

**California Community Choices Advisory Committee Meeting
July 31, 2008**

**Long-Term Care Finance Study
Select Preliminary Recommendations
FOR DISCUSSION PURPOSES**

California Community Choices, an initiative of the California Health and Human Services Agency (CHHS), is a five-year project focused on improving access to long-term services and supports so that individuals with disabilities and older adults can stay in their homes and communities. One component of the Choices project is a study that will look at how California pays for long-term services and supports, as well as the related laws, regulations, and policies.

Researchers

Dr. Robert Mollica, National Academy for State Health Policy
Dr. Leslie Hendrickson, Hendrickson Development

Purpose of Study

To improve the State's understanding of the financial and structural barriers to increasing access to home and community-based services and make recommendations to more effectively manage funding and long-term supports to promote community living options

Scope of Study

- Using existing resources, research and analyses on long-term care in California, analyze the laws, regulations, policies and payment methodologies related to long-term care financing in California.
- Make recommendations that will improve the management of funding for home and community-based services that should include funding, payment methodology, policy, legislation, leadership and commitment.
- To date, we have examined the following: In Home Supportive Services (IHSS), Adult Day Health Care, Multipurpose Senior Services Program (MSSP), nursing facility services, waiver programs and to a lesser extent services for individuals with developmental disabilities and mental health services.

Preliminary Findings

(Note: these findings do not yet reflect all the programs and services we are examining)

- California has an array of programs and services for individuals with disabilities. The programs are located in multiple agencies, use different delivery systems and challenge consumers, family members, advocates and providers seeking to access and coordinate services. The programs operate in separate silos which create fragmentation and barriers to obtaining information and access to services. Some programs are not available statewide.
- The state provides extensive funding for home and community based services. Over half of Medi-Cal long-term services spending pays for home and community based services compared to the national average of 39%.
- Despite the investment of \$10 billion in home and community based services and institutional long-term care service, the state 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 and staff responsible for managing the process that will guide decisions about the future of long-term services and supports.
- California needs to determine how it will set priorities for services for the future in order to maximize the use of finite resources. The Olmstead plan offers a framework for developing a strategic plan.
- The state's budget deficit makes consideration of changes that require investment in services or the delivery system more difficult in the short term. However, the current structure and operation of long-term care programs may contribute to the rate of institutional spending growth, and investments may improve the effectiveness of the overall delivery system and reduce the rate of growth.
- California operates the largest personal care program in the country. With over 400,000 participants, the IHSS caseload grew 85% between

January 2000 and March 2008. A similar program in Michigan grew 46% during the same period. Both states have comparable disability rates.

- IHSS serves both as an income support program and a service program.
 - IHSS participants with impairment in one Instrumental Activity of Daily Living are eligible for the program.
 - Limits on the maximum hours require that participants with higher functional needs that qualify for a home and community based services waiver must receive services from two programs. Other participants who need the additional services offered by a waiver program may not be served due to limited funding.
 - Consumers use a variety of programs to meet their support needs and to maximize family and formal caregiver capacity. Adult day health care may sometimes be used to supplement the cap on IHSS hours. Sixty percent of participants also receive services from IHSS.
- The assisted living waiver pilot program begins to address a gap in the array of services but serves a small number of participants and is not yet available statewide. Smaller home settings for older adults, commonly referred to as adult family or foster care, are not available to Medi-Cal beneficiaries who may prefer these options.
 - The Department of Developmental Services (DDS) contracts with a network of regional centers that operate as comprehensive entry points for community services for individuals with developmental disabilities.
 - While there is no comprehensive entry point for older adults and individuals with disabilities, Aging and Disability Resource Centers (ADRC) are being designed to provide information about the multiple services and access points.
 - The existing program structure and funding streams do not maximize incentives that support home and community based services.
 - Previous reports recommended consolidation of agencies and programs serving individuals with disabilities and older adults. However, each

program and agency has a long and rich tradition, a strong network of providers, advocates and consumers that seem more comfortable with the system they know, despite the fragmentation, than a new, untested and structure that is not clearly defined.

- Medically needy beneficiaries meet the share of cost in an institution quickly but face barriers meeting it in the community because they need to retain income to meet housing and other expenses.
- California ranks 43rd among states in the supply of nursing facility beds and 31st with an occupancy rate of 86%. The Medi-Cal nursing facility census has remained stable for the past ten years. However, nationally between December 2001 and June 2008, the average number of Medicaid residents in nursing facilities dropped 7% and 20 states experienced a reduction of 10% or greater which suggests that further reductions are possible through diversion and transition/relocation initiatives.
- Nursing home spending in California increased 44% between 2001 and 2006 while waiver spending for older adults and individuals with disabilities increased 10% during the same period (Medicaid expenditure data from Thomson Reuters).
- Medi-Cal spending for all nursing facility and ICF-MR services rose 48% between 2001 and 2006 and spending for IHSS, MR/DD and other waiver services 77%. Spending for IHSS and MR/DD waiver services accounted for most of the growth.
- Key informants differ on the extent to which existing programs substitute for institutional care due in part to the lack of data that compares consumers across programs and settings.
- New programs often build a new delivery system because there is no logical infrastructure to administer new programs.
- Consumers admitted to a nursing facility do not have access to a central source of information, assistance and access to community service options. Consumers living in the community who need assistance do not have access to options counseling to understand what services might be available to them in order to divert consumers who have other options to admission to an institution. The ADRCs, called Aging and Disability

Resource Connection programs in California, can perform this function if they are implemented statewide. To date, the pilot ADRCs, which are based on partnerships between Area Agencies on Aging and Independent Living Centers expand the information and assistance functions in existing organizations.

- The Money Follows the Person Demonstration offers an opportunity to develop and refine strategies that provide transition coordination to nursing facility residents who are interested in moving to the community. The fragmented delivery system poses additional challenges to transition coordination. The program's success will depend on the ability of the service network to provide access to the level of service needed by individuals who are interested in moving to the community.
- The state currently has scattered small nursing home transition programs. For example, Centers for Independent Living, 1915 (c) waivers and programs in San Francisco.

Select Preliminary Recommendations

General

The CHHS might develop a strategic plan that is based on the multiple reports and recommendations, describes which populations, services and programs will be addressed by the plan and describes the mission, values and goals for its long-term services and supports system. The 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 be based on the work of the Olmstead Committee whose report was released in 2003 by the CHHS as "a blueprint for an improved system in California and the steps needed to move towards achieving a system that will provide services in the most integrated setting appropriate for persons with disabilities." The Executive Order established the Olmstead Committee describes the Governor'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.

The strategic plan can follow the vision and values reflected in the principles of Olmstead plan that state:

- 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.
- 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 Recommendations Below Support Three Primary Goals:

- To increase spending on home and community based services for individuals who are at risk of entering an institution;
- To reduce the rate of growth in spending on institutional care; and
- To improve the management of home and community services programs.

Our preferred option for increasing spending is to shift resources from institutional to community programs by establishing a statewide nursing facility relocation program, building an infrastructure to divert people from institutional settings through options counseling, and setting a timetable for closing additional developmental centers.

Our less preferred but still a potential option is to focus IHSS resources on individuals who are at greater risk of admission to a nursing home or who move from an institution to the community.

1. Short-term (1 year)

► *Rates and fiscal incentives*

- Adopt a case mix reimbursement system for nursing facilities to create incentives to serve higher acuity residents.
- Establish an occupancy incentive that reduces the payment to Nursing Facility when their occupancy falls below a designated level.
- Convert the labor-driven operating allocation in the nursing home rate to an incentive to promote discharge planning or increased staffing.

► *Policies, laws and regulations that impact access to home and community based services*

- Adopt the 300% of Federal SSI eligibility option for Medi-Cal home and community based waiver service programs which enable individuals in the community to become Medi-Cal eligible without incurring expenses equal to the share of care.
 - This option also reduces the need for the Department of Social Service's share of cost buy out for individuals who meet the waiver level of care eligibility criteria.
- Expand the home maintenance income exclusion from \$209 a month to an amount that reflects the cost of maintaining a home. Options include setting a limit up to the SSI/SSP payment level; the Federal Poverty Level (FPL); a percentage of State Supplemental Payment or FPL or the actual cost of maintaining their shelter.
- Maintain the SSI/SSP Medi-Cal eligibility group during the first 90 days of an institutional stay for beneficiaries who are able to return home.
- Establish an Office of Nursing Home Transition to support the individual nursing home transition efforts now undertaken by different agencies.

- Expand the Assisted Living Waiver Program which offer elderly nursing home residents a home-like option in the community.

2. Medium range recommendations (1-2 years)

▶ *Rates and fiscal incentives*

- Create rate incentives perhaps using funds from the labor driven operating allocation, for example, for nursing facility providers to diversify by offering affordable housing, adult day health care or in-home services after reducing their bed capacity.

▶ *Mechanisms and structures that could result in more effective management of home and community based services*

- Establish data bases that allow policy makers to compare the health and functional characteristics and utilization patterns of individuals across programs.
- Provide options counseling about community alternatives for individuals in nursing homes and to individuals considering admission or recently admitted to a nursing home by agencies that are most familiar with the community programs and resources.
 - Options counseling should be available to all consumers who want to move to the community. If resources are limited, priority may be given as follows:
 - Options counseling might be targeted to all individuals approved for the Level 'A' level of care;
 - Individuals with short term Treatment Authorization Request (TAR) approvals; or
 - Selected Level 'B' NF approval (e.g., individuals with supportive family members or friends).
- Reinvest savings from institutional care into home and community based services or create a reserve fund for savings that may be used for investments in a subsequent fiscal year.

- Allow the nursing home appropriation 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.
- Expand Aging and Disability Resource Centers to provide information, assistance and screening for individuals exploring their options to admission to an institution.
- Expand residential options to offer a full array of service alternatives.
 - Residential Care Facilities
 - Small, family-style homes (licensed as Residential Care Facility for the Elderly (RCFEs), considered adult foster care in other states)
- Create a statewide nursing home transition or money follows the person program that uses the TAR approval dates to prioritize activities.
- Convert the portion of SSP payments that exceed the amount paid in 1983 to a Medi-Cal service such as:
 - IHSS in RCFEs
 - Add RCFEs to the MSSP and Nursing Facility/Acute Hospital waivers
- Expand housing subsidy options by converting a portion of the state share of the savings from Medi-Cal payments for individuals who relocate from an institution to a housing subsidy while they wait for a housing voucher or other federal housing subsidy.
- Regional Centers are required to have regular contact with residents who are placed in ICF-MRs, nursing facilities and other institutions. Establish a transition group comprised of DDS and regional center staff might be formed to develop further strategies to support transition of persons in these settings.
- Develop alternative budgeting approaches that, should budget reductions be enacted, serve individuals with greater functional impairments.

3. Longer-term recommendations (2 years or longer)

- ▶ *Mechanisms and structures that could result in more effective management of home and community based services*
- Create a Department of Long-Term Services and Supports.
- Create Comprehensive Entry Points that could be:
 - County based
 - Regional organizations selected through an Request For Proposals
 - Entities that build from the organizations that participate in the Money Follows the Person demonstration
 - Entities that operate under the ADRC program
- Create a unified long-term care budget at the county/regional level that includes nursing home spending, IHSS, and selected HCBS waiver programs.
 - Co-locate Medi-Cal financial eligibility workers in Comprehensive ADRCs.
- Develop an assessment tool that collects comparable data from participants in HCBS waivers, IHSS, adult day health care and nursing homes.

Potential further studies and data collection

- Study the reasons for discharge from IHSS and selected waiver programs to institutions to determine whether additional services might delay or avoid placement in an institution.
- Track the use of the home maintenance income exemption to determine how often it is used and the number of beneficiaries who are able to return to the community.