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Little Hoover Commission Testimony for
March 25, 2010 Hearing on
Long Term Care in California.

Thank you for the opportunity to contribute to the Commission's discussion of the continuum of care services for older adults and people with disabilities. My points will focus on activities supported by the California Health and Human Services Agency, and the priority areas for policy that have been identified by Olmstead Advisory Committee (OAC). These priorities have been elevated by this Administration and acknowledged federally through various grant solicitations and initiatives.

These priorities address a continuum of services and supports that older adults and people with disabilities of all ages may need to access as their health and functional needs change over time. A system of community and home-based services allows individuals with long-term care needs to access the right level of support, in the most appropriate setting and to avoid unnecessary and higher-cost institutional-based services.

Such a system requires strategies in several areas:

- Provider Capacity
- Connection to and Coordination among services
- Data
- Financing

Provider and Service Capacity

Medi-Cal Home and Community Based Services Waiver programs. These Medi-Cal programs are available to individuals who are assessed to have nursing facility level of care needs. In 2009 the Administration successfully renewed, with options to expand in some cases, several of these programs, including the:

- Assisted Living Program
- Multipurpose Senior Services Program
- Intermediate Care Facilities for individuals with developmental disabilities/CN

In addition, the IHSS Plus waiver was converted into a Medicaid State Plan element last year. The In-home Supportive Services program served 445,584 in 2009, up from 360,759 in 2006. In the past 10 years, the IHSS caseload has grown 71 percent. Another HCBS waiver for people with developmental disabilities has increased its cap annually by 5,000 which resulted in a capacity to serve more than 82,000 people in 2009.

Beginning 2006 the DHCS was granted an annual increase in General Fund support to support 160 additional slots in our primary HCBS waiver for Nursing Facility level of care through the authority of Senate Bill 643,Chapter 555, Statutes of 2005 (Chesbro). Since 2005 waiver capacity has increased from 2095 to 3025.

Community and environmental supports. One of the challenges that people often report when transitioning from long-stay institutional care is finding affordable and accessible housing. This demand was very apparent during the closure process of Agnews Developmental Center when the Department of Developmental Services worked to meet transition goals and needs identified in each resident's Individual Placement Plan. Investments in supportive housing have also been prioritized through Mental Health Services Act county plans. The Olmstead Advisory Committee has established a workgroup to help address this issue more broadly.

Models of managed care. Health plans such as SCAN and Programs for All Inclusive Care for the Elderly (PACE) incorporate social supports in addition to healthcare services for older adults in community settings. The PACE program has expanded since 2003. There are currently fifteen sites across the State.

As evident in California and in many other states' economic conditions and previous budget proposals, we cannot rely on continuous expansion to address the increasing demand. We must find ways to maximize and leverage our existing capacity and strengths.

Strategies that advance Connection to and Coordination among programs/services.

One of the primary objectives of the California Community Choices project administered by the California Health and Human Services Agency is to empower individuals by providing access to information about LTC services and supports. Funded by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Choices has established Aging and Disability Resource Connection (ADRC) programs in Orange and Riverside counties to provide a coordinated system of information, referral and assistance for any person seeking long-term care services and supports. These services are provided in-person, by phone or on-line.

The ADRCs maximize use of current resources available in a local community by creating partnerships across networks and funding. This is particularly important in time of budget reductions.

What's new about the ADRC?

- Closer working partnership between offices on aging and independent living Shared service provider databases
- Each caller is offered a broader view of home & community service options instead of narrowly defined networks (silos)
- Outreach and services are provided to anyone regardless of age, disability or eligibility for public programs
- "No wrong door" principle and a coordinated approach to consumers' needs

ADRCs empower consumers to make informed choices about long-term services and supports.

Hospital to Home Grant**.** Two ADRC programs that were funded originally through AoA at the CDA are participating in a recently-awarded Hospital to Home grant. In general, the grant focuses on services that connect, coordinate and empower individuals who are at high risk of repeat hospitalization or referral to LTC institutional settings at the time they discharge from an acute care hospitalization. The grant enhances the San Francisco and San Diego ADRC model to strengthen short-term care coordination and long-term options counseling services.

Also through this grant, the California Department of Health Care Services (DHCS) will modernize its existing Medical Case Management (MCM) Program through several strategies, including the development and implementation of a replicable and sustainable Person-centered Hospital Discharge Planning Model. DHCS' MCM Program has been working collaboratively for over 15 years with hospital discharge planners statewide to identify hospitalized fee-for-service (FFS) Medi-Cal beneficiaries who would benefit from additional assistance in preparing for and transitioning back home after discharge.

California is dedicated to achieving the following fundamental health and social service goals: 1) to ensure safe and person-centered discharges for all Californians; and 2) to maximize opportunities for individuals with long-term services and support needs to live in the community. Through this grant, the State intends to move closer to meeting its first goal by modernizing and strengthening MCM Program core operational practices to meet current *and* future beneficiary, provider, and systems challenges. DHCS will use the grant to: 1) conduct a predictive modeling analysis of Medi-Cal paid claims data to profile beneficiaries and/or beneficiary groups who could benefit from MCM to avoid emergency department visits or hospitalization, in order to develop and implement appropriate screening tools and protocols; 2) analyze evidence-based hospital discharge and patient empowerment models and pilot-test a selected model; and 3) develop a cross-agency Steering Committee with representatives from various State departments and State systems/initiatives, including the MCM Program, ADRCs, and others.

California Community Transitions. This project plan was approved by CMS in September of 2008. Since that time, approximately 200 individuals who have resided in long-term care facility settings for six-months or longer have transitioned to the community under the demonstration. Federal funds provide a greater match for these individuals for 12 months post-transition. Lead organizations can also bill for screening, assessment and transition planning services prior to the actual transitions. Currently 13 lead organizations serve 34 counties and include Independent Living Centers, Home Health Agencies, AAAs and MSSP providers as well as DDS.

Data.

Currently we are hard put to provide data-based answers to questions about what works? What works for whom? What exactly are the right services at the right time? The SCAN Foundation has partnered with the DHCS to fund a comprehensive analysis of Home and Community Based Services. An overview of the project has been provided to the Commission. The research will inform LTC policy by providing information on how HCBS prevent or delay institutionalization, reduce the use of emergency room services and hospitalizations and improving or maintaining people's quality of life. The Community Choices project is also commissioning a study to explore the opportunities for and benefits of a LTC database.

Financing.

CHHS identified LTC financing as a primary goal for the California Community Choices project as part of our grant application to the federal government in 2005, and again when funded in 2006. The final LTC finance report "Home and Community-based LTC: Recommendations to Improve Access for Californians," was completed in 2009 and is a foundational document for the administration's discussions for creating more sustainable financing solutions for long-term care services and supports.