nonprofit entity, selected by the regional center, for dedicated use by regional center consumers. In this arrangement, once the housing mortgage is paid in full, the provider's lease payment ceases. An inventory of stable community housing designed to meet the unique needs of individuals with developmental disabilities is thereby created, and the rate paid to the provider is reduced accordingly. Through this arrangement, the property is bought once, the residential service

[88] DDS Housing Background Briefing for the Olmstead Advisory Committee, (July 11, 2008).

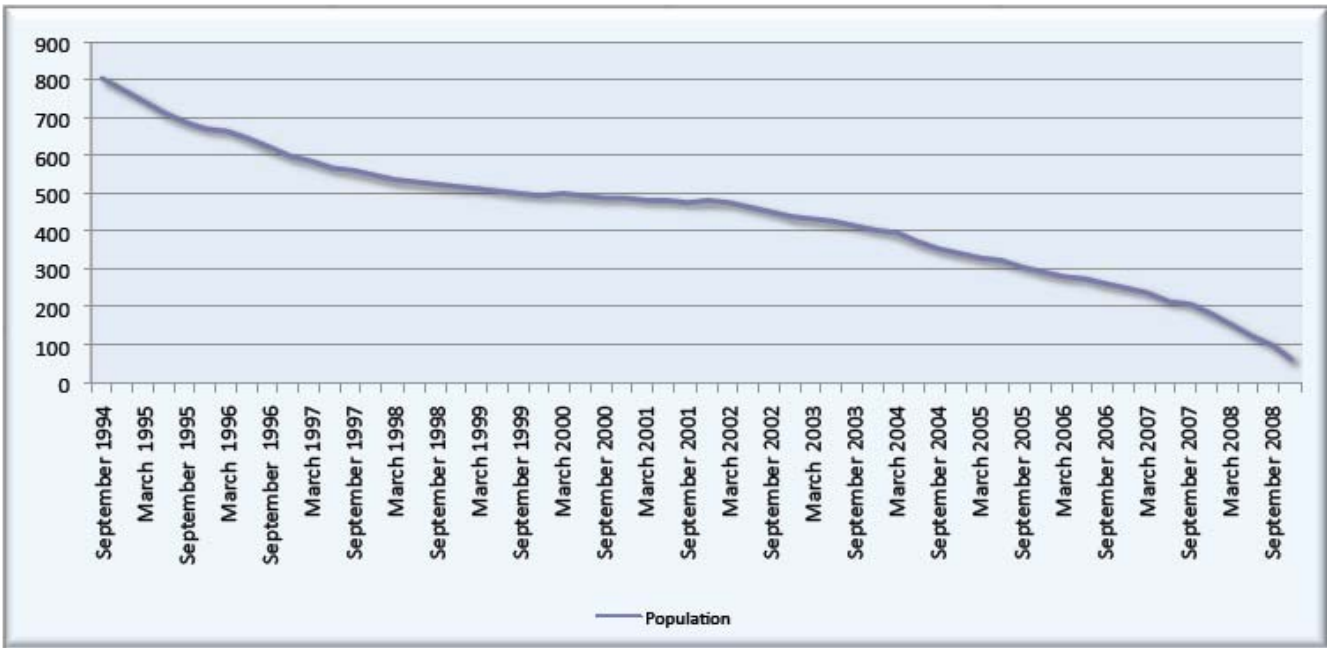
> rate decreases, and long-term cost savings are realized by the state.[89]

The update on the closure plan reported that as of November 30, 2008:

> 61 properties have been purchased and financed; 52 have been remodeled and either occupied or made ready for occupancy; 8 are under construction; and 1 remains in the permitting phase. It is anticipated that the remaining homes will be completed shortly and that the remaining consumers will be transitioned when supports and services are available.[90]

Caseload changes at the Agnews Developmental Center through November 2008 are shown in the next two figures. Figure 13 shows the steady decline in the Agnews population over time.

Figure 13: Agnews Population on Last Wednesday of Each Quarter: September 1994-December 2008



Data Source: Department of Developmental Services

The next figure looks at the quarterly percentage change in the net number of persons leaving the Agnews Center. For example, if there were 700 persons the previous quarter and the next quarter the caseload was 693 persons, then for that quarter the percentage of persons leaving the Agnews Center was 1%, or 7 of 700 persons. The figure shows a flat percentage increase in the number of persons leaving each quarter throughout the 1990s. In March of 2002 the trend changes, and higher percentages leave each quarter, until the percentages dramatically increase beginning in late 2007.

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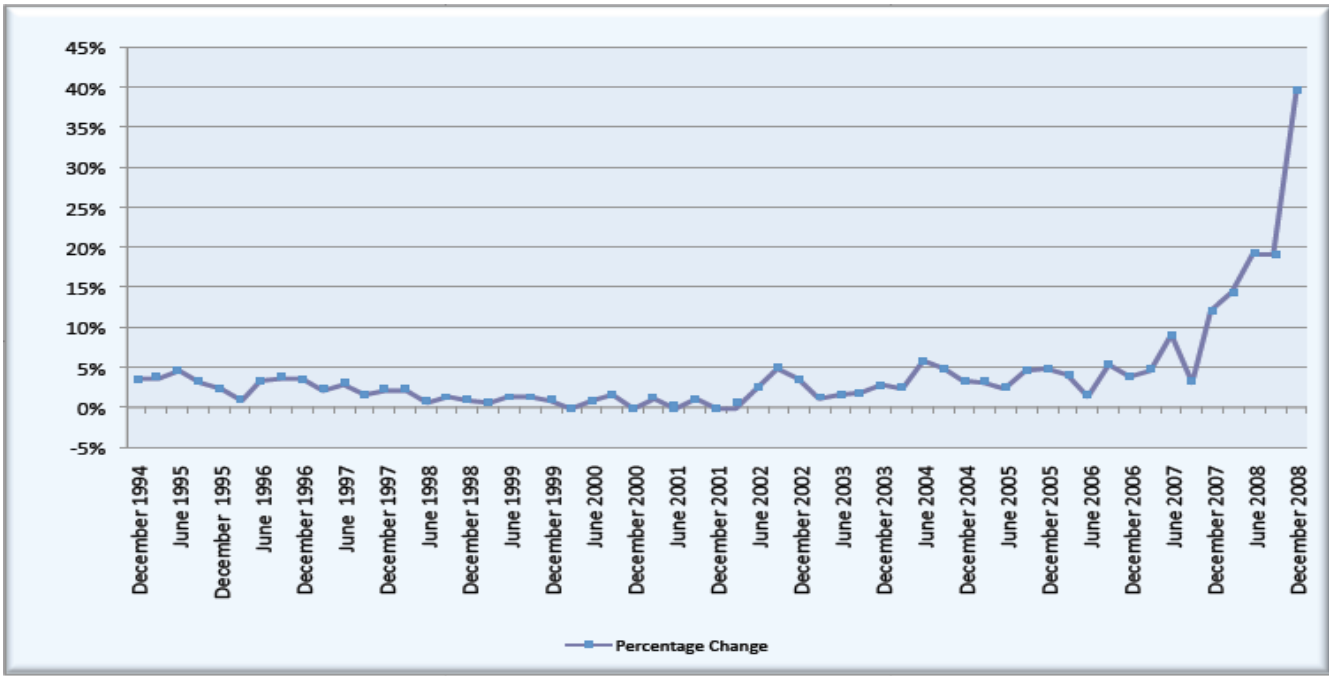
[89] Ibid.

[90] January 2009 *Report on the Plan for Closure of the Agnews Developmental Center*. Available at: http://www.dds.ca.gov/AgnewsClosure/docs/Jan2009_AgnewsClosurePlan.pdf.

Figure 14: Quarterly Net Percentage Change in Number of Persons Leaving Agnews: September 1994-December 2008



Data Source: Calculated by the Authors from Data of the Department of Developmental Services

Nonstate-Operated Intermediate Care Facilities (ICFs) and Skilled Nursing Facilities (SNFs)

The following table shows the number and percentages of persons with developmental disabilities receving DDS services from private ICFs and skilled nursing facilities (SNFs). As the table below shows, the number and percentage of DDS clients in SNFs declined slightly. The number of DDS clients in private ICFs has not declined, and the population of state-operated Developmental Centers declined significantly. In fact the private ICF population has increased by 3.48% from 7,156 to 7,405 persons. Because the size of the population served by DDS has increased faster than the number of persons in ICFs, the ICF percentage of the total decreased from 4.42% to 3.83%. According to DDS, 87.4% of consumers in ICFs reside in facilities with 15 or fewer beds.

Table 43: The Numbers and Percentages of Persons Receiving DDS Services in Nonstate-operated Intermediate Care Facilities (ICFs) and Skilled Nursing Facilities (SNFs): 2002–2007

Quarter	Number of DDS Clients in ICFs	% of All DDS Clients in ICFs	Number of DDS Clients in SNFs	% of All DDS Clients in SNFs
September 2002	7,156	4.42%	1,451	0.90%
December 2002	7,219	4.41%	1,448	0.88%
March 2003	7,246	4.38%	1,438	0.87%
June 2003	7,269	4.34%	1,449	0.86%
September 2003	7,267	4.29%	1,448	0.86%

Quarter	Number of DDS Clients in ICFs	% of All DDS Clients in ICFs	Number of DDS Clients in SNFs	% of All DDS Clients in SNFs
December 2003	7,275	4.26%	1,427	0.83%
March 2004	7,270	4.22%	1,437	0.83%
June 2004	7,286	4.19%	1,418	0.82%
September 2004	7,304	4.18%	1,452	0.83%
December 2004	7,308	4.14%	1,451	0.82%
March 2005	7,312	4.11%	1,462	0.82%
June 2005	7,337	4.10%	1,457	0.81%
September 2005	7,318	4.07%	1,479	0.82%
December 2005	7,346	4.05%	1,449	0.80%
March 2006	7,337	4.02%	1,446	0.79%
June 2006	7,349	4.00%	1,433	0.78%
September 2006	7,355	3.98%	1,408	0.76%
December 2006	7,370	3.95%	1,407	0.75%
March 2007	7,386	3.93%	1,407	0.75%
June 2007	7,367	3.88%	1,443	0.76%
September 2007	7,394	3.86%	1,424	0.74%
December 2007	7,405	3.83%	1,400	0.72%

Data Source: Department of Developmental Services

A settlement agreement was reached that will downsize ICFs-MR.

The April 2009 settlement of a class action lawsuit (Capitol People First v. DDS) will provide more information and choices to live in small community settings to individuals who currently live in government or privately operated facilities serving 16 or more persons including nursing facilities, ICFs and other settings.[91] Under the settlement agreement, DDS and regional centers will post information about community living options in these institutions and contact information for advocates who can assist consumers to access them. The agreement also describes actions that will expand the supply of integrated, affordable, sustainable and accessible housing for consumers in the community. Under the agreement, DDS will offer to lease ten acres at Fairview Developmental Center for the development of affordable housing. 20% of the units will be reserved for consumers. Regional centers will undertake a series of efforts to develop housing for consumers in their catchment areas and pledge to make diligent efforts to develop integrated, affordable, sustainable and accessible housing for consumers.

Downsizing Initiatives

DDS provides up to $3 million per year to regional centers to cover costs associated with downsizing large facilities. Regional center directors reported that some operators are reluctant

[91] Capitol People First Settlement Agreement. Access at: http://www.dds.ca.gov/CapitolPeopleFirst/index.cfm. See also the U.S. Department of Justice critical investigation of conditions at the Lanterman Developmental Center in Pomona. Retrieved on 5-18-09 from: http://clearinghouse.wustl.edu/detail.php?id=9656.

to change their business model and do not apply for funds. A DDS 2007 report stated that 16 large facilities, affecting 600 licensed beds, have been downsized.[92]
The table and figures below show changes in the sizes of facilities that persons with intellectual and developmental disabilities (ID/DD) occupy. The table shows both the steady growth of persons in these three settings and the growth in the number of persons in smaller settings.

Table 44: Number of Persons with ID/DD in 1-6, 7–15 and 16 + Bed Facilities: 1977–2007

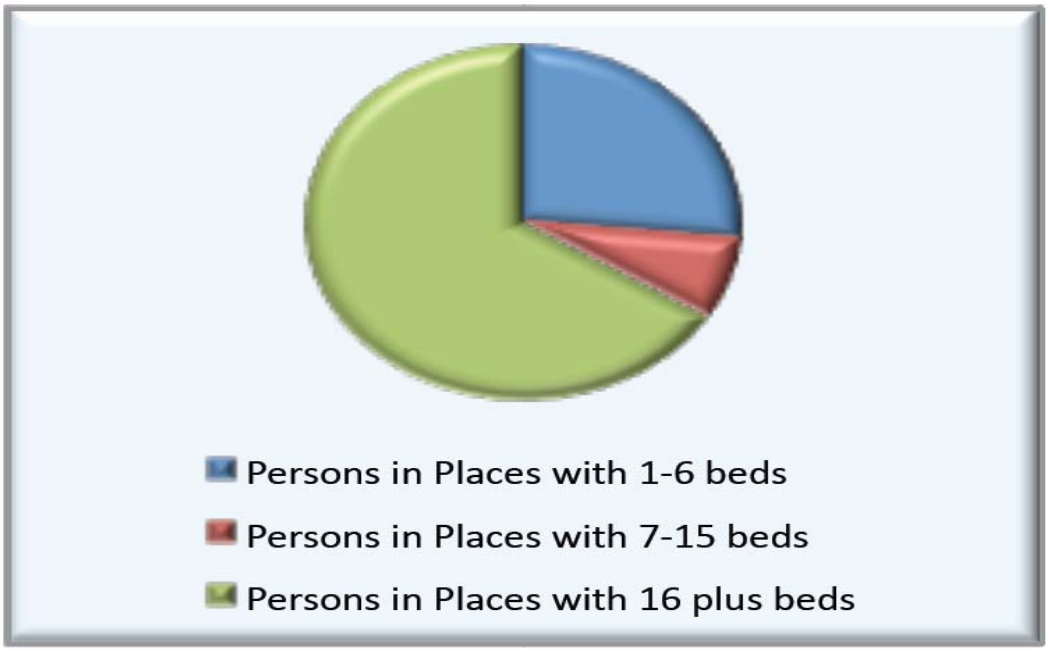
Year	Persons in Places with 1-6 Beds	Persons in Places with 7–15 Beds	Persons in Places with 16+ Beds	Total
1977	6,942	1,947	17,291	26,180
1982	8,759	2,592	15,715	27,066
1987	14,502	3,347	11,054	28,903
1989	15,339	3,052	13,143	31,534
1991	17,046	3,074	12,331	32,451
1994	27,822	3,328	11,551	42,701
1996	31,804	2,927	9,147	43,878
1998	33,864	2,420	7,647	43,931
2000	39,757	2,433	7,087	49,277
2002	42,053	1,775	6,678	50,506
2004	44,547	1,613	6,281	52,441
2006	46,617	1,408	5,353	53,378
2007	47,558	1,343	5,065	53,966

Data Source: Research and Training Center on Community Living Institute on Community Integration/UCEDD, University of Minnesota

The three figures below show the steady increase in smaller facilities from 1977 to 2007. In 1977 about 27% of the persons with ID/DD were living in places with 1-6 beds. By 2007 the percentage of persons with ID/DD living in places with 1-6 beds was 88%.

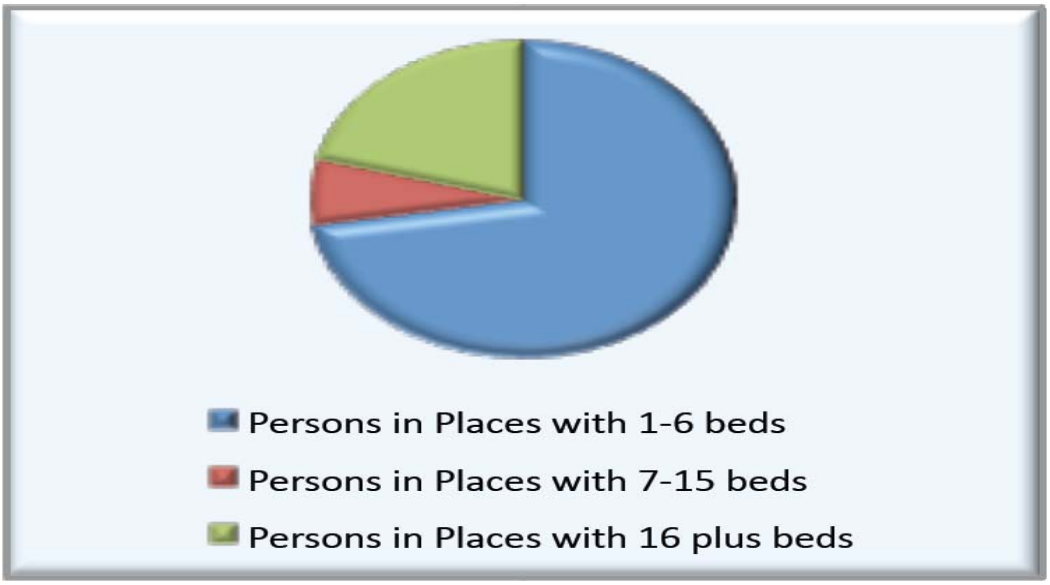
[92] *Controlling Regional Center Costs: Report to the Legislature*. (2007), Department of Developmental Services. December 2007. Available at: http://www.dds.ca.gov/Publications/docs/ControllingRCCosts2007.pdf.

Figure 15: Number of Persons in ID/DD Residential Settings: 1977



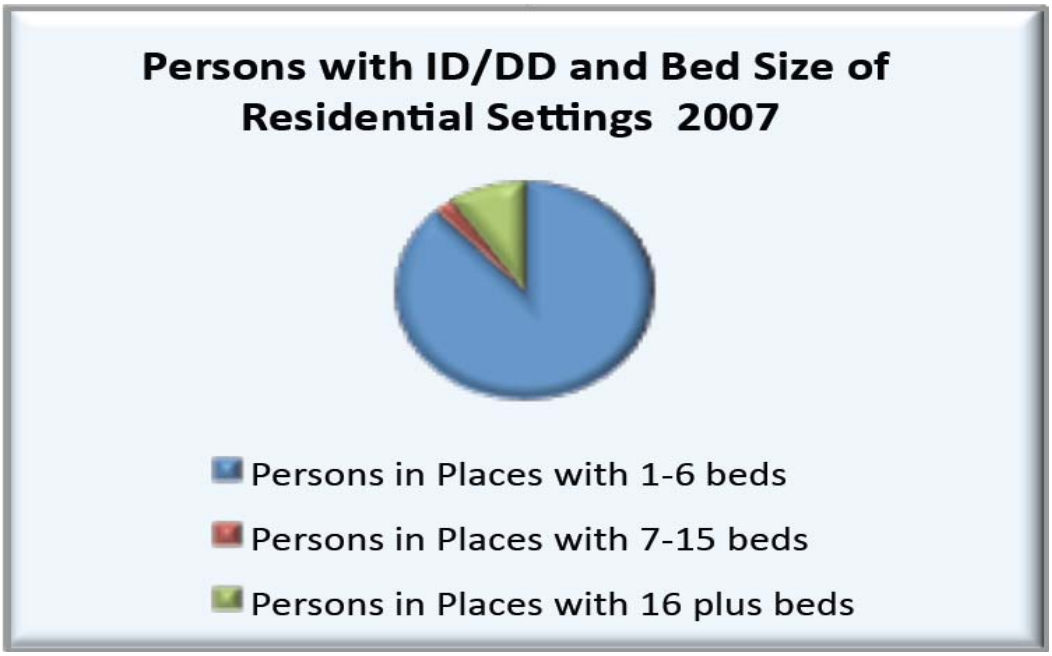
Data Source: Research and Training Center on Community Living
Institute on Community Integration/UCEDD, University of Minnesota

Figure 16: Number of Persons in ID/DD Residential Settings: 1996



Data Source: Research and Training Center on Community Living
Institute on Community Integration/UCEDD, University of Minnesota

Figure 17: Number of Persons in ID/DD Residential Settings: 2007



Data Source: Research and Training Center on Community Living
Institute on Community Integration/UCEDD, University of Minnesota

What are the characteristics of persons in the private ICFs and SNFs? Based on December 2007 data, Table 45 shows diagnoses of persons in ICFs and SNFs and the percentage of the persons with those diagnoses in ICFs and SNFs.[93] In December 2007, approximately 7,405 DDS clients, 3.83% of all clients, were in ICFs. However, the proportion of persons with cerebral palsy and epilepsy was two to three times higher. Persons with cerebral palsy and epilepsy have a much higher chance of being in a private ICF than persons with autism and other developmental disabilities.

Table 45: Diagnoses of Residents in ICFs and SNFs: December 2007

DDS Client Characteristics	# in ICFS	% in ICFs	# in SNFs	% in SNFs
Autism	346	0.94%	18	0.50%
Cerebral palsy	3,665	10.85%	480	1.39%
Epilepsy	3,570	9.42%	550	3.52%
Other developmental disabilities	304	1.49%	83	0.41%

Data Source: Department of Developmental Services

[93] December 2007 is the last publicly available data of this kind. For explanation of data availability see, retrieved on 1-22-09: http://www.dds.ca.gov/FactsStats/Diagnostic_Main.cfm#changes.

Table 46 shows the level of mental retardation of persons in ICFs and SNFs and the percentages of the persons at each level in ICFs and SNFs.

Table 46: Mental Retardation Levels of Residents in ICFs and SNFs: December 2007

DDS Client Characteristics	# in ICFS	% in ICFs	# in SNFs	% in SNFs
No mental retardation	256	0.52%	160	0.32%
Mild mental retardation	877	1.20%	480	0.66%
Moderate mental retardation	1,236	3.82%	260	0.80%
Severe mental retardation	1,740	11.61%	215	1.43%
Profound mental retardation	3,123	28.81%	247	2.28%
Retardation level not known	173	1.34%	38	0.29%
Total	7,405		1,400	

Data Source: Department of Developmental Services

A review of similar data for December 2003 shows similar numbers and percentages for both diagnoses and levels of mental retardation. The data indicates that there has been no change in the composition of these DDS populations between December 2003 and December 2008.

Department of Developmental Services (DDS) Summary

DDS has a strong single entry point delivery system that facilitates access to a range of services. DDS faces budgetary pressure because regional center services are considered an entitlement. The Department reports that 76,000 (32%) of the 241,000 persons served in 2008 receive HCBS Waiver services. Services for the remaining 165,000 are funded by general revenues.

The number of persons served in developmental centers declined by half from 1994 to 2009, to 2,259. The closing of the Agnews Center, though delayed, spawned innovative financing strategies to expand the supply of supported housing. No plans to close any of the remaining centers were identified.

The number of persons in private ICF/MRs and nursing facilities remained stable between 2003 and 2007.

DDS publishes an excellent budget document that describes funding for the regional centers and the assumptions used to support funding.[94] The 2009–2010 budget reduced funding for regional centers. The reductions include a 3% payment reduction to service providers and a 3% reduction in funding for regional center operations costs, for a savings of $40.4 million in state and federal funds. An additional $100 million will be saved through strategies to contain costs in the regional center system that will be developed through meetings with stakeholders. Based on the discussions, the Administration was required to submit containment proposals to the Legislature on April 1, 2009. If the proposed savings were not adopted prior to September 1, 2009, an additional payment reduction, up to 7.1%, would be applied to regional center service providers.

[94] Readers can find DDS budget documents at, retrieved on 9-3-09: http://www.dds.ca.gov/Budget/

Based on feedback from stakeholder forums and recommendations from a workgroup, DDS adopted a series of strategies to achieve the savings.

Section 5: Mental Health Services

Although individuals with long-term support needs may have a mental illness, mental health is not generally considered a long-term care service.[95] Mental health services were not considered part of the scope of work, and the report does not include a complete analysis of programs and services for persons with mental illness.

In 2006, approximately 646,000 persons were reported to have received mental health services. Of these, approximately 7,500 were served in state mental health hospitals and the rest were served through community programs.[96] The prevalence of mental illness is higher among older persons and persons with disabilities.[97] We interviewed staff of the Department of Mental Health (DMH) to discuss the Mental Health Services Act (MHSA) and the use of Institutions for Mental Disease (IMDs).[98]

The MHSA, which passed in November 2004, increased funding for county mental health programs that serve children, transition-age youth, adults, older adults and families with mental health needs. The MHSA is funded through a 1% tax on income above $1 million. The tax generated more than $4.1 billion through the end of FY 2007–2008 and is projected to raise an additional $1 billion in FY 2008-2009 and $914 million in FY 2009–2010.[99]

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[95] There is no standardized definition of "long-term care." In practice, it has revolved around the health care issues associated with persons using nursing homes and intermediate care facilities for the mentally retarded. This historical emphasis is found in the organization of federal and state agencies. For example, look at the issues of the Office of Disability, Aging, and Long-Term Care Policy in the federal Department of Health & Human Services or the issues covered by the Elderly and Disabled Group in the Centers for Medicare & Medicaid Services (CMS). See: http://aspe.hhs.gov/_/office_specific/daltcp.cfm. State agencies typically combine mental health and substance abuse responsibilities similar to the organization of responsibilities at the federal level - the Substance Abuse and Mental Health Services Administration (SAMHSA). For example, Oregon's Addictions and Mental Health Division.

[96] California state report, (2006), CMHS Uniform Reporting System Output Tables, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Washington, D.C. See, retrieved on 3-8-09: http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/URS2006.asp.

[97] For information about mental health and older adults see Office of the Surgeon General, (1999), *Mental Health: A Report of the Surgeon General*. U.S. Department of Health and Human Services, Washington, D.C. Chapter 5; see also Husaini, B, et al. (2000, October). *Economic Grand Rounds: Prevalence and Cost of Treating Mental Disorders Among Elderly Recipients of Medicare Services*. Psychiatric Services, 51:1245-1247. See:http://www.psychservices.psychiatryonline.org/cgi/content/full/51/10/1245; See also, Texas Transformation Working Group, (2006), *Voices Transforming Texas: Assessment of Mental Health Needs and Resource*. Austin, TX. Retrieved on 2-4-09: http://www.mhtransformation.org/documents/MHTAssessmentFINAL9-2006.pdf. See also Areán, P. & Alvidrez, J. (2001), The *Prevalence of Psychiatric Disorders and Subsyndromal Mental Illness in Low-Income, Medically Ill Elderly*. The International Journal of Psychiatry in Medicine, Volume 31, Number 1 http://baywood.metapress.com/app/home/contribution.asp?referrer=parent&backto=issue,2,9;journal,30,146;linkingpublicationresults,1:300314,1: and Lundgren, K. (February 28, 2006), *Mental Illness and the LTCI Policy.* The 6th Annual Intercompany LTCI Conference, Anaheim. CA. www.soa.org/files/ppt/2006-anaheim-lundgren-42.ppt.

[98] California mental health prevalence estimates by age are available at: http://www.dmh.ca.gov/Statistics_and_Data_Analysis/CNE2/Calif_CD/q5asr_htm/California/q5asr2k_wsmi01_ca_excel_Index_demographics.htm.

[99] California Department of Mental Health. *Mental Health Services Act Expenditure Report*. Fiscal Year 2008-2009. Sacramento, CA. (January, 2009), Retrieved on 9-3-09 from: http://www.dmh.ca.gov/Prop_63/MHSA/Publications/docs/Revised_Leg_Report_Format_FINAL_1-7_%20v11.pdf

The Department allocated almost $2 billion by the end of FY 2007–2008 and another $1.5 billion is expected to be distributed in FY 2008–2009. In the 2009–2010 budget, the DMH budgets about $1.1 million for a joint program with the Department of Developmental Services (DDS) to serve persons with a developmental disability who have co-occurring mental health illness.[100]

To receive funds, counties submit a three-year plan, which is updated annually and approved by the DMH after review and comment by an Oversight and Accountability Commission. DMH establishes criteria for the plans.

Institutions for mental diseases (IMDs) are licensed as nursing facilities or mental health rehabilitation centers. About 4,000 individuals reside in IMDs and counties are responsible for paying for their care. Since counties pay the full cost, they have an incentive to relocate residents to community settings and services that are eligible for state funding from the MHSA.

DMH funded a study in 2003 on strategies for community placement and alternatives to IMDs.[101] The report noted that counties were under pressure to reduce the use of expensive IMDs because of budget constraints and the emphasis on recovery and compliance with the Olmstead decision. IMDs serve two types of clients—short-term care for persons discharged from an acute care setting and long-term placement. IMDs often serve persons with the most serious behaviors. Clients with the longest stays were homicidal, suicidal and violent to self or others. While the study did not determine an acceptable or appropriate level of IMD use, the researchers found that strong leadership was necessary to reduce utilization and develop appropriate housing and community treatment resources. Systems dedicated to client-directed services and recovery are more effective. Other characteristics of effective systems included the use of centralized intake and monitoring, adequate staff for evaluations and follow up, clinicians with a good knowledge of available community resources and a gatekeeper function that allows admissions to IMDs as a last resort. The report recommended that the state DMH provide comprehensive data on IMD utilization to allow counties to compare their usage to other counties; work with counties to develop more supportive housing resources; encourage counties to offer intensive case management to transition clients to community settings; and work with the licensing agency to promote the appropriate use of community care facilities for clients with serious psychiatric disabilities.

DMH reported that they publicize the number of individuals in IMDs to focus attention on the potential savings to counties. The DMH technical assistance document suggests that counties should include in their plan the number of clients living in IMDs. The document also includes guidance on performance measures that includes IMD utilization as a "large-scale community indicator."[102]

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[100] See California Department of Mental Health (January, 2009), *A Report to the Legislature in Response to AB 131, Omnibus Health Budget Trailer Bill Chapter 80, Statutes of 2005*, Sacramento, CA. Retrieved on 3-8-09: http://www.dmh.ca.gov/Prop_63/MHSA/Publications/docs/Revised_Leg_Report_Format_FINAL_1-7_%20v11.pdf

[101] Abbott, B., Jordan, P. Meisel, J., & Elpers, R., (October, 2005), *Long Term Strategies for Community Placement: Alternatives to Institutions for Mental Disease*. Final Report, California Department of Mental Health, Sacramento, CA.

[102] Department of Mental Health. *Technical Assistance Documents To Aid Counties in Preparing The Three-Year Program and Expenditure Plan.* (May 23, 2005), Available at: http://www.dmh.ca.gov/Prop_63/MHSA/docs/CSSTechnicalAssistanceDocs.pdf.

Some individuals with mental illness live in nursing facilities and their care is covered by Medi-Cal rather than county mental health funds. The national Online Survey and Certification Reporting System (OSCAR) data for 2007 shows that 20.4% of nursing facility residents had other mental diseases and this has steadily grown from 15.8 % in 2001. Nationally, 21.4% of nursing facility residents had a mental illness (Harrington et al., 2008).

Money Follows the Person (MFP) Rebalancing Demonstration

MFP will transition 183 people with mental illness from nursing facilities.

Through the MFP Rebalancing Demonstration, California plans to transition 183 individuals with mental illness from nursing facilities to community settings over four years, FY 2008-2011. Facility residents who express a preference for living in the community will be identified in two ways: by transition coordinators through the Preference Interview process and/or by nursing facility staff who, after completing the Minimum Data Set (MDS) assessment, refer residents to transition coordinators. The transition coordinator is responsible for developing and implementing a transition plan with the participant. During the planning process, the transition coordinator determines the individual's interest in participating in the demonstration. If interested, the individual signs the "Participant Information Form" and the transition coordinator contacts the project nurse and/or the county Mental Health Department. The transition coordinator works jointly with the demonstration participant and a care manager/advocate. Counties provide and monitor services in the Specialty Mental Health Consolidation Program. At the end of a 12-month demonstration period, the County Mental Health Department continues to provide services.

The MFP activity will forge relationships between community organizations and county mental health departments that may provide more opportunities for individuals with mental illness who live in institutions to move to the community. DMH and the Department of Health Care Services (DHCS) should monitor the progress, modify the model as necessary and establish goals to transition additional Medi-Cal beneficiaries from nursing facilities.

The MFP operational protocol identifies "habilitation" services that will be provided as Demonstration Services—which could be provided by independent living coaches and peer mentors—that would benefit persons with mental health needs. Illinois and Washington provide similar services to individuals with mental illness who participate in the MFP demonstration. However, these services have not been specifically defined and are not yet available in California. Demonstration services are services that states may cover under HCBS Waivers, and they allow the state to test the impact of these services during the first 365 days after relocation from an eligible institution to the community. States are expected to amend their waivers to add services that will be needed following the end of the demonstration period, e.g., on day 366.

California does not operate a home and community-based services (HCBS) program that is designed specifically for persons with mental illness. The Medi-Cal state plan does cover rehabilitative mental health services that include individual and group mental health services, crisis intervention, crisis stabilization, medication management, day treatment, day rehabilitation, short-term crisis residential treatment and residential treatment. A package of services for nursing facility residents with a mental illness could be designed by adding services under either

a §1915(c) Waiver or a §1915(i) state plan HCBS amendment that will support persons with mental illness in community settings. For example, Iowa received CMS approval to cover habilitation under §1915(i).[103] Habilitation includes:

- **Home-based habilitation** means individually tailored supports that assist with the acquisition, retention or improvement in skills related to community living. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, and social and leisure skill development that assist the participant to reside in the most integrated setting appropriate to his/her needs. Home-based habilitation also includes personal care and protective oversight and supervision. Home-based habilitation is not covered for participants residing in a residential care facility of more than 16 persons. Services provided in a licensed residential care facility of 16 or fewer persons will be considered to take place in the participant's home when the participant's service plan documents that the participant resides there by their own choice and is provided with opportunities for independence and community integration. Participants are free to choose their provider from any enrolled provider of this service. The service plan will include a discharge plan and documentation of any rights restrictions.

- **Day habilitation** means assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills that takes place in a nonresidential setting, separate from the participant's private residence. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence and personal choice. Services are furnished four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the participant's service plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day). Day habilitation services focus on enabling the participant to attain or maintain his/her maximum functional level and are to be coordinated with any physical, occupational or speech therapies in the service plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in other settings.

- **Prevocational habilitation** means services that prepare a participant for paid or unpaid employment. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Services are not job-task oriented, but instead, aimed at a generalized result. Services are reflected in the participant's service plan and are directed to habilitative rather than explicit employment objectives. Participants are free to choose their provider from any enrolled provider of this service.

- **Supported employment habilitation** means services that consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports and who, because of their disabilities, need supports, to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the

[103] §1915 (i) State Plan Amendment available at: http://www.ime.state.ia.us/HCBS/HabilitationServices/documents.html.

participant. Supported employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by participants, including supervision and training.

Section 6: Nursing Facility Trends

Background

Studies have shown that lower nursing facility bed supply in states is associated with higher numbers of Medicaid home and community-based services (HCBS) participants, and higher percentages of HCBS spending.[104] A recent study showed that states with decreased nursing facility bed capacity were positively associated with state per capita rates of HCBS use, expenditures and the share of Medicaid long-term care funds supporting 1915(c) Waivers.[105] Four studies show that the regulation of nursing facility beds has a strong effect on increasing per capita spending on HCBS and the share of state spending on HCBS.[106]

California licenses residential settings for persons with disabilities—Residential Care Facilities for the Elderly (RCFEs), Residential Care Facilities for the Chronically Ill and Group Homes that could offer alternatives to nursing facility admission. California has 5.6 residential beds per 1,000 population compared to the national average of 4.9 beds per 1,000 population.[107] By comparison, New York's supply is 3.7 beds per 1,000; Pennsylvania is 7.7; and Texas is 2.5; Oregon is 11.1; Washington is 9.1 and Florida is 4.4.[108] See Appendix G.

California has a higher proportion of residential care units but a lower supply of nursing facility beds per 1,000 persons age 65 and older than the other large states. Table 48 shows the number of residential care and nursing facility beds per 1,000 persons age 65 and older and the percentage of HCBS spending for aged/disabled beneficiaries for selected states. California and Oregon both have over 40 residential/assisted living beds per 1,000 persons age 65 and older, and both spend over 50% of long-term care funds on HCBS. Florida has a low supply of residential care and nursing facility beds and spends 17.5% of its long-term care funds on HCBS.

Table 47: Supply of Residential and Nursing Facility Beds in Selected States

State	Residential Care Beds Per 1,000 Persons Age 65 and Older	Nursing Facility Beds Per 1,000 Persons Age 65 and Older	Percentage of HCBS Spending (Non DD)
CA	40.4	30.5	52.1%
FL	24.4	26.4	17.5%
NY	15.4	47.3	39.3%
PA	38.0	46.3	12.7%
OR	45.3	25.5	53.7%
TX	19.2	51.2	44.3%

Data Source: Authors' calculations and Burwell, B., Thomson Reuters.

[104] Kitchener, Carrillo and Harrington (2003-2004), Miller, Rubin et al., (2006), Harrington, Carrillo et al, (2000). Miller, Ramsland et al. (2001); Miller et al., (2008).
[105] Miller, Kitchener et al., (2006)
[106] Miller, Kitchener et al., 2005; Miller, Harrington et al., 2002; Miller, Ramsland et al., 2001; Miller, Harrington and Goldstein (2002).
[107] Harrington, C., Granda, B., Carrillo, H., Chang, J., Woleslagle, B., Swan, J.H., Dreyer, K., et al. (2008), *State Data Book on LTC, 2007: Program and Market Characteristics*. Reported Prepared for the US Dept. of Housing and Urban Development. San Francisco, CA: University of California.
[108] The data on residential settings applies primarily to non-developmentally disabled individuals.

While a majority of states use certificate-of-need (CON) and moratoria to slow the growth of nursing beds, California does not (see Harrington, Anzaldo et al., 2005). By 2007, 43 states (including the District of Columbia) regulated the growth of new nursing facility beds and/or facilities through a CON and/or a moratorium; 26 states regulated intermediate care facility services for the developmentally disabled (ICF-DD) facilities; and 12 states included residential care/assisted living facilities (Harrington, Granda et al. 2008).

Cost and Utilization Trends

Four significant sources of information are available to analyze long-term care cost and utilization trends. Before discussing these information sources, it is informative to briefly mention trends in Medicare hospital usage, since California nursing facilities are affected by trends in hospital discharges. Discharges from hospitals are increasing—from 10.5 million in 1985 to 12.5 million in 2006 (see Table 48). The table also shows that nationally the length of stay decreased from 8.7 days per stay in 1985 to 5.6 days per stay in 2006. As shown below, the increase in the number of discharges and the shorter length of stay results in increased admissions to nursing facilities of residents with more complex medical and rehabilitation needs.

Table 48: Medicare Short Stay Hospital Utilization, Discharges, Days of Care and Length of Stay: 1985–2006

Selected Fiscal Years	1985	1990	1999	2000	2004	2005	2006
Discharges							
Number in millions	10.5	10.5	11.7	11.8	13.0	13.0	12.5
Rate per 1,000 enrollees	347	313	310	303	316	308	291
Days of Care							
Number in millions	92	94	71	71	75	75	71
Rate per 1,000 enrollees	3,016	2,805	1,897	1,825	1,834	1,771	1,655
Average Lengths of Stay							
Short-stay in days	8.7	9.0	6.1	6.0	5.8	5.7	5.6
Excluded units in days	18.8	19.5	12.6	12.3	11.5	11.6	11.7
Total charges per day	$597	$1,060	$2,496	$2,720	$4,458	$4,882	$5,344

Data Source: CMS Medicaid 2007 Statistics, Baltimore, Md.

Nursing facility use in California takes place within the context of these larger national trends.

California Nursing Facility Trends Compared to National Trends

The sections below present data on nursing facility use in California from four sources. Each of the data sources provides a different view of California nursing facilities. The first source is the OSCAR data. This Centers for Medicare & Medicaid Services (CMS) database presents point-in-time information for the months of June and December of each year. The OSCAR data are available for all nursing facilities, which allow comparisons across states.

Table 49 shows the number of nursing facilities, residents, certified beds and the occupancy rates of nursing facilities in California compared to the three other largest states in the country for the period December 2002 to December 2008. The last column shows the percentage change from December 2002 to December 2008. The number of nursing facilities in California has declined approximately 6%, slightly above national trends. The number of nursing facility residents and nursing facility beds has also declined modestly, although less than the national decline, while the occupancy rate has increased slightly. In general, while the number of homes has declined, the changes in the number of residents, beds and occupancy rates are minimal.

The supply of nursing home beds dropped 6% between 2002 and 2008.

Table 49: Numbers of Nursing Facilities, Numbers of Residents, Numbers of Beds and Occupancy Rates for the United States, California, New York, Pennsylvania and Texas: December 2002–December 2008

Section 1: Number of Nursing Facilities								
State	**December 2002**	**December 2003**	**December 2004**	**December 2005**	**December 2006**	**December 2007**	**December 2008**	**2002–2008 % Change**
US	16,441	16,256	16,066	15,965	15,861	15,772	15,728	-4.34%
CA	**1,331**	**1,337**	**1,310**	**1,296**	**1,282**	**1,267**	**1,255**	**-5.71%**
FL	702	691	689	686	683	680	676	-3.70%
NY	674	671	662	658	655	654	651	-3.41%
TX	1,139	1,142	1,134	1,130	1,143	1,144	1,145	0.53%

Section 2: Number of Residents								
State	**December 2002**	**December 2003**	**December 2004**	**December 2005**	**December 2006**	**December 2007**	**December 2008**	**2002–2008 % Change**
US	1,454,566	1,447,222	1,438,866	1,433,435	1,429,622	1,420,217	1,412,414	-2.90%
CA	**104,924**	**107,503**	**105,895**	**106,451**	**105,381**	**103,984**	**103,487**	**-1.37%**
FL	70,734	71,974	72,611	72,849	72,583	72,279	71,833	1.55%
NY	113,628	113,554	112,777	112,257	112,141	111,174	110,836	-2.46%
TX	84,980	87,430	88,725	88,817	89,663	89,967	90,385	6.36%

Section 3: Number of Nursing Facility Beds								
State	**December 2002**	**December 2003**	**December 2004**	**December 2005**	**December 2006**	**December 2007**	**December 2008**	**2002–2008 % Change**
US	1,699,647	1,689,937	1,681,917	1,676,413	1,673,085	1,671,238	1,668,895	-1.81%
CA	**123,879**	**125,706**	**123,996**	**123,406**	**122,564**	**121,964**	**121,950**	**-1.56%**
FL	81,421	81,797	81,891	81,645	81,630	81,808	81,498	0.09%
NY	122,140	122,482	121,189	120,807	120,800	120,359	120,101	-1.67%
TX	109,896	112,806	114,741	115,313	119,055	121,731	122,635	11.59%

Section 4: Nursing Facility Occupancy Rates								
State	**December 2002**	**December 2003**	**December 2004**	**December 2005**	**December 2006**	**December 2007**	**December 2008**	**2002–2008 % Change**
US	85.58%	85.64%	85.55%	85.50%	85.40%	85.00%	84.50%	-1.26%
CA	**84.70%**	**85.52%**	**85.40%**	**86.30%**	**86.00%**	**85.30%**	**84.90%**	**0.24%**
FL	86.87%	87.99%	88.67%	89.20%	88.90%	88.40%	88.10%	1.42%
NY	93.03%	92.71%	93.06%	92.90%	92.80%	92.40%	92.30%	-0.78%
TX	77.33%	0.78	77.33%	0.8	75.30%	73.90%	73.70%	-4.69%

Data Source: Online Survey, Certification and Reporting (OSCAR) data obtained from the American Health Care Association.

Nursing Facility Use

As shown in Table 50, Medicare nursing facility use increased 26% in California and 34% nationally between 2001 and 2008. Nursing facilities all over the country are emphasizing post-acute rehabilitation services to Medicare residents. The shift is fueled by historically low margins on Medicaid reimbursement, higher reimbursement rates from Medicare compared to Medicaid and the shorter hospital lengths of stay as shown previously.

Medicare beneficiaries enter nursing facilities for post-acute or subacute care after a hospital stay for hip or knee replacements, cardiac care, strokes and significant surgery that requires continuous skilled care beyond the number of hospital inpatient days allowed. The post-acute rehabilitation services that they receive are covered by Medicare and include ongoing medical monitoring such as wound dressing and medication management, plus physical, occupational, speech and hearing therapy. Beneficiaries are admitted to nursing facilities with suction pumps, oxygen concentrators, new prosthetic devices and other medical equipment that 15 years ago required hospital care.

Table 50: Percentages of Medicare, Medicaid and Other Payor Residents, for the United States, California, New York, Pennsylvania and Texas: December 2002–December 2008

Percentages of Medicare Residents								
State	**December 2002**	**December 2003**	**December 2004**	**December 2005**	**December 2006**	**December 2007**	**December 2008**	**2002–2008 % Change**
US	10.46%	11.32%	12.12%	12.90%	13.31%	13.70%	14.00%	33.82%
CA	**10.70%**	**10.30%**	**11.17%**	**11.70%**	**12.59%**	**12.70%**	**13.50%**	**26.17%**
FL	16.00%	16.62%	17.95%	18.80%	19.37%	19.30%	20.00%	24.97%
NY	10.95%	11.91%	12.33%	13.00%	12.45%	12.60%	13.10%	19.62%
TX	9.73%	10.75%	11.69%	12.60%	13.25%	14.10%	14.40%	48.02%

Percentages of Medicaid Residents								
State	**December 2002**	**December 2003**	**December 2004**	**December 2005**	**December 2006**	**December 2007**	**December 2008**	**2002–2008 % Change**
US	66.74%	66.31%	65.88%	65.50%	64.85%	64.20%	63.50%	-4.85%
CA	**65.40%**	**66.12%**	**66.23%**	**66.50%**	**65.71%**	**65.50%**	**65.40%**	**0.00%**
FL	61.37%	61.41%	61.12%	59.80%	58.80%	57.90%	57.60%	-6.14%
NY	74.71%	73.68%	73.13%	72.40%	72.36%	71.90%	70.60%	-5.50%
TX	70.89%	69.46%	67.85%	67.70%	66.59%	65.20%	63.40%	-10.56%

Percentages of Private-pay Residents								
State	**December 2002**	**December 2003**	**December 2004**	**December 2005**	**December 2006**	**December 2007**	**December 2008**	**2002–2008 % Change**
US	22.80%	22.36%	22.00%	21.70%	21.84%	22.20%	22.50%	-1.32%
CA	**23.90%**	**23.59%**	**22.59%**	**21.80%**	**21.70%**	**21.70%**	**21.10%**	**-11.72%**
FL	22.63%	21.98%	20.93%	21.40%	21.82%	22.70%	22.50%	-0.58%
NY	14.34%	14.41%	14.54%	14.60%	15.20%	15.40%	16.30%	13.68%
TX	19.38%	19.79%	20.45%	19.70%	20.16%	20.70%	22.30%	15.04%

Data Source: Online Survey, Certification and Reporting (OSCAR) data obtained from the American Health Care Association

The California data show a large decline, 11.72%, in the proportion of "other payor" residents—non-Medicare or Medicaid. The drop represents about 3,200 private-pay residents, which occurred despite a burgeoning growth in the population of persons age 85 and older. The decrease in the percentage of private-pay is substantially higher than the national average and the trends in other large states. This indicates that individuals in California who can afford to pay for their care are finding other long-term care settings such as assisted living, residential care facilities for the elderly, or other in-home care.

The December 2002 OSCAR survey reported 68,719 California nursing facility residents were covered by Medicaid. In December 2008 there were 67,745 Medicaid residents, a drop of 974 persons in the period 2002-2008.[109]

The preference to serve Medicare patients is understandable considering the per patient day reimbursement of Medicare compared to other payor sources.[110] Table 51 shows per-person-per-day reimbursement for gross routine inpatient services received by California nursing facilities from different payor sources. The per diem payment from Medi-Cal is the lowest of the payor sources.

[109] The Research and Data section of the American HealthCare Association has good statistics on OSCAR data. See: http://www.ahcancal.org/research_data/Pages/default.aspx.

[110] The Office of Statewide Health Planning and Development publishes annual data on revenue and costs of California nursing homes. Retrieved on 12-15-08: http://www.oshpd.ca.gov/HID/Products/LTC/AnnFinanclData/PivotProfls/default.asp.

Table 51: Per Diem Revenue Payment by Payor Source for Gross Routine Inpatient Services: 2000–2007

Gross Routine Revenue by Payor Type						
Year	**Medicare**	**Medi-Cal**	**Self-Pay**	**Managed Care**	**Other Payors**	**Average**
2000	$ 159.65	$ 117.90	$ 129.98	$ 166.99	$ 147.25	$ 125.55
2001	$ 173.96	$ 128.44	$ 139.98	$ 172.42	$ 151.81	$ 136.28
2002	$ 167.13	$ 133.17	$ 148.13	$ 171.71	$ 183.61	$ 141.55
2003	$ 186.87	$ 144.65	$ 159.30	$ 176.33	$ 161.43	$ 152.88
2004	$ 189.51	$ 149.05	$ 164.91	$ 185.26	$ 175.46	$ 158.10
2005	$ 208.07	$ 159.78	$ 174.81	$ 193.16	$ 178.12	$ 169.54
2006	$ 210.12	$ 169.87	$ 185.47	$ 204.60	$ 201.54	$ 179.70
2007	$ 222.96	$ 176.67	$ 194.78	$ 218.80	$ 198.38	$ 187.73

Data Source: Office of Statewide Health Planning and Development

Table 52 shows even greater differences in gross inpatient ancillary costs. The per diem differences are considerable, and it is understandable that nursing facilities prefer to expand their Medicare and managed care subacute business and its profitable ancillary revenue.

Table 52: Per Diem Revenue by Payor Source for Gross Inpatient Ancillary Services: 2000–2007

Gross Inpatient Ancillary Revenue by Payor Type						
Year	**Medicare**	**Medi-Cal**	**Self-Pay**	**Managed Care**	**Other Payors**	**Average**
2000	$ 196.33	$ 2.19	$ 5.89	$ 164.05	$ 73.90	$ 22.48
2001	$ 197.89	$ 2.41	$ 6.21	$ 165.11	$ 43.53	$ 24.35
2002	$ 208.38	$ 2.56	$ 6.97	$ 146.12	$ 35.58	$ 27.12
2003	$ 207.06	$ 2.38	$ 6.72	$ 146.10	$ 29.79	$ 28.89
2004	$ 219.84	$ 2.71	$ 6.48	$ 150.89	$ 23.22	$ 32.96
2005	$ 238.65	$ 3.26	$ 7.42	$ 165.58	$ 24.86	$ 38.19
2006	$ 253.21	$ 2.95	$ 6.74	$ 176.92	$ 24.70	$ 42.94
2007	$ 268.76	$ 3.20	$ 7.32	$ 196.53	$ 25.90	$ 47.45

Data Source: Office of Statewide Health Planning and Development

California Long-Term Care Institutional Spending Compared to HCBS Spending

A second significant source of information compares expenditures on HCBS with institutional services. Below we present comparisons of institutional and community spending. These comparisons are based upon nationally distributed information from the vendor that collates and reports federal Medicaid expenditures for the CMS.

The overall growth of Medi-Cal spending has been well-studied.[111] Data comparing spending on HCBS is compiled annually by Burwell et al.[112] Expenditures for institutional services and HCBS do not include mental health services, drug and alcohol addiction services or services to children.

National statistics on long-term care populations generally distinguish between two large groups: older adults and individuals with physical disabilities, and individuals with developmental disabilities. The following statistics from Burwell et al. are based on these two population groups from the quarterly CMS 64 financial reports submitted by states. The expenditures reported in Tables 53 and 54 may underestimate California spending for FY 2007, since they do not reflect expected adjustments to the reports which usually increase California's reported expenditures. However, they give a preliminary view of changes in spending.

The CMS 64 does not collect information on the number of nursing facilities, number of persons receiving service or units of service provided. It only reports on expenditures paid during the federal fiscal year.

Older Adults and Adults with Physical Disabilities

California ranks 5th on HCBS spending for older adults and adults with physical disabilities.

Based on CMS 64 data, Table 53 compares California institutional and community spending for older adults and individuals with physical disabilities. Looking at the change of institutional spending for both California and the country as a whole, the proportion of long-term care dollars spent on institutions declined FFY 2004-2007. California nursing facility expenditures were flat in FFY 2004 and FFY 2005 but jumped substantially between FFY 2005 and 2007 by a little over $700 million due in part to AB 1629 which was implemented in August 2005. However, the percentage of funds spent on HCBS increased from 38.9% in FFY 2004 to 52.1% in FFY 2007, which shifted the balance from roughly 60% institutional and 40% community to 48% and 52% respectively. Compared to other states, California spends a higher proportion of its aged and persons with disabilities long-term dollars on community services than other states.. In FFY 2007, 52.1% of Medi-Cal long-term care spending paid for community services for these groups, compared to 31% nationally.

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[111] MaCurdy, T., Chan R., Chun, R., Johnson, H., and O'Brien-Strain, M. (June 2005), *Medi-Cal Expenditures: Historical Growth and Long Term Forecasts*. Public Policy Institute of California. San Francisco, CA.

[112] Thomson Reuters collects data from the CMS 64 form submitted quarterly by state Medicaid agencies. The form contains expenditures made during the quarter for the various Medicaid services. This information is based on "date of payment" rather than the "date of service" and is reported for federal fiscal years (October 1 to September 30). The major drawback of the CMS 64 is that it only reports expenditures and does not report on the number of persons using services or their utilization rates.

Based on CMS 64 data, California spends $100.04 per capita on nursing facility care, which is below the national average of $155.76 per capita. Per capita waiver spending for aged/disabled beneficiaries is $3.00 per capita compared to the national average of $21.02. California's per capita spending for state plan personal care services or in-home supportive services (IHSS) is well above the national average—$101.51 and $34.47 respectively.[113]

During the course of the study, researchers received conflicting information as to whether or not expenditures for nursing facilities which were distinct parts of hospitals were included in California's reporting of nursing facility expenditures to CMS. After discussion, it was determined that the amounts listed in the CMS 64 reporting, as shown in Table 53 below, were similar to the amounts reported by Medi-Cal as shown in Table 53. This can be seen in the comparison of 2007 data. The amounts in Table 53 include expenditures for distinct part nursing facilities. Additionally, both the Office of State Health Planning and Development and the Department of Health Care Services conducted a series of meetings and concluded that the CMS 64 reporting did include distinct part expenditures.

Table 53: Expenditures for Nursing Facility Services, HCBS and 1115 Waivers for Older Adults and Adults with Physical Disabilities

FFY	State	Institutional LTC Services		Community-Based Services		Total
2004	California	$3,033,946,724	61.1%	$1,927,897,109	38.9%	$4,961,843,833
2004	US	$45,835,646,786	74.9%	$15,341,483,326	25.1%	$61,177,130,112
2005	California	$3,039,955,403	50.1%	$3,025,105,590	49.9%	$6,065,060,993
2005	US	$47,237,755,643	72.9%	$17,594,430,463	27.1%	$64,832,186,106
2006	California	$3,760,933,316	51.7%	$3,514,274,426	48.3%	$7,275,207,742
2006	US	$47,706,589,564	71.4%	$19,148,352,736	28.6%	$66,854,942,300
2007	California	$3,656,631,647	47.9%	$3,980,054,087	52.1%	$7,636,685,734
2007	US	$46,980,338,539	69.0%	$21,129,494,817	31.0%	$68,109,833,356

Data Source: Burwell, B., et al.

Persons with Developmental Disabilities

Table 54 shows long-term care spending on persons with intellectual and developmental disabilities. Looking at the change of institutional spending for both California and the country as a whole, the proportion of long-term care dollars spent on institutions declined FFY 2004-2007. Spending on intermediate care facilities for the mentally retarded (ICF/MRs) increased almost $80 million FFY 2004-2007. However, the proportion of dollars spent on HCBS increased by about 25% FFY 2004-2007, shifting the balance from roughly 40% institutional and 60% community to about 38% institutional and 62% community. Spending for individuals with intellectual and developmental disabilities is nearly equal to the national average. In FFY 2007 it spent 62.3% of its long-term care dollars on community services vs. a national average of 63.1%.

[113] For Medicaid expenditures, rankings and per capita spending for all states, see Burwell, et al. Available at: http://www.hcbs.org/moreInfo.php/nb/doc/2375/Medicaid_HCBS_Waiver_Expenditures_FY_2002_through_

Table 54: Expenditures for ICF/MR Services, HCBS and 1115 Waivers for Persons with Intellectual and Developmental Disabilities

FFY	State	Institutional LTC Services		Community-Based Services		Total	Rank
2004	California	$698,896,037	39.8%	$1,055,061,036	60.2%	$1,753,957,073	30th
2004	US	$11,761,206,072	42.4%	$15,974,032,495	57.6%	$27,735,238,567	
2005	California	$ 649,831,934	38.2%	$ 1,050,006,600	61.8%	$ 1,699,838,534	29th
2005	US	$12,103,242,101	41.6%	$17,024,072,941	58.4%	$29,127,315,042	
2006	California	$ 706,596,048	34.7%	$ 1,331,641,909	65.3%	$ 2,038,237,957	29th
2006	US	$12,469,822,317	39.3%	$19,288,930,185	60.7%	$31,758,752,502	
2007	California	$ 777,520,467	37.7%	$ 1,283,868,589	62.3%	$ 2,061,389,056	34th
2007	US	$12,012,426,751	36.9%	$20,546,149,9112	63.1%	$32,558,576,663	

Data Source: Burwell, B., et al.

As noted above, these data may change after adjustments for prior year claims. Taking into account these retroactive adjustments for prior years (2005 and earlier), Tables 55 and 56 show California expenditures for both institutional and HCBS.[114]

Institutional and HCBS Population Groups

Table 55 shows that beginning in 2004 spending for HCBS exceeded spending on institutional services.

Table 55: Amount of Medicaid Expenditures on Institutional and Home and Community-Based Services (millions of dollars)

Service	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Nursing facility	$ 2,598.3	$ 2,877.9	$ 2,944.7	$ 3,103.5	$ 3,098.8	$ 3,760.9	$ 3,656.6
ICF-MR	$ 419.7	$ 663.90	$ 716.9	$ 824.9	$ 760.1	$ 706.5	$ 777.5
Total Institutional	$ 3,018.0	$ 3,541.9	$ 3,661.6	$ 3,928.4	$ 3,859.0	$ 4,467.5	$ 4,434.1
Personal care	$ 1,832.1	$ 1,757.7	$ 2,109.9	$ 2,562.9	$ 3,295.5	$ 3,248.1	$ 3,710.5
HCBS waivers total	$ 822.4	$ 997.5	$ 915.1	$ 1,306.4	$ 1,377.1	$ 1,463.5	$ 1,406.1
MR/DD waivers	$ 717.8	$ 889.5	$ 801.9	$ 1,192.4	$ 1,258.1	$ 1,347.3	$ 1,283.8
A/D waivers	$ 90.8	$ 93.5	$ 96.6	$ 97.4	$ 102.8	$ 101.5	$ 109.6
Other waivers	$ 13.7	$ 14.4	$ 16.5	$ 16.4	$ 16.1	$ 14.6	$ 12.6
Home health	$ 146.2	$ 146.1	$ 155.7	$ 162.6	$ 160.0	$ 165.9	$ 159.9
Total Community	$ 2,800.9	$ 2,901.4	$ 3,180.8	$ 4,032.0	$ 4,832.7	$ 4,877.6	$ 5,276.5

Data Source: Burwell, B., et al.

Table 56 shows the percentage change in Medicaid expenditures for institutional vs. HCBS. The percentage changes from year to year show substantial fluctuations. Overall, community spending on a percentage basis increased faster than institutional spending from FFY 2001 to FFY 2007, 88% vs. 47%. Within institutional spending, there was a substantial increase in reported state spending on Developmental Centers and other institutions from FFY 2001 to FFY 2002, and nursing facility expenditures jumped more than 20% from FFY 2005 to FFY 2006 and then declined between FFY 2006 and 2007 as reported on CMS form 64. HCBS Waivers and personal care spending were up 71% to 102% respectively and home health spending grew 9%.

[114] ICF/MR refers to "Intermediate Care Facilities for the Mentally Retarded." In California and other states, large state operated ICFs/MR are referred to as Developmental Centers.

Table 56: Percentage Change in Medicaid Expenditures on Institutional and Home and Community-Based Services: FFY 2001–2007

Service	% Change	% Change	% Change	% Change	% Change	% Change	% Change
	FY2001–FY2002	FY2002–FY2003	FY2003–FY2004	FY2004–FY2005	FY2005–FY2006	FY2006–FY2007	FY2001–FY2007
Nursing facility	10.76%	2.32%	5.39%	-0.15%	21.37%	-2.8%	40.7%
ICF/MR	58.19%	7.98%	15.06%	-7.85%	-7.05%	10.0%	85.2%
Total Institutional	17.36%	3.38%	7.29%	-1.77%	15.77%	-0.7%	46.9%
Personal care	-4.06%	20.04%	21.47%	28.58%	-1.44%	14.2%	102.5%
HCBS Waivers	21.28%	-8.26%	42.76%	5.42%	5.03%	-3.9%	71.0%
MR/DD Waivers	23.92%	-9.85%	48.70%	5.51%	5.84%	-4.7%	78.9%
A/D Waivers	2.97%	3.27%	0.88%	5.48%	-2.58%	7.9%	20.6%
Other waivers	4.51%	14.88%	-0.91%	-1.32%	-9.55%	-13.6%	-8.2%
Home health	-0.08%	6.57%	4.44%	-1.57%	3.65%	-3.6%	9.4%
Total Community	3.59%	9.63%	26.76%	19.86%	0.58%	8.2%	88.4%

Data Source: Burwell, B., et al.

Table 57 reflects the percentage of FFY 2007 expenditures spent on each service. [115] IHSS personal care and nursing facility spending each account for about 38% of total long-term care spending. Overall, in 2007 the state spent approximately 46% on institutional care and 54% on home and community services.

The table shows that about 15% of all expenditures are spent on Medicaid Waivers, with 13% for services to persons with intellectual and developmental disabilities. A later section of the report looks at waiver programs individually.

California's per capita spending is well below the national average for HCBS and nursing home spending.

Per capita spending presents a different perspective on spending. In FY 2007, California exceeded the national average for spending on state plan personal care services (IHSS)—$101.51 and $34.47 respectively. California's spending for HCBS Waivers for aged and disabled beneficiaries is $3.00 per capita compared to $21.02 nationally, and for individuals with mental retardation and developmental disabilities (MR/DD), per capita spending was $35.12 in California (targeted case management spending is not included) compared to $68.04 nationally. California spent less per capita than the national average on nursing facility care—$100.04 compared to $155.76 nationally and spending for ICF/MRs was $21.27 in California compared to $39.83 nationally.

[115] As noted above, definitions of institutional and home and community-based care used in national data sources do not include mental health services, drug and alcohol addiction programs or services to children. These services also have institutional and community components but are not considered long-term care services. Also, there is a likely consensus among researchers that home health spending should not be included as a home and community-based service. The authors included this spending to ensure consistency over time since it is included in the Thomson Reuters calculations.

Table 57: Percentage Distribution of Expenditures for Long-Term Care Services: FFY 2007

Service	FFY 2007 Expenditures	% of Expenditures
Nursing facility	$3,656,631,647	37.66%
ICF/MR	$ 777,520,467	8.01%
Total Institutional	$4,434,152,114	45.66%
Personal care	$3,710,518,703	38.21%
HCBS Waivers	$1,406,149,744	14.48%
MR/DD Waivers	$1,283,868,589	13.22%
A/D Waivers	$ 109,617,165	1.13%
Other waivers	$ 12,663,990	0.13%
Home health	$ 159,918,219	1.65%
Total Community	$5,276,586,666	54.34%
Grand Total	$9,710,738,780	100.00%

Data from the Office of Statewide Health Planning and Development

A third significant source of information about California nursing facilities is from the Office of Statewide Health Planning and Development (OSHPD).[116] This is a California-specific database containing self-reported data from the state's nursing facilities that spans both financial and utilization data. As Table 58 shows, the number of facilities and licensed beds decreased about 7% during the period CY 2000-2007, but admissions and discharges increased. Table 59 contains data on freestanding nursing facilities that are licensed as SNFs or skilled nursing facility residential (SNF/RES). A SNF/RES facility is licensed for skilled nursing or intermediate care, but it is an integral part of a residential care facility.

Table 58: Trends in Numbers of Facilities, Beds, Occupancy Rates, and Admissions and Discharges for Freestanding Nursing Facilities with License Category of SNF or SNF/RES: 2000–2007

Calendar Year	No. of Facilities	Average Licensed Beds	Occupancy Rates	Admissions	Discharges
2000	1,077	103,511	86.17%	221,993	221,019
2001	1,065	102,433	86.64%	228,768	228,146
2002	1,064	101,123	87.38%	238,555	236,135
2003	1,064	100,984	87.70%	238,679	237,359
2004	1,047	99,666	87.69%	248,066	246,985
2005	1,041	99,988	88.05%	260,725	259,148
2006	1,030	98,394	88.09%	257,878	264,457
2007	1,003	96,277	87.70%	274,885	281,161
Total Change	-6.87%	-6.99%	1.77%	23.83%	27.21%

Data Source: Office of Statewide Health Planning and Development (OSHPD)

A look at patient days shows that total patient days and fee-for-service Medi-Cal days have declined approximately 6%, Medicare and managed care days are up substantially, 83% and

[116] This data is available on the Office's website at: http://www.oshpd.ca.gov/HID/DataFlow/LTCFinancial.html.

60%, and self-pay days are down substantially, about 42%. The shift in Medicare days is understandable, as nursing facilities emphasize post-acute care to take advantage of the greater Medicare reimbursement. 40% is a significant drop in private-pay utilization, as more community and residential options are available to persons with resources. Would Medi-Cal days have dropped more if residential options were available through waivers?

Table 59: Trends in Total Patient Days and Medicare, Medi-Cal, and Self-Pay Days for Freestanding Nursing Facilities with License Category of SNF or SNF/RES: 2000–2007

Calendar Year	Total Patient Days	Medicare Days	Medi-Cal Days	Self Pay Days	Managed Care Days	Other Payor Days
2000	32,241,067	2,090,073	21,235,899	6,980,311	930,253	1,004,531
2001	31,748,941	2,266,812	21,043,378	6,518,411	1,230,808	689,532
2002	32,073,950	2,638,960	21,262,453	6,117,698	1,355,030	699,809
2003	31,335,769	2,956,431	20,865,852	5,471,739	1,255,684	786,063
2004	31,633,604	3,286,457	21,047,073	5,015,612	1,392,525	891,937
2005	31,759,983	3,529,186	20,951,287	4,710,249	1,446,108	1,123,153
2006	31,249,379	3,757,273	20,427,085	4,508,988	1,554,595	1,001,438
2007	30,392,901	3,828,293	19,981,886	4,049,126	1,489,150	1,044,446
Total Change	-5.73%	83.17%	-5.91%	-41.99%	60.08%	3.97%

Data Source: Office of Statewide Health Planning and Development (OSHPD)

Table 60 shows data on nursing facilities that are "distinct" parts of hospitals. The trends show that the number of such homes has declined and total patient days and Medicaid days are basically flat, while a decrease in Medicare days has been offset by increase in "Other" private-pay days.

Table 60: Trends in Total Patient Days, and Medicare, Medi-Cal, and Self-Pay Days for Nursing Facilities That Are Distinct Parts of Hospitals: 2000–2006

Year	Number Facilities	Patient Days	Medicaid Days	Medicare Days	Other Days
2001	226	5,589,888	2,836,247	881,288	1,872,353
2002	214	5,563,090	2,943,786	837,796	1,781,508
2003	205	5,641,644	3,019,250	847,816	1,774,578
2004	194	5,804,299	2,984,021	834,280	1,985,998
2005	183	5,668,650	2,874,065	774,108	2,020,477
2006	176	5,540,671	2,826,497	703,250	2,010,924

Data Source: Office of State Health Planning and Development (OSHPD), courtesy of the University of California, San Francisco.

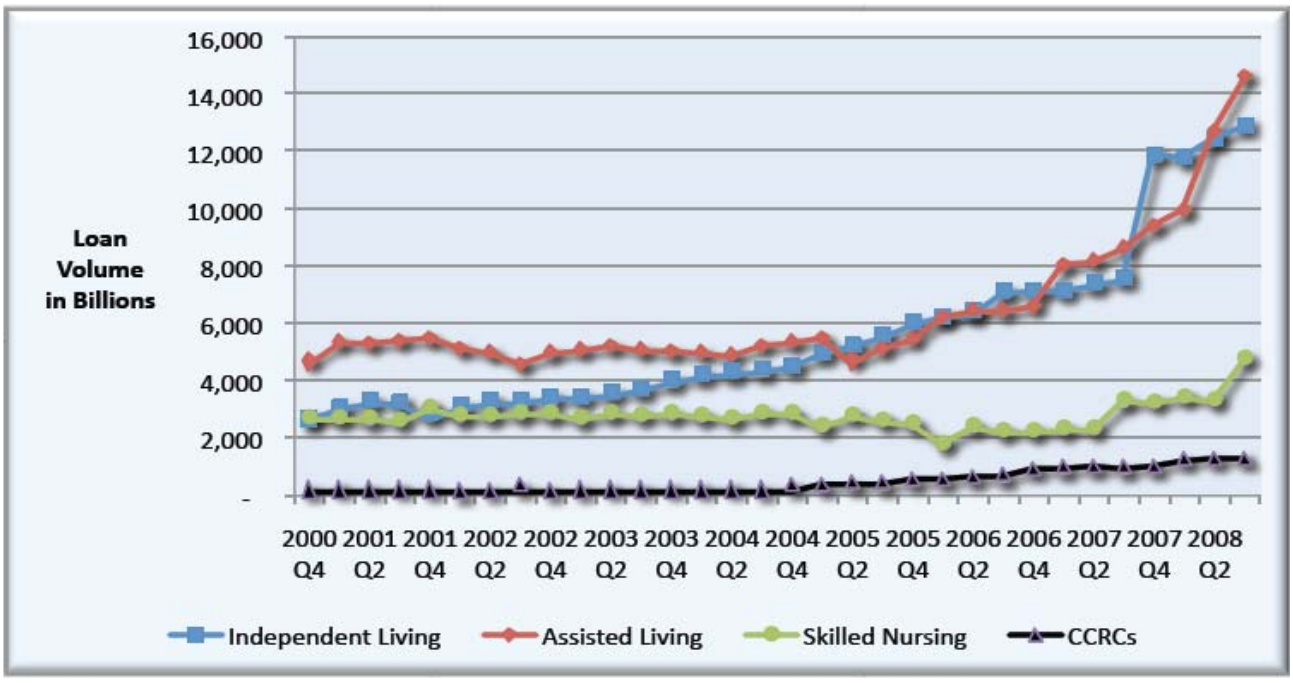
Nursing facilities provide housing and an array of services under one roof. As a housing and service option, nursing facilities operate in a competitive marketplace that includes Continuing Care Retirement Communities (CCRCs), assisted living and other supportive housing models. Some care models also compete with active adult communities, which have grown rapidly and compete with CCRCs for younger residents age 55–75 by emphasizing outdoor amenities like golf courses, tennis and basketball courts, walking paths, gyms and swimming pools. Apartment-style assisted living competes for older adults in the 75–85 range. In addition, senior apartments and independent living units that are not affiliated with CCRCs compete for the senior market.

Figure 18 contains national quarterly data on outstanding loan volumes in different types of senior housing. Similar data for California is not available; however, the authors believe a chart of California data would look similar. The outstanding loan volume data helps to establish the relative scale of these various senior living alternatives. The figure shows the substantial investments that are being made in independent and assisted living as opposed to skilled nursing facilities. Investments in CCRCs are still small compared to other senior living buildings. In California, there are only approximately 80 CCRCs with 18,000 residents.

As of February 9, 2009 there were 7,885 licensed RCFEs with a capacity to serve 168,347 persons.

The national occupancy rates for senior living reaffirm the trends shown in the OSHPD data. Again, the authors are not aware of comparable data on California but believe that these national trends apply to California as well. Nationally, occupancy rates have declined from their peaks in late 2006 and early 2007. The impact of the housing market and current recession on senior living is direct, since seniors typically fund their long-term care from the sale of their houses. These national data show that nursing facilities have traditionally had lower occupancy and that their occupancy has fallen more, almost 4%, since the current economic situation worsened, whereas assisted living has only fallen by about 1%. Utilization and financing trends suggest that market forces constrain the supply of nursing facilities.

Figure 18: National Quarterly Data on Short and Long-Term Senior Living Loan Volume



Data Source: National Investment Center for Senior Housing 9/30/08

Tables 61 and 62 show information on "mixed" and subacute nursing facilities. Mixed facilities are freestanding facilities that offer multiple levels of care (skilled nursing, intermediate care, subacute care). About half to two thirds of the nursing facilities shown below are licensed as subacute. The data show that this part of the nursing facility business has expanded substantially

since 2000, driven in part by rising Medicare demand. The number of such homes has expanded by about 40% and admissions increased about 71% 2000-2007.

Table 61: Trends for "Mixed" and Subacute Nursing Facilities in Numbers of Facilities, Beds, Occupancy Rates and Admissions and Discharges: 2000–2007

Calendar Year	No. of Facilities	Average Licensed Beds	Occupancy Rate	Admissions	Discharges
2000	54	7,352	85.14%	16,037	16,000
2001	56	7,585	87.18%	18,248	18,161
2002	61	8,367	87.12%	21,567	21,333
2003	62	8,783	87.62%	24,109	24,102
2004	64	9,117	85.61%	27,057	24,458
2005	71	9,697	86.34%	25,612	25,364
2006	79	10,737	84.74%	31,748	28,778
2007	76	9,903	86.46%	27,490	27,683
Total Change	40.74%	34.70%	1.56%	71.42%	73.02%

Data Source: Office of Statewide Health Planning and Development (OSHPD)

Table 62 shows that the mixed and subacute homes have increased their patient days by 37%, including a 47% increase in Medi-Cal days and a 162% increase in Medicare days.

Table 62: Trends for Mixed and Subacute Facilities in Total Patient Days and Medicare, Medi-Cal and Self-Pay Days: 2000–2007

Calendar Year	Total Patient Days	Medicare Days	Medi-Cal Days	Self-Pay Days	Managed Care Days	Other Payor Days
2000	2,267,938	106,552	1,608,106	300,997	125,321	126,962
2001	2,385,503	106,654	1,760,900	275,056	128,266	114,627
2002	2,641,682	137,465	1,939,507	267,024	141,013	156,673
2003	2,735,519	176,460	2,040,021	222,518	189,969	106,551
2004	2,850,653	210,969	2,148,298	198,564	217,187	75,635
2005	3,049,643	240,772	2,319,940	208,824	240,291	39,816
2006	3,383,227	290,139	2,532,416	218,451	253,600	88,621
2007	3,118,589	278,816	2,356,655	183,149	236,038	63,931
Total Change	37.51%	161.67%	46.55%	-39.15%	88.35%	-49.65%

Data Source: Office of Statewide Health Planning and Development (OSHPD)

While the number of Medicaid days in the regular skilled nursing facilities declined from 21.235 million days in 2000 to 19.981 million days in 2007, the number of Medicaid days in mixed and subacute homes increased from 1.608 million days in 2000 to 2.356 million days in 2007.

Medi-Cal Paid Claims Data for All Nursing Facility Care

The fourth source of data about California nursing facilities is the Medi-Cal paid claims database.[117] The California-specific data presented here are date-of-payment data per calendar years (CY). Table 63 covers calendar years 2000-2007 and includes all paid Medi-Cal claims for all 16 accommodation types related to nursing facilities, plus claims that did not have an "accommodation type" associated with them. The tables in this section show the complexity of nursing facility payments. On the one hand, it is correct to say that Medi-Cal pays for nursing facility services. On the other hand, it is more accurate to say that Medi-Cal makes 16 types of payments for nursing facility services.

Table 63 presents data on the number of unduplicated beneficiaries that used each type of nursing facility service and calculates their percentage growth for CY 2000-2007. This table shows that the number of persons using high-cost ventilator services expanded rapidly, while the number of person using regular nursing services declined slightly. The table shows significant growth, 200% to 300%, in the number of persons using freestanding ventilator services, while the number of unduplicated Medi-Cal beneficiaries using regular nursing facility Level B services declined 3.4% from CY 2000 to CY 2007.

Table 63: Users of Different Types of Nursing Facility Services: CY 2000–2007

Accommodation Codes	2000	2001	2002	2003	2004	2005	2006	2007	% Change
Freestanding NF-B-Ventilator Dependent-Bed Hold	206	257	348	443	499	679	812	945	358.7%
Freestanding NF-B-Ventilator Dependent	412	456	548	655	779	1,066	1,183	1,347	226.9%
Freestanding NF-B-Ventilator Dependent	64	82	89	110	119	156	180	188	193.8%
Freestanding NF-B-Non-Ventilator Dependent	449	476	598	713	872	1,066	1,183	1,246	177.5%
Freestanding NF-B-Non-Ventilator Dependent	98	93	108	111	122	153	160	147	50.0%
NF-B Regular-Leave Days Non-DD Patient	30,301	31,917	34,155	36,432	36,790	37,871	38,801	39,219	29.4%
None Listed: Service Not Related to Accommodation	49,878	51,128	51,744	53,846	54,867	56,794	56,286	56,146	12.6%
Hospital DP/NF-B-Ventilator Dependent	913	965	1,052	1,197	1,125	1,083	979	892	-2.3%
NF-B Regular	98,698	99,847	100,699	100,696	99,922	98,773	97,369	95,372	-3.4%
Hospital DP/NF-B-Non-Ventilator Dependent	74	86	105	101	95	81	66	70	-5.4%
Hospital DP/NF-B- Non-Ventilator Dependent	1,105	1,162	1,205	1,234	1,263	1,175	1,079	1,026	-7.1%
NF-B Rural Swing Bed Program	118	112	83	89	97	120	112	109	-7.6%
Psych NF-B Spec Treatment Prog-Mentally Disordered LTC	2,123	1,985	2,083	2,117	2,138	2,057	1,978	1,921	-9.5%
Hospital DP/NF-Ventilator Dependent	59	53	51	51	43	50	40	45	-23.7%
NF-A Regular-Leave	1,525	1,415	1,377	1,195	1,001	967	755	639	-58.1%

[117] This data is not publicly available and was provided to the authors by the Medical Care Statistics Section of the Department of Health Care Services.

Accommodation Codes	2000	2001	2002	2003	2004	2005	2006	2007	% Change
Days Non-DD Patient									
Hospital DP/NF-B-Ventilator Dependent-Bed Hold	157	220	270	318					
Freestanding NF-B-Non-Ventilator Dependent-Bed Hold					455	572	615	695	
Grand Total	**112,052**	**113,608**	**116,167**	**117,700**	**118,271**	**118,097**	**117,233**	**116,035**	**3.6%**

Data Source: Medical Care Statistics Section, California Department of Health Care Services
First Note: Several rows, e.g. Hospital DP/NF-B non Ventilator Dependent, have the same row labels but are actually different "accommodation types" in Medicaid claims processing.
Second Note: The total unduplicated count is not the sum of the rows since persons could have received services in more than one service setting during the year.

Table 64 shows expenditures by year and the percentage changes for CY 2000-2007. Overall expenditures increased 54.8% from $2.378 billion in CY 2000 to $3.681 billion in CY 2007. Expenditures for regular nursing facility Level B services increased 48.1% from $1.977 billion in CY 2000 to $2.929 billion in CY 2007. The largest year-to-year increases in the nursing facility Level B expenditures were from CY 2004 to CY 2006, when the total reimbursement went up approximately $200 million each year. The largest single percentage increases were in freestanding ventilator-related services, which increased more than 200% and more than 300% depending on the service.

Table 64 also shows expenditures for five types of distinct part nursing facilities. These are nursing facilities that are a distinct part of a hospital and their expenditures are shown separately in Table 65 in five rows. Each row that starts with the words "Hospital DP…" contains these distinct part expenditures. In CY 2007, these expenditures totaled $265.879 million. The largest single expenditure in CY 2007 was $142.495 million for the "Hospital DP/NF-B- Non-Ventilator Dependent" days.

Table 64: Medi-Cal Calendar Year Payments for Types of Nursing Facility Services: CY 2000–2007

Accommodation Codes	CY 2000	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	% Change
Free-Standing NF-B Ventilator Dependent-Bed Hold	$ 704,863	$ 1,008,989	$ 1,434,849	$ 1,810,333	$ 2,095,756	$ 2,780,982	$ 3,528,532	$ 4,437,654	529.58%
Free-Standing NF-B-Ventilator Dependent	$ 18,200,942	$ 23,682,397	$ 28,035,052	$ 35,447,835	$ 43,396,578	$ 56,644,932	$ 67,523,600	$ 77,453,790	325.55%
Free-Standing NF-B-Non-Ventilator Dependent	$ 22,760,672	$ 24,708,957	$ 30,669,025	$ 36,509,423	$ 46,193,677	$ 56,522,089	$ 66,686,637	$ 72,535,650	218.69%
Freestanding NF-B-Ventilator Dependent	$ 10,349,336	$ 11,749,354	$ 12,939,569	$ 16,580,828	$ 18,186,567	$ 24,974,787	$ 30,478,003	$ 32,452,752	213.57%
None Listed: Service not related to accomodation	$ 72,888,054	$ 81,333,482	$ 96,378,866	$ 116,333,113	$ 135,391,763	$ 157,856,768	$ 159,269,457	$ 170,224,127	133.54%
Freestanding NF-B-Non-Ventilator Dependent	$ 10,641,976	$ 11,436,949	$ 13,644,429	$ 13,881,324	$ 16,003,063	$ 17,967,733	$ 21,850,119	$ 22,646,508	112.80%
NF-B Regular-Leave Days non-DD Patient	$ 21,778,714	$ 25,819,320	$ 28,286,768	$ 31,609,157	$ 33,463,175	$ 38,760,677	$ 42,332,707	$ 44,294,087	103.38%
NF-B Rural Swing Bed Program	$ 1,925,797	$ 1,971,036	$ 2,035,635	$ 2,230,387	$ 2,439,283	$ 2,877,899	$ 3,177,875	$ 3,469,702	80.17%
Hospital DP/NF-B-Non-Ventilator Dependent	$ 7,007,240	$ 11,186,941	$ 12,683,145	$ 12,188,941	$ 14,005,786	$ 11,750,034	$ 11,442,778	$ 12,533,369	78.86%
All Other Accomodation Codes	$ 2,524,859	$ 2,569,139	$ 3,101,209	$ 3,439,905	$ 3,849,489	$ 3,774,655	$ 4,406,919	$ 4,223,855	67.29%
NF-B Regular	$ 1,977,664,643	$ 2,189,071,958	$ 2,247,476,584	$ 2,311,055,135	$ 2,433,593,046	$ 2,652,397,407	$ 2,859,606,687	$ 2,929,247,683	48.12%
Hospital DP/NF-B- Ventilator Dependent	$ 71,131,756	$ 77,860,178	$ 93,269,201	$ 105,783,425	$ 110,259,490	$ 103,730,137	$ 108,198,854	$ 104,069,836	46.31%
Psych NF-B Spec Treatment Prog-Mentally Disordered LTC	$ 29,815,091	$ 27,396,790	$ 28,483,554	$ 30,201,399	$ 33,223,829	$ 38,024,992	$ 41,172,384	$ 41,420,243	38.92%
Hospital DP/NF-B- Non-Ventilator Dependent	$ 106,947,958	$ 113,237,198	$ 118,694,189	$ 125,513,789	$ 132,306,890	$ 132,683,892	$ 132,750,908	$ 142,495,193	33.24%
Hospital DP/NF-Ventilator Dependent	$ 5,495,804	$ 5,882,346	$ 6,071,295	$ 5,921,764	$ 5,890,951	$ 6,172,909	$ 6,219,157	$ 6,781,211	23.39%
NF-A Regular-Leave Days non-DD patient	$ 18,162,324	$ 18,183,410	$ 17,790,785	$ 16,460,117	$ 14,713,672	$ 13,697,556	$ 12,582,096	$ 11,055,155	-39.13%
Hospital DP/NF-B- Ventilator Dependent-Bed Hold	$ 643,214	$ 835,082	$ 1,100,280	$ 1,295,347					
Free-Standing NF-B-non-Ventilator Dependent-Bed Hold					$ 1,497,979	$ 1,915,270	$ 2,157,257	$ 2,291,184	
Grand Total	**2,378,643,243**	**2,627,933,526**	**2,742,094,433**	**2,866,262,223**	**3,046,510,994**	**3,322,532,719**	**3,573,383,970**	**3,681,631,999**	**54.78%**

Data Source: Medical Care Statistics Section, California Department of Health Care Services

Table 65 shows the units of service paid for by Medi-Cal. Generally a unit of service is equal to a day. Ventilator days paid for have expanded significantly, and regular nursing facility Level B days have dropped by 3.3% from 21.681 million days in CY 2000 to 20.967 million days in CY 2007.

Table 65: Units of Service Paid for by Medi-Cal for Types of Nursing Facility Services: CY 2000–2007

Accommodation Codes	CY 2000	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	% Change
Free-Standing NF-B Ventilator Dependent-Bed Hold	1,938	2,690	3,758	4,686	5,355	6,831	8,403	10,634	448.7%
Free-Standing NF-B-Ventilator Dependent	51,069	62,790	73,834	91,772	109,916	138,815	158,012	181,797	256.0%
Free-Standing NF-B-Non-Ventilator Dependent	67,589	70,225	87,193	102,695	126,805	149,428	168,324	183,172	171.0%
Freestanding NF-B-Ventilator Dependent	17,222	18,307	19,791	24,925	27,036	36,173	42,221	43,800	154.3%
Freestanding NF-B-Non-Ventilator Dependent	19,490	19,581	22,893	22,878	26,079	28,531	33,269	33,505	71.9%
Hospital DP/NF-B-Non-Ventilator Dependent	11,797	17,842	19,775	18,700	21,263	17,493	16,259	17,286	46.5%
NF-B Regular-Leave Days non-DD Patient	236,539	255,819	275,425	299,624	301,109	311,980	321,481	326,257	37.9%
NF-B Rural Swing Bed Program	9,901	9,974	9,577	10,305	11,164	12,636	13,158	13,323	34.6%
Hospital DP/NF-B-Ventilator Dependent	140,863	150,730	173,786	192,982	198,673	183,156	179,403	160,523	14.0%
Hospital DP/NF-B- Non-Ventilator Dependent	220,590	228,751	233,314	242,553	251,412	246,195	231,910	233,546	5.9%
NF-B Regular	**21,681,082**	**21,711,192**	**21,909,602**	**21,863,830**	**21,759,949**	**21,340,066**	**21,192,945**	**20,967,434**	**-3.3%**
All Other Accommodation Codes	12,005	10,640	12,388	13,190	13,584	12,089	11,725	10,664	-11.2%
Psych NF-B Spec Treatment Prog-Mentally Disordered LTC	297,789	247,075	252,942	258,800	269,662	281,780	277,792	267,699	-10.1%
Hospital DP/NF-Ventilator Dependent	8,780	8,612	8,700	8,336	8,206	8,390	8,077	8,617	-1.9%
None Listed: Service not related to accommodation	6,465,306	5,648,801	5,762,154	5,932,484	5,608,944	5,401,862	4,350,141	3,680,094	-43.1%
NF-A Regular-Leave Days non-DD patient	314,505	294,814	280,908	242,935	209,654	197,615	174,454	144,956	-53.9%
Hospital DP/NF-B-Ventilator Dependent-Bed Hold	1,264	1,659	2,103	2,407					
Free-Standing NF-B-non-Ventilator Dependent-Bed Hold					4,149	5,082	5,518	5,963	
Grand Total	**29,557,729**	**28,759,502**	**29,148,143**	**29,333,102**	**28,952,960**	**28,378,122**	**27,193,092**	**26,289,270**	**-11.1%**

Data Source: Medical Care Statistics Section, California Department of Health Care Services

Table 66 shows the cost per unit. The cost per unit is derived from the previous tables showing the number of units Medi-Cal paid for during these calendar years and the value of the payments. The cost per unit for NF-B regular homes is close to the published costs associated with AB 1629 discussion but should not be expected to match them. [118]

[118] The Department of Health Care Services comments on the draft of this report state that the statewide weighted average rate for AB 1629 facilities was $142.11 for the 2005-2006 rate year, $148.59 for the 2006-2007 rate year, $152.48 for the 2007-2008 rate year, and $161.81 for the 2008-2009 rate year.

Table 66: Cost per Unit of Service Paid for by Medi-Cal for Types of Nursing Facility Services: CY 2000–2007

Accommodation Codes	CY 2000	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	% Change
None Listed: Service not related to accomodation	$ 11.27	$ 14.40	$ 16.73	$ 19.61	$ 24.14	$ 29.22	$ 36.61	$ 46.26	310.29%
All Other Accomodation Codes	$ 210.32	$ 241.46	$ 250.34	$ 260.80	$ 283.38	$ 312.24	$ 375.86	$ 396.09	88.33%
Psych NF-B Spec Treatment Prog-Mentally Disordered LTC	$ 100.12	$ 110.88	$ 112.61	$ 116.70	$ 123.21	$ 134.95	$ 148.21	$ 154.73	54.54%
NF-B Regular	$ 91.22	$ 100.83	$ 102.58	$ 105.70	$ 111.84	$ 124.29	$ 134.93	$ 139.70	53.16%
NF-B Regular-Leave Days non-DD Patient	$ 92.07	$ 100.93	$ 102.70	$ 105.50	$ 111.13	$ 124.24	$ 131.68	$ 135.76	47.45%
NF-B Rural Swing Bed Program	$ 194.51	$ 197.62	$ 212.55	$ 216.44	$ 218.50	$ 227.75	$ 241.52	$ 260.43	33.89%
NF-A Regular-Leave Days non-DD patient	$ 57.75	$ 61.68	$ 63.33	$ 67.76	$ 70.18	$ 69.31	$ 72.12	$ 76.27	32.06%
Hospital DP/NF-B-Ventilator Dependent	$ 504.97	$ 516.55	$ 536.69	$ 548.15	$ 554.98	$ 566.35	$ 603.11	$ 648.32	28.39%
Hospital DP/NF-B- Non-Ventilator Dependent	$ 484.83	$ 495.02	$ 508.73	$ 517.47	$ 526.26	$ 538.94	$ 572.42	$ 610.14	25.85%
Hospital DP/NF-Ventilator Dependent	$ 625.95	$ 683.04	$ 697.85	$ 710.38	$ 717.88	$ 735.75	$ 769.98	$ 786.96	25.72%
Freestanding NF-B-Non-Ventilator Dependent	$ 546.02	$ 584.08	$ 596.01	$ 606.75	$ 613.64	$ 629.76	$ 656.77	$ 675.91	23.79%
Freestanding NF-B-Ventilator Dependent	$ 600.94	$ 641.80	$ 653.81	$ 665.23	$ 672.68	$ 690.43	$ 721.87	$ 740.93	23.30%
Hospital DP/NF-B-Non-Ventilator Dependent	$ 593.98	$ 627.00	$ 641.37	$ 651.82	$ 658.69	$ 671.70	$ 703.78	$ 725.06	22.07%
Free-Standing NF-B-Ventilator Dependent	$ 356.40	$ 377.17	$ 379.70	$ 386.26	$ 394.82	$ 408.06	$ 427.33	$ 426.05	19.54%
Free-Standing NF-B-Non-Ventilator Dependent	$ 336.75	$ 351.85	$ 351.74	$ 355.51	$ 364.29	$ 378.26	$ 396.18	$ 396.00	17.59%
Free-Standing NF-B Ventilator Dependent-Bed Hold	$ 363.71	$ 375.09	$ 381.81	$ 386.33	$ 391.36	$ 407.11	$ 419.91	$ 417.31	14.74%
Hospital DP/NF-B-Ventilator Dependent-Bed Hold	$ 508.87	$ 503.36	$ 523.20	$ 538.16					
Free-Standing NF-B-non-Ventilator Dependent-Bed Hold					$ 361.05	$ 376.87	$ 390.95	$ 384.23	

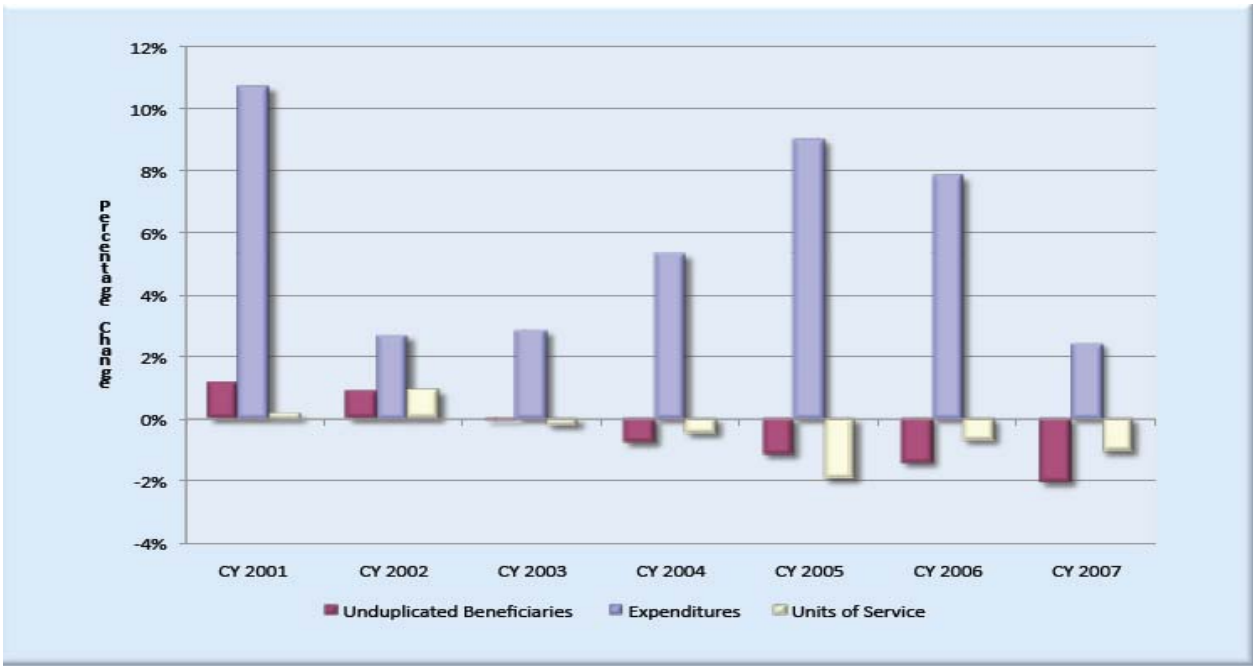
Data Source: Medical Care Statistics Section, California Department of Health Care Services

A rate analysis would ordinarily decompose the change in total expenditures into the impacts of changes in the number of beneficiaries, changes in the intensity of use of services and changes in the rate paid. A decomposition study is not necessary based on the total expenditures of nursing facility Level B services. Almost all the increase is due to a change in the cost of the units of service—the per diem paid by the state to the nursing facility. Such a decomposition study would be necessary to further study the significant increases in ventilator expenditures, since the figures above show substantial increases in the number of persons using the services. If the state were

interested in controlling nursing facility expenditures, then a study of ventilator costs and utilization might be a cost-effective activity.

Figure 19 summarizes the percentage changes in the number of beneficiaries, the expenditures and the units of service paid for by Medi-Cal CY 2000-2007. In CY 2001 expenditures increased more than 10%, while the percentage change in the number of beneficiaries and their units of service was less than 2%. After 2003, both the beneficiaries and units of service decrease each year, while the percentage change in total expenditures increases.

Figure 19: Nursing Facility Level B Percentage Changes in Beneficiaries, Expenditures and Units of Service: CY 2000–2007



Data Source: Medical Care Statistics Section, California Department of Health Care Services

California inflation increases show that the per diem increases, perhaps due to AB 1629, are greater than what would be expected on cost-based per diem reimbursement where inflation was the major contributor to increased costs. The data in Table 67 on the per diem is taken from the preceding table.

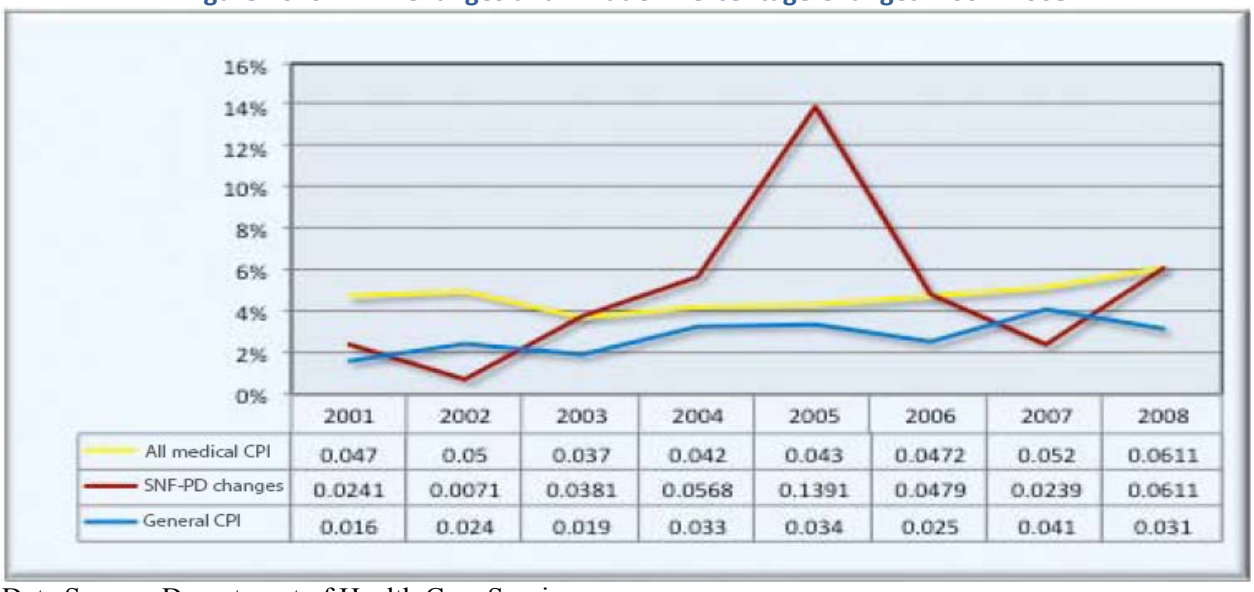
Table 67: Percentage Increases in the Nursing Facility Level B Per Diem

Year	Nursing Facility Level B Per Diem	% Increase in Per Diem	California Inflation
CY 2000	$ 91.22		
CY 2001	$ 100.83	10.54%	4.50%
CY 2002	$ 102.58	1.74%	2.20%
CY 2003	$ 105.70	3.04%	2.20%
CY 2004	$ 111.84	5.80%	2.20%
CY 2005	$ 124.29	11.14%	3.20%
CY 2006	$ 134.93	8.56%	3.70%
CY 2007	$ 139.70	3.54%	3.20%

Data Source: Sacramento Forecast Project, California State University at Sacramento[119]

A similar comparison was done by the DHCS for the AB 1629 Workgroup.[120] The following figure presents their data. The data in Table 67 and Figure 20 use different inflation estimates and different choices of which nursing facility per diem to compare; however, the results are similar. The increases in nursing facility per diem, however measured, have been cumulatively greater than general inflation 2001–2008 and have kept up with medical inflation.

Figure 20: SNF PD Changes and Inflation Percentage Changes: 2001–2008



	2001	2002	2003	2004	2005	2006	2007	2008
All medical CPI	0.047	0.05	0.037	0.042	0.043	0.0472	0.052	0.0611
SNF-PD changes	0.0241	0.0071	0.0381	0.0568	0.1391	0.0479	0.0239	0.0611
General CPI	0.016	0.024	0.019	0.033	0.034	0.025	0.041	0.031

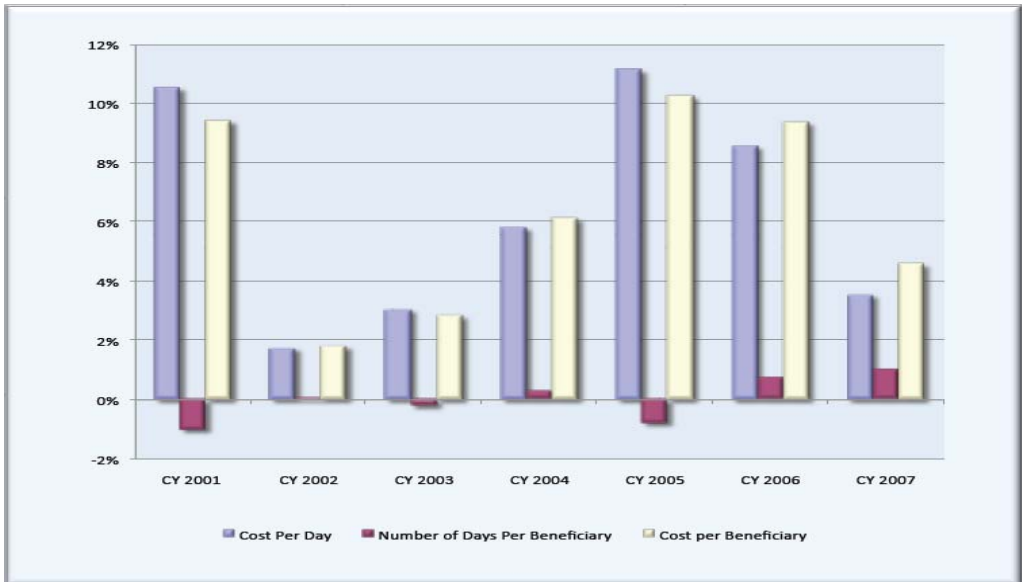
Data Source: Department of Health Care Services

Figure 21, the last figure in this series, shows the percentage changes in the nursing facility Level B cost per day, the number of days per beneficiary and the cost per beneficiary CY 2000-CY 2007. The average number of days per beneficiary and the percentage change in the number of days used by each beneficiary is flat. The cost per day and therefore the cost per

[119] For the Forecast Project's data see http://www.csus.edu/indiv/j/jensena/sfp/ca/CALIF.htm.
[120] See the DHCS graph at, retrieved on 3-2-09: http://www.dhcs.ca.gov/services/medi-cal/Documents/SNF%20Quality%20Workgroup/12InflAB1629%20Work%20Group.pdf.

beneficiary increased. The average yearly cost of NF/B services per beneficiary increased from $20,038 in CY 2000 to $30,714 in CY 2007.

Figure 21: Nursing Facility Level B Percentage Changes in the Cost per Day, Number of Days per Beneficiary and Cost per Beneficiary: CY 2000–2007



Data Source: Medical Care Statistics Section, California Department of Health Care Services

Although the number of private-pay residents has substantially declined, the beneficial impact of the increased Medicaid payments and increased Medicare utilization increased the operating margin of nursing facilities. Table 68 shows the operating margins of nursing facilities have increased substantially since 2000.

Table 68: Nursing Facility Operating Margins: 2000–2007

Calendar Year	Operating Margin
2000	0.57%
2001	1.30%
2002	0.35%
2003	-0.96%
2004	1.03%
2005	1.82%
2006	3.18%
2007	3.57%

Data Source: Office of Statewide Health Planning and Development

Section 7: Nursing Facility Reimbursement and Rate Setting

Assembly Bill (AB) 1629 (Chapter 875, Statutes of 2004) enacted the Skilled Nursing Facility Quality Assurance Fee (QAF) Program and the Medi-Cal Long-Term Care Reimbursement Act. The programs were approved by the Centers for Medicare & Medicaid Services (CMS) on September 9, 2005 and incorporated into the Medicaid State Plan as Supplement 4 to Attachment 4.19-D.

AB 1629 was the first major revision in Medi-Cal reimbursement for California nursing facilities since 1965, and it replaced a "flat-rate" system with a facility-specific, cost-based system. The reimbursement system became effective on August 1, 2005, and was originally scheduled to sunset after FY 2007–2008, but it was extended by the Legislature to FY 2011. The origins and consequences of the bill have been the subject of two major studies as well as newspaper articles.[121, 122] The AB 1629 Workgroup recommendations presented extensive information about nursing facility complaints, deficiencies, staffing levels, wages and benefits, and turnover rates, and it seems redundant to comment on these issues in this report.[123]

AB 1629 Rate Setting

The Medi-Cal 2007–2008 weighted average rate paid to nursing facilities under the AB 1629 Methodology was $152.48. An AARP study of nursing facility rates reported that California had the 25th highest nursing facility rate in the country in 2002 and 24th in 1998.[124] A BDO Seidman study of 2005 rates reported California had the 27th highest nursing facility rate out of 40 states. California nursing facility rates are in the middle one-third of nursing facility rates nationally.

There is no national data measuring the complexity of nursing facility reimbursement systems. California appears to have a reasonably straightforward system for reimbursing its regular NF-B nursing facilities. The ability to understand the rate setting is considerably aided by the transparent placing of all key rate setting worksheets on the Department of Health Care Services (DHCS) AB 1629 website including helpful annotations on the worksheets and informative accompanying narratives.[125]

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[121] Alteras, T. (July, 2007), *Adult Day Health Care Services: Serving the Chronic Health Needs of Frail Elderly through Cost-Effective Non-Institutional Care*. Health Management Associates.

[122] The first study was done by Harrington, C., et al. *Impact of California's Medi-Cal Long Term Care Reimbursement Act On Access, Quality and Costs*. UCSF. San Francisco, CA. (April 1, 2008). The second study was done by Schnelle et al. Evaluation of AB 1629. Available at: http://www.pascenter.org/documents/CHCF_NH_Reimbursement.pdf.

[123] A workgroup was established to provide recommendations about AB 1629. See the AB 1629 website for a list of comments about these topics. Retrieved on 3-2-09: http://www.dhcs.ca.gov/services/medi-cal/Pages/SNFQualityWorkgroup.aspx.

[124] AARP. *Across The States Profiles of Long-Term Care and Independent Living: California*. Washington, D.C. (2006 and 2004).

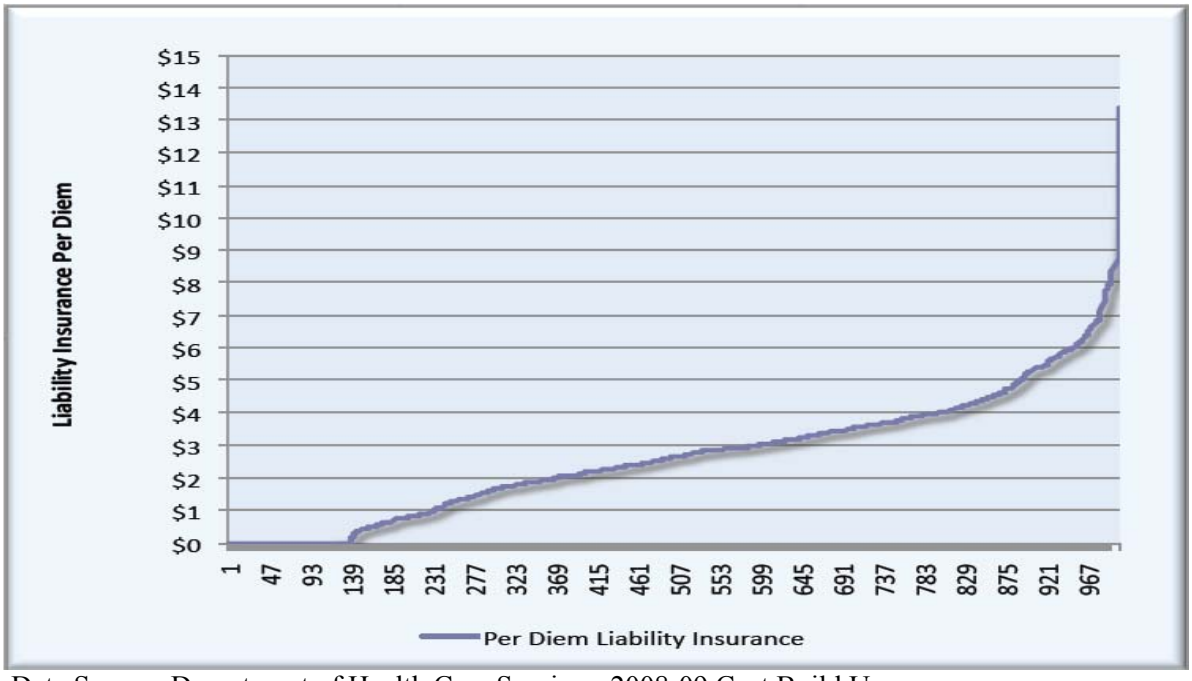
[125] See retrieved on 9-3-2009 http://www.dhcs.ca.gov/services/medi-cal/Pages/SNFQualityWorkgroup.aspx

Audited costs that have been inflated are divided into cost categories or cost centers. Four of these categories (direct care labor, indirect care labor, direct and indirect care non-labor, and administration) are limited by benchmark per diem caps developed for each of seven peer groups using percentile arrays.[126] Other costs are passed through the rate and not exposed to benchmark caps. These include property tax, liability insurance, license fees, caregiver training, and new state and federal mandates.

Liability Insurance

The exclusion of 100% of liability insurance costs from the administrative cost pool is puzzling, since it means that 100% of the liability insurance cost is "passed through" to the rate. A more efficient reimbursement would screen out the highest insurance costs. Figure 22 is a cumulative frequency distribution. It shows the per diem liability insurance rates used in the 2008–2009 NF-B rates AB 1629 rate setting calculations. The figure shows the amount of the insurance per diem on the vertical axis and the number of homes at that per diem or less on the horizontal axis. Each point on the curve shows the number of homes with a rate the same or below the per diem amount on the vertical axis. About 115 homes reported no liability insurance costs. On the other hand, about 50 homes paid more than $6.00 per day. The other 95% of the homes paid less than $6.00 per day.

Figure 22: Per Diem Liability Insurance Amounts in NF-B Nursing Facility Rates: 2008–2009



Data Source: Department of Health Care Services, 2008-09 Cost Build Up

[126] For a description of the AB 1629 peer group methodology see http://www.dhcs.ca.gov/services/medi-cal/Pages/LTCAB1629.aspx. Select "Peer-Grouping methodology" and click on it.

Caregiver Training

Theoretically, the same argument applies to caregiver training which is also a "pass-through."[127] However, so few homes report caregiver training expenses and the per diems are so low, the majority under $1.00 day, it is not worth the administrative effort to implement a screen.

Fair Rental Value System

Adequate capital reimbursement promotes quality of life and quality of care. A fair rental value system (FRV) is used to reimburse for capital costs. The heart of the FRV model is a 7% rental factor. Although the methodology seems reasonable, if you combine the property tax per diem and the FRV per diem, about 75% of the homes had a property-related per diem of between 4% and 7% of their total final per diem after all adjustments. The frequency distribution of per diems "feels" low and raises the possibility that property expenses may not be reimbursed at a level high enough to maintain the property. A fuller examination of this topic is beyond the scope of the report, but it is a topic that is worth looking at in more depth.

Other Rate Comments

Add-ons to the rate calculation include the Medi-Cal portion of the Quality Assurance Fee (QAF) and a minimum wage adjustment. California rates are held to a maximum annual increase of 5.5% of the weighted average Medi-Cal rate for the previous year, adjusted for changes in the cost to comply with new state and federal mandates. The 5.5% cap is a significant cost control and was used in the calculation of the 2008–2009 rates to bring the average aggregate increase down to 5.5% from 6.5% had not the overall cap been in place.

The use of an allowable 5.5% increase on institutional costs without a corresponding allowable increase in home and community-based care contributes to an institutional bias in the long-term care rates.

Quality Assurance Fee

The QAF and its administration have been closely examined by the Legislative Analyst's Office.[128] The QAF on nursing facilities is established by the Health and Safety Code at 1324.20 -1324.30. Section 1324.21 describes the calculation of the amount.

> For the rate year 2005–06 and subsequent rate years through and including the 2010–11 rate year, the net revenue shall be projected for all skilled nursing facilities subject to the uniform quality assurance fee. The projection of net revenue shall be based on the

[127] Applying a screen to caregiver training is more a principle than a practicality. Only about 54 homes reported caregiver training for the 2008-2009 rates, down from 60 in 2007-2008. There is one home that reports about $7.50 a day and this kind of outlier can be dealt with as an audit exception.

[128] For an explanation of the quality assurance fee, see fee recommendations provided later in the report and the Legislative Analyst's Office. *2009-10 Budget Analysis Series: Health, DHCS—Nursing Home Fee Program Should Be Revised.* Sacramento, CA. Retrieved on 3-2-09: http://www.lao.ca.gov/analysis_2009/health/health_anl09003003.aspx.

> prior rate year's data. Once determined, the aggregate projected net revenue for all facilities shall be multiplied by 6%, as determined under the approved methodology, and then divided by the projected total resident days of all providers subject to the fee.[129]

Net revenue is defined as gross resident revenue minus Medicare revenue.[130] The redefinition of revenue to include Medicare revenue would increase the per diem QAF by as much as $26 million according to one estimate.[131]

Use of Benchmarks

The use of benchmarks and the seven peer groups are the major way the state removes excessive costs from the pool of funds used for reimbursement. The benchmarks are limits above which the state will not provide 100% reimbursement of reported costs. Table 69 compares the per diems before and after they were screened by the benchmarks. In the 2007–2008 rates, the benchmarking process removed approximately 3.63% of all costs, approximately $153.6 million. It is difficult to say whether this is too much or too little, since comparative percentages are not typically reported by other states.

Why are the amounts of direct and indirect costs screened smaller than the direct/indirect non-labor and administrative costs? The last column of Table 69 shows that the peer group percentile screens are set at different levels for the different cost centers. For direct and indirect labor per diems, only per diems that are in the top 10% of per diems are "screened out," whereas the highest 25% of per diems for direct and indirect non-labor are screened out, and the highest 50% of administrative per diems are screened out.

Table 69: Amount of Initial Cost Removed from Each Cost Center by 2007–2008 Benchmarks

Cost Center	Reported Cost	Cost Left after Screening	Difference	% Difference	Benchmark Percentile
Direct labor	$ 2,480,883,827	$2,451,512,770	$ (29,371,057)	-1.18%	90th
Indirect labor	$ 613,095,213	$ 604,753,539	$ (8,341,674)	-1.36%	90th
Direct/indirect non-labor	$ 561,769,361	$ 526,230,981	$ (35,538,380)	-6.33%	75th
Administration	$ 571,933,842	$ 491,553,248	$ (80,380,594)	-14.05%	50th
Total	$ 4,227,682,243	$4,074,050,538	$(153,631,705)	-3.63%	

Data Source: Calculated by the Authors

[129] HSC 1324.21(b)(2). See also retrieved on 9-3-2009 http://www.aroundthecapitol.com/code/getcode.html?file=./hsc/01001-02000/1324.20-1324.30

[130] HSC 1324.20(c)(1).

[131] Legislative Analyst's Office, (November 11, 2008), *Overview of the Governor's Special Session Proposals.* Sacramento, CA. p. 25. Retrieved on 3-2-2009: http://www.lao.ca.gov/2008/bud/nov_revise/nov_revise_overview_111108.pdf.

Control for Low Occupancy

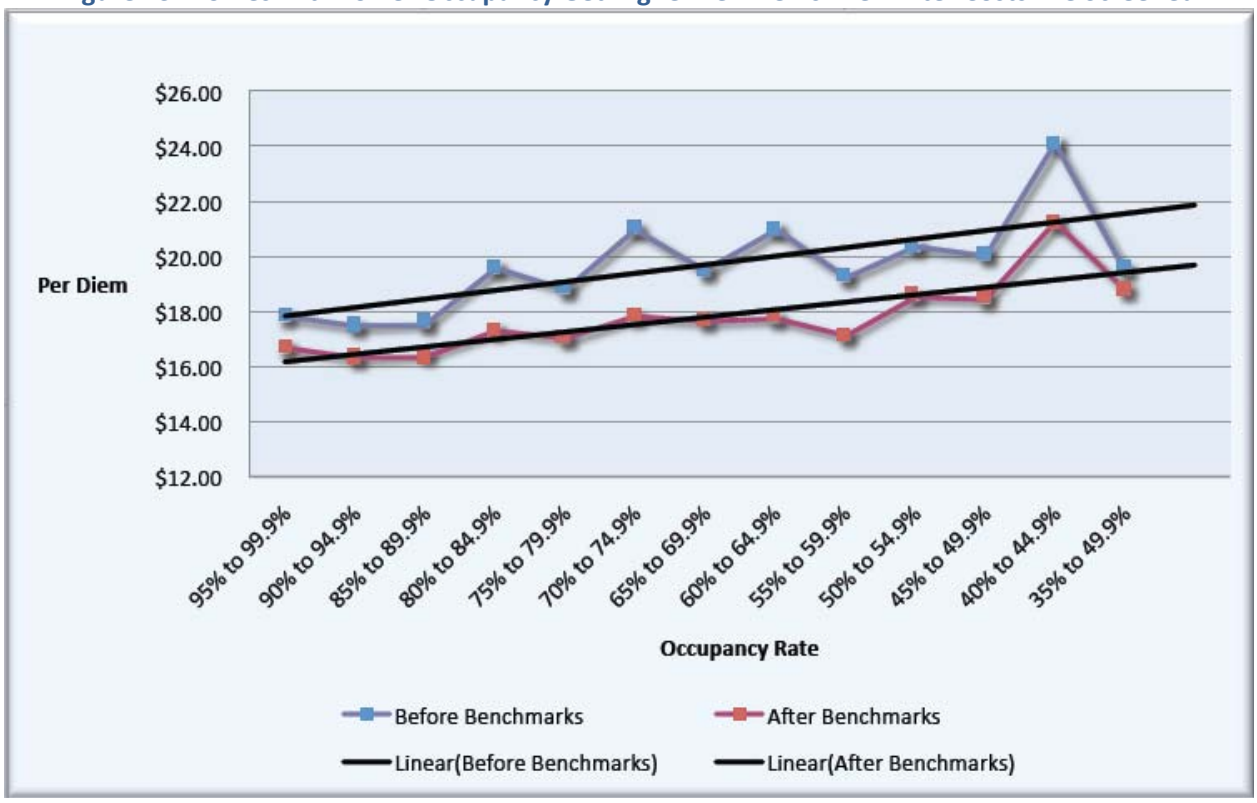
The AB 1629 methodology does not control for low occupancy. In per diem reimbursement systems, costs are divided by days of service. As the number of days becomes smaller, the cost per day goes up. Unless low occupancy rates are controlled for, the entities receiving the per diem reimbursement will get more money per person as they serve fewer persons. The next table shows the impact of applying the benchmarks for nursing facilities with similar occupancy rates. The table shows two trends. First, applying the benchmarks lowers the rate at all levels of occupancy. Second, both before and after the benchmarks are applied, there is a tendency for rates to increase as occupancy declines.

Table 70: Direct/Indirect Non-labor Per Diem Rates Before and After Benchmarks Are Applied: 2007–2008

Occupancy Rate	Average Direct/Indirect Non-Labor Per Diem Before Benchmarks	Average Direct/Indirect Non-Labor Per Diem After Benchmarks	Count of Nursing Facilities
95% to 99.9%	$17.82	$16.68	231
90% to 94.9%	$17.47	$16.32	366
85% to 89.9%	$17.59	$16.45	167
80% to 84.9%	$19.57	$17.32	92
75% to 79.9%	$18.81	$17.04	47
70% to 74.9%	$20.99	$17.82	32
65% to 69.9%	$19.46	$17.68	22
60% to 64.9%	$20.97	$17.77	13
55% to 59.9%	$19.27	$17.13	11
50% to 54.9%	$20.34	$18.57	4
45% to 49.9%	$20.06	$18.47	5
40% to 44.9%	$24.10	$21.24	1
35% to 49.9%	$19.51	$18.79	3

Figure 23 graphs the per diems before and after the application of the percentile controls by the benchmark rates. Two trend lines have been added to the figure to show the upward slope of how per diems increase as occupancy declines. The similar slope of the trend lines shows that the application of benchmarks lowers the per diems paid, but it does not control for the fact that homes with lower occupancy rates have higher per diems.

Figure 23: Homes with Lower Occupancy Get Higher Per Diems Even After Costs Are Screened



Why do homes with lower occupancy rates have higher per diems? One likely reason is that the AB 1629 methodology does not control for low occupancy. Many states use a minimum occupancy provision in the rate setting procedure. California does not use such a provision and this is relevant to the growth of home and community-based (HCBS) care programs. A minimum occupancy standard is the practice of reducing nursing facility per diems for selected cost centers when the home's occupancy falls below a certain level. It is intended to encourage homes to reduce their bed capacity and thus minimize state payment of nursing facility overhead expenses for empty beds. Occupancy penalties could create incentives to increase occupancy; however, nursing facility operators already seek to maximize Medicare and private-pay occupancy, and operators are more likely to delicense beds to meet the occupancy threshold.

Table 71 demonstrates the impact of minimum occupancy provisions. The data are hypothetical. Without an occupancy provision, the per diem continues to rise as a home's occupancy declines. The table assumes this 60-bed nursing facility has operational costs of $4,000,000 per year and capital costs of $400,000 per year, for a total of $4,400,000. The example shows per diems at different occupancy levels. The table uses an assumed minimum occupancy rate of 88%. As the home's occupancy declines, the per diem goes up until an 88% level is reached and after that the per diem is held constant at the 88% level and will not rise above $228.31.

Table 71: Impact of Minimum Occupancy Provision at 88% on the Per Diem of a Hypothetical Nursing Facility

Hypothetical Operational and Capital Cost of 60-Bed Nursing Facility	Hypothetical Number of Days	Resulting Occupancy Rate	Per Diem Without Minimum Occupancy (Current Method Used)	Per Diem If Minimum Occupancy Rate of 88% Is Assumed
$4,400,000	21,900	100%	$200.91	$200.91
$4,400,000	21,681	99%	$202.94	$202.94
$4,400,000	21,243	97%	$207.13	$207.13
$4,400,000	21,024	96%	$209.28	$209.28
$4,400,000	20,805	95%	$211.49	$211.49
$4,400,000	20,367	93%	$216.04	$216.04
$4,400,000	20,148	92%	$218.38	$218.38
$4,400,000	19,710	90%	$223.24	$223.24
$4,400,000	19,491	89%	$225.75	$225.75
$4,400,000	19,272	88%	$228.31	$228.31
$4,400,000	18,834	86%	$233.62	$228.31
$4,400,000	18,615	85%	$236.37	$228.31
$4,400,000	18,396	84%	$239.18	$228.31
$4,400,000	17,958	82%	$245.02	$228.31
$4,400,000	17,739	81%	$248.04	$228.31
$4,400,000	17,301	79%	$254.32	$228.31
$4,400,000	17,082	78%	$257.58	$228.31
$4,400,000	16,863	77%	$260.93	$228.31
$4,400,000	16,425	75%	$267.88	$228.31
$4,400,000	16,206	74%	$271.50	$228.31
$4,400,000	15,987	73%	$275.22	$228.31
$4,400,000	15,549	71%	$282.98	$228.31
$4,400,000	15,330	70%	$287.02	$228.31

Occupancy controls are widely used. There is no annual publication that identifies how many states use minimum occupancy provisions, the cost centers they are applied to, or at what occupancy level the reduction of the cost center's per diem takes effect.[132] A Government Accountability Office (GAO) report of 2003 found that 17 of the 19 states it studied had a minimum occupancy provision and the average across all states was 88.6%. Texas, South Dakota and Florida had occupancy provisions that were tied to the statewide average occupancy rate; e.g. the minimum occupancy provision would take effect if the home's occupancy rate was three points lower than the statewide average occupancy percentage.[133] In the GAO study, seven of the

[132] Inquiries to the CMS indicate that CMS does not collect this data.

[133] Government Accountability Office, (October, 2003), *Medicaid Nursing Home Payments: States' Payment Rates Largely Unaffected by Recent Fiscal Pressures*. Report Number GAO-04-143. Washington, D.C.

19 states applied these minimum occupancy provisions to all cost centers, while the other states applied them to administrative, indirect or capital cost centers.

The analysis of a state's minimum occupancy is an issue raised in discussions of balancing long-term care programs. For example, in 2005 The Louisiana Legislative Auditor's Office conducted a broad review of Louisiana long-term care programs and suggested raising the state's minimum occupancy rate from 70% to 90%.[134] The Louisiana Department of Health and Hospitals still uses a 70% minimum occupancy standard.[135] On March 20, 2009, Louisiana amended its use of occupancy provisions by adding a new provision saying that if a nursing facility's occupancy is less than 90% the reimbursement for hospital leave days and facility leave days will be 10% of the per diem rate. If a nursing facility's occupancy is greater than or equal to 90%, then the reimbursement for hospital and home leave days will be 90% of the per diem rate (up to 7 hospital/15 facility leave days per occurrence). The average occupancy of nursing facilities in Louisiana is 73% so this March 2009 provision appears to have the practical effect of reducing reimbursement to 10% of the regular per diem for days when the resident is away from the nursing facility.

The fiscal impact of implementing a minimum occupancy provision would depend on what level of occupancy is chosen and which costs are affected by the threshold. However, a look at the 2007–2008 occupancy rates of California nursing facilities provides an estimation of how many nursing facilities might be affected. The lower the occupancy, the greater the effect. The table shows about 60% of the homes are above 90% occupancy and another 16.8% are between 85% and 90%. The remaining 25% are below 85% level of occupancy.

Table 72: Occupancy Rates of 995 California Nursing Facilities: FY 2007-2008

Occupancy Level	Number of Homes at This Level	Percentage of Homes at This Level
95% to 99.9%	231	23.2%
90% to 94.9%	366	36.8%
85% to 89.9%	167	16.8%
80% to 84.9%	92	9.2%
75% to 79.9%	47	4.7%
70% to 74.9%	32	3.2%
65% to 69.9%	22	2.2%
60% to 64.9%	13	1.3%
55% to 59.9%	11	1.1%
under 55%	14	1.4%
Total	995	100.0%

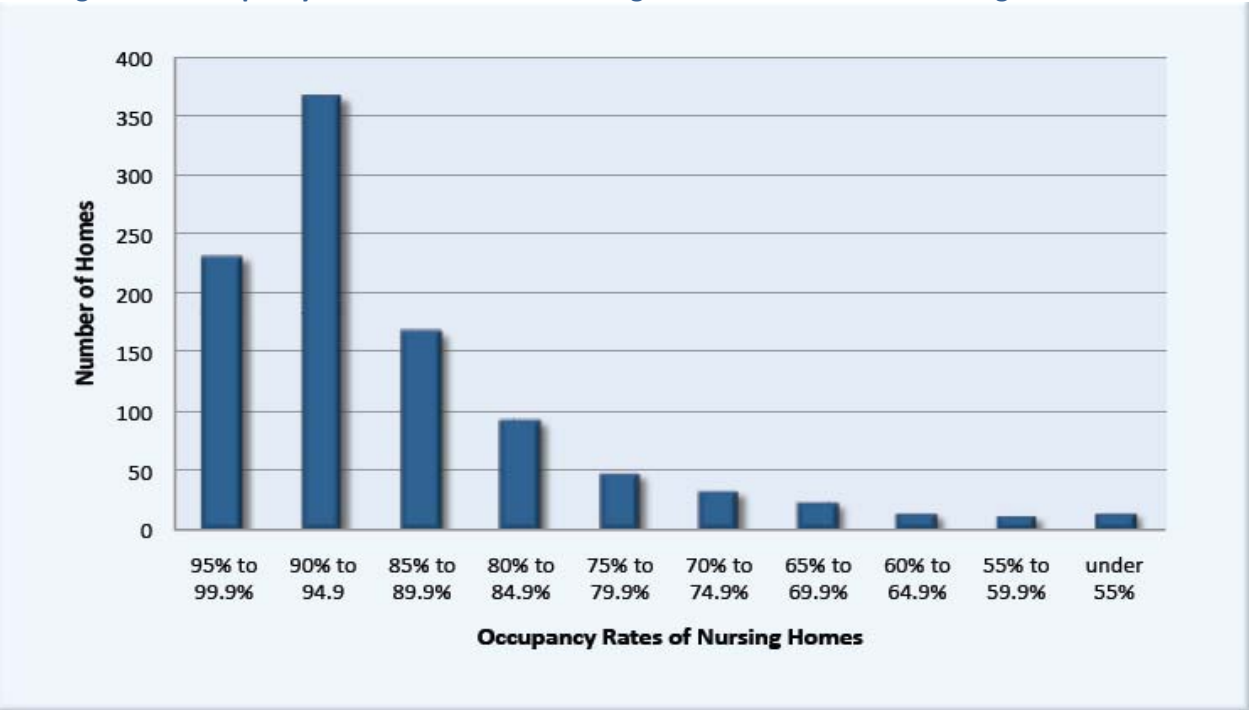
Data Source: Department of Health Care Services

[134] Louisiana Legislative Auditor. Performance Audit Report—Audit Control #04102391, Baton Rouge, LA. (March 2005).

[135] Authors interview with Louisiana State staff on 9-2-2009. Staff did indicate that there is periodic discussion of raising the minimum occupancy rate because of concerns about "paying for empty beds."

Figure 24 shows this same information in a bar graph.

Figure 24: Occupancy Rates of California Nursing Facilities Used in Rate Setting: FY 2007–2008



Data Source: Department of Health Care Services

The use of occupancy provisions is usually opposed by state nursing facility associations because it is another way in which states do not pay the cost experience of nursing facilities. Associations often seek to remove the occupancy provision entirely or reduce the threshold at which it is applied. State budget and fiscal offices usually support the use of occupancy provisions since it controls overhead costs and avoids "paying for empty beds." Advocates of HCBS care programs generally support occupancy provisions because of a belief that nursing facility transition efforts in states with an occupancy provision are more cost-effective, i.e. more "money follows the person." [136]

Labor-Driven Operating Allocation

The Labor-Driven Operating Allocation is an "add on" to the nursing facility rate. It is not a reimbursement for cost incurred by the nursing facilities; rather it is an additional amount that is added into the rates. Based on its method of calculation, it appears to be an incentive for nursing facilities to hire permanent staff and not hire agency or contracted staff. The amount added to the per diem is based on 8% of the sum of the inflated direct and indirect costs where the staff costs

[136] Wade, K. and Hendrickson, L. *Modeling the Impact of Declining Occupancy on Nursing Home Reimbursement.* Rutgers Center for State Health Policy, Rutgers University, New Brunswick, NJ. (June, 2008), Retrieved on July 13, 2008: http://www.cshp.rutgers.edu/cle/Products/7800.pdf.

do not include temporary staff. This per diem is then capped and cannot exceed more than 5% of the sum of the other per diems.[137]

In FY 2008–2009 rate setting worksheets, if we multiply the final per diem labor-driven offset by the number of Medi-Cal days for each home, the sum is about $168.4 million across the 1,000 or so NF-B nursing facilities. Given the magnitude of the per diem and the fact that the offset does not reimburse an actual cost, it seems reasonable to suggest that the state rethink this incentive and exercise policy-related control over it.

There are alternative incentives that the state could construct. For example, the benchmark screens on direct and indirect labor could be removed. The $29.4 million and $8.3 million currently screened could be offset by a corresponding reduction in the labor-driven operating allocation. The allocation funds could be redirected to encourage more discharge planning. For example, the state is undertaking a significant Money Follow the Person (MFP) Rebalancing Demonstration. It makes sense to find ways to create incentives for nursing facilities to cooperate with the demonstration by increasing the reimbursement for those that do. Another use of the funds could be to assist those nursing facilities that wish to remake their programs such as the "Culture Change" movement in nursing facilities, Eden Alternatives and the Green House Project. Pay for performance to improve quality of care and quality of life could be added to the rate setting methodology. Or the funds could be used to help nursing facility owners convert part of their facilities to assisted living facilities or dementia care units. Caregiver training could be encouraged. Only 54 homes reported caregiver training expenses for the 2008–2009 rates. The offset funds could be used to encourage the hiring of registered nurses or other direct care staff. The offset is a large sum to be spent without having a policy that directs how it is used and the benefit gained. Given the other incentives that the money could be used for, it does not seem reasonable to have the only incentive in the nursing facility budget be one that discourages the hiring of temporary staff.

For example, Pennsylvania is using three incentives to encourage nursing facility providers to convert or eliminate existing nursing facility beds.[138] The Pennsylvania state plan language describing these incentives is shown in the Appendices, and Pennsylvania activities are described in greater length in Section 9.

Case-Mix Reimbursement

The point of view of this report is that reimbursement, where possible, should be linked to the characteristics of the person whose care is being reimbursed rather than the setting in which care is delivered. The state uses prospective, cost-based rates that are not adjusted for the acuity of the residents. The practice of using an acuity-linked reimbursement system is widespread in both federal and state practice. CMS uses acuity measurements in their reimbursements of acute inpatient, outpatient, rehabilitation and nursing facility services. The rationale for payment on the

[137] A description of this calculation can be obtained at: http://www.dhcs.ca.gov/services/medi-cal/Documents/AB1629/Final%20Rates%20Narrative.pdf.

[138] The incentives are called the Permanent Rate Incentive (PRI), the Adjusting Reconfiguration Incentive (ARI) and the Benchmarked Rate Incentive (BRI). An overview is available at: http://www.nashp.org/Files/Pezzuti_NASHP2008.pdf.

characteristics of the individual receiving services is that providers are more appropriately reimbursed for the resources needed to provide care.

Approximately 30 states use a case-mix concept to reimburse nursing facilities. Residents of nursing facilities are assigned to resource utilization groups or RUGs based on their answers to questions on the Minimum Data Set (MDS), a national assessment instrument required by CMS.

Every reimbursement system has advantages and disadvantages, incentives and disincentives.

A flat rate system:

- Easy to administer as everyone gets paid the same rate
- Unfair to providers who serve higher acuity residents
- Doesn't recognize regional or other cost variations

A cost-based system, like AB 1629:

- Uses blunt controls as everyone whose costs exceed a certain level does not get paid for the excess amount
- Doesn't differentiate well if a provider's costs can increase because they take care of residents with greater need or if the provider is less efficient
- Usually uses "screens," "limits" and other cost controls

A case-mix system:

- Encourages access to heavy care patients
- Includes the burden of monitoring the acuity measurement system to ensure it is not abused through upcoding of patient assessment scores to indicate that patients have more intensive needs justifying higher reimbursement
- Often pays a flat rate for administration
- Could conceivably better control hospital-based nursing facility and ventilator payment rates

Considering the advantages and disadvantages, California policy makers might consider a case-mix system for the staffing component of nursing facility costs that links payment to acuity level, a linkage that is not established by reimbursing high-cost providers for their costs. Such a linkage pays providers more for taking care of more seriously ill residents and reimburses them less for taking care of less seriously ill residents. As noted above in the

discussion of AB 1629, there has been considerable research and discussion as to whether or not nursing facility staffing has increased as a result of AB 1629's enhanced payments. Such discussions will continue and remain a controversy as long as payments and staffing are disconnected from the needs of the persons receiving nursing facility services.

A case-mix reimbursement system for nursing facility providers has a modest practical linkage to HCBS. If the state had a case-mix system for nursing facilities and a statewide nursing facility transition program, then an option would be created to link payments in the nursing facility to community payments. The largest and most significant example of this is Texas. While Texas is converting its Texas Index for Level of Effort (TILE) system to a RUGs case-mix system, it has historically linked the amount of community funding available for persons being transitioned out of a nursing facility to the acuity-based level of effort needed to take care of them in the nursing facility. The Texas MFP effort has been very successful. Between September 1, 2001 and September 31, 2008, Texas transitioned 16,306 nursing facility residents to community settings.[139] By January 31, 2009, the number increased to 17,117 transitions.[140] State officials reported that about 5% of the persons who transition return to a nursing facility.

Interviews with staffs in Pennsylvania's well-known transition program indicate that they believe a case-mix system makes their work easier, since nursing facility providers are more interested in admitting and taking care of more impaired persons and are less interested in taking care of patients with fewer impairments. Pennsylvania helped 5,000 persons move from nursing facilities since January 2007.[141]

[139] Texas Health and Human Services Commission (2009), *2008 Revised Texas Promoting Independence Plan.* HHSC, Austin, Texas. Available at: http://www.dads.state.tx.us/providers/pi/piplan/2008revisedpiplan.pdf.
[140] Personal Communication from Marc Gold, Director, Promoting Independence Initiative. Texas Department of Aging and Disability Services. (March 30, 2009).
[141] Interviews by the authors with Pennsylvania state staffs in March 2009.

Section 8: Home and Community-Based Services (HCBS) Expenditures, Reimbursement and Rate Setting

This section describes service expenditures, reimbursement and rate setting practices for HCBS.

Acquired Immune Deficiency Syndrome (AIDS) Waiver

During CY 2006 almost all AIDS waiver participants received case management; 44% received non-emergency medical transportation; 35% received nutritional supplements or home-delivered meals; and 30% received attendant care. About 87% of the expenditures were spent on three services: 50% was spent on case management, 26% on attendant care and 11% on homemaker services.

The §1915(c) Waiver application to the Centers for Medicare & Medicaid Services (CMS) Waiver described the methodology used to set provider rates. The rate setting for the monthly case management fee was "determined by surveying waiver agencies to collect information on staff salaries, number of hours spent monthly performing case management and administrative activities." There is no explicit description of how non-emergency transportation or nutritional supplements are priced.

The attendant care services rate is the same as the rate paid under other waivers and the Medicaid State Plan. The §1915(c) application stated that the Rate Development Branch (RDB) sets hourly rates for Skilled Nursing (Registered Nurse and Licensed Vocational Nurse) and Home Health Aide Services (Attendant Care) services used by all HCBS Waivers and conducts surveys in the local community to determine current rates or user rates established by legislatively mandated programs.[142] The table below shows the procedure codes, services, rate amounts and effective dates of the rate for the services obtainable through the AIDS Waiver.[143]

Table 73: Procedure Codes, Services, Rate Amounts and Effective Dates for Acquired Immune Deficiency (AIDS) Waiver Services

HCPCS Code	Description	Maximum Rate	Effective Date
Z5000	Case Management	$229.17 per client month	7/1/2001
Z5002	Skilled Nursing (RN)	$40.57 per hour	8/1/2000
Z5004	Skilled Nursing (LVN)	$29.41 per hour	8/1/2000
Z5006	Psychotherapy	$51.00 per hour	7/1/2001

[142] See Appendix I-2 of the 1915(c) waiver application with effective date of January 1, 2007. The waiver application does not appear to be available on state or federal sites. The authors obtained a copy from California staffs.

[143] See, retrieved on 12-18-08: http://files.medical.ca.gov/pubsdoco/DocFrame.asp?wURL=publications%2Fmasters%2Dmtp%2Fpart2%2Faidsbilcd%5Fo02%2Edoc.

HCPCS Code	Description	Maximum Rate	Effective Date
Z5008	Attendant Care	$18.90 per hour	8/1/2000
Z5010	Homemaker Services	$11.56 per hour	7/1/1999
Z5012	Medi-Cal Supplement for Infants and Children in Foster Care	$338.00 per client per month	1/1/1991
Z5014	Specialized Medical Equipment and Supplies and Minor Physical Adaptations to the Home	$1,000 per client per year	1/1/1993
Z5016	Non-Emergency Medical Transportation	$40.00 per client per month	1/1/1993
Z5018	Administrative Expenses	$170.28 per client per month.	7/1/2001
Z5020	Nutritional Counseling	$33.48 per hour	1/1/1993
Z5022	Nutritional Supplements and Home-Delivered Meals	$150 per client per month	1/1/1993

Data Source: State of California

Based on the effective dates of the rates, five rates have not been changed since the early 1990s, and the last time any rate was changed was in July 2001. The AIDS Waiver application was made in 2006 and it projected maintaining these same rates for the entire five years of the waiver, 2007-2011.

Freezing waiver rates for a prolonged period may hinder access for waiver participants, reduce the number of providers, change the mix of providers by attracting more marginal lower-cost providers and complicate program management.

Multipurpose Senior Services Program (MSSP) Waiver

The Multipurpose Senior Services Program (MSSP) Waiver offers ten general services comprised of some 50 specific procedure codes that are billed separately. In 1977, the California Legislature authorized the MSSP as a four-year research and demonstration project. The objective of the project was to obtain information on cost-effective methods of preventing inappropriate institutionalization of elderly persons. The Torres-Felando Long-Term Heath Care Reform Act of 1982 continued MSSP. The state obtained CMS approval to operate the program through a §1915(c) HCBS Waiver in 1983.[144]

[144] A controlled study of MSSP's first year of operation showed it emphasized case management and reduced hospital admissions from 40% to 63%, but did not affect nursing home admissions. See Vetrees, J., Manton, K. & Adler, G. (Summer 1989), *Cost effectiveness of home and community-based care*. Health Care Financing Review, Centers for Medicare & Medicaid Services, Baltimore, MD. Retrieved on 7-21-08: http://findarticles.com/p/articles/mi_m0795/is_n4_v10/ai_8134853/pg_1?tag=artBody;col1.

MSSP was designed as a care management program and has retained this focus over time. The sites are required to maintain a caseload of 40 persons per care manager. Approximately 77% of all dollars are currently spent on care management. Almost all the participants also receive services from the In-Home Supportive Services (IHSS) program provided under the Medi-Cal personal care option. As described by state staff, the MSSP case management is provided monthly and does not duplicate IHSS activities because the IHSS social workers do not provide service coordination or regular oversight. IHSS case management is an eligibility and care plan approval activity and is not comprehensive.

Unlike other waivers, the MSSP Waiver is not funded on a procedure code basis. Sites receive a rate for the direct staff costs of the nurses and social workers that provide the care management and another rate for the indirect costs of supporting the nurses and social workers. The California Department of Aging (CDA) establishes a cost cap for each "slot," or full-time equivalent person served on the waiver. The dollars appropriated for the waiver are divided by the number of slots, which was 11,789 in Fall 2008, to get a cost cap, which was set at $4,285. Each site receives the same amount per person, although the total amount received by the sites varies because the sites are responsible for different numbers of participants.

At the start of the fiscal year, CDA reviews the cost report data and submissions from the sites and sets retrospective rates for both case management and indirect case management. These rates are retrospective because they are "cost-settled" at the end of the year when actual costs for the year are compared to payments received. Sites are audited.

Other services covered are purchased by the MSSP sites through competitive bidding. These services are: Adult Day Support Center, Housing Assistance, In-Home Supportive Services, Respite Care, Transportation, Meal Service, Protective Services and Special Communications.

The state exercises cost control in the MSSP program by controlling the number of "slots" that will be filled, setting limits on the cost per slot paid for through appropriating total program dollars, fixing retrospective rates to fit existing budget authority, and then monitoring and auditing the MSSP care management sites.

Developmental Services Programs

As an entitlement program, services to persons with developmental disabilities are funded through general funds and an HCBS Waiver. During 2006, the services used by the largest number of persons on the Developmentally Disabled (DD) Waiver were: day habilitation, 59%; transportation, 58%; adult residential care, 39%; respite care, 31%, and prevocational programs, 12%. About 46% of the funding was spent on adult residential care, 30% on day habilitation, 7% on transportation, and the other 17% was spread across the other services. In addition to receiving services from the DD Waiver, about 40,000 waiver participants received personal care through IHSS.
In general, Title 17 of the California Code provides good rate setting methodologies for developmentally disabled services provided outside of the waiver; however, continued budget efforts to control program expenditures have resulted in what are now permanent rate freezes for

providers. This is true of almost all rates with a few exceptions, e.g. usual and customary charges for taxis and transportation services.[145] The following descriptions of rate setting methodology are based on the methods that were used prior to the 2009 budget-driven state actions.

The rate used to reimburse day habilitation services depends on the provider type. Day habilitation spans a broad category of services and can be provided by:

- Mobility Trainer - Service Agency
- Mobility Trainer - Specialist
- Community Integration Services
- Day Program
    - Activity Center
    - Adult Developmental Center [17 CCR 54342 (a)(6)]
    - Behavior Management Program [17 CCR 54342 (a)(14)]
    - Independent Living Program [17 CCR 54342 (a)(35)]
    - Social Recreation Program [17 CCR 54342 (a)(74)]
- Supplemental Day Services Program Support
- Creative Art Program
- Developmental Specialist
- Supported Employment Services
- Prevocational Services
- In-Home Day Program

Some rates, for example a mobility training service agency or a behavioral management assistant, are reimbursed on a usual and customary basis. Although rates for behavioral management assistants may be set at a usual and customary rate, the rates may also be negotiated. The majority of behavioral management assistants' rates are set by negotiation. In addition, new providers are subject to median rates.[146] Other providers can be reimbursed on a negotiated rate, or a cost-based rate based on average costs of all providers of their type. The use of cost reports and allowable costs to reimburse developmental services is discussed at 17 CCR §56903 ff. and 17 CCR §57510 ff.[147]

[145] See the California Welfare and Institutions Code, sections 4681.5, 4681.6, 4689.8, and 4691.9.
[146] See: http://www.dds.ca.gov/Title17/T17SectionView.cfm?Section=57332.htm&SearchString=behavioral%20management%20assistant&Anchor=behavioral%20management%20assistant#behavioral%20management%20assistant.
[147] The California Code of Regulation can be found at: http://government.westlaw.com/linkedslice/default.asp?SP=CCR-1000. See Title 17 Division 2 for the Department of Developmental Services' regulations.

Table 74 shows the ways that transportation services are reimbursed.

Table 74: Rate Basis for Transportation Services Paid by Department of Developmental Services

RATES OF REIMBURSEMENT FOR TRANSPORTATION SERVICES

Service Code	Service Description	Basis for Rate
425	Transportation – Family Member	Standard Rate Schedule developed by the regional center.
875	Transportation Companies	Request for Proposal, negotiated amount or cost statement, at the regional center's discretion.
880	Transportation – Additional Component	Request for Proposal, negotiated amount, or cost statement, at the regional center's discretion.
882	Transportation – Assistant	Usual & Customary or Negotiated rate. (Negotiated if vendor has no Usual & Customary rate.)
883	Transportation Broker	Negotiated rate.
885	Transportation – Medical	Schedule of Maximum Allowance
890	Transportation – Auto Driver	Mileage rate paid to regional center employees or Standard Rate Schedule developed by the regional center.
895	Transportation – Public Transit Authority, Dial-A-Ride, Rental Car Agency or Taxi	Usual & Customary or Negotiated rate. (Negotiated if vendor has no Usual & Customary rate.)

Data Source: Department of Developmental Services[148]

Adult residential care payment is based on 17 CCR §56000 ff. The methodology uses a cost-report-based rate. Information on costs is used to arrive at allowable costs for provider types, adjustments are made to allowable costs and a rate is determined. The methodology is noteworthy because it contains inflation adjustments, authorized in 17 CCR 56915. Other California waivers have no inflation adjustments.

In-home respite programs are reimbursed according to an annual rate schedule.[149] For rates effective January 1, 2008, in-home respite, service category 862, was reimbursed at a lower limit of $14.75, an upper limit of $21.27 and a "Temporary Payment Rate" of $18.12.[150] The methodology for calculating the rates is described at 17 CCR Subchapters 13 and 14, sections 58100 ff. The rates determined appear to be vendor-specific rates based on cost finding, a determination of allowable costs and adjustments to costs.

[148] Data retrieved on 12-18-08: http://www.dds.ca.gov/Rates/docs/RATES_TRANSPORTATION.pdf.
[149] The DDS website has a page documenting rates for different services including respite care. See, retrieved on 12-19-08: http://www.dds.ca.gov/Rates/ReimbRates.cfm.
[150] See, retrieved on 12-19-08: http://www.dds.ca.gov/Rates/docs/Comm_Based_Respite.pdf.

Similarly, prevocational programs have established hourly rates.[151] 17 CCR 58860 describes a cost-based approach that groups vendors into three cost pools based on the number of consumers served. Cost containment adjustments are applied, for example administration is capped at 32.12% of allowable costs as per 17 CCR 58871. Maximum payment levels by vendor group are set, and costs that exceed these levels are not reimbursed.

In general, nonresidential rates were negotiated and, pursuant to statute, median rates are now in place effective July 1, 2008 in lieu of negotiated rate setting. The extent and depth of negotiated rates and the degree to which negotiations are used in the cost-based approaches is not reported on by the Department of Developmental Services (DDS), and the uniformity of rate payments across regional centers is not known.[152]

While DDS has reasonable rate-setting methodologies, the methodology has been overtaken by the budget problems. Most rates were frozen on June 30, 2008. DDS no longer analyzes cost reports and is now using a median rate methodology for new providers. New providers are given the lower of the median regional center rate or the median statewide rate. With the exception of mandated minimum wage rates, most rates have not had an increase. The rates for usual and customary bus fare, taxi fare and adult diapers are not frozen. To be considered for usual and customary, at least 30% of a provider's customers must not be clients of DDS.

What impact does freezing rates have on providers? It is hard to find national studies or specific case studies of state programs. On the one hand, as mentioned in the discussion of the AIDS Waiver, freezing waiver rates for a prolonged period may hinder access for waiver participants, reduce the number of providers, change the mix of providers by attracting more marginal lower-cost providers and complicate program management. There is some anecdotal evidence from Ohio that indicates that while the number of providers does not decline, the provider mix changes as larger more established agencies drop out of the program and smaller agencies with lower-cost overhead take their place.[153] On the other hand, DDS staffs indicate that for the developmental services waiver the opposite takes effect, especially in the Central Valley of California, where programs going out of business have been purchased by large nationwide companies and not smaller agencies.

DDS issued a report outlining policy choices for reducing regional center costs.[154] The report presented options, including the use of policy-based methods that are tied to eligibility, kinds of providers and services or characteristics of persons receiving services.

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[151] Work activity and supported employment rates are shown at: http://www.dds.ca.gov/Rates/docs/WAP_SEP_Rates.pdf.

[152] CMS has issued letters to two states, Colorado and Ohio, in the last five years questioning variability in negotiated waiver rates. For a discussion of CMS concerns with Colorado's HCBS payments for DD programs, see http://aspe.hhs.gov/daltcp/reports/2006/gauging.htm#CO , http://www.thearcofco.org/documents/FebNewsletter1-6.pdf and http://www.ccbpartners.org/documents/HCBSW_Changes_Draft_05-01-08.pdf . CMS correspondence, See the Public Consulting Group report on OHIO HCBS services for discussion of Ohio. Retrieved on 12-19-08: http://aging.ohio.gov/resources/publications/2008_PP_AL_Rate_Evaluation.pdf .

[153] See the Public Consulting Group's recent study of the Ohio PASSPORT program, *PASSPORT/Assisted Living Services Rate Methodology Evaluation*. Retrieved on 2-5-09: http://www.aging.ohio.gov/resources/publications/2008_PP_AL_Rate_Evaluation.pdf

In-Home Supportive Services (IHSS)

In March 2009 the IHSS program served approximately 440,000 persons. Three different programs are included under the IHSS program: the IHSS Residual program, the IHSS Plus Waiver and the Personal Care Services program. The IHSS Residual program is a program funded by state and county funds that is administered by counties and overseen by the California Department of Social Services (CDSS). On behalf of the Department of Health Care Services (DHCS) pursuant to interagency agreements, the California Department of Social Services (CDSS) also administers the IHSS-Plus Waiver and Personal Care Services programs, which are federally funded Medi-Cal programs for which DHCS has oversight responsibilities as the designated Medicaid single state agency. DHCS oversees and monitors CDSS' implementation of these programs to ensure that both programs are operated in compliance with state and federal Medicaid laws. The program relies on over 376,000 providers to provide supportive services to the 445,000 recipients. In June 2009, approximately 39.0 million hours of service were rendered. An estimated 58% of providers are relatives of persons receiving services. The FY 2007–2008 IHSS budget included about $4.6 billion, of which $1.5 billion were state General Fund support. Federal funds paid for 50% of the projected expenditures and county funds for 17.5%. The $4.5 billion was an increase of approximately $224 million, or 5%, compared to FY 2006–2007.[155]

State law, Welfare and Institutions Code (WIC), Section 12301.6 allows counties at their option to contract with a nonprofit consortium (NPC) or to establish, by ordinance, a public authority to perform certain specified program functions.

In California there are 56 counties in which a public authority or nonprofit consortium operates. Three counties, Inyo, Modoc and Mono, formed a NPC. Three counties, Nevada, Plumas and Sierra, formed a joint powers agreement (JPA) which regionalized their public authority, and are included in the 56 counties. The remaining two counties, Alpine and Tuolumne, are considered to be the Employer of Record for their County and are not considered to be public authorities.

The authorities become the employer of record for collective bargaining purposes and fulfill the county employer requirements of AB 1682 (Chapter 90, Statutes of 1999). By statute (WIC section 12301.6), a public authority is required to do the following:

- Provide assistance to recipients in finding in-home supportive services personnel
- Investigate the qualifications and background of potential providers
- Establish a referral system under which in-home supportive services providers are referred to recipients
- Provide training for providers and recipients
- Perform any other functions related to the delivery of in-home supportive services, as delegated by the county

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[154] Department of Developmental Services, (December, 2007), *Controlling Regional Center Costs: Report to the Legislature Submitted to fulfill the requirements of Section 102.5, Chapter 188, Statutes of 2007.* Sacramento, CA. Retrieved on 3-4-09: http://www.dds.ca.gov/Publications/docs/ControllingRCCosts2007.pdf.
[155] Ibid.

- Ensure that the requirements of the personal care option pursuant to Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are met

The Public Authority/Nonprofit Consortium Rate is the total amount per hour that is claimed as a cost for purposes of obtaining federal reimbursement. It is specific to each county. The rate consists of taking allowable federal costs for four components: wages, benefits, payroll taxes and administrative costs. These are aggregated and divided by the total hours of service. The state and CMS have agreed that there is a federal cap on the hourly rate submitted for federal Medicaid reimbursement. The cap is set at 200% of the state's minimum wage. Effective January 1, 2008, the state's minimum wage became $8.00 per hour; therefore 200% of the state's minimum wage is $16.00 per hour.[156] If an authority's rate exceeds $16.00, the amount over $16.00 will not receive a federal match.

After hourly wages and benefits are negotiated between the public authorities and/or counties and the union, they are approved by the county Board of Supervisors, DSS and DHCS. Table 75 shows August 2008 wages and rates by county.[157]

The total hourly state financial participation in IHSS provider wages and benefits was capped at $12.10 per hour in the Fall of 2008. The $12.10 includes $.60 toward health benefits. If an authority's IHSS provider wage and benefits exceed $12.10 per hour, the amount over $12.10 does not receive a state match. Wages are paid through the statewide Case Management, Information and Payroll System (CMIPS). The State Controller's Office provides either direct deposit payroll or paper checks to the provider(s).

The Health Benefits/State Share is the amount of the health benefits that the state is willing to pay for when the amount of the wage and health benefit is at or below $12.10. The Above State Participation Level (County/Federal Share only) amount includes all costs above $12.10. Although the level of state financial participation was reduced in February 2009 to $10.10 per hour, the state was enjoined by the U.S. District Court on June 26, 2009 from implementing the reduction. The injunction is being appealed at the time of this report.

[156] The California minimum wage did not change in 2009.

[157] The impact of increasing IHSS wage and benefits has a long history of study. See references to Howes 2002 and 2004 in the bibliography which show that increasing wages and benefits to IHSS workers reduces labor turnover and increases supply of workers.

Table 75: County IHSS Hourly Rates Including Health Benefits: April 2009

County	PA/NPC Rate Claimed for Federal Match	Wage Paid Provider	Health Benefits/ State Share	Above State Participation Level (County /Federal Share Only)
ALAMEDA	$ 12.76	$ 10.50	$ 0.99	$ -
ALPINE	$ -	$ -	$ -	$ -
AMADOR	$ 10.07	$ 8.00	$ 0.60	$ -
BUTTE	$ 9.59	$ 8.15	$ 0.60	$ -
CALAVERAS	$ 12.17	$ 9.75	$ 0.51	$ -
COLUSA	$ 9.47	$ 8.00	$ -	$ -
CONTRA COSTA	$ 14.15	$ 11.50	$ 0.60	$ 0.85
DEL NORTE	$ 10.42	$ 9.00	$ 0.60	$ -
EL DORADO	$ 11.01	$ 9.00	$ 0.60	$ -
FRESNO	$ 12.19	$ 10.25	$ 0.85	$ -
GLENN	$ 9.65	$ 8.15	$ -	$ -
HUMBOLDT	$ 8.85	$ 8.00	$ -	$ -
IMPERIAL	$ 10.50	$ 9.00	$ 0.60	$ -
INYO	$ 9.30	$ 8.00	$ -	$ -
KERN	$ 9.34	$ 8.00	$ 0.55	$ -
KINGS	$ 10.74	$ 9.00	$ 0.60	$ -
LAKE	$ 10.49	$ 8.75	$ 0.60	$ -
LASSEN	$ 8.92	$ 8.00	$ -	$ -
LOS ANGELES	$ 9.86	$ 8.45	$ 0.51	$ -
LOS ANGELES (BUAPP)	$ 13.76	$ 12.00	$ 0.51	$ -
MADERA	$ 10.90	$ 9.20	$ 0.60	$ -
MARIN	$ 13.72	$ 11.55	$ 0.82	$ -
MARIPOSA	$ 9.53	$ 8.00	$ -	$ -
MENDOCINO	$ 11.69	$ 9.90	$ 0.60	$ -
MERCED	$ 11.47	$ 9.00	$ 0.60	$ -
MODOC	$ 9.45	$ 8.00	$ -	$ -
MONO	$ 11.03	$ 8.00	$ -	$ -
MONTEREY	$ 14.47	$ 11.50	$ 0.60	$ -
NAPA	$ 12.97	$ 11.50	$ 0.60	$ -
NEVADA	$ 10.69	$ 8.56	$ 0.60	$ -
ORANGE	$ 10.19	$ 8.90	$ 0.60	$ -
PLACER	$ 11.99	$ 10.00	$ 0.60	$ -
PLUMAS	$ 10.69	$ 8.56	$ 0.60	$ -
RIVERSIDE	$ 11.91	$ 10.25	$ 0.60	$ -
SACRAMENTO	$ 12.12	$ 10.40	$ 0.70	$ -
SAN BENITO	$ 11.67	$ 9.80	$ 0.60	$ -
SAN BERNARDINO	$ 10.54	$ 9.25	$ 0.38	$ -

County	PA/NPC Rate Claimed for Federal Match	Wage Paid Provider	Health Benefits/ State Share	Above State Participation Level (County /Federal Share Only)
SAN DIEGO	$ 10.93	$ 9.25	$ 0.46	$ -
SAN FRANCISCO	$ 14.79	$ 11.54	$ 0.60	$ 1.25
SAN JOAQUIN	$ 10.70	$ 8.95	$ 0.61	$ -
SAN LUIS OBISPO	$ 11.77	$ 10.00	$ 0.60	$ -
SAN MATEO	$ 13.82	$ 11.50	$ 0.60	$ 0.27
SANTA BARBARA	$ 12.42	$ 10.50	$ 0.60	$ -
SANTA CLARA	$ 15.85	$ 12.10	$ -	$ 2.33
SANTA CRUZ	$ 14.32	$ 11.50	$ 0.60	$ -
SHASTA	$ 10.29	$ 8.40	$ 0.60	$ -
SIERRA	$ 10.69	$ 8.56	$ 0.60	$ -
SISKIYOU	$ 8.85	$ 8.00	$ -	$ -
SOLANO	$ 13.27	$ 10.50	$ 0.60	$ -
SONOMA	$ 13.07	$ 11.20	$ 0.70	$ -
STANISLAUS	$ 10.86	$ 9.11	$ 0.60	$ -
SUTTER	$ 10.22	$ 8.25	$ 0.60	$ -
TEHAMA	$ 9.67	$ 8.00	$ 0.60	$ -
TRINITY	$ 8.18	$ 8.00	$ -	$ -
TULARE	$ 10.74	$ 9.00	$ 0.60	$ -
TUOLUMNE	$ -	$ -	$ -	$ -
VENTURA	$ 11.11	$ 9.50	$ 0.60	$ -
YOLO	$ 12.66	$ 10.50	$ 0.60	$ -
YUBA	$ 11.75	$ 9.50	$ 0.60	$ -

Data Source: Department of Social Services, Adult Programs Branch

Seven counties have contracted rates with personal care agencies. All-County Letter (ACL) 02-95 established an IHSS Maximum Allowable Contract Rate (MACR) for all counties and is the maximum which the state will reimburse. The MACR methodology uses Employment Development Department (EDD) data to determine the average entry-level wage for each county, with an adjustment for inflation. The MACR hourly rate includes provider wages and contractors' administrative costs, including provider benefits.

In practice, the MACR is comparable to the state and federal rate package with a $16.00 per hour limit on federal participation on wages and benefits for public authorities. Like the authorities' rates for independent, non-agency providers, a county's contract rate may exceed the MACR, but would not receive federal financial participation for the amount of the rate in excess of $16.00 per hour.

Table 76: IHSS Contractors' Rates by County: August 2008

County	Rate	Wage	MACR	Contractor
Butte	$ 14.91	$ 8.43	$ 14.93	Addus
Riverside	$ 16.88	$ 10.75	$ 16.88	Addus
San Francisco	$ 26.77	$ 10.50	$ 19.02	IHSS Consortium
San Joaquin	$ 18.79	$ 9.20	$ 14.85	Addus
San Mateo	$ 19.02	$ 10.34	$ 19.02	Addus
Santa Barbara	$ 19.14	$ 9.80	$ 19.15	Addus
Stanislaus	$ 21.36	$ 12.32	$ -	Homemaker

Data Source: Department of Social Services, Adult Programs Branch

Nursing Facility/Acute Hospital (NF/AH) Waiver

This is the first of three recent applications the state has made for a 1915(c) Waiver to the CMS. The application's appendices contain a detailed description of each service offered and the methodology for projecting utilization and costs.

The table below for the NF/AH Waiver was prepared based on the application's Appendices I and J and interviews with DHCS staffs. The application, submitted on December 15, 2006, was both for a renewal of the waiver and a consolidation of previous waivers.

Table 77 shows that two frequently used services, case management and private-duty nursing, are based on Medicaid State Plan fee code amounts. The third frequently used service, personal care, is based on county IHSS rates, and payment for the personal care services is processed through the DSS Case Management, Information and Payroll System (CMIPS).

Table 77: Methods Used to Arrive at Cost and Utilization Estimates for Services Provided under the Nursing Facility/Acute Hospital (NF/AH) Waiver: First Year Costs

Services Categories	Method of Estimating Costs	Method of Estimating Utilization	Benefit Level
Case Management	Adoption of published service rates for similar state plan services	Assume all 2,392 use 29 hours each	$40.60 per hour
Community Transition Services	By report for prior authorized services	1 person will use this service	Capped at lifetime benefit of $5,000
Environmental Accessibility Adaptations	By report for prior authorized services	1 person will use this service	Capped at lifetime benefit of $5,000
Family Training	Adoption of published service rates for similar state plan Services	68 persons will use this service for 21 hours each	$40.60 per hour

Services Categories	Method of Estimating Costs	Method of Estimating Utilization	Benefit Level
Habilitation	Adoption of published service rates for similar state plan services	8 persons will use this service for 416 hours each	$30.68 per hour
Medical Equipment Operating Expenses	By report for prior authorized services	68 persons will use this service for 12 months each	Assumes average utility expense of operating equipment at $25 per month
Personal Emergency Response Systems	By report for prior authorized services	5 persons per year will use this service	$31.51 per month
Personal Emergency Response Systems - Installation and Testing	By report for prior authorized services	5 persons per year will use this service	$35 per installation
Private-Duty Nursing, Including Shared Services	Adoption of published service rates for similar state plan services	1,163 persons will use this service for 3,385 hours per year each	$30.25 per year
Facility Respite	Annual cost studies	13 persons will use this service for 5 days each	$313.57 per day
Home Respite	Adoption of published service rates for similar state plan services	25 persons will use this service for 40 hours each	$23.62 per hour
Transitional Case Management	Adoption of published service rates for similar state plan services	29 persons will use this service for 12 hours each	$40.60 per hour
Waiver Personal Care Services	Hourly rates established by county/authorities	721 persons will use 2,588 hours each	$12.02 per hour

Data Source: Department of Health Care Services

Unlike the AIDS Waiver, the projected costs over a five-year period allow for annual changes in the rates of payment for services. The financial projections assume a 2% increase each year in the cost of both waiver and non-waiver services received by participants, an annual 6% growth in the number of participants and no change in utilization. Total expenditures under the waiver thus are projected to increase between 7% to 8% per year, of which 2% is due to the cost of service and 6% to the increase in users. The 2% increase in waiver reimbursement requires approval by the California Department of Finance and the State Legislature of appropriations to support an increase in waiver expenditures. The average length of stay on the waiver is assumed to be 365 days.

The financial analysis overstates the cost of the waiver by assuming that all 6% of the new participants each year will receive the full 12 months of service. There is no analysis of the likely

event that new waiver recipients would be phased in over the course of the year. If a 12-month phase-in were assumed, the effect would be a 3% increase in costs due to new enrollees rather than 6%.

Assisted Living Waiver Pilot Project (ALWPP)

This is the second of three recent applications the state has made for a 1915(c) Waiver to the CMS. The application's appendices contain a detailed description of each service offered and the methodology for projecting utilization and costs.

The ALWPP Waiver was approved for three years: 2006, 2007 and 2008.[158] Table 80 is based on Appendix G of the July 2005 application and interviews with Department of Health Care Services (DHCS) staffs. Cost projections take into account previous waiver cost and utilization experience, California specific costs and utilization and the experiences of other states.

Residential Care Facilities for the Elderly (RCFE) providers receive a daily rate for assisted living services that varies with the needs of the resident. The project developed a four-tiered payment methodology based on the tiers used in Arkansas. The bundled rate includes payment for the following services: 24-hour awake staff to provide oversight and meet the scheduled and unscheduled needs of residents; provision and oversight personal and supportive services (assistance with activities of daily living and instrumental activities of daily living); health-related services (e.g., medication management services); social services; recreational activities; meals; housekeeping and laundry; and transportation.

Room and board is not included in the tiered rate. The Supplemental Security Income/State Supplement Program (SSI/SSP) payment standard in licensed facilities is $1,075 per month including a personal needs allowance of $125 per month.

Table 78: Methods Used to Determine Cost and Utilization Estimates for Services Provided under the Assisted Living Waiver Pilot Project (ALWPP): First Year Costs

Services Categories	Method of Estimating Costs	Method of Estimating Utilization	Benefit Level and Caps
Care Coordination	Used MSSP and NF/AB cost experience	Assumed 11 months per year based on MSSP and NF/AB utilization experience	$200 per month
NF Transition Care Coordination	Estimate of amount of work necessary	Assumed 10% of persons would transition and receive five months of care coordination	$1,000 per participant
Community Transition Services	Average of costs from Indiana, Nebraska, New Hampshire and New Jersey	Assumed 10% of persons would transition	One time only capped at $2,500

[158] In 2009 CMS approved a new AL 1915(c) waiver application and the waiver ceased to be a pilot project.

Services Categories	Method of Estimating Costs	Method of Estimating Utilization	Benefit Level and Caps
Translation and Interpretation	Rates charged by California Healthcare Interpretation Association	Assumed 15% rate based on MSSP and NF/AB utilization experience	$59 per hour
Consumer Education Services	Cost data supplied by Area Agencies on Aging and Centers for Independent Living	Estimated that 50% of clients will use 50% of benefit	$22 per hour
Environmental Accessibility Adaptations	Used MSSP and NF/AB cost experience	Assumed 85% of persons in public housing will use 85% of the benefit. Based on MSSP and NF/AB utilization experience	One time only capped at $1,500
Assisted Living Bundled Service Array (RCFE)	Developed provider business model and studied costs of Oregon, Washington and Vermont	Assumed 70% will use AL services. Developed four tiers based on Alabama, Arkansas, Oregon, Vermont and Washington	Tier 1: $52 per day Tier 2: $62 per day Tier 3: $71 per day Tier 4: $82 per day
Assisted Care Benefit in Public Housing (HHA Provider)	Developed provider business model and studied costs of Oregon, Washington and Vermont	Assumed 30% will use public housing for average length of stay of 322 days	Tier 1: $52 per day Tier 2: $62 per day Tier 3: $71 per day Tier 4: $82 per day

Data Source: Department of Health Care Services

In the 2005 three-year financial projections, the cost per unit of service was assumed to be the same, the utilization per person was assumed to be constant, and the average length of stay was also assumed to be 292 days for each of the three years. The assumption of no change in the cost per service over the three years of the waiver was explicitly addressed in the waiver's narrative. Since nursing facilities were not expected to get a Consumer Price Index (CPI) increase, no change in waiver cost per service was assumed in order to maintain cost neutrality. The waiver narrative is informative and discusses the cost and utilization assumptions at length. For example, the waiver narrative stated that the state did not anticipate that holding rates constant would cause problems with the number of providers who wanted to participate in the waiver.

The number of participants was projected to increase over the course of the waiver by 200 the first year, 600 the second year, and 1,000 the third year. Program operating statistics show that in 2006, there were 79 participants and 12 providers, and that in 2007, 438 participants were enrolled and there were 20 providers. As of June 2008, approximately 1,000 persons had received waiver services, of which 667 were still on the waiver and were being served by 40 providers.

The new ALW is for a five-year period effective March 1, 2009 and projects serving 1,300 persons the first year and increasing to 3,700 persons by the fifth year of the waiver.

In-Home Operations (IHO) Waiver

This is the third of three recent applications the state has made for a 1915(c) Waiver to the CMS. The application's appendices contain a detailed description of each service offered and the methodology for projecting utilization and costs.

Table 79 for the IHO Waiver was prepared based on the application's Appendices I and J and interviews with DHCS staffs.

The In-Home Operations (IHO) Waiver has a heavy emphasis on private-duty nursing supplemented by personal care services. Determining the cost per unit to pay for services is straightforward, since similar services have been paid in other state programs. Projecting total cost is more difficult, since this involves estimating how many persons will use each service and how many service units they will likely use. For example, approximately 18 of the persons served on the waiver were projected to have intellectual or developmental disabilities that would benefit from habilitation services. The federal application used the following cost and utilization estimation methodology.

Table 79: Methods Used to Arrive at Costs and Utilization Estimates for Services Provided Under the In-Home Operations (IHO) Waiver: First Year Costs

Services Categories	Method of Estimating Costs	Method of Estimating Utilization	Benefit Level
Case Management	Adoption of published service rates for similar state plan services	All 210 persons will use 18 hours each	$40.60 per hour
Community Transition Services	By report for prior authorized services	1 person will use this service	Capped at lifetime benefit of $5,000
Environmental Accessibility Adaptations	By report for prior authorized services	10 persons will use this service	Capped at lifetime benefit of $5,000
Family Training	Adoption of published service rates for similar state plan services	24 persons will use this services for 7 hours each	$40.60 per hour
Habilitation	Adoption of published service rates for similar state plan services	18 persons will use this service for 389 hours each	$30.68 per hour
Medical Equipment Operating Expenses	By report for prior authorized services	10 persons will use this service for 9 months each	Assumes average utility expense of operating equipment at $25 per month
Personal Emergency Response Systems	By report for prior authorized services	2 persons will use this service per year	$31.51 per month
Personal Emergency Response Systems - Installation and Testing	By report for prior authorized services	2 persons will use this service per year	$35 per installation

Services Categories	Method of Estimating Costs	Method of Estimating Utilization	Benefit Level
Private-Duty Nursing, Including Shared Services	Depends on type of provider	171 persons will use this service for 2,329 hours per year each	$30.25 per hour
Facility Respite	Annual cost studies	5 persons will use this service for 5 days each	$238.57 per day
Home Respite	Adoption of published service rates for similar state plan services	14 persons will use this service for 40 hours each	$23.62 per hour
Transitional Case Management	Adoption of published service rates for similar state plan services	1 person will use this service and 12 hours of case management will be provided	$40.60 per hour
Waiver Personal Care Services	Hourly rates established by county/authorities	70 persons will use this service for 1,479 hours each	$12.02 per hour

Data Source: Department of Health Care Services

The three-year financial projections assume the same numbers of persons will use the waiver each year and, with two minor differences, utilization is also constant. The hourly rates for case management, private-duty nursing and personal care services that were used in the NF/AH Waiver application are also used here. As with the NF/AH Waiver, the cost of services is projected to increase 2% per year depending on Department of Finance and legislative approval. Given the same caseload and utilization, the increase in total program costs is due solely to the 2% increase in the cost of services.

Cost-Effectiveness of HCBS and the "Woodwork Effect"

A national discussion is ongoing about the impact of HCBS Waivers on total spending. Budget officials often say that waivers do not substitute for institutional care and HCBS spending increases aggregate spending. Policy staffs contend that waivers prevent or delay admission to an institution and reduce the growth rate of spending on institutional services. Reducing the growth rate requires an array of actions—a single gateway or entry point for all long-term care services, a full array of services, flexible budgeting that creates an equal playing field, ongoing care management for individuals living in institutions, transition coordination for those who want to move to the community and an assessment and options counseling for individuals seeking long-term care services. Working with hospital staffs, families, and consumers, options counseling supports the diversion of individuals who might otherwise be admitted to a nursing facility.

States interested in expanding HCBS typically turn to three sources to finance the expansion: new revenues, reallocation of funds that pay for institutional care (money follows the person), or targeting existing spending on individuals who are either at imminent risk of entering an institution or who may move from an institution to the community.

In long-term care programs, as in other health care areas, cost savings are obtained by reducing rates paid to providers, reducing the number of persons served, reducing the number of services paid for or reducing the cost per service per person. Providing lower-cost HCBS instead of higher-cost nursing facility services is a traditional and widely practiced cost avoidance/savings concept in state long-term care programs.

Despite the growth in HCBS programs, state budget staffs often have reservations about the cost-effectiveness of HCBS programs. The discussion of cost effectiveness often occurs in the context of the so-called "woodwork effect". The woodwork effect means that people who qualify for, but would not enter, an institution are likely to apply for in-home services covered through a waiver. In economic terms, the woodwork effect is an "induced demand" concern. As the supply of a desired good increases, demand for the good also increases. If people apply for waiver services who would not enter an institution, net aggregate expenditures would increase and the waiver expansion would not substitute for institutional care.

Reservations about the cost effectiveness of HCBS programs stem from the 1987 National Long-Term Care Channeling Demonstration.[159] The study was widely interpreted as concluding that HCBS care was not cost-effective. However, there are two potential limitations on the applicability of the results to state HCBS programs.

First, the evaluation focused on all governmental spending including federal Medicare and Social Security expenditures and administrative costs and did not present results separately for state costs or exclude administrative costs which were high, especially in what it called the "financial control model." The Channeling Demonstration found and clearly states that costs increased by

[159] See *National Long-Term Care Channeling Demonstration: Summary of Demonstration and Reports*. Retrieved on 1-11-09: http://aspe.hhs.gov/daltcp/reports/chansum.htm for a website relevant to the study.

10-17% depending on the model used due to additional case management and community services.[160]

Second, the Channeling Demonstration did not control for persons who would have gone into a nursing facility. Participants were randomly selected and assigned to control and treatment groups. The control group received additional services, which cost more money. A 1989 report by Mathematica found:

> It is clear that channeling tested the effect of adding comprehensive case management and expanded community care to service systems that already provided such services to some of the frail elderly. It was not an evaluation of community care compared to its total absence. Its population, which voluntarily applied to the demonstration, was extremely frail and had unmet service needs but turned out to be not at high risk of nursing home placement. Substantial reductions in nursing home use were not possible given that only a relatively small portion of the population would have used nursing homes even without channeling.[161]

The woodwork effect has been controversial since the advent of 1915 (c) waivers in 1981. Despite the debate, waivers continue to grow as states seek to reduce the growth rate for spending on institutional care and to offer consumers more service options. States have four options to deal with the woodwork effect. First, states could assume that changing demographics and rising need will lead to an increase in the number of people receiving Medicaid long-term care services. States have two primary choices for meeting the increased need: continue to expand the supply of institutional facilities or hold the supply of institutional resources constant and expand residential and community services. Over time, this scenario will lower the expenditure growth trend line and serve more people for less aggregate costs than would have occurred if the state relied primarily on institutional resources. This option is discussed below as cost avoidance.

The second option assumes that a given state will serve no more beneficiaries under Medicaid than it does in the current fiscal year. States may still expand community resources, serving more beneficiaries, and maintain or lower spending. This can be achieved by shifting the supply of services and financing from institutions to community settings. In this scenario, states must

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[160] Mathematica Policy Research, Inc. *Analysis of the Benefits and Costs of Channeling: Executive Summary*. Report prepared under contract #HHS-100-80-0157 with the U.S. Department of Health and Human Services (HHS), Office of Social Services Policy (now the Office of Disability, Aging and Long-Term Care Policy). (May 1986), Retrieved on 1-11-09: http://aspe.hhs.gov/daltcp/reports/costes.htm.

[161] Mathematica Policy Research, Inc. *The Evaluation of the National Long Term Care Demonstration: Final Report Executive Summary*. Report prepared under contract #HHS-100-80-0157 with the U.S. Department of Health and Human Services (HHS), Office of Social Services Policy (now the Office of Disability, Aging and Long-Term Care Policy). (May 1986), Retrieved on 1-11-09: http://aspe.hhs.gov/daltcp/reports/chanes.htm.

actively reduce institutional occupancy rates, reduce the supply of licensed capacity and expand alternative services[162].

Third, states can reserve a portion of the waiver capacity for specified purposes subject to CMS review and approval. This provision allows a state to set aside waiver slots for persons who relocate from an institution to the community.

Finally, states can also conduct a "break even" analysis which is described below.

Since the channeling studies, a series of studies and policy decisions over the last 20 years has offered options to analyze the cost-effectiveness of HCBS care. One approach used has been to estimate the institutional costs that have been "avoided" or not incurred. In the next section we apply a cost-avoidance analysis to California nursing facility utilization.

Cost Avoidance from Lower Utilization of Medi-Cal Nursing Facility Services

The number of California nursing facility residents has shown a modest decline of about 2,000 persons since 2001, despite significant population growth. The table below shows U.S. Census data for the year 2000 and estimates for the years 2004–2007. The U.S. Census estimates that California had approximately 2,985,000 more residents in 2007 than in 2000.

Table 80: U. S. Census Data for the year 2000 and Interim Population Projections for California: 2004–2007

Age	Census 2000	Population Projection 2004	Population Projection 2005	Population Projection 2006	Population Projection 2007	Change 2000-2007	% Change 2000-2007
< 65	30,275,990	31,801,032	32,138,666	32,473,975	32,793,109	2,517,119	8.31%
65-74	1,887,823	1,956,557	1,990,108	2,031,112	2,091,895	204,072	10.81%
75-84	1,282,178	1,362,960	1,375,345	1,380,007	1,378,371	96,193	7.50%
85+	425,657	507,417	534,740	564,286	593,694	168,037	39.48%
Total	33,871,648	35,627,966	36,038,859	36,449,380	36,857,069	2,985,421	8.81%

Data Source: U.S. Census, File 4. Interim State Projections of Population by Single Year of Age and Sex: July 1, 2004 to 2030

Table 81 calculates expected utilization of nursing facility services using U.S. Census projected population data and applying nursing facility utilization rates for these age cohorts. The age-specific utilization rates are obtained from the National Center for Health Statistics (NCHS) and projected nursing facility utilization is shown below.

[162] For a report on Medicaid spending that says the expansion of HCBS reduces institutional expenditures and there is no national evidence of a woodwork effect see Holahan, J. & Yemene A. (September –October, 2009), *Enrollment is Driving Medicaid Costs --- But Two Targets Can Yield Savings*, Health Affairs. 28 (4): 1460.

Table 81: Changes in California Population and Expected Growth in Nursing Facility Residents: 2000-2007

Age	Change 2000-2007	Nursing Facility Use Per 10,000	Expected 2007 Nursing Facility Growth in Residents
< 65	2,517,119	6.8	1,712
65-74	204,072	94.3	1,924
75-84	96,193	361.3	3,475
85+	168,037	1,387.90	23,322
Total	2,985,421		30,433

Based on the NCHS utilization rates, given a population growth of 2,985,421 persons, California would have served an additional 30,433 persons in nursing facilities between 2000 and 2007.[163] As shown in Online Survey and Certification Reporting System (OSCAR) data, there were 105,270 nursing facility residents in December 2001 and utilization declined by 1.22% to 103,984 in December 2007. A 3 million rise in the number of residents age 65 and older would have resulted in higher nursing facility use, and the declining use rate suggests that costs were avoided.

A similar analysis can be applied using national utilization figures. Table 82 shows that applying national utilization rates implies that California nursing facilities would have 174,000 residents, versus the 103,984 reported in the December 2007 OSCAR data. Approximately 70,000 fewer persons are in nursing facilities in California than would be expected based on national trends. This is not an exact estimate. It does not control for other factors that might affect nursing facility utilization such as ethnicity differences in populations between California and the country as a whole. Nor does the analysis control for level of care criteria or cost differences in nursing facilities that might differentially affect utilization in California.

Table 82: Estimates of the Numbers of Residents in California Nursing Facilities Assuming National Utilization Rates: 2007

Age	Population Projection 2007	Rate of Nursing Facility Use Per 10,000	Estimated Nursing Facility Population
< 65	32,793,109	6.8	22,299
65-74	2,091,895	94.3	19,727
75-84	1,378,371	361.3	49,801
85+	593,694	1,387.9	82,399
Total	36,857,069		174,225

[163] National Center for Health Statistics. *National Nursing Home Survey, Table 1, Number, percent distribution, and rate per 10,000 population of nursing home residents by selected resident characteristics and age at interview: United States, 2004*, Retrieved on 1-11-09: http://www.cdc.gov/nchs/data/nnhsd/Estimates/nnhs/Estimates_Demographics_Tables.pdf#Table01.

Given a Medi-Cal utilization rate of 66% in nursing facilities, 66% of 70,000 is 46,200 persons. These data would thus indicate that there are 46,200 fewer Medi-Cal beneficiaries in nursing facilities than would be expected using national utilization rates. What are the cost-avoidance savings to Medi-Cal? As shown above in the 2007 description of nursing facility rates, the average per diem for a person in a regular nursing facility Level B in 2007 was $139.70 per day, and the average Medi-Cal person used 219 days of nursing facility level services per year. If these 42,600 persons had been receiving nursing facility Level B services for 219 days each at a cost of $139.70, the state would have spent an additional $1.4 billion per year on nursing facility services.

A complete analysis of net savings would take into account the cost of providing alternative services. There are established methodologies for doing a net analysis, and they generally entail figuring out what alternative services these persons are receiving, if any, and what the cost of these services is to the state.

The Cost-Effectiveness of California 1915(c) Waivers

CMS requires a cost-neutrality test before approving a waiver. The test was revised during the Clinton administration, which simplified a complicated test into four components. The neutrality formula determines whether the sum of the average cost for HCBS plus the average cost of Medicaid acute care for persons receiving HCBS services is less than the average cost of the institutional services plus the average cost of acute care of persons receiving institutional services. While CMS prefers the term "cost neutrality," it is convenient to think of this test as a measure of the difference in cost between average institutional and average HCBS, taking into account average differences in acute care costs.

DHCS Waiver staffs supplied the following cost-neutrality information for five waivers. The information shows that the waivers meet federal cost-neutrality tests. Only the Nursing Facility A/B (NF/AB) Waiver did not meet the cost-neutrality test initially; however, the data show that DHCS gradually reduced the cost to achieve cost neutrality. Had each of the persons on the waivers been served in institutions—a nursing facility, a developmental center or a hospital—the cost would have been about $3 billion more in 2006.

Budget analysts usually ask how much money the state saves using waivers. There are two issues to consider in asking this question. The first is how many persons who receive waiver services would have entered an institution if the waiver services were not available? One approach to limiting uncertainty about institutional use is to target waiver enrollment to current institutional residents. For example, in 2008 the Assisted Living Waiver eligibility criteria were changed to limit enrollment only to Medi-Cal nursing facility residents who relocate to a residential setting, after initial program data showed that one out of six persons using the new residential waiver services came from a nursing facility.[164] This targeting strategy could create incentives for people to enter a nursing facility in order to receive services in the community.

[164] See also the 2007 Money Follows the Person Rebalancing Demonstration Grants authorized by the CMS which contained the provision that enhanced federal match is only available for transitioning persons who had been in a nursing home for six months or longer. See, retrieved on 1-12-09: http://www.cms.hhs.gov/DeficitReductionAct/20_MFP.asp.

Waivers that enroll participants living in the community who qualify for admission to a nursing facility and who are at risk of admission are not able to identify individuals who would actually seek admission in the absence of waiver services. However, depending on the per capita cost of waiver and state plan services, they serve three to four participants for the cost of serving one person in an institution. If one of the three or four participants would enter an institution, the waiver reduces spending.

The difference in cost between institutional and community care, $45,000, is for participants in the DD Waiver. Table 83 shows the number of persons using the DD Waiver and the cost difference between average waiver costs and average institutional costs taking into account average acute care costs.

Table 83: Cost Differences of Developmentally Disabled (DD) Waiver: 1995–2006

Reporting Period	Unduplicated Persons	Cost Difference Per Person	Cost Difference
FFY 1995	27,194	$ 36,737	$ 999,025,752
FFY 1996	29,314	$ 37,634	$ 1,103,214,114
FFY 1997	35,105	$ 41,569	$ 1,459,289,664
FFY 1998	34,212	$ 39,503	$ 1,351,487,230
FFY 1999	30,205	$ 24,128	$ 728,798,868
FFY 2000	30,602	$ 24,717	$ 756,384,779
FFY 2001	35,372	$ 17,466	$ 617,814,375
FFY 2002	42,377	$ 39,213	$ 1,661,749,731
FFY 2003	51,203	$ 42,512	$ 2,176,732,989
FFY 2004	54,682	$ 43,977	$ 2,404,742,528
FFY 2005	62,224	$ 45,338	$ 2,821,091,694
FFY 2006	57,973	$ 43,652	$ 2,530,612,156

Data Source: Department of Health Care Services

All waiver participants meet the institutional level of care criteria. In the absence of the waiver, it is unlikely that all 58,000 waiver participants would enter a Developmental Center. DDS does not publish data that compares the characteristics of persons in the Developmental Centers with the characteristics of persons receiving DD Waiver services. For example DDS reports the degree of retardation experienced by persons in the Developmental Centers compared to persons receiving community services. The latest published data for December 2007, shown below, shows that residents of Developmental Centers have significantly higher rates of retardation than persons served in community programs. However, the waiver would still be cost-effective if it diverts a portion of the participants from entering an institution and it provides valuable services to participants who might not enter an institution in the absence of the waiver. For example, Table 84 shows that 26% of all community clients do not have a mental retardation condition whereas only .03% clients in Developmental Centers do not have a mental retardation condition.

Table 84: Differences in Retardation Conditions Between Developmental Center Residents and Community Clients: December 2007

Retardation Condition	Developmental Center Clients	% Center Clients	Community Clients	% Community Clients
Not MR	8	0.3%	49,549	26.0%
Mild	449	16.8%	72,416	37.9%
Moderate	238	8.9%	32,152	16.8%
Severe	370	13.9%	14,614	7.7%
Profound	1,585	59.4%	9,256	4.8%
Unknown	20	0.7%	12,865	6.7%
Total	2,670	100.0%	190,852	99.9%

Data Source: Department of Developmental Services, CDER Master File January 7, 2008 Table #03

While it is difficult to estimate savings, it is reasonable to assume that some proportion of the persons on waivers would have been served in more expensive hospitals, developmental centers and nursing facilities. For example, at the start of the decade on December 31, 1999, there were 3,876 persons in California Developmental Centers. As of December 31, 2008, there were 2,404 persons.[165] Given the usual long length of time that persons with intellectual disabilities spend in Medicaid programs, it is reasonable to assume that the persons who have left the Centers are being served by community programs.

What is not reported are the characteristics of waiver participants, and we are not able to estimate how many persons on the waiver would have physical and developmental conditions similar to persons in the Developmental Centers. Yet, we would expect that given the array of HCBS, there would be differences between persons living in the community and those in an institution. It may be more difficult to arrange and coordinate community services for someone with more intensive needs. The key unknown is how many waiver participants would enter an institution if the waiver were not available.

The second point of discussion about cost savings due to waivers is the extent to which waivers divert participants from seeking admission to an institution. Waiver participants must meet the same functional and medical eligibility requirements that persons using institutional services meet. To what extent do the waivers delay admission to an institution? Since waiver participants are at risk of entering an institution, how long do waiver services delay or postpone the admission? While it is difficult to determine the number of actual diversions, it is reasonable to assume some diversion occurs. For example, consider the AIDS Waiver, which is designed to maintain persons with AIDS in their homes. In 2006, about 29% of the waiver beneficiaries received attendant care services. If the participant's physical condition is serious enough that they need attendant care, then absent the waiver these persons probably would be served in more expensive outpatient or inpatient programs. The operation of the AIDS Waiver probably delays admission to these more expensive programs.

[165] Quarterly data on developmental center populations are available at: http://www.dds.ca.gov/DevCtrs/AllFacPop.cfm.

Tables 85–90 show the cost differences between waiver expenses and institutional costs. For 2006, the sum of these differences is $3 billion. Given a $3 billion cost difference, it is only necessary to assume a modest percentage of persons would have been served in institutions, or assume a modest delay in institutional admission, in order to generate savings from the operation of the waiver programs. For example, if we assume that only half the waiver participants would have been institutionalized somewhere, then the waiver savings would be about $1.5 billion. As shown in the table below, except for the NF A/B Waiver, the waivers have a consistent history of costing substantially less per person than comparable institutional services. This report takes the point of view that because of the magnitude of the cost differences, the waivers are generally cost-effective, but the effectiveness cannot be measured easily.

Table 85: Cost Differences of Acquired Immune Deficiency Syndrome (AIDS): CY 1996-2006

Reporting Period	Unduplicated Persons	Cost Difference Per Person	Cost Difference
CY 1996	3,021	$ 57,906	$ 174,933,132
CY 1997	2,669	$ 62,101	$ 165,748,173
CY 1998	2,497	$ 56,514	$ 141,115,538
CY 1999	2,619	$ 56,694	$ 148,481,586
CY 2000	2,518	$ 67,367	$ 169,630,031
CY 2001	2,453	$ 79,342	$ 194,626,096
CY 2002	2,852	$ 86,730	$ 247,353,404
CY 2003	2,846	$ 80,432	$ 228,910,469
CY 2004	2,830	$ 48,051	$ 135,985,580
CY 2005	2,882	$ 33,816	$ 97,459,104
CY 2006	2,495	$ 51,012	$ 127,275,964

Data Source: Department of Health Care Services

Table 86: Cost Differences of Multipurpose Senior Services Program (MSSP) Waiver: FY 1995–2006

Reporting Period	Unduplicated Persons	Cost Difference Per Person	Cost Difference
FY 1995	8,022	$ 11,246	$ 90,218,860
FY 1996	8,076	$ 9,797	$ 79,121,656
FY 1997	8,004	$ 8,869	$ 70,990,878
FY 1998	7,890	$ 10,163	$ 80,187,202
FY 1999	8,489	$ 9,068	$ 76,977,767
FY 2000	10,781	$ 9,437	$ 101,735,340
FY 2001	12,070	$ 11,314	$ 136,560,560
FY 2002	14,042	$ 11,130	$ 156,288,092
FY 2003	14,182	$ 9,743	$ 138,178,654
FY 2004	13,889	$ 9,796	$ 136,059,487
FY 2005	13,911	$ 11,772	$ 163,758,022
FY 2006	13,840	$ 18,574	$ 257,060,933

Data Source: Department of Health Care Services

Table 87: Cost Differences of In-Home Medical Care (IHMC) Waiver: FY 2001–2006

Reporting Period	Unduplicated Persons	Cost Difference Per Person	Cost Difference
FY 2001	41	$ 135,815	$ 5,568,397
FY 2002	42	$ 170,523	$ 7,161,983
FY 2003	78	$ 341,392	$ 26,628,538
FY 2004	76	$ 311,034	$ 23,638,570
FY 2005	67	$ 211,487	$ 14,169,626
FY 2006	65	$ 170,105	$ 11,056,821

Data Source: Department of Health Care Services

Table 88: Savings from Nursing Facility Subacute (NF/SA) Waiver: 2002–2006

Reporting Period	Unduplicated Persons	Cost Difference Per Person	Cost Difference
6/2002–3/2003	364	$ 31,138	$ 11,334,083
4/2003–5/2004	386	$ 71,077	$ 27,435,606
6/2004–3/2005	477	$ 75,084	$ 35,815,291
4/2005–5/2006	562	$ 89,216	$ 50,139,402

Data Source: Department of Health Care Services

Table 89: Cost Differences of Nursing Facility AB (NF/AB) Waiver: 2001–2006

Reporting Period	Unduplicated Persons	Cost Difference Per Person	Cost Difference
FY 2001	538	$ (83,934)	$ (45,156,509)
7/2001 to 5/2002	501	$ (75,603)	$ (37,876,935)
CY 2002	316	$ (19,461)	$ (6,149,813)
CY 2003	427	$ (19,264)	$ (8,225,693)
CY 2004	556	$ (13,452)	$ (7,479,097)
CY 2005	663	$ 8,847	$ 5,865,678
CY 2006	645	$ 4,166	$ 2,687,070

Data Source: Department of Health Care Services

Table 90: Cost Differences of Developmentally Disabled (DD) Waiver: FFY 1995–2006

Reporting Period	Unduplicated Persons	Cost Difference Per Person	Cost Difference
FFY 1995	27,194	$ 36,737	$ 999,025,752
FFY 1996	29,314	$ 37,634	$ 1,103,214,114
FFY 1997	35,105	$ 41,569	$ 1,459,289,664
FFY 1998	34,212	$ 39,503	$ 1,351,487,230
FFY 1999	30,205	$ 24,128	$ 728,798,868
FFY 2000	30,602	$ 24,717	$ 756,384,779
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FFY 2003	51,203	$ 42,512	$ 2,176,732,989
FFY 2004	54,682	$ 43,977	$ 2,404,742,528
FFY 2005	62,224	$ 45,338	$ 2,821,091,694
FFY 2006	57,973	$ 43,652	$ 2,530,612,156

Data Source: Department of Health Care Services

A review of previous studies on California long-term care and discussions with state budget staff found no studies of the woodwork effect on California's waivers. Program staff must address concerns raised by budget staff seeking assurances that a waiver will substitute for admission to an institution and by advocates seeking services for people who need assistance to function independently. To the best of the authors' knowledge, no studies were completed of the costs of persons with traumatic brain injury to see if a waiver would be cost effective, or if new persons with traumatic brain injury problems that were not previously receiving services would be induced to use the new waiver services.

While the woodwork effect has not been documented in California, budgetary concerns have limited further efforts to divert or transition persons from nursing homes. Instead, recent budget decisions could increase institutional costs. For example, the budget for FY 2009-2010 enacted in February eliminated optional Medi-Cal benefits for adults living in the community effective July 1, 2009. However, these services will continue to be available for persons in nursing facilities. Persons needing these services are thus induced to seek admission to an institution.

Break Even Analysis

As discussed earlier, it is not possible to say with certainty how many persons on a waiver would have entered an institution in the absence of the waiver services. However, it is possible to do a "breakeven analysis" and identify how many new persons can be served before a waiver loses its cost effectiveness.

Table 91 displays results from a breakeven analysis for the Acquired Immune Deficiency Syndrome (AIDS) Waiver. Using data submitted to CMS, the breakeven analysis takes the cost difference between the waiver and institutional expenses and divides it by the cost of waiver services. The data for 2006 for the AIDS waiver show that you could serve 12.6 persons from the savings for every person who would have entered a hospital. If 198 persons would have been admitted to a hospital and incurred expenses of $51,012 per person, the savings from serving these 198 persons would have funded the waiver services for 2,297 other persons. This waiver ceases to be cost effective when the woodwork factor hits 2,298 persons.

A good breakeven analysis also includes a discussion of how the institutional costs are analyzed and the targeting or eligibility for waiver participants. To the extent that selection procedures take into account past utilization and target persons with high costs, as the procedures of the In-Home and Assisted Living waivers do, the woodwork effect will be measured and controlled. As noted earlier, the waiver application can reserve waiver capacity in a way that further manages induced demand.

Similar breakeven analyses could be performed for other waivers. The perspective of this report is the "woodwork" effect is simply another program operations issue that needs to be measured and managed.

Table 91: Breakeven Analysis of Woodwork Effect for Acquired Immune Deficiency Syndrome (AIDS) Waiver: 2006 Data

Acquired Immune Deficiency (AIDS) Waiver	2006 Data	Data Source/Calculations
Number of persons served on Waiver	2,495	Table 85
Cost difference between waiver and institution	$ 51,012	Table 85
Cost per person for waiver services	$ 4,050	Table 15
Cost Ratio	12.60	51,012/4,050
Breakeven number of persons	198	(1/12.60)*2495
Additional number that could be served	2,297	2,495-198
Breakeven percentage	7.94%	198/2,495

Studies of Cost-Effectiveness Using California Data

Two recent studies that included California are relevant to the consideration of cost-effectiveness in California. The first is a national study of the relation between nursing facility and HCBS cost trends.[166] Kaye et al. (2009) examined long-term care spending trends 1995–2005 in states that had expanded their HCBS versus spending trends in states that had not expanded their HCBS, for both aged and mental retardation and developmental disabilities (MR/DD) populations. States that had well-established HCBS programs had much less overall long-term care (LTC) spending growth than those with low HCBS spending, because these states were able to reduce institutional spending. A lag of several years appeared to occur before institutional spending declined. In contrast, states with low levels of HCBS expenditures had an increase in overall costs, as their institutional costs increased. Thus, states that established HCBS programs have not had increased costs or have had a reduction in their total LTC costs over time.

"....real savings in institutional costs occur only when the number of Medicaid-financed nursing facility residents is reduced, a process that can take years."

California was one of the states that expanded its HCBS program for non-MR/DD persons and resulted in lower long-term care spending for aged persons.[167] For MR/DD persons, California was considered to be a state that had not expanded its HCBS care programs as much as other states and spent more on institutional care because of it. The report states: "… real savings in institutional costs occur only when the number of Medicaid-financed nursing facility residents is reduced, a process that can take years."

A second recent report relevant to cost-effectiveness was completed by the Rutgers Center for State Health Policy on the impact of declining occupancy on nursing facility reimbursement.[168]

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[166] Kaye, H., LaPlante, M. & Harrington, C. (January, 2009), *Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?* Health Affairs, Vol. 28, No. 1 pp. 262-272. An abstract of the article can be found at, retrieved on 1-11-09: http://content.healthaffairs.org/cgi/content/abstract/28/1/262. DDS staffs commented upon this article and expressed the view that they were uncertain if all DDS expenditures in such a targeted case were appropriately included in the comparison.

[167] Kaye, H., LaPlante, M. & Harrington, C. (2009), Exhibit 1.

[168] Wade, K. & Hendrickson, L. (June, 2008), *Modeling the Impact of Declining Occupancy on Nursing Home Reimbursement.* Center for State Health Policy, Rutgers University, New Brunswick, NJ. Retrieved on 1-11-09: http://www.cshp.rutgers.edu/cle/Products/7800.pdf.

This study looked at the theoretical issue of how much cost is actually saved by Medicaid when nursing facility occupancy drops in a cost-based system. The issue was explored because in a cost-based system costs are divided by the bed days to determine the per diem. Therefore there is a belief that if occupancy drops, there is no savings to Medicaid, since the same costs would simply be spread over fewer residents and thus the per diem paid by Medicaid would increase.

This expectation was found to be only partially true in practice. California was one of three states whose nursing facility reimbursement regulations were modeled and the study found, given the modeling assumptions, that approximately 57% to 60% of the savings due to declining occupancy were realized by the state. These were substantially lower percentages than the savings of the other two states, probably because California did not have an occupancy provision to control for low occupancy.[169]

Based on these conclusions, California could improve balance and cost-effectiveness by maximizing use of waiver services and developing strategies to reduce its institutional bed capacity. Strategies to maximize use of waivers include addressing waiting lists, increasing waiver capacity and reviewing the services covered to ensure they continue to meet the needs of participants.

Other Cost-Effectiveness Studies

In a 2005 study, the Lewin Group published a report on the fiscal impact of Indiana Senate Act 493.[170] One of the impacts examined was the extent to which the costs of expanding Indiana's Aged and Disabled Waiver could be offset by savings from reduced institutional costs. The report determined that, over time, diversion and transition savings would build each year and that by 2015 55% of the new waiver enrollees would otherwise have been nursing facility residents.[171]

In 2006, Grabowski completed a literature review of studies of the cost-effectiveness of home and HCBS programs.[172] Grabowski concluded that it was difficult to point out a connection between institutional and HCBS spending. He did note that two studies showed a reduction in overall Medicaid spending but felt their evidence was weak. The earliest cost-effectiveness study was by the Government Accountability Office (GAO) in 1994 and studied Oregon, Washington and Wisconsin.[173] This study found that HCBS programs were able to manage expected growth

[169] Wade, K. & Hendrickson, L. (2008), Table 5.
[170] The Lewin Group. *Impact of SEA 493 Provisions on Indiana's Aged and Disabled Waiver*. Report prepared under contract for the Indiana Family and Social Services Administration, Indianapolis, IN. (May 2005), Retrieved on 1-12-09: http://www.lewin.com/content/publications/3232.pdf.
[171] Lewin, ibid. (2005), pp. 65-66.
[172] Grabowski, D. (February, 2006), *The Cost-Effectiveness of NonInstitutional Long-Term Care Services: Review and Synthesis of the Most Recent Evidence.* Medical Care Research and Review, Vol. 63, No. 1, 3-28. For abstract see retrieved on 1-12-09: http://mcr.sagepub.com/cgi/content/abstract/63/1/3.
[173]U.S. General Accounting Office, (August, 1994), *Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs.* GAO/HEHS-94-167. Washington, DC.
Retrieved on 1-12-09: http://archive.gao.gov/t2pbat2/152298.pdf.

in demand and control overall expenditures, and the programs were cost-effective because of savings that result from control on the number and use of nursing facility beds.

The GAO report agreed with state staff that the three state programs did appear to limit expenditures while controlling for costs. In personal interviews with state staffs, the GAO staff expressed the view that discussions of cost-effectiveness were focused on state and federal Medicaid expenditures and did not include increased food stamp and other non-Medicaid costs in the community.[174]

After the GAO report, the AARP sponsored a report by the Lewin Group in 1996 to determine whether HCBS were cost-effective.[175] This was a widely cited report and estimated the amount of savings resulting from HCBS programs in Colorado, Oregon and Washington. The study found that HCBS programs produced savings in 1994 of $33.8 million in Colorado, $49 million in Oregon and $57.1 million in Washington.

Grabowski concluded that the states interviewed by GAO and Lewin had numerous policies which worked together to lower costs, and that it is difficult to establish a simple relationship between expanding HCBS services and lower institutional costs.

A GAO study reported that HCBS programs produce savings in long-term care spending.

Colorado, New Jersey, Oregon and Washington had existing nursing facility transition programs when federal interest in these activities increased. In 1998–2000 CMS awarded Nursing Home Transition (NHT) grants to 12 states. Additional NHT grants were awarded under the Real Choices Systems Change program. CMS awarded grants to 33 states and 10 Independent Living Centers during two rounds of funding in 2001 and 2002. A 2006 study by Reinhard and Hendrickson of state approaches to measuring their cost-effectiveness reported state staffs uniformly believed they were cost-effective since they help persons leave a higher-cost institutional setting.[176]

In 2007, Muramatsu et al. found that state HCBS effects were conditional on child availability among older Americans. Living in a state with higher HCBS expenditures was associated with a statistically significant lower risk of nursing facility admission among childless seniors. However, the association was not statistically significant among seniors with living children. Doubling state HCBS expenditures per person age 65 and older would reduce the risk of nursing facility admission among childless seniors by 35%.[177]

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[174] The second author of this report was interviewed by both GAO staff and Lewin staff as part of their work on these cost-effectiveness studies.

[175] Alecxih, L., Lutzky, S. & Corea, J. (1996), *Estimated Cost Savings from the Use of Home and Community-Based Alternatives to Nursing Facility Care in Three States.* AARP Public Policy Institute. Publication #9618, Washington, D.C.

[176] Reinhard, S. and Hendrickson, L. (September, 2006) , *Money Follows the Person: State Approaches to Calculating Cost Effectiveness*. Center for State Health Policy, Rutgers University, New Brunswick, NJ. Retrieved on 1-12-09: http://www.cshp.rutgers.edu/cle/Products/MFPCalcCostEffectivenessWEB.pdf.

[177] Muramatsu, N. et.al. (May, 2007), *Risk of Nursing Home Admission Among Older Americans: Does States' Spending on Home- and Community-Based Services Matter?*, Journal of Gerontology B Psychol Sci Soc Sci.; 62(3): S169–S178. Retrieved on 4-29-09: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2093949.

The federal emphasis on support for transition efforts has continued with the 2007 Money Follows the Person (MFP) Rebalancing Demonstration Project which provides enhanced federal matching funds to over 30 states to help them transition persons from institutions.[178] The federal approach to cost-effectiveness in this demonstration program limits payment of the enhanced federal reimbursement to individuals who live in an institution for at least six months before transitioning to the community.

There have also been state-specific studies in the last five years that addressed cost-effectiveness. Both the Public Consulting Group's study of MFP in West Virginia and the Lewin Group's study of MFP in Delaware described the assumptions and methodology used to review the cost-effectiveness of a state transition effort.[179] In 2009, Mollica et al. presented case studies of Vermont and Washington examining their cost-effectiveness.[180]

There have been occasional studies of the cost-effectiveness of specific HCBS policies.[181] As discussed above in the section on nursing facility trends, there have also been systematic studies of state data looking at the relationship between nursing facility use and HCBS use. [182] These studies have found that lower utilization and supply of nursing facility beds is positively correlated with more HCBS, implying that there is a proportion of persons whose needs could be met either by a nursing facility or by HCBS services. Since HCBS services are less costly, it is cost-effective for the state to grow HCBS capacity and monitor the tradeoff between declining nursing facility occupancy and increasing HCBS use.

The literature cited above shows that HCBS care programs can be operated in a cost-effective manner. States that do not expand these programs lose an opportunity to control long-term care costs. Cost-effectiveness is not a product of a single program as much as it is the outcome of creating multiple mutually reinforcing policies. Do California's HCBS care programs produce substantial savings of institutional costs? Yes, given the data on the state's lower than expected nursing facility utilization and the cost savings differences between the waivers and institutional cost, they do—especially for nursing facility utilization. Could more savings be obtained if HCBS were expanded? Yes, if transition, diversion, uniform assessment and supporting policies are developed and integrated with the expansion of HCBS. The Assessment/Transition

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[178] See, retrieved on 1-12-09: http://www.cms.hhs.gov/DeficitReductionAct/20_MFP.asp.

[179] The Lewin Group report is available at: http://ddc.delaware.gov/$$$finalmfpreport21306.pdf. The Public Consulting Group report is discussed at: http://www.allbusiness.com/government/government-bodies-offices-regional-local/11693606-1.html.

[180] Mollica, R. (March, 2009), Taking the Long View: Investing in Medicaid Home and Community-Based Services Is Cost-Effective, AARP Public Policy Institute, Washington, D.C. Retrieved on 4-28-09: http://www.hcbs.org/moreInfo.php/nb/doc/2562.

[181] For a recent such report based on random samples in four states see Lakin, C. et al.. (2008), *Factors Associated With Expenditures for Medicaid Home and Community-Based Services (HCBS) and Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) Services for Persons with Intellectual and Developmental Disabilities.* Intellectual and Developmental Disabilities. (2008), 46:3 pp. 200-214. Abstract retrieved on 1-23-09: http://aaidd.allenpress.com/aamronline/?request=get-abstract&doi=10.1352%2F2008.46:200-214.
For a less recent example see Kochera, A. (2002), *Falls among Older Persons and the Role of the Home: An Analysis of Cost, Incidence, and Potential Savings from Home Modification*. AARP Public Policy Institute. Washington. D.C. (March, 2002).

[182]For example, Miller, N. et al.. (March, 2001), *Use of Medicaid 1915(c) Waivers to Reconfigure State Long Term Care Systems*, Medical Care Research and Review, Vol. 58:100-119.

Workgroup of the Olmstead Advisory Committee has already laid out the kinds of mutually integrating policies that need to be developed. [183]

The various CHHS Departments have ongoing contracts that could be used to study the cost effectiveness of existing and proposed waivers. This report recommends that the state study expanding the use of waivers, including the costs and savings.

[183] The recommendations of the Assessment/Transition Workgroup can be found at, retrieved on 4-29-09: http://www.chhs.ca.gov/initiatives/Olmstead/Documents/OAC%20recommendations%20-n-%20State%20actions-strategies-HANDOUT.pdf.

Section 9: Fiscal Incentives Affecting Institutions and Home and Community-Based Services (HCBS)

This section examines three factors that encourage and discourage the use of both institutional and HCBS: declining revenues, provider fees and state efforts to work with long-term care providers. In addition to implementing a case-mix system, the state might consider the following factors.

Potential Impact of Budget Reductions Due to Declining Revenues

During periods of declining revenues, state policymakers face very difficult challenges. They must operate within available revenues and avoid decisions that reduce spending in one program that lead to additional spending in another. Policymakers must also deal with the institutional bias inherent in basic federal Medicaid policy. Medicaid beneficiaries are "entitled" to receive all state plan services if they meet the medical necessity criteria for the services. Specific Medicaid services may be covered as a mandatory state plan service, an optional state plan service (personal care) or a waiver service under §1915(c).

Nursing facility services are a mandatory state plan service and personal care In-Home Supportive Services (IHSS) is covered as an optional state plan service. HCBS are covered under §1915(c) Waivers and §1115 Demonstration Waivers.

States have four primary options to reduce spending—reduce financial eligibility, reduce provider rates, eliminate services or change the medical necessity criteria to qualify for a service. Each option has its limitations. Limiting eligibility may place people at greater risk. Reducing provider rates may force providers to withdraw from the program or reduce the already low wages of workers, which can affect quality of care. Eliminating services may lead to health declines that increase utilization of higher-cost services. Changing the medical necessity criteria continues services for persons at greatest risk but eliminates access for persons whose conditions may then decline.

States have more control over HCBS Waiver programs, and they are therefore more vulnerable when revenues are limited. States may set limits on the number of beneficiaries that can be served through waiver programs. The limits are defined as expenditure caps that are part of the cost-neutrality formula required for Centers for Medicare & Medicaid Services (CMS) approval. Waivers are only approved if the state demonstrates that Medicaid long-term care expenditures under the waiver will not exceed expenditures that would have been made in the absence of the waiver. States do not receive federal reimbursement for waiver expenditures that exceed the amount stated in the cost-neutrality calculation approved by CMS. As Kaye et al. reported, states that expand HCBS over time reduce the rate of overall growth in long-term care spending. Therefore, reducing funding for HCBS is likely to increase institutional spending growth over time.

Potential Impact of Provider Fees as a Fiscal Incentive to Promote Home and Community-Based Care

On the one hand, the state has severe budget problems and the desire to reduce expenditures is understandable. On the other hand, federal law does not preclude provider fees on HCBS. While nursing facilities and intermediate care facilities have been frequent subjects of provider fees, during this decade states have adopted fees on other provider as well. For example, Alabama charges fees to pharmacy providers.[184] Indiana imposed fees on community-based mental retardation programs.[185] Kentucky charged fees for home health care providers and health maintenance organizations.[186] Louisiana charged fees for pharmacies, physicians and medical transportation providers.[187] Minnesota charged fees for physicians, hospitals and HMOs.[188] California could implement a broader range of provider fees on health care providers if it so wished.

The argument that institutions should be spared budget reductions because of existing provider fees is understandable but is neither equitable nor cost-effective. Holding institutions harmless from budget reductions while reducing payments to HCBS providers is a clear disincentive to serving beneficiaries in the community. It is contrary to the Olmstead decision and efforts to support consumer choice.

Provider fees can be applied to HCBS programs.

Provider fees have been used in the Medicaid program since the mid-1980s. States like Maryland and Michigan levied a "fee" on providers such as hospitals and let the hospitals claim the cost of paying the fees as an allowable cost for purposes of Medicaid reimbursement. The state then paid the amount of the fee back to the providers and billed the Federal Medicaid for a match on the cost. By late 1991 33 states had such fees.[189] Illinois, for example, projected raising almost $735 million in new federal funds.[190]

A simple example shows why this practice generated additional revenue. Let's say the state imposes a fee on health care institutions and raises $400 million from the fee but then increases reimbursement rates by $400 million, which effectively returns the fee revenue back to the providers who were charged fees. The state then claims the $400 million as a federal matchable expense. Let's assume the state's federal Medicaid program match is 50%. The federal Medicaid agency would then be obligated to match 50% of the $400 million and provide the state an additional $200 million. The result is that the providers are held harmless, the state has $200 million in new federal revenue, and the federal Medicaid agency has $200 million less.

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[184] See Alabama code at Title 40 Chapter 26B sections 21 and 25.
[185] Authorized in Indiana statute at IC 12-15-32-11. IN Admin. rules at 405 IAC 1-12-24.
[186] See Kentucky Revised Statutes 142.301 to 142.359.
[187] See Revised Statutes 46:2625 and Louisiana Register Vol. 26. No. 7 (July 7, 2000). ICF/MRs is defined broadly in RC28:421 to include all residential providers.
[188] See Minnesota Statutes 256.9657 et. seq.
[189] See 1992 Oklahoma discussion of provider taxes, retrieved on 1-15-09, at: http://www.coph.ouhsc.edu/coph/HealthPolicyCenter/Pubs/1992/chpr9208.pdf.
[190] See http://www.lib.niu.edu/1992/ii920818.html.

After long negotiations, in 1991 Congress passed a law adding Sub-Section (w) to Section 1903 of the Social Security Act regulating the use of donations and fees in Medicaid, and in November of 1992 CMS issued rules implementing the new restriction. The regulations limited provider fees to 6%, a rate that has not effectively changed since 1992.

It is reasonable that a provider fee program for HCBS providers be implemented to take advantage of this federal provision and that the money should be used to increase reimbursement rates to providers.[191] The 2004 revenue maximization study by The California Endowment also suggested the use of provider fees.[192]

Potential Impact of State Efforts to Work with Long-Term Care Providers

At least nine states created programs to work with nursing facility providers to "downsize," "convert" or "rightsize" their states' nursing facility bed supply. These initiatives work with nursing facility and other long-term care developers and provide business and financial assistance so that they can renovate the building (with fewer licensed beds) and reconfigure their programs. An early example of this approach occurred in the late 1990s in Nebraska when the Medicaid program provided funds to nursing facilities to convert to assisted living programs.

Nebraska staff examined work done in New Hampshire, Oregon, Virginia and Washington and mapped out the location of nursing facilities in the state. They collected demographic information about their catchment area and operating data on the homes such as occupancy rate. The state worked with the nursing facility association, the Nebraska Health Care Association, and offered smaller planning grants and larger grants to nursing facilities to convert to assisted living programs. Close to 1,000 nursing facility beds were converted, and no new nursing facility beds have been built in Nebraska in more than ten years.[193]

The first part of this decade saw other states also use a cooperative financial approach to create incentives to alter long-term care delivery capacity. These states include: Indiana, Iowa,

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[191] It is difficult to obtain information on how many states use what kind of provider tax. Discussions with the staffs of the Centers for Medicaid and Medicare Services, the General Accounting Office and the Office of the Inspector General for Health and Human Services found no federal agency collects such information. The national nursing home association collects information on provider taxes on nursing homes and reported that by FY 2008 some 32 states of the 41 states responding to their survey had provider taxes on nursing homes up from 20 states in 2003. See Eljay LCC. *A Report on Shortfalls in Medicaid Funding for Nursing Home Care*. Prepared for the American Health Care Association. Washington D.C. (October, 2008). Retrieved on 1-15-09: http://www.ahcancal.org/research_data/funding/Documents/2008%20Medicaid%20Shortfall%20Report.pdf.

[192] Health Management Associates. *Revenue Maximization Strategies: Final Report*. Prepared for The California Endowment. Los Angeles, CA (December, 2004), p. 4. Retrieved on 1-15-09: http://www.healthmanagement.com/files/CA%20Revenue%20Max%20Final%20Version%20-Dec%2017.pdf.

[193] The Minutes of the July 24, 2008 Nursing Home Conversion Work Group contain a good historical description of this work. Retrieved on 1-15-09: http://www.state.il.us/aging/1athome/oasa/minutes/wg-nhc_minutes2007-07.pdf.

Michigan, Minnesota, New York, North Dakota and Wisconsin.[194] The initiatives generally follow the same pattern:

- A funding source is identified, e.g. Indiana used provider fees and Nebraska used intergovernmental transfer funds.
- A process is established and an agency is designated to administer it, e.g. the 2001 Iowa Senior Living Trust Fund administered by Department of Human Services and the 2004 Senior Living Revolving Loan Fund administered by the Iowa Finance Authority.
- Nursing facilities have an incentive to close beds through multiple financial methods including loans, grants and adjustments to Medicaid reimbursement rates, e.g. Minnesota's planned closure rate adjustment (PCRA).
- The program converts buildings to multiple uses, e.g. Wisconsin is converting buildings to assisted living, residential care apartment complexes (RCACs), community-based residential facilities (CBRFs) and adult family homes.

In 2008, Pennsylvania announced the Total Senior Care Initiative to reduce nursing facility bed supply and invest the savings in affordable housing and community services.[195] The initiative has three components: an Adjusting Reconfiguration Incentive (ARI); a Permanent Rate Incentive (PRI) that changes the Medical Assistance reimbursement rate and a Benchmarked Rate Incentive (BRI) using one-time grants. Pennsylvania submitted a Medicaid State Plan Amendment to CMS to approve the mechanism, and approval is pending.[196]

A PRI may be used to delicense empty beds and raise the rate for the remaining beds, similar to an occupancy provision. The rate increase is capped at 5%. To estimate the impact of a PRI, the Pennsylvania Office of Long-Term Living (OLTL) staffs applied the concept to a 217-bed facility with an 84% occupancy rate and 60% Medicaid occupancy and a daily rate of $170.78. Using PRI, the facility reduces capacity to 157 beds. Medicaid occupancy falls from 109 to 91 residents. The PRI of $8.54 per day raises the rate to $179.32. OLTL staff estimated annual net state savings (including the cost of additional waiver services) of $152,420 per year.

The Adjusting Reconfiguration Rate Incentive (ARI) may be used for older facilities that require renovation where the owner lacks the funds to begin remodeling. As a result of the renovation, the number of beds would be reduced and the rate incentive phases down to zero over a nine-year period. This approach produces an estimated $7.7 million savings over 30 years. The BRI option makes four to six upfront payments for major reconstruction when

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[194] The Center for State Health Policy at Rutgers University produced a report with short descriptions of these efforts. See Morris, M. *Reducing Nursing Home Utilization and Expenditures and Expanding Community-Based Options.* Center for State Health Policy, Rutgers University, New Brunswick, NJ. (February, 2007), Retrieved on 1-15-09: http://www.cshp.rutgers.edu/cle/Products/NursingHomeAlternatives%20FEB2007%20--FINAL.pdf.

[195] See announcements, retrieved 1-15-09 at: http://www.pennlive.com/midstate/index.ssf/2008/06/pennsylvania_welfare_departmen.html and http://www.medicalnewstoday.com/articles/93363.php.

[196] The wording of the Pennsylvania Medicaid state plan amendment is contained in the Appendices of this report.

specific milestones are achieved. All three models reduce Medicaid payments to nursing facilities and reinvest the savings in alternative services.[197]

Pennsylvania developed this nursing facility initiative as one of its multiple efforts to offer more choice of long-term living options to its citizens. These efforts include years of sustained work around housing and rental assistance programs and a well-funded statewide nursing transition program that has grown steadily since the early 2000s. Organizationally, there was a centralization of long-term living programs in the Office of Long Term Living headed by a director who is a deputy secretary in two departments, Aging and Public Welfare, to better integrate long-term living programs. Plus there were the logistical developments of policies, computer systems, training programs, state conferences and the other administrative mechanisms necessary to support major initiatives.[198]

Roughly 20% of the states, including two large states, New York and Pennsylvania, have developed initiatives to work with long-term care providers, and it is reasonable for California to also consider how it might work with providers. For example, California policy makers could review work done in New York and Pennsylvania to understand the policy considerations that prompted their initiatives and why they choose to implement them the way they did.

[197] See Appendix E for the draft Medicaid State Plan Amendment.
[198] See: http://www.nashp.org/Files/Pezzuti_NASHP2008.pdf.

Section 10: Transitioning from Institutions

California has experience assisting Medi-Cal beneficiaries to transition from institutions to community settings, but these efforts are small and could benefit by being consolidated under a single office.[199]

The Department of Rehabilitation (DOR) and the state's Independent Living Centers (ILCs) have built a modest but effective nursing facility transition program using Title VII Part B funding. The program began in 2003 and served 19 persons, rising to 93 persons in 2007–2008. The program is not able to pay for department or center staff to perform transitions, but it does pay for transition services. In 2007–2008 the program paid an average of $1,798 per person for transition expenses such as the first month's rent, basic household items and modest personal care services until the In-Home Supportive Services (IHSS) or other funding source was accessed.

As of mid-2008 California had 28 ILCs, and seven of the ILCs received transition assistance funds from the DOR. Other centers may have provided funds from their own accounts but have not reported this to the department.

The Community Resources for Independence, an ILC, received a Nursing Home Transition (NHT) grant from the Centers for Medicare & Medicaid Services (CMS) in 2002. The project operated in Sonoma County. Staff developed an outreach plan to educate the community about transition services. Staff reached an agreement with the Sonoma County Community Development Commission to set aside 15 housing vouchers for individuals transitioning. The project transitioned 35 individuals and diverted 14 individuals from admission to a nursing facility. During the project, staff developed a model transition protocol for ILCs and developed a transition manual. The final report cited the following barriers:

- Lack of a statewide outreach policy to inform nursing facility residents about their options to transition to the community
- Lack of a standardized comprehensive transition assessment tool that determines both medical/nursing needs and social needs
- Lack of standardized education and training for workers[200]

During 2002, the California Department on Aging (CDA) added "de-institutionalization case management" to the Multipurpose Senior Services Program (MSSP) program manual. While contractors are allowed to transition nursing facility residents, most did not because they have

[199] This point has been eloquently and repeatedly made in the Olmstead Committee's reports and minutes of its meetings.

[200] O'Keeffe, J., O'Keeffe, C., Osber, D., Siebenaler, K., and Brown, D. (July, 2007), *Real Choice Systems Change Grant Program - FY 2002 Nursing Facility Transition Grantees: Final Report*. Centers for the Medicare & Medicaid Services. Available at: http://www.hcbs.org/moreInfo.php/nb/doc/2060.

waiting lists and do not work with nursing facilities in this way. MSSP sites do focus on existing clients who were terminated after 30 days in a nursing facility for post-acute rehabilitative care.

Locally, the City and County of San Francisco launched a $3 million Community Living Fund (CLF) in 2007, which is administered by the Department of Aging and Adult Services (DAAS) through the Institute on Aging and seven partner organizations. The top priority of the program is patients at Laguna Honda and San Francisco General Hospital who wish to live in the community. Persons on waiting lists for these institutions and other persons in the community who are at risk of institutionalization are also priority persons for the program.

California was one of nine states that received a 2003 Money Follows the Person (MFP) Rebalancing Demonstration grant whose goals were to develop and test a preference assessment instrument, assess up to 220 residents in eight nursing facilities, identify transition candidates, their needs, and the costs of the NFT process, and transition consumers to the appropriate Home and Community-Based Services (HCBS) programs.[201] Four nursing facilities agreed to participate. Over 200 assessments were completed. Of those assessed, 56 expressed a preference to move to the community, and 39 were referred to community agencies to initiate the transition. About 12 residents actually completed the move. The barriers to relocation included the financial constraints facing community organizations, the lack of affordable housing, the lack of adequate community alternatives and unstable medical conditions.[202] Staff reported that although post-acute nursing facility residents are appropriately excluded from transition programs, candidates should be identified early after completion of the post-acute stay.

In 2007, California received an award from CMS to implement the California Community Transitions (CCT) project under MFP authorized by the Deficit Reduction Act of 2005. Grantees had to submit an Operational Protocol that describes how the project will be implemented. The protocol was approved in 2008. The CCT Operational Protocol states, "the State views implementing the Demonstration as part of a larger effort to make improvements to existing systems, making home and community-based services more accessible and understandable to consumers, thereby increasing the use of HCBS Waivers and certain State Plan services." The protocol lists eight priorities:

- Proactively inform consumers to create a broader public understanding of HCBS long-term care alternatives

- Proactively engage inpatient facility residents so they are aware of individuals and services available to work with them if they want to return to community living

- Maximize existing Medi-Cal HCBS options across networks

[201] Anderson, W., Wiener, J., and O'Keeffe, J. (June, 2006), *Real Choice Systems Change Grant Program: Money Follows the Person Initiatives of the Systems Change Grantees*. Centers for Medicare & Medicaid Services.
[202] Osterweil, D. (May 6, 2007), Money Follows the Person. Presentation at NASHP meeting for grantees.

- Expand or enhance existing service definitions that previously were limited to only certain subpopulation groups (for example, habilitation services can also be interpreted to mean coaching and training non-developmentally disabled participants in independent living skills)

- Gain experience with successful transitions to community living

- Gain experience upon which to evaluate the state's inpatient facility and HCBS level of care criteria

- Amend existing HCBS Waivers, where necessary, to clarify service definitions and/or the numbers of individuals who can enroll in HCBS Waivers

- Develop new HCBS policy based on experience, e.g., new waivers, State Plan amendments, level of care criteria, financial assumptions, etc.

The state originally estimated the MFP project would allow approximately 2,000 persons to transition (see Table 92) by September 30, 2011.

Table 92: Estimated Number of Money Follows the Person (MFP) Transitions by Category of Person

Year	Elderly	Developmental Disability	Physical Disability	Mental Illness	Dual Diagnosis	Total
2008	17	0	16	8	10	51
2009	122	75	254	50	50	551
2010	130	98	290	65	65	648
2011	150	143	337	60	60	750
Total	419	316	897	183	185	2,000

Source: MFP application

State officials indicated that MFP would enroll persons who transition into a waiver. The demonstration would be used to restructure relationships at the local level to improve coordination among multiple provider organizations—Home Health Agencies, ILCs, Area Agencies on Aging (AAAs) and Aging and Disability Resource Connection (ADRC) programs. A proposal template and guidelines were issued to select local lead agencies that are responsible for facilitating transition teams. Each team includes representatives from the above organizations and others as they are interested. In January 2009, four lead organizations were selected—two ILCs, one Home Health Agency and one MSSP site. To obtain statewide coverage, additional lead organizations are needed, and local outreach efforts to MSSP sites, ILCs and other organizations are planned by the project director.

Each lead organization establishes one or more transition teams. Organizations and roles that are represented on the team include:

- Area Agency on Aging
- Regional Center
- Affordable Housing Representative or Expert
- County Medi-Cal Eligibility Worker
- County IHSS Worker or IHSS Public Authority Representative
- Home Health Agency Representative
- HCBS Waiver Program Representative
- Independent Living Coach
- Long-Term Care Ombudsman

Each team designates one or more members to serve as transition coordinator(s) to facilitate service coordination for residents who elect to participate in the demonstration. The transition coordinators promote the project and conduct an initial preference interview and a follow-up interview to confirm the resident's interest. Transition coordinators meet qualifications specified in the approved waivers (Nursing Facility/Acute Hospital, Assisted Living Waiver Pilot Project or MSSP) so service can be reimbursed under existing Medi-Cal provider and service codes. Coordinators are social workers, nurses or other individuals with documented expertise with senior services, independent living or other related work. Transition coordinators can be employed by the lead organization or by other organizations represented on the teams.

The team completes an assessment and prepares a comprehensive service plan with the participant while the project staffs verify that the participant meets the six-month length of stay requirement. If the participant plans to enroll in an HCBS Waiver, the transition coordinator submits the comprehensive service plan to the project nurse who forwards the plan to the intake staffs for the appropriate waiver. The waiver registered nurse completes an assessment to determine whether the participant meets the waiver level of care criteria. Once the level of care is determined, the participant is enrolled in the waiver.

Other states operate effective nursing facility transition programs. The Washington Aging and Disability Services Administration assigns case managers to each nursing facility to work with residents. Each case manager is responsible for working with residents in two to three facilities. The caseload ratio is 1:400 for maintenance case management and 1:100 for active relocation. Case managers had been assigned to hospitals to work with discharge planners, but the state found that persons being discharged from hospitals frequently needed short-term rehabilitation services before they could return home. The state shifted staff from hospitals to nursing facilities to work with residents as their potential to move home improved.

Case managers, who may be social workers or registered nurses, contact residents within seven days of admission to the nursing facility to inform them of their right to decide where they will live, discuss their preferences, likely care needs, the supports that are available in the community and other service options. A full comprehensive assessment is completed

when the consumer indicates that he/she is interested in working with the social worker to relocate and the nurse/social worker develops a transition plan with the consumer.

Community Choice Counselors in New Jersey are state employees that are cross-trained to do nursing facility pre-admission screening, options counseling and transition support. They work with ILCs to transition persons age 60 and younger who prefer peer support. In 2003 there were 73 clinical staff (12 social workers and 61 registered nurses) who were funded with a federal match of 50% for social workers and 75% for RNs. They were organized into three regions, with assignments to specific hospitals and nursing facilities in those regions. They followed a specific caseload of "track II" persons who had been screened and determined to need short-term nursing facility care, but who had the potential to return to the community.

Cost-Effectiveness of Transition Programs

Savings through community transition programs are likely.

Transition programs have been found to be cost-effective. Other West Coast states like Oregon and Washington developed a set of reinforcing policies that reduced use of institutions and shifted the savings to expand their residential and in-home service capacity. The increased capacity further reduced institutional utilization and the resulting savings further expanded the use of HCBS. This financing cycle is at the heart of rebalancing long-term care programs.

There is a perception among some state staffs that nursing facility rates in California are low compared to the rest of the nation, a topic addressed elsewhere in this report. However, reviews of reported state rates for both 2005 and 2006 show California has average rates nationally.[203] Because California's nursing facility rates are average rather than low, it is reasonable to assume that reducing institutional populations through a statewide transition program will produce significant savings.

The various transition efforts now underway pose a challenge to policy makers and managers. Two approaches can be considered—form single entry point entities whose duties would include transition coordination or create an office for transition within DHCS to provide technical assistance, funding and logistical support including websites, regulatory change efforts, training, and statewide and regional conferences. The coordination model operated in the Commonwealth of Pennsylvania through the Office of Long-Term Living (OLTL).

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[203] The 2005 rates are reported in BDO Seidman. (September 2007), A *Report on Shortfalls in Medicaid Funding for Nursing Home Care*. Prepared for the American Health Care Association, Washington, D.C.. Table 1. Retrieved on 1-16-09: http://www.ahcancal.org/research_data/funding/Documents/2007_Report_on_Shortfalls_in_Medicaid_Funding.pdf The 2006 rates are reported in Eljay. (October, 2008), *A Report on Shortfalls in Medicaid Funding for Nursing Home Care*. A report prepared for the American Health Care Association, Washington, D.C. Table 1. Retrieved on 1-16-09: http://www.ahcancal.org/research_data/funding/Documents/2008%20Medicaid%20Shortfall%20Report.pdf.

Building on an earlier federal transition grant, in Pennsylvania, the nursing facility transition program was expanded statewide through AAAs, ILCs and one other nonprofit organization in 2006. OLTL provided state-level leadership, training and program management. In six months of operation from January 2006 to June 2006 the program transitioned approximately 500 persons and in FY 2006–2007 helped approximately 1,450.[204] From January 2007 to April 2009 Pennsylvania helped 5,000 persons move from nursing facilities. For an example of the infrastructure support provided by the state, see the Pennsylvania Department of Aging website at http://www.aging.state.pa.us/aging/cwp/view.asp?A=558&Q=254383. Searching the Internet for "Pennsylvania Nursing home transition results" produces multiple local community agency websites that describe nursing facility transition activities.

The MEDSTAT evaluation of the New Jersey Community Choice program found that more than 3,400 persons left nursing facilities with the help of Community Choice counseling from FY 1998-2001. During FY 2000-2001, Community Choice assisted an average of 1,500 former nursing facility residents each year.[205]

If a state one-quarter the size of California can transition 1,500 persons per year, it is reasonable to expect that a statewide effort in California could help several thousand persons per year. Relocating 2,000 persons per year would generate millions of dollars in savings, which could be used to offset revenue shortfalls and to expand waiver capacity to create opportunities for others to transition.

Access to Affordable Housing

Housing costs are often identified as a barrier to transitioning individuals who have been in an institution. A report on Real Choice Systems Change grants for nursing facility transition projects found that:

> Many nursing home residents lack alternative housing options. The lack of affordable housing is particularly a problem for individuals eligible for the Supplemental Security Income (SSI) program, who may be unable to afford housing even with rental assistance. Contributing factors include an insufficient supply of Section 8 vouchers relative to demand, with multiyear waiting lists and an insufficient voucher subsidy amount given high rents. Lack of transportation compounds the problem because less expensive

[204] For a good description of the PA Nursing Home Transition Program see, retrieved on 1-16-09: www.mhapa.org/documents/NursingHomeTransitionProgram05-01-08.ppt. The FY 2006-2007 data is from interviews with Pennsylvania state staff done in October 2007.

[205] Eiken, S. (December 22, 2003), *Community Choice: New Jersey's Nursing Home Transition Program*, Report prepared for the U.S. Department of Health and Human Services (HHS), Office of Disability, Aging and Long-Term Care Policy. Retrieved on 4-29-09: http://aspe.hhs.gov/daltcp/Reports/NJtrans.htm.

> housing is generally located in areas with limited public transportation.[206]

A report on 2003 MFP grants emphasized the importance of maintaining or establishing housing for persons who want to return to the community.

> ..... a major transition barrier is the widespread lack of affordable and accessible housing. According to state officials, many institutional residents who could be served in the community remain in nursing homes due to lack of housing. States may need to address the following issues: policies to help newly-admitted residents maintain their community residence, use of residential care facilities and the lack of affordable and accessible housing.
>
> Individuals with their own home or apartment at the time of nursing home admission often have trouble keeping them because states are free to place a limit on how long income will be protected for purposes of maintaining a home. Because the lack of affordable and accessible housing is a major transition barrier, states may want to consider increasing the amount of time that income is protected for maintaining a residence so that consumers who want to return to their homes are not physically precluded from doing so. [207]

A thorough analysis of California housing is beyond the scope of this report, however, strategies are available to promote access to affordable housing: increase the home maintenance exemption to allow people to pay the rent and utilities for up to six months after entering an institution or to exempt income of persons in institutions to accumulate funds to pay for rent and utility deposits, convert a portion of the state share of savings to a temporary rent subsidy and allow SSI/SSP beneficiaries who expect to return to their homes to maintain their Medi-Cal community eligibility status for up to 90 days in order to maintain their homes.

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[206] O'Keeffe, J., O'Keeffe, C., Osber, D., Siebenaler, K., and Brown, D. (2007). *Nursing Facility Transition Grantees: Final Report.* Prepared for the Centers for Medicare & Medicaid Services. (July, 2007).

[207] Anderson, W., Wiener, J., and O'Keeffe, J. (2006), *Money Follows the Person Initiatives of Systems Change Grantees* (July, 2006), Available at: http://www.hcbs.org/files/96/4769/MFP.pdf.

Section 11: California Community Choices Forum and Survey Results

The scope of work for the study included involvement from stakeholders. To obtain stakeholder perspectives, the project team held five community forums and a webcast during March 25–28, 2008, to learn about the priorities and perspectives of stakeholders. The forums were held in Sacramento, Nevada City, Oakland, Los Angeles and Orange County and were attended by 165 participants representing consumers, advocates, family members, caregivers, Independent Living Centers (ILCs), community organizations, Area Agencies on Aging (AAAs), researchers or research organizations, provider organizations, and local or state agencies. A web-based survey was also conducted to provide stakeholders who could not attend a forum to offer their perspectives.

Table 93: Forum and Survey Participant Affiliations

Affiliation	Forums N=165	Survey* N=86
Consumers	4.8%	11.4%
Advocates	11.5%	20.3%
Family Members	3.0%	8.9%
Caregivers	6.1%	3.8%
Independent Living Centers	10.9%	2.5%
Community Organizations	12.1%	15.2%
Area Agencies on Aging	5.5%	7.6%
Researchers	1.8%	0.0%
Provider Organizations	23.0%	16.5%
Local or State Agencies	21.2%	13.9%

* In addition, two respondents were affiliated with a regional center and two with an IHSS Public Authority.

During each forum, participants were asked to rate the importance of questions using electronic voting keypads. Six questions were rated very important by over 70% of the participants. Nearly 90% of the participants responded that it was very important to establish a long-term services and support center in each county/region (one-stop-shopping) to help people find and receive the services they need, validating the California strategy of building ADRCs. Over 86% said it was very important to increase hospital-to-home discharge planning services and discussion of this point highlighted perceptions that discharge planning needed to be improved. Approximately, 75% said that allowing case managers to expedite the Medi-Cal financial eligibility process for beneficiaries who are at risk of entering a nursing facility was very important. Expanding the long-term care workforce also received high ratings. See table 94 for the ranking of each question.

Questions with the lowest very important ratings were creating incentives for and encouraging purchase of long-term care insurance, using a single assessment tool for Medi-Cal beneficiaries who apply for admission to a nursing facility that provides opportunities for options counseling, developing a single assessment tool for long-term care services and establishing one department for long-term services and supports.

Results for the web survey were consistent with the forums. The top six rankings were nearly identical and both groups rated long-term insurance lowest. At each forum participants were asked to identify the most important change that should be made in California's long-term care systems and, from among the changes listed, to vote for the most important change. The highest ranked changes are presented in Table 94. Aggregate results from the forums and the web survey are presented in Tables 95 and 96.

The public comments were valuable in guiding the report's work. A comparison of this report's recommendations and the results of the forums and surveys show how many of the public comments are reflected in the recommendations.

Table 94: Forum Priorities

Location[208]	Priority	Percentage
Nevada City	Increased funding for LTSS and IHSS	31%
	Universal health care	22%
	Expand local decision making in funding	13%
	Increase options to prevent institutionalization	13%
Sacramento	Single payer healthcare	54%
	Housing and transportation	21%
	Long-term care integration	8%
Los Angeles	Ending institutional bias	33%
	Provide a one-stop shop	22%
	Provide adequate funding	22%
	Streamline eligibility process	11%
	Affordable and accessible housing	11%
Orange County	Pass the Community Choices Act of 2008	24%
	Integrate funding streams for medical and LTSS	21%
	Create an inventory of LTSS	15%
	Simplify funding process and program requirements	13%

[208] Due to technical difficulties, the results from the Oakland forum were not recorded. Each of the topics listed were discussed at each forum.

Table 95: California Community Choices Forum Results

Questions - How Important Is It to:	Very Important	Important	Somewhat Important	Not Important	Not Sure
Provide information about services and supports that enable people to live at home and in the community rather than in nursing facilities.	89.4%	8.8%	1.2%	0.6%	0.0%
Increase hospital-to-home discharge planning services and supports.	86.5%	7.7%	3.2%	1.9%	0.6%
Improve access to home and community-based services, enable case managers to speed up Medi-Cal eligibility process for individuals at risk of admission to a nursing facility.	75.7%	9.0%	7.6%	4.9%	2.8%
Develop strategies to retain and expand the long-term care workforce.	72.4%	16.4%	4.6%	5.3%	1.3%
Create the same financial requirements for nursing facility and home and community-based Medi-Cal eligibility to make it easier for Medi-Cal eligible individuals to receive services and supports at home and in the community.	72.2%	10.6%	0.7%	2.6%	13.9%
Establish a long-term care services and supports center in each county/region (one-stop-shopping) to help people find and receive the services they need.	71.2%	17.6%	8.2%	1.2%	1.8%
Increase Medi-Cal asset and income eligibility requirements.	68.4%	8.6%	9.2%	5.3%	8.6%
Expand managed long-term care program options.*	67.1%	14.3%	2.9%	4.3%	11.4%
Create one state budget (one line item) that combines funding for home and community-based services and nursing facilities so that funds could be used to respond to consumer preferences.	62.3%	13.2%	6.6%	5.3%	12.6%
Develop more cost-effective strategies to reduce the rate of growth in Medi-Cal spending for long-term care services and supports (including both institutional and home and community-based services).	57.2%	22.4%	4.6%	3.3%	12.5%
Provide Medi-Cal Waiver funding for services in residential settings (for example, expand the Assisted Living Waiver Pilot Program or add assisted living to the Multipurpose Senior Services Program Waiver).	53.6%	23.2%	8.6%	4.0%	10.6%
Allow In-Home Support Services to be provided in RCFEs.	49.7%	17.9%	9.7%	14.5%	8.3%
Create a state department that combines long-term care services and supports.	41.0%	27.1%	13.3%	9.6%	9.0%
Use a single statewide assessment tool for HCBS such as In-Home Supportive Services, Adult Day Health Care and other in-home services.	36.0%	29.1%	17.4%	5.2%	12.2%
Use the (single statewide) home and community-based assessment tool for nursing facility placement.	32.7%	23.4%	18.1%	9.4%	16.4%
Encourage and provide incentives for people to purchase long-term care insurance.	30.1%	21.6%	18.3%	13.1%	17.0%

* This question was only asked during the forum in Orange County.

Table 96: California Community Choices Web Survey Results

Questions - How Important Is It to:	Very Important	Important	Somewhat Important	Not Important	Not Sure
Provide information about services and supports that enable people to live at home and in the community rather than in nursing facilities.	82.6%	12.8%	2.3%	1.2%	1.2%
Improve access to home and community-based services, enable case managers to speed up Medi-Cal eligibility process for individuals at risk of admission to a nursing facility.	76.5%	17.6%	3.5%	1.2%	1.2%
Increase hospital-to-home discharge planning services and supports.	64.7%	25.9%	5.9%	0.0%	3.5%
Develop strategies to retain and expand the long-term care workforce.	63.9%	30.1%	3.6%	1.2%	1.2%
Create the same financial requirements for nursing facility and home and community-based Medi-Cal eligibility to make it easier for Medi-Cal eligible individuals to receive services and supports at home and in the community.	60.0%	30.6%	2.4%	1.2%	5.9%
Establish a long-term care services and support center in each county/region (one-stop-shopping) to help people find and receive the services they need.	58.8%	21.2%	10.6%	3.5%	5.9%
Increase Medi-Cal asset and income eligibility requirements.	56.0%	23.8%	7.1%	4.8%	8.3%
Provide Medi-Cal Waiver funding for services in residential settings (for example, expand the Assisted Living Waiver Pilot Program or add assisted living to the Multipurpose Senior Services Program Waiver).	53.7%	31.7%	4.9%	0.0%	9.8%
Create a state department that combines long-term care services and supports.	52.3%	29.1%	7.0%	4.7%	7.0%
Develop more cost-effective strategies to reduce the rate of growth in Medi-Cal spending for long-term care services and supports (including both institutional and home and community-based services).	51.8%	18.8%	17.6%	3.5%	8.2%
Use a single statewide assessment tool for home and community-based services such as In-Home Supportive Services, Adult Day Health Care and other in-home services.	45.8%	20.5%	21.7%	6.0%	6.0%
Create one state budget (one line item) that combines funding for HCBS and nursing facilities so that funds could be used to respond to consumer preferences.	45.2%	28.6%	8.3%	4.8%	13.1%
Use the (single stateside) home and community-based assessment tool for nursing facility placement.	36.6%	24.4%	19.5%	7.3%	12.2%
Allow In Home Support Services to be provided in Residential Care Facilities for the Elderly.	36.6%	29.3%	12.2%	6.1%	15.9%
Expand managed long-term care program options.	37.8%	37.8%	4.9%	2.4%	17.1%
Encourage, and provide incentives for people to purchase LTCI.	31.3%	27.7%	21.7%	10.8%	8.4%

Section 12: Findings

General Findings

- Approximately 2.4 million persons in California report having two or more disabilities and an estimated 400,000 plus have intellectual or developmental disabilities.

- California has more persons age 65 and older than other states. In 2007, California was home to 4.0 million persons age 65 and older, or 11.0% of the total population. By 2010 the number of Californians age 65 and older will increase to 4.4 million or 14.7%, and will increase to 8.3 million or 17.8% of all Californians in 2030.

- The system is organized by program rather than by person. California's services for older adults and individuals with disabilities are covered through programs managed by multiple state agencies and organizations. However, the programs provide a core of similar services that include support with activities of daily living (ADL), instrumental activities of daily living (IADL) and health and social needs. Tens of thousands of persons receive services from multiple programs, while others shift between programs in complex passages resulting in costs and consumer outcomes that are rarely studied, since no one department is responsible for the entirety of a person's care and services.

- In 2009, California's DD programs ranked seventh in the nation for the best performing state Medicaid programs in a national study by United Cerebral Palsy which measured 20 factors.

- California ranks 1st in the nation on the number of personal care participants per 1,000 population, 19th on home health participants per 1,000 population, and 42nd on Home and Community-Based Services (HCBS) Waiver participants per 1,000 population. California ranks 6th in total HCBS participants per 1,000 population and 17th in total HCBS expenditures per capita in 2005.

- For older adults and adults with physical disabilities, California was ranked 5th nationally in the percentage of HCBS spending with 48% on institutional care and 52% on HCBS in 2007.

  Note: The annual table of the percentage of spending on HCBS prepared by Thomson Reuters reports all Medicaid State Plan personal care expenditures (IHSS) under data for aged and disabled beneficiaries. Medicaid service expenditures reported on CMS Form 64 are frequently used to rank states on long-term care spending. However, the Form 64 data under-report spending for community services in California and other states.

- In 2007, California was 48th in the nation on per capita spending for waiver expenditures, 4th on personal care and 18th overall on total HCBS.

  Note: Comparing California's rank for per capita HCBS spending to other states may be misleading since state expenditures on related Medi-Cal state plan services and services under the Lanterman Developmental Disabilities Services Act (Lanterman Act) funded by state general revenues are not captured in HCBS data reported on the CMS Form 64.

- In 2007, HCBS accounted for 62% of developmentally disabled (DD) spending and 38% for institutional care, which placed California 32nd among states. When spending for targeted case management and clinical services is included, the ratio is 66% HCBS and 34% institutional.

  Note: Comparing California's rank for waiver spending for persons with developmental disabilities, to other states may be misleading since the state spends such a large amount on IHSS, other Medi-Cal state plan services and services under the Lanterman Act funded by state general revenues. Data on these expenditures are not captured in the CMS Form 64, which is frequently used to rank states on long-term care spending.

- Per capita per year spending presents a different perspective on spending. In FY 2007, California exceeded the national average for spending on state plan personal care services (IHSS)—$101.51 versus $34.47. California's spending for HCBS Waivers for aged and disabled beneficiaries is $3.00 per capita per year compared to $21.02 nationally, and for individuals with mental retardation and developmental disabilities (MR/DD), per capita spending was $35.12 in California compared to $68.04 nationally. Including targeted case management spending would increase per capita spending.

- California spent less per capita per year than the national FY 2007 average on nursing facility care—$100.04 per day compared to $155.76 per day nationally, and spending for intermediate care facilities for the mentally retarded (ICF/MR) was $21.27 per day in California compared to $39.83 per day nationally.

- Nursing facility spending increased 40.7% between 2001 and 2007 while waiver spending for older adults and individuals with disabilities increased 20.6% during the same period. Nationally, nursing facility spending increased 10% and waiver spending for older adults and individuals with disabilities rose 85% during the same period.

- Medi-Cal spending for all nursing facility and ICF/MR institutional services rose 46.9% between 2001 and 2007, while spending for community services—In-Home Supportive Services (IHSS), MR/DD and other waiver services—rose 88.4%.

- The state does not take full advantage of Medicaid provider fees.

System Design

- California lacks a strategic plan based on priorities for services for the future to maximize the use of finite resources. The Olmstead plan offers a framework for developing a strategic plan.

- New programs often require a new delivery system because there is no logical infrastructure or statewide entry point to administer new programs. Consumers admitted to a nursing facility do not have access to a central source of information, preadmission screening, or assistance and support to access community service options. Consumers living in the community who need assistance do not have access to options counseling to understand what services might be available to them in order to divert consumers who have other options from admission to an institution.

- The state's budget deficit makes consideration of changes that require investment in services or the delivery system more difficult in the short term. However, investments in HCBS programs would likely improve the effectiveness of the overall delivery system and reduce the rate of growth by shifting more resources to community services.

- While there is no statewide entry point for older adults and individuals with disabilities, ADRCs are being designed to provide information about the multiple services and access points.

- Collaboration between community service organizations and hospital discharge planners to divert admissions to nursing facilities is not well developed.

- Previous reports recommended consolidation of agencies and programs serving individuals with disabilities and older adults. However, each program and agency has a long and rich tradition, a strong network of providers, advocates and consumers that seem more comfortable with the system they know than a new, untested structure that is not clearly defined.

In-Home Supportive Services (IHHS)

- Opinions about the reasons for IHSS caseload growth differed. Persons interviewed attributed the growth to the:
  - Low functional eligibility requirements
  - Widespread awareness of the program
  - Use of family and friends as caregivers
  - Statewide availability of services
  - Difficulty of accessing HCBS Waivers
  - The program's well-established history
  - Aging of the population

- Persons interviewed stated that the low IHSS functional eligibility requirements help prevent further decline and that allowing family and friends to be reimbursed (which is becoming more common in state programs) addresses tight labor pools and supports family caregiving.

- New IHSS participants have higher assessed levels of impairment than persons who entered the program eight years ago.

- The IHSS limit on the maximum number of hours of service that may be authorized, 283 hours per month, is higher than almost all other states. However, persons interviewed said exceptions to the cap are warranted for participants with more intensive needs to reduce the need for supplemental services through HCBS Waivers.

- Studies about the impact of wage and benefit increases to personal care workers report that increases have predictable positive impacts on their willingness to work and reduce job turnover.

Home and Community-Based Services (HCBS) Waiver Programs

- Recent research found that states with well-established HCBS programs had much less overall LTC spending growth. In contrast, states with low levels of HCBS expenditures had an increase in overall costs, as their institutional costs increased. California was rated an expanding HCBS state for non-MR/DD services and a low HCBS state for DD Waiver services.

- The Medi-Cal level of care criteria used to determine eligibility for each program seem appropriate given the intended populations to be served and the program services to be provided.

- MSSP enrollment is limited by funding but experienced periods of growth. The program primarily provides case management to persons age 65 and older who also receive IHSS services. Stakeholders noted that expanding MSSP services to provide more transition assistance to persons wishing to leave institutions would be a useful program development.

- The Assisted Living Waiver (ALW) expands long-term care settings by providing residential service choices but serves persons in a limited number of counties and is not available statewide.

- California does not use the special income level eligibility option, which would streamline access for individuals with income below 300% of the federal SSI benefit.

- The cost differences between waiver expenses and institutional costs totaled $3 billion in FY 2006, which suggests that HCBS programs are cost-effective and delay or substitute for hospital, nursing facility and ICF/MR care even if only a modest

percentage of persons would have been served in institutions in the absence of the programs.

- The state has not studied the cost effectiveness of its waiver programs.

- Stakeholders commented that the number of waiver slots is low relative to most other states, and expanding the waiver capacity would be important to address in a strategic plan for long-term care.

Department of Developmental Services (DDS)

- The Regional Center delivery system for individuals with developmental disabilities is well developed. It is California's only long-term care system that operates as a single entry point that provides access to comprehensive services.

- The growth in the number of persons served in DDS programs has been steady throughout the last decade. The caseload has grown from just over 180,000 in 2001 to over 247,001 in July 2009.

- The state has made significant progress in helping persons with intellectual and developmental disabilities leave state-operated institutions. DDS stated that the effort to transition individuals out of private facilities focused on relocating persons with developmental disabilities from large facilities to small home-like settings. While the number of persons in private facilities overall has increased, the number of persons in large ICF-MRs has declined and the number of persons in smaller facilities has increased.

- Prior to July 1, 2008, Regional Centers negotiated rates for nonresidential services. The extent and depth of negotiated rates, and the degree to which negotiations are used in the cost-based approaches is not reported on by DDS. The uniformity of rate payments across regional centers is not known.

- The two main drivers of DD Waiver costs are the sustained increases in enrollment and utilization. Once a person enrolls in the waiver, they tend to remain, although DDS staff indicated that between 5,000-6,000 persons disenroll from the waiver each year.

Adult Day Health Care (ADHC)

- A study of programs in six states (California, Maryland, New Jersey, New York, Texas and Washington) found that ADHC can save the Medicaid program significant resources by delaying or avoiding inappropriate entry into more costly institutional care.

- Over 80% of ADHC participants are age 65 and older and fewer than half are age 80 and older, which is comparable to recipients who receive services in a nursing facility.

- ADHC often serves beneficiaries who receive other services. A review of paid Medi-Cal claims found that 60% also received IHSS services. A state official suggested that ADHC may supplement IHSS for participants who need more hours than can be authorized under IHSS. ADHC also provides skilled services that are not available through IHSS, and the combined services meet a broader range of health and functional needs.

- Legislation passed in 2006 made significant changes in the ADHC program and reduced expenditures.

- ADHCs serve two distinct populations—one receives temporary rehabilitative services and the other receives longer-term support and medical services.

- A review of Treatment Authorization Requests (TARs) estimated that 30–40% of all participants would need nursing facility care in the absence of ADHC services. The specific level of nursing facility care—Level A, Level B or Subacute—was not indicated.

Mental Health

- California does not operate an HCBS program that is designed specifically for persons with mental illness. A package of services for nursing facility residents with a mental illness could be designed under a §1915(c) Waiver or a §1915(i) state plan HCBS amendment.

Nursing Facilities

- California ranks 43rd among states in the supply of nursing facility beds per capita and 31st with an occupancy rate of 86%. The Medi-Cal nursing facility resident census has declined slightly, -1.4%, over the past eight years. However, between December 2001 and December 2008, the number of Medicaid residents in nursing facilities dropped 8% nationally and 22 states experienced a reduction of 10% or greater, which suggests that further reductions are possible through diversion and transition/relocation initiatives. Although other factors may contribute to California's modest decline, effective diversion and transition programs, along with fiscal incentives for counties, would continue the trend.

- From December 2002 to December 2008, the number of nursing facilities in California declined approximately 6%, slightly above the national average. The

numbers of nursing facility residents and nursing facility beds have also declined modestly although less than the national decline, while the occupancy rate has increased slightly.

- While there is a perception among persons interviewed that California has a history of low nursing facility reimbursement rates, a review of national rates from 1998 to 2005 shows that California ranks in the midrange compared to other states in nominal dollar terms.

- California has a higher proportion of residential care and a lower supply of nursing facility beds per 1,000 persons age 65 and older than the other large states.

- Medicare nursing facility use increased 26% in California and 34% nationally between 2001 and 2008. Nursing facilities prefer to expand their Medicare and managed care subacute business and its profitable ancillary revenue.

- Increases in nursing facility per diem in California have been greater than general inflation from 2001 to 2008 and have kept up with medical inflation.

- Operating margins of nursing facilities have increased substantially in California since 2000.

- Only about 55–60 nursing facilities report any caregiver training expenses, although it is a 100% pass-through cost.

- California's nursing facility cost reimbursement methodology does not control for low occupancy. In per diem reimbursement systems, costs are divided by days of service. As the number of days becomes smaller, the cost per day goes up. Unless low occupancy rates are controlled for, the entities receiving the per diem reimbursement will get more money per person as they serve fewer persons.

- California also uses prospective cost-based rates that are not adjusted for the acuity of the residents.

- If California had the same nursing facility usage as the national average, about 42,600 more persons would have their nursing facility stay paid for by Medi-Cal. At 2007 costs, if these 42,600 persons had been receiving nursing facility Level B services for 219 days each at a cost of $139.70 (the average number of days and costs in California in 2007), the state would have spent an additional $1.4 billion per year.

Transition Programs

- The state currently operates nursing facility transition initiatives through the Department of Rehabilitation, Centers for Independent Living, 1915(c) Waivers, a

program in San Francisco and the new Money Follows the Person (MFP) Rebalancing Demonstration.

- MFP offers an opportunity to develop and refine strategies that provide transition coordination to nursing facility residents who are interested in moving to the community. The fragmented delivery system poses additional challenges to transition coordination. The program's success will depend on the ability of the service network to provide access to the level of service needed by individuals who are interested in moving to the community.

- Access to affordable housing is a barrier to transitioning for persons who want to return to the community but lack a source of housing.

Section 13: Recommendations for Improving the Management of Funding for Home and Community-Based (HCBS) Services

The recommendations presented below address Medicaid's institutional bias and will result in more cost-effective management of the long-term care system. They address policies, laws, regulations, rates and fiscal incentives that impact access to HCBS.

Reduce Institutional Bias

Medicaid long-term care policy has evolved over its nearly 40-year history but it retains its bias toward institutional care. HCBS Waiver programs began as a separate long-term supports option with dedicated, but limited, funding. As these programs matured and expenditures grew, Medicaid's institutional bias increased the barriers to accessing HCBS. Individuals continued to have access to institutional settings while preferred options were not available. At the national level Money Follows the Person (MFP) emerged as a strategy to reduce bias by allowing Medicaid funds to support access to services in community and residential settings.

Despite consumer preferences to receive services in their homes, institutional care is easier to access because of restrictions in the Social Security Act, Medicaid regulations and the options states choose. Institutional bias can be found in financial eligibility categories, service coverage and the delivery systems through which services are accessed. Addressing institutional bias means creating a level playing field that allows Medicaid beneficiaries to choose the services and settings that they prefer.

Bias results from multiple factors:

Entitlement

Care in a nursing facility is a mandatory Medicaid state plan service and all beneficiaries in specific eligibility groups that meet the criteria to receive care in a nursing facility must be covered by Medicaid. Nursing facility care must be offered statewide to everyone who qualifies. Nursing facilities have an important role for persons who need short-term rehabilitative care or have ongoing medical problems, or advanced dementia and other conditions that make it difficult to receive care in the community. However, others live in an institution because they were not able to access services in the community, because they lacked accessible, affordable housing or because they were not aware of the community options.

In most states, care provided in the community, which most people prefer, is currently covered through Medicaid waivers and state-funded programs. HCBS are not listed in the Social Security Act as mandatory or optional Medicaid state plan services and are not an entitlement. That is, Medicaid does not have to reimburse providers for HCBS to beneficiaries who meet the criteria for the service. Under HCBS Waivers, states may limit the number of persons who will be served and the geographic areas in which services will be

offered. When states reach the number of persons that they choose to serve under their waiver, a waiting list may be established.

The Deficit Reduction Act of 2005 added a new state plan option that is not as flexible as the 1915(c) Waiver program. See Appendix D.

The entitlement bias has directly led to a passive financial policy where institutional budgets are protected in times of budget duress despite their greater cost while the budgets of HCBS programs are reduced.

Financial Eligibility

Individuals who are financially eligible for Medicaid in an institution may not be eligible in the community. States may cover beneficiaries in an institution whose income is less than 300% of the Federal Supplemental Security Income (SSI) benefit, but are not required to cover the same person in the community under HCBS Waivers. Individuals in states with a Medically Needy program are more likely to be eligible in an institution than in the community. The high cost of their nursing facility care easily depletes the income and resources of low-income individuals. In the community, low-income individuals need their income and resources to maintain their home. The cost of HCBS is less likely to meet the "spend down" requirement, and they may not have enough resources to meet their expenses for services until they are eligible for Medicaid. These conditions encourage nursing facility use. Adoption of the 300% of SSI special income group in HCBS Waivers reduced institutional bias.

The process for determining financial eligibility also creates an additional barrier. States have up to 45 days to determine financial eligibility. If the individual enters an institution, the provider knows they will get some payment in the event that the individual is not eligible for Medicaid. For example, nursing facilities are likely to receive a Medicare payment for the first 20 days, which provides payment for some of the period while Medicaid eligibility is being determined. Because there is less risk of nonpayment, institutional providers are more willing to admit a person while the Medicaid financial application is pending. In the community, in-home service providers usually wait to initiate services until the financial decision is made.

Service Array

Institutions provide housing, meals and services that people need in one setting. Under federal law, federal payments for room and board are available while a person is in an institution, but room and board payments are not available to persons living in the community. Also, in the community, individuals with disabilities may need supports from multiple programs and service providers. Some services received in an institution may not be available in the community, since states may cover a narrower list of HCBS under their waivers, such as California, which has emphasized a strong in-home program but has only recently provided residential options for Medi-Cal recipients.

Delivery System—Pathways to Service

Nursing facilities provide skilled nursing, post-acute rehabilitative care and longer-term supportive or custodial care. Physicians and hospital discharge planners rely on nursing

facilities for timely transfers of persons leaving a hospital. HCBS systems are less well known to physicians, consumers and family members, and they require more time to determine eligibility and arrange services. While states facilitate access through organizations that inform consumers about their options and authorize and expedite access to services, services that might be available in the community are less well known.

The stakeholder forums provided numerous comments about the need to minimize the institutional bias. The recommendations below reflect those comments.

1. Establish the Philosophy and Legislative Intent

While statutes describe the role and purpose of California's different long-term care programs serving older adults and adults with physical disabilities, taken together they do not establish a framework for making decisions about new programs, nor do they address the "system" as a whole. Despite the investment of $10 billion in FY 2007 in HCBS and institutional long-term care services, California does not have a strategic plan that identifies the goals for the state's long-term care system, changes that will be needed to reach the goals, actions that will be taken, and the agency, staff and timelines responsible for managing the process that will guide decisions about the future of long-term care services and supports.

Examples of the intent of programs that comprise components of California's long-term care (LTC) system are presented below.

The intent of the Multipurpose Senior Services Program (MSSP) is to prevent the premature disengagement of older individuals from their communities and subsequent commitment to institutions and to assist frail older individuals who have the capacity to remain in an independent living situation with the access to appropriate social and health services without which independent living would not be possible.[209]

The statute also expects the MSSP program to coordinate, integrate and link these social and health services, including county social services, by removing obstacles that impede or limit improvements in delivery of these services.

Section 9250 addresses the need for a coordinated system of care. It states that the Legislature finds that the "delivery of long-term care needs to be vastly improved in order to coordinate services that are appropriate to each individual's functional needs and financial situation. Care services should be holistic and address the needs of the entire person, including the person's mental, physical, social, and emotional needs." It also finds that multiple funding streams and varied eligibility criteria have created 'silos' of services, making it difficult for consumers to move with ease from one service or program to another. Separate funding streams and uncoordinated services for older adults and adults with disabilities have created barriers in services for these populations. Adults with disabilities often receive LTC services designed to

[209] Welfare and Institutions Code, Sections 9205-9256.

support and protect the institutionalized older population. Instead, services need to be individualized to empower older adults and persons with disabilities to live in the community.

The section states that the intent of the Legislature is to enact legislation to:

- Ensure that each consumer is able to connect with the appropriate services necessary to meet individual needs
- Better coordinate long-term care delivery, recognizing the elements that are already in place, and expand the availability of long-term care
- Deliver long-term care services and supports in the most cost-effective manner
- Access multiple public and private funding streams, without supplanting existing funding for programs and services

Section 14521 describes the intent of the Legislature to authorize adult day health care (ADHC) as a Medi-Cal benefit to establish and continue a community-based system of quality day health services which will ensure that elderly persons not be institutionalized prematurely and inappropriately, and which will provide appropriate health and social services designed to maintain elderly persons in their own homes.

The statute establishing the Program for All Inclusive Care for the Elderly (PACE) states that community-based services are often uncoordinated, fragmented, inappropriate or insufficient to meet the needs of frail elderly who are at risk of institutionalization, often resulting in unnecessary placement in nursing facilities.

The law authorizing the LTC integration pilot program also recognized the fragmentation and lack of coordination among services. It described the system as, “an uncoordinated array of categorical programs offering medical, social, and other support services that are funded and administered by a variety of federal, state, and local agencies and are replete with gaps, duplication, and little or no emphasis on the specific concerns of individual consumers.” The Legislature said, “Numerous obstacles prevent its development, including inflexible and inconsistent funding sources, economic incentives that encourage the placement of consumers in the highest levels of care, lack of coordination between aging, health, and social service agencies at both state and local levels, and inflexible state and federal regulations,” and that there is a “growing interest in community-directed systems of funding and organizing the broad array of health, support, and community living services needed by persons of all ages with disabilities.”

The Act further states: “It is in the interest of those in need of long-term care services, and the state as a whole, to develop a long-term care system that provides dignity and maximum independence for the consumer, creates home and community-based alternatives to unnecessary out-of-home placement, and is cost-effective.”

Developing public policy involves multiple decision makers and stakeholders, and it includes executive branch agencies, the Legislature, providers, consumers, families and advocacy

organizations. Reaching consensus requires balancing the perspectives and interests of each group of stakeholders. Developing a philosophy establishes a baseline to discuss policy options and strategies. Once stakeholders agree, new proposals can be evaluated based on whether they are consistent with the purpose and philosophy of the system.

The statutes that created each program recognize the fragmentation and lack of coordination among programs, but they do not create an overarching framework to address it. The statutes imply that each program will develop mechanisms to do so, but do not enable the programs to coordinate. Examples of statutes in Oregon and Washington are described below.

Oregon and Washington describe their philosophies for LTC programs that guide policy, budget and program decisions. Oregon's statute states:

> The Legislative Assembly finds and declares that, in keeping with the traditional concept of the inherent dignity of the individual in our democratic society, the older citizens of this state are entitled to enjoy their later years in health, honor, dignity, and disabled citizens are entitled to live lives of maximum freedom and independence. (ORS§410.010)

The statute directs that policies coordinate the effective and efficient provision of community services to older citizens and disabled citizens so that services will be readily available to the greatest number over the widest geographic area, and that information on these services is available in each locality and assures that older citizens and disabled citizens retain the right of free choice in planning and managing their lives, by increasing the number of options in life styles available by strengthening the natural support systems of family, friends and neighbors to further self-care and independent living (ORS§410.020).

State law in Washington (Revised Code of Washington (RCW) §74.39.005) describes its vision of a comprehensive long-term care system and directs the Aging and Disability Services Administration to:

- Establish a balanced range of health, social and supportive services that deliver long-term care services to chronically, functionally disabled persons of all ages

- Ensure that functional ability shall be the determining factor in defining long-term care service needs and that these needs will be determined by a uniform system for comprehensively assessing functional disability

- Ensure that services are provided in the most independent living situations consistent with individual needs

- Ensure that long-term care service options shall be developed and made available that enable functionally disabled persons to continue to live in their homes or other

community residential facilities while in the care of their families or other volunteer support persons

- Ensure that long-term care services are coordinated in a way that minimizes administrative cost, eliminates unnecessarily complex organization, minimizes program and service duplication, and maximizes the use of financial resources in directly meeting the needs of persons with functional limitations

- Encourage the development of a statewide long-term care case management system that effectively coordinates the plan of care and services provided to eligible clients

- Ensure that individuals and organizations affected by or interested in long-term care programs have an opportunity to participate in identification of needs and priorities, policy development, planning and development, implementation and monitoring of state supported long-term care programs

- Support educational institutions in Washington state to assist in the procurement of federal support for expanded research and training in long-term care

- Facilitate the development of a coordinated system of long-term care education that is clearly articulated between all levels of higher education and reflective of both in-home care needs and institutional care needs of functionally disabled persons

Washington Section 74.39A.005 states: "The Legislature further finds that the public interest would best be served by a broad array of long-term care services that support persons who need such services at home or in the community whenever practicable and that promote individual autonomy, dignity, and choice."

Each state considers program options and budget decisions in the context of its own state. Legislators in Oregon and Washington consider funding and policy changes in light of the philosophy contained in statutes. Revenue shortfalls pose challenges for states as they make policy and program decisions about spending for institutional and HCBS services.[210] Many states are able to respond to budget constraints by moving resources from institutional to community services. Washington was able to avoid reductions in its community-based programs because of its commitment to reduce the nursing facility caseload and expand HCBS Waiver spending. However, in the FY 2010 proposed budget, the Governor proposed elimination of ADHC services, which are covered as a state plan service. The larger HCBS Waiver and state plan personal care programs were not reduced. California needs to establish a comparable philosophy that spans multiple programs.

[210] For an Oregon example of this see Auerbach, R. (May, 2008), *Fiscal Challenges to a Strong Home and Community-Based Long-Term Care System: Oregon's Fight to Maintain Leadership*, Center for State Health Policy, Rutgers University, New Brunswick, NJ. Retrieved on 4-29-09: http://www.cshp.rutgers.edu/cle/Products/Impact%20of%20Budget%20Reductions%20on%20Oregon%20HCBS%20Programs%20May%202008.pdf.

2. Develop a Strategic Plan

California should develop a strategic plan that considers previous multiple reports and their recommendations, and describes which populations, services and programs will be addressed by the plan, as well as the mission, values and goals for its long-term services and supports system. The goals should include measurable targets to improve the balance between HCBS and institutional services for all populations. Possible measures could include the percentage of funds spent for institutional and HCBS services, the number of beneficiaries served in institutions and HCBS programs, and the number of participant days of institutional and HCBS services.

The Department of Health Care Services (DHCS) developed a strategic plan for the department in 2008.[211] The plan includes LTC components and addresses important priorities. A similar LTC plan with a cross-agency perspective should be developed and span multiple departments. A LTC strategic plan would include short, medium and long-term goals that include objectives, tasks that will be undertaken to achieve the objectives and the agency and staff that will be responsible for implementing them.

The plan should consider information in the Olmstead Plan released by the California Health and Human Services Agency (CHHS) in 2003 as well as other work products developed by the Olmstead Advisory Committee in subsequent years. The plan should be implemented in a way that improves service delivery and cost-effectiveness of LTC services and supports. Executive Order S-10-08 issued September 24, 2008 by the Governor described the state's vision for long-term services and supports:

> The state affirms its commitment to provide services to people with disabilities in the most integrated setting, and to adopt and adhere to policies and practices that make it possible for persons with disabilities to remain in their communities and avoid unnecessary institutionalization.[212]

The strategic plan should follow the vision and values reflected in the principles of the Olmstead Report:

- Self-determination by persons with disabilities about their own lives, including where they will live, must be the core value of all activities flowing from the Olmstead Plan.
- Promote and honor consumer choice and ensure that consumers have the information on community programs and services, in a culturally competent and understandable form, to assist them in making their choices.
- To support the integration of persons with disabilities into all aspects of community life, persons with disabilities who may live in community-based non-institutional settings must be given the opportunity to fully participate in the community's services and activities through their own choices.

[211] Available at: http://www.dhcs.ca.gov/Pages/DHCSStrategicPlanandImplementationPlan.aspx.
[212] Available at: http://gov.ca.gov/executive-order/10606/.

- Consistent with informed choice of consumers, community-based services that are culturally competent and accessible should be directed, to the maximum extent possible, to allow persons with disabilities of all ages and with all types of disabilities to live in the community in non-institutional settings.

The plan would also operationalize the mission and vision established by the Choices Stakeholder Advisory Committee in January 2007:

Mission: We are a statewide partnership committed to developing an infrastructure that will increase access to, capacity of and funding for home and community-based services to provide all Californians with greater choice in how and where they receive long-term care services, in accordance with the Olmstead Principles.

Vision: California will have strategies and recommendations for its long-term care system, featuring replicable and sustainable models that empower individuals through enhanced opportunities for choice and independence.

Balanced Long-Term Care Systems

What is a "balanced" long-term care system? What is the right balance? Ideally, the right balance reflects consumer preferences. That is, the system permits consumers to choose the service(s) that best meets their needs. Consumer preferences, health and welfare assurances required by the Centers for Medicare & Medicaid Services (CMS) in HCBS Waiver programs and cost-effectiveness all affect the services that a person receives. The assurances and cost-effectiveness may conflict with the consumer's preference if, for example, skilled services are needed throughout the day.

Balance is also relative and depends on what is being measured. Policymakers and stakeholders first need to define what a balanced system means in California, and set measurable goals for achieving balance and design strategies that will move the state forward. Increasing the capacity of HCBS Waivers would be necessary to improve the state's per capita ranking and benchmarks for improving the balance between institutional and community care.

Figure 25 displays the percentage of funds that would be spent on HCBS for persons with developmental disabilities using three growth rates, 2%, 4% and 6%. The percentage spent on HCBS in 2014 would reach 76% if the balance grew 2% per year, 92% at 4% per year and 100% at 6% per year. Including targeted case management would increase the base to 66% and accelerate the increase.

Figure 25: Projected Spending on HCBS for Persons with Developmental Disabilities Using Three Growth Rates: 2007–2014

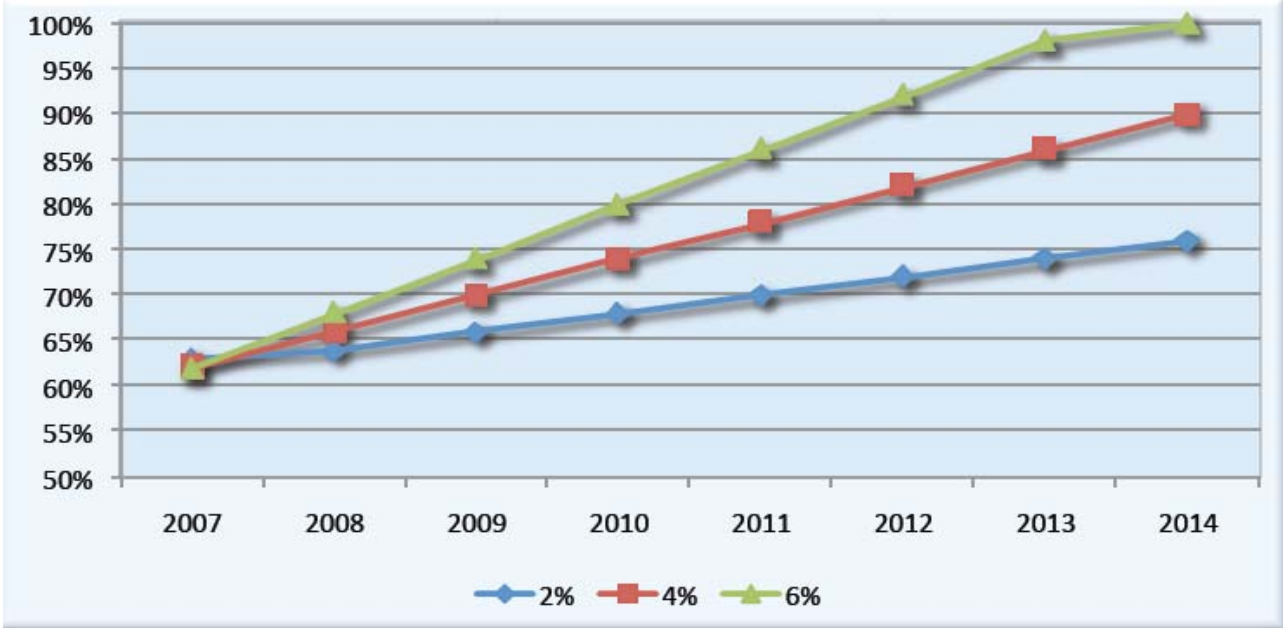
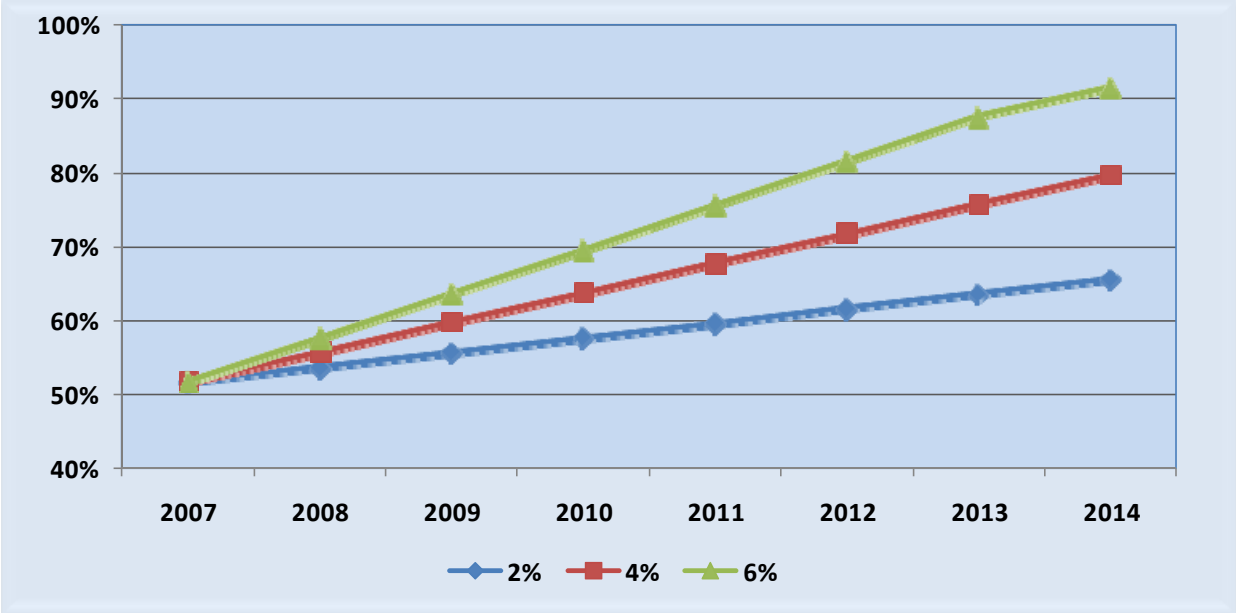


Figure 26 displays the percentage of funds that would be spent on HCBS for aged and disabled persons using three growth rates, 2%, 4% and 6%. The percentage spent on HCBS in 2014 would reach 66% if the balance grew 2% per year, 80% at 4% per year and 92% at 6% per year.

Figure 26: Projected Spending on HCBS for the Aged and Persons with Physical Disabilities Using Three Growth Rates: 2007–2014



The preferred option for increasing spending is to shift resources from institutional to community programs by establishing a statewide nursing facility transition program, building an infrastructure to divert people from institutional settings through options counseling and improved hospital discharge planning and setting a timetable for closing additional developmental centers.

The strategic plan should include key components described below. Single Entry Points (SEPs) such as the ADRCs is the central building block to divert unnecessary admissions to institutions through preadmission screening/options counseling, assist individuals who prefer to move from an institution to the community, and provide a central source of information about community LTC resources for hospital discharge planners, nursing facility social workers, other providers and community organizations, consumers and family members.

The recommendations below support five primary goals:

- Define goals for balancing the long-term care system
- Expand HCBS programs over time as the economy recovers and state revenues increase
- Reduce the rate of growth in spending on institutional care
- Invest savings from a lower rate of institutional growth in HCBS for individuals who are at risk of entering an institution
- Improve the management of HCBS programs.

Short-Term Recommendations

Short-term recommendations can be expected to be implemented within one year.

3. Add a Special Income Level Eligibility Group

California should add the 300% of SSI special income eligibility option to facilitate access to HCBS services. Federal Medicaid regulations allow states to provide home and community-based waiver services to individuals with incomes below 300% of the Federal SSI payment standard, which is $2,022 per month in 2009.[213] The 300% option enables individuals in the community who would otherwise have to incur expenses equal to the share of cost under the Medically Needy option to become Medi-Cal eligible. Meeting the spend-down creates a barrier

[213] Effective January 2009, the SSI payment for an eligible individual is $674 per month and $1,011 per month for an eligible couple. For January 2008, the SSI payment for an eligible individual was $637 per month and $956 per month for an eligible couple.

for persons who readily meet the share of cost in a nursing facility, but cannot afford the share of cost in the community and retain enough income to meet their expenses.

The rules require that the state cover applicants in an institution with incomes under 300% of SSI. Adopting this option does not expand eligibility in a nursing facility since these individuals would readily meet the Medically Needy Medi-Cal share of cost.

Section 1915(c) Waivers use the post-eligibility treatment of income rules. These rules require that states set a maintenance allowance, using "reasonable standards," that allows applicants to retain income that is needed to pay for everyday living expenses (e.g., rent, food and other living expenses). The state may vary the allowance based on the beneficiary's circumstances. States typically set a single maintenance allowance for all waiver participants. However, the rules allow states to set different maintenance allowances for each individual or for groups of individuals, if they believe that different amounts are justified by the needs of the individuals or groups. For example, states can set a lower allowance for beneficiaries whose rent is subsidized. A lower maintenance amount for individuals with rent subsidies means more income is available to share the cost of services.

Implications

Adopting the Special Income Level eligibility option makes it possible for beneficiaries who readily meet the share of cost in an institution but have more difficulty meeting it in the community to be eligible for HCBS Waiver programs. The Special Income Level does not expand eligibility for individuals in institutions. Once a person is determined to have income below 300% of SSI, the state sets a maintenance allowance, an amount the beneficiary retains to cover living expenses. The maintenance allowance increases Medi-Cal Waiver services costs because the beneficiary's share of cost is reduced. The increased state costs are offset by the difference between the Medi-Cal nursing facility costs and the HCBS Waiver costs for individuals who remain in the community.

4. Increase the Home Maintenance Income Exemption

California should increase the home maintenance exemption. Maintaining or establishing a home in the community is a major obstacle (page 176) for Medicaid beneficiaries who want to return home after admission to an institution. Medicaid eligibility rules give states the flexibility to support this goal and allow states to exempt income to maintain a home. The exemption may be allowed for up to 180 days after admission to a nursing facility when a physician certifies that the person is likely to return home within 180 days (42 CFR 435.700 (d) and 435.832 (d)). The exemption can also be granted for up to 180 days to allow beneficiaries living in a nursing facility to re-establish a residence.

Medically Needy Medi-Cal beneficiaries who enter a nursing facility apply all their income above a personal needs allowance to the cost of care. California's regulations (22 CCR 50605 (b), (c)) allow beneficiaries to retain 133 1/3% of the in-kind value of housing for

Washington, Vermont, Pennsylvania and Texas are examples of states with higher home maintenance allowances.

one person if the applicant or beneficiary has been living alone in the home. The method that California uses translates to $209 per month, which is not enough to pay rent and utilities or to maintain a home owned by the beneficiary. There are three options for changing the home maintenance exemption:

- Allow actual maintenance costs up to 100% of the federal poverty level

  Washington allows applicants to keep monthly income up to 100% of the federal poverty level to maintain a residence for things such as rent, mortgage, property taxes/insurance and basic utilities. The cost of recreational items such as cable or internet is not included.

- Establish the exemption in relation to the Supplemental Security Income/State Supplement Program (SSI/SSP) payment standard.

  Vermont allows beneficiaries to deduct three quarters of the SSI/SSP payment level for a single individual living in the community. The payment standard is $689.04 per month and the exemption in 2008 is $516.78 per month. The department deducts expenses from the monthly income of an individual receiving LTC services in a nursing facility or receiving enhanced residential care services to help maintain their owned or rented home in the community.

- Allow actual maintenance cost up to the SSI payment standard

  Texas and Pennsylvania set the maximum allowance at the SSI payment standard. Texas allows applicants to deduct mortgage or rent payments and average utility charges, excluding telephone charges.

The maintenance exemption should also be available to beneficiaries living in an institution who need to establish a home and do not have the funds for deposits or other expenses needed to establish a home.

Implications

The current home maintenance allowance is $209 per month and has not been adjusted for nearly two decades. Setting the allowance at a reasonable amount will allow individuals to maintain their home during a nursing facility stay that is expected to last no more than six months. Closer coordination is necessary between the Medi-Cal financial eligibility process, the nursing facility Treatment Authorization Requests (TAR) process and waiver enrollment process to identify beneficiaries who require HCBS to make a choice about returning home and to ensure that appropriate services are arranged within the six-month period of the exemption. Coordination will be needed to identify individuals whose length of stay in an institution can be limited to no more than six months if appropriate in-home services can be arranged. Increasing the exemption would potentially increase the state's share of institutional costs for beneficiaries who do not return home.

5. Maintain the Supplemental Security Income/State Supplement Program (SSI/SSP) Medi-Cal Eligibility Status

This recommendation will allow beneficiaries to retain their full SSI/SSP during the first 90 days of an institutional stay for beneficiaries who are able to return home.

Medi-Cal SSI/SSP beneficiaries who enter a nursing facility for a stay that is expected to last for 90 days or less may retain their full benefits to maintain their home when a physician certifies that the stay will be 90 days or less, and the beneficiary demonstrates that they need to pay some or all of the expenses of maintaining a home.

Income eligibility workers may not be aware of this option or may have difficulty determining whether the beneficiary's stay will be 90 days or less or may not be available to help develop and implement a discharge plan. The DHCS field office makes a determination of the expected length of stay when they approve the TAR based on information contained in the Minimum Data Set (MDS) submitted by the nursing facility. A more active transition assistance or relocation care management function using the community preference tool could identify individuals who want to return to their homes, but need assistance to do so. The MFP Rebalancing Demonstration could develop this capacity. Although the demonstration can only enroll participants who have lived in a nursing facility for six months or longer, the transition coordinators could serve individuals who are not officially enrolled in the demonstration.
Counseling about the SSI/SSP benefit should be part of the options counseling offered.

Implications

This initiative is one component of a statewide nursing facility transition program described below. As a stand-alone policy, it depends upon coordination between the Medi-Cal long-term care financial eligibility process and the TAR process. Beneficiaries admitted to a nursing facility depend upon their own initiatives and support from family and friends, if they are available, to develop a transition plan, unless it is part of a larger transition initiative.

DHCS would have to develop a process to determine who can benefit from this option and offer the resources needed to work with beneficiaries to develop a transition plan.

6. Adopt a Case-Mix Reimbursement System for Nursing Facilities

California does not use a case-mix system to reimburse the staffing component of nursing facility costs. The concept of case-mix reimbursement is discussed in Section 7 of the report (page 130). A case-mix reimbursement system would create incentives to serve high-acuity residents and facilitate community transition for lower-acuity residents.

Implications

The case-mix system would be "zero sum" and not result in additional payments to nursing facilities.

7. Establish a Nursing Facility Occupancy Provision

An occupancy provision reduces the payment to a nursing facility when its occupancy falls below a designated level and creates an incentive for facilities to reduce their licensed capacities, which ensures that beds will not be back-filled as residents relocate or new admissions are diverted through options counseling. The use of occupancy provisions is usually opposed by state nursing facility associations, because it is another way in which states do not pay the full cost of operating nursing facilities. Associations often seek to remove the occupancy provision entirely or reduce the threshold at which it is applied. State budget and fiscal offices usually support the use of occupancy provisions since it controls overhead costs and avoids "paying for empty beds." Advocates of HCBS care programs generally support occupancy provisions because of a belief that nursing facility transition efforts in states with an occupancy provision are more cost-effective, i.e. more "money follows the person."

Implications

The use of a minimum occupancy provision is discussed at length in Section 7 or the report (page 126).

8. Convert the Labor Driven Operating Allocation to an Incentive to Promote Discharge Planning or Increased Quality of Care

The "Labor Driven Operating Allocation" is an "add on" to the nursing facility rate. It is not a cost incurred by the nursing facilities; rather it is an additional amount that is added into the rates. Based on its method of calculation it appears to be an incentive for nursing facilities to hire permanent staff and not hire agency or contracted staff. The amount added to the per diem is based on 8% of the sum of the inflated direct and indirect costs where the staff costs do not include temporary staff. This per diem is then capped and cannot exceed more than 5% of the sum of the other per diems. Given the magnitude of the per diem and the fact that the offset does not reimburse an actual cost, it seems reasonable to suggest that the state rethink this incentive and exercise policy-related control over it.

Implications

The use of a labor-driven operating allocation is discussed at length in Section 7 of the report (page 129).

9. Review Department of Developmental Services (DDS) Regional Centers Rates for Nonresidential Services

Should budget conditions improve and the rate freeze be lifted, before restoring previous rate methodologies, DDS should review the use of negotiated rates (page 138) and the degree to which negotiations are used in the cost-based approaches to avoid concerns about compliance with CMS policy.

10. Conduct a Study of Need for Waiver Expansion

California does not have an empirical basis for determining the extent to which existing waivers should be expanded and new ones should be created. State planning would benefit by estimating the number of persons who need waiver services, and the cost and savings context of serving them. The state's federal reporting shows evidence of cost savings from the operation of the waivers. However, these reports may not satisfy budget staff seeking confirmation that waivers reduce long-term care spending or reduce the rate of growth in spending. Studies of the cost effectiveness of current waivers and the need for waiver expansion are useful planning activities for the state to undertake.

As part of these studies, we suggest that Medi-Cal review the TARs of a sample of nursing facility residents to determine how many might have been diverted to a Residential Care Facility for the Elderly (RCFE). The sample should include recent admissions and reassessments of longer-stay residents to exclude short-term admissions. A similar review should be conducted of MSSP and nursing facility/acute hospital (NF/AH) Waiver participants who moved to a nursing facility to determine how many might have moved to an RCFE if coverage were available.

The state has developed contracting procedures that permit it to hire a firm to provide multi-year consulting advice about rate setting issues. On January 20, 2009, the state issued a request for bids, Proposal (RFP) Number 08-85158, entitled, "Rate Reimbursement Support Services Project." Such a study could be done under this open-ended contract. In other words, there is an existing contract and vendor that could perform such a study, when the state is ready to lay the groundwork for expanding its waivers.

Medium-Range Recommendations

Medium-range recommendations are presumed to require one to two years to implement.

11. Establish a Statewide Institutional Transition Program

The absence of a strong central transition program is a barrier to the effective rebalancing of state programs. This recommendation would establish a nursing facility relocation assistance or transition program that provides options counseling about community alternatives for individuals in nursing facilities and the larger Intermediate Care Facilities for the Mentally Retarded (ICFs/MR).

Ideally, the transition program would be part of the single entry point entities and reflect the experience from the California Community Transitions program. Until single entry point entities are established, the current MFP program, which plans to transition 2,000 persons, should continue and expand statewide so that regional teams are established throughout the state. The focus of the demonstration is to improve coordination among multiple provider organizations, to serve as a building block for single entry points by forming collaborative relationships among existing organizations and to facilitate access to multiple waivers and services.

Without a strong statewide program, California misses an opportunity to support cost-effective transition programs. California could also:

1. provide additional funds to the Department of Rehabilitation to fund staff at Independent Living Centers (ILCs) for enhanced transition support activities
2. provide additional funds to the Department of Aging to fund staff and training for MSSP sites to support transition coordination and to strengthen the role of Area Agencies on Aging and nursing home ombudsman and
3. continue to encourage the Department of Developmental Services to transition persons from the larger private ICFs/MR.

In addition a strong state program could support local efforts such as the one implemented in San Francisco. Statewide transition programs in Washington and New Jersey (page 174) describe how this recommendation might be implemented.

Washington assigns case managers to all nursing facilities to support relocation for consumers who want to move to the community.

Implications

Transition activities do not require changes in state laws or administrative regulations. Nor do they require cuts in provider reimbursement or reductions in services. In a time of budget cutbacks, these are cost effective actions the state can take to lower its institutional costs.

Ideally, transition programs would operate as part of a single entry point system that facilitates access to all LTC services. The California Community Transition (CCT) program is an essential first step since it already operates in parts of the state. The collaboration among organizations that participate in the transition will improve access to community services and could prepare the way for single entry point organizations to emerge, depending on the approach the state may take to create single entry points. The formation of transition teams and lead agencies to create opportunities for residents of institutions to relocate to the community is dependent on funding to support the activities.

Creating a statewide transition program is complicated by the structure of the programs that provide HCBS. In addition to MFP, the NF/AH and MSSP Waivers also contain some transition activities. Regional centers are responsible for assisting individuals with developmental disabilities to relocate to community settings. While the nursing facility transition initiatives are relatively small in scale, CHHS has an opportunity to create a cost-effective plan with one infrastructure to manage all nursing facility transition activities.

12. Reinvest Savings from Institutional Care in HCBS

Reducing use of institutional settings and expanding community alternatives are interdependent. Funds previously spent on institutional care must be invested in HCBS, and expanding HCBS requires savings from what would have been spent on institutional care. This is a "positive feedback loop." There are three ways to use savings:

- Savings from beneficiaries who transition from institutions to community settings can be transferred to HCBS program accounts.
- A reserve fund can be created for savings that may be used for investments in a subsequent fiscal year.
- The nursing facility appropriation can be used to pay for services in the community for individuals who relocate from an institution when waiver programs have reached their maximum capacity and wait lists are established.

Examples of these strategies from Wisconsin, Michigan and Vermont are described below.[214] In the 1990s, Wisconsin created a budget strategy to shift funds from the nursing facility appropriations to HCBS. At the end of the fiscal year, the difference between the budgeted Medicaid bed days and actual Medicaid bed days was multiplied by the average Medicaid payment. The savings were available to be shifted to the HCBS Waiver program in the following year. In other words, savings from decreased nursing facility use were identified and transferred to programs that made the savings possible.

Michigan also allows surplus funds appropriated for nursing facility care to be used for HCBS. The appropriations bill states:

> If there is a net decrease in the number of Medicaid nursing home days of care during the most recent quarter in comparison with the previous quarter and the net cost savings attributable to moving individuals from a nursing home to the home and community-based services waiver program, the department shall transfer the net cost savings to the home- and community-based services waiver. [215]

In its report to the Legislature, the Michigan Department of Community Health stated:

> The MI choice waiver program transitioned three hundred thirty-seven individuals into the MI Choice Waiver program during

[214] For a discussion of Oregon, Texas, Washington, Wisconsin and Vermont see also Hendrickson L. & Reinhardt S. (2004) *Global Budgeting: Promoting Flexible Funding to Support Long-Term Care Choices*, Rutgers Center for State Health Policy, New Brunswick, NJ. Retrieved on 9-27-09 from http://www.hcbs.org/files/52/2599/State_policy_in_practice.pdf

[215] Report available at: http://www.michigan.gov/documents/mdch/1689_2__11_01_06_190350_7.pdf

> Fiscal Year 2006. These transitions were reported in the MI Choice Waiting List Report. This represents a savings of approximately $4.43 million in FY 2006. The ability of Michigan senior citizens to age in the setting of their choice offers a measure of dignity and respect that goes far beyond the fiscal savings. These cost savings are reflected in the increased service costs associated with our current nursing facility transition procedures.

In the mid-1990s the Vermont Legislature passed Act 160, which directed the Department on Aging and Disabilities to reduce nursing facility spending in FY 1997-2000. The reductions required a drop in the Medicaid census of 46 beds in FY 1997, 68 beds in FY 1998, 59 beds in FY 1999 and 61 beds in FY 2000. The Act gave the Secretary of Human Services the authority to reduce the supply of nursing facilities:

> …if it develops a plan to assure that the supply and distribution of beds do not diminish or reduce the quality of services available to nursing home residents; force any nursing home resident to involuntarily accept home and community-based services in lieu of nursing home services; or cause any nursing home resident to be involuntarily transferred or discharged as the result of a change in the resident's method of payment for nursing home services or exhaustion of the resident's personal financial resources.

Act 160 also allowed the Secretary to place any unspent funds at the end of each fiscal year into a trust fund for use in subsequent years for HCBS or for mechanisms that reduce the number of nursing facility beds. Funds were used for services provided through the HCBS Waiver, the Traumatic Brain Injury (TBI) Waiver, residential care homes waiver, attendant services program, homemaker services program, Older Americans Act services, adult day care and the Vermont Independence Fund. Pilot projects to recruit and train volunteer respite care providers to provide support to family caregivers of individuals who have Alzheimer's disease or related disorders and live in rural areas of the state were also authorized.[216]

Implications

The number of Medi-Cal beneficiaries in nursing facilities declined steadily since 2001. The decline can be attributed to availability of In-Home Supportive Services (IHSS) and HCBS Waiver programs. The trend is likely to continue if community services are able to expand. The source of funds to support the expansion is most likely to come from savings in the nursing facility appropriation. Three factors may affect whether there are savings and how they are used. First, the budgeting process and the extent to which savings are assumed prior to being achieved affect the availability of savings. In this case, funds that would have been appropriated for

[216] Mollica, R., Kane R., and Priester, R. (December, 2005), *Rebalancing Long-Term Care Systems in Vermont*. Available at: http://www.hpm.umn.edu/ltcresourcecenter/research/rebalancing/attachments/baseline_case_studies/Vermont_long_baseline_case_study.pdf.

nursing facility care would instead be appropriated for HCBS programs. Savings beyond what is presumed might be used as described above.

Second, before funds are invested in other programs, policy makers will want assurance that the savings are not due to unusual circumstances that may change within the fiscal year because an increase in utilization could create a deficit in the appropriation.

Third, policy makers may prefer to use the savings to offset deficits in other programs. In Wisconsin, the Legislature allowed half the savings to be invested in community programs the first year, and by the second or third year all savings were used to offset the overall budget deficit and the mechanism was not used again. Creating a dedicated trust fund, like Vermont, would assure that savings from lower nursing facility utilization are set aside to support the programs that make the savings possible.

13. Promote Diversion through Preadmission Screening/Options Counseling about Community Alternatives through Single Entry Points and Aging and Disability Resource Connections (ADRCs) and by Working with Hospitals

Preadmission screening/options counseling should be available to all consumers when they apply for or enter an institution or leave a hospital with health and supportive service needs. Staff providing options counseling could use the Preference Assessment Tool developed by the 2003 MFP grant. With nursing facilities, the program could be phased in as follows:

- Make options counseling available to all individuals approved for Level A care.
- Add individuals with short-term TAR approvals.
- Add selected Level B nursing facility approval (e.g., individuals with supportive family members or friends).

The new version of the MDS, version 3.0, has a different Section Q than version 2.0, and its answers might be of help in identifying persons to work with.[217] Under version 2.0, no follow up referrals or activities were required when a nursing facility resident indicated a preference for returning to the community. The revised version asks residents who indicate that they want to return to the community whether they want to speak to someone about it. Nursing facility staff then check a place on the form indicating whether a referral has been made to a local agency.

[217] For a discussion of Section Q in version 2.0 of the Minimum Data Set see Reinhard, S. & Hendrickson L. (June, 2007), *The Minimum Data Set: Recommendations to Help States Better Support Nursing Home Residents Who Seek Community Living.* Center for State Health Policy, Rutgers University, New Brunswick, NJ. Retrieved on 3-8-09: http://www.cshp.rutgers.edu/cle/Products/2007The%20Minimum%20Data%20Set%20-%20Recommendations%20to%20Help%20States.pdf.

Options counseling or benefits counseling, which includes but is broader than preadmission screening, is a strategy to inform individuals and family members who apply for admission to an institution about the community services that are available to help them remain at home. Options counseling is often mandatory for Medicaid beneficiaries seeking admission to a nursing facility. It may be advisory for individuals who are not eligible for Medicaid but are likely to spend down within six months of admission. In some situations, the case manager informs the individuals who are not Medicaid beneficiaries about community alternatives. If the person does not meet the Medicaid level of care criteria, they are informed that Medicaid will not be able to pay for their care if they choose to enter a nursing facility and later apply for Medicaid. Options counseling allows individuals to make an informed decision about entering or remaining in an institution.

For example, legislation adopted in Arkansas in 2007 created an options counseling program within the Department of Health and Human Services (DHHS). The program offers individuals information about long-term care options and costs, an assessment of functional capabilities and a professional review, assessment and determination of appropriate LTC options. It also includes information about sources of payment for the options, factors to consider in choosing available programs, services and benefits and opportunities for maximizing independence. Participants receive a written summary of the options and resources that are available to meet their needs.

The Arkansas program, which began in January 2008, is available to all individuals admitted to a nursing facility regardless of payment source, individuals admitted to a nursing facility who apply for Medicaid and any individual who requests a consultation. The counseling may be offered prior to or after someone is admitted to a nursing facility. Nursing facilities are required to notify the department of all admissions within three days.

Indiana provides counseling for all Medicaid beneficiaries applying for waiver services or admission to a nursing facility. Counseling is required for all consumers seeking admission to a nursing facility.

Since 1993, Maine has required preadmission screening for all applicants for admission to a nursing facility, including private-pay applicants, and for HCBS. Maine's rules provide:

> If the assessment finds the level of nursing facility care clinically appropriate, the department shall determine whether the applicant also could live appropriately and cost-effectively at home or in some other community-based setting if home-based or community-based services were available to the applicant. If the department determines that a home or other community-based setting is clinically appropriate and cost-effective, the department shall:
>
> - Advise the applicant that a home or other community-based setting is appropriate
>
> - Provide a proposed care plan and inform the applicant regarding the degree to which the services in the care plan are available at home or in some other

community-based setting and explain the relative cost to the applicant of choosing community-based care rather than nursing facility care

- Offer a care plan and case management services to the applicant on a sliding scale basis if the applicant chooses a home-based or community-based alternative to nursing facility care

Minnesota provides Long-Term Care Consultation (LTCC) to assist consumers in choosing the services that best meet their needs.[218] LTCC evolved from a prior pre-admission screening program. State law requires screening prior to admission to a Medicaid-certified nursing facility or boarding home. All individuals may request a consultation. Minnesota ADRCs developed a web-based decision tool that allows the consumer to enter information and receive information about the options that might be available in their community.

Ohio added long-term care consultation for non-Medicaid beneficiaries in 2005. Preadmission screening for Medicaid nursing facility applicants was implemented in 2000. The statute defines long-term care consultation as a "process used to provide services under the long-term care consultation program established pursuant to this section, including, but not limited to, such services as the provision of information about long-term care options and costs, the assessment of an individual's functional capabilities and the conduct of all or part of the reviews, assessments and determinations specified" in the Medicaid statute.[219]
Information is provided on the availability of all long-term care options that are available to the individual, the sources of financing for long-term care services, factors to consider when choosing among the available programs, services and benefits and opportunities and methods for maximizing independence and self-reliance, including support services provided by the individual's family, friends and community. Consultations are required for all nursing facility applicants and current residents who apply for Medicaid. Nursing facilities that contract with Medicaid are not allowed to admit or retain any individual as a resident unless the nursing facility has received evidence that a long-term care consultation has been completed or the applicant does not meet the criteria to receive a consultation.

Oregon screens all Medicaid beneficiaries seeking nursing facility care and private-pay applicants who are likely to convert to Medicaid within three months of admission to a nursing facility or HCBS services, as well as private-pay consumers who will become Medicaid eligible within 90 days of admission. Washington and New Jersey screen private-pay applicants who are likely to spend down within 180 days of admission.

Pennsylvania has had an extensive options counseling program since 2006**.** The counseling initially used answers to questions on the Minimum Data Set (MDS) to select who might best desire such counseling.

In addition to preadmission screening/options counseling, diversion programs also include work with hospitals and hospital discharge planners. Stimulated by funding from the CMS and the

[218] Auerbach, R., and Reinhard, S. *Minnesota Long Term Care Consultation Services*. Available at: http://www.hcbs.org/openFile.php/fid/3965/did/1426.
[219] Ohio Revised Code Section 173.42.

Administration on Aging (AoA), states have developed diversion efforts that seek to work with hospitals and their discharge planners.[220] For example, AoA launched its Nursing Home Diversion initiative in the fall of 2007. In its initial year, AoA issued awards to 12 states for a combined federal and nonfederal funded grant program of $8.8 million. In 2008, AoA issued awards to 14 states that totaled a combined federal and nonfederal amount of approximately $16.2 million.

There are two major difficulties with diversion programs—the pressure on hospitals to discharge persons quickly and sorting out the persons who might remain in a nursing facility from the large number of persons who enter the nursing facility for a short-term rehabilitation stay. However, the ADRC Technical Assistance Exchange has developed a process for states wishing to explore a hospital diversion program and the steps outlined below are a pragmatic approach for getting started.[221]

- Investigate whether the hospital discharge process presents opportunities in your state
- Decide which diversion models to pursue
- Decide what you want to do then choose your personnel
- Do some homework
- Establish relationships with hospital administrators and discharge planning staff
- Learn the local hospital culture
- Develop protocols to complement best practices and counter the negative ones

There is a wealth of information available about the hospital-related diversion efforts of other states and California would benefit by learning from them.

Implications

Options counseling is an important strategy for diverting admissions to nursing facilities and beginning the process of transitioning residents who are admitted for post-acute services in a nursing facility. These services are most effective and seamless when the care manager that provides options counseling also manages/authorizes community services or is employed by the organization that manages other programs. This service is an important component of single entry point organizations. However, in the absence of a single entry point system, options counseling can be performed by ADRCs that collaborate with the organizations responsible for operating HCBS programs.

Hospital-based diversion programs complement and strengthen transition and counseling efforts by educating hospital discharge planners and the persons who might stay in nursing facilities unnecessarily. These are not easy programs to develop, but they contribute to controlling institutional costs.

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[220] The ADRC Technical Assistance Exchange website contains 21 articles about diversion and is an excellent source of information.

[221] Englehardt, T. (February 25, 2008), *Hospital-based Nursing Facility Diversion Initiatives: Considerations for ADRCs*, Aging and Disability Resource Centers Technical Assistance Exchange. Retrieved on 4-28-09: http://www.adrc-tae.org/tiki-searchresults.php?words=hospital-based+diversion&where=pages&x=7&y=11.

14. Expand Coverage of Residential Options Statewide to Offer More Service Alternatives for Older Adults

California currently offers limited coverage of services in Residential Care Facilities for the Elderly (RCFEs) through the Assisted Living Waiver (ALW) Program. Offering services in residential settings as part of the Medi-Cal program gives older adults additional options to in-home services or nursing facility care. Residential settings are particularly useful for consumers who do not have a caregiver at night and on weekends, need 24-hour supervision, do not have a home or apartment or access to assistance that cannot be scheduled.

Two options are recommended—allow In-Home Supportive Services (IHSS) to be provided in a RCFE and add assisted living services in RCFEs to the MSSP and NF/AH Waivers.

Implications

This recommendation will expand services and offer beneficiaries residential options in addition to the current option of nursing facilities and in-home care. It will provide lower-cost options for nursing facility residents who want to transition to a residential setting and divert others who would seek admission because their needs cannot be met in their own homes or apartments. Residential settings are an important option for nursing facility transition programs. Texas began its MFP transition program in 2001. By 2003, 32% of the 2,000 persons who transitioned moved to an assisted living residence. More recently the percentage of persons relocating to assisted living is around 20%.

RCFEs are currently covered under the ALW program and for some months in 2008 eligibility was only available to beneficiaries who moved from a nursing facility. One goal in the ALW is that one-third of new participants will relocate from nursing facilities. A residential option is often appropriate for persons who desire to transition from a nursing facility. Adding RCFEs to other waivers allows more persons to be served and avoids disenrolling participants from one waiver and enrolling them in another. It also avoids gaps if there is a waiting list for the ALW program.

Stakeholders were concerned that Assisted Living Facilities (ALFs) nationally and RCFEs in California have the appearance of and operate like institutions. Approximately a dozen states only allow ALFs that offer apartment units and meet other criteria to be licensed as an ALF. States without these requirements have a mix of facilities—some that appear institutional and others that are residential.

CMS may be developing regulations that address whether assisted living is a community or institutional setting.[222] Proposed 1915(i) regulations describe concerns that assisted living includes a range of settings and some might be considered institutional while others are

[222] CMS is concerned with promoting more "homelike" care. Its April 10, 2009 instructions to Nursing Home Survey and Certification staff are an example of this concern. See, retrieved on 4-29-09: http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter09_31.pdf.

clearly “community settings.” CMS intends to establish minimum standards and a process to consider whether a facility will be consider “community.”

The draft regulations state that:

> We interpret the distinction between "institutional services" and "home or community-based services" in terms of opportunities for independence and community integration as well as the size of a residence. Applicable factors include the residents’ ability to control access to private personal quarters, and the option to furnish and decorate that area; if the personal quarters are not a private room, then unscheduled access to private areas for telephone and visitors, and the option to choose with whom they share their personal living space; unscheduled access to food and food preparation facilities; assistance coordinating and arranging for the residents’ choice of community pursuits outside the residence; and the right to assume risk. Services provided in settings lacking these characteristics, with scheduled daily routines that reduce personal choice and initiative, or without personal living spaces, cannot be considered services provided in the home or community.

California could address the concern by contracting only with RCFEs that offer private occupancy or shared occupancy only by residents’ choice. Units would have a kitchen area equipped with a refrigerator, a cooking appliance and microwave, and storage space for utensils and supplies. These criteria are applied to providers in the ALW program.

We suggest that Medi-Cal review the TARs of a sample of nursing facility residents to determine how many might have been diverted to RCFEs. The sample should include recent admissions and reassessments of longer-stay residents to exclude short-term admissions. A similar review should be conducted of MSSP and NF/AH Waiver participants who moved to a nursing facility to determine how many might have moved to an RCFE if coverage were available.

15. Increase the Use of Provider Fees for HCBS Providers

Provider fees are discussed at length in the report in Section 9 (page 166) under the heading “Provider Fees as a Fiscal Incentive to Promote Home and Community-Based Care.” The state should benefit from the financial advantages that are permitted under federal regulations. Permissible health care-related fees are discussed in the Code of Federal Regulations at 42 CFR 433.68. This section requires that the fees be broad based, uniformly imposed throughout a jurisdiction and not violate the hold harmless provisions of the regulations. California has only recently used such financing options. For example, in 2002 it did not apply provider fees on either nursing facilities or intermediate care facilities for the mentally retarded (ICFs/MR). In

general, the state has not made a systematic effort to inventory all its health care programs and apply provider fees to them.

Some states have implemented such fees administratively and others have done so through legislation. However it is done, the first step in the analysis would be to inventory all programs for which such fees might be applied and prepare a fiscal estimate of the possible savings that might accrue to California. The next step is to identify what steps need to be taken for each program to construct such a fee.

The types of major steps that might be taken include:

- Working with provider groups to explain what a fee is and obtaining agreements as to how the fee proceeds should be used
- Identifying the specific methodology used for the fee
- Drafting legislation, administrative regulations and Medicaid state plan amendments
- Setting up the administrative apparatus to collect the fees and monitor payments

There is no one methodology to create a fee and the kind of fee may vary by provider group. In general, while the fee must meet federal specifications such as being uniformly imposed, the definition of uniform imposition in the Code of Federal Regulations exemplifies methodologies that may be used to create the fee. 42 CFR 433.68(d) states that a health care-related fee is considered to be imposed uniformly if any one of the following criteria is met:

- If the fee is a licensing fee or similar fee imposed on a class of health care services or providers, the fee is the same amount for every provider furnishing those items or services within the class.
- If the fee is a licensing fee or similar fee imposed on a class of health care services or providers, the amount of the fee is the same for each bed of each provider of those items or services in the class.
- If the fee is imposed on provider revenue or receipts with respect to a class of items or services, the fee rate is imposed at a uniform rate for all services in the class, or on all the gross revenue or net operating revenues relating to the provision of all items or services.

The major steps above outline a logical process to identify and implement provider fees. They have been commonly used in other states and California would benefit from their expanded use.

Implications

This recommendation would reduce the net state cost for long-term care services. Without assumptions as to which specific provider groups would be charged a fee and a fiscal impact analysis, it is not possible to estimate the amount of savings.

16. Explore Converting a Portion of State Supplement Program (SSP) Payments to Provide Services in Residential Settings

Note: The 2009/2010 budget agreement reduced the SSP payment to 1983 levels and this option is no longer possible. We have retained this recommendation for reference.

California might explore converting the portion of the SSP payment that exceeds the amount paid in 1983 to a Medi-Cal service in residential settings that serves SSI/SSP beneficiaries. The conversion would allow California to use state revenues as a match for federal Medicaid reimbursement. Federal law allows states that increased the SSI State Supplement Program payment since 1983 to reduce the supplement to 1983 levels. General revenues saved by lowering the payment could be used to expand Medi-Cal personal care services in RCFEs without reducing the payment to residents.

Three states, Florida, South Carolina and Vermont, created a new SSI living arrangement in residential settings and used the difference between the previous SSP payment and the new payment to cover Medicaid services. These states do not cover personal care under the state plan and instead added assistive community care services, or other similar terms, to the state plan. Since California covers personal care under the state Medicaid plan, it could expand coverage to RCFEs using the "saved" general revenue, or a portion of it, for the state match.

Using 2008 payment standards, Table 97 presents two options to the current SSI/SSP payment. In 2008, SSI/SSP consumers living in RCFEs received a federal SSI payment of $637 per month and an SSP payment of $412 per month for a total payment of $1,049 with a net state cost of $412. The net state cost is lower because the state would receive federal matching payments for assistive care services (ACS). Beneficiaries would not have their benefits reduced. The personal needs allowance would remain the same.

Option 1 reduces the SSP to the amount paid in 1983 or $215.70 per month. An ACS payment of $392.60 is made to the facility using the $215.30 difference for the state match. The net state cost remains the same at $412 per month.

Option 2 sets an ACS payment of $292.60 per month, using a portion of the difference as the state match and reduces the net state cost to $362 per month.

Table 97: SSI/SSP Monthly Payment Options for RCFEs

Component	Current	Option 1	Option 2
SSI	$637.00	$637.00	$637.00
SSP	$412.00	$215.70	$215.70
ACS	- 0-	$392.60	$292.60
Total	$1,049.00	$1,245.30	$1,1945.30
Net State Cost	$412.00	$412.00	$362.00

Implications

The recommendation does not reduce support for Medi-Cal beneficiaries who are receiving SSP in an RCFE since they retain a personal needs allowance that will not change. It allows RCFEs to receive additional payments that are needed to support residents with greater needs and creates additional housing and service options for beneficiaries.

This recommendation was affected by the budget proposal that reduced the SSP to 1983 levels as a cost reduction. However, the recommendation to use the SSP would have generated savings in that the state is able to reduce nursing facility use due to coverage of services in RCFEs.

This recommendation requires a change in statute and all operators would have to enroll as IHSS providers. There are other considerations. First, SSP is available in licensed Non-Medical Out-of-Home Care settings and the conversion would have to be implemented in all the categories or RCFEs would have to be added as a separate living arrangement with the Social Security Administration. However, the number of existing living arrangements exceeds the allowed federal number and approval of a new arrangement is unlikely. Policy makers could explore options for consolidating living arrangements in a way that allows a separate payment standard in RCFEs. Second, since the service would be provided in all settings, the service definition would have to address the needs of all residents in each setting. Finally, CMS has notified states, including California, that services that are not specifically listed under Title XIX §1905 as state plan services cannot be approved.

17. Create a Temporary Rental Assistance Housing Subsidy

Housing is consistently identified by transition teams, Independent Living Centers (ILCs) and ADRCs as a barrier for individuals with disabilities who want to move from an institution to the community. A temporary rental assistance subsidy can be created by converting a portion of the state share of the savings from Medi-Cal payments for individuals who transition from an institution to a housing subsidy while they wait for a housing voucher or other federal housing subsidy.

Medi-Cal beneficiaries living in an institution quickly lose their community residences. Re-establishing a community residence is a barrier to transition from an institution since beneficiaries may not be able to afford market rate housing and there are long waiting lists for subsidized units. States do have options to expand funding for rental assistance for existing units.[223]

In most cases, the net state cost to serve individuals with disabilities in the community is considerably less than the net state cost in an institution. Reducing housing barriers will allow states to increase the number of persons who transition from institutions. Policy makers could consider using state general revenues to provide state rental assistance payments to avoid

[223] For example in West Hollywood there is a five to seven year wait. See retrieved on 3-8-09: http://www.tenant.net/Other_Areas/Calif/wholly/income.html.

extended periods of institutional care while consumers wait for a housing voucher. The state general revenues would be offset by savings in the state's share of the Medicaid payments to an institution. In effect, the state would "convert" some of the state match savings to a temporary rental assistance payment. There are two options:

- Rental assistance funds could be appropriated in a separate line item based on the projected number of individuals who will be transitioned and must wait for a housing voucher and the average amount of the subsidy.

- Rental assistance payment could also be funded from the state match that is appropriated for the Medicaid program.

California's budget requirements may limit how Medicaid matching funds are spent. Some states may have the flexibility to use matching funds for other purposes. Others may need language in the budget line item that expressly permits such use. The key point is that no federal funds would be used or claimed for rental assistance payments.

State Rental Assistance Payments would be provided to institutionalized Medi-Cal beneficiaries who are moving to a community setting, cannot afford unsubsidized housing and cannot access a housing voucher because of limited funding and long waiting lists. State Rental Assistance Payments could be available without time limits as long as the individual is on a waiting list to receive a housing voucher. Payments could be time limited. However, extensions may be needed if a voucher is not available when the period ends. Policy makers could ask housing agencies that manage vouchers how long the wait period is and set time limitations accordingly. Policy makers might also ask if the housing agency gives preference to elders and persons with disabilities who are moving from an institution. If they do not give preference to these groups, state officials would have to work with housing agencies to explore their willingness to add this preference if a temporary state subsidy is available.

Implications

A vigorous sustained housing effort is a necessary component of long-term care transition efforts. A state rental assistance program creates a bridge to federal housing subsidies that allows individuals living in an institution access to affordable housing in areas of the state that have waiting lists for housing vouchers. State rental assistance subsidies are temporary until the person reaches the top of the waiting list. One difficulty is the length of the waiting list and therefore the duration of time spent on the waiting list. Setting a limit on the duration of the state subsidy limits the state's cost; however, it may create a crisis if the state subsidy ends and a federal housing voucher is not available.

These variables determine whether it is cost-effective to convert the state share of the Medicaid savings to a Rental Assistance Payment when beneficiaries move to a community setting:

- The net monthly cost in an institution

- The net monthly cost of HCBS Waiver services

- The Housing and Urban Development (HUD) Fair Market Rents (FMR) in the community in which the consumer will live

- The rent payment that will be paid by the consumer (30% of income)

- The amount of the subsidy that will be required (the difference between the FMR and the rent paid by the consumer)

- The amount of the subsidy in relation to the net state savings

The amount of the subsidy will vary by geographic area within the state, based on variations in the fair market rents calculated by HUD. HUD guidelines state that FMRs are used to determine the payment standard amounts for the Housing Choice Voucher program, determine initial and renewal rents for some expiring project-based Section 8 contracts, determine initial rents for housing assistance payment contracts and serve as a rent ceiling for the HOME program. HUD calculates and publishes FMRs for metropolitan areas and nonmetropolitan counties annually for the Office of Management and Budget (OMB).

The subsidy will also vary based on the consumer's income in the community. In general, subsidies for SSI beneficiaries will be higher than those for beneficiaries who are not receiving SSI. Variations in FMRs may offset the differences in income in some areas.

18. Allow Presumptive Medi-Cal Eligibility for HCBS Waiver Applicants

The recommendation would allow case managers in a single entry point system to "fast track" or presume Medi-Cal eligibility to enroll applicants in a waiver program and avoid admission to a nursing facility. Providing access to appropriate long-term care services as quickly as possible is an important goal of state long-term care delivery systems. The array of community, residential and institutional service options, fragmented delivery systems and the confusing, often time-consuming Medicaid eligibility process make it difficult for individuals, family members and state and local staffs to navigate the Medicaid maze.

States have an incentive to expedite applications from individuals seeking long-term care services, although the incentive may be less apparent to the staff and managers responsible for these determinations. Eligibility delays influence the service choices that may be available to the applicant. Financial eligibility is often determined by an agency that is not under the direct control of the State Medicaid Agency (SMA), which makes setting priorities and managing work flow more difficult for the Medicaid agency. The Medicaid staff may be more concerned that errors will be made that force the agency to forego federal reimbursements for HCBS.

A report to CMS from Thomson Reuters on presumptive eligibility reported that almost half of all nursing facility residents are admitted from hospitals and another 11% are admitted from

other nursing facilities.[224] Less than 30% come from private or semi-private residences. Delays in determining Medicaid eligibility may affect the decision about where services may be available. Nursing facilities are more willing to admit individuals while their Medicaid application is pending than community care providers who face a higher risk of not being paid for services delivered. Residents who are found ineligible, or their families, can be charged for services delivered and expected to pay. Nursing facilities are able to measure the resident's income and resources and judge whether they will become a Medicaid beneficiary or remain private-pay.

Community service agencies have less experience with Medicaid eligibility criteria and less assurance that individuals who are found ineligible will be able to pay for services. Uncertainty about Medicaid eligibility and a source of payment means that community agencies are less willing to accept a referral while the Medicaid application is processed. Therefore, individuals who are not able to pay privately for in-home or residential services are more likely to enter a nursing facility.

There are two primary ways to expedite eligibility. Presumptive eligibility allows eligibility workers or case managers, the nurses and social workers usually responsible for the functional assessment and level of care decision, to decide whether the individual is likely to be financially eligible based on presumptive criteria and to initiate services before the official determination has been made by the eligibility staff.

Another way of expediting eligibility is to speed up the process. "Fast-track" initiatives accelerate the process and address the factors that are most likely to cause delays—fully completing the application and providing the necessary documentation. Under these arrangements, staff, usually affiliated with the agency responsible for administering and managing HCBS, help the individual or family member complete the application and attach sufficient documentation of income, bank accounts and other assets to allow the financial eligibility worker to make a decision. Fast-track processes reduce the time it takes to complete a financial application using the normal channels. Staff responsible for making the decision does not change.

For example, the Washington Aging and Disability Services Administration (ADSA) developed a presumptive eligibility process for long-term care programs for adults with disabilities and elders.[225] The social workers and nurses that conduct assessments and authorize long-term care services and the financial eligibility workers are located within ADSA. The policy allows social workers or nurses to authorize delivery of essential services before the full eligibility process is completed. It is used when the case manager has sufficient financial information, including a statement or declaration by the individual that leads staff to the reasonable conclusion that the applicant will be financially eligible for Medicaid. The case manager consults with the financial worker, completes an assessment and service plan and authorizes services for 90 days. The

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[224] Stevenson, D., McDonald J., & Burwell, B. (2002, August 23), *Presumptive Eligibility for Individuals with Long Term Care Needs: An Analysis of a Potential Medicaid State Option.* Prepared for the Centers for Medicare & Medicaid Services, by Thomson Reuters (formerly the Medstat Group, Inc.).

[225] Mollica, R. *Expediting Medicaid Financial Eligibility*. Rutgers/NASHP Community Living Exchange. (August 2004), Available at: http://www.nashp.org/Files/presumptive_eligibility.pdf.

individual must submit a formal application for Medicaid within ten days of the service start date. Individuals sign a fast-track agreement that specifies that services are time limited and the applicant must complete an application within ten days and will be liable for the cost of delivered services if they are found ineligible.

Eligibility workers are able to "presume" eligibility and approve Medicaid coverage in a day if it means that a beneficiary can receive services in a residential or community setting instead of a nursing facility.

Since Federal Financial Participation (FFP) is not available for services delivered if the applicant is not eligible for Medicaid, state funds are used to pay for services in the few instances in which the applicant is found ineligible. State officials believe that the risk is limited compared to the savings realized by serving a person in the community. Washington officials have determined that clients presumed eligible save Medicaid an average of $1,964 per month by authorizing community services for persons who would have entered an institution if services were delayed.

Nebraska is another example. Nebraska allows presumptive eligibility for potential waiver clients when the client has signed and submitted a Medicaid application to the Medicaid eligibility staff. To avoid confusion with the federally approved presumptive eligibility option, Nebraska named its program "Waiver While Waiting." Financial eligibility is the responsibility of a state agency that is separate from the division responsible for waiver services. However, staff in both divisions have joint access to the data system that is used for Medicaid eligibility and for waiver services authorization, provider enrollment and billing and payment. Service coordinators receive some training on the Medicaid financial eligibility criteria but do not advise applicants.

In the Nebraska program, service coordinators work closely with the financial eligibility worker to determine when a person may be presumed eligible. After the assessment has been completed and the level of care determined, clients are given a choice of entering a nursing facility or receiving waiver services. The service coordinator contacts the Medicaid eligibility staff to determine if the applicant is likely to be Medicaid eligible. To receive services under presumed eligibility, the applicant must agree to complete the application, submit all necessary financial records and meet any cost-sharing obligations. Applicants sign a consent form and a notation is made on the consent form indicating that the applicant is presumed eligible until a final Medicaid eligibility decision has been made. When the consent form is approved by the financial eligibility worker, service coordinators may authorize ongoing waiver services and medical transportation services for clients while the application is being processed. Home modifications and assistive technology services may not be presumptively authorized.

The services coordinator maintains regular contact with the Medicaid eligibility staff until a final decision is made. If the client is found ineligible, the services coordinator sends a written notification to the client that services are terminated and offers assistance and referrals to other programs or resources. A ten-day notice is not permitted. In the few instances in which applicants were later found ineligible, Social Services Block Funds were used to pay for the services delivered.

While Washington and Nebraska apply these policies to the entire state, it is also possible to use "fast track" procedures in parts of the state the way Pennsylvania does.

19. Develop HCBS That Address Individuals with Mental Illness

California does not operate an HCBS program that is designed specifically for persons with mental illness.[226] A package of services for nursing facility residents with a mental illness could be designed under a §1915(c) Waiver or a §1915(i) state plan HCBS amendment. The MFP project includes "Demonstration Services" that address the needs of persons with mental illness living in nursing facilities. The MFP operational protocol identifies habilitation services that will be provided as Demonstration Services—which could be provided by independent living coaches and peer mentors—that would benefit persons with mental health needs. The services should be defined and implemented to improve the project's ability to meet the benchmarks for this population. States are expected to amend their waivers to add services that will be needed following the end of the demonstration period and these services will be needed to continue services received by persons who transition. See the discussion in Appendix D for more information about 1915(i) Waivers.

20. Create Rate and Other Incentives to Reduce Nursing Facility Capacity

This recommendation would create rate incentives, perhaps using funds from the labor-driven operating allocation for nursing facility providers, to downsize nursing facilities and the resulting savings could be used to expand affordable housing, adult day health care and in-home services.

Implications

Nursing homes provide an essential long-term care service and the state should develop positive ways of working with them. The use of incentives is discussed in the labor-driven operating allocation part of Section 7 and also in Appendix E.

Longer-Term Recommendations

Long-term recommendations require two years or longer to be implemented.

Comprehensive long-term services and supports systems have these interconnected features:

- One state department that is responsible and accountable for policy development, financing, management, regulation and oversight

[226] The Department of Mental Health was directed by SB 1911 (Ortiz), Chapter 887, statutes of 2002, to develop a waiver for children and youth under age 21 with MH treatment needs but it was never implemented.

- Local or regional single point of access, e.g. county-based, for information and assistance, referrals, assessment, options counseling, functional eligibility, care planning, service authorization, coordination, monitoring and reassessment

- Institutional, residential, community and in-home services

- Active transition and diversion efforts that fund local transition workers

- A housing component based on frequent meetings with state and federal housing officials

- Consumer choice of the services and settings

Comprehensive system reform requires leaders with a vision and a commitment to change to persuade stakeholders that improving access to services consumers prefer and reducing fragmentation is more important than protecting the self-interests of all current stakeholders.

Delivery systems can be local or regional. Counties, groups of counties or sections of very large counties are the logical entry points because of the size of the California programs such as the IHSS program and DD operations.

Previous reports recommended consolidation of agencies and programs serving individuals with disabilities and older adults. Each program and agency has a long and rich tradition, a strong network of providers, advocates and consumers that seem more comfortable with the system they know, despite the fragmentation, than a new, untested structure that is not clearly defined.

21. Create a Department of Long-Term Services and Supports

Long-term care services and supports programs for elders and adults with physical disabilities are spread across multiple agencies. Earlier reports on California programs and legislative comments typically use the word "fragmentation" or a synonym to describe the challenges state officials and local organizations encounter in coordinating California long-term care programs. A parallel complexity and challenge is encountered by consumers and family members trying to access the information they need in order to choose which program or service will best meet their needs.

Consolidating responsibility for long-term care programs in one agency was recommended by the Little Hoover Commission in 1996. The report said:

> The Governor and the Legislature should consolidate the multiple departments that provide or oversee long-term care services into a single department. Interdepartmental cooperation is a hit-and-miss proposition that usually lacks mission unity and aggressive leadership. If the state is serious about creating an effective long-term care system—and with looming demographics that promise

> an explosion of those who need such care, the state should be concerned about that goal—then it must reorganize departments into a single entity to oversee all long-term care. The new department should take advantage of the opportunities presented to create a consumer-centered philosophy that maximizes choice, effectiveness and efficient use of multiple resources.

Legislation to combine the Department of Social Services and the Department of Aging Programs or to create a separate new Department for Aging, Disability and Long-Term Services and Supports has not advanced.

Individuals with developmental disabilities for the most part access services managed by one state agency and a strong comprehensive entry point system operated by 21 regional centers. While some consumers receive IHSS services, the vast majority of HCBS services are accessed through regional centers. No similar structure is available to serve older adults and individuals with physical disabilities. As a result, new initiatives are often built through new structures and administrative arrangements. Inadequate revenues and budget deficits have prevented statewide initiatives that expand services or build the infrastructure needed to improve coordination and management across programs. New initiatives are limited to pilot programs such as the ALW Pilot Program or initiatives funded by grants from the CMS or the AoA.

Other states addressed similar fragmentation. Oregon and Washington consolidated all long-term care functions, including determining Medicaid financial eligibility, in a single agency. Responsibility for licensing nursing facility and residential settings, budget, rate setting, policy, management, contracting, Medicaid financial eligibility and oversight are located in the Aging and Disability Services Administration in Washington and in the Seniors and People with Disabilities Division in Oregon. One administrator is accountable for long-term care. Controlling nursing facility spending was a priority, and the administrators were able to reduce spending by expanding HCBS services. Vermont and New Jersey consolidated all the functions except Medicaid financial eligibility, and Massachusetts and New Mexico implemented partial consolidations. The Pennsylvania consolidation into the Office of Long-Term Living is a recent example of how a large state went about obtaining management control over its programs.

Persons interviewed discussed the benefits and obstacles to consolidating responsibilities for long-term care in a single agency similar to the structure implemented in Washington and Oregon in the 1990s.

Charles Reed, a former Assistant Secretary in the state of Washington, indicates that as well as he collaborated with his peers prior to the reorganization, they often had different priorities and made decisions that did not support the goals and philosophy of the long-term care system. Reed contends that it is much easier to implement the state's philosophy and policy when you have the authority to make decisions rather than negotiating with the director of another agency whose priorities are different from yours. For example, most state agencies responsible for licensing and oversight of nursing facilities are concerned about compliance with regulations and the survey process. The long-term care agency is concerned about helping persons in nursing facilities move

to the community if they are able to do so. When these functions are consolidated, you can do both more easily. This consolidation needs to be specified in the strategic plan.

22. Create Single Entry Points (SEPs) to Access Services for Aged and Disabled Beneficiaries

Consumers, family members and advocates frequently describe their frustration trying to obtain information about the long-term care services that are available to them. Without a visible entity that offers seamless entry to the system, consumers often have to contact multiple agencies and organizations, complete multiple application forms and apply for programs that have different financial and functional eligibility criteria or they may not learn of the service options that are available to them.

The 1996 Little Hoover Commission report[227] recommended that the Governor and the Legislature mandate that the new state department establish an effective one-stop service for consumers to obtain information, preliminary assessment of needs and referral to appropriate options. The report further noted:

> What consumers have identified repeatedly as their most pressing need is a reliable source of information so they may understand the choices that are available to them. While the State has the backbone for such a system in place, with the 33 regional Area Agencies on Aging and a special 1-800 number, the resources are not available for personalized, one-stop counseling. In particular, the ability is lacking to access information about programs and individuals by computer so that counseling is person-specific. Over time, as the State makes progress on integrating programs, these referral centers should also serve as program entry points, with unified applications and common eligibility screening.

The greater the numbers of programs and access points, the greater the need for an entity that can help consumers understand the choices available. The absence of SEPs often leads to further fragmentation as new programs emerge without an existing delivery system that is capable of carrying out the new programs. The ALW Pilot Project and the developing MFP are examples of programs that address important needs that had to develop their own infrastructures to implement their activities. Other factors certainly contribute to the need for new structures—targeting implementation to a small number of geographic areas initially and the varying amount of interest among existing entities to expand their activities. Other programs, while available statewide, are small in scope and it would not be effective to use the existing infrastructure to serve few consumers in any given area. The NF/AH Waiver is one example.

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[227] *Long Term Care: Providing Compassion Without Confusion*. Little Hoover Commission. (December, 1996), Report #140. Available at: http://www.lhc.ca.gov/reports/healthhumanservices.html.

SEPs are important vehicles to divert admissions to institutions and to help people relocate from institutions to community settings. They have been established in states to reduce fragmentation, provide information about long-term care options and streamline access to services.[228] The regional centers created by the DDS are a good example of a SEP that enables consumers to access long-term and supportive services through one agency or organization. In their broadest forms, these organizations perform activities that may include information, referral and assistance, screening, nursing facility pre-admission screening and options counseling, assessment, care planning, service authorization, and monitoring and reassessment using one or more funding sources. SEPs may also provide protective services. SEPs may use websites, like CalCareNet, to provide information or screening tools that help consumers and family members understand their needs and the resources available to them.

The California Care Network portal, CalCareNet, is a pilot project sponsored by the CHHS under the California Community Choices Project [229] with funding by a federal Real Choice Systems Transformation Grant. CalCareNet is a comprehensive, accessible website for consumers, caregivers, family members and providers seeking information on long-term care services and supports (also called long-term care).[230] The goal of CalCareNet is to provide access to information and tools that empower individuals and families to find the most appropriate services to meet their needs.

Organizations that only provide information, referral and assistance are not considered SEPs. A SEP may serve all consumers, including private-pay, and offer options or benefits counseling and nursing facility relocation or transition assistance. SEPs do not typically provide services that they authorize.

Consumers and family members typically need LTC during a crisis. Delays accessing services needed to stay at home or return home after a hospital admission can lead to preventable nursing facility admissions. Short-term nursing facility stays can become long-term stays if nursing facility social workers do not actively implement a discharge plan or case managers from community agencies do not work with the individual to assess their needs and arrange for community services. States have used two strategies to help people make choices and remain in or return to their home.

Twenty-four states operate SEPs that serve older adults.[231] All SEPs manage access to Medicaid-funded HCBS and many manage Medicaid state plan services, Older Americans Act services and programs funded by state general revenues. Case managers complete assessments, determine functional eligibility, prepare care plans, authorize services in the care plan, arrange services and coordinate service providers, monitor implementation of the care plan and conduct periodic reassessments. SEP functions may be combined in a single agency or split among agencies. In most cases, a particular agency or organization is the SEP, although some functions are

[228] Mollica, R. and Gillespie, J. (2003), *Single Entry Point Systems: State Survey Results*. Rutgers/NASHP Community Living Exchange. (August 2003). Available at: http://www.nashp.org/Files/SEPReport11.7.03.pdf.
[229] Available at: http://www.communitychoices.info/index.html.
[230] See the CalCare Net website at, retrieved on 9-3-2009, http://calcarenet.ca.gov/

[231] Ibid.

contracted out to other organizations. For example, the local Area Agencies on Aging (AAAs) may serve as the SEP and contract with local community-based nonprofit organizations to perform specific tasks, but the AAA is the responsible party. In other cases, functions are split between agencies. For example, in Washington, the state agency performs the assessment, eligibility determination, service authorization and ongoing case management for individuals in nursing facilities, adult family homes and assisted living, while AAAs implement the consumer's care plan and provide ongoing case management for individuals living in the community. Other states may separate the information and screening functions from the authorization and care management activities. SEPs in a particular state may facilitate access to one or more, but not necessarily all, funding sources or programs.

The more services and programs the SEP manages, the smoother the pathway to service. SEPs do not provide services directly and therefore do not have a financial incentive to favor one service over another. The role of the care manager is to facilitate access to the services and settings chosen by the consumer.

The available programs and services vary. SEPs that serve older adults and adults with physical disabilities often determine whether an individual meets the level of care for admission to a nursing facility though they do not pay claims.

SEPs could be developed through the following organizations:

- Entities that operate under the ADRC program
- Area Agencies on Aging and county-government based SEPs
- Regional or county-based organizations selected through a request for proposal (RFP). Counties interested in functioning as a SEP would be included. Rather than designate organizations, under this approach the state agency sets the requirements and expectations, and organizations that meet the requirements are eligible to submit a proposal
- Entities that build from the organizations that participate in the MFP demonstration

23. Co-locate Medi-Cal Financial Eligibility Workers in Single Entry Points/ADRCs

Determining financial eligibility quickly can mean the difference between entering a nursing facility or returning home. At least two states, Oregon and Washington, assign responsibility for determining Medicaid eligibility for individuals applying for LTC services to the same agency that manages Medicaid LTC services. This organizational arrangement gives the agency that is responsible for all LTC policy and management responsibility better and more timely control over eligibility determinations, and therefore over access to services. Expedited processes address the factors that are most likely to cause delays—failure to fully complete the application and failure to provide the necessary documentation. Under these arrangements, staff, who are usually affiliated with the agency responsible for administering and managing HCBS, help the

individual or family member complete the application and attach sufficient documentation of income, bank accounts and other assets to allow the financial eligibility worker to make a decision. Expedited processes reduce the time it takes to complete a financial application using the normal channels. Staff responsible for making the decision does not change.

24. Create a Unified Long-Term Care Budget

The recommendation would create a unified long-term care budget at the county or regional level that includes nursing facility spending, IHSS and selected HCBS Waiver programs.

One strategy to create financial incentives to offer consumers choices is through a modified unified budget. A unified budget consolidates funding in a single appropriation. Funds may be spent on institutional care, residential, in-home and other community services. States with a unified budget tend to be state-administered rather than county-administered systems. Because the largest program, IHSS, is administered by counties, we suggest that policy makers consider consolidating funding for selected services at a county level—nursing facility care, IHSS, the MSSP and NF/AH Waivers. Counties would be responsible for providing options counseling and authorizing services. Counties would also be responsible for paying a share of the consolidated programs; however, the share would be budget neutral initially. Counties, on average, pay 18.5% of the cost of IHSS. Under this budget approach, the cost of the consolidated services would be determined for each county. The total would be divided by the county's cost of IHSS and, going forward, counties would be responsible for the percentage of the costs. For example, if the counties' spending for IHSS were 8% of the cost of the consolidated services, they would be responsible for 8% of those services in subsequent years.

DHCS would continue to make payments for institutional services and spending would be tracked against each county's budget allocation. Counties would receive monthly expenditure and caseload reports to monitor their spending activity. Budgets for subsequent years would be based on a caseload forecast and any rate increases approved for specific provider groups. If spending increased, counties would bear an increased cost and, if consumers were diverted from entering an institution or relocated from an institution, counties would benefit from the lower spending.

A unified budget would also be established in the new Department of Long-Term Services and Supports to simplify contracting and resource management.

Implications

Broadening services and reducing the county share proportionally creates an incentive for counties to provide information and assistance to consumers, options counseling and an incentive to develop services people prefer to divert consumers from institutional settings and to provide transition coordination to help nursing facility residents transition to the community, if they are interested in moving and the services can be developed to support them.

This recommendation would require some additional staffing and reallocation of funds that now pay for case management activities among the waiver programs.

The nursing facility rate structure may make it more difficult for counties to control institutional spending to the extent that future rate increases for nursing facility services add to the amount that must be budgeted. On the other hand, such increases intensify the incentive to divert and transition more consumers from these settings.

25. Create a Standardized Rate Structure for HCBS Based on the Acuity of Persons Receiving Services

Long-term care services should be managed as if they are a single program. Persons with physical impairments and disabilities use multiple programs both over time and at the same time. Eligibility and service delivery changes in one program impact the utilization of other programs. Providers cross programs as well. An electronic information system and an organizational structure should be developed to support this activity.

Fortunately, some progress has been made on the development of a computer infrastructure for long-term care programs. The California Community Choices project has initiated a data warehouse study that is to be completed in November 2010. A data warehouse that collected information on each person that used long-term care services and made this information accessible to managers across programs would be a useful contribution to the effective management of these programs.

One facet of operating a single large program is to consider the benefits and costs of adopting a standardized rate structure for HCBS across target populations and among providers.
The benefits of a standardized rate structure are more efficient administrative and program operations for the state, a program that is easier for providers to understand and work with and a greater assurance that persons with similar needs are treated in an equitable manner. The state faces considerable challenges converting current rate-setting practices to a standardized program. Like most states, California operates multiple waiver and state plan programs that provide similar services to populations with similar needs. These needs typically include help with activities of daily living (ADL), often include some type of housing assistance and sometimes include assistance finding and maintaining employment, e.g. supported employment or vocational programs. Other funding streams outside of HCBS typically cover medical and rehabilitative needs.

The current budget travails highlight the independence of the programs. For example, consider the impact of a 10% or 3% reduction applied to all long-term care programs. Instead of having the reduction implemented quickly and uniformly, some programs, e.g. nursing facilities, are not affected as much as programs whose supporters are not as successful in lobbying for funding. For example, small programs which can be cost-effective, such as traumatic brain injury programs, lack the political clout of larger programs and thus have difficulty becoming established, let alone surviving in a difficult budget environment.

Some waivers provide for inflation increases and others do not. A standardized rate structure treats programs uniformly as a coherent whole. Program labels are less important than equitably

paying for similar services to persons with approximately similar needs. How is standardization encouraged or maintained? One way this happens is to tie reimbursement to the acuities or level of need of the person whose care is being reimbursed. Providers should be paid more for taking care of persons with more needs and paid less for serving persons with fewer or less severe impairments. The collection of common information across programs means providers can be compared both within programs and across programs to see what level of acuity they are taking care of, and acuity changes in programs can be studied to see who is using programs,

To base reimbursement on acuity, it is necessary to collect information in a uniform manner across programs, build computer systems to capture the data and databases, e.g. the data warehouse being studied under the Community Choices Project, count how many persons have what types of physical, cognitive and health care needs, and create payment procedures appropriate for the providers and rates reflecting persons' acuity levels. The collection of assessment information for the purpose of reimbursement is different than the collection of assessment information for care planning. Care planning assessment requires more detailed data on medical conditions, care preferences, support from family and friends, and the home environment. Assessment information for the purposes of management and reimbursement typically collects a smaller set of facts about the person's physical and mental condition.

The IHSS program is an example of this. It scores a person on fourteen ADLs, instrumental activities of daily living (IADLs), cognitive factors and a few medical factors. A similar reimbursement assessment could be established across all HCBS programs. Not all services provided in HCBS programs are suitable for this methodology, e.g. supported employment and personal emergency response system monitoring. However, most are.

An assessment emphasizing ADLs and IADLs and selected medical conditions is consistent with the nursing facility eligibility standards in the California Code of Regulations. To be eligible for services provided by an HCBS Waiver, applicants must meet the state's level of care criteria for nursing facility care. These standards are in the California Code of Regulations at Title 22 Division 3 Sections 51334 and 51335.[232] Standards for developmentally disabled programs are covered at Section 51343. ADLs play a more prominent part in Sections 51334 and 51343, but they are also mentioned in Section 51335.

The implementation costs of developing a standardized reimbursement methodology are not possible to estimate without detailed specifications as to how such a system would be implemented. The operation of the system can be cost-neutral compared to the costs of the current reimbursement methodologies. However, there would be conversion costs to change data-processing capabilities. For example, eligibility for LTC services is often initiated with a Treatment Authorization Request Form 20-1. For persons in nursing facilities, the TARS are accompanied by a copy of the latest MDS assessment. The MDS is the form the federal Medicaid agency, CMS, mandates nursing facilities use when assessing their residents.[233] The

[232] See Section Title 22 § 51335.

[233] For a copy of the MDS see the website of the Centers for Medicare & Medicaid Services at: http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp. For an example of its use in home and community-based programs see Reinhard, S. & Hendrickson L. (June, 2006), *Money Follows the Person: States' Progress Using the Minimum Data Set (MDS) to Facilitate Nursing Home Transition*. Rutgers University, Center

MDS form collects information, some of which is similar to the ADL, IADL and cognition information collected by the IHSS program.[234] The Medicaid office that receives the forms gets both a hard copy and electronic versions of each person's TARs and MDS. The hard copies are scanned and put in the Service Utilization Review Guidance and Evaluation (SURGE) data system. The electronic versions go directly into the SURGE system.

Persons using ADHCs submit TARs to the same Medicaid field office. The SURGE system can be used to look up individuals if you know their "control number," but would need modifications to be used for management and program analyses purposes, since it cannot be used in query mode to group persons or summarize characteristics of groups of persons whose records are in SURGE. Thus the SURGE program is an example of the need to change a data processing system.

In general, the costs of the conversion work would entail:

- Deciding what programs will be included in a standardized reimbursement system
- Identifying administrative regulations and state statues that might need changing
- Ensuring that the same acuity information is collected on everyone across programs
- Identifying who will do the assessment since providers benefiting from the reimbursement should not be involved in making the assessment
- Ensuring that the acuity information is periodically updated and verified
- Ensuring that utilization and cost data can be retrieved on all providers and persons using the reimbursement system
- Establishing the level of reimbursement to be used with each acuity category
- Modeling the new system against the old to ensure its cost neutrality
- Putting on training for state, regional and provider staff
- Deciding what adjustments should be made to rates, e.g. using wage labor data by area to set a geographical adjustment[235]

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for State Health Policy, New Brunswick, NJ. Retrieved on 1-19-09: http://www.cshp.rutgers.edu/cle/Products/MDSIIWEB.pdf.

[234] In MDS 2.0, ADLs questions are in section G 1 and 2, memory, cognition, and judgment questions are in Section A 3, 4, 5, and 6, and respiration capability is asked about in section I,1, hh and ii.

[235] In general geographical adjustments in a large state are reasonable. The Employment Development Department (EDD) maintains regional wage data for Home Health Aides (SOC311011) and Personal and Home Care Aides (SOC 399021) and county level data could be used to create regional rates. For example, see the Local Area Profiles at, retrieved on 9-3-09: http://www.labormarketinfo.edd.ca.gov/ and for an Alameda County example see:

- Creating budget expectations that if budget reductions are necessary then the least impaired persons, regardless of which program they are in, will have services reduced first—in other words, to create an expectation that budget reductions should be made on the basis of acuity rather than the political skill of the program's advocates

As the list of tasks shows, the use of a standardized rate structure implies a standardized policy. Whether rates are negotiated, set using costs, frozen or increased with inflation increments, providers should be reimbursed using similar methodologies if they are providing reasonably similar services for persons with similar needs. The major issues are not funding but the development of new ways of thinking about what is being reimbursed, how the assessment is done, what computer infrastructure is necessary to support programs, and how budget reductions should implement good policy rather than political considerations.

26. Create Incentives for HCBS through Managed Long-Term Care and Capitation

Some of the earliest managed LTC programs were developed in California. The SCAN Health Plan was one of four Social Health Maintenance Organizations funded in 1980. Begun in the 1970s, On Lok Senior Health Services in San Francisco evolved into the national Program of All-Inclusive Care for the Elderly program (PACE). PACE provides preventive, primary, acute, and long-term care services from Medicaid and Medicare for individuals who are age 55 and older and meet the criteria to be admitted to a nursing facility. In 2008, 61 PACE programs operated in 29 states.[236] In California, the PACE program serves 1,600 frail elderly at four sites throughout the state.

The 2006 Legislature considered a bill, AB 2979, that would have required DHCS, in consultation with stakeholders, to develop a statewide education and outreach program directed at the needs of older adults and persons with disabilities to promote a greater understanding of, and increased enrollment in, Medi-Cal managed care. This bill also authorized DHCS to implement a Medicare/Medi-Cal pilot project for dually eligible individuals to provide a coordinated system of care and benefits. The bill passed the Assembly but did not pass the Senate.

A review of managed long-term care programs prepared for the Assistant Secretary for Planning and Evaluation (ASPE) in 2006 found that, "Most studies have found and officials report that managed long-term care programs reduce the use of institutional services and increase the use of home- and community-based services relative to fee-for-service programs, and that consumer satisfaction is high. Undesirable outcomes, such as higher death rates or preventable admissions, have not emerged as a concern. Cost findings are mixed and more difficult to summarize, though in general studies that examined the costs of Medicaid-only programs have found them to be

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http://www.labormarketinfo.edd.ca.gov/cgi/databrowsing/occExplorerQSDetails.asp?searchCriteria=Clerk&careerID=&menuChoice=occExplorer&geogArea=0604000001&soccode=399021&search=Explore+Occupation.

[236] See: http://www.npaonline.org/website/article.asp?id=12.

cost-effective more consistently than studies looking at both Medicaid and Medicare costs for integrated programs."[237]

Managed Medicaid LTC programs interest policymakers as a way to address the inefficiencies of the fee-for-service system in which institutional care is an entitlement and HCBS are usually covered under waivers which may have limited funding. States with managed LTC programs note the potential for better care coordination for beneficiaries with complex health and LTC needs through multidisciplinary care management. States with significant experience operating managed LTC programs include: Arizona, Florida, Massachusetts, Minnesota, New York, Texas and Wisconsin. See Table 98 for a comparison of selected features of managed LTC programs.[238]

Table 98: Comparison of Selected State-Managed Long-Term Care Programs

Program	Population Served	Participation	Medicaid Services	Medicare Services
Arizona LTC System	Aged and disabled at NF level of care	Mandatory	Capitated primary, acute and LTC	Fee for service
Florida Diversion Program	Aged at NF level of care	Voluntary	Capitated primary, acute and LTC	Fee for service
Massachusetts Senior Care	Aged	Voluntary	Capitated primary, acute and LTC	Capitated
Minnesota Senior Health Options	Aged	Voluntary	Capitated primary, acute and LTC	Capitated
New York MLTC Plan	Aged and disabled at NF level of care	Voluntary	Capitated LTC	Fee for service
Texas Star+Plus	Aged and disabled	Mandatory	Capitated primary, acute, and LTC	Fee for service
Wisconsin Family Care	Aged and disabled at NF level of care and MR/DD	Mandatory	Capitated LTC	Fee for service
Wisconsin Partnership	Aged and disabled	Voluntary	Capitated primary, acute, and LTC	Capitated

These states represent models from fully integrated to capitation for LTC services only. Wisconsin's Family Care program falls between a fully integrated primary, acute and LTC program, and an HCBS program with case management. The program is being implemented statewide after operating as a pilot program. The program serves persons with physical disabilities, persons with developmental disabilities and frail elders, to improve their choices, improve access to services, improve quality through a focus on health and social outcomes, and create a cost-effective system. In July 2008, Family Care served 14,089 beneficiaries.

Family Care operates through two organizational components:

[237] Saucier, P., Burwell, B., and Gerst, K. (April, 2005), *The Past, Present and Future of Managed Long-Term Care*. US Department of Health and Human Services, ASPE. Washington, DC. Available at: http://aspe.hhs.gov/daltcp/reports/mltc.htm.
[238] Adapted from Saucier, et al. Ibid.

- ADRCs provide information and assistance about the range of resources available.

- Managed care organizations (MCOs) authorize and provide services previously available from multiple programs.

Family Care provides traditional Medicaid HCBS Waiver services, and regular state plan services such as nursing facility care, home health, skilled nursing, mental health services, therapies and assistance coordinating primary and acute care.

Attempts were made to implement managed LTC models in California. AB 1040 (Bates), Chapter 875, Statutes of 1995 established an LTC integration pilot to integrate the financing and administration of LTC services. Findings described in the bill passed 13 years ago are still relevant today:

> Long-term care services in California include an uncoordinated array of categorical programs offering medical, social, and other support services that are funded and administered by a variety of federal, state, and local agencies and are replete with gaps, duplication, and little or no emphasis on the specific concerns of individual consumers.
>
> Although the need for a coordinated continuum of long-term care services has long been apparent, numerous obstacles prevent its development, including inflexible and inconsistent funding sources, economic incentives that encourage the placement of consumers in the highest levels of care, lack of coordination between aging, health, and social service agencies at both state and local levels, and inflexible state and federal regulations.

In 2004, SB 1671 would have established the Cal Care Options (CCO) program, which would integrate services for dually eligible Medi-Cal beneficiaries. Findings in SB 1671 stated that:

> California's acute and long-term care system has long been plagued with system fragmentation stemming from a multiplicity of funding streams and assessment procedures and a lack of coordination between the medical and social systems of care.
>
> System fragmentation can lead to higher-than-necessary rates of hospitalization and nursing home expenditures, characterized by a lack of coordination between primary, acute, and long-term care systems.

In 2003, AB 43, which passed but was vetoed by the Governor, would have modified the Long-Term Care Integration Pilot Program to require the SDHS to administer a pilot program that

would have integrated the financing and administration of LTC in up to five pilot project sites around the state. Existing law establishes specified goals for the pilot program. The bill renamed the program "the Chronic Care Integration (CCI) program." Each CCI program site would have offered services to meet the medical, social and supportive needs, including the LTC needs, of Medi-Cal beneficiaries in his/her home, community, residential facility, nursing facility or other location.

This bill designated San Diego County as the site of a CCI pilot project if the county chose to participate. This bill would have required that each of the CCI pilot project sites provide medical, social and supportive services to all enrolled CCI pilot program beneficiaries. This bill also specified as a goal of the CCI pilot project that Medicare be included as a funding source.

Despite the interest and support for PACE, other managed LTC programs have not been implemented. Except in Arizona and eventually in Wisconsin and Minnesota, these models do not replace the fee-for-service options but offer beneficiaries a choice of delivery systems.

27. Create Financing Strategies That Improve the Balance between Community and Institutional Services

States need financial tools to implement a balancing plan and create a level playing field. As discussed above in the section on institutional bias, nursing facility care is an entitlement under the Medicaid state plan, while the preferred HCBS Waiver services can be capped and often have waiting lists. Program-specific appropriations can be a barrier to consumer choice and a balanced system. Creating a level playing field means removing barriers for individuals to choose community options.

Budgets for LTC services in Washington are based on caseload forecasts prepared by an independent Caseload Forecasting Council. The Council projects and adjusts the expected caseloads for nursing facility and HCBS programs for elders and adults with physical disabilities. Projections are based on historical trends and changes in policy that affect eligibility or the amount of services that may be authorized. Caseloads are projected for each month of the biennium. Oregon has a similar process.

Funds for nursing facility and HCBS are appropriated in a single line item and the state agency has the ability to allocate and spend funds flexibly.

Table 99: Washington Trends for Elders and Adults with Physical Disabilities

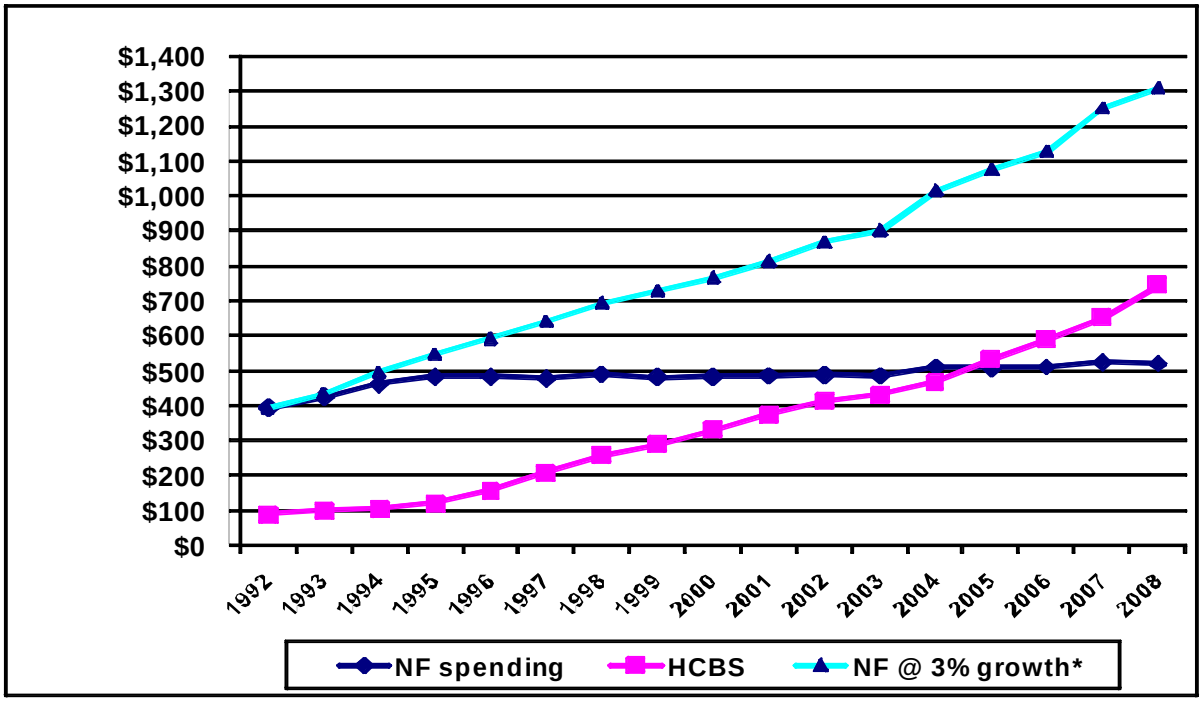
Fiscal Year	Community Services		Nursing Facility		Projected Nursing Facility	
	Average # Consumers	Spending (Millions)	Average # Consumers	Spending (Millions)	Average # Consumers	Spending (Millions)
1995	19,772	$118.9	16,642	$481.6	18,962	$548.7
1996	20,887	$158.5	15,904	$482.1	19,531	$592.0
1997	23,116	$206.8	14,992	$477.7	20,117	$640.9
1998	25,675	$257.6	14,643	$490.4	20,721	$693.9
1999	27,675	$289.5	14,080	$480.9	21,343	$728.9

Fiscal Year	Community Services		Nursing Facility		Projected Nursing Facility	
	Average # Consumers	Spending (Millions)	Average # Consumers	Spending (Millions)	Average # Consumers	Spending (Millions)
2000	29,319	$329.9	13,782	$481.8	21,983	$768.5
2001	30,913	$374.2	13,529	$486.3	22,642	$813.9
2002	32,213	$414.4	13,152	$487.5	23,331	$864.4
2003	33,729	$432.4	12,943	$485.8	24,021	$901.6
2004	34,636	$467.8	12,446	$512.6	24,742	$1,018.9
2005	35,516	$533.2	12,084	$509.8	25,484	$1,075.2
2006	37,042	$589.9	11,900	$511.5	26,249	$1,128.3
2007	38,095	$652.1	11,322	$524.7	27,036	$1,252.9
2008	39,505	$745.0	11,075	$521.2	27,847	$1,310.4

Source: Washington Aging and Adult Services Administration

The average number of consumers served in the community rose from 19,772 per month in FY 1995 to 34,639 per month in FY 2004 and 39,505 in FY 2008. Spending for community services increased from $119 million in FY 1995 to $467 million in FY 2004 and $745 million in FY 2008. The number of Medicaid beneficiaries served in nursing facilities dropped from 16,642 per month in FY 1995 to 12,447 in FY 2004 and 11,075 in FY 2008. Nursing facility spending was $482 million in FY 1995, $513 million in FY 2004 and $521.2 million in FY 2008. State officials estimated the number of persons served in nursing facilities would have been 18,962 per month in FY 1995 and 27,847 in FY 2008 if community services had not expanded and the nursing facility caseload grew at the previous historical average rate of 3% year. Figure 27 shows the expected growth in nursing facility use that would have occurred at the historical 3% rate of increase. The figure also shows the actual growth of nursing facility expenditures as the state reinvested money into its home and community programs.

Figure 27: Projected Expenditures With and Without HCBS Expansion in Washington



* Note: The projection of nursing facility expenditures assumes an increase at the historical rate of 3% per year. Source: Washington Aging and Disability Services Administration.

Vermont, although a small state, offers another example. Since 1995, Medicaid spending for HCBS rose from 12% of Medicaid spending to 32% in 2005. The Legislature passed Act 160 in 1996, which allowed unspent nursing facility funds at the end of each fiscal year to be placed into a trust fund for use in subsequent years for HCBS or for mechanisms that reduce the number of nursing facility beds. The law gave priority to nursing facility residents who wanted to relocate to a community setting, anyone on a waiting list who was at the highest risk of admission to a nursing facility, others at high risk and persons with the greatest social and economic need.

The Department of Aging and Independent Living Services (DAIL) set a goal to spend 40% of LTC funds on community services. State officials are considering raising the goal to 50%. The number of Medicaid nursing facility beneficiaries declined by 12%, or 466 persons, between 1994 and 2004, and the number of HCBS participants rose 238%, or 838 participants. State officials indicated that the shift reduced nursing facility spending by 33% from what would have been spent if the number of waiver participants had not expanded.

The Demonstration requires that savings from institutional care be invested in HCBS.

In 2005, Vermont implemented "Choices for Care" through a §1115 Demonstration Waiver. The initiative is a unique demonstration program that equalizes access to institutional, residential, community and in-home services for elders and individuals with disabilities who meet the "highest need" criteria. DAIL developed the demonstration as a financing and delivery

system reform due in part to limited state revenues that threatened to undermine Act 160, which expanded HCBS services in the mid-1990s. The proposal submitted to CMS stated that the state may be forced to reduce HCBS funding in order to fund the entitlement to nursing facility services. The Choices for Care program addresses the institutional bias of the Medicaid program.

The state believes that offering choice through a global budget that gives equal access to HCBS and nursing facility services would allow more beneficiaries to select HCBS. The Choices for Care Demonstration creates a global budget for in-home, community, residential and nursing facility services.[239]

A 2008 report[240] issued by the Kaiser Commission on Medicaid and the Uninsured found that Choices for Care reduced spending growth far below state projections when the program was designed. Growth in state spending was less than half of what was expected three years ago. The report said, "Spending growth was just 1.3% in FY 2006 and grew to 5.5% in FY 2007, putting the state on par with national spending growth for nursing facility and home health services."[241]

The number of beneficiaries served in nursing facilities dropped 10% under Choices for Care between October 2005 and July 2008, and the HCBS in-home caseload grew 50%. Vermont is also able to serve beneficiaries with moderate needs who do not meet the nursing facility level of care. The demonstration allowed the state to increase the in-home and residential caseload 124% at a cost that was less than half of what was projected in the budget neutrality formula. See Figure 28.[242] The statute authorizing the demonstration requires that any savings from lower nursing facility use must be invested in HCBS.

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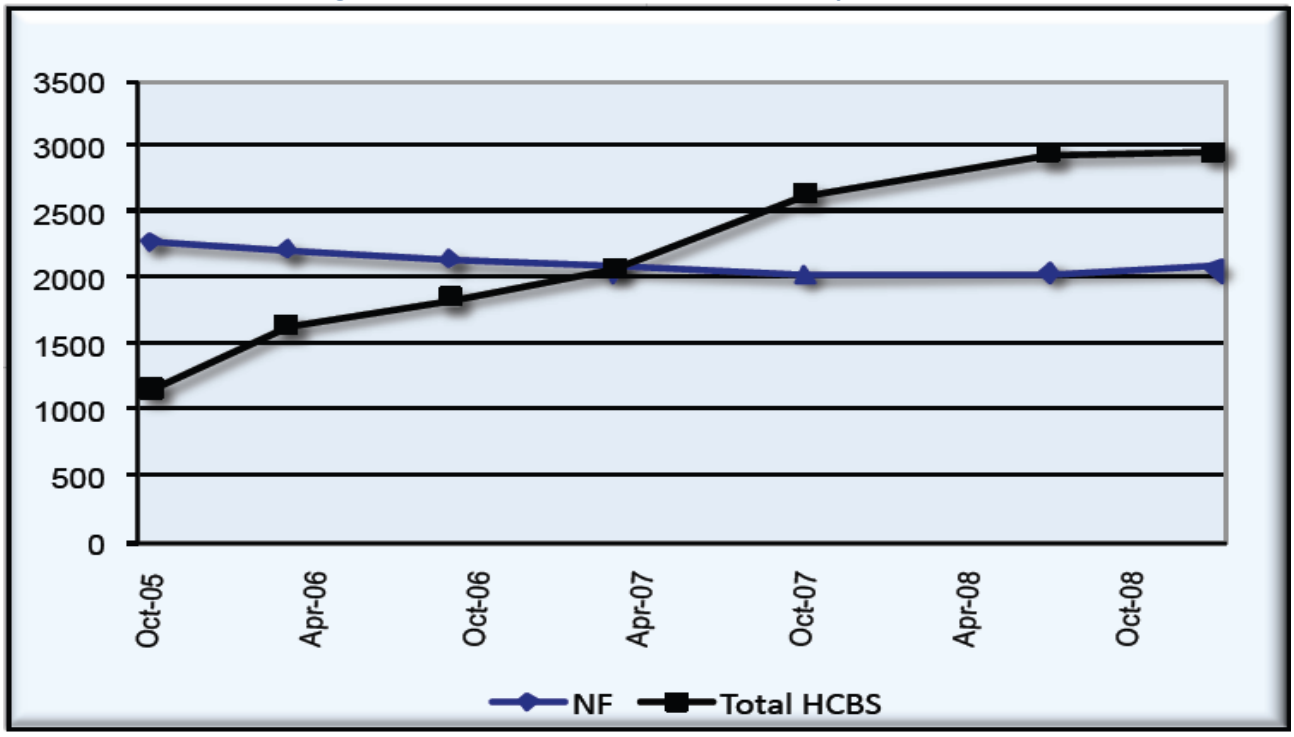
[239] For a discussion of global budgeting see Hendrickson, L. & Reinhard, S. (2004), *Global Budgeting: Promoting Flexible Funding to Support Long-Term Care Choices*, Center for State Health Policy, Rutgers University, New Brunswick, NJ. Retrieved on 4-28-09: http://www.hcbs.org/files/52/2599/State_policy_in_practice.pdf.

[240] Crowley, J., and O'Malley, M. (November, 2008), *Vermont's Choice for Care Medicaid Long-Term Services Waiver: Progress and Challenges as the Program Concluded its Third Year*. Kaiser Commission on Medicaid and the Uninsured. Washington, DC.

[241] Ibid.

[242] Mollica, R., Kane, R., and Priester, R. *Rebalancing Long-Term Care Systems in Vermont: State Case Study as of December 2007*. Crowley and O'Malley, ibid. (June, 2008).

Figure 28: Vermont Choices for Care Participant Trends



Washington and Vermont use a global budget to support institutional and community LTC services. This strategy allows funding to "follow the person." State officials monitor total spending for multiple programs and services rather than individual appropriations.

28. Develop a Long-Term Care Database

In the absence of a single department or other administrative structure, it may be possible to create a more coordination and centralized management by developing a long-term care database or data warehouse. Currently, data are organized by program and rather at the individual level. The Departments can report on how many persons receive service in HCBS waivers, IHSS, ADHC and nursing facilities, but cannot readily report on the total number of unduplicated persons who receive these services, what their costs are, or compare the characteristics of persons receiving services in different programs. The management of state programs would benefit substantially from having a long-term care data base that contains information on the physical and mental characteristics and service utilization history of persons using long term care services. The purpose of the database is to enable the state to manage long-term care services as though it were one program. The database will permit the comparison of persons across programs so the state can understand who uses programs, what services they receive, and what the total costs are.

Legislation filed in 2006 (AB 3019) would have required development of a single assessment tool, the Community Options and Assessment Protocol (COAP), to replace multiple assessment instruments. COAP would be used for IHSS, MSSP and other waiver services. These programs

have separate applications, assessment and eligibility processes and information is not shared across programs.

The project had the following goals:

- Facilitate consumer access and cross-referrals to home and community-based services
- Assess an individual's unique abilities, functions, needs and personal preferences appropriately
- Develop sufficient information to support preliminary care planning
- Develop sufficient information to support preliminary service authorizations across medical and supportive services and the continuum of long-term care services
- Identify resource limitations and statutory, administrative, organizational and any other obstacles that hinder the implementation of a coordinated assessment protocol
- Develop and test a process that can better help consumers access HCBS in a timely manner
- Identify a common set of data elements that are collected across the full spectrum of home and community-based programs

While the bill was not signed into law, the bill's objectives are compelling and are consistent with this recommendation. A standardized assessment tool supports determination of functional eligibility for all available programs and services, identification of unmet needs for health and supportive services and development of a care plan. At least nine states use sophisticated automated assessment tools.[243] The assessment information is used to determine level of care for HCBS Waivers and admission to a nursing facility. In Maine, Oregon and Washington, the tools are linked to the state's financial eligibility system and the Medicaid payment system. A standard, automated tool helps minimize differences among case managers in the assessment process and preparation of the care plan.

A database of persons using LTC is essential for the efficient operation of programs. At a minimum the database needs to contain information on why persons are eligible for LTC.

Implications

California lacks common participant data across all programs. As a result, policy makers are not able to compare the health and functional characteristics and utilization patterns of individuals in different settings who receive services. Nor is information collected on their residential needs.

[243] Mollica, R., and Reinhard, S. (2006), *Rebalancing State Long Term Care Systems*. Ethics, Law and Aging Review. 11, 23-41.

One implication of this proposal is the need for continuing work on the interconnections between housing assistance and LTC needs.

California currently manages its LTC programs as though they were separate programs. A different way of thinking is to assume there is one LTC program with separate parts. The development of common participant data is a necessary step to build the capability of managing these parts in a coherent manner.

Conclusion

While California has an extensive commitment to funding for HCBS and operates the largest single program, IHSS, in the country, there are cost-effective improvements that can be made. The recommendations contained in this report recognize that comprehensive systems have:

- A philosophy that emphasizes consumer choice, independence and community services
- Clear goals and a strategic plan to guide policy decisions
- Flexible funding through global budgeting or pooled financing that allow funds to follow the person
- Single entry points that streamline access to HCBS, residential settings and institutional services
- Consolidation of state responsibilities in one state agency
- Options counseling and diversion programs for persons seeking long-term care services
- Transition coordination for individuals in institutions who want to return to the community
- Residential, in-home, nursing facilities, day care and other services
- Eligibility criteria that facilitate access to community services

The report includes recommendations that can be implemented over time based on the complexity, planning and development needed to carry them out.

Appendices

Appendix A: Related Reports and Articles

Acosta, P. & Hendrickson, L. (2008), *Advancing Medicaid HCBS Policy: From Capped Consumer to Consumer Directed*, Rutgers University, Rutgers Center for State Health Policy. New Brunswick, N.J. http://www.cshp.rutgers.edu/cle/Products/Advancing HCBS Policy 3-31.doc

Assembly Committee on Aging and Long-Term Care, (September, 2006), *Building an Aging Agenda for the 21st Century*, State of California, Sacramento, CA. http://www.assembly.ca.gov/acs/committee/c406/publications/Building%20an%20Aging%20Agenda%20for%20the%2021st%20Century.pdf

Berkeley Policy Associates, (January 30, 2005), *Independent Evaluation of the Traumatic Brain Injury Services of California*, a legislative report prepared for the Department of Mental Health, Sacramento, CA. http://www.dmh.ca.gov/Services_and_Programs/Adults/docs/TBI_docs/TBI_Eval_Leg_Rep_0106.pdf

Burwell, B., Sredl, K., and Eiken, S. (2008), *Medicaid LTC Expenditures in FY 2007.* Thomson Reuters, September.

California Center for Long Term Care Integration, (May, 2003), *Nursing Home Utilization Would Be Higher Without Home & Community-Based Services (HCBS)*, Home to Home & Community-Based Services, Policy Issue Brief: Andrus Gerontology Center University of Southern California, Los Angeles, CA.

California Center for Long Term Care Integration, (July, 2003), *Long Term Care Service Delivery Options for California Counties aka. The Options Paper*, Andrus Gerontology Center University of Southern California, Los Angeles.

California Center for Long Term Care Integration, (February, 2004), *Cost Savings Research*, Andrus Gerontology Center University of Southern California, Los Angeles, CA.

California Center for Long Term Care Integration, (March 16, 2004), *Aggregate 1999–2000 California data by county on Medicare and Medicaid expenses of IHSS program participants.*

California Center for Long Term Care Integration, (March 16, 2004), *Aggregate 1999–2000 California data by county on Medicare and Medicaid expenses of persons with developmental disabilities.*

California Center for Long Term Care Integration, (March 16, 2004), *Aggregate 1999–2000 California data by county on Medicare and Medicaid expenses of persons who are dually eligible for Medicare and Medicaid whose age is 65 or greater.*

California Center for Long Term Care Integration, (March 16, 2004), *Aggregate 1999–2000 California data by county on Medicare and Medicaid expenses of persons who are dually eligible for Medicare and Medicaid whose age is 65 or greater and who are disabled.*

California Center for Long Term Care Integration, (March 16, 2004), *Aggregate 1999–2000 California data by county on Medi-Cal beneficiaries*.

California Center for Long Term Care Integration, (March 16, 2004), *Aggregate 1999–2000 California data by county on persons who are both Medicaid and Medicare eligible and who are disabled.*

California Commission on Aging, (May 22, 2003), *The SB-910 Long Range Strategic Plan for Aging* Sacramento, CA. http://www.ccoa.ca.gov/about/SB_910.asp

California Department of Aging. Undated Report on AB 1215. Sacramento, CA.

California Health Care Foundation, (1996), *Little Hoover Commission, 1996 Report on Long-Term Care in California, Summary of Key Findings and Recommendations*, Oakland, CA. http://www.chcf.org/documents/hospitals/LittleHooverCommLTC1996.pdf

California Health Care Foundation, (2007), *The Changing Face of California's Nursing Home Industry*, Oakland, CA. http://www.chcf.org/documents/hospitals/ChangingFaceNursingHome07.pdf

California Health and Human Services Agency, (1999), *Report on Long-Term Care Programs and Options for Integration (AB1215/Mazzoni)*, Sacramento, CA.

California Health and Human Services Agency, (October 14, 2003), *Strategic Plan for An Aging California Population: Getting California Ready for the "Baby Boomers,"* State of California, Sacramento, CA. http://www.ccoa.ca.gov/pdf/population.pdf

California Health Care Foundation, (2007), *Long Term Care: Facts and Figures*, Oakland, CA. http://www.chcf.org/documents/hospitals/LTCFactFigures07.pdf

California Performance Review, (August, 2004), *HHS24 Intermediate Care Facilities for Individuals with Developmental Disabilities not Benefiting from Full Federal Participation,* A Report submitted to Gov. Arnold Schwarzenegger, Sacramento, CA. Retrieved on 9-3-2009 http://cpr.ca.gov/CPR_Report/Issues_and_Recommendations/Chapter_2_Health_and_Human_Services/HHS24.html

California Performance Review, (August, 2004), *HHS32 Transfer the In-Home Supportive Services Program to the Department of Health Services to transfer IHSS to Medi-Cal.* A Report submitted to Gov. Arnold Schwarzenegger, Sacramento, CA. Retrieved on 9-3-2009 from http://cpr.ca.gov/CPR_Report/Issues_and_Recommendations/Chapter_2_Health_and_Human_Services/HHS32.html

California State Auditor, (February, 2007), *Department of Health Services: It Has Not Yet Fully Implemented Legislation Intended to Improve the Quality of Care in Skilled Nursing Facilities,* Report 2006-035, State of California, Sacramento, CA. http://www.bsa.ca.gov/pdfs/reports/2006-035.pdf

California Strategic Plan on Aging Advisory Committee, (May, 2004), *Planning for an Aging California Population: Preparing for the "Aging Baby Boomers,"* A report prepared for the Assembly Committee on Aging and Long Term Care, State of California, Sacramento, CA. http://www.nbrc.net/Links-pictures/AgingBabyBoomers.pdf

Darwin, B. (December, 2006), *Long Term Care Reform: Ten Years after Little Hoover* Commission Report, California Health Care Foundation, Oakland, CA. http://www.chcf.org/documents/hospitals/LTCLittleHoover.pdf

Darwin, B. (June, 2007), *Long Term Care Reform: Recommendations for Change* California Health Care Foundation, Oakland, CA. http://www.chcf.org/documents/chronicdisease/LTCRecommendationsSummary.pdf

Department of Developmental Services, (December, 2007), *Controlling Regional Center Costs: Report to the Legislature Submitted to fulfill the requirements of Section 102.5, Chapter 188, Statutes of 2007***,** Sacramento, CA. http://www.dds.ca.gov/Publications/docs/ControllingRCCosts2007.pdf

Donaldson, C. (October, 2007), *Medi-Cal Aid Codes Documentation*, Medical Care Statistics Section, California Department of Health Services, State of California, Sacramento, CA. http://www.dhs.ca.gov/mcss/General Information/Aid Codes Documentation full.pdf

Boris E., Delp L. & Howes, C. (March 22, 2007*), The Current Budget Proposal and its Implications for the In-Home Supportive Services (IHSS) Program*, Briefing for California State Legislative Staff.

Expert Panel to Review California Department of Aging Structure, (September, 2004), *Planning for an Aging California Population Restructuring the California Department of Aging and Long-Term Care Services in California*, A Report prepared for the Assembly Committee on Aging and Long Term Care, State of California, Sacramento, CA.

Fishman, E., Vladeck, B., Palermo, A., & Davis, M. (December, 2003), *The Olmstead Decision and Long-Term Care in California: Lessons on Service, Access and Costs from Colorado, Washington and Wisconsin*, California Health Care Foundation, Oakland, CA. http://www.chcf.org/documents/policy/OlmsteadLessonsForCalif.pdf

General Accounting Office, (October, 2003), *Medicaid Nursing Home Payments: States' Payment Rates Largely Unaffected by Recent Fiscal Pressures*. GAO-04-143, Washington D.C. http://www.gao.gov/atext/d04143.txt

Harrington, C., Carrillo, H., Wellin, V., Norwood, F., and Miller, N.A. (2001), *Access of Target Groups To 1915(c) Medicaid Home and Community-Based Waiver*. Home Health and Community Care Services Quarterly. 20 (2): 61-80.

Harrington, C., LeBlanc, A.J., Wood, J., Satten, N., (2002), *Met and Unmet Need for Medicaid Home and Community Services in the States*. Journal of Applied Gerontology. 21 (4):524-55

Harrington, C., Anzaldo, S., Burdin, A., Kitchener, M., and Miller, N. (2005), *Trends in State Certificate of Need and Moratoria Programs for Long Term Care Providers.* Journal of Health and Social Policy. 19 (2):31-58.

Harrington, C., Chapman, S., Miller, E., Miller, N. and Newcomer, R.J. (2005), *Trends in the Supply of Long-Term-Care Facilities and Beds in the U.S.* J. of Applied Gerontology. 24 (4): 265–282.

Harrington, C., O'Meara, J., Collier, E., Kang, T., Stephens, C., & Chang, J.,(April 1, 2008), *Impact of California's Medi-Cal Long Term Care Reimbursement Act On Access, Quality and Costs*. Department of Social and Behavioral Sciences, UCSF. Retrieved on 2-3-09 from http://sbs.ucsf.edu/public/ab1629.pdf

Harrington, C., Carrillo, H., and Woleslagle Blank, B. (2008), *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2001 Through 2007.* San Francisco, CA: University of California, Department of Social and Behavioral Sciences. www.pascenter.org; http://www.nccnhr.org/public/50_155_433.cfm

Harrington, C., Granda, B., Carrillo, H., Chang, J., Woleslagle, B., Swan, J.H., Dreyer, K., et al. (2008), *State Data Book on LTC, 2007: Program and Market Characteristics.* Reported Prepared for the US Dept. of Housing and Urban Development San Francisco, CA: University of California.

Harrington, C. and Kang, T. (2008), *Disparities in Service Utilization and Expenditures for Individuals with Developmental Disabilities*. Disability and Health Journal. 1 (4):181–244.

Health Management Associates, (2004, December), *Revenue Maximization Strategies Final Report*, A report prepared for The California Endowment, Los Angeles, CA. http://www.healthmanagement.com/news_details.asp?newsarticleid=73

Hendrickson L. & Reinhardt S. (2004) *Global Budgeting: Promoting Flexible Funding to Support Long-Term Care Choices*, Rutgers Center for State Health Policy, New Brunswick, N.J. Retrieved on 9-27-09 from http://www.hcbs.org/files/52/2599/State_policy_in_practice.pdf

Hendrickson, L. and Kyzr-Sheeley, G. (March, 2008), *Determining Medicaid Nursing Home Eligibility: A Survey of State Level of Care Assessment*, Rutgers University, Center for State Health Policy, New Brunswick, N.J. http://www.cshp.rutgers.edu/cle/Products/Nursing%20Facility%20Level%20of%20Care%20FINAL.pdf

Hendrickson, L. & Blume, R. (2008), *A Survey of Medicaid Brain Injury Programs*, Rutgers University, Rutgers Center for State Health Policy. New Brunswick, N.J. http://www.cshp.rutgers.edu/cle/Products/Brain%20Injury%20Waivers.pdf

Holahan, J. & Yemene A. (September –October, 2009), *Enrollment is Driving Medicaid Costs --- But Two Targets Can Yield Savings*, Health Affairs. 28 (4): 1460.

Howes, C. (2004), *Upgrading California's Home Care Workforce: The Impact of Political Action and Unionization*. The State of California Labor. Berkeley, CA: University of California, Institute for Labor and Employment, Multi-Campus Research Unit. Retrieved on January 20, 2008 from: http://www.irle.ucla.edu/research/scl/pdf04/scl2004ch3.pdf

Howes, C. (November, 2002), *The Impact of a large wage increase on the workforce stability of IHSS Home Care Workers in San Francisco County*. Berkeley, CA: University of California, Center for Labor Education Research. Retrieved on January 20, 2008 from: http://www.directcareclearinghouse.org/download/WorkforceStabilityPaper.pdf

Jasinski, C. (February 3, 2004), *SB 910 California's Strategic Plan for an Aging Population: Getting Ready for the Aging Boomers*, California Commission on Aging, Sacramento, CA. http://sinet2.sen.ca.gov/aging/HEARINGS/CHERI_JASINJKI.PPS

Kang, T. and Harrington, C. (2008), *Variation in Types of Service Use and Expenditures for Individuals with Developmental Disabilite.* Disability and Health Journal. 1:30-41.

Kaye, H., LaPlante, M. & Harrington, C. (January, 2009), *Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?* Health Affairs, Vol. 28, No. 1 pp. 262–272. An abstract of the article can be found at, retrieved on 1-11-09, http://content.healthaffairs.org/cgi/content/abstract/28/1/262

Kaye, H.S., Chapman, S., Newcomer, R.J., and Harrington, C. (2006), *The Personal Assistance Workforce: Trends in Supply and Demand*. Health Affairs. 25 (4): 1113–1120.

Kim, J., Atkins, S. (December, 2003), *Risk Factors for Long-Term Nursing Facility Placement Among Dually Eligible IHSS Users Aged 65+*, Research Brief #1**,** California Center for Long Term Care Integration, Andrus Gerontology Center University of Southern California, Los Angeles, CA.

Kitchener, M., Carrillo, H., and Harrington, C. (2003), *Medicaid Community-Based programs: A Longitudinal Analysis of State Variation in Expenditures and Utilization.* Inquiry. 40(4): 375-389.

Kitchener, M., Ng, T., and Harrington, C. (2004), *Medicaid 1915c Home and Community-Based Services Waivers: A National Survey of Eligibility Criteria, Caps, and Waiting Lists.* Home Health and Community Services Quarterly. 23 (2):55-69.

Kitchener, M., Ng, T., Grossman, B. and Harrington, C. (2005), *Medicaid Waiver Programs for Traumatic Brain and Spinal Cord Injury*. J. of Health and Social Policy. 20 (3): 51-66.

Kitchener, M., Ng, T., Miller, N., and Harrington, C. (2005), *Medicaid Home and Community-Based Services: National Program Trends.* Health Affairs. 24 (1): 206–212.

Kitchener, M., Hernandez, M., Ng, T., and Harrington, C. (2006), *Residential Care Provision in Medicaid Home and Community-Based Waivers: A National Study of Program Trends.* The Gerontologist. 46 (2):165–172.

Kitchener, M., Swan J., & Harrington, C. (2006), *Medicaid Nursing Facility Utilization*, Research on Aging 28:493-514.

Kitchener, M., Ng, T., Miller, N, and Harrington, C. (2006), *Institutional and Community-Based Term Care: A Comparative Estimate of Public Costs*. J. of Health and Social Policy. 22 (2):31-50.

Kitchener, M., Ng, T., Carrillo, H., Miller, N.A., and Harrington, C. (2007), *Developing Personal Care Programs: National Trends and Inter-state Variation, 1992–2002.* Inquiry. 44 (1): 69-87.

Kitchener, M., Ng, T., and Harrington, C. (2007), *Medicaid Home and Community-Based Services for the Elderly: Trends in Programs and Policies.* J. of Applied Gerontology. 26 (3): 303-324.

Kitchener, M., Ng, T., and Harrington, C. (2007), *State Medicaid Home Care Policies: Inside the Black Box.* Home Health Care Services Quarterly. 26 (3): 23-38.

Kitchener, M., Ng, T., and Harrington, C. (2007), *Medicaid State Plan Personal Care Services: Trends in Programs and Policies.* J. of Health and Social Policy. 19 (3): 9–26.

LaPlante, M.P., Harrington, C., and Kang, T. (2002), *Estimating Paid and Unpaid Hours of Personal Assistance Services in Activities of Daily Living Provided to Adults Living at Home*. Health Services Research. 37 (2): 397-415.

LaPlante, M.P., Kaye, H.S. and Harrington, C. (2007), *Estimating the Expense of a Mandatory Home and Community-Based Personal Assistance Services Under Medicaid: The Case of MiCASSA*. J. of Health and Social Policy. 19 (3): 47-64.

Lee, R. & Villa, V. (November 16, 2000), *Population Aging in California* The Center on the Economics and Demography of Aging, Demography Department, The University of California, Berkeley. http://www.ceda.berkeley.edu/papers/rlee/PopAging-villa2.pdf

Legislative Analyst's Office, (February, 2006), *Analysis of the 2006-07 Budget Bill*, State of California, Sacramento, CA. http://www.lao.ca.gov/analysis_2006/health_ss/hss_02_anl06.html

Legislative Analyst's Office, (October 16, 2007), *In-Home Supportive Services: Background on Budget, Providers, and Registries*, State of California, Sacramento, CA. http://www.lao.ca.gov/laoapp/PubDetails.aspx?id=1677

Legislative Analyst's Office, (November 11, 2008), *Overview of the Governor's Special Session Proposals,* Sacramento, CA.

Legislative Analyst's Office, *2009–2010 Budget Analysis Series Health DHCS—Nursing Home Fee Program Should Be Revised,* Sacramento, CA.

Legislative Analyst's Office, (Undated), *Analysis of the 2007-08 Budget Bill: Health and Social Services,* Medi-Cal (4260), State of California, Sacramento, CA. http://www.lao.ca.gov/analysis_2007/health_ss/hss_04_4260_anl07.aspx

Little Hoover Commission, (December, 1996), *Long-Term Care:Providing Compassion Without Confusion,* Report #140, Sacramento, CA. Retrieved on 9-3-09 from http://www.lhc.ca.gov/studies/140/report140.pdf

MaCurdy, T., Chan, R., Chun, R., Johnson, H., & O'Brien-strain (June, 2005), *Medi-Cal Expenditures: Historical Growth and Long Term Forecasts*, Public Policy Institute of California, San Francisco, CA. http://www.ppic.org/main/publication.asp?i=619

McGarry K. & Kaskie, Brian (2001), *The Economic Wellbeing of Older Californians,* Working Paper: Strategic Planning on Aging, California Policy Research Center, University of California. No copy available.

Medical Care Statistics Section, (January, 2005), *Medi-Cal Managed Care Expansion—Aged, Blind, Disabled, and Long-Term Care Populations*, California Department of Health Services, Sacramento, CA. Retrieved on 9-3-09 from http://www2.sdcounty.ca.gov/hhsa/ltc/pdf/SeniorsanddreportRevised-1.7.pdf

Medi-Cal, (February, 2006), *Medi-Cal Update Part 2 billing and Policy*, Bulletin 347 State of California, Sacramento, CA. Retrieved on 9-3-09 from http://www.dhcs.ca.gov/services/medi-cal/Documents/AB%201629%20Prov.Bulletins.Policy/Medi-Cal%20Bulletin%20347.pdf

Miller, N.A., Ramsland, S., Goldstein, E. and Harrington, C. (2001), *Use of Medicaid 1915c Home and Community-Based Care Waivers to Reconfigure State Long Term Care Systems*. Medical Care Research and Review. 58 (1):100–119.

Miller, N.A., Harrington, C. and Goldstein, E. (2002), *Access to Community-Based Long Term Care—Medicaid's Role*. Journal of Aging and Health. 14 (1):138–159.

Miller, N.A., Harrington, C., Ramsland, S., and Goldstein, E. (2002), *State Policy Choices and Medicaid Long-Term Care Expenditures.* Research on Aging. 24 (4):413-444.

Miller, N.A., Kitchener, M., Elder, K.T., Kang, Y., Rubin, A., Harrington, C. (2005), *Variation by Disability in State Predictors of 1915C Waiver Use and Expenditures*. The Gerontologist. 45 (6):764-772.

Miller, N.A., Rubin, A., Elder, K.T., Kitchener, M., and Harrington, C. (2006), *Strengthening Home and Community-Based Care Through Medicaid Waivers*. J. of Aging & Social Policy. 18 (1): 1–16.

Miller, N., Elder, K.T., Kitchener, M., Kang, Y. and Harrington, C. (2008), *Medicaid 1915c Waiver Use and Expenditures for Persons Living with HIV/AIDS.* Medicare Care Research and Review. 65 (3) 338-55.

Mollica, R. and Gillespie, J. (August, 2003), *State Single Entry Point Systems: State Survey Results*. Rutgers/NASHP community Living Exchange. http://www.nashp.org/Files/SEPReport11.7.03.pdf

Mollica, R. (August, 2004), *Expediting Medicaid Financial Eligibility*. Rutgers/NASHP Community Living Exchange. Available at: http://www.nashp.org/Files/presumptive_eligibility.pdf.

Mollica, R., Kane R., and Priester, R. (December, 2005), *Rebalancing Long-Term Care Systems in Vermont.* Available at: http://www.hpm.umn.edu/ltcresourcecenter/research/rebalancing/attachments/baseline_case_studies/Vermont_long_baseline_case_study.pdf

Mollica, R., and Reinhard, S. (2006), *Rebalancing State Long Term Care Systems*. Ethics, Law and Aging Review. 11, 23-41.

Mollica, R., Sims-Kastelein, K., and O'Keeffe, J. *Residential Care and Assisted Living Compendium: 2007*. US DHHS, Office of the Assistant Secretary for Planning and Evaluation. http://aspe.hhs.gov/daltcp/reports/2007/07alcom.htm

Ng, T., Kitchener, M., and Harrington, C. (2006), *Medicaid Home Care Waivers for Persons with HIV/AIDS: Program Expenditures, Participants and Policies.* AIDS and Public Policy Journal. 19 (3/4):95–109.

Ng, T., Harrington, C., and O'Malley, M. (2008), *Medicaid Home and Community-Based Service Programs:Data Update.* Report prepared for the Kaiser Commission on Medicaid and the Uninsured, Washington, DC: Kaiser Commission on Medicaid and the Uninsured. http://www.kff.org/medicaid/upload/7720_02.pdf

Ng, T. and Harrington, C. (2008), Medicaid *Home and Community-Based Service Program Data. Unpublished Form 372 and Survey Data from States*. San Francisco, CA: University of California.

Reich, M., Hall P., and Jacobs, K. (2002), *Living wages and economic performance: The San Francisco Airport model. Berkley, CA: University of California, Institute of Industrial Relations.*

Reinhard, S. and Hendrickson, L. (September , 2006), *Money Follows the Person: State Approaches to Calculating Cost Effectiveness*. Center for State Health Policy, Rutgers University, New Brunswick, NJ. http://www.cshp.rutgers.edu/cle/Products/MFPCalcCostEffectivenessWEB.pdf

Reinhard, S. & Hendrickson L. (June, 2006), Money *Follows the Person: State' Progressin Using the Minimum Data Set (MDS) to Facilitate Nursing Home Transition*. Rutgers University, Center for State Health Policy, New Brunswick, NJ. http://www.cshp.rutgers.edu/cle/Products/MDSIIWEB.pdf

Reinhard, S. & Hendrickson L. (June, 2007), *The Minimum Data Set:Recommendations to Help States Better Support Nursing Home Residents Who Seek Community Living,* Center for State Health Policy, Rutgers University, New Brunswick, NJ.

Schnelle, J., Mukamel, D., Sato, H.W., & Chang, J. (March, 2008), *Evaluation of AB 1629*. Vanderbilt University, Center for Quality Aging, Vanderbilt University Medical Center, Department of Medicine. Nashville, TN.

Scharlach, A., Torres-Gil, F. & Kaskie, B. (May, 2001), *Strategic Planning Framework for an Aging Population*, California Policy Research Center, California Policy Research Center University of California.
http://www.aging.state.pa.us/aging/lib/aging/sb910aging1.pdf

Shugarman, L. (November 1, 2002), *Information Systems in California*, PowerPoint presented to Gerontological Society of America, Andrus Gerontology Center University of Southern California, Los Angeles, CA.

Social and Economics Science Research Center, (September, 2008), Home *Care QualityAuthority Individual Provider Phone Survey***,** A report prepared for the Washington Home Care Authority, Olympia, WA. http://www.hcqa.wa.gov/Surveys/survey_docs/HCQA_2008_ProviderSurvey_phone.pdf

State of California, (February, 2002), *Text of AB 1629*, Department of health Care Services, Long Term Care System Development Unit, Sacramento, CA.
http://www.dhs.ca.gov/mcs/mcpd/rdb/ltcsdu/pdfs/Legislation.pdf

Summer, L. & Ihara, E. (August, 2005), *The Medicaid Personal Care Services Benefit: Practices in States that Offer the Optional State Plan Benefit***,** Georgetown University Health Policy Institute, Report prepared for AARP Public Policy Institute, Washington, D.C.

Tonner, M.C., Harrington, C. and LeBlanc, A.J. (2001), *State Long Term Care Screening and Assessment Programs in 1999*. Home Health and Community Care Services Quarterly. 19 (3): 57-85.

Tonner, C. and Harrington, C. (2004), *Nursing Facility and Home and Community-Based Service Need Criteria in the United States*. Home Health and Community Services Quarterly. 22 (4): 65-83.

United Cerebral Palsy, (2009), *The Case for Inclusion: An Analysis of Medicaid for Americans with Intellectual and Developmental Disabilities*, Washington, D. C. Retrieved on 9-29-2009 from http://www.ucp.org/medicaid/main.cfm

Wade, K. and Hendrickson, L. (June 2008), *Modeling the Impact of Declining Occupancy on Nursing Home Reimbursement.* Rutgers Center for State Health Policy, Rutgers University, New Brunswick, NJ. http://www.cshp.rutgers.edu/cle/Products/7800.pdf

Wilber, K., & Alkema, G. (May 12, 2003), *Caring Counts! Creating a Seamless, Coordinated and Integrated Long-Term Care System in California:Where We Are and Where We Need to Go*, California Center for Long Term Care Integration, University of Southern California, Los Angeles, CA.
Wilber, K. (June, 2003), *Service and System Development in California: SB 910 and Other System Development Efforts*, PowerPoint presented at The American Society on Aging, Summer Series 2003, Andrus Gerontology Center University of Southern California, Los Angeles.

Wyoming Department of Health, (November, 2002), *Report to the Joint Appropriations Committee on the impact of funding for direct staff salary increases in adult developmental disabilities community-based programs* (Ref S-2002-749). Cheyenne, WY. Wyoming Department of Health. Retrieved on 9-3-2009 from http://www.pascenter.org/documents/WY_2002.pdf

Appendix B: Glossary and Acronyms

Glossary

Activities of Daily Living (ADL): Basic personal activities which include bathing, eating, dressing, mobility, transferring from bed to chair and using the toilet. ADLs are used to measure how dependent a person may be on requiring assistance in performing any or all of these activities.

Acuity: As used in discussions of long-term care, it refers to the degree of impairment in a person's physical or mental conditions. For example, a person with substantial impairments is said to have high acuities.

Adult Care Home (Also called ***board and care home*** or ***group home***.): Residence which offers housing and personal care services for 3-16 residents. Services (such as meals, supervision and transportation) are usually provided by the owner or manager. May be a single family home.

Adult Day Care: A daytime community-based program for functionally impaired adults that provides a variety of health, social and related support services in a protective setting.

Alzheimer's Disease: A progressive, irreversible disease characterized by degeneration of the brain cells and severe loss of memory, causing the individual to become dysfunctional and dependent upon others for basic living needs.

Assisted Living: Residences that provide a "home with services" and that emphasize residents' privacy and choice. Residents typically have private locking rooms (only shared by choice) and bathrooms. Personal care services are available on a 24-hour-a-day basis.

Assistive Devices: Tools that enable individuals with disabilities to perform essential job functions, e.g., telephone headsets, adapted computer keyboards and enhanced computer monitors.

Board and Care Home (Also called ***adult care home*** or ***group home***.): Residence which offers housing and personal care services for 3-16 residents. Services (such as meals, supervision and transportation) are usually provided by the owner or manager. May be a single family home.

Capitation: A method of payment for health services in which the provider is paid a fixed amount for each patient without regard to the actual number or nature of services provided. Capitation payments are characteristic of health maintenance organizations (HMOs). Also, a method of public support of health professional schools in which eligible schools receive a fixed grant for each student enrolled.

Care Plan (Also called ***service plan*** or ***treatment plan***.): Written document which outlines the types and frequency of the long-term care services that a consumer receives. It may include treatment goals for him/her for a specified time period.

Caregiver: Person who provides support and assistance with various activities to a family member, friend or neighbor. May provide emotional or financial support, as well as hands-on help with different tasks. Caregiving may also be done from long distance.

Care/Case Management: Assessment of clients' needs, creation of service plans, and coordination and monitoring of services; they may operate privately or may be employed by social service agencies or public programs. Typically case managers are nurses or social workers.

Case Mix: A method by which a health care provider measures the service needs of the patient population which may be based on age, medical diagnosis, severity of illness or length of stay. A nursing facility or hospital's actual case mix influences cost and scope of the services provided by the facility to the patient, and case-mix reimbursement systems adjust payment rates accordingly.

Certificate of Need (CON): A certificate issued by a government body to a health care provider who is proposing to construct, modify or expand facilities, or to offer new or different types of health services. CON is intended to prevent duplication of services and overbedding. The certificate signifies that the change has been approved.

Chore Services: Help with chores such as home repairs, yard work and heavy housecleaning.

Chronic Care: Care and treatment given to individuals whose health problems are of a long-term and continuing nature. Rehabilitation facilities, nursing facilities and mental hospitals may be considered chronic care facilities.

Chronic Illness: Long-term or permanent illness (e.g., diabetes, arthritis) which often results in some type of disability and which may require a person to seek help with various activities.

Co-Insurance (Also called ***co-payment***.): The specified portion (dollar amount or percentage) that Medicare, health insurance or a service program may require a person to pay toward his/her medical bills or services.

Cognitive Impairment: Deterioration or loss of intellectual capacity which requires continual supervision to protect the insured or others, as measured by clinical evidence and standardized tests that reliably measure impairment in the area of (1) short or long-term memory, (2) orientation as to person, place and time or (3) deductive or abstract reasoning. Such loss in intellectual capacity can result from Alzheimer's disease or similar forms of senility or Irreversible Dementia.

Community-Based Services: Services designed to help older persons remain independent and in their own homes which can include senior centers, transportation, delivered meals or onsite congregate meals, visiting nurses or home health aides, adult day care and homemaker services.

Congregate Housing: Individual apartments in which residents may receive some services, such as a daily meal with other tenants. Other services may be included as well. Buildings usually have some common areas such as a dining room and lounge as well as additional safety measures such as emergency call buttons. May be rent-subsidized (known as Section 8 housing).

Continuing Care Retirement Community (CCRC): Communities which offer multiple levels of care (e.g. independent living, assisted living, skilled nursing care) housed in different areas of the same community or campus and which give residents the opportunity to remain in the same community if their needs change. Provide residential services (meals, housekeeping and laundry), social and recreational services, health care services, personal care and nursing care. Require payment of a monthly fee and possibly a large lump-sum entrance fee.

Continuum of Care: The entire spectrum of specialized health, rehabilitative and residential services available to the frail and chronically ill. The services focus on the social, residential, rehabilitative and supportive needs of individuals as well as needs that are essentially medical in nature.

Deinstitutionalization: Policy which calls for the provision of supportive care and treatment for medically and socially dependent individuals in the community rather than in an institutional setting.

Dementia: Term which describes a group of degenerative chronic diseases affecting the brain (including Alzheimer's Disease) which are characterized by memory loss and other declines in mental functioning. In most states it is the 9th or 10th leading cause of death.

Developmental Disability: A disability which originates before age 18 and can be expected to continue indefinitely, and constitutes a substantial handicap to the person's ability to function normally.

Disability: The limitation of normal physical, mental, social activity of an individual. There are varying types (functional, occupational, learning), degrees (partial or total), and durations (temporary or permanent) of disability. Benefits are often available only for specific disabilities, such as total and permanent (the requirement for Social Security and Medicare).

Durable Medical Equipment (DME) (Also called ***home medical equipment***.): Equipment such as hospital beds, wheelchairs and prosthetics used at home. May be covered by Medicaid and in part by Medicare or private insurance.

Escort Services (Also called ***transportation services***.): Transportation for older adults to services and appointments. May use bus, taxi, volunteer drivers or van services that can accommodate wheelchairs and persons with other special needs.

Functionally Disabled: A person with a physical or mental impairment that limits the individual's capacity for independent living.

Group Home (Also called ***adult care home*** or ***board and care home***.): Residence which offers housing and personal care services for 3-16 residents. Services (such as meals, supervision and transportation) are usually provided by the owner or manager. May be a single family home.

Home and Community-Based Services (HCBS): Services that are designed to support community living and delay or prevent admission to an institution for persons with various disabilities. HCBS can be funded by Medicaid state plan personal care, HCBS Waivers, state general revenues, the Older Americans Act, the Social Services Block and other sources, though Medicaid is the primary source of public funding.

Home and Community-Based Waivers: Section 2176 of the Omnibus Reconciliation Act permits states to offer, under a waiver, a wide array of home and community-based services that an individual may need to avoid institutionalization. Regulations to implement the act list the following services as community and home-based services which may be offered under the waiver program: case management, homemaker, home health aide, personal care, adult day health care, habilitation, respite care and other services.

Home Health Agency (HHA): A public or private organization that provides home health services supervised by a licensed health professional in the patient's home either directly or through arrangements with other organizations.

Home Health Aide: A person who, under the supervision of a home health or social service agency, assists elderly, ill or disabled person with household chores, bathing, personal care and other daily living needs. Social service agency personnel are sometimes called *personal care aides*.

Home Health Care: Includes a wide range of health-related services such as assistance with medications, wound care, intravenous (IV) therapy, and help with basic needs such as bathing, dressing, mobility, etc., which are delivered at a person's home.

Home Medical Equipment (Also called ***durable medical equipment***.): Equipment such as hospital beds, wheelchairs and prosthetics used at home. May be covered by Medicaid and in part by Medicare or private insurance.

Homebound: One of the requirements to qualify for Medicare home health care. Means that someone is generally unable to leave the home, and if they do leave home, it is only for a short time (e.g., for a medical appointment) and requires much effort.

Homemaker Services: In-home help with meal preparation, shopping, light housekeeping, money management, personal hygiene and grooming and laundry.

Independent Living: Rental units in which services are not included as part of the rent, although services may be available on site and may be purchased by residents for an additional fee.

Indirect Cost: Cost which cannot be identified directly with a particular activity, service or product of the program experiencing the cost. Indirect costs are usually apportioned among the program's services in proportion to each service's share of direct costs.

Instrumental Activities of Daily Living (IADL): Household/independent living tasks which include using the telephone, taking medications, money management, housework, meal preparation, laundry and grocery shopping.

Intermediate: Occasional nursing and rehabilitative care ordered by a doctor and performed or supervised by skilled medical personnel.

Intermediate Care Facility (ICF): A nursing facility, recognized under the Medicaid program, which provides health-related care and services to individuals who do not require acute or skilled nursing care, but who, because of their mental or physical condition, require care and services above the level of room and board available only through facility placement. Specific requirements for ICFs vary by state. Institutions for care of the mentally retarded or persons with related conditions (ICF/MR) are also included. The distinction between "health-related care and services" and "room and board" is important since ICFs are subject to different regulations and coverage requirements than institutions which do not provide health-related care and services.

Intermediate Care Facility for the Mentally Retarded (ICF/MR): An ICF which cares specifically for the mentally retarded.

Level of Care (LOC): Amount of assistance required by consumers which may determine their eligibility for programs and services. Levels include protective, intermediate and skilled.

Long-Term Care (LTC): Medical and/or social services designed to help persons who have disabilities or chronic care needs. Services may be short or long-term and may be provided in a person's home, in the community or in residential facilities (e.g., nursing facilities or assisted living facilities).

Managed Care: Method of organizing and financing health care services which emphasizes cost-effectiveness and coordination of care. Managed care organizations (including HMOs, PPOs and PSOs) receive a fixed amount of money per client/member per month (called a capitation), no matter how much care a member needs during that month.

Medi-Cal: California's Medicaid program.

Medicaid (Title XIX): Federal and state-funded program of medical assistance to low-income individuals of all ages. There are income eligibility requirements for Medicaid.

Medical Necessity: Services or supplies which are appropriate and consistent with the diagnosis in accord with accepted standards of community practice and are not considered experimental. They also cannot be omitted without adversely affecting the individual's condition or the quality of medical care.

Mental Health: The capacity in an individual to function effectively in society. Mental health is a concept influenced by biological, environmental, emotional and cultural factors and is highly variable in definition, depending on time and place. It is often defined in practice as the absence of any identifiable or significant mental disorder and sometimes improperly used as a synonym for mental illness.

Mental Health Services: Variety of services provided to persons of all ages, including counseling, psychotherapy, psychiatric services, crisis intervention and support groups. Issues addressed include depression, grief, anxiety and stress, as well as severe mental illnesses.

Mental Illness/Impairment: A deficiency in the ability to think, perceive, reason or remember, resulting in loss of the ability to take care of one's daily living needs.

Nursing Facility: Facility licensed by the state to offer residents personal care as well as skilled nursing care on a 24-hour-a-day basis. Provides nursing care, personal care, room and board, supervision, medication, therapies and rehabilitation. Rooms are often shared, and communal dining is common.

Olmstead: Refers to the June 22, 1999 Supreme Court decision *Olmstead v. L.C and E.W*. In rejecting the state of Georgia's appeal to enforce institutionalization of individuals with disabilities, the Supreme Court affirmed the right of individuals with disabilities to live in their community in its 6-3 ruling against the state of Georgia in the case. Under Title II of the federal Americans with Disabilities Act, said Justice Ruth Bader Ginsburg, delivering the opinion of the court, "states are required to place persons with mental disabilities in community settings rather than in institutions when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. "

Ombudsman: A representative of a public agency or a private nonprofit organization who investigates and resolves complaints made by or on behalf of older individuals who are residents of long-term care facilities.

Personal Care: Assistance with activities of daily living as well as with self-administration of medications and preparing special diets.

Rehabilitation: The combined and coordinated use of medical, social, educational and vocational measures for training or retaining individuals disabled by disease or injury to the highest possible level of functional ability. Different types of rehabilitation are distinguished: vocational, social, psychological, medical and educational.

Rehabilitation Services: Services designed to improve or restore a person's functioning, including physical therapy, occupational therapy and/or speech therapy. May be provided at home or in long-term care facilities. Costs may be covered in part by Medicare.

Reimbursement: The process by which health care providers receive payment for their services. Because of the nature of the health care environment, providers are often reimbursed by third parties who insure and represent patients.

Residential Care: The provision of room, board and personal care. Residential care falls between the nursing care delivered in skilled and intermediate care facilities and the assistance provided through social services. It can be broadly defined as the provision of 24-hour supervision of individuals who, because of old age or impairments, need assistance with the activities of daily living.

Respite Care: Service in which trained professionals or volunteers come into the home to provide short-term care (from a few hours to a few days) for an older person to allow caregivers some time away from their caregiving role.

Service Plan (Also called ***care plan*** or ***treatment plan***.): Written document which outlines the types and frequency of the long-term care services that a consumer receives. It may include treatment goals for him/her for a specified time period.

Skilled Care: "Higher level" of care (such as injections, catheterizations and dressing changes) provided by trained medical professionals, including nurses, doctors and physical therapists.

Skilled Nursing Care: Daily nursing and rehabilitative care that can be performed only by, or under the supervision of, skilled medical personnel.

Skilled Nursing Facility (SNF): Facility that is certified by Medicare to provide 24-hour nursing care and rehabilitation services in addition to other medical services. (See also ***nursing facility***.)

Special Care Units: Long-term care facility units with services specifically for persons with Alzheimer's Disease, dementia, head injuries or other disorders.

Spend-Down: Medicaid financial eligibility requirements are strict and may require beneficiaries to spend down (use up) assets or income until they reach the eligibility level.

Spousal Impoverishment: Federal regulations preserve some income and assets for the spouse of a nursing facility resident whose stay is covered by Medicaid.

Standard Error: In statistics, the standard error is defined as the standard deviation of an estimate. That is, multiple measurements of a given value will generally group around the mean (or average) value in a normal distribution. The shape of this distribution is known as the standard error.

Supplemental Security Income (SSI): A program of support for low-income aged, blind and disabled persons, established by Title XVI of the Social Security Act. SSI replaced state welfare programs for the aged, blind and disabled in 1972 with a federally administered program, paying a monthly basic benefit nationwide of $284.30 for an individual and $426.40 for a couple in 1983. States may supplement this basic benefit amount.

Support Groups: Groups of persons who share a common bond (e.g. caregivers) who come together on a regular basis to share problems and experiences. May be sponsored by social service agencies, senior centers, religious organizations or organizations such as the Alzheimer's Association.

Transportation Services (Also called ***escort services***.): Transportation for older adults to services and appointments. May use bus, taxi, volunteer drivers or van services that can accommodate wheelchairs and persons with other special needs.

Overview of Reimbursement Terms

In order to clarify a discussion of reimbursement, it is useful to describe terms that are used in the discussion:

Available Dollars: The amount of money that is going to be allowed into the rate. Can be a sum equal to a previous year's expenditures or budgeted dollars for the coming year.

Bed Hold: The reimbursement practice of paying a provider to hold a bed for someone who is temporarily absent. The rate for bed hold days is often set lower than the rate paid for a day in which the person occupies the bed.

Bidding: Practice of establishing payment rates by collecting bids from potential providers.

Budgeted Cost: Anticipated or projected amounts that might be incurred for a fiscal period. Not actual costs, even though they are frequently referred to as costs.

Cost-Based: A rate that is dependent on the specific provider's past or anticipated costs.

Cost Center: An activity, organization or object for which cost information is collected. Examples include direct service costs, indirect costs and general and administrative costs.

Date of Payment: Data on paid claims or expenditures reported for the date the claims were paid.

Date of Service: Data on paid claims or expenditures reported for the date the services were provided rather than the date the claims were paid.

Efficiency Incentives: Payment of some portion of the difference between an upper limit and actual costs below the limit.

Fixed Costs: Expenses that do not change in proportion to the activity of a business.

Flat Rate: Rates established by dividing available dollars by the projected number of users of a service or the projected number of services. May also be set through negotiation between payers and providers or be dependent upon the persuasive ability of providers to argue for a particular rate.

Freestanding: Refers to a program that is not part of a larger program. For example, a freestanding nursing facility is one that is not physically placed within a hospital or medical center.

Historical Cost: Actual cost incurred in a previous time period.

Inflated: An rate with an inflation factor added to it to provide an amount for projected inflation.

Marginal Costs: Change in total cost attributable to the production of an additional unit of service.

Pass-Through: Costs that are reimbursed 100% instead of having cost limits applied to them that reduce the amount that will be reimbursed.

Peer Groups: Practice of dividing providers into similar subgroups based on geography, size, ownership or some other characteristics of providers. The rates paid would then vary by peer group.
See http://www.dhcs.ca.gov/services/medi-cal/Documents/AB1629/PeerGroupingAnalysis.pdf

Percentiles: The practice of arraying provider costs into a distribution from high to low and only paying amounts that are at or under a certain percentile of the distribution. This payment practice results in a ceiling or cap on the amount that would be paid. For example, if a 75th percentile were used, providers' per diems that were less than or equal to the 75th percentile would be reimbursed in full, and per diems above the 75th percentile would only be paid the amount at the 75th percentile.

Price-Based: A rate that the payor is willing to pay a provider group for a specific service. Can be developed based on benchmarks, such as means, medians or percentiles of the actual cost experience of the provider group. Can also be based on an analysis of a hypothetical provider and the average market prices it would pay for goods and services to produce its products.

Projected Inflation Factor: Factor used to set the amount of money that providers will receive to compensate for changes in their costs during the rate period.
Provider Specific: Rates that are unique to a particular provider generally based on their cost experience.

Prospective Rate: A rate paid for a time period that will not be later readjusted based on costs incurred during the time period.

Rebasing: The practice of collecting cost information from providers to reset the rate using current cost information.

Retrospective Rate: A rate paid for a time period that is then adjusted or reconciled with actual costs incurred during the time period.

SSP: State Supplementary Payment that is funded from state general revenues to the Federal SSI payment.

Upper Limits (Also referred to as **ceilings**.): Maximum amounts per cost center that will be reimbursed, usually arrived at by arraying each provider's costs in a frequency distribution and picking a point in the distribution such as 115% of the distribution's median value.

Variable Costs: Expenses that change in relation to the activity of the business.

Acronyms

AAA	Area Agencies on Aging
ACL	All County Letter
ALF	Assisted Living Facility
ACS	Assistive Care Services
ADC	Adult Day Care
ADHC	Adult Day Health Care
ADL	Activities of Daily Living
ADRC	Aging and Disability Resource Connection
ADSA	Aging and Disability Services Administration
ALW	Assisted Living Waiver
ALWPP	Assisted Living Waiver Pilot Project
AIDS	Acquired Immune Deficiency Syndrome
AoA	Administration on Aging
ARI	Adjusting Reconfiguration Incentive
ASPE	Assistant Secretary for Planning and Evaluation
BAHP	Bay Area Housing Plan
BRI	Benchmarked Rate Incentive
BUAPP	Back-Up Attendant Pilot Program
CalHFA	California Housing Finance Agency
CBRF	Community-Based Residential Facility
CCI	Chronic Care Integration

CCO	Cal Care Options
CCR	California Code of Regulations
CCT	California Community Transitions
CCRC	Continuing Care Retirement Communities
CDA	California Department of Aging
CDSS	California Department of Social Services
CHHS	California Health and Human Services Agency
CLF	Community Living Fund
CMIPS	Case Management, Information and Payroll System
CMP	Case Management Program
CMS	Centers for Medicare & Medicaid Services
COAP	Community Options and Assessment Protocol
CON	Certificate of Need
CPI	Consumer Price Index
CPP	Community Placement Plan
CY	Calendar Year
DAAS	Department of Aging and Adult Services
DAIL	Department of Aging and Independent Living Services
DD	Developmentally Disabled
DDS	Department of Developmental Services
DHCS	The Department of Health Care Services
DMH	Department of Mental Health
DOR	Department of Rehabilitation
DRA	Deficit Reduction Act
DSS	Department of Social Services
EDD	Employment Development Department
FFP	Federal Financial Participation
FFY	Federal Fiscal Year
FI	Functional Index
FMR	Fair Market Rent
FPL	Federal Poverty Level
FRV	Fair Rental Value
FY	Fiscal Year
GAO	Government Accountability Office
HCBS	Home and Community-Based Services
HHS	Health and Human Services
HIV	Human Immunodeficiency Virus
HUD	Housing and Urban Development
IADL	Instrumental Activities of Daily Living
ICF	Intermediate Care Facility
ICF/DD	Intermediate Care Facility for the Developmentally Disabled
ICF/DD-H	Intermediate Care Facility for the Developmentally Disabled -Habilitative
ICF/DD-N	Intermediate Care Facility for the Developmentally Disabled -Nursing
ICF/MR	Intermediate Care Facility for the Mentally Retarded
ID/DD	Intellectual and Developmental Disabilities
IFSP	Individual Family Services Plan

IHO	In-Home Operations
IHSS	In-Home Supportive Services
IHMC	In-Home Medical Care
ILC	Independent Living Center
IMD	Institutions for Mental Disease
IPP	Individual Program Plan
JPA	Joint Powers Agreement
LAO	Legislative Analyst's Office
LTC	Long-Term Care
LTCC	Long-Term Care Consultation
MACR	Maximum Allowable Contract Rate
MCO	Managed Care Organization
MCWP	Medi-Cal Waiver Program
MDS	Minimum Data Set
MFP	Money Follows the Person
MHSA	Mental Health Services Act
MR/DD	Mental Retardation and Developmental Disabilities
MSSP	Multipurpose Senior Services Program
NF/AB	Nursing Facility A/B
NF/AH	Nursing Facility/Acute Hospital
NHT	Nursing Home Transition
NPC	Nonprofit Consortium
OLTL	Office of Long Term Living
OMB	Office of Management and Budget
OSCAR	Online Survey and Certification Reporting System
OSHPD	Office of Statewide Health Planning and Development
PA	Public Authority
PACE	Program for All-Inclusive Care for the Elderly
PAS/options	Preadmission Screening and Options
PDN	Private Duty Nursing
PERS	Personal Emergency Response Systems
PRI	Permanent Rate Incentive
QAF	Quality Assurance Fee
RCAC	Residential Care Apartment Complex
RCFE	Residential Care Facility for the Elderly
RDB	Rate Development Branch
RFP	Request for Proposal
RUGs	Resource Utilization Groups
SEP	Single Entry Point
SLS	Supported Living Services
SMA	State Medicaid Agency
SNF	Skilled Nursing Facility
SNF/RES	Skilled Nursing Facility -Residential
SPA	State Plan Amendment
SSI	Supplemental Security Income
SSP	State Supplement Program

SURGE	Service Utilization Review Guidance and Evaluation
TAR	Treatment Authorization Requests
TBI	Traumatic Brain Injuries
TILE	Texas Index for Level of Effort
WIC	Welfare and Institutions Code

Appendix C: California Aging Population Data

Table 100: Persons Age 75 and Older by County in California: 2006

County	Age 75–79	Age 80–84	Age 85 and Older	County	Age 75–79	Age 80–84	Age 85 and Older
Alameda	2.0%	1.7%	1.5%	Orange	2.0%	1.7%	1.4%
Alpine	2.6%	1.5%	2.3%	Placer	3.5%	2.0%	1.6%
Amador	3.9%	2.9%	2.2%	Plumas	4.1%	2.9%	2.3%
Butte	3.2%	2.3%	2.6%	Riverside	2.5%	1.7%	1.6%
Calaveras	4.0%	2.6%	2.4%	Sacramento	2.1%	1.7%	1.6%
Colusa	2.2%	1.6%	1.6%	San Benito	1.6%	1.3%	1.1%
Contra Costa	2.3%	1.8%	1.4%	San Bernardino	1.6%	1.3%	0.9%
Del Norte	2.6%	1.9%	1.5%	San Diego	2.4%	1.9%	1.5%
El Dorado	2.0%	1.7%	1.4%	San Francisco	3.0%	2.4%	2.4%
Fresno	1.8%	1.6%	1.4%	San Joaquin	1.8%	1.7%	1.3%
Glenn	2.6%	2.0%	1.8%	San Luis Obispo	2.6%	2.3%	2.6%
Humboldt	2.6%	2.2%	1.4%	San Mateo	2.5%	2.0%	2.0%
Imperial	2.6%	1.5%	1.0%	Santa Barbara	2.6%	2.3%	1.9%
Inyo	4.0%	3.1%	2.8%	Santa Clara	1.9%	1.7%	1.3%
Kern	1.8%	1.4%	0.8%	Santa Cruz	1.6%	2.0%	1.7%
Kings	1.0%	1.2%	1.0%	Shasta	3.1%	2.6%	1.8%
Lake	2.7%	3.0%	2.1%	Sierra	3.8%	2.3%	3.0%
Lassen	3.0%	2.4%	1.8%	Siskiyou	3.9%	2.9%	2.5%
Los Angeles	2.0%	1.6%	1.4%	Solano	2.1%	1.5%	1.3%
Madera	1.9%	1.5%	1.7%	Sonoma	2.4%	2.2%	2.0%
Marin	3.1%	2.2%	1.8%	Stanislaus	2.0%	1.5%	1.3%
Mariposa	3.8%	2.5%	2.1%	Sutter	2.3%	1.9%	1.5%
Mendocino	2.2%	2.2%	3.0%	Tehama	3.1%	2.3%	1.9%
Merced	1.7%	1.3%	1.1%	Trinity	3.9%	2.4%	1.9%
Modoc	3.6%	2.7%	2.3%	Tulare	1.8%	1.4%	1.2%
Mono	2.0%	1.2%	0.8%	Tuolumne	4.2%	3.0%	2.5%
Monterey	2.2%	1.4%	1.4%	Ventura	2.1%	1.7%	1.3%
Napa	2.6%	2.8%	1.9%	Yolo	1.9%	1.8%	1.2%
Nevada	3.9%	2.0%	2.4%	Yuba	1.7%	1.6%	0.8%

Data Source: 2006 American Community Survey and California Department of Finance

Table 101: Sizes of Older Populations Ranked by Percentage Change in Age 85 and Older: 2010–2030

County	2010 Age 75-79	2010 Age 80-84	2010 Age 85+	% Change 2020 Age 75-79	% Change 2020 Age 80-84	% Change 2020 Age 85+	% Change 2030 Age 75-79	% Change 2030 Age 80-84	% Change 2030 Age 85+
Mono	314	205	149	49%	57%	109%	158%	160%	256%
Alpine	48	32	43	21%	97%	114%	160%	194%	209%
Mariposa	734	527	462	58%	35%	47%	123%	107%	144%
Sutter	2,524	1,754	1,563	37%	38%	58%	101%	106%	143%
Trinity	582	424	351	44%	30%	54%	98%	106%	143%
Calaveras	2,023	1,336	1,273	44%	50%	51%	94%	113%	138%
Madera	3,377	2,283	2,467	62%	38%	42%	178%	165%	135%
Imperial	4,051	3,222	2,585	22%	14%	72%	107%	74%	131%
Lassen	730	551	520	44%	25%	47%	146%	131%	125%
San Benito	1,025	747	756	58%	24%	41%	152%	138%	124%
San Bernardino	35,200	25,819	23,604	45%	24%	42%	149%	124%	116%
El Dorado	4,851	3,277	3,291	57%	37%	31%	164%	159%	114%
Yuba	1,579	1,149	1,034	30%	25%	47%	95%	90%	114%
Amador	1,504	1,185	1,038	50%	27%	37%	112%	97%	112%
Kings	2,185	1,548	1,449	40%	33%	39%	129%	116%	111%
Del Norte	759	582	561	31%	18%	42%	111%	90%	107%
Solano	8,559	6,327	6,330	50%	24%	33%	157%	143%	103%
Kern	13,779	10,274	8,984	40%	19%	38%	135%	103%	102%
Lake	2,828	1,831	1,588	33%	25%	36%	85%	101%	101%
Stanislaus	10,752	8,207	8,066	39%	21%	38%	118%	101%	99%
Merced	4,672	3,338	3,152	26%	19%	40%	102%	89%	97%
Plumas	865	685	603	26%	15%	40%	68%	54%	94%
Tuolumne	2,519	1,838	1,734	31%	21%	36%	90%	85%	93%
San Joaquin	13,544	10,701	10,384	44%	17%	32%	124%	98%	92%
Placer	9,764	7,304	7,503	34%	25%	37%	107%	98%	91%
Tulare	7,967	5,916	5,790	39%	22%	30%	120%	104%	91%
Ventura	17,254	12,618	12,996	53%	27%	22%	131%	126%	90%
Yolo	3,505	2,602	2,727	50%	24%	22%	154%	129%	90%
Santa Clara	37,459	28,347	29,136	51%	26%	24%	132%	114%	89%
Orange	61,985	47,501	49,015	45%	21%	24%	109%	101%	87%
Contra Costa	23,037	17,575	18,522	60%	26%	16%	141%	133%	86%
Sierra	157	92	102	12%	34%	38%	56%	83%	84%
Modoc	406	264	301	22%	22%	32%	90%	126%	83%
Shasta	5,540	4,218	3,961	43%	19%	23%	106%	90%	79%
Mendocino	2,388	1,932	2,000	55%	13%	18%	120%	119%	77%
Nevada	3,492	2,519	2,379	52%	20%	10%	133%	123%	76%
Fresno	16,602	12,881	12,886	40%	14%	22%	129%	101%	76%

Marin	6,926	5,369	6,095	68%	21%	8%	120%	129%	75%
Sacramento	30,018	22,953	23,337	35%	15%	23%	125%	105%	74%
Glenn	708	600	611	46%	14%	25%	110%	66%	74%
California	784,021	611,699	628,276	39%	14%	21%	119%	96%	72%
Colusa	468	375	399	37%	7%	32%	129%	78%	72%
Monterey	8,561	7,077	7,259	38%	5%	22%	114%	92%	68%
Alameda	29,668	23,473	26,104	49%	14%	13%	139%	121%	67%
Tehama	2,001	1,464	1,445	17%	18%	26%	62%	59%	67%
Riverside	44,584	35,887	33,847	22%	5%	26%	101%	63%	66%
Los Angeles	205,957	161,478	166,704	34%	10%	18%	110%	85%	65%
Humboldt	3,041	2,478	2,461	42%	7%	17%	134%	108%	62%
Siskiyou	1,705	1,387	1,404	26%	3%	25%	78%	64%	62%
San Luis Obispo	8,182	6,557	6,520	32%	7%	18%	104%	82%	61%
Inyo	722	608	615	18%	-8%	28%	80%	45%	57%
Santa Cruz	4,132	3,349	4,175	67%	6%	-3%	211%	167%	51%
San Diego	62,018	50,543	54,188	35%	4%	10%	135%	93%	49%
Napa	3,725	2,881	3,552	41%	13%	3%	97%	90%	47%
San Mateo	15,876	13,456	15,439	40%	6%	4%	113%	87%	44%
Santa Barbara	9,895	8,298	9,133	26%	1%	8%	97%	64%	39%
Sonoma	10,031	8,463	9,808	59%	2%	-7%	156%	123%	39%
San Francisco	21,185	18,274	20,445	14%	-2%	17%	64%	54%	37%
Butte	6,058	5,118	5,430	34%	3%	0%	113%	74%	34%

Data Source: California Department of Finance, Calculations by the Authors

Figures 29-32 are maps that display the percentage of persons age 85 and older by county. Five shades are used in each map. Each color contains approximately 20% of the 58 counties and, the darker the color, the higher the percentage of persons age 85 and older. For example, the darkest color is used for those 12 counties whose percentage of persons age 85 and older ranges from 2.3% to 3.0%. The next lightest color shows those 12 counties whose percentage of persons age 85 and older ranges from 1.8% to 2.2%. The next three colors represent the percentages, 1.5% to 1.7%, 1.3% to 1.4% and .08 to 1.2%. The first map shows the entire state, and the three following maps show more details for selected areas of the state.

Figure 29: Map of California by County Showing Percentage of Persons Age 85 and Older

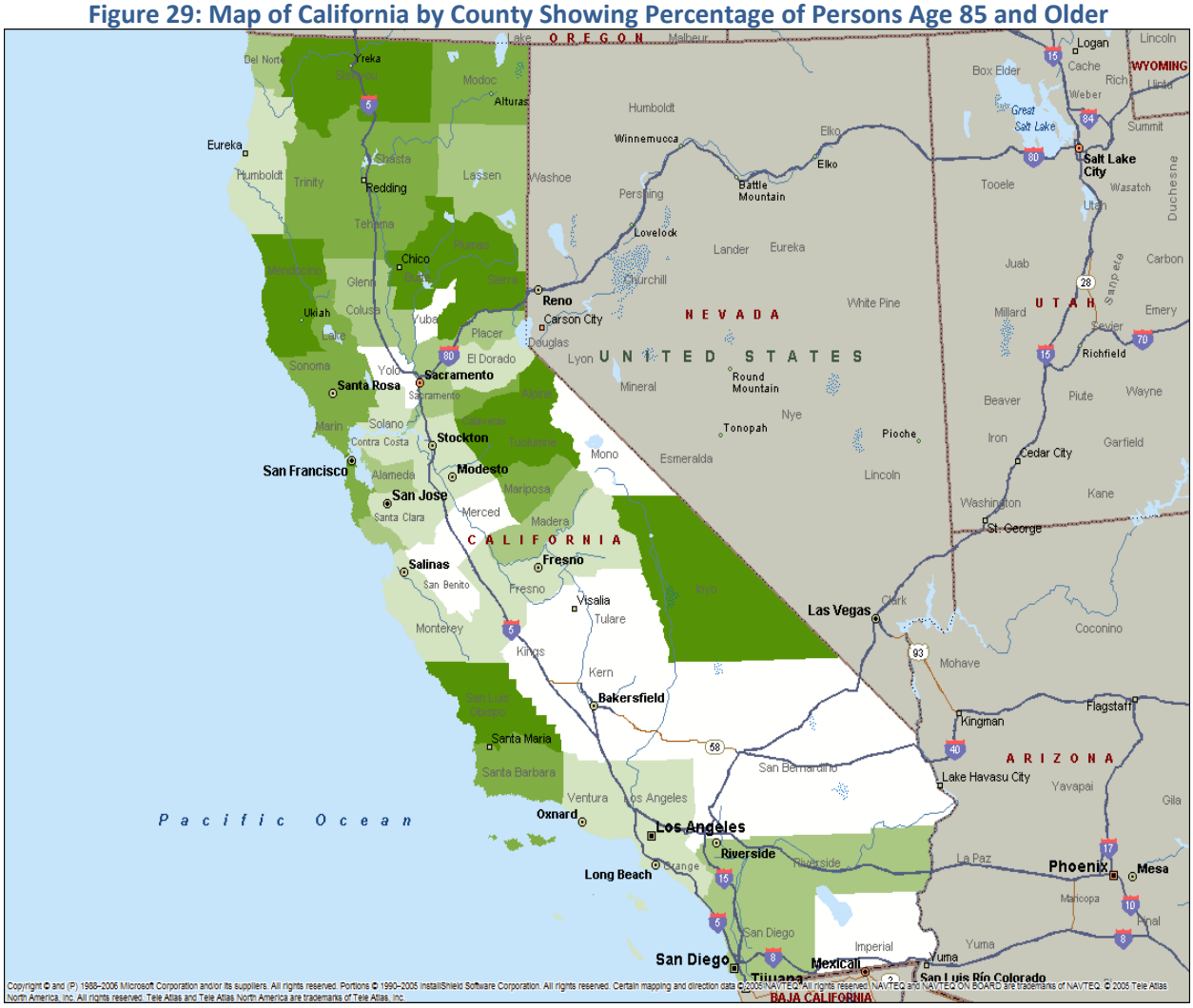


Figure 30: Map of Northern California by County Showing Percentage of Persons Age 85 and Older

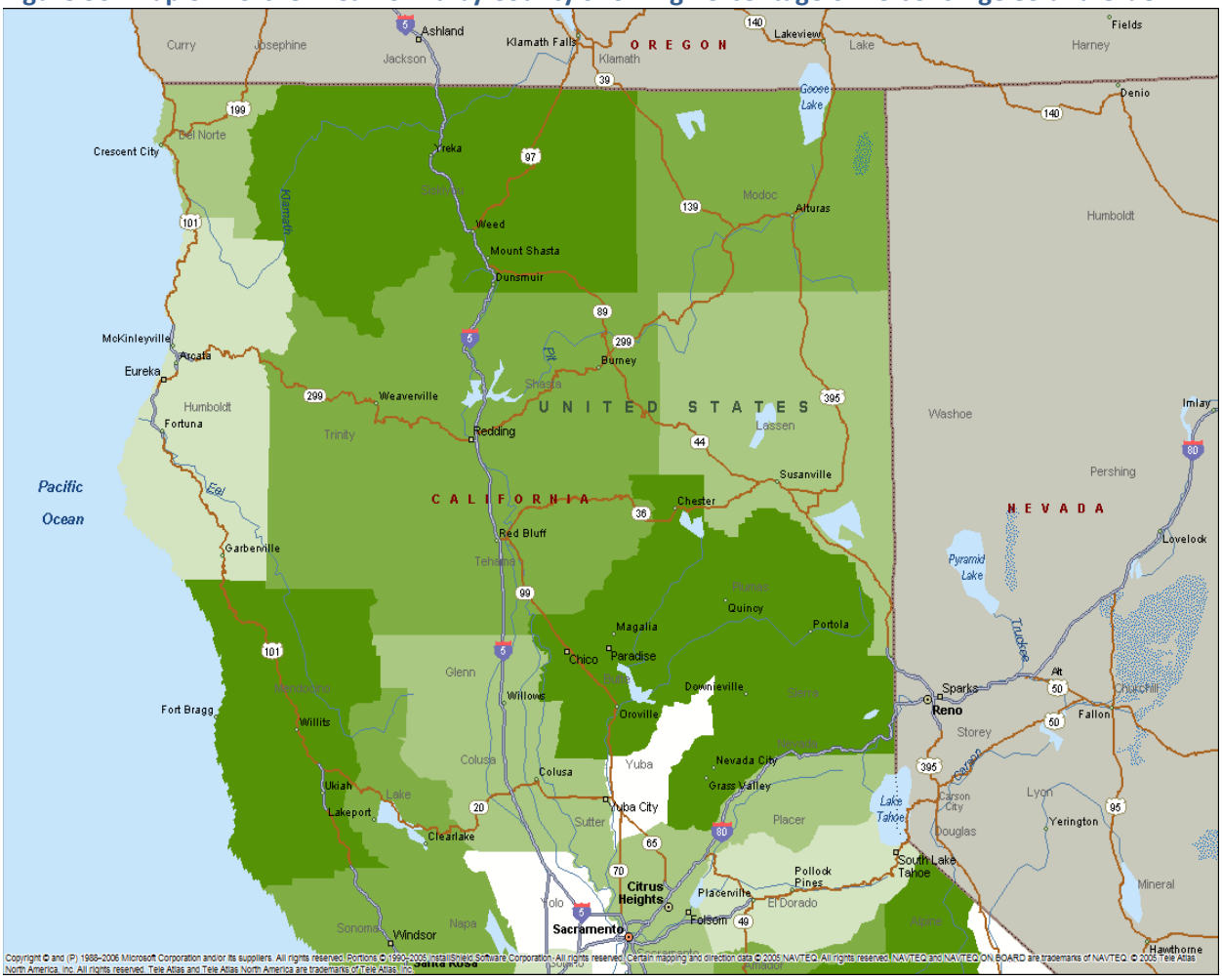
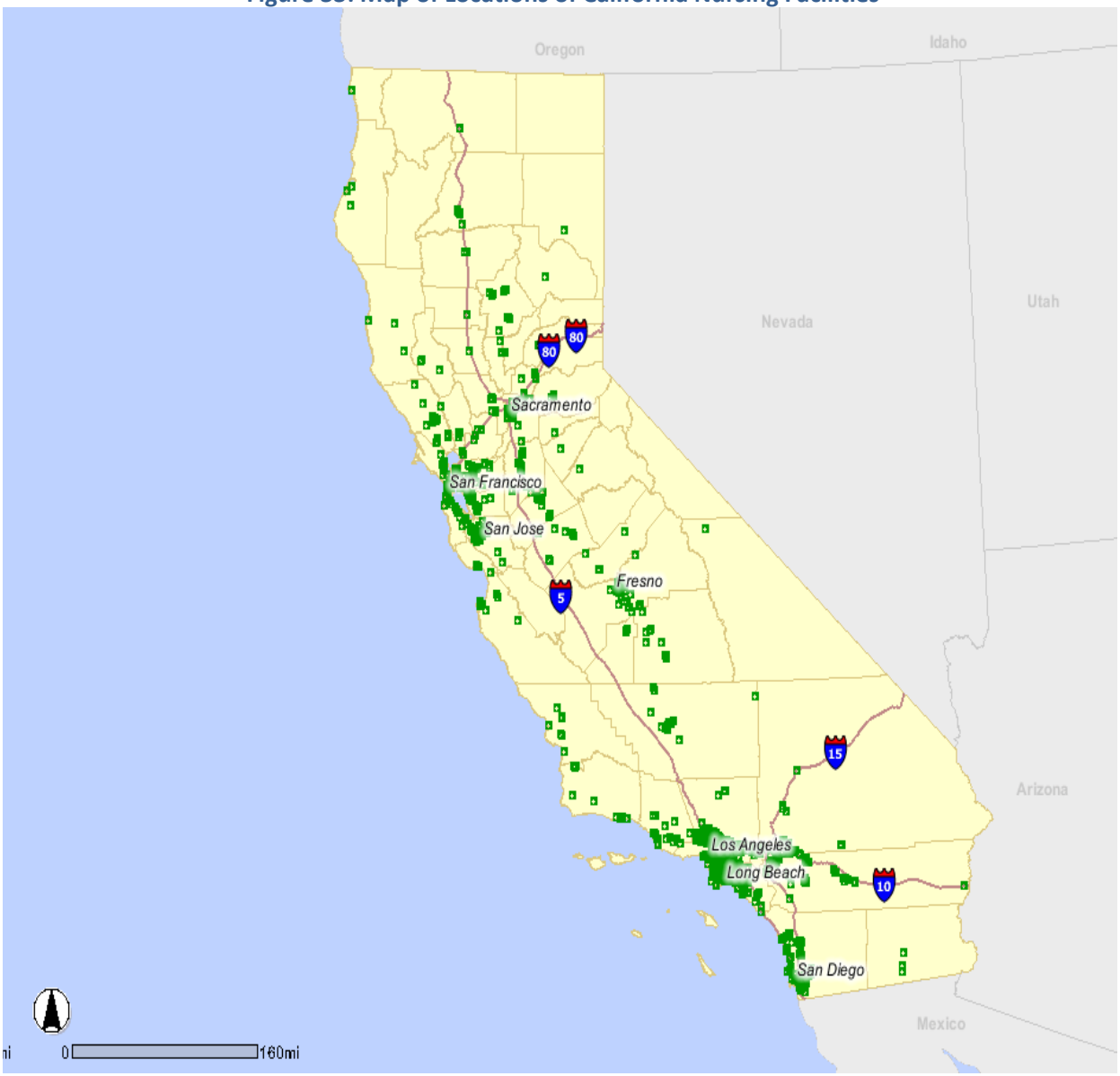


Figure 31: Map of Central California by County Showing Percentage of Persons Age 85 and Older

Figure 32: Map of Southern California by County Showing Percentage of Persons Age 85 and Older

Figure 33: Map of Locations of California Nursing Facilities



Appendix D: State Plan Home and Community-Based Services Option - §1915(i)

The Deficit Reduction Act (DRA) of 2005 created a new HCBS option, 1915(i), that allows states to provide HCBS through a State Plan Amendment (SPA) to individuals who are eligible for medical assistance under the state plan and whose income does not exceed 150% of the federal poverty level. This provision does not establish a new eligibility group. Rather, the 150% income limit is an eligibility requirement which must be met in addition to meeting the requirements of some eligibility group covered under the state plan.

The DRA allows states to cover services that are specifically listed in Section 1915(c)—case management, homemaker, personal care, adult day health, habilitation, respite care and day treatment. States cannot cover "and other services approved by the Secretary."

Needs Criteria

The SPA HCBS option drops the 1915(c) requirement to serve individuals who meet the institutional level of need criteria to receive HCBS services. States are required to set needs-based criteria for HCBS SPA services, and the criteria must be less stringent than the criteria for institutional services (hospital, ICF/MR and nursing facility). This requirement may be met by raising the institutional level of need criteria and retaining (or lowering) the community level of need, or by keeping the current institutional level of care and lowering the community level of need criteria.

The criteria for institutional and HCB services requires an assessment of the individual's support needs, and *may* take into account the individual's inability to perform two or more activities of daily living (ADLs) (bathing, dressing, eating, transferring, toileting and continence), or the need for significant assistance to perform ADLs and other risk factors as the state may determine.

Changing the Level of Need Criteria

States may modify the level of need criteria by giving 60 days notice to the public and the Centers for Medicare & Medicaid Services (CMS) if enrollment exceeds the estimated number of participants. Participating individuals who no longer meet the modified criteria may continue to receive services *for at least* 12 months from the date they first received services, not from the date of the modification. The regulations will clarify whether states may continue to serve beneficiaries for longer than 12 months.

Targeting

The DRA does not allow states to target groups of beneficiaries such as aged or disabled or individuals with developmental disabilities. All Medicaid beneficiaries who meet the level of need criteria for the SPA option must be served within limits described below. However, it appears that states might be able to indirectly target a specific group of individuals by carefully designing the benefits that are covered. If a state wanted to serve individuals with mental illness, they might limit the SPA option benefit to habilitation or day treatment and define the service in a way that only someone with a mental illness would use it. However, if a state tried to limit who will be served in this way, it may affect eligibility for others who receive HCBS Waiver services. Because the state will have established more stringent level of need criteria for the waiver, even

if it limits the services covered under the state plan, it would appear that the more stringent criteria would have to apply to all waiver beneficiaries.

Enrollment May Be Capped

Unlike other state plan services, §1915(i) allows states to limit the number of individuals that will be served under the HCBS SPA. States submit an estimate of the number of individuals who will be served. If the number served exceeds the estimate, states may either establish a waiting list or revise the level of need criteria. Revisions to the level of need criteria made because participation exceeded the estimate may be implemented with 60 days notice to the public and CMS. Approval by CMS is not required for this revision. Changes made to the level of need for other purposes must be approved by CMS.

Evaluation and Assessment

§1915(i) requires that applicants receive an independent evaluation of their eligibility and an independent assessment of their service needs. States must use an independent assessment for individuals eligible for HCBS SPA services to determine the level of services and supports to be provided, to prevent unnecessary and inappropriate services and to establish an individualized care plan. The assessor must be free from conflicts of interest with providers, with the individual and with concerns for the budget.

Presumptive Eligibility

The DRA allows states to presume eligibility for SPA HCBS services. Eligibility must be verified within 60 days and the presumption of eligibility only applies to the evaluation of eligibility, the assessment process and the services delivered within the 60-day period. The presumed eligibility does not apply to state plan services that are not part of the HCBS SPA.

Appendix E: Pennsylvania Incentives to Reduce Nursing Facility Capacity

Below is the Medicaid State Plan Amendment language that Pennsylvania submitted to CMS in 2008 regarding incentives to reduce nursing facility capacity.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT ATTACHMENT 4.19D

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The Department will conduct audits to ensure that a nursing facility receiving payment authorized by an exceptional DME grant adjusts its reported costs on the cost report to account for the exceptional payments. Payment(s) received by a nursing facility pursuant to an exceptional DME grant is payment in full for nursing facility services involving exceptional DME related services and items.

K. Reconfiguration Incentive Program

The objective of the reconfiguration incentive program is to improve the cost efficiency of the MA Program by causing excess beds to be eliminated. To achieve that objective, the reconfiguration incentive program offers three monetary incentives. These incentives are only available to nonpublic nursing facilities enrolled in the MA Program.

Incentives and their limits. The amount of any particular incentive will be determined by the Department and be subject to the limits specified below.

Limits on paid incentive days. Each incentive payment will be made on a per diem basis, for a number of days not to exceed the number set forth in an agreement between the department and the nursing facility, which number shall not exceed the number of MA days of care that would be provided if the nursing facility's current overall occupancy and MA occupancy levels were to remain unchanged, despite any changes to the nursing facility's bed complement.

Limits on combined incentives. The Benchmarked Rate Incentive cannot be combined with any other incentive. However, if a reconfiguration project would result in the elimination of at least fifty beds, the Department will consider whether to agree to pay a combination of the Permanent Rate Incentive (PRI) and the Adjustable Rate Incentive (ARI). In the event that the Department agrees to such a combination:

- The number of paid incentive days will be distributed between the two incentives, such that only one incentive is paid for any given paid incentive day.

- The amount of each incentive payment will be subject to the applicable incentive limits set forth below.

Estimated MA Net Savings. In evaluating the possible benefits of a proposed reconfiguration project, the Department will compute the project's estimated MA net savings by comparing the estimated total MA expenditures that would be made in a twelve-month period if the reconfiguration project did not occur and the estimated total MA expenditures that would be made in that same period if the reconfiguration project were to occur. The following information will be considered in this calculation:

(a) The number of occupied beds the nursing facility is proposing to close and decertify.
(b) The nursing facility's number of current MA beds.
(c) The nursing facility's number of proposed MA beds.
(d) The nursing facility's current total facility and MA occupancy.
(e) The nursing facility's proposed total facility and MA occupancy.
(f) The nursing facility's current MA days.
(g) The nursing facility's projected MA days.
(h) The nursing facility's current MA per diem rate.
(i) The nursing facility's qualification status for disproportionate share payments.
(j) The impact on the Nursing Facility Assessment revenues.
(k) The number of residents that will be placed in other MA nursing facilities and the associated MA payments.
(l) The number of residents that will be placed in the community and receive home and community-based waiver services and the associated MA payments.
(m) The impact on the nursing facility's MA per diem rate.
(n) Any other factors relevant to the individual project.

The Reconfiguration Incentives.

1. *Permanent Rate Incentive (PRI).*

The PRI is a per diem amount that will be paid to the nursing facility for as long as the facility maintains MA certification as a provider of nursing facility services. The PRI payment is made to the nursing facility each rate year for a fixed number of MA days of care. The amount of a nursing facility's PRI is fixed, and will not exceed the lowest of the following:

- 5% of the nursing facility's MA per diem payment rate in effect on July 1st of the rate year in which the PRI is first authorized.

- An amount that provides the Department no less than a 100% Annual Internal Rate of Return (PRI) on the Permanent Incentive amount during the first full 12-month period that the Permanent Incentive will be paid.

A nursing facility's PRI is not adjusted or indexed.

2. Adjustable Rate Incentive (ARI).

The ARI is a per diem rate that will be paid to the nursing facility for each quarter of a period of ten consecutive rate years. For each rate year, the ARI rate payment is made for a fixed number of MA days of care. For each of the first five rate years, the ARI rate will be the lower of the following:

- 50% of the Gross Annual MA Savings that will result from the project during the first full 12-month period that the ARI will be paid, divided by the total projected MA days that the nursing facility will provide during the same 12-month period.

- The amount that provided the Department an Annual Internal Rate of Return (ARI) on the Incentive of no less than 50% during the five-year period when the Incentive is a fixed amount.

During each of the next five rate years, the ARI will be the amount of the Incentive for the preceding year, reduced by 16.67% of the Year 5 ARI.

3. Benchmarked Rate Incentive (BRI).

A BRI is a payment or series of payments made to a nursing facility upon attainment of a benchmark (or series of benchmarks). The amount of the payment(s) is computed on a per diem basis. If the project has multiple benchmarks, the Incentive is paid in installments, and each installment is linked to the satisfaction of a particular benchmark. If the benchmark is not met, the payment is not made.

If the BRI will consist of a single payment, the amount of the payment will be computed using the number of benchmark days, the number of agreed upon MA days of care for the agreed-upon period. If the Incentive will be disbursed in multiple payments, the number of MA days for each benchmark will be determined by dividing the total number of benchmark days by the number of benchmarks.

The amount of a nursing facility's BRI will not exceed 100% of the Estimated MA Net savings calculated for a period of one year.

Procedure.

In order for a nonpublic nursing facility to receive any type of incentive payment, the nursing facility must submit a proposal to the Department; the Department must review and not reject the proposal; the parties must successfully negotiate an addendum to the nursing facility's MA provider agreement; and the nursing facility must satisfy all post-acceptance requirements.

The nursing facility's proposal.

To receive a reconfiguration incentive, a nonpublic nursing facility that is enrolled in the MA Program must submit a "Reconfiguration Proposal" (proposal) to the Department.

In order for a proposal to be considered on its merits, it must satisfy one of the following conditions:

- The proposal offers to eliminate a number of beds which equal or exceeds the sum of (i) the average number of unoccupied beds at the nursing facility as determined by data in the Nursing Facility Assessment System (NAS) for the four most recent Resident Day Quarters, plus (ii) at least two additional beds.

- The MA nursing facility that submits the proposal is related through common ownership or control to two or more nonpublic MA nursing facilities and the proposal offers to permanently close and decertify all beds in at least one but less than all of those related nursing facilities.

The Department's Evaluation and Response.

Upon receiving a proper proposal, the Department will evaluate it and consider:

- The likely economic impact on the MA Program.
- The likely effect upon access to care.
- The likely effect upon the quality of care.

If the Department determines that a proposal may be in the best interest of the MA Program, the Department may proceed with negotiations with the MA nursing facility. A determination to proceed with negotiations involves an exercise of the Department's discretionary judgment.

Negotiations.

If the Department does not reject a proposal, it will enter into negotiations with the nursing facility for the purpose of arriving at particular terms and conditions under which the reconfiguration incentive payments will be made. In order for these negotiations to be successfully concluded, the Department must accept a signed addendum to the nursing facility's MA provider agreement that sets forth the specific terms and conditions for the reconfiguration project and associated incentive(s).

Post-Acceptance Conditions.

Once the negotiations between the Department and a nursing facility have resulted in the addition of an addendum to the nursing facility's MA provider agreement, the Department's obligation to pay an incentive to the nursing facility is subject to the following conditions:

1. The nursing facility must be enrolled in the MA Program as a provider of nursing facility services at the site of the nursing facility.

2. The nursing facility must have taken all necessary steps to cause the Department of Health to remove the eliminated beds from the nursing facility's bed complement.

3. The nursing facility must be in compliance with all cost report submission requirements.

4. The nursing facility must be current in payment of any nursing facility assessment.

5. The nursing facility must have satisfied any and all conditions precedent set forth in the amendment to the nursing facility's MA Provider Agreement.

L. Related Provisions.

1. Supplement I contains the Department's Chapter 1187 Nursing Facility Service Regulations.

2. Supplement II contains the upper payment limit phase-out for state fiscal years 2003–2004 through 2009–2010.

3. The RUG-III index scores; peer groups; and the Financial and Statistical Report form (MA-11) are available for review upon request.

The Commonwealth of Pennsylvania has in place a process that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Appendix F: Nonfinancial Eligibility Requirements for Long-Term Care Services

This appendix contains California administrative code language describing the functional eligibility for five nursing facility and intermediate care facility levels of care. The words "functional eligibility" refer to the medical, physical and mental conditions of persons that make them eligible to receive the services offered to persons who meet that level of care condition.

The five levels of care below are arrayed in order of the severity of the acuities and the medical and nursing attention needed to meet the level of care conditions. The ranking is based on conversations with state staff and the authors' judgments.

All of these sections are in Title 22 of the California Administrative Code and the Code can be searched by section at http://government.westlaw.com/linkedslice/default.asp?SP=CCR-1000.

The IHSS program eligibility is extensively described in a May 4, 2007 DSS letter to the counties that can be retrieved at http://www.dss.cahwnet.gov/lettersnotices/entres/getinfo/acl06/pdf/06-34E2.pdf.

§ 51335. Skilled Nursing Facility Services

Subsection (j) In order to qualify for skilled nursing facility services, a patient shall have a medical condition which needs visits by a physician at least every 60 days and constantly available skilled nursing services. The following criteria together with the provisions of section 51124 will assist in determining appropriate placement:

(1) Need for patient observation, evaluation of treatment plans, and updating of medical orders by the responsible physician;

(2) Need for constantly available skilled nursing services. A patient may qualify for nursing home services if the patient has one or more of the following conditions:

(A) A condition which needs therapeutic procedures. A condition such as the following may weigh in favor of nursing home placement.

1. Dressing of postsurgical wounds, decubiti, leg ulcers, etc. The severity of the lesions and the frequency of dressings will be determining factors in evaluating whether they require nursing home care.

2. Tracheostomy care, nasal catheter maintenance.

3. Indwelling catheter in conjunction with other conditions. Its presence without a requirement for other skilled nursing care is not a sufficient criterion for nursing home placement.

4. Gastrostomy feeding or other tube feeding.

5. Colostomy care for initial or debilitated patients. Facilities shall be required to instruct in self-care, where such is feasible for the patient. Colostomy care alone should not be a reason for continuing nursing home placement.

6. Bladder and bowel training for incontinent patients.

(B) A condition which needs patient skilled nursing observation. Patients whose medical condition requires continuous skilled nursing observation of the following may be in a nursing home dependent on the severity of the condition. Observation must, however, be needed at frequent intervals throughout the 24 hours to warrant care in a nursing home:

1. Regular observation of blood pressure, pulse, and respiration is indicated by the diagnosis or medication and ordered by the attending physician.

2. Regular observation of skin for conditions such as decubiti, edema, color, and turgor.

3. Careful measurement of intake and output is indicated by the diagnosis or medication and ordered by the attending physician.

(C) The patient needs medications which cannot be self-administered and requires skilled nursing services for administration of the medications. Nursing home placement may be necessary for reasons such as the following:

1. Injections administered during more than one nursing shift. If this is the only reason for nursing home placement, consideration should be given to other therapeutic approaches or the possibility of teaching the patient or a family member to give the injections.

2. Medications prescribed on an as needed basis. This will depend on the nature of the drug and the condition being treated and frequency of need as documented. Many medications are now self-administered on a PRN basis in residential care facilities.

3. Use of restricted or dangerous drugs, if required more than during the daytime, requiring close nursing supervision.

4. Use of new medications requiring close observation during initial stabilization for selected patients. Depending upon the circumstances, such patients may also be candidates for intermediate care facilities.

(D) A physical or mental functional limitation.

1. Physical limitations. The physical functional incapacity of certain patients may exceed the patient care capability of intermediate care facilities.

a. Bedfast patients.

b. Quadriplegics, or other severe paralysis cases. Severe quadriplegics may require such demanding attention (skin care, personal assistance, respiratory embarrassment) as to justify placement in nursing homes.
c. Patients who are unable to feed themselves.

2. Mental limitations. Persons with a primary diagnosis of mental illness (including mental retardation), when such patients are severely incapacitated by mental illness or mental retardation.

The following criteria are used when considering the type of facility most suitable for the mentally ill and mentally retarded person where care is related to his mental condition.

a. The severity of unpredictability of the patient's behavior or emotional state.
b. The intensity of the care, treatment, services or skilled observation that his condition requires and,
c. The physical environment of the facility, its equipment, and the qualifications of staff and,
d. The impact of the particular patient on other patients under care in the facility.

(3) The general criteria identified above are not intended to be either all-inclusive or mutually exclusive. In practice, they should be applied as a total package in evaluation of an approved admission.

§ 51343.2. Intermediate Care Facility Services for the Developmentally Disabled-Nursing

(e) The beneficiary's medical condition shall be determined on an individual basis by the Department's Medi-Cal consultant. However, in determining the need for ICF/DD-N services the following conditions shall be met:

(1) A regional center has diagnosed the beneficiary as being developmentally disabled, or has determined that the beneficiary demonstrates significant developmental delay that may lead to a developmental disability if not treated.

(2) The beneficiary's medical condition is such that 24-hour nursing supervision, in accordance with Title 22, California Code of Regulations, Section 73839(a) personal care, and developmental services are required. The stability of the beneficiary's medical condition and frequency of required skilled nursing services shall be the determining factors in evaluating whether beneficiaries are appropriate for ICF/DD-N placements.

(3) Each beneficiary shall have a physician's certification that continuous skilled nursing care is not required and that the beneficiary's medical condition is stable. Beneficiaries convalescing from surgical procedures shall be stable enough that only intermittent nursing care is needed.

(4) The beneficiary needs a level of developmental, training and habilitative program services and recurring but intermittent skilled nursing services which are not available through other

small (4–15 bed) community-based health facilities.

(5) The beneficiary's condition is such that there is a need for the provision of active treatment services as described at Section 73801, thereby leading to a higher level of beneficiary functioning and a lessening dependence on others in carrying out daily living activities or in the prevention of regression or in ameliorating developmental delay.

(6) The beneficiary shall have two or more developmental deficits as measured on the Client Developmental Evaluation Report prescribed by the Department of Developmental Services in any one or combination of the following three domains:

(A) Self-help domain:

1. Eating
2. Toileting
3. Bladder control
4. Dressing

(B) Motor domain:

1. Ambulation
2. Crawling and standing
3. Wheelchair mobility
4. Rolling and sitting

(C) Social emotional domain:

1. Aggression -has had one or more violent episodes causing minor physical injury within the past year or has resorted to verbal abuse and threats but has not caused physical injury within the past year.
2. Self-injurious behavior -behavior exists but results only in minor injuries which require first aid.
3. Smearing feces -smears once a week or more but less than once a day.
4. Destruction of property.
5. Running or wandering away.
6. Temper tantrums, or emotional outburst.
7. Unacceptable social behavior -positive social participation is impossible unless closely supervised or redirected.

(f) The beneficiary must have a need for active treatment, defined at Section 73801, Title 22, California Code of Regulations, and intermittent skilled nursing services such as:

(1) Apnea monitoring
(2) Colostomy care
(3) Gastrostomy feeding and care
(4) Naso-gastric feeding

(5) Tracheostomy care and suctioning
(6) Oxygen therapy
(7) Intermittent positive-pressure breathing
(8) Licensed nurse evaluation on an intermittent basis
(9) Catheterization
(10) Wound irrigation and dressing
(11) The beneficiary needs special feeding assistance.
(12) The beneficiary needs repositioning to avoid skin breakdown which would lead to decubitus ulcers and contractures.

(g) Conditions which would exclude beneficiaries from placement in an ICF/DD-N are as follows:

(1) Beneficiaries shall not have any of the following extreme developmental deficits in the social-emotional area:

(A) Aggression -has had violent episodes which have caused serious physical injury in the past year.
(B) Self-injurious behavior -causes severe injury which requires physician treatment at least once per year.
(C) Smearing -smears at every opportunity.

(2) Beneficiaries shall not be admitted to or approved for service in an intermediate care facility for the developmentally disabled-nursing if those beneficiaries have a decubitus ulcer at the third or fourth stage of development as defined in Title 22, California Code of Regulations, Section 73811.

(3) Beneficiaries shall not be admitted with clinical evidence of an active communicable disease that is required to be reported in accordance with Section 2500, Title 17, California Code of Regulations.

§ 51334. Intermediate Care Services

(k) A need for a special services program for the developmentally disabled or mentally disordered is not sufficient justification for a beneficiary to be placed in an intermediate care facility. All beneficiaries admitted to intermediate care facilities must meet the criteria found in paragraph (l) of this section.

(l) In order to qualify for intermediate care services, a patient shall have a medical condition which needs an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration. Intermediate care services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encouragement of individual patient independence to the extent of his ability. As a guide in determining the need for intermediate care services, the following factors may assist in determining appropriate placement:

(1) The complexity of the patient's medical problems is such that he requires skilled nursing care or observation on an ongoing intermittent basis and 24-hour supervision to meet his health needs.

(2) Medications may be mainly supportive or stabilizing but still require professional nurse observation for response and effect on an intermittent basis. Patients on daily injectable medications or regular doses of PRN narcotics may not qualify.

(3) Diet may be of a special type, but patient needs little or no assistance in feeding himself.

(4) The patient may require minor assistance or supervision in personal care, such as in bathing or dressing.

(5) The patient may need encouragement in restorative measures for increasing and strengthening his functional capacity to work toward greater independence.

(6) The patient may have some degree of vision, hearing or sensory loss.

(7) The patient may have some limitation in movement, but must be ambulatory with or without an assistive device such as a cane, walker, crutches, prosthesis, wheelchair, etc.

(8) The patient may need some supervision or assistance in transferring to a wheelchair, but must be able to ambulate the chair independently.

(9) The patient may be occasionally incontinent of urine; however, patient who is incontinent of bowels or totally incontinent of urine may qualify for intermediate care service when the patient has been taught and can care for himself.

(10) The patient may exhibit some mild confusion or depression; however, his behavior must be stabilized to such an extent that it poses no threat to himself or others.

§ 51343.1. Intermediate Care Facility Services for the Developmentally Disabled Habilitative

(e) Covered services shall be limited to individuals who are defined as developmentally disabled in Welfare and Institutions Code, Section 4512. In determining the need for intermediate care facility services for the developmentally disabled habilitative, the following criteria shall be considered:

(1) The complexity of the beneficiary's medical problems is such that skilled nursing care on an ongoing but intermittent basis is needed. Individuals shall be placed in an ICF-DDH only if their predominant skilled nursing needs are predictable and advance arrangements can be made for licensed nurses to provide needed services at prescribed intervals. Individuals who require skilled nursing procedures on an "as needed basis" are not candidates for placement in an ICF-DDH.

(2) Medication may be mainly supportive or stabilizing but still requires professional nurse evaluation on an intermittent basis.

(3) The beneficiary needs specialized developmental, training and habilitative program services which are not available through other levels of care.

(4) The extent to which provision of specialized developmental, training and habilitative program services can be expected to result in a higher level of beneficiary functioning and a lessening dependence on others in carrying out daily living activities or in the prevention of regression.

(5) The beneficiary must have two or more developmental deficits as measured on standardized evaluation forms prescribed and furnished by the Department of Developmental Services in any one of the following two domains:

(A) Self-help domain:
1. Eating
2. Toileting
3. Bladder Control
4. Dressing

(B) Social-emotional domain:

1. Aggression -has had one or more violent episodes causing minor physical injury within the past year or has resorted to verbal abuse and threats but has not caused physical injury within the past year.
2. Self-injurious behavior -behavior exists but results only in minor injuries which require first aid.
3. Smearing feces -smears once a week or more but less than once a day.
4. Destruction of property.
5. Running or wandering away.
6. Temper tantrums, or emotional outbursts.
7. Unacceptable social behavior -positive social participation is impossible unless closely supervised or redirected.

(6) Beneficiaries shall not have any of the following extreme developmental deficits in the socio-emotional area:

(A) Aggression -has had violent episodes which have caused serious physical injury in the past year.
(B) Self-injurious behavior -causes severe injury which requires physician attention at least once per year.
(C) Smearing -smears at every opportunity.

(7) Beneficiaries shall not be admitted to or approved for service in an intermediate care facility for the developmentally disabled habilitative if those beneficiaries have a decubitus ulcer.

(8) Beneficiaries shall not be admitted with clinical evidence of an active communicable disease that is required to be reported in accordance with Section 2500 of Title 17 of the California Administrative Code.

(9) Beneficiaries shall not be admitted to an ICF/DDH for purposes of respite care with the exception of clients enrolled in a federally approved home and community-based care program under Section 1915(c) of the Social Security Act.

§ 51343. Intermediate Care Facility Services for the Developmentally Disabled

(l) Services shall be covered only for developmentally disabled persons as defined in Section 51164. Intermediate care services for the developmentally disabled are limited to those persons who require and will benefit from services provided pursuant to the provisions of Sections 76301 through 76413 of Title 22 of the California Administrative Code. The "Manual of Criteria for Medi-Cal Authorization," published by the Department, shall be the basis for the professional judgments of Medi-Cal consultants in their decision on authorization for services provided pursuant to this section. In determining the need for intermediate care facility services in institutions for the developmentally disabled, the following factors shall be considered:

(1) The extent of psychosocial and developmental service needs.

(2) The need for specialized developmental and training services which are not available through other levels of care.

(3) The extent to which provisions of specialized developmental and training services can reasonably be expected to result in a higher level of patient functioning and a lessening dependence on others in carrying out daily living activities.

(4) The individual's score on an assessment form approved by the Department of Developmental Services for the determination of intermediate care facility/developmentally disabled eligibility.

(5) Whether the patient has a qualifying developmental deficit in either a self-help area or social-emotional area as follows:

(A) A qualifying developmental deficit shall be determined in the self-help skill area if the patient has two moderate or severe skill task impairments in eating, toileting, bladder control or dressing skill task; or

(B) A qualifying developmental deficit shall be determined in the social-emotional area if the patient exhibits two moderate or severe impairments from a combination of the following assessment items:

1. Social behavior,
2. Aggression,
3. Self-injurious behavior,
4. Smearing,
5. Destruction of property,
6. Running or wandering away,
7. Temper tantrums, or emotional outbursts.

Appendix G: State and National Statistics on Nursing Facilities and RCFEs

Table 102: Residential and Nursing Facility Bed Supply Ratios

Residential and Nursing Facility Bed Supply Ratios						
Licensed Residential Bed Supply Per 1,000 65+				NF Supply/1,000 65+		Percentage HCBS (A/D)
State	2007 65+	Supply	Beds/1,000	NF Supply	Beds Per 1,000	
AL	625,756	9,509	15.2	26,336	42.1	13.1
AK	47,935	1,912	39.9	725	15.1	50.6
AR	397,108	5,018	12.6	24,449	61.6	25.9
AZ	820,391	27,000	32.9	15,862	19.3	64.0
CA	4,003,593	161,586	40.4	121,964	30.5	52.1
CO	492,685	14,237	28.9	19,758	40.1	34.9
CT	472,284	2,808	5.9	29,612	62.7	20.7
DE	117,678	1,804	15.3	4,689	42.8	13.7
DC	69,741	509	7.3	2,984	42.8	34.9
FL	3,098,364	75,480	24.4	81,808	26.4	17.5
GA	942,832	26,500	28.1	40,159	42.6	24.0
HI	183,994	4,284	23.3	4,043	22.0	17.8
ID	174,946	6,819	39.0	6,052	34.6	40.4
IL	1,548,781	16,800	10.8	97,413	62.9	24.9
IN	795,441	14,655	18.4	49,204	61.9	14.5
IA	438,448	13,072	29.8	32,620	74.4	26.2
KS	360,216	7,186	19.9	23,276	64.6	35.2
KY	549,504	6,802	12.4	25,739	46.8	18.9
LA	522,334	4,889	9.4	35,310	67.6	26.8
ME	194,986	8,703	44.6	7,196	36.9	26.6
MD	661,809	20,093	30.4	29,149	44.0	15.9
MA	858,939	11,900	13.9	49,465	57.6	26.4
MI	1,280,152	46,095	36.0	46,549	36.4	19.0
MN	636,216	NA	-	33,529	52.7	46.6
MO	788,371	21,166	26.8	50,839	64.5	31.1
MS	364,614	5,133	14.1	18,296	50.2	2.2
MT	133,578	4,351	32.6	7,118	53.3	29.3
NE	236,648	10,063	42.5	15,959	67.4	22.3
NV	285,654	3,941	13.8	5,643	19.8	35.1
NH	165,742	4,283	25.8	7,768	46.9	14.4
NJ	1,134,636	17,761	15.7	50,779	44.8	21.0
NM	250,235	NR	-	6,808	27.2	60.7
NY	2,546,405	39,170	15.4	120,359	47.3	39.3
NC	1,103,413	41,642	37.7	43,498	39.4	42.7
ND	93,285	3,472	37.2	6,387	68.5	6.3
OH	1,545,085	44,005	28.5	92,491	59.9	20.8
OK	480,140	9,302	19.4	29,522	61.5	28.7
OR	488,936	22,130	45.3	12,449	25.5	56.5
PA	1,889,660	71,831	38.0	87,570	46.3	12.7
RI	146,847	3,574	24.3	8,758	59.6	12.6
SC	573,098	16,279	28.4	18,000	31.4	23.0
SD	113,555	3,578	31.5	6,553	57.7	11.5
TN	793,117	16,289	20.5	37,043	46.7	1.3
TX	2,394,157	45,853	19.2	122,635	51.2	44.3
UT	233,982	5,256	22.5	7882	33.7	10.7
VA	909,522	31,964	35.1	31,005	34.1	26.8
VT	84,425	2,610	30.9	3,242	38.4	28.5
WA	757,852	26,829	35.4	22,340	29.5	55.6
WV	280,666	3,510	12.5	10,905	38.9	23.4
WI	736,301	31,782	43.2	37,350	50.7	30.7
WY	63,901	1,436	22.5	3,052	47.8	20.4
Total	37,887,958	974,871	25.7	1,671,238	44.1	31.0

Source: The number of licensed residential settings was reported by state licensing agencies. See Mollica, R., Sims-Kastelein, K., and O'Keeffe, J. Residential Care and Assisted Living Compendium: (2007), US DHHS, Office of the Assistant Secretary for Planning and Evaluation. http://aspe.hhs.gov/daltcp/reports/2007/07alcom.htm.

Table 103: Number of Certified Licensed Nursing Facility Beds

Number of Certified Licensed Nursing Facility Beds									
State	**Dec 2001**	**Dec 2002**	**Dec 2003**	**Dec 2004**	**Dec 2005**	**Dec 2006**	**Dec 2007**	**Dec 2008**	**Change**
US	1,695,446	1,699,647	1,689,937	1,681,917	1,676,413	1,673,085	1,671,238	1,668,895	-1.6%
AK	744	749	738	718	695	705	725	725	-2.6%
AL	25,572	26,036	26,187	26,466	26,354	26,581	26,336	26,809	4.8%
AR	24,385	24,723	24,369	23,840	24,151	24,634	24,449	24,395	0.0%
AZ	16,155	15,824	15,825	16,112	16,155	15,602	15,862	15,747	-2.5%
CA	122,680	123,879	125,706	123,996	123,406	122,564	121,964	121,950	-0.6%
CO	19,644	20,054	19,815	19,821	19,839	19,954	19,758	19,943	1.5%
CT	31,001	30,751	30,602	30,280	30,169	29,662	29,612	29,265	-5.6%
DC	3,071	3,112	3,114	3,061	3,036	2,988	2,984	2,645	-13.9%
DE	4,273	4,279	4,350	4,320	4,200	4,475	4,689	4,787	12.0%
FL	82,378	81,421	81,797	81,891	81,645	81,630	81,808	81,498	-1.1%
GA	39,748	39,761	39,938	40,054	40,112	39,900	40,159	39,726	-0.1%
HI	3,985	3,973	3,682	4,026	4,019	4,032	4,043	4,142	3.9%
IA	34,297	33,942	33,421	33,301	33,363	32,925	32,620	32,301	-5.8%
ID	6,368	6,328	6,258	6,270	6,065	6,195	6,052	6,034	-5.2%
IL	99,602	99,442	99,227	98,425	97,458	97,331	97,413	96,226	-3.4%
IN	54,464	52,138	48,464	47,994	47,991	48,488	49,204	49,081	-9.9%
KS	24,522	24,471	24,611	24,244	23,712	23,295	23,276	23,017	-6.1%
KY	24,809	25,057	25,197	25,469	25,816	25,513	25,739	25,526	2.9%
LA	37,588	37,759	37,296	37,592	37,420	35,714	35,310	35,401	-5.8%
MA	53,200	52,874	51,211	50,750	50,157	49,736	49,465	48,510	-8.8%
MD	27,901	29,363	29,386	29,144	29,197	29,020	29,149	28,800	3.2%
ME	7,710	7,567	7,425	7,377	7,368	7,329	7,196	7,201	-6.6%
MI	47,684	47,292	47,529	47,138	47,102	46,286	46,549	46,848	-1.8%
MN	39,406	40,182	37,693	37,185	35,389	34,777	33,529	33,144	-15.9%
MO	50,720	50,250	49,336	50,302	50,211	50,832	50,839	51,752	2.0%
MS	17,428	17,983	18,124	18,290	18,339	18,309	18,296	18,340	5.2%
MT	7,549	7,492	7,452	7,447	7,329	7,336	7,118	7,016	-7.1%
NC	40,849	42,083	42,596	42,736	42,968	43,127	43,498	43,205	5.8%
ND	6,581	6,586	6,527	6,529	6,508	6,502	6,387	6,395	-2.8%
NE	16,294	15,919	15,561	15,787	15,809	15,835	15,959	15,963	-2.0%
NH	7,742	7,772	7,705	7,745	7,817	7,818	7,768	7,708	-0.4%
NJ	50,769	50,777	50,510	50,627	51,195	51,816	50,779	51,130	0.7%
NM	6,891	7,245	7,352	7,163	6,909	6,881	6,808	6,750	-2.0%
NV	5,049	5,100	5,138	5,072	5,360	5,554	5,643	5,613	11.2%
NY	117,502	122,140	122,482	121,189	120,807	120,800	120,359	120,101	2.2%
OH	92,714	93,521	93,058	92,212	91,351	91,730	92,491	92,484	-0.2%
OK	31,578	31,583	32,231	32,198	31,237	30,516	29,522	29,667	-6.1%
OR	12,718	12,541	12,715	12,634	12,696	12,561	12,449	12,473	-1.9%
PA	94,147	92,766	90,136	89,075	88,878	88,407	87,570	87,860	-6.7%
RI	9,943	9,474	8,764	8,594	9,044	8,867	8,758	8,850	-11.0%
SC	17,372	17,240	17,670	17,769	17,767	17,948	18,000	18,328	5.5%
SD	7,196	7,417	7,363	7,208	7,108	6,706	6,553	6,530	-9.3%
TN	38,051	37,570	37,520	36,944	37,215	36,874	37,043	36,598	-3.8%
TX	109,572	109,896	112,806	114,741	115,313	119,055	121,731	122,635	11.9%
State	**Dec 2001**	**Dec 2002**	**Dec 2003**	**Dec 2004**	**Dec 2005**	**Dec 2006**	**Dec 2007**	**Dec 2008**	**Change**
UT	7,572	7,295	7,290	7,498	7,787	7,685	7,882	7,933	4.8%

Number of Certified Licensed Nursing Facility Beds									
VA	29,386	30,098	30,689	30,951	31,146	31,156	31,005	31,535	7.3%
WA	23,695	24,420	23,322	22,455	22,472	22,415	22,340	22,194	-6.3%
WI	45,019	43,736	42,166	39,769	38,899	37,665	37,350	37,022	-17.8%
WV	11,214	11,133	11,073	11,006	10,929	10,924	10,905	10,831	-3.4%
WY	3,086	3,061	3,061	3,061	3,051	3,049	3,052	2,993	-3.0%
Source: OSCAR data compiled by the American Health Care Association.									

Table 104: Medicaid Nursing Facility Census Data

Medicaid Nursing Facility Census Data									
State	**Dec 2001**	**Dec 2002**	**Dec 2003**	**Dec 2004**	**Dec 2005**	**Dec 2006**	**Dec 2007**	**Dec 2008**	**Change**
US	977,678	971,398	961,774	949,575	939,728	928,876	913,784	896,495	-8.3%
AK	535	543	518	490	507	510	455	456	-14.8%
AL	17,169	17,133	17,050	16,977	16,784	16,500	16,246	15,950	-7.1%
AR	13,826	13,318	13,090	12,739	12,393	12,638	12,377	12,279	-11.2%
AZ	8,571	8,496	8,704	8,560	8,274	7,733	7,737	7,664	-10.6%
CA	67,996	68,719	71,077	70,138	70,836	69,251	68,229	67,698	-0.4%
CO	10,151	9,748	9,718	9,496	9,652	9,725	9,689	9,603	-5.4%
CT	19,281	19,330	19,188	18,484	18,491	18,017	17,959	17,765	-7.9%
DC	2,336	2,291	2,340	2,221	2,077	2,140	2,224	1,996	-14.6%
DE	2,213	2,263	2,323	2,230	2,226	2,251	2,345	2,248	1.6%
FL	43,079	43,406	44,197	44,379	43,542	42,681	41,903	41,347	-4.0%
GA	28,090	28,334	28,160	27,643	27,454	26,719	26,386	25,628	-8.8%
HI	2,748	2,758	2,495	2,766	2,755	2,769	2,721	2,688	-2.2%
IA	14,247	14,348	13,809	13,607	13,323	13,253	12,923	12,474	-12.4%
ID	2,755	2,856	2,952	2,866	2,794	2,796	2,737	2,670	-3.1%
IL	52,014	51,113	50,188	49,629	49,070	48,257	48,300	47,387	-8.9%
IN	27,421	27,137	26,328	25,789	25,202	24,903	24,773	24,371	-11.1%
KS	11,415	11,381	11,340	11,126	10,887	10,515	10,419	10,187	-10.8%
KY	16,712	16,388	16,502	15,533	15,502	15,487	15,634	15,357	-8.1%
LA	23,545	23,142	21,847	21,878	21,568	20,552	19,428	19,062	-19.0%
MA	34,002	33,293	31,899	30,948	30,030	29,765	29,312	27,607	-18.8%
MD	14,908	15,652	15,627	15,534	15,459	15,457	15,481	15,351	3.0%
ME	4,906	4,906	4,793	4,826	4,480	4,446	4,349	4,309	-12.2%
MI	28,001	27,924	27,639	27,426	27,577	26,850	26,253	25,413	-9.2%
MN	22,846	22,128	21,391	20,677	19,774	19,147	18,194	17,448	-23.6%
MO	25,610	24,579	23,962	23,709	23,746	23,842	23,315	22,739	-11.2%
MS	12,795	12,656	12,747	12,809	12,459	12,434	12,608	12,496	-2.3%
MT	3,438	3,336	3,246	3,227	3,138	3,174	3,011	2,977	-13.4%
NC	26,636	26,730	26,448	26,718	26,684	26,431	25,802	25,448	-4.5%
ND	3,505	3,491	3,347	3,315	3,331	3,306	3,294	3,207	-8.5%
NE	7,640	7,432	7,308	7,184	7,162	6,992	6,883	6,662	-12.8%
NH	4,939	4,874	4,797	4,861	4,669	4,656	4,491	4,439	-10.1%
NJ	29,834	29,014	28,927	29,000	29,185	29,064	28,572	28,791	-3.5%
NM	4,329	4,554	4,471	4,216	4,152	4,036	3,916	3,478	-19.7%
NV	2,614	2,706	2,598	2,614	2,676	2,793	2,743	2,757	5.5%
NY	81,085	84,891	83,663	83,004	81,328	81,142	80,109	78,249	-3.5%
OH	53,174	52,625	52,091	51,806	51,961	51,905	51,198	50,938	-4.2%
OK	14,368	14,105	13,936	13,735	13,461	13,409	12,859	12,960	-9.8%
OR	5,856	5,737	5,300	5,047	5,039	4,910	5,013	5,002	-14.6%
PA	53,147	52,110	51,744	51,565	51,055	51,775	50,797	50,105	-5.7%
RI	6,374	6,091	5,708	5,560	5,523	5,365	5,344	5,164	-19.0%
SC	11,715	11,563	11,615	11,472	11,539	11,196	10,930	10,946	-6.6%
SD	3,966	4,044	4,019	3,842	3,762	3,727	3,720	3,703	-6.6%
TN	25,106	24,312	23,886	22,899	22,394	21,697	21,558	21,276	-15.3%
TX	62,050	60,240	60,741	60,227	60,153	59,787	58,686	57,268	-7.7%
State	**Dec 2001**	**Dec 2002**	**Dec 2003**	**Dec 2004**	**Dec 2005**	**Dec 2006**	**Dec 2007**	**Dec 2008**	**Change**
UT	3,285	3,174	3,200	3,100	3,034	2,986	2,975	2,907	-11.5%

Medicaid Nursing Facility Census Data									
VA	17,760	18,002	17,642	17,935	17,815	17,691	17,196	16,882	-4.9%
VT	2,225	2,120	2,157	2,165	2,081	1,941	1,997	2,007	-9.8%
WA	13,290	13,169	12,659	12,157	12,014	12,111	11,668	11,205	-15.7%
WI	25,229	24,389	23,693	22,783	22,058	21,488	20,465	19,431	-23.0%
WV	7,363	7,307	7,162	7,155	7,175	7,164	7,120	7,039	-4.4%
WY	1,578	1,540	1,532	1,508	1,477	1,492	1,440	1,461	-7.4%
Source: CMS OSCAR Form 672: F75–F78									
American Health Care Association - Health Services Research and Evaluation									

Table 105: Licensed Residential Settings

Licensed Residential Settings									
State	Aged/Adult		Children		DD/MH/Other		Total		Beds Per 1,000 Population
	Facilities	Beds	Facilities	Beds	Facilities	Beds	Facilities	Beds	
AK	255	2,015	1,644	4,993	302	1,005	2,201	8,013	11.7
AL	313	9,556	87	1,775	1,690	7,641	2,090	18,972	4.1
AR	127	5,629	50	1,569	-	-	177	7,198	2.5
AZ	1,811	26,429	242	2,717	218	5,382	2,271	34,528	5.5
CA	7,782	143,613	3,235	8,295	5,500	54,366	16,517	206,274	5.6
CO	488	14,409	2,792	7,357	237	1,739	3,517	23,505	4.8
CT	767	5,638	130	2,010	282	2,360	1,179	10,008	2.9
DC	26	594	20	386	110	729	156	1,709	2.9
DE	31	1,834	311	997	258	968	600	3,799	4.4
FL	3,064	78,979	90	1,739	12	217	3,166	80,935	4.4
GA	2,039	27,843	260	5,109	371	1,304	2,670	34,256	3.6
HI	492	3,742	1,441	2,449	117	1,019	2,050	7,210	5.6
IA	376	18,010	70	1,288	102	1,234	548	20,532	6.9
ID	282	6,692	52	1,194	-	-	334	7,886	5.3
IL	185	8,248	na	na	na	na	185	8,248	0.6
IN	598	15,129	6,374	22,725	127	1,442	7,099	39,296	6.2
KS	266	7,923	2,513	8,920	39	378	2,818	17,221	6.2
KY	173	4,515	89	1,901	14	254	276	6,670	1.6
LA	107	4,736	56	1,436	83	1,774	246	7,946	1.9
MA	190	11,830	na	na	na	na	190	11,830	1.8
MD	1,404	20,950	355	6,481	3,925	5,278	5,684	32,709	5.8
ME	750	9,193	na	na	na	na	750	9,193	7.0
MI	4,755	48,808	6,926	24,568	-	-	11,681	73,376	7.3
MN	4,609	18,100	4,539	18,790	326	5,253	9,474	42,143	8.1
MO	631	21,727	6,538	17,609	182	1,457	7,351	40,793	6.9
MS	178	5,054	77	1,225	146	1,754	401	8,033	2.8
MT	278	4,616	63	670	13	315	354	5,601	5.9
NC	1,290	40,049	833	5,058	1,762	7,702	3,885	52,809	5.8
ND	118	3,826	875	2,907	30	258	1,023	6,991	10.9
NE	277	10,549	97	2,454	230	2,398	604	15,400	8.7
NH	199	4,834	10	256	4	50	213	5,140	3.9
NJ	211	18,009	217	6,358	3,239	19,806	3,667	44,173	5.1
NM	259	5,650	113	1,314	-	-	372	6,964	3.5
NV	532	6,211	7	527	3,539	6,405	4,078	13,143	5.1
NY	500	39,170	691	9,476	781	22,181	1,972	70,827	3.7
OH	1,204	45,098	1,646	15,350	116	962	2,966	61,410	5.4
OK	232	11,501	44	412	-	-	276	11,913	3.3
OR	2,641	32,063	414	3,888	1,252	5,703	4,307	41,654	11.1
PA	1,483	71,830	881	15,486	438	8,972	2,802	96,288	7.7
RI	62	3,499	244	1,674	344	2,196	650	7,369	7.0
SC	486	16,297	147	3,874	15	220	648	20,391	4.6
SD	190	3,743	961	1,870	16	495	1,167	6,108	7.7
TN	326	14,720	na	na	3	56	329	14,776	2.4
TX	1,465	46,845	87	3,890	165	8,755	1,717	59,490	2.5
UT	155	5,317	188	6,245	195	2,748	538	14,310	5.4

Licensed Residential Settings									
State	Aged/Adult		Children		DD/MH/Other		Total		Beds Per 1,000 Population
	Facilities	Beds	Facilities	Beds	Facilities	Beds	Facilities	Beds	
VA	702	33,415	345	8,176	1,214	7,406	2,261	48,997	6.4
VT	117	2,596	1,320	2,385	35	327	1,472	5,308	8.5
WA	3,099	40,871	6,058	14,600	90	3,532	9,247	59,003	9.1
WI	2,531	28,289	244	17,037	-	-	2,775	45,326	8.1
WV	114	3,284	55	854	204	1,436	373	5,574	3.1
WY	35	1,444	43	976	2	23	80	2,443	4.7
US	50,205	1,014,922	53,474	271,270	27,728	197,499	131,407	1,483,691	4.9

Source: Harrington, C., Granda, B., Carrillo, H., Chang, J., Woleslagle, B., Swan, J.H., Dreyer, K., et al. 2008. State Data Book on LTC, 2007: Program and Market Characteristics. Reported Prepared for the US Dept. of Housing and Urban Development. San Francisco, CA: University of California.