

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

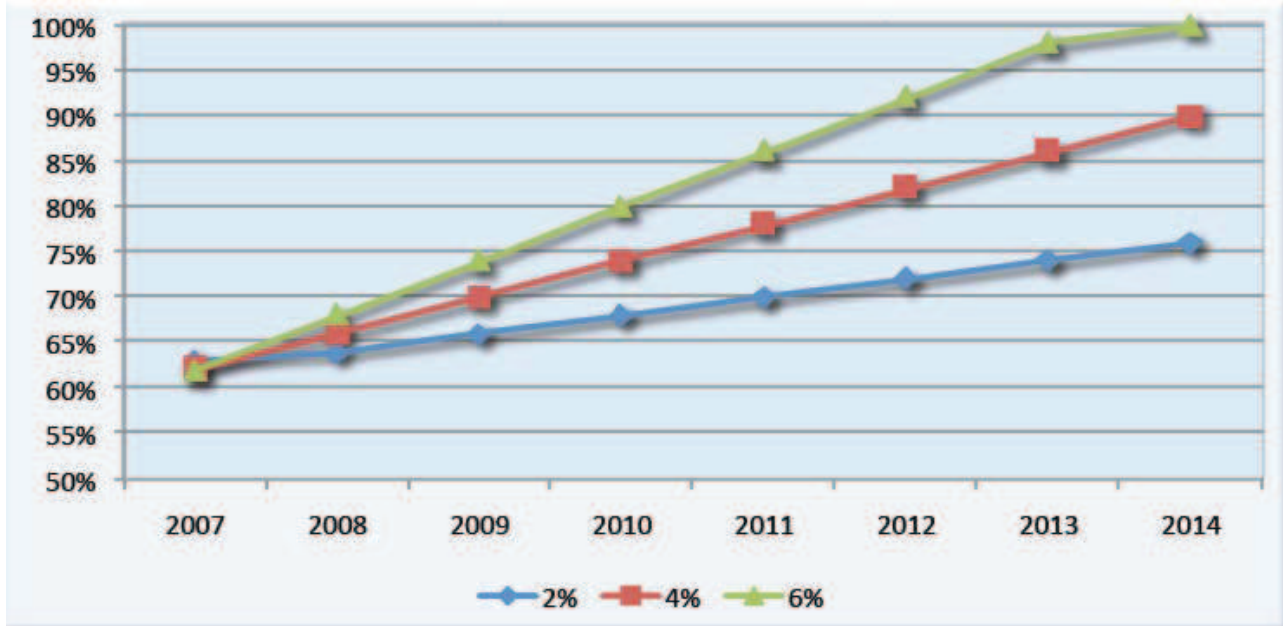
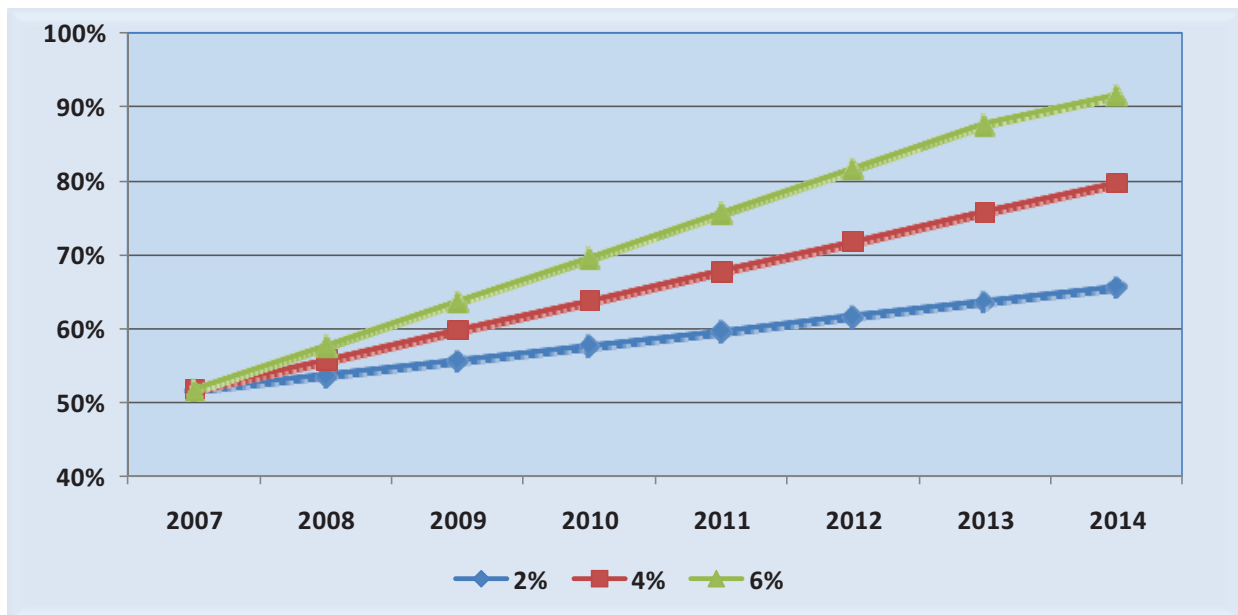


Figure 26 displays the percentage of funds that would be spent on HCBS for aged and disabled persons using three growth rates, 2%, 4% and 6%. The percentage spent on HCBS in 2014 would reach 66% if the balance grew 2% per year, 80% at 4% per year and 92% at 6% per year.

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 of 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/ltrresourcecenter/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.

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	\$1,194.30
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

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 report²²⁷ 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.

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 acuties 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 statutes 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 adjustment²³⁵

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, I, 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

<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

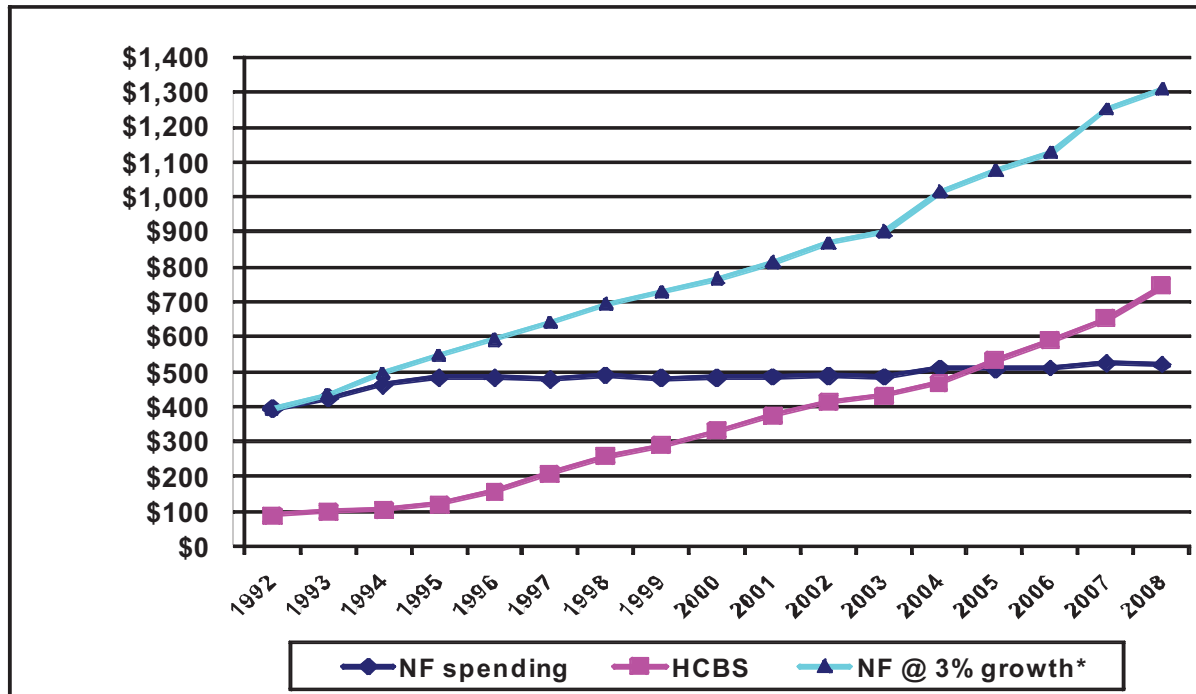
Fiscal Year	Community Services		Nursing Facility		Projected Nursing Facility	
	Average # Consumers	Spending (Millions)	Average # Consumers	Spending (Millions)	Average # Consumers	Spending (Millions)
1995	19,772	\$118.9	16,642	\$481.6	18,962	\$548.7
1996	20,887	\$158.5	15,904	\$482.1	19,531	\$592.0
1997	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.

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

The Demonstration requires that savings from institutional care be invested in HCBS.

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 report²⁴⁰ 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.

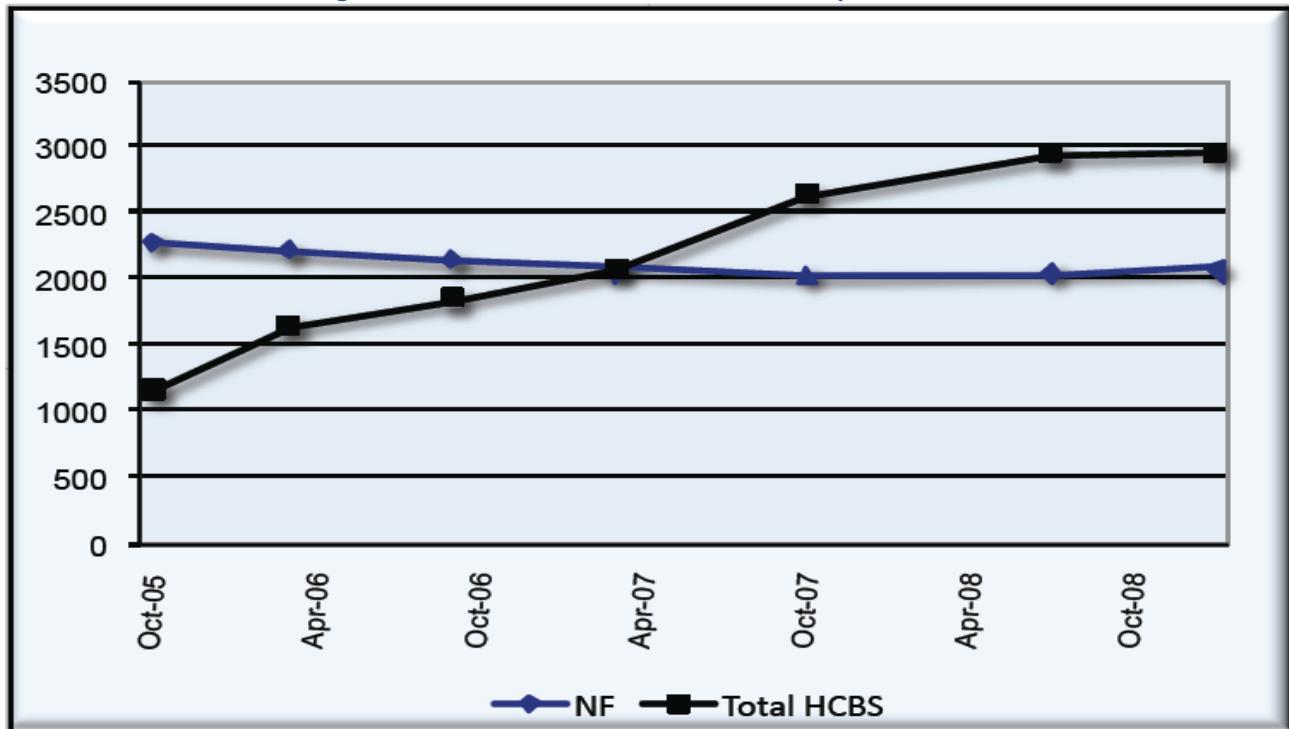
²³⁹ For a discussion of global budgeting see Hendrickson, L. & Reinhard, S. (2004), *Global Budgeting: Promoting Flexible Funding to Support Long-Term Care Choices*, Center for State Health Policy, Rutgers University, New Brunswick, NJ. Retrieved on 4-28-09: http://www.hcbs.org/files/52/2599/State_policy_in_practice.pdf.

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.