
***A LONG-TERM STRATEGY
FOR LONG-TERM CARE***



LITTLE HOOVER COMMISSION

April 2011

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By statute, the Commission is a bipartisan board composed of five public members appointed by the governor, four public members appointed by the Legislature, two senators and two assemblymembers.

In creating the Commission in 1962, the Legislature declared its purpose:

...to secure assistance for the Governor and itself in promoting economy, efficiency and improved services in the transaction of the public business in the various departments, agencies and instrumentalities of the executive branch of the state government, and in making the operation of all state departments, agencies and instrumentalities, and all expenditures of public funds, more directly responsive to the wishes of the people as expressed by their elected representatives....

The Commission fulfills this charge by listening to the public, consulting with the experts and conferring with the wise. In the course of its investigations, the Commission typically empanels advisory committees, conducts public hearings and visits government operations in action.

Its conclusions are submitted to the governor and the Legislature for their consideration. Recommendations often take the form of legislation, which the Commission supports through the legislative process.

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LITTLE HOOVER COMMISSION

April 28, 2011

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Governor of California

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Marilyn C. Brewer

Virginia Ellis

The Honorable John A. Pérez
Speaker of the Assembly
and members of the Assembly

The Honorable Connie Conway
Assembly Minority Leader

Marshall Geller

Alyson Huber
Assemblymember

Loren Kaye

Dear Governor and Members of the Legislature:

Michael J. Rubio
Senator

California has delayed developing a strategy to manage its long-term care programs as a cohesive system for decades. Now the state struggles with sharply reduced resources and faces a projected surge in its senior population. California leaders must act to develop and implement a strategy to put increasingly scarce dollars to their best use in meeting the needs of low-income elderly and disabled Californians.

David A. Schwarz

Jonathan Shapiro

Mark Wyland
Senator

Stuart Drown
Executive Director

California has no shortage of good ideas, long-term care programs, examples of innovative local approaches or dedicated caregivers. What is lacking at the state level are vision, strategy and leadership.

The state must develop a vision for long-term care in California, one that anticipates the changes ahead to create a continuum of care from the most independent setting to the most supportive. The state must build a strategy around this vision that sets out the role of state-level departments and programs in a way that recognizes that local governments, given adequate resources and flexibility, are best positioned to create integrated long-term care systems that reflect their populations' needs.

To begin the process, California needs an identifiable leader at the agency level who can act as a champion for long-term care in state government, an executive who can align and coordinate state-level long-term care programs and identify and manage cost drivers. This leader also can serve as a communication link for local governments and a nexus of accountability to the Legislature. This leader should oversee the ultimate consolidation of long-term care programs at the state level. Such a consolidation will create opportunities for better planning, more systematic budgeting and greater accountability.

California led the nation in innovating services for seniors and the disabled, pioneering the independent living movement for the disabled and creating an in-home support program for seniors that now is the nation's largest. Over the past three decades, the state has developed dozens of programs to deliver long-term care services, some of them emulated by other states even though they failed to grow to scale here.

Today, these programs are dispersed over seven different departments in the Health and Human Services Agency, leading to duplication of efforts in some cases and gaps between programs in others. A major goal they share is helping seniors and disabled Californians live securely in home and community-based settings for as long as possible and to avoid or delay more costly institutional settings, which is now required by the law. But from the client's perspective, the collection of programs appears as a confusing maze, not a coordinated, integrated system.

At the state level, there is little coordination of activities, sharing of information about successful programs, standardization of assessment or streamlining of enrollment, even when several programs often serve the same person. This inefficiency diverts dollars that could be better put into services. The way programs are funded further complicates the ability of state departments to work together. The absence of information that can be shared across programs impedes the state's ability to most efficiently use limited resources, or determine which clients are the most vulnerable. The result is that no one can assess, or manage, or provide oversight, for the system as a whole.

In the case of the In-Home Supportive Services program, one state entity, the Department of Social Services, is responsible for administering an entitlement program in which care is delivered through individual contracts at the local level, while much of the funding is supplied through a separate department, the Department of Health Care Services. A separate state program, Multiple Senior Services Program, located in yet another department, the Department of Aging, has responsibility for administering local efforts to provide case management for social and health care needs for frail seniors who wish to stay in the community rather than enter a nursing home. This program has a separate process for determining need and eligibility than does In-Home Supportive Services, though the programs' clients often are the same people.

In-Home Supportive Services, which has experienced soaring costs and surging enrollment over the past decade, has been criticized for a lack of accountability that in large degree is embedded in its decentralized structure. Yet the state relies on this program to deliver the bulk of the home and community-based care to seniors and the disabled. Despite its overlapping client population, In-Home Supportive Services is not integrated into other long-term care programs at the state level and differences in assessment tools and eligibility requirements complicate local government's efforts to integrate it into a broader long-term care strategy at the local level.

The Commission found that several counties have made significant progress in consolidating programs into an integrated local system, among them San Diego, San Mateo and San Francisco counties. In Orange County, new flexibility made possible by a waiver to federal law is allowing the state and an established Medi-Cal managed care health plan to expand its long-term care services, testing a model that could be replicated in other counties.

In its 1996 study, *Long Term Care: Providing Compassion Without Confusion*, the Commission found similar problems and recommended consolidating all long-term care programs into a single state department. Consolidation still should be a goal, but undertaken in a way that supports and expands local governments' ability to create integrated service delivery systems that best meet local conditions.

The need for long-term care is great and will become greater. The work ahead does not require more state programs or additional bureaucracy. It requires a vision for long-term care, strategy and leadership. The Commission looks forward to assisting you in this effort.

Sincerely,

A handwritten signature in black ink, appearing to read "Daniel W. Hancock", written in a cursive style.

Daniel W. Hancock
Chairman

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Executive Summary

California’s long-term care system is broken. The state has no reliable means of gauging what clients need, what benefits they receive, which services are used by whom, how much each service costs the state, and which programs work the best and are the most cost-effective in keeping people in their homes. There is virtually no coordination or communication between programs and staff responsible for long-term care services. There is no integrated management or coordination of financing, service delivery or assessment of long-term care client needs or of providers. These fundamental structural flaws leave the system unable to effectively or efficiently deal with current needs and make it woefully unprepared for the “silver tsunami” of seniors who will lack services in the years to come. Furthermore, California lacks a single leader within the Health and Human Services Agency accountable for managing and modernizing long-term care in the state, which creates significant challenges to any attempt to systematically harness the dozens of long-term care programs and the many billions of dollars spent on them. Evidence of the system’s failure include the following:

- Consumer confusion and difficulty in accessing needed services results in over-utilization of unnecessary and costly care, such as emergency room visits or longer-than-required nursing home stays. The process of transitioning clients from institutional to community-based care is inconsistent.
- Lack of integrated service delivery causes duplication of state, county and non-profit effort and resources, such as the multiple and duplicative assessments conducted on a single client.
- Lack of care coordination, planning and management inhibit clients’ ability to find the right care at the right time in the right place.
- State-level leadership, vision and prioritization of long-term care services and system improvement are lacking.
- Focused oversight and accountability of program efficiency and outcomes are absent.
- The state administrative structure is fragmented, which isolates programs, a problem reinforced by rigid funding rules and a lack

of data that could be used for better decision-making and program planning.

- Budget cuts make delivering a full range of services difficult for state and county providers.

The lack of information about the state's long-term care programs means that the state, at any given moment, cannot say how much money California spends on long-term care for the aged and the disabled. The most recent estimate is \$7 billion for the state's share, from the 2005-06 budget year, a figure aggregated by the Legislative Analyst's Office. With federal and state contributions, total spending was \$13.7 billion for the period. Absent a way to assess the state's long-term care programs as a whole, the state lacks the ability to identify cost-drivers and address them in the context of other program options that may be available.

Spending on individual programs has grown rapidly in recent years, most noticeably in the In-Home Supportive Services (IHSS) program. This entitlement program must be integrated into the broader menu of long-term care options, to reduce overlap, to ensure that enough qualified caregivers and providers are available, and to improve the state's ability to prioritize services so that resources are directed to those most in need. Growth in participation across programs is projected to accelerate with the retirement of the Baby Boom generation. As the first group of the Baby Boom generation turn 65 this year, the number of Californians ages 65 and older is projected to nearly double over the next two decades, to 8.84 million in 2030 from 4.64 million in 2010. The need to make better use of existing funding through more consolidated and streamlined management becomes only more critical as ongoing budget shortfalls require government to become leaner and more efficient. The addition of legal requirements, most significantly the *Olmstead v. L.C.* decision by the U.S. Supreme Court in 1999, impose greater obligations on the state to keep people out of institutions and, instead, integrated into the community, requiring that the state do even more to keep people in their homes and transition them back home after being hospitalized.

California once was a pioneer in alternative care for seniors and people with disabilities, but it has failed to integrate long-term care programs at the state level. At the local level, innovative counties have worked to provide a more seamless system of care at the local level despite the state's siloed departmental structure. During its study, the Commission saw several promising local approaches to this kind of more integrated method, whether through an actual consolidation of programs, as in San Diego County, or through creative coordination of county health and social services programs that includes expansion of the county-organized managed care plan, as in San Mateo County.

County efforts to integrate services into a cohesive system of care are impeded by the state's fragmented bureaucracy. As funding streams for county programs originate in different state programs, county officials must go through layers of state program staff in order to make changes to local long-term care services, including changes needed simply to integrate services. Most long-term care services already are provided at the local level, but controlled or monitored at the state level. Governor Brown's realignment plan proposed in his January 2011 budget, though not yet applicable to long-term care, is a reminder that successful realignment requires integrated strategies at both the state and local levels so that counties can have the support and flexibility they need to best deliver services to seniors and people with disabilities. This report recommends changes that should be made to the current system as well as incorporated into any realignment plan, which necessarily will require a consolidation of long-term care activities at the state level.

Care Coordination

As the state braces for the oncoming wave of aging Baby Boomers alongside the recurring budget cuts, California's long-term care system must be streamlined and managed in a way that maximizes all resources. Federal, state, local, non-profit, community, and individual assets must be aligned in order to provide the best care at the most economical cost. The linchpin to this alignment is "care coordination" – a mechanism to ensure that a senior or person with disabilities receives the right care at the right time in the right setting – a goal that tends to keep people in their homes and communities and out of costly institutions. Care coordination means creating a true continuum of long-term care services, one that is easy to understand and accessible to the client. It should be well-organized at the local level, either through county programs or contracted non-profit groups.

In California, services are provided piecemeal, with different eligibility criteria and separate assessments for each program; there is no coordinated management of care or even data about a client's care or condition in a central database system that can be used by more than one program. Clients have no path or system to follow to understand their care options, while state leaders have no overall understanding of client population needs, service utilization, the cost of available options, or even which programs produce the best outcomes or are the most cost-effective. Funding and policy decisions, including changes and cuts made to In-Home Supportive Services, for example, are made lacking a full understanding of consequences to the system as a whole.

The state has neither the tools necessary to manage the system nor the ability to coordinate care – an absolute necessity – for the vast majority of beneficiaries in California’s publicly funded long-term care programs.

The Commission has long recognized the need for streamlined management and coordination of long-term care programs and in 1996 recommended the consolidation of long-term care services into one department. The Commission also has advocated for greater flexibility and control over service delivery at the local level for decades, with much of this work synthesized into recommendations for an agency-wide restructuring in the Commission’s 2004 report: *Real Lives, Real Reforms: Improving Health and Human Services*.

A true continuum of care would start with a client receiving a single assessment of needs as well as a determination of eligibility for a range of services, and then include help in finding the appropriate services, which may change over time. County programs and other local long-term care programs, with their close contact to clients, providers and community groups, are best situated to ensure the care coordination that is necessary for both quality care and for finding the most cost-effective solution to a client’s needs. As the Commission heard during its study process, beneficiaries generally choose to receive services in the more cost-effective manner because people largely prefer to stay in their own homes, a far cheaper option for the state than nursing home care.

Coordinating care around the client’s needs serves multiple goals, such as improving the quality and accessibility of care for a senior or person with disabilities by connecting them to the appropriate services they need, helping keep people in their homes and out of institutions, decreasing state costs by reducing duplication of assessments and services and reserving nursing home and other institutional options for those whose needs cannot be served in any other way, and providing a vehicle for gathering and sharing information across departments. Systematic care coordination means helping seniors and people with disabilities receive the most appropriate care in a timely way in the most appropriate setting. Done well, it can make for a more satisfied client and a more effective service provider, as well as provide the state with tools that would enhance its ability to understand and manage the system as a whole.

Leadership, Vision and Action

California’s long-term care services are administered in programs scattered across seven state departments: Aging, Social Services, Health Care Services, Public Health, Mental Health, Developmental Services and

Rehabilitation. This fragmented organizational structure and lack of a specific leader or entity responsible for long-term care in California leaves the state with a leadership vacuum that complicates any effort to take on comprehensive long-term care reform. The leadership gap also thwarts local efforts to improve the system, as forward-thinking counties seeking to integrate their programs try to obtain state approval for changes find themselves stymied in dealing with the different departments and are left with no one at the state who can facilitate their efforts at the local level.

The state must gain an understanding of how the system looks currently and how it should be improved. Most important to this task is a leader who can take action and follow through in implementing a statewide strategy. A state long-term care leader within the Health and Human Services Agency should create a vision for long-term care in California, have the authority to make decisions and provide direction to department heads regarding long-term care programs, manage efforts to improve the system, and be accountable for outcomes. The long-term care leader would report directly to the Health and Human Services Agency Secretary and would be a liaison and advocate on long-term care vis-à-vis counties, non-profit organizations, state departments, federal agencies and the California Legislature.

Despite the state-level fragmentation and lack of leadership, the Health and Human Services Agency has implemented several key initiatives to advance long-term care in California, such as the California Community Choices project aimed at increasing consumer access to home and community-based long-term care services, Money-Follows-the-person/California Community Transitions program to transition people from nursing facilities to home and a comprehensive analysis of data across multiple home and community-based programs, to name a few. The state has tremendous expertise and experience in the ranks of its program staff whose value can be leveraged through better coordination and leadership.

In the meantime, local jurisdictions such as San Diego, San Francisco and San Mateo are weaving together their long-term care services, despite many state and federal rules that impede true integration. These counties need an ally at the state level who can help them navigate and amend state rules and seek greater federal flexibility that will allow them to reform their systems locally.

These efforts are promising, but need a leader at the state level to ensure they reach their potential and are advanced within a specific and broader vision for long-term care. Equally important: Long-term care reform needs the support of the state Legislature, both in policy and budget development, but in oversight as well.

State Organization

The structure of California's state long-term care programs does not support a system designed around the needs of the person who requires and is eligible to receive care. Nor does it allow for a systematic assessment of expenditures and outcomes. Rather, the system is designed around funding streams tied to state and federal laws that often are unrelated to each other, and programs that were established independently over time in many different departments. The fragmentation of programs reaches from the state down to the county level. California must consolidate its long-term care programs in one place to ensure that it can effectively oversee the management, integration and coordination of locally-delivered services around the consumer.

Since the Commission's 1996 recommendation to consolidate long-term care programs, the *Olmstead* decision mandated that people with disabilities be served in the most community-integrated (non-institutional) setting possible.

Multiple advisory committees and workgroups also recommended consolidation and have presented options for how a new structure could be designed. A key goal of consolidation of long-term care programs under one leader should be to centralize budgeting authority, a starting point for better management as well as greater accountability. The state of Washington's former Assistant Secretary for State Aging and Adult Services Administration, Charles Reed, told the Commission that global budgeting is fundamental if true system reform is to occur as it gives the state the macro-level ability to move funds from one program to another based on patterns of use and emerging needs, as well as the micro-level authority to match care to an individual's needs.

A consolidated structure also allows for data collection that helps policy-makers and program administrators understand the health status of beneficiaries and their needs, service use and trends – all of which are essential when making budget decisions about which programs to cut or how to prioritize spending on the most needy beneficiaries. Consolidation also would improve the state's ability to identify population and cost trends and, given an array of program options, steer scarce funding to the programs that produce the best outcomes. Currently, California departments may be reluctant to share data with other departments, which makes it difficult to collect information that will help policy-makers understand the state's overall distribution of services and resources.

Consolidation also would create the conditions for extending more flexibility and control to local jurisdictions to deliver services along a true continuum of long-term care – with or without realignment.

The state’s ultimate goal should be a county-based system in which local decision-makers design the most cost-effective continuum of long-term services that reflect their communities’ specific needs. Counties would be equipped with a uniform assessment tool that could detail a client’s needs and condition as well as determine eligibility for a range of programs. The evolution necessarily would consolidate and reduce existing state administration of programs and departments serving long-term care consumers.

Recommendation 1: California needs a streamlined and consolidated organizational structure at the state level.

- ❑ The Governor and Legislature should consolidate all long-term care programs and funding into a single long-term care entity within the Health and Human Services Agency, led by a long-term care leader reporting directly to the Agency Secretary.
- ❑ The long-term care department should retain state-level global budget authority for all long-term care programs and services.
- ❑ The long-term care department should serve as the single point of state-level contact to provide leadership to local jurisdictions in sharing and encouraging best practices and to ensure oversight of locally-delivered long-term care services.

Recommendation 2: California must develop a strategy for how to create a seamless continuum of long-term care services.

- ❑ The long-term care leader should lead the creation of a vision and strategy for the future of long-term care in California.
- ❑ The strategy should incorporate information gathered in the California Community Choices project data warehouse study, the California Medicaid Research Institute/SCAN Foundation study, and other data as it becomes available in order to understand the state’s current long-term care programs, determine how to move forward and measure the results of future actions.
- ❑ The visioning and strategy-building process must include stakeholders.
- ❑ The vision should design a continuum of care that wraps around the individual senior or person with disabilities, gives local jurisdictions the flexibility needed to provide the right care in the right place at the right time, holds these jurisdictions accountable for results and

fosters a culture that regards seniors and people with disabilities as community assets.

- ❑ The strategy should list specific actions that will be taken to achieve the vision.

Recommendation 3: California needs a champion to lead development of a coordinated continuum of long-term care services for seniors and people with disabilities.

- ❑ The long-term care leader must have the authority and expertise to pull together long-term care data and programs from multiple state departments, initiate better coordination, create the conditions for greater innovation and facilitate integration of long-term care programs at the local level.
- ❑ The long-term care leader should annually report to the legislative policy committees about the current status of long-term care in California, the level of state spending across long-term care programs, the progress of improving the continuum of services, and the next steps that must be taken to continue to enhance the coordination and delivery of services.
- ❑ The state Health and Human Services Agency should develop the following tools to create a seamless and coordinated continuum of long-term care services:
 - ✓ A single and uniform assessment tool to better manage a client's long-term care needs across programs over time.
 - ✓ Information technology that enables the integration of services virtually, facilitates consumer case management, collects data and provides information to the county and the state to allow for effective management of the system.
- ❑ Local jurisdictions must become the single point-of-entry for long-term care services and should have the flexibility to assess needs, coordinate care, connect clients to the services they need and for which they qualify, and be able to help clients transition from program to program as needed.
- ❑ The state should provide local jurisdictions the right incentives, flexible funding and program support needed to ensure that local jurisdictions have the framework and resources needed to meet client needs.

Introduction

California's In-Home Supportive Services (IHSS) program experienced rapid growth during the first decade of this century, its caseload more than doubling to 430,000 in 2009 from 208,000 ten years earlier, during a time when the state's population grew about 16 percent. During the same decade, the average annual cost for each IHSS beneficiary more than doubled, to \$13,000 from \$6,300.

Given the growth in IHSS, the Commission in early 2010 began to assess a study of the program. After its initial research, it found that issues behind the rapid growth of the IHSS program led to larger questions about California's system of long-term care as a whole, of which IHSS was one piece. Opportunities for changing IHSS are linked to a broader set of issues for California's long-term care programs. Rather than examine IHSS in isolation, the Commission was encouraged to extend the scope of its study to include the other programs that provide long-term care, whether it is the social, rehabilitative or medical services that allow people to live as independently as possible in their own homes, or nursing home facilities or other institutions at the other end of the spectrum of cost and dependence.

Long-term care in one form or another is the responsibility of more than a half-dozen departments across the Health and Human Services Agency, as well as local governments, community-based organizations and the federal government. Given the expansive range of players, organizations and state and federal rules around long-term care, the Commission chose to look broadly at long-term care through what changes could be made at the state level to pull together a collection of programs, including IHSS, into a cohesive system.

The Commission previously reviewed long-term care in 1996. In its study, *Long Term Care: Providing Compassion Without Confusion*, the Commission found the state's structure too fragmented to allow effective coordination and integration services. The Commission recommended consolidating long-term care into a single state agency and increasing resources for programs that allow enrollees to avoid or delay institutionalization.

Such a consolidation has not occurred, although some efforts since 1996 have created additional opportunities to enhance services aimed at

keeping people in their own homes. The background chapter of this report includes an overview of steps that have been taken and progress that has been made since the Commission's 1996 report. The remaining chapters discuss the problems that still exist and the Commission's recommendations for how to move management and delivery of long-term care forward given the current state environment.

This study began with a hearing in March 2010 that provided an introduction to the major issues facing California in long-term care, foremost among them the projected rising demand for long-term care services over coming decades as the number of seniors increase. Other issues included the range of services offered throughout the state, the level of state spending, the fragmentation of state-level programs at the patient-level and the legal and fiscal challenges that complicate attempts at reform.

A second hearing in May 2010 allowed the Commission to explore the *Olmstead v. L.C.* decision that was issued by the U.S. Supreme Court in 1999 and the shift toward home and community-based services as the preferred alternative to residential facilities. Witnesses, including representatives from the National Senior Citizens Law Center and researchers from the National Center for Personal Assistance Services at the University of California, San Francisco, told the Commission that home and community-based care is not only the favored option of those needing long-term care, it also is cost-effective compared with institutionalization and is, in many cases, legally required under *Olmstead*. For home and community-based care, California relies heavily on IHSS. The program's recipients represent more than 80 percent of the long-term care beneficiaries enrolled in home and community-based care in California.

The Commission visited On Lok Lifeways in San Francisco in July 2010, to learn about the nation's first Program of All-Inclusive Care for the Elderly (PACE), developed in the late 1970s. PACE is the only fully-integrated model of care for the frail elderly, and the only model that aligns all fiscal incentives to encourage preventive measures to maintain the health and well-being of its participants in the most integrated setting possible. To qualify, low-income seniors must be eligible for nursing home care.

In August 2010, the Commission convened a panel of stakeholders to discuss the status of the In-Home Supportive Services program and the changes made to the program over the last several years. Meeting participants included state Department of Social Services representatives, county social workers, senior and disability advocates, public authority leaders, district attorneys working on IHSS fraud cases

and union representatives. It was the first time many of these stakeholders had met as a group since 2004.

The Commission's third hearing in August 2010 highlighted successful models for integrating long-term care services, and discussed opportunities where California could bolster its long-term care system. Commissioners heard about systems in other states and in some localities within California. Witnesses from other states emphasized the importance of a single state long-term care department with sole responsibility for addressing long-term care needs, as well as global budgeting authority. The witnesses also discussed the need for flexibility to make decisions about where to allocate resources, uniform assessment and case management via a single-point of entry into programs and access to service utilization data through a comprehensive information technology system.

To explore the ways technology can integrate long-term care services, the Commission met with staff from Social Interest Solutions in September 2010. The Commission learned about the non-profit organization's role in developing an application and eligibility determination software – One-e-App – that creates a single point-of-entry for a range of local and state-administered health and social service programs. Staff and Commissioners discussed with the Social Interest Solutions team the potential for integrating long-term care services through a similar process.

The Commission's long-term care subcommittee met with San Diego officials in October 2010 to learn about San Diego County's process of reorganizing and consolidating its long-term care services for seniors and people with disabilities under one department, called the Aging and Independence Services. Commissioners also toured the county's call-in center that serves as the Aging and Disability Resource Center and heard about the county's Long-Term Care Integration Project that aims to integrate long-term care services into a comprehensive, consumer-centered continuum of care.

In November 2010, the Commission's long-term care subcommittee met with more than two dozen stakeholders in Sacramento to discuss the challenges of providing long-term care services in rural counties. The Commission and staff learned that fragmentation of services, isolation, funding limitations and lack of critical support factors, such as transportation and family proximity, further complicate the delivery of long-term care services in rural California.

Also in November 2010, the Commission's long-term care subcommittee met with officials in San Mateo County, which was the first California

county to establish an Aging and Adult Services Office under its Health Department in the 1980s. San Mateo officials have consolidated many of the county's long-term care services into this office, and they are working to further integrate programs and streamline funding through the Long-Term Support Services Project, which aims to integrate and streamline funding for acute care and nursing facility services alongside funding for home and community-based services through the county's organized Health Plan. As part of a pilot program authorized by the state in 2003, San Mateo County also created a uniform assessment tool for home and community-based services which it plans to continue to use and expand.

A list of witnesses who testified at Commission hearings is included in Appendix A. Lists of all public meeting participants are included in Appendix B.

Commission staff received valuable feedback from a number of experts, through meetings as well as one-on-one interviews, who offered various perspectives on California's long-term care system. Staff also observed meetings held by other organizations. The Commission greatly benefited from the contributions of all who shared their expertise, but the findings and recommendations in this report are the Commission's own.

This report and all written testimony submitted electronically for each of the hearings, is available online at the Commission Web site, www.lhc.ca.gov.

Long-Term Care in California

In California, more than a million people use long-term care services provided in whole or in part by public money. Need for those services is expected to swell as the population of seniors nearly doubles over the next two decades to 8.84 million, then climbs to 11.6 million by 2050.

For many Californians, the image of long-term care that most easily comes to mind is the nursing home, providing medical services and other services to elderly and disabled Californians whose health needs require full-time care. The state's Medi-Cal program spent roughly \$3.8 billion for nursing home care in 2007, of which half was paid out of the General Fund.¹

While this amount represents roughly half of the total the state spends on long-term care through various programs, nursing home patients account for only about 20 percent of the people enrolled in long-term care programs. The remaining 80 percent of long-term care beneficiaries receive a combination of home and community-based services also administered by programs run by departments in California's Health and Human Services Agency. Services offered by these programs are delivered by county governments and non-profit organizations. The menu and availability of services, and the extent to which they are integrated, vary by county.

In terms of the number of people served, California's single largest long-term care program is In-Home Supportive Services, with more than 456,000 beneficiaries. The program became the focus of intense political debate during the 2010 budget discussions, first because the pace of the program's double-digit cost increases and fast-rising enrollment between 1999 and 2009,² then because of allegations of systemic fraud. At one point, the IHSS program was slated for 2010-11 budget reductions that would have eliminated services to 87 percent of IHSS recipients. For the 2011-12 budget, still in development, the Legislature has approved changes that would require a physician's certification that services are necessary to prevent out-of-home care and that reduce the program's number of authorized hours by 8.4 percent. IHSS, however, is only one piece of the puzzle in California's network of care for seniors and people with disabilities.

The mosaic of state programs that exist today for long-term care in California is the result of several strands of reform, over decades, originating from different social groups. This mosaic has been shaped by the California-born Independent Living Movement of the 1970s, fueled by the civil rights movement, which led to changes in the law and benefits that allowed people with serious disabilities and chronic illnesses to live outside of institutions and participate in education and the workplace. Home-based care services in California date back more than 50 years, when blind, disabled and elderly Californians were given cash support to hire caregivers. A homemaker program later was added, administered by counties, which employed and assigned caregivers to enrollees. IHSS was formed by the merger of these programs in 1973 and was funded by a combination of state and county money. Through legislation, the program was able to use federal Medicaid money earmarked for personal care services beginning in 1993. The independent living movement and IHSS and other services led to a growth of home and community-based programs. This shift in approach from institutional to home and community-based care was made the law of the land by the U.S. Supreme Court's 1999 *Olmstead* ruling that required states to provide care for the disabled in the least restrictive setting that their needs could be reasonably accommodated.

What is Long-Term Care?

Unlike medical care for acute health needs, long-term care focuses on managing ongoing conditions over time, such as a disability or a chronic illness, that need attention in amounts that vary over time. The condition may be due to deteriorating health as a person ages or because of an inherited or acquired disabling condition that existed at birth or came on at any time during one's life from internal or external factors, such as a disability caused by a car accident.³

Today, long-term care services can range from paid or unpaid social or medical assistance, supervision, standby assistance and, more recently, technological devices that can help meet the needs of the individual in lieu of a personal assistant. These long-term care services generally are designed to provide help with a person's activities of daily living (ADLs), a standard list of activities including bathing, dressing, eating, transferring and walking. Instrumental activities of daily living (IADLs) include additional indirect activities in which assistance is needed to keep a person functioning fairly independently, such as meal preparation, house cleaning and medication management. Services are offered in a variety of settings: at home, in the community, in residential settings or in institutional facilities.⁴

It is useful to think of long-term care in terms of a spectrum of programs and options, through which a person might progress in a straight line from, at one end, community-based care that allows the person to live at home or care services delivered in the home, to, at the far end, institutional settings in which care is provided on a 24-hour basis. In reality, people with chronic illnesses or disabilities that impair their health need to be able to move forward and back along the spectrum as their conditions worsen or improve. Some services, such as administering drugs or hospice care, can be provided in a variety of settings.

Eligibility for such services varies by program. Skilled nursing facilities serve elderly people who are enrolled in Medi-Cal, the California program that delivers Medicaid services to low-income families and elderly, as well as the disabled and the medically needy. State hospitals serve people with serious diagnosed mental health problems. Developmental centers

Long-Term Care Varies by Setting

Eligibility for one program does not guarantee eligibility for others. Costs vary greatly by program and are not always shared the same way by federal, state and local governments.

Skilled Nursing Facilities/Nursing Homes: Provide skilled and therapeutic nursing care by licensed nurses (Registered Nurses, Licensed Vocational Nurses or Licensed Practical Nurses) on a continuous basis for an extended period of time.

Intermediate Care Facilities: Serving only the developmentally disabled, these facilities provide less intensive nursing care than skilled nursing, and also provide dietary, pharmacy, personal care, and social and activity services.

Residential Care Facilities: Also called community care, assisted living, board and care, or independent living facilities, these facilities help people who do not need skilled nursing and are able to live independently with limited assistance.

Home- and Community-Based Services: Innovative long-term care programs designed by states to help people with disabilities receive care at home or in their communities so they do not have to rely on institutional care. This overall term refers to home health care, personal care or home care, and 1915 (c) waivers.

Home Health Care: Individuals who need skilled nursing and other professional services may receive home health care from trained workers who visit the home to help with care needs. To be eligible for home health services, an individual must have a doctor's orders for either skilled nursing care or therapy services (such as physical, occupational or speech therapy). The services are provided by state-licensed home health agencies.

Personal Care Services/Home Care: Used by individuals who require assistance with the activities of everyday living such as dressing, eating or bathing. Services do not include skilled nursing care, and providers do not need to be certified as home health caregivers.

Hospice: An approach to caring for terminally ill clients that stresses relief of pain and uncomfortable symptoms. The goal of hospice care is to minimize pain and suffering, not to cure illness. Hospice clients are cared for by a team of professionals and volunteers who specialize in different types of care. Hospice care can be provided at the client's home, skilled nursing facilities, special units in hospitals or stand-alone hospice facilities.

Waivers: States receive waivers of certain Medicaid requirements under Section 1915 (c) of the Social Security Act to set up the programs, which vary from state to state, and are aimed at helping people with disabilities live independently. The waiver programs provide services to people with disabilities under age 65 (including children with disabilities) and the elderly whose need for long-term care has become a financial burden. The waiver programs also allow the state to limit services, eligibility and spending in ways that are not allowed by the traditional Medi-Cal program.

Source: California HealthCare Foundation. November 2009. "California Health Care Almanac: Long Term Care Facts and Figures."

**Long-Term Care Programs Available in California,
Fiscal Year 2006-07**

Program	Service Description	Organization involved	Number served
Institutional Care			
Nursing/Intermediate Care Facilities	Continuous skilled nursing and supportive care in private, licensed facilities for Medi-Cal eligible elderly, disabled or needy.	DHCS	68,060
State Hospitals	Inpatient treatment services in a state institution for mental health patients.	DMH	5,609
Developmental Centers	Twenty-four-hour services and supports to people in need of a secure environment through licensed and certified nursing facilities, intermediate care facilities for mentally retarded and acute care hospitals. Serve developmentally disabled people who have been formally determined to meet admission criteria by a court.	DDS	3,016
Intermediate Care Facilities - Developmentally Disabled	Twenty-four-hour personal care, habilitation, developmental and supportive health services for Medi-Cal eligible people who are developmentally disabled.	CDPH	6,320
Nursing Facilities - Managed Care	Long-term care provided by County Organized Health Systems in an institutional setting for those who are Medi-Cal eligible elderly, disabled or needy.	DHCS	8,446
Veterans' Homes – Nursing Facilities and IFCs	Serve elderly or disabled veterans.	DVA	2,340
Veterans' Homes - Residential	Serve elderly or disabled veterans.	DVA	3,295
Community-Based Care			
Adult Day Health Care	Health, therapeutic, social services on a less-than-24-hour basis to prevent institutionalization. Serves elderly or younger disabled adults who are at risk of nursing home placement.	CDPH (licensing), CDA (certification)	40,800
Adult Protective Services	Advocacy, counseling, money management, out-of-home placement, or conservatorship; reports and investigates abuse of care. Serves elderly or dependent adults, who are victims of abuse, neglect or exploitation.	CDSS, CDA	
AIDS Waiver Program	Case management, skilled nursing, attendant care, psychotherapy, meals, medical supplies, non-emergency medical transportation and other services as an alternative to nursing facility or hospital care for Medi-Cal eligible people with HIV infections, AIDS.	DHCS	2,897
Alzheimer's Day Care Resource Center Program	Support services and individual care plans to prevent premature or inappropriate institutional placement. Serves individuals with Alzheimer's disease and other dementia, regardless of age or financial resources.	CDA, AAAs	3,168
Alzheimer's Disease Program (Alzheimer's Disease Research Centers of California)	Diagnostic, treatment, education and research services through the Alzheimer's Disease Research Centers of California. Serves people and families afflicted with Alzheimer's disease and related disorders.	CDPH	3,228
Assisted Living Waiver	Home and Community-Based services - daily living, health related, skilled nursing, transportation, recreation, housekeeping – to Medi-Cal beneficiaries.	DHCS	
Brown Bag Program	Surplus and donated fruits, vegetables and other food to low-income people 60+.	CDA	
California Aging and Disability Resource Center (Connections)	Assists individuals in accessing health care, medical care, social supports and other long-term services and supports. Counseling, service coordination. One-stop approach for the disabled and those with chronic conditions.	CDA	
California Community Transitions Project (MFP)	Transitional support from institutions to a community setting for Medi-Cal beneficiaries who have received services in an institution for 90 days or more.	DHCS	
Caregiver Resource Centers	Information, short-term counseling, respite, education, training, support for families and caregivers of people with Alzheimer's, stroke, Parkinson's disease and other disorders.	DMH	N/A
Community Care Licensing	Oversight and enforcement of licensed facilities, including residential care facilities for the elderly and continuing care retirement communities. Care, supervision and assistance with daily living. Serves people who are 60 or older, and the disabled.	CDSS	
Forensic Conditional Release Program	Community-based services for specified forensic patients, including assessment, treatment and supervision, for judicially committed people with mental disorders.	DMH	709
Early and Periodic Screening, Diagnosis & Treatment (EPSDT) Shift Nursing	In-home private duty for the Medi-Cal eligible who are under age 21.	DHCS	1,682
Family Caregiver Support Program	Coordinates information, counseling and training support, temporary respite and limited supplemental services for caregivers of the elderly and grandparents raising children.	CDA, AAAs	17,378
Foster Grandparent Program	Foster grandparent volunteers aid children and youth with special needs. Serves volunteers who are 60 or older and of low income.	CDA, AAAs	
Health Insurance Counseling and Advocacy Program	information on Medicare, Medicare supplemental insurance, managed care, long-term care planning and health insurance for Medicare beneficiaries.	CDA, AAAs	
Home and Community-Based Services Waiver for Developmentally Disabled	Home and community-based services, including home health aide services, respite care, habilitation, environmental accessibility adaptations, skilled nursing, transportation, to residents with Medi-Cal, developmental disabilities, regional center consumers who meet the level of care for an intermediate care facility for the developmentally disabled.	DHCS (oversight), DDS (operations)	

LONG-TERM CARE IN CALIFORNIA

Program	Description	Organization involved	Number served
Independent Living Centers	Provide independent living services, including housing referrals, information and referral, peer counseling, personal assistant services, independent living skills training and individual and systems change advocacy. Serve the disabled.	DOR	41,000
In-Home Medical Care Waiver (now part of Nursing Facility/Acute Hospital Waiver)	Alternative to care in an acute hospital for people who are Medi-Cal eligible, severely disabled requiring care in an acute hospital for 90 days..	DHCS	67
In-Home Operations Waiver	Environmental accessibility adaptations, case management, respite care, personal emergency response system, community transition services, home health aide and habilitation services, family training, etc. Serves those who are Medi-Cal eligible, physically disabled and qualify for care in an inpatient nursing facility.	DHCS	
In-Home Supportive Services	Provides in-home personal care with daily tasks and case management services coordinated by county welfare departments to allow individuals to remain in their homes. Serves people who are 65 or older, of low income, or blind or disabled.	CDSS	374,986
Licensing and Certification of Nursing Facilities	Licensing and certification of health care facilities and nursing homes.	CDPH	
Linkages	Provides comprehensive care management to prevent/delay institutional placement for elderly or younger disbled adults not eligible for other care management programs.	CDA	4,319
Long-Term Care Ombudsman Program	Advocate for residents of long-term care facilities. Resolve elder abuse complaints in long-term care and residential facilities.	CDA	45,873
Multipurpose Senior Services Program	Provides social and health care management, adult day care, housing assistance, protective supervision, respite, transportation, chore and personal care, meal, social and communication services to prevent or delay premature institutional placement. Serves Medi-Cal eligible elderly, 65 or older, who are certifiable for nursing facility care.	CDA	13,867
Nursing Facility A/B Waiver (now part of Nursing Facility/Acute Hospital Waiver)	Alternative to nursing facility level A or B for Medi-Cal eligible, physically disabled individuals who meet nursing facility A or B care criteria for 365 days.	DHCS	289
Nursing Facility/Acute Hospital Waiver	Provides community-based alternatives to institutional care. Transition to home or community. Serves individuals of any age who are Medi-Cal eligible and have long-term medical conditions.		
Nursing Facility Subacute Waiver (now part of Nursing Facility/Acute Hospital Waiver)	Home and community-based alternative to nursing facility subacute care. Serves Medi-Cal eligible, physically disabled individuals who meet nursing facility subacute care criteria for 180 days.	DHCS	281
Nutrition Services	Provides meals in congregate or home settings for seniors and the disabled.	CDA, AAAs	18 million meals served
Program of All-Inclusive Care for the Elderly	Full range of care, including adult day health, case management, personal care, provided on a capitated basis. Serves seniors who qualify for nursing facilities.	DHCS	2,102
Regional Centers	Day programs, community care facilities and supportive services provide access to comprehensive services by coordinating outreach, intake and assessment, preventive services, case management/service coordination. Serve the developmentally disabled who reside in their own homes, relatives' homes, or community care facilities.	DDS	205,155
Respite Care	Temporary or periodic services to relieve primary and unpaid caregivers. Serves the elderly and disabled and their caregivers.	CDA	26,476
Senior Care Action Network	Provides home and community-based medical, social and case management services provided on a capitated basis. Serves those who are 65 or older, Medicare A and B eligible, full-scope Medi-Cal in specific counties.	DHCS	3,929
Senior Community Service Employment Program	Provides part-time work-based training opportunities and support, such as personal and job-related counseling, job training and referral for low-income individuals 55 or older.	CDA, AAAs	
Senior Companion Program	Provides respite for caregivers, companionship, assistance with chores, grocery shopping, meal preparation, transportation and other services. Volunteer. Serves seniors and the disabled.	CDA	235
SSI/ SSP Nonmedical Out-of-Home	Cash grant for residential care (generally, grants used for Residential Care Facilities) for the elderly or disabled as eligible according to income and assets.	DSS	59,568
Supportive Services	Programs for the elderly authorized by the Older Americans Act, including case management and transportation.	CDA	944,821
Traumatic Brain Injury Program	Provides community reintegration, service coordination, family and community education, vocational supportive services and service coordination for those who are disabled due to a traumatic brain injury.	DOR, DMH	1,204
Vocational Rehabilitation Services	Assists disabled individuals obtain and retain employment to live independently in the community; services include counseling and guidance, referrals, job search and placement assistance, vocational and other training, transportation, on-the-job personal assistance services.	DOR	

Note: In some cases, caseload may be a monthly average, and therefore not represent the number of persons served annually.

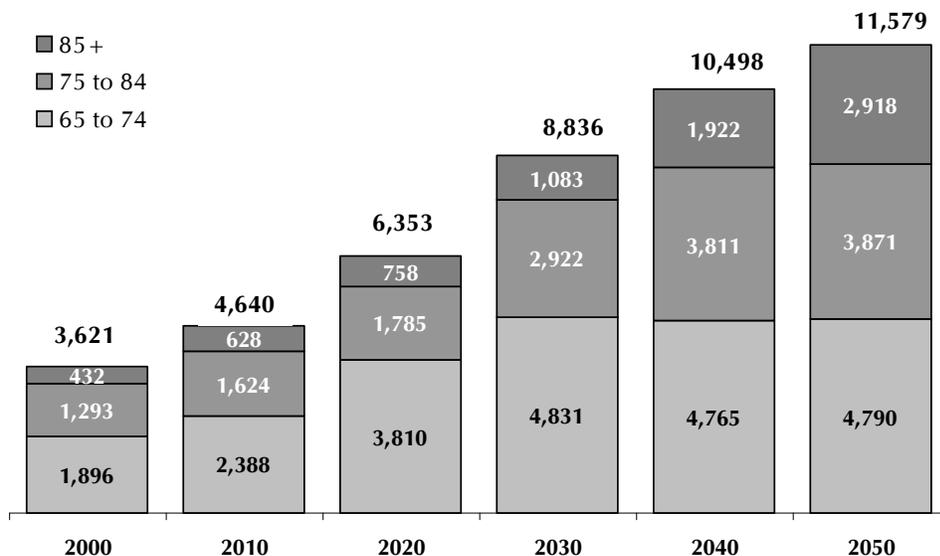
Sources: Legislative Analyst's Office. February 2006. Analysis of the 2006-07 Budget Bill. "Improving Long-Term Care." Also, SCAN Foundation. May 25, 2010. Program Compendium. Written testimony to the Commission.

serve people who have been formally determined to be developmentally disabled or who are referred by a court. Various home-care support services are open to people who are disabled and who might not require medical care, depending on their needs, such as bathing and preparing to go to work or school. In-home personal care also can be provided to low-income elderly, in varying amounts depending on their functional abilities and needs. In California, paid caregivers can include relatives who live in the client’s home.

Growing Demand for Long-Term Care

The start of 2011 brought with it a slew of news stories about the retirement of the front end of the demographic bulge known as the Baby Boom generation. The cohort includes 75 million Americans born between 1946 and 1964 who will begin to turn 65 in 2011, placing an unprecedented level of demand for health care resources.⁵ The number of California seniors – residents over age 65 – is projected to double by 2030 to 8.84 million people, or 18 percent of California’s population.⁶ Working age adults with disabilities likely will increase in number to more than half a million by 2030, exerting additional pressure on California’s long-term care system. The aging population also is living longer, many with physical or cognitive disabilities or chronic illnesses such as Alzheimer’s Disease, high blood pressure, diabetes and obesity, or with a history of heart attack or stroke.

California's Aging Population, 2000-2050
Projected number of residents, age 65 and older (in thousands)



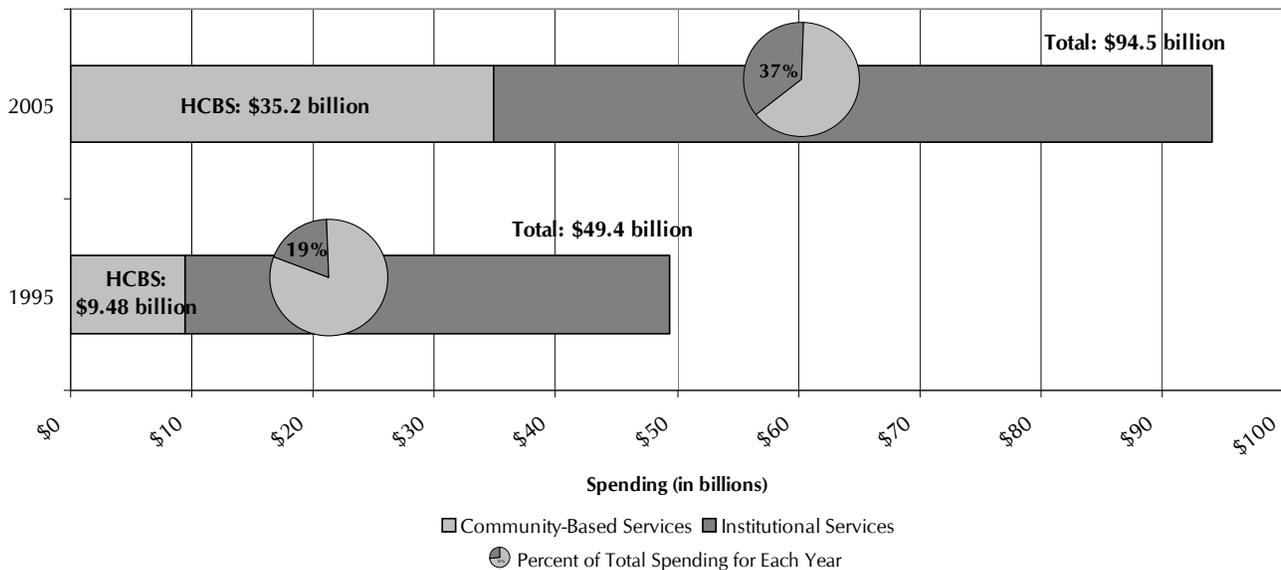
Note: Data for 2010 to 2050 are projections.
 Source: State Population Projections and Population Projections Program. Population Division, State of California, California Department of Finance Population Division. State Population Projections and Population Projections Program. 2007. "Race/Ethnic Population with Age and Sex Detail, 2000-2050." Sacramento, CA. Cited in California HealthCare Foundation. November 2009. "California Health Care Almanac: Long Term Care Facts and Figures." Page 3.

Home and Community-Based Services Now a Priority

Over the past three decades, the focus of attention for long-term care has shifted from skilled nursing facilities and institutional facilities toward home and community-based settings. This shift has been accompanied by an expansion of the definition of long-term care to include medical care services as well as social services, blurring the line between the two.⁷ The shift has been supported by an increase in the amount of resources and attention devoted to long-term care services that help keep people out of nursing facilities and in their homes. The national consensus that has emerged among long-term care experts over the past 30 years is that “long-term care financing and delivery systems should encourage use of home and community-based services to the extent that people with chronic disabilities who require long-term care prefer to reside in the community and can get their needs met there.”⁸

For this reason, “rebalancing” – or shifting toward home and community-based programs from a long-standing bias that favored institutions for long-term care – has been the focus of state Medicaid programs for the last few decades. In recent years, more money has been directed to states for programs that encouraged rebalancing. Spending on home and community-based services nearly doubled from 1995 to 2005 as a portion of national Medicaid Long-Term Care expenditures.⁹

National Growth in Home and Community-Based Care as a Percentage of Total Long-Term Care Spending



Note: Home and Community-Based Services include personal care, HCBS waiver and home health; Institutional LTC Services include nursing home and ICF-MR.

Sources: B. Burwell. 2001. “Medicaid Long Term Care Expenditures in FY 2000.” Cambridge, MA.: Medstat. Also, B. Burwell, K. Sredl and S. Eiken, 2006. “Medicaid Long Term Care Expenditures in FY 2005.” Cambridge, MA: Medstat.

Rebalancing received strong reinforcement in 1999 with the landmark U.S. Supreme Court Case, *Olmstead v. L.C.*, in which the High Court found that the unjustified institutional isolation of people with disabilities violated the Americans with Disabilities Act (ADA) of 1990. Specifically, the court concluded that confining persons with disabilities in institutions without adequate medical reasons is a form of discrimination under federal law. The court said states are required to make reasonable modifications to their programs and policies to avoid unnecessary institutionalization.¹⁰

Olmstead applies broadly to include people with physical and mental disabilities both in and out of institutions. Under the ruling, states cannot make institutionalization a condition for publicly-funded health coverage unless it is clinically mandated. States carry the burden of proof to show why community care is not appropriate; in response, they must focus their health programs more on community-based care. Though limiting states in how they provide care, the *Olmstead* decision pushed states in the direction they already were headed – toward more expansive home and community-based services for people with disabilities.¹¹

States received some guidance from the court and also from federal agencies on how to comply with *Olmstead*. The court suggested states should make “reasonable accommodations” to their long-term care systems and that states could demonstrate compliance with *Olmstead* and the ADA by creating a comprehensive working plan, commonly dubbed the state “Olmstead Plan,” to increase home and community-based services and reduce institutionalization. The federal government since has provided ongoing policy guidance for state Olmstead Plans and has promoted expansion of home and community-based programs through waivers that provide flexibility in Medicaid programs to offer more home and community-based options.¹²

Litigation stemming from the *Olmstead* decision has been increasing nationally against states that have been slow to implement changes. President Obama proclaimed 2009 as the “Year of Community Living” in honor of the 10th anniversary of the landmark disability case.¹³ The U.S. Department of Justice accordingly has made it a priority to enforce *Olmstead* and announced in May 2010, that it filed a lawsuit against the state of Arkansas for failure to provide services to individuals with disabilities in the most integrated settings appropriate for their needs.

California's Progress

California once led the nation in offering home and community-based services to aged and disabled residents. It now ranks fifth nationally in the percentage of its spending on home and community-based services compared to its spending on institutional facilities, devoting 52 percent of its current total long-term care spending to home and community programs and 48 percent on institutional care.¹⁴ California's 52 percent spending on home and community-based programs is well above the national average of 31 percent.¹⁵ A closer look at the composition of programs shows that California's home and community care services are highly concentrated in the In-Home Supportive Services program and that the state's dispersed system makes it difficult to ensure that people are receiving the most appropriate and resource-efficient care for their needs. Moreover, the lack of data with which to measure outcomes complicates any effort to determine the value of care received or the cost-effectiveness of California's overall long-term care spending.

State Patchwork of Programs

In addition to IHSS, other long-term care programs in California have developed through a piecemeal evolution across multiple departments within the state's Health and Human Services Agency. Over time, new programs have been added, resulting in unintended overlap of services as well as gaps in authority and responsibility. Each department operates some or many long-term care programs as part of a range of programs for which the department is responsible. Currently, long-term care programs span seven departments, each with its own separate budget, administration, program and technical staff.

The seven departments are listed as follows, along with a description of the long-term care programs within each:

Department of Social Services. The Department of Social Services is the hub for providing aid, services and protection to vulnerable children and adults to strengthen and preserve families, encourage personal responsibility and foster independence. Within the department, the Adult Programs Division provides oversight, policy and program functions to serve the aged, blind and disabled through its In-Home Supportive Services program. Other programs include the Cash Assistance Program for Immigrants and California Veterans Cash Benefit. Another division within the department oversees and investigates licensed facilities serving children, parents and the elderly, including residential care facilities for the elderly, continuing care

retirement communities, social rehabilitation facilities and adult day care programs.

Within the Department of Social Services, ***the In-Home Supportive Services program*** provides a range of services to eligible aged, blind or disabled Californians living in their own homes, with a goal of keeping participants out of institutions. With 456,000 beneficiaries, California's IHSS program is the nation's largest. Services available through IHSS include domestic and related services (housecleaning, meal preparation, laundry, grocery shopping, etc.), personal care services (bathing, dressing, toileting, etc.), paramedical services, accompaniment to medical appointments and protective supervision for recipients whose cognitive or mental functioning puts them at risk.¹⁶

Between 2001-02 and 2008-09, IHSS caseload rose 61 percent, while General Fund outlays for IHSS climbed 110 percent. In Fiscal Year 2009-10, the state's outlay for IHSS was \$1.394 billion out of total program expenditures of \$5.4 billion.¹⁷ According to the Legislative Analyst's Office, primary cost drivers were rising case loads, increasing hourly pay to service providers and an increase in the average number of service hours received by beneficiaries.

Funded through a combination of federal, state and local money, the IHSS program is administered at the county level. In California, In-Home Supportive Services are administered through an "individual-provider mode," where a person who qualified for IHSS care is assessed by a social worker who determines what level of services a beneficiary requires and then assigns a certain number of hours of assistance. The beneficiary hires the provider, sets the work schedule and supervises the provider, who is paid with a combination of federal, state and county funds through a separate entity known as a "public authority," the employer of record. In 2008, more than 60 percent of IHSS beneficiaries were cared for by providers who were relatives, about half of whom lived with the beneficiary.¹⁸

The size and growth of California's IHSS program, as well as the diffused accountability structure, have put it in the spotlight, prompting reforms that are now in the process of being implemented. The 2010-11 budget contained deep cuts to the program, but many of the proposed savings were blocked by court rulings.

IHSS began in the early 1970s primarily as a state and county-funded program with some federal Social Services Block Grant funding. The program changed substantially in 1993, when most IHSS services became financed as personal care services through California's Medicaid program, Medi-Cal, which covered 50 percent of program costs, though

required a state match. Some IHSS participants did not qualify for Medi-Cal; the cost for those few participants not covered by Medi-Cal was referred to as “residual program” services, covered by the state and counties. More recently, in 2004, a third category of funding has emerged, as federal Medicaid authorizers reclassified IHSS and established it as a demonstration program under an “1115 waiver,” adding flexibility. The funding breakdown is noteworthy because the changes have allowed the state to pull in a greater amount of federal money to the program and expand services. The changes also have allowed federal review of the program to determine, among other things, the program’s cost-effectiveness compared with institutional placement, as well as the program’s efficiency of paying legally responsible family members to care for program enrollees.

The U.S. Department of Health and Human Services conducted a review of California’s IHSS program in 2008 as part of the 1115 Medicaid waiver demonstration process. The federal department found that California’s practice of allowing personal care services to be provided by “legally responsible” family members is unlikely to increase – and may even decrease – Medi-Cal costs. The study also found that IHSS expenditures are lower for a recipient who is cared for by a relative living in the household than for one whose caregiver is a non-relative, and that allowing spouses, parents and other relatives to be paid IHSS providers serves as an advantage for Medi-Cal.¹⁹

Despite this positive review and the reputation California has enjoyed as a national leader because of In-Home Supportive Services, the program still generates controversy among California policy-makers. Program and budget staff debate the best way to shrink IHSS as part of statewide budget reductions, creating uncertainty in the program’s funding and design from year to year.

The state offers few other home and community-based care options to IHSS, though for many IHSS beneficiaries, it is not an either/or choice. Many do not require the level of medical attention or personal care services delivered in an institutional setting. The program uses an evaluation system that assigns a number of hours of care to a beneficiary according to a five-level functional index. The assessment provides little information about the beneficiaries’ health condition or indication of how that condition would change with more or fewer hours of care, or different forms of care, such as care for chronic conditions or communal activities that could reduce issues such as isolation. In California, the state’s continuum of care consists largely of In-Home Supportive Services or services provided in institutional settings such as skilled nursing facilities, with comparatively fewer offerings in the form of assisted living or other community-based programs.

Though designed as a social services program, IHSS has evolved into a program that now receives federal funds through the nation's Medicaid program, which historically has focused on medical support. The Medicaid program's mission also has shifted over time to blend medical and personal care programs, similar to those offered by social services agencies. This brings both benefits and challenges, as California's overall long-term care system and funding mechanisms are split between its Medi-Cal program and its In-Home Supportive Services program, and made more complex with myriad other social and medical programs that have developed over time across several state departments beyond the Department of Social Services.

Department of Aging. The Department of Aging administers programs that serve older adults, as well as adults with disabilities, family caregivers and residents in long-term care facilities throughout California. These programs include supportive services and meals, the Multipurpose Senior Services Program, the National Family Caregiver Support Program, Alzheimer's Day Care Resource Centers, Respite, Adult Day Care, Adult Day Health Care, Brown Bag, Foster Grandparent and Senior Companion. The department administers funds allocated under the federal Older Americans Act as well as the Older Californians Act and through the Medi-Cal program for seniors.

Federal law requires the department to develop a State Plan on Aging in order to receive federal funding. The plan sets out the state goals and objectives in implementing the Older Americans Act and provides information about resource allocation, local Area Agencies on Aging, a snapshot of the aging population and other information such as state priorities and promising practices. The department contracts with the 33 local Area Agencies on Aging, which directly manage a wide array of federal and state-funded services that help older adults find employment, support older and disabled individuals in living as independently as possible in the community, promote healthy aging and community involvement and assist family members in their vital care giving role.

Department of Health Care Services. The Department of Health Care Services administers health care service delivery programs, the largest being Medi-Cal (California's Medicaid program), which includes coverage for nursing facility care for low-income, aged and disabled Californians. This large department's Long-Term Care Division also provides services for Medi-Cal-eligible frail seniors and disabled people to live in their own homes or community-based settings, including programs that operate under waivers to California's Medicaid State Plan. These waivers include the Assisted Living Waiver Project, In-Home Supportive Services Plus Waiver, Multi-Purpose Senior Services Program and Senior Care Action Network Health Plan. The Long-Term Care Division also manages a

federal “Money-Follows-the-Person” project, called California Community Transitions, which includes \$130 million in federal funds over the next four years, to move Medi-Cal-eligible residents from long-term care institutions back to living in the community. Programs of All-Inclusive Care for the Elderly (PACE) and the California Partnership for Long-Term Care, a long-term care insurance program, are also overseen by the Long-Term Care Division.

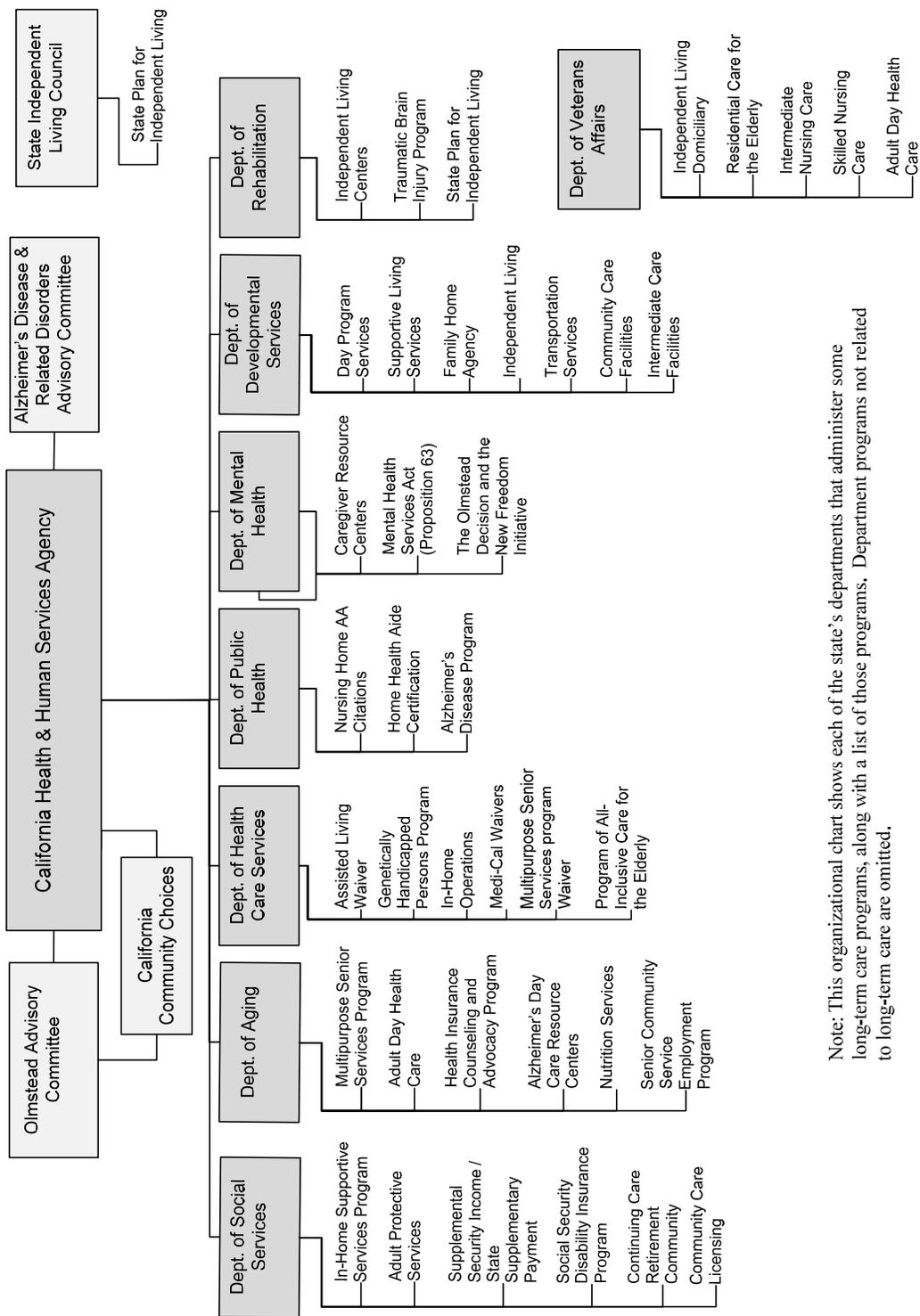
The department also has a Systems of Care Division that, through its Medical Case Management system, seeks to provide coordinated care for Medi-Cal fee-for-service patients who are chronically or catastrophically ill.²⁰

Department of Public Health. When the Department of Health Services split in 2007, licensing and certification duties went to the new Department of Public Health. Today, the department’s Center for Health Care Quality is responsible for regulatory oversight of health facilities and health professionals, which is where consumers can find information about hospital and nursing facility penalties and citations, and health care workers can be tested to become certified nurse’s aides and home health aides.

Department of Mental Health. The Department of Mental Health leads California’s mental health system, an array of services that deliver care to adults and children with mental disabilities. These services include five state hospital facilities, and separately, three acute care facilities within the Department of Corrections and Rehabilitation, administering funding for county programs, as well as coordination with non-profit Caregiver Resource Centers to support and assist families and caregivers who care for adults with cognitive impairments.

Department of Developmental Services. Californians with developmental disabilities (including mental retardation, cerebral palsy, epilepsy and autism) can receive support and services through the Department of Developmental Services by way of state-operated developmental centers, community facilities, or one of 21 non-profit regional centers that provide or coordinate services locally for individuals and their families through state contracts.²¹

California's Departments and Programs for Long-Term Care



Note: This organizational chart shows each of the state's departments that administer some long-term care programs, along with a list of those programs. Department programs not related to long-term care are omitted.

Department of Rehabilitation. The Department of Rehabilitation works in partnership with consumers and other stakeholders to provide services and advocacy resulting in employment, independent living and equality for persons with disabilities.²² The department awards grants to support roughly 30 non-profit independent living centers and to fund services offering information and referral, independent living skills training, housing advocacy and peer counseling.²³ The department also works alongside the State Rehabilitation Council – with members appointed by the Governor – to review, evaluate and advise the department on its performance and effectiveness.²⁴

State Independent Living Council. Originally the Independent Living Advisory Council to the Department of Rehabilitation, the State Independent Living Council is now an autonomous state agency designed to represent people with disabilities. Required by the federal Rehabilitation Act in order to receive federal funds for independent living services, the council is responsible for allocating federal funds for independent living, advising the Governor and Legislature on issues affecting people with disabilities, creating projects that enhance opportunities for independent living and assuring compliance with state and federal laws governing independent living. It consists of 18 members – all volunteers.²⁵

Olmstead Advisory Committee. The Olmstead Advisory Committee was formed in 2004 in response to the U.S. Supreme Court’s *Olmstead v. L.C.* decision to ensure California’s commitment to provide services to people with disabilities in the most integrated setting and to support opportunities for people with disabilities to remain in their communities and avoid unnecessary institutionalization.²⁶ This committee oversees the Community Choices Project, discussed in greater detail later in this chapter. The committee consists of members appointed by the Health and Human Services Agency secretary and was originally given the task of revising the 2003 state plan for complying with the *Olmstead* ruling. It continues to meet roughly four times a year to advise the administration on how to improve long-term care in California.²⁷

California had developed its first Olmstead Plan with the help of the state Long-Term Care Council in 2003. The plan outlined current programs within the Health and Human Services Agency and its relevant departments and laid out a list of future actions the state should take to achieve the goals articulated in the plan.²⁸ The Long-Term Care Council, comprised of the directors of the departments, later dissolved, but the Health and Human Services secretary created the Olmstead Advisory Committee in 2004 to continue the mission.

Funding of Long-Term Care Programs

The department structure is a starting point for understanding California's long-term care arena, but a full appreciation of the complexity of the system requires an understanding of how long-term care programs are funded. These programs, taken together, represented total outlays of more than \$13 billion in 2005-06, the most recent year for which comprehensive data is available. The California Legislative Analyst, in creating the estimate, calculated total state spending on long-term care at roughly \$7 billion for the 2005-06 budget year.²⁹ A report released in 2009 by the California Community Choices Project in collaboration with the Health and Human Services Agency estimated the state's total long-term care spending at more than \$10 billion annually.³⁰

The state's portion comes primarily from the General Fund and accounts for just over 50 percent of total government spending on long-term care. Federal funds cover about 43 percent of total spending and the remainder is paid from local coffers. Much of the funds for long-term care services flow from the Medi-Cal program, which requires the state to provide institutional benefits to all eligible persons, though it also permits the state to fund community-based services offered through waivers to federal rules. Many of these federal funds are a match to the state's contributions; additional federal funds come through grants to incentivize rebalancing, such as the grants to increase community-based services.³¹

Nationally, long-term care services are among the most expensive of those services offered through the Medicaid program. Seniors and people with disabilities represent 24 percent of those enrolled in Medicaid programs nationwide, but account for 70 percent of all Medicaid expenditures.³² Experts across the country and in California acknowledge that the most costly aspect of long-term care occurs when a person is housed in an institution, such as a skilled nursing facility, where costs in California in 2007 exceeded \$51,000 a year for Medi-Cal beneficiaries.³³ In California, some programs offer services that can delay or prevent a person from entering a nursing facility by addressing their needs in a home or community-based setting. Other programs can facilitate minimizing a person's stay in a hospital or skilled nursing facility after an acute medical need is met and rehabilitation is complete, by helping the individual transfer back to a home or community-based care setting.

Though state departments administer the programs, most of the services are delivered at the local level. In many cases, the goals of different programs serving the same population are not aligned, nor are services

coordinated in a way that consistently produces the best outcome for beneficiaries in the most cost-effective way. This is in part because the state departments administering the programs do not systematically coordinate program design, and the wide range of funding sources and requirements complicates efforts to standardize enrollment and eligibility processes across programs.

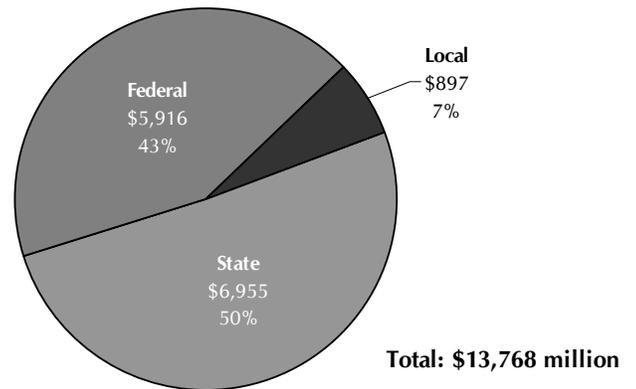
Multiple Calls for System Reform

The scattered arrangement of programs across the seven departments that are involved in providing long-term care services in California has prompted many calls for reform over the years. The Commission’s study in 1996, *Long Term Care: Providing Compassion Without Confusion*, found the state's structure too fragmented to allow effective coordination and integration of long-term care services. The Commission found that many of the state's policies favored expensive placement in an institution over home and community-based services, and that regulatory change had not kept pace with the demands placed on residential care facilities. The Commission recommended consolidating long-term care into a single state agency, increasing resources for programs that allow enrollees to avoid or put off institutionalization and strengthening the consumer complaint systems for skilled nursing and residential care facilities.

To assess the progress made since the Commission’s 1996 report, the California HealthCare Foundation in 2006 conducted an electronic survey and held a series of meetings with long-term care experts to identify new recommendations for enhancing care. The foundation concluded that no systemic reform had been achieved toward the goal of creating consumer-directed, outcome-based services that are provided in the least restrictive setting appropriate for each person. The foundation’s *Long Term Care Reform: Recommendations for Change*, released in 2007, set three priority areas for reform:

1. **Cost.** Comprehensive health care financing reform must look at the impact of long-term care costs. A state commission should be created to assess the impact of future long-term care spending on health coverage in California and examine ways in which the state can maximize its resources.
2. **Quality.** Consistent quality services must be provided across all programs, whether the person resides in a nursing home, an assisted-living center, or is being cared for by an individual from a home health agency or hospice agency or In-Home Supportive

Long-Term Care Services Funding, FY 2005-06 (in millions)



Source: Legislative Analyst’s Office. February 2006. Analysis of the 2006-07 Budget Bill. "Improving Long-Term Care."

Services. Residential care facilities should report annually to the Department of Social Services on resident characteristics staffing levels, facility characteristics and costs. The Department of Social Services should report the information in a centralized location along with complaints and deficiencies.

3. **Transitions.** Enhancing hospital discharge planning would lead to smoother transitions between institutions and home and community-based care settings. These transitions, along the continuum of services from hospitals to home and community-based services, must be improved to help prevent premature deterioration and avoid institutional placement.

The experts who participated in the California HealthCare Foundation's review concluded that reform focused on cost, quality and transitions would result in increased consumer satisfaction and more efficient use of state resources.³⁴

Commission Recommendations in 1996

In 1996, the Commission issued broad recommendations to consolidate long-term care services at the state level and made numerous specific recommendations regarding oversight of community, skilled nursing and residential care. Recommendations on state structure included:

- Consolidate the multiple departments that provide or oversee long-term care services into a single department.
- 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.
- Require departments involved in long-term care to pursue federal waivers and options that will infuse flexibility into programs and funding.
- Adopt a multi-pronged strategy for coping with the expected rising demand for and cost of long-term care services.
- Ensure that the State's policies are consumer-focused by establishing an advisory committee that can have a persuasive voice in policy formation, program implementation and quality assurance.
- Develop a program for quality assurance and control that is outcome-based and consumer-oriented rather than prescriptive and process-oriented.

Source: Little Hoover Commission. December 1996. "Long Term Care: Providing Compassion Without Confusion."

Both the Commission's 1996 report and the foundation's 2007 report described the long-term care "system" as a maze of state departments, disparate funding streams, and programmatic silos with independent assessments of patient needs and separate data, with no way to account for the true costs – let alone cost savings – of programs and services. Federal funding and programs, as well as county and community programs, add yet further layers of complexity and duplication. The problems identified in these and previous reviews continue to exist in the state's "non-system" of long-term care.

The Commission took a broader look at health and social services in its 2004 report, *Real Lives, Real Reforms*, which called for a reorganization and realignment of the Health and Human Services Agency and related programs. In that report, the Commission recommended realigning delivery of health and social services to the local level, where they could be better integrated and prioritized according to local needs, and called for a restructuring of the Health and Human Services Agency to focus more on oversight, monitoring quality, creating flexibility in

federal funding streams, disseminating best practices and creating incentives for innovation at the local level.

Legislative Efforts to Improve the System

Following the Commission's recommendations in 1996, the Legislature in 1997 passed a bill requiring the Health and Human Services Agency, under the Wilson administration, to prepare a report on California's long-term care services.³⁵ The report provided an inventory of the state's services, options for improved state-level administration and suggestions for combining licensing and certification programs. It laid out three potential options for achieving improved efficiency:

- Partial consolidation of long-term care services.
- Comprehensive consolidation of services.
- A new center for long-term care systems development.

The report cautioned that a restructuring, while potentially eliminating some barriers to better coordination of services, would not automatically improve access and coordination from the consumer's perspective.

Years later, the Legislature created a group named the Expert Panel to Review the California Department of Aging Structure, which issued a report in 2004 that called for increased coordination of services and a single administrative entity at the state level. The expert panel concluded that reliance upon improved coordination of long-term care programs is not enough; rather, structural changes are needed at the state level along with political change in the legislative level.³⁶ Following the 2004 report, legislation was introduced to consolidate long-term care programs, but the bill failed to pass the Legislature.³⁷

California Performance Review and Agency Response

Governor Schwarzenegger's California Performance Review in 2004 suggested reorganizing the Health and Human Services Agency to reduce duplication of services and to better streamline operations.

In response, Health and Human Services Agency Secretary Kimberly Belshé convened a workgroup of involved long-term care experts and leaders to analyze the CPR recommendations in view of how the proposal would affect long-term care programs. The workgroup reported that the proposed CPR reorganization would offer "no real enhancement in coordination and integration than what exists with the state's current organizational structure" and that "in some cases, the CPR recommended changes may result in lost opportunities."³⁸

The workgroup instead suggested its own organizational structure to improve the state's administration of long-term care. The workgroup proposed the creation of a Division for Adult and Community Living that would have responsibility for policy development, budgeting and program and system planning for home, community and institutional long-term care programs, and would include everything from the administration and policy development for IHSS to nursing facility care, policy and budgeting. The white paper produced by the workgroup is included in Appendix D of this report.

Agency Actions to Enhance Home and Community-Based Services

Despite the obstacles to coordination that remain in the state's current structure, the California Health and Human Services Agency has pursued and won many federal grants in recent years to help advance home and community-based programs, while also partnering with the SCAN Foundation to conduct research on long-term care services.

One of the federal grant programs is the California Community Choices project. This project began in 2006 when the Health and Human Services Agency received a grant from the federal Centers for Medicare and Medicaid Services for a five-year project to increase access, capacity and funding for home and community-based programs in California. Partnering with the California Institute on Human Services, the California Olmstead Advisory Committee and other stakeholders, the project began with three goals:

- Establish two one-stop resource center pilot sites called California Aging and Disability Resource Centers to provide coordinated information and referral assistance for people needing long-term care services.
- Develop an integrated Web-based information system (www.CalCareNet.ca.gov) to give consumers and caregivers access to information and tools to empower them to find home and community-based long-term care services that best meet their needs.
- Complete a comprehensive study that suggests ways to improve home and community-based services.

To date, the Community Choices Project has established Aging and Disability Resource Connection centers in Riverside County, Orange County, San Diego County, San Francisco, North Central (located in Chico serving Butte, Colusa, Glenn, Tehama and Plumas counties), and Del Norte County. It also is piloting the CalCareNet Web site in Orange

and Riverside counties and plans to expand coverage to more communities over time.

The project in 2009 released a thorough report that examined the laws, regulations, policies and payment methodologies around the financing of California's long-term care services. The 300-page report, *Home and Community-Based Long-Term Care: Recommendations to Improve Access*, aims to help California eliminate financial and structural barriers to accessing long-term care supports and to promote home and community living options. The report listed 28 specific recommendations, from general suggestions that the state develop a strategic plan to specific changes to rate payment methodologies for nursing facilities.

Additional efforts stemming from the California Community Choices project are in development, including a grant recently awarded to the State Independent Living Council to create a plan for how the state can replicate more Aging and Disability Resource Centers statewide. The project also is working with researchers from the University of Southern California to obtain a comprehensive understanding of the long-term care data collected by the various departments and to make recommendations for future data warehousing.

The Health and Human Services Agency also is implementing the following programs to improve long-term care service delivery:

1. **Hospital-to-Home Grant** – A pilot program administered by the Aging and Disability Resource Centers in San Francisco and San Diego to connect, coordinate and empower individuals at high risk of repeat hospitalization or referral to institutional settings after discharge from an acute care hospital.
2. **Medical Case Management Modernization** – As part of the Hospital-to-Home grant, the Department of Health Care Services will modernize its existing Medical Case Management Program by developing a person-centered hospital discharge model to help understand the needs of beneficiaries and implement appropriate screening tools and protocols.
3. **Money Follows the Person/California Community Transitions Project** – Though a project to implement a “Money Follows the Person” rebalancing demonstration, California Community Transitions seeks to move people who have lived in long-term care facilities for six months or longer back into the community where possible. Roughly 200 people have transitioned to the community through the demonstration project, which will continue until December 2011. Once the demonstration project has ended, people who have transitioned and are eligible for Medi-Cal

benefits will continue to receive Medi-Cal and other home and community-based services.

4. ***Comprehensive Analysis of Home and Community Based Services*** – A three-year project that began in January 2010, funded by the SCAN Foundation and the Department of Health Care Services, is reviewing home and community-based services in California. Researchers from the California Medicaid Research Institute at U.C. San Francisco will review published literature, analyze how services have been used as well as the associated costs. The goal is to determine ways to enhance or streamline Medi-Cal benefit packages for home and community-based services to increase cost savings while improving client utilization, outcomes and satisfaction.³⁹

1115 Waiver Program Renewal

In addition to these projects, California received authorization from the federal Centers for Medicare and Medicaid Services to expand the state’s “1115 waiver” program, which will allow more flexibility and opportunities for program innovation. Section 1115 of the federal Social Services Act allows states the broadest ability to test innovative approaches to financing and delivering services to Medicaid beneficiaries. An “1115 demonstration” or “1115 waiver” program must be amenable to rigorous evaluation in order to be used for further Medicaid policy development on a nationwide basis.⁴⁰

California’s previous 1115 waiver, which expired in August 2010, focused on family planning and hospital and clinical care for Medi-Cal and uninsured patients. In anticipation of the waiver’s expiration, the Schwarzenegger Administration sought a new and expanded waiver program to achieve long-term cost savings. As part of the preparation for the new waiver’s approval, AB 6 X4 was enacted in 2009 to restructure Medi-Cal to slow the growth of long-term care spending while improving health care outcomes, in part by encouraging more long-term care to be delivered through home and community-based services.

David Maxwell-Jolly, former director of the Department of Health Care Services, said the waiver program would serve seniors and people with disabilities who previously had used the fee-for-services option of the Medi-Cal program by enrolling them into managed care organizations where they existed. The system would consist of a provider network, care management and coordination.

Community Choices Recommendations for Home and Community-Based Services

The California Health and Human Services Agency released a report in November 2009 with recommendations to expand and strengthen the spectrum of services the state provides to individuals with long-term care needs, with a particular focus on home and community-based services, and to move away from an institutional bias.

General Recommendations

1. Establish the philosophy and legislative intent.
2. Develop a strategic plan.

Short-term Recommendations – One year to implement

3. Add a special income level eligibility group.
4. Increase the home maintenance income exemption.
5. Maintain the SSI/SSP Medi-Cal eligibility status.
6. Adopt a case-mix reimbursement system for nursing facilities.
7. Establish a nursing facility occupancy provision.
8. Convert the labor-driven operating allocation to an incentive to promote discharge planning or increased quality of care.
9. Review Department of Developmental Services Regional Center rates for nonresidential services.
10. Conduct a study of need for waiver expansion.

Medium-range Recommendations – One to two years to implement

11. Establish a statewide institutional transition program.
12. Reinvest savings from institutional care in home and community-based services.
13. Provide diversion through preadmission screening/options counseling about community alternatives through single entry points and aging and disability resource connections and by working with hospitals.
14. Expand coverage of residential options statewide to offer more service alternatives for older adults.
15. Increase the use of provider fees for home and community-based services providers.
16. Explore converting a portion of state supplemental program (SSP) payments to provide services in residential settings.
17. Create a temporary rental assistance housing subsidy.
18. Allow presumptive Medi-Cal eligibility for Home and Community-Based Services waiver applicants.
19. Develop HCBS that address individuals with mental illness.
20. Create rate and other incentives to reduce nursing facility capacity.

Long-term Recommendations – Two years or longer to implement

21. Create a Department of Long-Term Services and Supports.
22. Create single entry points to access services for aged/disabled beneficiaries.
23. Co-locate Medi-Cal financial eligibility workers in single entry points/aging & disability resource centers.
24. Create a unified long-term care budget.
25. Create a standardized rate structure for HCBS based on the acuity of persons receiving services.
26. Create incentives for home and community-based services through managed long-term care capitation.
27. Create financing strategies that improve the balance between community and institutional services.
28. Develop a long-term care database.

Source: Robert Mollica, National Academy for State Health Policy, and Leslie Hendrickson, Hendrickson Development. November 2009. "Home and Community-Based Long-Term Care: Recommendations to Improve Access for Californians." Pages x-xiii.

Clients would have access to community-based care, and plans would manage and monitor service utilization to guide discharge planning and transitions when needed as well as provide member support once a client has returned to home or community-based care. Mr. Maxwell-Jolly said that, moving forward, the managed care organization naturally would expand the availability of home and community-based services as it would be in its best financial-interest to do so. The 1115 waiver renewal process began in August 2009, received authorization in 2010, and continues to progress with stakeholder involvement.

Federal Health Care Reform

The federal Patient Protection and Affordable Care Act and subsequent Health Care and Education Reconciliation Act of 2010 contained a series of initiatives aimed at improving care all along the continuum of services, including primary, acute, rehabilitative medical and supportive services. The long-term care provisions of the health care reform bills focus on bolstering supportive services delivered at home and in the community and improving coordination of health care and supportive services.

To aid in enhancing home and community-based services, the new law creates a public long-term care insurance program, the Community Living Assistance Services and Supports (CLASS) plan, for the middle class to purchase community living assistance services when functional abilities deteriorate. It also included measures like the Community First Choice Option that allows a 6 percent increase in federal Medicaid funding for state plan community-based attendant services, as well as expansion of Money-Follows-the-Person demonstration projects (\$621 million in grants available to states over five years) and Aging and Disability Resource Connection centers (\$10 million going to the states), and financial incentives for states to move Medicaid beneficiaries from institutions to home and community-based settings.⁴¹

The health care reform law further enumerates a number of programs to improve coordination of health care and supportive services, establishing a federal office to coordinate care for “dual eligibles” who receive both Medicare and Medicaid services, along with another federal office devoted to innovation of payment and delivery arrangements. Additional demonstration programs and benefits are included in the law to support care coordination, such as transitions from institution to community settings and patient navigator programs to facilitate access and information about care for individuals in need.⁴²

More detail about the specific long-term care provisions of the Affordable Care Act can be found in the SCAN Foundation policy brief in Appendix E of this report.

Building California's Long-Term Care Continuum

California now sits at a critical long-term care crossroad. Revenues to fund long-term care programs have shrunk. The future funding outlook is uncertain. Demand for long-term services is expected to grow, fueled by swelling numbers of older Californians who are living longer, as well as an increase in the number of disabled Californians who, as a population, have a wide range of personal care and medical needs. Yet opportunities exist within the state and at the federal level to enhance home and community-based care and to create a more seamless system.

California's leaders must decide whether care for its most frail and vulnerable populations – seniors and people with disabilities – is a priority, and how policies and programs should be shaped and integrated to ensure that the state's substantial expenditures for long-term care are both wise and effective. The state's broad, if uncoordinated, array of long-term care programs has been studied many times, yet the same problems persist. Though recommended repeatedly, a state-level department reorganization has not been implemented, yet the state, through many piecemeal efforts, has pursued improving home and community-based options and has put in motion efforts to better coordinate services in some local jurisdictions.

This report seeks to provide a roadmap for creating a true continuum of long-term care services and supports in order to meet the needs of California's growing population of seniors and people with disabilities, and to do it in a way that improves consumer choice, integrates strategic management and maximizes state and local resources.

The Long-Term Care Un-System

When the long-term care movement took hold in the 1970s, California was a leader in developing services, originating the model that became Programs for All-Inclusive Care and driving innovations such as the In-Home Supportive Services program and Adult Day Health Care, to name just a few. Although these programs were well-designed for their times and established models followed by other states, California's programs have not kept pace with changes over the past 40 years, and California has ceded its reputation for innovation to other states.⁴³

This has left California ill-prepared for the oncoming wave of seniors and the growing population of people with disabilities in need of services.

Not only is the state facing a looming "silver tsunami" of aging Baby Boomers, but California also still struggles to adjust to steep revenue declines and budget cuts in the continuing aftermath of the 2008-09 recession. The state continues to face billions of dollars in budget reductions each year, with the 2011-12 budget negotiations commencing with a \$25 billion shortfall. The most vulnerable programs for budget reduction are those that appear to be wasteful or unnecessary, that lack state or federal mandates or that are not medically required, though they may help the state avoid the more costly medical expenses. Unfortunately, the state lacks the data or ability to show the benefits of these programs and their value in the spectrum of long-term care services. In reducing money for such programs as In-Home Supportive Services, Adult Day Health Care and the Multi-Purpose Senior Services Program – programs that made California an early leader in home and community-based care – policy-makers may very well be sacrificing long-term cost savings, particularly in future years as the number of California's elderly swells.

Without a system that allows the state to look at the long-term care spectrum as a whole and understand which programs have proven most beneficial over time, policy-makers lack critically important information they need to make informed budget and policy decisions.

In the current climate, budget cutting is an acute concern overtaking the broader problem of the state's inability to organize its long-term care activities into a system to be managed, as a system, in the most efficient and cost-effective manner. Long-term care in California is a vast

collection of services and supports for people who need help with basic activities of daily living – whether in the home, out in the community, or in a residential or nursing facility. Many state departments, local government programs, non-profit and for-profit groups and varying types of institutional and community-based programs play a role in the care system. Services often overlap, and changes in one program can influence the utilization – and potential costs – of other state and local programs. At the state level, staff and programs responsible for long-term care services are scattered throughout several departments, with little communication between programs and no management or coordination of financing, assessment, or service delivery. This leads not only to an inability to manage the system from the state’s perspective, but just as important, it results in a convoluted and confusing maze of programs to be navigated by the long-term care consumer, or client.

In addition, new legal rules, mainly the *Olmstead* decision by the U.S. Supreme Court in 1999, impose greater obligations on the state to keep people out of institutions and integrated into the community, requiring that the state do even more to keep people in their homes and effectively transition clients back home after being hospitalized.

Throughout the Commission’s study process, experts across the board said that the greatest problem with California’s long-term care system is the fragmentation of programs at the state level. The fragmentation and diffused authority that characterize California’s long-term care system create the following inefficiencies:

- Consumer confusion and difficulty in accessing needed services results in over-utilization of unnecessary and costly care, such as emergency room visits or longer-than-required nursing home stays. Transitioning clients from institutional to community-based care is inconsistent.
- Lack of integrated service delivery causes duplication of state, county and non-profit efforts and resources, such as the multiple assessments conducted on a single client.
- Lack of care coordination, planning and management inhibit clients’ ability to find the right care at the right time in the right place.
- Difficulty in transitioning clients from institutional to community-based care results in part from a lack of incentives and lack of information.
- Lack of state-level leadership, vision and prioritization of long-term care services and system improvements.

- No focused oversight and accountability of program efficiency and outcomes.
- Fragmented state administrative structure, isolating programs, a problem reinforced by rigid funding rules and a lack of data that could be used for better decision-making and program planning.

Numerous reports on California's long-term care system over the last few decades have cited the need for consolidating state-level programs, including the Commission's 1996 report, *Long-Term Care: Providing Compassion Without Confusion*. In that report, the Commission found that the "state structure for long-term care oversight [was] not conducive to a coordinated continuum of care and [failed] to focus state efforts on consumer-centered, least-restrictive, best-value services."⁴⁴

Consumers See a Maze of Programs

When a senior or person with a disability embarks to find long-term care services – whether they need help with a few daily activities or require full care in an institution – they must navigate on their own the maze of services that may be available to them. If they are lucky, they may have a family member to help in providing or finding care for them. However, regardless of who is looking for services, the task is daunting and requires one to make a series of inquiries, phone calls, internet searches and visits to administrative offices in a number of places. Consumer confusion and difficulty finding services is common, leading to inadequate access to care, poor delivery of services, and overutilization of some services which may be more costly to the state than if the person found what they needed at the right time and in the right place.

The disconnect between these programs means that even if a person found one service that helps, they may not know where to go next, especially when their needs change. For example, a senior who falls and suffers a broken hip might find himself or herself in the hospital but with no link to services that would help him or her return home safely. Hospital staff often do not have the time, resources or knowledge of what is available in the community to help in the transition. Even when there is a human link, often there is a waiting list for the service, such as In-Home Supportive Services or the Multi-Purpose Senior Services Program – and the person is discharged from the hospital before obtaining access to help. Without adequate assistance in returning home, a person is at greater risk for repeat hospitalization or placement in a nursing facility.⁴⁵

Redundancy Across Programs

Once a consumer finds a program that might help at the time of need, the beneficiary may be subject to multiple assessments that require them to answer similar, but not identical, questions about themselves and their needs. For example, a client might be eligible for both the In-Home Supportive Services program through the Department of Social Services, as well as the Multi-Purpose Senior Services Program, offered by the Department of Aging. Each program involves a separate functional assessment to determine the client's eligibility and need for services, requiring separate case workers to conduct in-person assessments of the client, file case work and follow up to keep the client in the program. Each program also maintains separate data systems and reports information to separate state departments through which they receive funding. This duplication of services and assessments can be found among many of the state's long-term care programs.⁴⁶

No Care Coordination or Continuum of Services

When the Commission began this study, it sought to examine the array of services provided through the state's more than three dozen programs to make recommendations that could bolster California's continuum of services. But the Commission found no continuum; instead, the long-term care system is a mix of distinct programs, each floating on its own, with clients swimming from one service to the next, hoping to get enough help from each to stay afloat.

The lack of coordination among the various long-term care programs makes it particularly difficult to ensure that home and community-based services are designed and managed in ways that both meet required *Olmstead* goals and achieve cost-savings to the state.

In-Home Supportive Services, for example, is one piece in the system; it costs what it does because it is "out there floating by itself," Brenda Premo, chair of California's *Olmstead* Advisory Committee, told the Commission. She added that continued budget focus on individual programs will not solve the state's long-term care problems.⁴⁷ Instead, Ms. Premo promotes a system of "care in the long-term" that offers supportive services that keep people in their homes, prevents health decline, encourages independent living and creates employment opportunities for people with disabilities. Under the current scheme of piecemeal services, however, budget cuts and subsequent program changes are made without a strategy or larger picture in view. The system should be designed in a more precise way so that services are provided – and reduced when necessary – depending on a client's

Long-Term Care System Challenges

Steven Lutzky, a national long-term care expert, identified the following system challenges to increasing home and community-based services:

1. **Consumer Process.** The process of moving clients through the available home and community-based services – from outreach to eligibility determinations to assessments to provider selection and service utilization – is hindered by the following problems:
 - a. **Access/Eligibility.** The current system lacks a systematic, statewide process for targeting people with the highest needs or those who might benefit most from care coordination services.
 - b. **Assessment and Service Planning.** No standardized process exists to determine what services seniors need, what they currently are receiving or what else is needed. There also is no ability to tailor levels of care management to each consumer.
 - c. **Provider Selection.** Consumers lack information about home and community-based services providers, which vary in quality, capability, sophistication and cost.
2. **Provider Processes.** In addition to experiencing the same problems as consumers in attempting to deliver services to clients, providers also bear the challenges of the administrative dysfunction of the system, such as lack of training, inability to monitor their own performance and difficulty negotiating provider rates, all of which impact the cost of providing services.
3. **Systems Management.** There is little system-wide information to understand the dynamics of the long-term care system that are needed for proper management – no performance-based measurements, for example, and too much reliance on arcane rules and forms.

Source: The SCAN Foundation. May 2009. "The Future of Care Coordination in California: A Synthesis of the 'Beyond the MSSP Waiver' Convening."

functional needs rather than on specific types of services that can be offered because of funding availability.

Lack of care coordination in California also results in difficulty transitioning a person back home after a hospital, rehabilitative or nursing facility stay, which has enormous cost implications for the state. If a consumer is discharged from an institution without the necessary services and supports in place at home, they are at greater risk of being re-admitted.⁴⁸ Roughly one in five hospital stays by seniors and people with disabilities ends with a return to the hospital for an unresolved issue related to the initial condition. A 2011 report by the California Discharge Planning Collaborative noted that "reducing hospital stays from avoidable readmissions by just one day would save about \$227 million annually. For a fraction of this sum, we could greatly improve discharge planning and enhance home and community support services. This would result in better outcomes for patients and improved efficiency in the health care system."⁴⁹

Institutional Bias Still Inherent in State System

In California and across the nation, long-term care services are among the most expensive within the Medicaid program. Seniors and people with disabilities represent 24 percent of Medicaid participants though they account for 70 percent of all Medicaid expenditures.⁵⁰ Experts acknowledge that the most costly aspect of long-term care occurs when a person is housed in an institution such as a skilled nursing facility or a facility that provides full-time supervision. Despite the state and national trends leading toward greater home and community-based programs, California's system still reflects an institutional bias. The funding and policy priority – as evident in state budget negotiations over the past few years – is not on

those programs that can delay or prevent a person from entering a nursing facility, nor on those that can help transfer a person out and

keep them out after a hospital or rehabilitative stay. In testimony to the Commission, the SCAN Foundation's senior policy fellow, Sarah Steenhausen, described how Medicaid laws reinforce institutional bias by providing an entitlement to institutional care, requiring states to cover the costs, split with the federal government, of nursing home care for Medicaid beneficiaries.

With certain exceptions, home and community-based services are optional – permissible but not mandatory. California's home and community-based services exist as a patchwork of Medi-Cal optional State Plan services and Medi-Cal waiver programs that provide community-based programs for people who otherwise require care in a nursing home or hospital. These waiver programs serve a limited number of people and often have long waiting lists, Ms. Steenhausen said. The only population that is guaranteed access to California's home and community-based services are eligible individuals with developmental disabilities as described in the landmark Lanterman Development Disabilities Act of 1969.

System Incentivizes Institutionalization

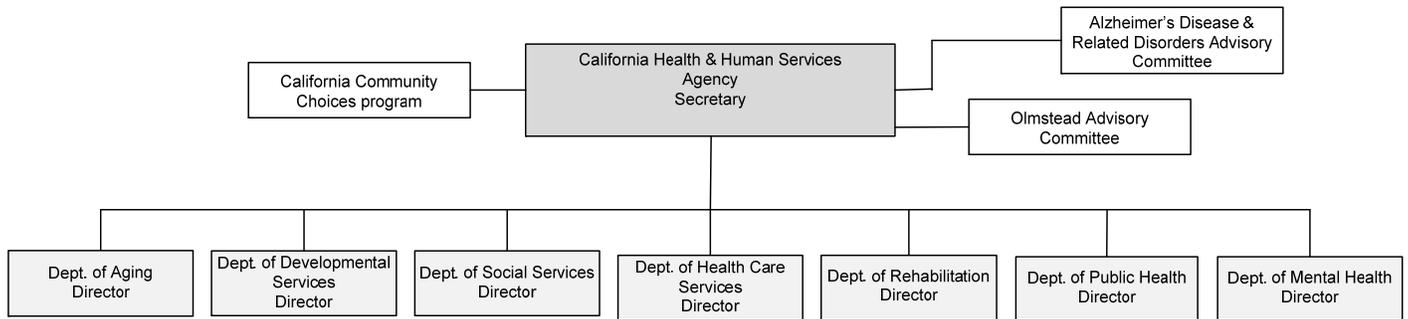
A dichotomy in how the state's two largest long-term care programs are funded further complicates how home and community-based programs are developed and delivered, Ms. Steenhausen said. For the state's biggest home and community-based program, In-Home Supportive Services, counties pay 17.5 percent of the total cost, while the state contributes 32.5 percent and the federal government covers the remaining 50 percent. For nursing home care, counties pay no share of the cost, which is split between the state and federal government.⁵¹ This funding structure means that counties pay more for a client who is placed in the In-Home Supportive Services program than if that same client was placed in a nursing facility, giving counties a financial incentive to institutionalize patients.

No Central Management or Leadership

Because long-term care programs are scattered across seven departments, no one person or organization within California state government is responsible for leading the state's long-term care system. The individual who has ultimate responsibility for long-term care is the Health and Human Services Agency secretary; however, as head of one of the largest state agencies in California, the secretary cannot and should not be expected to focus solely on long-term care. Effective management necessarily would require extensive attention to program-level details, and it would be impossible for the agency secretary to assume such a

role. This passes the responsibility for management down to the seven department directors, each of whom has their own long list of programs to administer. With no one person in charge, long-term care lacks a leader or champion to assess consumer needs and program performance, manage the system or advocate on behalf of long-term care clients.

Existing Leadership Structure for Long-Term Care Programs



Many Entities Have Long-Term Care Focus, But Gaps Remain

On the surface, it might appear that there are a handful of groups that could provide direction for long-term care, though none have the ability or scope of authority to take the lead on this issue across multiple departments, and none have stepped forward to assume such an ambitious undertaking.

Long-Term Care Division. The Long-Term Care Division, an office within the Department of Health Care Services health care operations unit, is responsible for overseeing Medicaid waiver programs and ensuring compliance with program requirements. These include waivers to California’s Medicaid State Plan that target specific groups of Medi-Cal recipients, including the Nursing Facility/Acute Hospital Waiver, In-Home Operations Waiver, Assisted Living Waiver Pilot Project, In-Home Supportive Services Plus Waiver, Developmental Services Waiver, Multi-Purpose Senior Services Program and Senior Care Action Network Health Plan. The division also authorizes private duty nursing and pediatric day health care services for approximately 3,000 Medi-Cal beneficiaries through the Early and Periodic Screening, Diagnosis and Treatment supplemental services benefit.⁵²

In addition, the Long-Term Care Division coordinates the federal Money Follows the Person grant project (\$130 million in federal funds over a five year period from 2007 through 2011) to transition 2,000 Medi-Cal-

eligible residents from long-term care institutions back to community living arrangements.⁵³ The division partnered with nine departments or agencies, and administers the program through “lead organizations” that are providers who apply for the ability to participate in the project.⁵⁴ Under the Money Follows the Person grant, called California Community Transitions, 336 people who had resided in nursing facilities for more than six months had successfully transitioned to community living as of February 2011.⁵⁵

The Long-Term Care Division also serves as the approval authority for the Program of All-Inclusive Care for the Elderly, which is covered as an optional service under the Medicaid State Plan. And the Division manages and oversees the California Partnership for Long-Term Care, a federally recognized program, established before federal health care reform, that provides long-term care insurance to middle-income Californians through five selected insurance companies and CalPERS.⁵⁶

While the Long-Term Care Division is responsible for managing waiver compliance for a number of long-term care programs, it is not designed, authorized or equipped to provide leadership on long-term care across programs and departments, nor does it manage any of the social services, such as IHSS, that make up critical parts of the long-term care continuum.

California Commission on Aging. The California Commission on Aging, with 25 volunteer commissioners, is “the principal advocate in the state on behalf of older individuals, including, but not limited to, advisory participation in the consideration of all legislation and regulations made by state and federal departments and agencies relating to programs and services that affect older individuals.”⁵⁷ Established in 1973, it has sponsored forums on aging over the years and assisted the Health and Human Services Agency with the development of the 2003 Strategic Plan for an Aging California. The Commission on Aging issued a report in 2009 documenting the condition and discussing the future of senior centers in California. As a volunteer advisory body, the Commission on Aging has neither the capacity nor authority to manage the full array of long-term care programs, nor is it in a position to drive change toward improved coordination within the administration.

Long-Term Care Council. The Legislature in 1999 created the Long-Term Care Council, consisting of the directors of the departments that house long-term care programs, to coordinate long-term care policy development, program operations and strategic planning. The council helped develop California’s 2003 Olmstead Plan, which then led to the creation of the California Olmstead Advisory Committee. The committee

soon took the place of the Long-Term Care Council, when its authority expired in 2006.

Olmstead Advisory Committee. The Olmstead Advisory Committee was formed in 2004 by the Health and Human Services secretary to advise the administration on long-term care and to review, update and monitor the state's Olmstead Plan. Committee members include long-term care consumers, family members, providers and advocates who meet three or four times per year on a voluntary basis. Kim Belshé regularly joined committee meetings during her term as the Health and Human Services Agency secretary, along with department directors who oversaw long-term care programs.

The committee is the closest the state gets to a vehicle for discussion and action to improve long-term care in California on a broad scale. It tackles the most pressing issues in the long-term care arena, as evidenced by the committee's November 2010 meeting agenda that included the following discussion items: home and community-based services opportunities under health care reform, the state's 1115 waiver program implementation, transportation issues for seniors and people with disabilities and the California Alzheimer's Disease Plan. Its chairman and members show dedicated commitment to the issues and to the work of the committee.

Although the committee provides important input to the Health and Human Services Agency secretary, there are limits to the committee's impact. The committee is merely advisory and has no authority to take action, and its quarterly meeting schedule hinders its ability to respond quickly to time-sensitive matters.

Advocates say that California is making no progress on its Olmstead Plan and barriers still exist to prevent people from living in their homes.⁵⁸

The current Olmstead Plan has no timeline for completion or benchmarks for implementation. The Olmstead Advisory Committee, advocates say, is mostly about process, and its advice can be ignored by the administration.

Most importantly, the committee has almost no staff to facilitate action or follow-up on committee recommendations. It is staffed with part of one position within the Health and Human Services Agency – an assistant secretary who also works on other advisory committees, interdepartmental issues on long-term care and grant programs. This assistant secretary position is not designed to provide the leadership and cross-department coordination and authority that are needed for effective and comprehensive action to improve long-term care in the state.

Many Long-Term Care Assets, But No One to Lead

Within the Health and Human Services Agency, long-term care programs over the past few years have had to compete for attention with health care reform, the creation of a separate Department of Public Health and the flux created by simultaneously cutting budgets while harnessing federal stimulus money. Despite this, the agency has implemented several key initiatives to advance long-term care in California, including the California Community Choices project, Hospital to Home Grant program, Money Follows the Person demonstration program, and a review of all home and community-based program data to understand program utilization and cost over a five-year period of time. These initiatives add to the wealth of assets in the state's existing numerous and valuable – yet siloed – programs for long-term care. There is no champion, however, to take the information learned or the advances made by these programs and capitalize on them.

Former California Department of Aging director Lynn Daucher told the Commission there is no leader to move forward on the work that has been done, such as the California Community Choices project report.⁵⁹ As discussed in the background chapter, the Community Choices report – compiled by two national long-term care experts – lists 28 specific recommendations to improve the state's ability to provide effective home and community-based services. The report was endorsed repeatedly by numerous long-term care experts during conversations with the Commission, yet no one could say how the recommendations would become reality or who would be in charge of such an endeavor. The Community Choices advisory committee has begun to prioritize the recommendations and is discussing how to help move the recommendations forward, but the committee, like the Olmstead Advisory Committee, has only one staff to assist in their efforts. It too, is designed as an advisory body and has no authority to implement changes within the agency or departments.

Costs, Data for Long-Term Care Unclear

Long-term care in California is a multi-billion dollar endeavor, yet it is difficult to know exactly how much money the state spends on long-term care at any point in time given the scattered nature in which care is administered and funded through several departments and the diverse programs within them. There is no way to see a comprehensive spread of state and federal expenditures without manually compiling budget information from each of the multiple departments and programs. The California Legislative Analyst assembled such a list in 2006, with total state spending on long-term care coming in at roughly \$7 billion for the

2005-06 budget year.⁶⁰ The list of programs, with cost and caseload information, is shown on the next page.

Meanwhile, the report released in 2009 by the California Community Choices Project in collaboration with the Health and Human Services Agency put the state's total long-term care spending at more than \$10 billion annually.⁶¹ Other than these compilations, there is no regular comprehensive accounting of long-term care programs. Without an accurate and holistic picture of the costs and fluctuations of each long-term care program, the state lacks an important management tool. State administrators and policy-makers do not have a clear understanding of the system as it exists, let alone know where to make changes to improve the system.

Overall budget information is just one area where the state lacks data and information on long-term care. The state also lacks information on the health conditions of beneficiaries in different programs, and how changes in one program may influence another. During a January 26, 2010, hearing of the Senate Budget and Fiscal Review Committee, senators expressed frustration at being presented with budget cuts for programs without being given information on how eliminating or curtailing Adult Day Health Care services – an optional service under Medi-Cal, might increase demand for nursing home care, a mandatory service under Medi-Cal.

Lisa Shugarman, policy director for the SCAN Foundation, told the Commission that under the existing, fragmented long-term care system, “there is no easy way to understand who is being served across these programs, what are the total costs of care and how best to plan for the needs of the long-term care population.”⁶²

The SCAN Foundation's Ms. Steenhausen, who previously served as former assistant secretary for long-term care in the Health and Human Services Agency, said no central entity within the agency collects and reports long-term care data and that “without comprehensive data, it is difficult to evaluate the cost-effectiveness of home and community-based services and to determine how to best meet the needs of the population.” She added that “data and planning are essential components to preparation” for dealing with the growing demand for long-term care services.⁶³

Thus, from a management perspective, the system is not set up to allow policy-makers and administrators to make choices based on what might be most efficient and cost-effective for the state in the long run, let alone attempt to make strategic decisions that keep the focus of services on the consumer.

Long-Term Care Services Funding and Caseload

(Funding in millions)

Program	2005-06 Budget Act Funding ^a				Estimated Caseload ^b	Annual Cost per Case
	State	Federal	Local	Total		
Institutional Care						
Nursing facilities/ Intermediate Care Facilities (ICF) - fee-for-service	\$1,501	\$1,501	–	\$3,001	68,060	\$44,100
State Hospitals	809	8	\$71	888	5,609	158,317
Developmental Centers	381	327	–	708	3,016	234,748
ICF-Developmentally Disabled	187	287	–	374	6,320	59,157
Nursing Facilities - managed care	127	127	–	254	8,446	30,102
Veterans' Homes - nursing facilities and ICFs	37	20	–	57	2,340	24,235
Veterans' Homes - residential	36	14	–	50	3,295	15,182
Institutional Care Totals	(\$3,077)	(\$2,184)	(\$71)	(\$5,332)	97,086	(\$54,924)
Community-Based Care						
In-Home Supportive Services	\$1,241	\$1,895	\$675	\$3,811	374,986	\$10,163
Regional Centers	1,881	1,051	–	2,932	205,155	14,292
SSI/ SSP nonmedical out-of-home	270	228	–	498	59,568	8,361
Adult Day Health Care	209	209	–	418	40,800	10,250
Nutrition Services	9	65	75	148	8,841,884 ^c	4
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) shift nursing	73	73	–	147	1,682	84,718
Supportive services	2	35	48	85	944,821	39
Program of All-Inclusive Care for the Elderly	41	41	–	83	2,102	39,340
Senior Care Action Network	32	32	–	64	3,929	16,321
Multipurpose Senior Services Program	22	22	–	45	13,867	3,216
Family Caregiver Support Program	–	23	12	36	17,378	1,341
Nursing Facility Subacute Waiver	16	16	–	33	281	117,025
Conditional Release Program	22	–	–	22	709	30,324
AIDS Waiver	10	10	–	20	2,897	5,370
Nursing Facility A/B Waiver	8	8	–	16	289	54,478
Alzheimer's Day Care Resource Centers	4	–	10	14	3,168	1,326
In-Home Medical Care Waiver	7	7	–	14	67	200,955
Independent Living Centers	–	13	–	13	41,000	305
Caregiver Resource Centers	12	–	–	12	e	e
Long-Term Care Ombudsman	5	3	3	11	45,873	172
Linkages	8	–	2	10	4,319	1,922
Alzheimer's Disease Research Centers of California	\$4	–	–	\$4	3,228	\$1,239
Traumatic Brain Injury project	1	–	–	1	1,204	914
Senior Companion Program	–	–	1	1	235	1,702
Respite care	>1	–	–	>1	26,476	15
Community Care Totals	(\$3,878)	(\$3,732)	(\$826)	(\$8,436)	d	d
Totals	\$6,955	\$5,916	\$897	\$13,768	d	d

^a Budget Act amounts unavailable for some programs, therefore funding levels are estimated based on prior year.

^b Caseload may be a monthly average, and therefore not represent the number of persons served annually.

^c Number of meals served.

^d An unduplicated count of clients across programs could not be calculated.

^e Caseload data not available.

Source: Legislative Analyst's Office. February 2006. Analysis of the 2006-07 Budget Bill. "Improving Long-Term Care."

State System Hinders Local Ability to Coordinate

Governor Brown's proposed budget released in January 2011 refocused attention on realigning state resources and responsibilities for public programs to the local government level, where most services are delivered. The Governor's proposal discussed extending the realignment of juvenile justice programs while adding adult parole, as well as shifting significant program responsibilities from the Health and Human Services Agency, including alcohol and drug treatment, foster care, adult protective services and several mental health services, to counties.

The Commission has recommended realigning juvenile justice and supervision of released adult offenders, as well as mental health and many social services programs. In previous studies, the Commission saw how counties, adequately funded and given the freedom to innovate and design service delivery, can integrate programs in ways that better meet needs and increase efficiency and accountability by placing service delivery and decision-making at the same level of government.

Several counties have fashioned integrated long-term care systems at the local level, often through consolidating programs into a single department. Many, however, encounter state-level obstacles that inhibit greater integration, including the need to have separate assessments by program, limits by program on spending, and requirements to track spending by funding stream, all the result of the lack of program integration at the state level. County officials told the Commission they must go through layers of state program staff in order to make changes to local services.

Leaders in San Mateo, for example, noted that as they work on integrating programs, there is no one at the state level to help them get the changes necessary to allow their integration to move forward. If they need to amend a state requirement, they must go through different chains of state staff for help.⁶⁴

When realignment works, the state and counties each have separate sets of responsibilities; efficiencies can be gained and accountability improved when two different levels of government are no longer duplicating duties and when counties can design programs to fit their specific needs. The difficulty for California is in designing realigned systems when the state's 58 counties have such a wide range in their ability to deliver services. The following chapter discusses how several counties integrated long-term care services and provides recommendations for how the state can help them, as well as other counties, move forward in developing a more strategic approach to long-term care.

Rural Counties Need Special Attention

As policy-makers discuss services necessary for a growing population of seniors, particular attention will need to be heeded to the added challenges of providing effective long-term care in rural California. While long-term care needs in California's rural counties are similar to the needs of individuals in urban centers, the solutions to meeting those needs may be very different.

California's 44 rural counties – defined as those in which at least 80 percent of the land is inhabited by fewer than 250 people per square mile – are home 5.2 million people, just 14 percent of Californians, but account for 80 percent of the state's land mass. The population in rural counties tends to be older, poorer and less healthy than the population in urban areas. Rural Californians tend to have higher poverty rates and unemployment, and are less likely to have health insurance. Simultaneously, rural areas have fewer traditional providers of health care – hospitals, home health agencies, hospice organizations, long-term care facilities and primary care clinics – and less of the human infrastructure that accompanies these institutions.

Because of their remoteness, rural communities are particularly challenged in addressing access to care. Though many challenges faced by rural communities are similar to those in urban areas, the range of possible solutions is different because of the rural context. Rural communities face particular challenges in terms of:

Transportation. Rural areas do not have taxi cabs, wheelchair-accessible transportation or paratransit. Some areas are connected to main population centers by only a few roads that can require snow removal or flood control during winter months.

Isolation. In addition to isolation issues that cut across urban and rural communities, outlying areas can be removed from highways and other populated areas, sometimes hours away from emergency services.

Funding. The state distributes money to counties based on the size of its population, leaving rural and even less populous "frontier" communities, with few resources. Also, because the state's In-Home Supportive Services program requires counties to pay a share of the cost, some counties with limited resources favor the more expensive, but state-subsidized nursing home care because it does not require a share of cost.

Service fragmentation. Rural counties tend to invest limited resources in acute care and skilled nursing facilities, which are partly subsidized by state support, rather than social, non-medical support. As a result, in some rural communities, a patient may be treated in a skilled nursing facility because there are no resources available to support that patient at home.

Need for case management and hospital-to-home transitions. With a lack of case workers and transition programs, patients in rural communities may have a harder time transitioning from a hospital or skilled nursing facility to their home. Many rural agency providers will not transition patients home unless they live in stable environments, but that can be challenging in rural settings, especially in isolated communities where some people live in sub-standard housing. Nursing facilities are expensive, but case workers and transition programs could help patients by enabling them to be treated at home.

Family support. Because rural communities tend to have fewer job opportunities, younger generations often must move away from home, and their parents, to build a career. As a result, many families are scattered over several communities making it more difficult for an adult child to provide intensive in-home care for his or her senior parent. Also, even when families live in the same community, some adult children who are seniors themselves may not be able caretakers.

Some programs are looking for ways to broaden access to long-term care services in rural communities. For example, the SCAN Foundation recently partnered with San Francisco's On Lok to study the feasibility of expanding the PACE model into Humboldt, San Joaquin and Riverside counties. That project generated several recommendations for improving long-term care service delivery in rural communities through regulatory waivers, increased use of telemedicine and other fiscal flexibilities.

California Telehealth Network, part of the University of California, Davis Health System's Center for Health and Technology, is a pilot program that will build the foundation for the state's telemedicine infrastructure. It is not designed to address long-term care services, but could bring expertise to rural areas in fields such as geriatrics. The network aims to link remote and underserved communities to health care providers across the state.

Sources: Little Hoover Commission advisory committee meeting on rural long-term care. November 3, 2010. Sacramento, CA. Also, California Telehealth Network.

Conclusion

Long-term care services in California are provided piecemeal, with different eligibility criteria and separate assessments for each program, and no coordinated management of care or even data about patient care in a central database system. Consumers have no guide or system to follow to understand their care options, and state leaders have no comprehensive understanding of consumer needs, service utilization, costs of available options, or even which programs work best for the lowest cost to the state. Funding and policy decisions, including changes and cuts made to IHSS, for example, are made in the dark, with no understanding of the system as a whole or the consequences that will result.

The state currently has neither the tools necessary to manage the system nor the ability to coordinate care – an absolute necessity – for the vast majority of consumers in the long-term care universe. To address these complex issues, the next chapter suggests changes that must be made to the system from the consumer perspective to better coordinate and deliver long-term care services to improve both efficiency and quality, along with recommendations to enhance state-level leadership and structural organization to allow policy-makers and administrators to effectively manage the system.

A True Continuum of Care

A state-level consolidation may seem like an obvious place to start to begin to improve how California delivers its long-term care services. Such a consolidation has been recommended repeatedly, by this Commission and others. Ultimately, a consolidation is essential. Rather than wait, however, it is better to start putting in place the pieces that can begin to improve long-term care delivery right away, and help ensure the state makes the best use of increasingly scarce dollars for the most vulnerable of California's seniors and persons with disabilities. Such improvements may inform the process of a state-level consolidation and make it inevitable.

The previous chapter enumerated the problems California faces in harnessing its long-term care programs and expertise: A fragmented state structure, a lack of focused leadership at the state level, funding requirements that inhibit integration, a lack of information about the needs and conditions of the people the state wants to help, a lack of an overall perspective on how much the state spends on long-term care and what outcomes its efforts produce. The result, from the view of the people this tangle of programs is supposed help, often is a confusing maze.

Many of these problems existed when the Commission last examined long-term care in 1996. It would be wrong, however, to suggest that no progress has been made since.

As part of its study, the Commission has seen firsthand advances at the local level, in places like San Francisco, San Mateo County and San Diego County, and heard from experts about system-wide long-term care improvements in states such as Washington and Oregon, all ample reason for optimism. At the state level in California, too, consistent experimentation in the intervening period has provided a valuable cache of ideas and examples that can be tested on a broader scale. As well, a new state/local initiative in Orange County – imbedding long-term care into a county-based Medi-Cal managed care plan – bears watching, particularly as the county-based managed care plan already has a record of accounting for members' broader needs to keep them healthy.

Separately, the *Olmstead* decision has made the state's policy direction clear: Focus on helping more people receive care services in their homes and in community-based settings.

The last 15 years also have seen the development of software tools, such as those used in Washington and Oregon, that can better track beneficiaries and assess their needs. These systems give states a more finely grained picture of their clients and their system needs. In California, a software system created to help enrollment for health care programs and social services for low-income families and children as well as a client assessment tool developed for use by San Mateo County highlight the potential of a uniform assessment and enrollment system for long-term care. Using such a tool in concert with an integrated service delivery system at the local level could create a virtual consolidation of California's long-term care programs, at least from the client's perspective.

To that end, the state's perspective should focus on the client as it builds California's long-term care continuum. This requires thinking about the care the client needs, rather than what care can be delivered as determined by how the state's departments are structured. Critical to this shift in perspective is developing a more detailed assessment of each client's condition and needs – and the costs of meeting those needs successfully. In this way, the state can create a picture of California's overall needs and, when budgets shrink, can direct scarce resources to those most in need and whose conditions, left unaddressed, could take them to far-more-expensive institutional settings.

The key to this endeavor is “care coordination” – a mechanism to ensure that a senior or person with disabilities receives the right care at the right time in the right setting – which, given the preferences of clients and the *Olmstead* imperative, tends to keep people in their homes and communities and out of costly institutions. Care coordination means creating a true continuum of long-term care that is accessible and easily navigated by the client, well-organized and delivered by the county, and effectively led and managed by the state as part of a comprehensive system that facilitates quality and cost-effectiveness overall.

An argument heard by the Commission during the study process was that if the system was easier to navigate, more people would sign up for long-term care services and state costs would rise. However, researchers told the Commission that giving consumers more choices in a well-organized system actually saves the state in Medi-Cal costs because consumers typically choose the option that keeps them in their own homes, a far less expensive way to provide long-term care than a system that relies unnecessarily on emergency rooms, hospitals and nursing

homes to deliver un-coordinated care.⁶⁵ It is less expensive to provide a ramp or grab bar for an elderly client, for example, than to pay for emergency services, surgery and hospital and rehabilitative care in an institution when that same client instead falls and breaks a hip because the person's home was not equipped with basic safety features. While a shift in focus to the client could save the state money, it clearly would enhance the quality of care and quality of life for clients as well.

A true continuum of care would provide both the system and the client with an avenue for a single assessment and assistance with finding services that meet the consumer's needs and the flexibility to move among the various options along the spectrum depending on changes in the consumer's condition. County programs and other local long-term care programs, with their close contact with consumers, communities and providers, are best situated to ensure the care coordination that is necessary for both consumer satisfaction and for finding the most cost-effective solution. The system must therefore provide counties with the flexibility and resources they need to ensure that good care coordination is in place for seniors and people with disabilities in their communities.

Envisioning Care Coordination

Coordinating care around the consumer serves multiple goals, such as improving the quality and accessibility of care for seniors or persons with disabilities by connecting them to the appropriate services they need, helping keep people in their homes and out of institutions, decreasing state costs by reducing duplication of assessments and services, reducing avoidable nursing home stays, and providing a vehicle for gathering and sharing information across department silos.

Good care coordination, however, is impossible without creating the conditions that will allow such coordination to thrive. The state must take action to create these conditions, but it must first articulate a vision for how its long-term care system should look from the consumer's perspective.

Legislative Efforts to Improve Care Coordination

- AB 1040 (Bates, Chapter 875, 1995). This law added a requirement that the Department of Health Care Services implement up to five pilot projects to integrate delivery and funding of institutional and home and community-based services, but no pilots were established.
- AB 1339 (Shelley, 1999). This bill would have required Area Agencies on Aging to be the single point-of-entry for long-term care services for seniors and would have created a uniform assessment tool to evaluate functional needs of seniors and people with disabilities. The bill failed to pass the Legislature.
- AB 3019 (Daucher, 2006). This bill would have called on the Health and Human Services Agency to create a single assessment protocol for home and community-based services assessment to minimize duplication and redundancy. The bill failed to pass the Legislature.
- Additional proposals were introduced to integrate medical and home and community-based service systems but failed to pass the Legislature. These include AB 43 (Daucher, 2003), SB 1671 (Vasconcellos, 2004), and the Acute and Long-Term Care Integration of 2005 and the Access Plus/Community Choices of 2006 proposals in the Governor's budget.

Source: Sarah Steenhausen, Senior policy fellow, SCAN Foundation; and former assistant secretary for long-term care, California Health and Human Services Agency. March 25, 2010. Written testimony to the Commission.

California can build on the considerable work that has been done in other states, as well as counties in this state, that can provide specific examples as California creates a cohesive vision for long-term care. Throughout the Commission's study, many experts articulated the elements that are needed in a well-designed and coordinated long-term care system. In addition to a client-centered approach, an integrated system should feature a single point-of-entry, a flexible continuum of services, effective transitions between programs, comprehensive assessment of needs, flexible funding, comprehensive services, clear accountability and the ability to adapt to change.⁶⁶

Lynn Daucher, former director of the California Department of Aging, told the Commission that the "recognition of the importance of home and community-based services and the need to link consumers with these services could be the beginning of an integrated system of care" and "by linking home and community-based services with medical services, older adults and adults with disabilities will have the greatest opportunity to age in place." She added that "the appropriate targeting of home and community-based services and Medi-Cal services could save money by avoiding institutionalization and hospitalization."⁶⁷

These are the kinds of goals that should be laid out in a state vision for long-term care so that the state can then begin taking steps toward building a structure to implement that vision.

Innovations in State-Level Integration

States and counties that have been most successful in providing cost-effective and quality care are those in which the care is coordinated along a continuum of services. While a consolidated state structure might facilitate such coordination and should be part of the long-term care vision, it is not a prerequisite for care coordination, particularly from the clients' or service providers' perspectives. Washington and Oregon, for example, consolidated their long-term care programs at the state level, but they also created standardized case management, a uniform assessment tool, and an information technology system, which combined serve their single point-of-entry strategy for a person needing any level of long-term care service.

Washington. Long-term care experts across the nation point to the state of Washington as a model system for its coordinated delivery of long-term care services. Its system was developed over the course of several decades, beginning with a task force established in the early 1980s of all of the departmental offices involved in long-term care. The task force spearheaded a long-term care system development project that created the following tools:

- A 49-page pre-admission screening model of Medicaid community-option waivers called CARES (Comprehensive Adult Resources Evaluation System), which provides a multi-disciplinary assessment of the strengths and needs of persons at risk of entering a nursing home or other residential setting.
- A better-coordinated delivery system, based on the CARES individualized assessment as well as care planning.
- Expanded case-management services.⁶⁸

The task force later evolved into an ongoing Long-Term Care Planning Group that made policy recommendations to Washington's Department of Social and Health Services – the umbrella organization akin to the California Health and Human Services Agency.⁶⁹

By 1986, Washington adopted case management standards to be used by staff in state field offices and local aging organizations. These standards helped lay the foundation for a comprehensive and coordinated delivery system. During the same year, the state's Aging and Adult Services Administration was formed through the combination of the Bureau of Aging and Adult Services and the Bureau of Nursing Home Affairs. The Aging and Adult Services Administration merged again in 2002 with the Division of Developmental Disabilities to become the Aging and Disability Services Administration, which is now home to all of Washington's long-term care services.

At the heart of Washington's system is a computer program that serves as a tool for assessment, case management and data collection for state long-term care services. Each person receiving state or Medicaid-funded long-term care services must enter through one door, making contact through a state employee working in a local field office. The state employee – a social worker – inputs information about the recipient into the computer system using a universal assessment form. Once entered into the state's database, the person can be monitored and have his or her case be managed from anywhere in the state by either a state employee or staff of an Area Agency on Aging. The system takes the information received about each person or group of enrollees and organizes it into data charts that provide a clear picture of service utilization, caseload, user characteristics and other data to inform policy-makers and agency officials so they can manage the programs effectively.⁷⁰

The result is a long-term care system that provides uniform and consistent assessment and case management across programs, along with access to service utilization data through its computer system. The framework also provides a single point-of-entry for the consumer. All

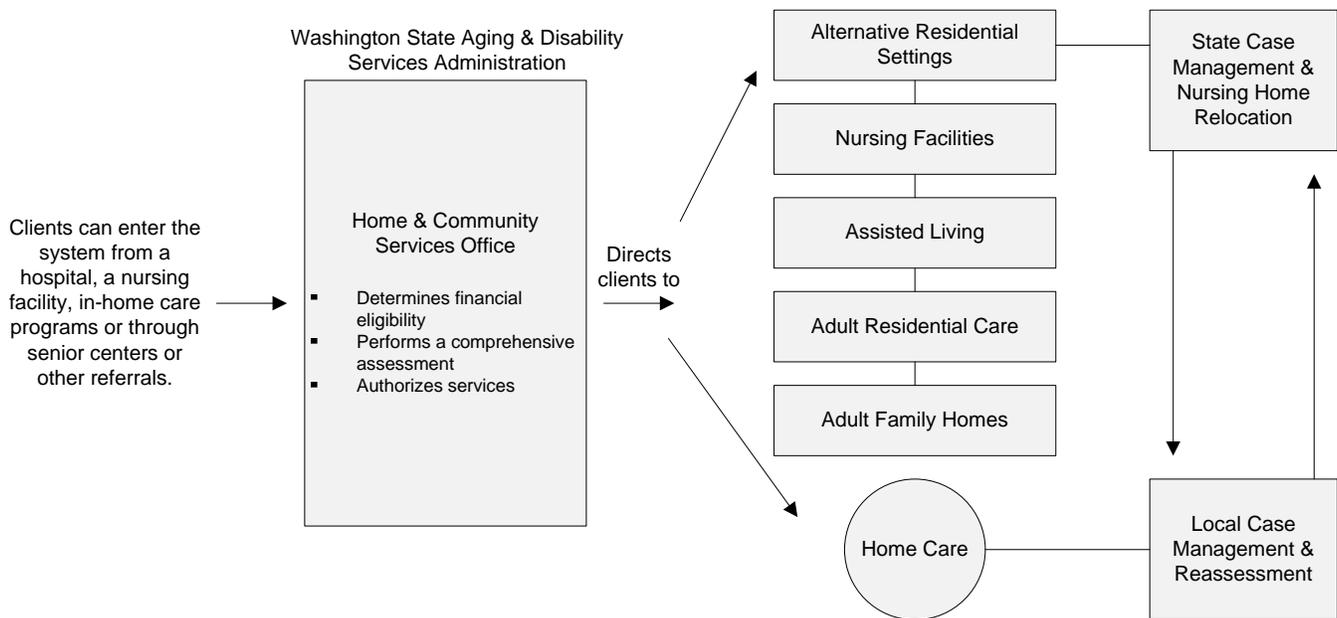
recipients of state long-term care services or funding must enter the system through the state or local Area Agency on Aging staff and the computer assessment system before receiving services.⁷¹

To put data on long-term care and other programs to work and to better understand and project caseload, the Washington State Legislature created a Caseload Forecasting Council in 1997 to project future caseload. This enhances the state’s ability to make informed budget decisions on all of its entitlement program caseloads, including long-term care. The council reports official caseload forecasts to the Governor and Legislature at least three times a year for programs that are within the areas of health, education and corrections. The Governor and Legislature use this information to set department funding during the state budget process.⁷²

Washington models the core elements suggested by experts for an effective long-term care system: single point-of-entry, uniform assessment, case management, data collection, global/flexible budgeting and a single department that houses all long-term care programs.

Former assistant secretary of Washington State’s Aging and Adult Services Administration Charles Reed, who led the state’s consolidation of long-term care programs, suggested to the Commission that California

Washington State Long-Term Care Delivery System



Source: Washington State Department of Social and Health Services, Aging and Disability Services Administration. August 2003. "The LTC Delivery System."

take the following steps toward a better system:

- Develop a set of core values of what is important to the state, with client choice being paramount.
- House all state long-term care functions in one place.
- Develop an array of services from which people can select and for which they are eligible that will meet their personal needs.

Given options among home and community-based care alternatives, Washington's experience was that people generally chose to stay in their own homes, the least expensive option overall.⁷³

Program Coordination at the County Level

Better coordination of client services does not have to wait for state-level consolidation. Several California counties have forged ahead to integrate service delivery at the local level. County governments in San Francisco, San Diego, and San Mateo have taken steps to create a more seamless system in their communities, braiding separate funding streams and program requirements that originate in different departments at the state level. The state can learn from these innovative counties both in how to incorporate elements of their systems into the state vision, but also to better understand what the state can do differently to encourage greater integration at the local level.

San Francisco. The city and county of San Francisco coordinates its long-term care services through its Department of Aging and Adult Services, which incorporates In-Home Supportive Services with other home and community-based programs. The department, which also serves as the region's Area Agency on Aging, has as its goals maximizing its clients' self-sufficiency, safety, health and independence so that seniors and people with disabilities can remain living in the community for as long as possible and maintain the highest possible quality of life.⁷⁴

In addition to housing all city and county long-term care services under one department, San Francisco established the Community Living Fund and sets aside \$3 million annually from its General Fund to provide community-based long-term care alternatives and to direct people away from institutional care and transition them back home after being institutionalized. The Community Living Fund is a case management program with a component that allows for the purchase of goods or services not covered by Medi-Cal-funded services, but that are both essential and cost-effective solutions to keeping a client living at home – such as a wheelchair, grab bar or ramp. The fund gives the department flexibility to pay for goods or services based on what a person needs,

San Francisco Aging and Adult Services

Services available through the San Francisco Department of Aging and Adult Services include the following:

1. Adult Protective Services.
2. In-Home Supportive Services.
3. Low-Cost Meals for Seniors.
4. Information, Resources, Advocacy and Legal Services.
 - Aging and Disability Resource Centers.
 - Online Web site to support community living.
 - Health insurance counseling and advocacy program.
 - Ombudsman program.
5. Veterans Services.
6. Services for Frail Seniors and Their Families.
 - Community Living Fund.
 - Alzheimer's Day Care Resource Centers.
 - Caregiver Support Program.
 - Case Management Services.
 - Linkages Program.
 - Multi-Purpose Senior Service Program.
 - Senior activity centers and wellness programs.
7. Programs Serving Vulnerable Adults (mentally disabled or unable to provide for their own personal or financial needs).
8. Public Administrator (to help manage estates).
9. Office on the Aging (AAA).
10. San Francisco Partnership for Community-Based Care and Support (to partner with community-based service organizations).

Source: Human Services Agency of San Francisco, Department of Aging and Adult Services. "Seniors and Adults with Disabilities." <http://www.sfgov.org/site/frame.asp?u=http://www.sfhsa.org/DAAS.htm>. Accessed August 4, 2010.

rather than be limited to the options permitted by federal or state-funded programs. Department staff, however, first try to address all client needs through the usual array of available services, using the Community Living Fund as a last resort to fill any remaining gaps.⁷⁵

San Francisco also has incorporated a Diversion and Community Integration Program for people referred for admission to the county nursing home or for current nursing home residents who soon could be discharged from the hospital and, without examining other options, could be headed back to a skilled nursing facility. The goal of the program is to place individuals in the most integrated setting appropriate for their needs and preferences. The program regularly convenes a group of decision-makers who, as a team, can authorize and commit services to address a client's needs. The group relies on electronically linked information about a client, which members of the group can view prior to meeting. The group then creates a community living plan that builds services around the needs and desires of the client.⁷⁶

San Diego. San Diego initiated the Long-Term Care Integration Project in 1995 with the goal of developing a plan for a comprehensive, integrated system of acute and long-term care services for the aged, blind, and disabled. Aided by the passage of

AB 1040 in 1995 to begin the pilot project and by subsequent grants from the state Office of Long-Term Care within the Department of Health Care Services, the county convened a planning committee of over 800 stakeholders of health and social service providers, consumers, caregivers and advocates to design the model.⁷⁷ The county's vision was a continuum that:

- Provides a single point-of-entry to care across the health and social service continuum.
- Pools funding to maximize resources and minimize process.

- Is consumer-driven and responsive, and expands community-based options for care.
- Expands access to health and social services through a single point of entry.
- Decreases fragmentation, barriers and duplication.
- Improves quality and cost-effectiveness while being “budget-neutral.”
- Is supported by case management and an integrated database.
- Uses existing providers, and insures fair compensation across the continuum.

After examining several different models for delivering care, San Diego stakeholders reached consensus and in 2001 recommended exploring the feasibility of using San Diego County’s existing Medi-Cal managed care plan, Healthy San Diego, as the preferred delivery system model. The County Board of Supervisors approved the recommendation and requested two additional components, one that recognized that clients often had multiple chronic medical conditions, the care for which was not well coordinated, the other that served as a focal point for pulling together all available non-medical long-term care services.

The result was a three-pronged strategy to integrate long-term care services into a comprehensive continuum of care:

1. **Health Plan Model.** Healthy San Diego Plus is a voluntary, fully-integrated medical managed care plan with capitated payment through Medi-Cal, and from Medicare, for clients who are eligible for both programs. This service delivery model is designed to provide a full continuum of health and social services based on San Diego’s existing Medi-Cal managed care plan.
2. **Physician Strategy to Improve Chronic Care.** Dubbed “Team San Diego,” this community health education strategy aims to train physicians and other care givers who see aged and disabled patients who are not enrolled in a Medi-Cal managed care plan. Often the physicians share patients with multiple chronic conditions, such as diabetes or heart disease, that are being treated separately. The program is designed to educate caregivers about their patients’ needs as well as the various services available to their patients that could improve their conditions. The program seeks to link caregivers around their patients’ needs to provide more coordinated care to multiple chronic conditions, in part by taking advantage of shared electronic medical records, and by educating patients about how

they can take a bigger role in creating care networks around themselves.

3. ***Aging and Disability Resource Connection (ADRC).*** The Aging and Disability Resource Connection is a single place for information about long-term care services and supports as well as access to long-term support programs and benefits. San Diego's ADRC consists of the county's Network of Care Web site, a call center staffed by trained specialists with access to client information and the authority to direct clients to services, and a partnership with the San Diego County Independent Living Center, Access to Independence. San Diego's ADRC is one of a handful of centers that have benefitted from the California Community Choices Project, the federal grant program to enhance home and community-based options. This component of the three-part strategy relies heavily on the consolidated Aging and Independence Services within the county's Health and Human Services Agency. This unit includes Adult Protective Services, Care Giver Support, In-Home Supportive Services, Mental Health, Nutrition and Veterans Services.

San Mateo. San Mateo was the first county to create an Aging and Adult Services Office in the late 1980s as part of its county health department. Since then, it has consolidated many of its long-term care services into this office. The county currently is working to expand and further integrate services through the Long-Term Supportive Services Project, which seeks to integrate and streamline funding for acute care and nursing facility services with funding for home and community-based services through a capitated payment contract, in which the state pays the county a set rate for each member each month, regardless of the number or amount of services the member needs. Rates are often adjusted for age, gender and location. Such a system transfers risk to the provider, which must manage services and costs across its membership base to remain below its overall contract amount. The county proposes to consolidate funding into a single capitated payment to the Health Plan of San Mateo, which is the county's organized health system and mandatory health plan for the county's Medi-Cal population. The Health Plan then would be responsible for managing a seamless continuum of health and social services provided to the eligible population.

The San Mateo Aging and Adult Services Office, which also serves as the county's Area Agency on Aging, includes the following home and community-based services:

- Information and referral.
- Adult Protective Services.

- Case management programs (Multipurpose Senior Services Program, Linkages, the Healthier Outcomes through Multidisciplinary Engagement Team for the management of frequent emergency department users, and the AIDS case management program).
- Family Caregiver Support Program.
- In-Home Supportive Services.
- Public Authority for In-Home Supportive Services.
- Representative Payee Services.
- Public Guardian Services.

In addition, San Mateo County received authorization via AB 786 in 2003 to serve as the pilot for the state in developing and implementing a Uniform Assessment Tool for home and community-based services to support an integrated model.⁷⁸ The goal of the assessment was to create and test a tool that integrated similar assessment elements across numerous programs within the Aging and Adult Services Division. The programs included in the pilot were Adult Protective Services, Healthier Outcomes through Multidisciplinary Engagement Team, In-Home Supportive Services, Linkages, Meals on Wheels, Multipurpose Senior Services Program and the Public Guardian program. In-Home Supportive Services, however, was pulled from the uniform assessment pilot due to state limitations that could not be resolved. Nevertheless, San Mateo County plans to continue and expand the use of the Uniform Assessment Tool.

Designing a Coordinated System

Drawing from the experiences of innovating counties and states, several components required for coordination emerge as essential building blocks. These include a single point-of-entry, uniform assessment, care coordination, virtual integration and more flexible funding for counties. Developing and disseminating these pieces is an important role for California’s Health and Human Services Agency, which can build on

Principles of a Long-Term Care Continuum

San Francisco Aging and Adult Services Department Director Anne Hinton identified the following principals on which their model of long-term care services is built:

1. ***Consumer-Centered.*** Services and support should be consumer-driven, person-centered and culturally sensitive.
2. ***Single Point-of-Entry.*** Consumers should enter the long-term care system through a single point-of-entry.
3. ***Flexible Continuum.*** Consumers should have access to a comprehensive package of long-term care services that changes as a consumer’s needs change.
4. ***Transitions.*** Transitions between services and care settings should be seamless.
5. ***Comprehensive Assessment.*** A package of long-term care services should be designed based on a comprehensive assessment that incorporates the consumer’s preferences.
6. ***Flexible Funding.*** Funding for services must be flexible to allow for the purchase of the goods or services needed by the consumer.
7. ***Comprehensive Services.*** The system should offer a full-range of services including information and assistance, evidence-based interventions, prevention services, home and community-based supports and services and linkages to and from institutional care.
8. ***Accountability.*** The system should provide clear lines of responsibility and oversight to ensure quality.
9. ***Adaptability.*** The system should be adaptable to change over time as needed.

Source: Anne Hinton, Executive Director, San Francisco Department of Aging and Adult Services. August 26, 2010. Written and oral testimony to the Commission.

them to enhance long-term care service delivery, management and availability of home and community-based services.

Single Entry Point

To eliminate consumer confusion that results from the multiple program “doors” that a person might stumble upon while searching for long-term care services, experts told the Commission that the state should establish a single point-of-entry that will allow access to all of the long-term care services available. A single entry point can reduce fragmentation, provide information about long-term care options and streamline access to services.

The California Community Choices project report, which analyzed ways to enhance home and community-based services, recommended creation of a single entry point where seniors and people with disabilities can access long-term care services. The report explained that a single entry point could provide information, referral, assistance, screening, nursing facility pre-admission screening and options counseling, assessment, care planning, service authorization, protective services, monitoring and reassessment.⁷⁹ The report goes on to describe how 24 states use single entry points (SEPs) to serve older adults:⁸⁰

All SEPs manage access to Medicaid-funded home and community-based services 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 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.⁸¹

Given the variability of possible single entry points and the framework of California's long-term care infrastructure, the following organizations could serve as a single entry point, according to the report:

- Entities that operate under the Aging and Disability Resource Connections program (created by the Community Choices project).
- Area Agencies on Aging and county-government based single entry points.
- Regional or county-based organizations via request for proposal by the state, which sets the requirements and expectations.
- Entities that stem from organizations that participate in the Money Follows the Person demonstration project.⁸²

Depending on the way the single entry point system is built, some or all of the above organizations could provide such a service. Key to implementation of a single point-of-entry will be a uniform assessment tool as well as the type of technology used at the single entry point.

Uniform Assessment

One tool that goes hand-in-hand with a single entry point would be a uniform assessment instrument that could gather all of the information needed from a client to access available services and be screened for eligibility. Such a tool has been the goal of many stakeholders in California for years but has been frustratingly difficult to put in place.

Currently, long-term care clients in California must be assessed separately for each service they seek, such as In-Home Supportive Services, Multi-purpose Senior Services Program, Adult Protective Services and nursing facility services, to name a few. Each of these assessments asks similar but not identical questions, and each was developed to determine eligibility for services that are specific to the program rather than to focus solely on the consumer's range of needs. Among the programs that require individual assessments, IHSS is the largest and most isolated program, and the fact that it is not incorporated into a broader long-term care assessment and coordinated-care approach is a significant problem.

IHSS uses a five-level “functional index” rating scale to determine how many hours of assistance a client is eligible to receive. While the elderly and people with severe disabilities in general receive the greatest number of hours from caregivers, the functional index rating scale does not gather information about health condition, so gives little information about which of the program’s 456,000 clients would likely end up in a skilled nursing facility in the absence of in-home care services. This detracts from the state’s ability to prioritize care when making budget cuts.

California can look to other states for examples of how to design a uniform assessment tool. A review of state assessment instruments by Rutgers Center for State Health Policy and the National Academy for State Health Policy found that while there is significant variability in how assessment instruments are used by other states, trends show that states are moving toward integrating as many components of the eligibility determination, assessment and care planning processes as possible.⁸³ Health experts who have compared state comprehensive assessments say that “a well-designed assessment instrument identifies the full range of a consumer’s service needs so that they can be addressed when possible, thus preventing or delaying the need for institutionalization.” Such assessments are an important part of providing more long-term care through home and community-based services than institutions. Generally, an assessment is deemed comprehensive when it covers the following six domains:

- Physical health.
- Mental health.
- Functioning.
- Social resources.
- Economic resources.
- Physical environment.⁸⁴

Attempts to develop a uniform assessment in California have generally failed, with the exception of San Mateo’s uniform assessment tool that was piloted successfully in 2009. Even in San Mateo, however, the IHSS program eventually was pulled out of the development of the comprehensive tool because of difficulty in getting state approval for making changes to the IHSS questions that were asked in the assessment.⁸⁵ Many of the flaws within the IHSS program – isolation from all other long-term care programs, duplicative assessment for long-term care services, and too much focus on program eligibility and number of service hours needed rather than the comprehensive needs of the consumer – could be eliminated or minimized by incorporating the

program into a broader and more coordinated long-term care assessment and care management scheme.

Creating a uniform assessment tool that incorporates all long-term care services in California will not be easy. It will require focused leadership, buy-in from departments and programs and creativity in designing a tool that could incorporate all of the different program requirements into a workable instrument. Other states have succeeded, Oregon with an 18-point service priority level rating system that proved invaluable when it came time to prioritize spending; Washington with a 49-page questionnaire that is the foundation of its care coordination system. Oregon's list of service priority levels is included in Appendix F of this report.

Some states developed their assessment tools in an automated, modular format that begins with a core set of questions that are asked of all clients, regardless of the program they seek. Those core questions then trigger only those assessment questions that are relevant based on the individual's initial answers.⁸⁶ This way, irrelevant questions automatically are skipped and the assessment continues on with only the pertinent information. Once an assessment tool is designed, California's long-term care leaders will need to obtain legislative approval of changes to be able to implement the tool.

Virtual Coordination

Coordination of services also is occurring through the creation of virtual "systems," which use technology to bridge gaps between siloed programs. One example from outside the long-term care realm is an information technology platform called One-e-App, a universal electronic application system that has been embraced in some counties to serve as a single point-of-entry for a range of local and state-administered health and social service programs such as Medi-Cal, Healthy Families, nutrition programs, the Child Health and Disability Program, and others. The software system provides a "front end" portal that looks to the client like a single assessment yet consolidates functions across health and social

Foundations Could Help Build, Fund a New Information Technology System

One-e-App, the information technology system that serves as a single point-of-entry application process for some county health and social services, originated as a project of the California HealthCare Foundation (CHCF).

In 1999, the foundation sought to automate enrollment in Medicaid and the State Children's Health Insurance Program through a Web-based program. In 2001, the CHCF licensed the system, called Health-e-App, to the State of California at no cost. California counties later partnered with the foundation and The California Endowment to expand the Health-e-App concept to create a single point-of-entry for a range of local and state-administered health and social service programs through a technology platform called One-e-App.

CHCF and The California Endowment established Social Interest Solutions (originally named The Center to Promote HealthCare Access, Inc.) in 2005 to manage the ongoing development and operations of these and other innovative technology solutions. A year later, Social Interest Solutions became an independent non-profit organization that now manages a portfolio of technology solutions to improve quality of life by connecting people to the services they need. It develops and implements innovative technology solutions in partnership with state, county and local agencies and with staff expertise in human services, technology and policy.

Source: Little Hoover Commission subcommittee meeting on service integration through technology. September 16, 2010. Sacramento, CA.

programs that otherwise would not have been integrated.

Through a “virtual consolidation,” technology could cull enrollment and assessment processes for multiple long-term care programs, giving at least the appearance of a system to the consumer or caretaker trying to negotiate the process. Such a system not only could bridge the access and assessment gap for consumers but could provide the state with more information to help it understand the system and make informed policy decisions.

A virtual consolidation, without state-level consolidation of programs, would not produce the benefits of global budgeting or state-level system-wide management, but from the client perspective, care coordination would be enhanced, and the state could gather more information about how clients use programs as well as their associated costs and outcomes. California needs to increase its routine data gathering and analysis, as well as its ability to easily pull together information across programs, if it is to be able to understand long-term care program utilization and costs as well as the demographics of long-term care clients.

Local Coordination

Ideally, the single entry point should be situated at the local level, within a county health and social services department or Area Agency on Aging. The state should be responsible for developing a system that supports a single entry point and uniform assessment, as well as the technology to facilitate both. The county should provide the direct assessments and care coordination that will be needed to complete the continuum.

To fulfill their role, counties need the resources and flexibility to design care systems that address local needs and conditions. Some counties have attempted to improve the delivery of long-term care locally, yet efforts to integrate services into a cohesive system of care are impeded by the state’s fragmented bureaucracy.

The state therefore needs to find ways to facilitate county innovation while also creating tools for those counties that are unable to move forward on their own. Federal, state, local, non-profit, community or individual assets must be aligned in order to provide the best care at the most economical cost.

The ultimate goal should be a county-based system in which local decision-makers design the most cost-effective continuum of care reflecting their communities’ specific needs. In order to achieve this, the state should design and support a comprehensive long-term care system that gives more flexibility and control to local jurisdictions. The state

should have the flexibility to step back where appropriate, allowing counties that have demonstrated their capacity to deliver services to take the lead. In such cases, the state's role would be to set the ground rules, provide resources, help them with needed waivers for federal or state rules, ensure that they develop performance standards, hold them to such standards, and learn and share best practices. In counties that lack similar capacity, the state's role would be more involved, providing incentives to use existing resources more efficiently and providing tools to help streamline and coordinate programs.

Governor Edmund G. Brown Jr. in January 2011 proposed realignment of some state and county roles and funding as a way to more efficiently and effectively provide services to Californians. The Governor's proposed 2011-12 budget included broad provisions for realignment of government services from the state back to the county, reversing three decades of consolidation at the state level. The Commission has long recognized the need for streamlined management and coordination of health care programs and has advocated for more flexibility and local control of government services for decades, with much of this work being synthesized into an agency-wide model in the Commission's 2004 report: *Real Lives, Real Reforms: Improving Health and Human Services*. This philosophy applies to long-term care programs as well. Whether or not realignment of long-term care programs materializes in the coming years, facilitation of county delivery of services must be part of the long-term care solution.

State Needs a Long-Term Care Champion

At the state level, responsibility for delivering California's long-term care services are shared by the directors of seven different departments, most of whom also have other large program areas for which they are responsible.

In other states, such as Oregon and Washington, reforms and restructurings that created models for integrated long-term care systems were initiated by leaders who had the authority and vision to consolidate programs at the state level, had a focus on long-term care and could take steps to implement their vision.

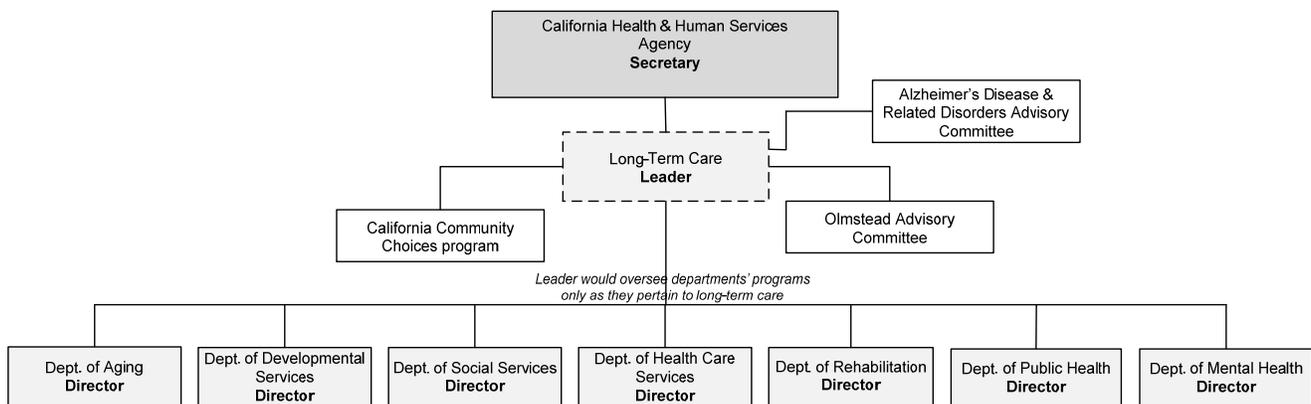
Former assistant secretary of Washington State's Aging and Adult Services Administration, Charles Reed, who led the state's consolidation of long-term care programs, told the Commission that the integration of Washington's system took 20 years, but that he and his predecessors accomplished system reform by taking on one issue at a time and having a champion to lead the way. Reform requires "one person who has the

priority to make the system work better for consumers,” Mr. Reed told the Commission.⁸⁷ Oregon’s system developed similarly, with one person providing leadership and pulling programs together, one after another.⁸⁸

California needs this kind of individual leadership to start the reform process. There must be a state long-term care official within the Health and Human Services Agency who has the vision and the authority to make decisions and provide direction to department heads, counties and the public to harness the state’s long-term care assets, as well as coordinate all efforts to manage and improve long-term care in California, and be held accountable for operations and outcomes. Given the absence of a separate long-term care department, the state must create a position for a long-term care champion who reports directly to the Health and Human Services Agency secretary and has the authority and autonomy to consult with and instruct department directors on long-term care issues, as indicated in the diagram below.

Focused leadership on long-term care should achieve a number of objectives. First, the leader should work with agency and department staff to regularly pool the available data on long-term care, identify strengths and weaknesses of the existing range of programs and begin to set priorities for improving long-term care in California. This will begin the process of centralizing information, management, action and accountability on long-term care issues and programs in the state. Further, it will provide the agency with a point person who can build relationships with stakeholders and Legislators to listen, educate and advocate for improvements in long-term care. The long-term care champion should regularly report to the Legislature on the status, progress, needs and future plans for advancing California’s long-term care programs.

Leader Should Coordinate Long-Term Care Programs



The long-term care leader also should focus on facilitating local efforts to improve or integrate long-term care programs and should serve as a liaison to counties in this endeavor. Effective leadership could help expand PACE programs in California, particularly in facilitating approval and administrative oversight of PACE initiatives. Focused leadership also would improve the state's ability to partner with non-profit and private organizations, June Simmons, President and CEO of Partners in Care Foundation and Chair of the California Community Choices Project Advisory Committee, told the Commission. Ms. Simmons said that leadership skills are critical in forming these kinds of collaborations.⁸⁹ A leader also must have the authority to develop the appropriate incentives to promote such partnerships.

Leader Should Create a Strategic Plan for Long-Term Care

A top priority for the state's long-term care leader should be developing a strategic plan that encompasses the roles of each of the state departments involved in long-term care. The process of developing a plan would help the long-term care leader establish a vision and communicate priorities. Sarah Steenhausen, former assistant secretary for long-term care in the Health and Human Services Agency, told the Commission that "while some individual departments have developed strategic plans, there is no system-wide, long-range strategic plan that would set priorities and maximize the use of limited resources."⁹⁰ Ms. Steenhausen said the 2003 Olmstead Plan included several recommendations for enhancing the state's home and community-based services in order to implement the goals of the *Olmstead* decision, but the plan lacked deliverable action items or timelines for implementation.

Building on Existing Frameworks

Important strategic planning work already has been completed by advisory groups on long-term care. Most prominent are the 2003 Olmstead Plan and subsequent Olmstead Advisory Committee efforts, as well as the California Community Choices project.

The Olmstead Plan endorsed the following principles:

- Self-determination by persons with disabilities about their own lives, including where they will live, must be the core value of all activities.
- 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.
- Support the integration of persons with disabilities into all aspects of community life persons with disabilities who 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 Community Choices project Advisory Committee follows a mission that says it is 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." The committee envisions that "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."

Source: Robert Mollica, National Academy for State Health Policy, and Leslie Hendrickson, Hendrickson Development. November 2009. "Home and Community-Based Long-Term Care: Recommendations to Improve Access for Californians." Pages 197-198.

“California needs a holistic strategic plan for long-term care.”

June Simmons, President and CEO of Partners in Care Foundation and Chair of the California Community Choices Project Advisory Committee.

The 2009 Community Choices report recommended developing a strategic plan that spanned departments and that incorporated information from the state’s 2003 Olmstead Plan and subsequent work by the Olmstead Advisory Committee. The plan, according to the report, should:

- Define goals for balancing the long-term care system.
- Expand home and community-based services 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 home and community-based services for individuals who are at risk of entering an institution.
- Improve the management of home and community-based services.⁹¹

Changes in Managed Care Important to Long-Term Care

It will be important for the long-term care leader to participate in the implementation of California’s Medicaid 1115 Waiver renewal, authorized in 2010. The Department of Health Care Services led the renewal efforts, which will expand the state’s Medi-Cal managed care system by requiring seniors and disabled Californians enrolled in Medi-Cal to sign up for Medi-Cal managed care plans where they exist, rather than fee-for-service Medi-Cal. State leaders expect the program expansion will have a positive impact on the coordination of care for long-term care clients. As part of the waiver, the state is initiating a demonstration project that bundles funds for all of a client’s health and social care into one capitated payment to a managed-care provider, to create the incentives for the provider to find the most cost-effective approach to keeping a client living healthy at home. The state is working with CalOptima, a Medi-Cal managed care provider in Orange County that has a history of providing non-medical services for members, such as grab bars and wheelchair ramps, as part of a broader strategy to lower the use of medical services by its members.

Long-Term Care Consolidation Still Needed

As noted above, the state can make great strides in helping counties coordinate care, create single points of entry and build uniform assessment tools that can be used throughout the state, short of a consolidation of long-term care programs at the state level. Experts, however, told the Commission that the state will not be able to effectively plan and manage its current array of programs, or meet the challenges

posed by a fast-growing senior population without unifying budget and oversight under one management structure.

The Expert Panel to Review California Department of Aging Structure, convened by Assemblywoman Patty Berg, chair of the Assembly Committee on Aging and Long-Term Care, issued a report in 2004 that called for increased coordination of services and a single administrative entity at the state level. The panel concluded that reliance upon improved coordination of long-term care programs would not be sufficient; structural changes are needed at the state level as well as political change at the legislative level.⁹²

A system redesign will not be easy. Viewed from both the top and the bottom, California's long-term care programs are scattered and confusing to navigate, the disarray is reinforced by separate funding streams, program location, gaps in available services and the lack of an identifiable state long-term care leader. The current system is a result of decades of program growth within the existing siloed state structure. Reorganizing such a complex system should be conducted through a deliberative process, with the involvement of appropriate stakeholders who share the goal of designing a system that is best for California overall. Participating stakeholders must be committed to creating a structure that works for everyone.

The driving reason for consolidation of long-term care programs under one leader is to centralize budgeting authority, a starting point for better management as well as greater accountability. A unified or global budget consolidates funding into a single appropriation so that funds may be spent on home and community-based services, residential care or institutional care.⁹³ It can promote a more balanced and cost-effective long-term care system by pooling financing, establishing a cap on total spending and providing the freedom to manage costs within the system, notwithstanding the difficulty in creating a budget that includes both entitlement programs as well as optional programs.⁹⁴ Washington state's former long-term care leader Charles Reed told the Commission that global budgeting is what allows true system reform to occur as it gives the state the

Washington State's Consolidation

While Washington incorporated system coordination and new technology as discussed previously, it also consolidated its long-term care programs into one department starting in 1986 and continuing on for the next 20 years. This consolidation meant that, for the first time, one administrative entity was responsible for the full array of services available to meet long-term care needs, including in-home services, community residential services and nursing home care. In subsequent years, the administration was able to roll out a strategic plan for long-term care and additional assisted-living options, as well as provide relocation assistance to nursing home residents as a way to absorb budget cuts in the early 1990s. By 2002, the consolidation resulted in a comprehensive Aging and Disability Services Administration, which is where all of Washington's long-term care services – and the money to pay for them through a consolidated “global budget” – reside.

An organizational chart showing Washington State's consolidated structure of long-term care programs in one division is included as Appendix G of this report, alongside a comparable depiction of California's structure that shows the seven separate departments with long-term care programs.

In comparing the two structures, and in light of the problems that have been identified in California's system, it becomes clear that what is missing in California's system is both a central leader for long-term care, as well as an effective grouping of long-term care services into one department.

Source: Aging and Disability Services Administration, Department of Social and Health Services. “The History of Long Term Care Balancing in Washington State 1981-2005.”

Goals and Responsibilities of a New, Consolidated Entity

In thinking about a new organizational structure for California's long-term care programs, an expert panel convened by Patty Berg in 2004 said the new state-level entity should serve both older adults and younger disabled persons and should achieve the following goals:

1. Create a system that is more responsive to the holistic needs of the consumer.
2. Ensure that providers have a single authority that sets standards that are consistent from program to program.
3. Allows policy makers to better review program costs and operations.

The panel further suggested that the following functions would be the responsibility of the new organization:

1. Procurement of services at the local level.
2. Adoption of a common (uniform) assessment process.
3. Implementation of a scoring system that results in delivery of a specified level of services at specified rates.
4. Accountability/performance review.
5. Certification standards for case managers.
6. Dissemination and adoption of best practices.
7. Providing technical assistance to local providers.
8. Strategic planning and program development.
9. Marketing of services to consumers.
10. Fulfill the Older Americans Act State Unit on Aging fiscal responsibilities, including auditing.

Source: Expert Panel to Review California Department of Aging Structure. September 2004. "Planning for an Aging Population. Restructuring the California Department of Aging and Long-Term Care Services in California." Page 11.

macro-level ability to move funds from one program to another based on utilization patterns and emerging needs, as well as the micro-level authority to match care to an individual's needs.⁹⁵

A consolidated structure also facilitates data collection that helps policy-makers and program administrators understand consumer needs, service utilization and trends – all of which are essential when making budget decisions about which programs or recipients to cut. Currently, California departments are often reluctant to share data with another department, which makes it difficult to collect information that will help policy-makers understand the state's existing distribution of services and resources. The structure must allow for comprehensive data collection across all long-term care programs in order to give the state a comprehensive understanding of the system as a whole.

Developing a Consolidated Organizational Structure

Considerable work has been done to conceptualize how long-term care programs could be consolidated. The 2004 Assembly effort led by then-Assemblywoman Patty Berg offered two suggested models: A corporate or quasi-governmental structure and a traditional department structure.

- **Quasi-Governmental Model.** This approach would create an independent entity led by a board of directors appointed by the Governor and Legislature, whose budget would be approved by the Governor and Legislature. The board would hire an executive director and oversee organizational performance. A separate advisory body would provide citizen input and oversight.⁹⁶
- **Traditional Department Structure.** This approach would consolidate all aging and long-term care services into one department under the Health and Human Services Agency, similar to the proposal developed in response to the California

Structure Proposed by California Health and Human Services Agency Workgroup

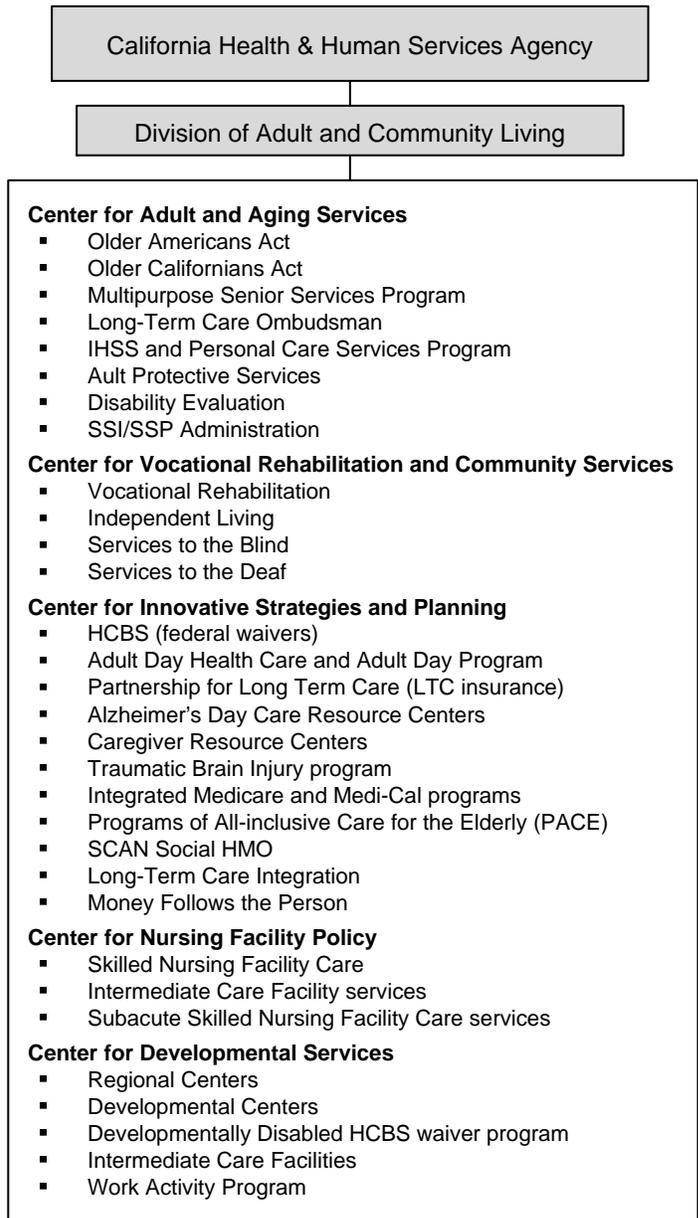
Performance Review. The new department would provide “overall strategic coordination function for all current programs as well as responsibility for policy development, development of best practices models for service delivery, technical assistance, legal, budget development, resource allocation and quality improvement.”⁹⁷

A visual representation of each of the proposed models is included as Appendix H.

Two proposals from the Schwarzenegger administration also were produced in 2004. Governor Schwarzenegger’s California Performance Review (CPR) suggested reorganizing the Health and Human Services Agency to reduce duplication of services throughout the departments and to better streamline operations.

In response, Health and Human Services Agency Secretary Kim Belshé convened a workgroup to analyze the CPR recommendations in view of how it would affect long-term care programs. The workgroup reported that the proposed CPR reorganization would offer “no real enhancement in coordination and integration than what exists with the state’s current organizational structure” and that “in some cases, the CPR recommended changes may result in lost opportunities.”

The workgroup instead suggested its own organizational structure to improve the state’s administration of long-term care. The workgroup’s proposed Division for Adult and Community Living would have responsibility for policy development, budgeting and program and system planning for home, community and institutional long-term care programs, and it would include everything from IHSS administration and policy to nursing facility care, policy and budgeting – a consolidated structure similar to Washington state’s model framework. The white paper from this work group is included as Appendix D.



Ultimately, the long-term care leader should direct the process of planning and consolidating long-term care programs, building on the work of the above reform efforts and incorporating the numerous long-term care assets in California.

A New System for a New Era

California's long-term care system has failed to evolve with the changing realities of providing long-term care in the United States. To manage the challenge presented by the swelling number of the retiring Baby Boom generation who require long-term care services, California's collection of programs must be redesigned to blend medical and social services and facilitate the goal of keeping people out of institutions and in their own homes. California has many established long-term care assets, such as the In-Home Supportive Services program, county efforts to integrate service delivery and promising new projects to improve transitions from institution to home and better streamline consumer information about long-term care services. The state also is working with Medi-Cal managed care to incorporate long-term care services within the managed care framework, and new federal health care reform measures bring another layer of opportunities to advance home and community-based services. These are assets and opportunities that must be leveraged by effective and focused leadership to ensure that California can serve its most vulnerable populations despite budget reductions that likely will continue into the next several years.

Coordinating care around the client must be the driving goal of any attempt to improve the long-term care system. Better knowing the client's needs and condition can help ensure that a person receives the right care, at the right time and in the right place. Done well, the state has the potential to avoid costs while enhancing consumer choice, quality of care and quality of life. To achieve this, the system must be equipped with these essential tools: a single point-of-entry, uniform assessment and case management, data collection and management and technology that can bridge siloed programs.

While care coordination could be enhanced superficially through the use of technology – a virtual consolidation of sorts – an actual state-level structural consolidation would go farther to reduce state program administration and provide the global budgeting necessary for optimal coordination, accountability and efficiency. It also would provide the best conditions for extending more flexibility and control to local jurisdictions to deliver services along a true continuum of long-term care.

Recommendation 1: California needs a streamlined and consolidated organizational structure at the state level.

- ❑ The Governor and Legislature should consolidate all long-term care programs and funding into a single long-term care entity within the Health and Human Services Agency, led by a long-term care leader reporting directly to the Agency Secretary.
- ❑ The long-term care department should retain state-level global budget authority for all long-term care programs and services.
- ❑ The long-term care department should serve as the single point of state-level contact to provide leadership to local jurisdictions in sharing and encouraging best practices and to ensure oversight of locally-delivered long-term care services.

Recommendation 2: California must develop a strategy for how to create a seamless continuum of long-term care services.

- ❑ The long-term care leader should lead the creation of a vision and strategy for the future of long-term care in California.
- ❑ The strategy should incorporate information gathered in the California Community Choices project data warehouse study, the California Medicaid Research Institute/SCAN Foundation study, and other data as it becomes available in order to understand the state's current long-term care programs, determine how to move forward and measure the results of future actions.
- ❑ The visioning and strategy-building process must include stakeholders.
- ❑ The vision should design a continuum of care that wraps around the individual senior or person with disabilities, gives local jurisdictions the flexibility needed to provide the right care in the right place at the right time, holds these jurisdictions accountable for results and fosters a culture that regards seniors and people with disabilities as community assets.
- ❑ The strategy should list specific actions that will be taken to achieve the vision.

Recommendation 3: California needs a champion to lead development of a coordinated continuum of long-term care services for seniors and people with disabilities.

- ❑ The long-term care leader must have the authority and expertise to pull together long-term care data and programs from multiple state departments, initiate better coordination, create the conditions for greater innovation and facilitate integration of long-term care programs at the local level.

- ❑ The long-term care leader should annually report to the legislative policy committees about the current status of long-term care in California, the level of state spending across long-term care programs, the progress of improving the continuum of services, and the next steps that must be taken to continue to enhance the coordination and delivery of services.
- ❑ The state Health and Human Services Agency should develop the following tools to create a seamless and coordinated continuum of long-term care services:
 - ✓ A single and uniform assessment tool to better manage a client's long-term care needs across programs over time.
 - ✓ Information technology that enables the integration of services virtually, facilitates consumer case management, collects data and provides information to the county and the state to allow for effective management of the system.
- ❑ Local jurisdictions must become the single point-of-entry for long-term care services and should have the flexibility to assess needs, coordinate care, connect clients to the services they need and for which they qualify, and be able to help clients transition from program to program as needed.
- ❑ The state should provide local jurisdictions the right incentives, flexible funding and program support needed to ensure that local jurisdictions have the framework and resources needed to meet client needs.

Conclusion

As more Californians reach retirement age in the coming years, lifestyles will change and, with them, people's needs, particularly their needs for assistance and support. This assistance may take the form of help with a few household tasks, such as housecleaning and cooking, that will allow seniors to remain safe and healthy in their own home or, at the other end of the continuum, nursing home care from skilled care-givers.

Currently, California's array of long-term care programs and services for its low-income elderly and disabled is fragmented. Programs and funding streams are not coordinated at the state level, complicating efforts of local government leaders to integrate their systems to best meet their clients' needs in the most cost-effective way. This fragmentation also inhibits the state's ability to spot trends in enrollment and costs that could be better managed through an integrated system that provides greater program options.

In its work over the years, the Commission has found that local government often is best positioned to deliver services, and regularly has produced innovations that can be replicated elsewhere. Local governments need flexibility and a stable source of funding, and in return, should be held accountable for producing agreed-upon outcomes in serving the people of their communities. But this requires the support and assistance of state leaders, and a shared vision of priorities, the willingness to create flexibility and the commitment to get various state departments to work together as part of an integrated strategy. The state's lack of an integrated strategy makes it difficult for local governments to create what should appear to clients as a seamless continuum of care services.

Duplication of assessments and overlap of programs create inefficiencies the state cannot afford, while gaps in services can lead people to seek care in settings that are far more expensive than required.

The emphasis for delivering long-term care services must shift from the current unfocused piecemeal approach and toward a comprehensive, strategically managed approach. The state must develop a vision for a continuum of long-term care services that puts clients at the center,

learning more about the clients to better serve them and learning more about outcomes to better manage the resources available.

People seeking help need to be assessed for the full range of available programs for which they are qualified. The state needs information from this assessment to determine a client's needs and condition, both for care management and for program management. Clients, or their care givers, need to be able to go to a central location for help, where they can be assessed and where they can learn about their options. These options must be part of a broad strategy to keep low income seniors and disabled Californians in their home or appropriate community-based settings.

The single point of entry to long-term care services must be at the local level. Local service providers must have the flexibility to build care delivery systems that meet their local conditions. They must have the ability to assess individual client needs, coordinate care and connect clients to the services they need.

To make this happen, California needs a champion at the state level to lead development of a coordinated continuum of long-term care programs and services. This leader should build on the work and the progress that has been made through numerous efforts to enhance home and community-based services, such as the California Community Choices project, the Money-Follows-the-Person/California Community Transitions program and studies regarding long-term care data.

The long-term care leader must have the ability to pull data from multiple state departments to be able to build a complete and accurate picture of what services are available and being used, how much programs and services cost and which are most effective at keeping people safe and healthy. Policy-makers must see the system as a whole, and be able to gauge how cuts or changes in one program will effect another program, being able to estimate, for example, whether cutting or changing criteria for In-Home Support Services or adult day health care will drive up use of skilled nursing care.

In this report, the Commission concludes that if counties are to be successful at the local level, change at the state level is essential. First, however, state leaders must develop a vision for a long-term care continuum, establish a leader in state government who can act as a long-term care champion, and develop a strategy to create a seamless continuum of services that supports the changing needs of Californians. Ultimately, the state should consolidate programs and services at the state level into a single long-term care department to create a single point of contact and accountability and better align all of the various state long-term care programs.

Appendices & Notes

- ✓ *Public Hearing Witnesses*
- ✓ *Little Hoover Commission Public Meetings*
- ✓ *California's Olmstead Plan*
- ✓ *White Paper by CHHSA Aging and Long-Term Care Workgroup*
 - ✓ *SCAN Foundation Policy Brief No. 2*
 - ✓ *Oregon Department of Human Services Seniors and People with Disabilities Division Service Priority Levels*
- ✓ *Organizational Chart Comparison, Washington and California*
 - ✓ *Organizational Charts for Proposed Consolidation Models*
 - ✓ *In-Home Supportive Services Program Reforms*
 - ✓ *Notes*

Appendix A

Public Hearing Witnesses

Public Hearing on Long-term Care March 25, 2010

Lynn Daucher, Director, California Department of Aging

Lisa Shugarman, Director of Policy, The SCAN Foundation

Leslie Hendrickson, Principal, Hendrickson Development

Sarah Steenhausen, Senior Policy Fellow, The SCAN Foundation

Megan Juring, Assistant Secretary for Program and Fiscal Affairs, California Health and Human Services Agency

Public Hearing on Long-term Care May 27, 2010

Eric Carlson, Directing Attorney, National Senior Citizens Law Center

David Maxwell-Jolly, Director, Department of Health Care Services

Stephen Kaye, Associate Professor, Department of Social and Behavioral Sciences and Institute for Health and Aging, U.C. San Francisco; Co-Principal Investigator, National Center for Personal Assistance Services

Brenda Premo, Chair, Olmstead Advisory Committee and Director, Western University's Center for Disability Issues and the Health Professions

Mitchell LaPlante, Professor, Department of Social and Behavioral Sciences and Institute for Health and Aging, U.C. San Francisco; Co-Principal Investigator, National Center for Personal Assistance Services

***Public Hearing on Long-term Care
August 26, 2010***

Anne Hinton, Executive Director, San Francisco Department of Aging and Adult Services

Lisa Shugarman, Director of Policy, The SCAN Foundation

Gary Passmore, Director, Congress of California Seniors

June Simmons, President and Chief Executive Officer, Partners in Care Foundation

Charles Reed, Consultant, Reed Associates; former Assistant Secretary, Washington State Aging and Adult Services Administration

Appendix B

Little Hoover Commission Public Meetings

*On Lok William L. Gee Center Site Visit – July 7, 2010
San Francisco, California*

Eileen Kunz, Director of Policy and
Government Relations, On Lok

Amy Shin, Chief Administrative Officer, On Lok

Dr. Cheryl Phillips, Chief Medical Officer, On
Lok

Sue Wong, Chief Financial Officer, On Lok

Allison Ruff, Consultant, Assembly Committee
on Aging and Long-Term Care

Robert Edmondson, Executive Director/Chief
Executive Officer, On Lok

**Advisory Committee Meeting – August 25, 2010
Sacramento, California**

Jovan Agee, Political and Legislative Director,
United Domestic Workers Homecare Providers
Union/AFSCME

Ginni Bella, Senior Fiscal and Policy Analyst,
Legislative Analyst's Office

Pete Cervinka, Program Deputy Director for
Benefits and Services, California Department of
Social Services

Deborah Doctor, Legislative Advocate,
Disability Rights California

Michael Estrada, Chief of Investigations,
Department of Health Care Services

Lori Greene, Assistant Chief Deputy District
Attorney, Sacramento County District
Attorney's Office

Robert Harris, SEIU California

Sawait Hezchias, SEIU-ULTCW

Karen Keeslar, Executive Director, California
Association of Public Authorities for IHSS

Jackie McGrath, State Public Policy Director,
Alzheimer's Association

Frank Mecca, Executive Director, County
Welfare Directors Association

Francie Newfield, Director, Adult and Long-
Term Care Services, Santa Cruz County

Bob O'Neill, Deputy Director of Audits and
Investigations, Department of Health Care
Services

Gary Passmore, Director, Congress of
California Seniors

Brenda Premo, Director, Western University
Center for Disability Issues and the Health
Profession

Nancy Reagan, Director of Legislative Affairs,
California Association of Health Facilities

Michael Schumacher, Investigative Auditor
Supervisor, California Department of Justice

Patrick Sequeira, Assistant Head of Public
Assistance Fraud Unit, Los Angeles District
Attorney's Office

Greg Thompson, Executive Director, Los
Angeles Personal Assistance Services Council

Mary Tinker, Executive Director, Santa Clara
Public Authority

Laura West, Deputy District Attorney,
Sacramento County District Attorney's Office

Janie Whiteford, President Emeritus, California
IHSS Consumer Alliance

Meredith Wurden, Fiscal and Policy Analyst,
Legislative Analyst's Office

Casey Young, Senior Legislative
Representative, AARP

**Subcommittee Meeting – September 16, 2010
Sacramento, California**

Monisha Avery, Federal Legislative Coordinator, California Department of Social Services	Ashok Rout, Solutions Manager, Social Interest Solutions
Ginni Bella, Senior Fiscal and Policy Analyst, Legislative Analyst's Office	Lucy Streett, Senior Policy Manager, Social Interest Solutions
Megan Juring, Assistant Secretary, California Health and Human Services Agency	Greg Thompson, Executive Director, Los Angeles Personal Assistance Services Council
Claudia Page, Director, Social Interest Solutions	Bobbie Wilbur, Director of Application Solutions, Social Interest Solutions

**Site Visit and Subcommittee Meeting – October 7, 2010
San Diego, California**

Kristina Bass-Hamilton, budget and policy analyst, United Domestic Workers	Ellen Schmeding, assistant deputy director, Aging & Independent Services
Sharon Cordice, program manager, call center; ombudsman, home & community-based care, Aging & Independent Services	Brenda Schmitthenner, aging program administrator, Aging & Independent Services
Joe Diaz, regional director, California Association of Health Facilities	Pam Smith, director, Aging & Independent Services
Mimi Khalili, regional political coordinator, United Domestic Workers	Keyla Whitenhill, policy analyst, SCAN Foundation
Taryn Nader, project manager, CalOptima	

**Advisory Committee Meeting – November 3, 2010
Sacramento, California**

Gene Acevedo, Director of Community Outreach, Hospice of San Joaquin	Margery Minney, Executive Director, Valley Caregiver Resource Center
Lauren Beyeler, Chief Financial Officer, Desert Oasis Healthcare	Michelle Nevins, Executive Director, Del Oro Caregiver Resource Center
Patricia Blaisdell, Vice President of Post-acute Care Services, California Hospital Association	Gary Passmore, Director, Congress of California Seniors
Diana Boyer, Senior Policy Analyst, County Welfare Director's Association	Nancy Powers-Stone, Director, Redwood Caregiver Resource Center
Gretchen Brickson, Director of Technical Assistance, On Lok PACEpartners	Mickey Richie, Senior Analyst, Regional Council of Rural Counties
Tom Dey, Director of Public & Government Affairs, SCAN Health Plan	Allison Ruff, Chief Consultant, California Assembly Committee on Aging and Long-term Care
Sandra Fitzpatrick, Executive Director, California Commission on Aging	Carol Sewell, Program Analyst on Aging, California Commission on Aging
Jennifer Gabales, Policy Advocate, California Association for Adult Day Services	Havard Staggs, Vice Chair, California Commission on Aging and Past President, Area Agency on Aging Council of California
Angelica Gonzalez, Government Affairs Analyst, UC Davis Health System/Betty Irene Moore School of Nursing	Sarah Steenhausen, Senior Policy Advisor, The SCAN Foundation
Heather Harrison, Vice President, California Assisted Living Association	Barbara Swanson, Executive Director, Area 2 Agency on Aging
Joyce Hayes, Executive Director, Humboldt Senior Resource Center	Jean Turner, Director, Inyo County Health & Human Services/ Inyo Mono Area 16 Agency on Aging
Janet Heath, President, MSSP Site Association	Renee Vis, PACE Expansion Specialist, On Lok
Deborah Johnston, Long-Term Care Ombudsman Program, Area 29 Agency on Aging	Peggy Wheeler, Vice President of Rural Health Care, California Hospital Association
Derrell Kelch, Executive Director, California Association of Area Agencies on Aging	Sandra Willburn, Chief, State Office of Rural Health, California Department of Health Care Services
Ninon McCullough, Program Manager, Humboldt County Department of Health & Human Services	

***Subcommittee Meeting – November 10, 2010
San Mateo, California***

Maya Altman, Chief Executive Officer, Health
Plan of San Mateo

Susan Joseph, Medical Director, Ron Robinson
Senior Care Center

Jean Fraser, Chief, San Mateo County Health
System

Lisa Mancini, Director, Aging and Adult
Services Office

Appendix C

California's Olmstead Plan

The 2003 Olmstead Plan outlines the following policy goals:

1. **State Commitment.** State rules, regulations and laws are consistent with *Olmstead*.
2. **Data.** Improve information and data collection systems.
3. **Comprehensive Service Coordination.** Implement a comprehensive service coordination system that will improve the long-term care system.
4. **Assessment.** Provide timely assessments for persons in and out of institutions to determine supports and services needed to either remain in or return to the community.
5. **Diversion.** Divert individuals from entering institutions and ensure that they are served in the most integrated setting appropriate.
6. **Transition.** Transition individuals from institutions to the most integrated setting appropriate.
7. **Community Service Capacity.** Develop a full array of community services so that individuals can live in the community and avoid unnecessary institutionalization, including participating in community activities, developing social relationships, and managing his or her personal life by exercising personal decisions related to, among other things, housing, health care, transportation, financial services, religious and cultural involvement, recreation and leisure activities, education and employment. Services should be appropriate to individuals living with and without family or other informal caregivers, and family caregivers should be supported.
8. **Housing.** Expand the availability of housing options for persons with disabilities and ensure options that facilitate the full inclusion of the person into the community.
9. **"Money Follows the Individual" and Other Funding.** Develop a "Money Follows the Individual" model to provide resources for individuals to live in the community rather than an institution. Seek opportunities to increase resources and funding options.
10. **Consumer Information.** Provide comprehensive information regarding services to persons with disabilities in order to make informed choices and for service planners for planning purposes.
11. **Community Awareness.** Educate communities regarding the *Olmstead* decision, the Americans with Disabilities Act, the Fair Housing Amendments Act, and other related federal and state laws so that community planning can address the needs of the disabled.
12. **Quality Assurance.** Continually improve the quality of services based on desirable outcomes and measures and increase the level of consumer satisfaction.

Source: California Health and Human Services Agency. May 2003. "California Olmstead Plan."

Appendix D

**White Paper by CHHSA Aging and Long-Term Care Workgroup
October 5, 2004**

WHITE PAPER

The California Performance Review

and

**State-Level Organization of Home, Community and Institutional
Programs**

Serving Disabled and Older Adults

**CHHSA Aging and Long-Term Care Workgroup
October 5, 2004**

I. Introduction

This White Paper considers the merits of the state-level restructuring recommendations of the California Performance Review (CPR) as they would affect the organization of home, community and institutional programs and services for disabled and older adult populations. Toward this end, this paper includes several sections. The CPR restructuring proposal as it would affect these programs and services is briefly outlined in Section II. In Section III, the larger policy context for consideration of a state level restructuring of these programs and services is presented. This section also considers the limitations of the state's current organization for these programs and services. Using the criteria requested by the California Health and Human Services Agency, Section IV considers the merits of the CPR proposal and its potential for improving the effectiveness of these programs and services in serving their diverse client populations. Finally, Section V presents guiding principles for improving upon the CPR proposal and includes a proposed alternative organizational structure for consideration.

This White Paper was developed through collaboration between the Aging and Long-Term Care Workgroup and the Disabled Services Workgroup, which were established by the California Health and Human Services Agency, among other workgroups, to review and consider the CPR proposals. It distills the issues, considerations and recommendations that have, to date, been offered by a variety of state department representatives and other interested parties.

II. California Performance Review (CPR) Reorganization Proposal and Services to Disabled and Older Adult Populations

The California Performance Review (CPR) proposes a new state-level organizational framework for the California Health and Human Services Agency (CHHSA). Under this new framework, CHHSA would be renamed the California Health and Human Services Department and the new department would oversee six (6) divisions. The organization of home, community and institutional services for disabled and older adult populations would span five divisions of the new department:

Services to Disabled Division

- State Council on Developmental Disabilities
- Regional Centers for the Developmentally Disabled
- Developmental Centers
- Developmentally Disabled home and community-based waiver program
- Work Activity Program
- Independent Living Centers
- Services to the Blind
- Services to the Deaf

Social Services Division

- Services to the Aging
 - Older American's Act
 - Older Californian's Act
 - Multipurpose Senior Services Program*
 - LTC Ombudsman Program
- SSI/SSP Administration
- Disability Evaluation
- Adult Protective Services
- Cash Assistance Program for Immigrants
- California Veterans Cash Benefits Program

Health Purchasing Division

- Skilled Nursing Facility Care (Medi-Cal)
- Intermediate Care Facility services (Medi-Cal)
- Subacute Skilled Nursing Facility Care services (Medi-Cal)
- In-Home Supportive Services and Personal Care Services (Medi-Cal)
- Home and Community Based Services federal waivers:
 - In-Home Medical Care
 - Nursing Facility, Level A/B
 - Nursing Facility Subacute Level
- Adult Day Health Care (Medi-Cal)
- Targeted Case Management (Medi-Cal)
- Medical Case Management (Medi-Cal)
- Partnership for Long Term Care (LTC insurance)
- DHS Long Term Care Policy*
- Integrated Medicare and Medi-Cal programs*
- Programs of All-inclusive Care for the Elderly (PACE)*
- Senior Care Action Network (SCAN Social HMO)*
- Long Term Care Integration*
- Money Follows the Person federal grant*

*Assumed location; CPR proposal does not clearly specify.

Behavioral Health Division

- Community Mental Health Programs
 - Short-Doyle/Medi-Cal program
 - Adult Integrated Service program
 - AIDS Mental Health program
 - Caregiver Resource Centers
 - Traumatic Brain Injury program
 - Community Mental Health Services
 - PATH program for the homeless

Public Health Division

- AIDS Wavier (Office of AIDS)

III. Policy Context for Organizational Restructuring

In reviewing the organizational structure proposed by CPR as it may affect programs and services for disabled and older adult populations, it is important to frame the larger policy context. This context is shaped by three major considerations: 1) California's history of restructuring proposals; 2) the Olmstead decision; and, 3) an assessment of the limitations of California's current organization of programs and services for disabled and older adult populations. These matters are briefly presented below.

A. Previous Restructuring Proposals for Services to Disabled and Older Adult Populations

The state's organizational structure of programs and services for disabled and older adult populations has been the subject of discussion for more than two decades. The underlying basis for this discussion has been a collective agreement among many decision-makers and stakeholders that the state's approach is fragmented and does not effectively serve California's diverse clientele seeking home and community-based long-term care services. Accordingly, a variety of organizational proposals have been introduced in the past which were intended to result in improved client service delivery, improved client outcomes, and a more cost-effective utilization of resources.

Previous restructuring proposals that have been offered include, but are not limited to:

- California Competes (Wilson Administration, 1996)
- California Health and Human Services Agency Report on Long-Term Care Programs and Options for Integration (AB 1215/Mazzoni, 1999)
- California Health and Human Services Agency California Olmstead Plan (2003)
- Consolidation of the California Department of Aging and the California Department of Social Services (Legislative Analyst, FY 2003-04 Budget Analysis)
- AB 784 (Assemblemember Daucher, 2003-04 Legislative Session)

B. Olmstead v. L.C.

In 1999, the Supreme Court decided in *Olmstead v. L.C.* that states are obliged by the Americans with Disabilities Act to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when:

- The state's treatment professionals have determined that community placement is appropriate;
- The individual does not object to community placement; and

- The placement can be reasonably accommodated, taking in to account the resources available to the state and the needs of others with disabilities.

The court's decision has significant implications for the federal and state governments in how they fund and administer disability and aging services. Following the court ruling, the Center for Medicare and Medicaid (CMS) took the following actions:

- Issued a series of Medicaid Director Letters discussing the implications of *Olmstead*; providing some additional flexibility to support institutional transition; and encouraging states to develop *Olmstead* plans and engage persons with disabilities in all stages of their plan's development and implementation.
- Internally developed organizational linkage between the Medicare program (which serves older adults and some younger persons with disabilities) and the Medicaid program (which serves low income persons) and established an office to work across these major systems and foster home and community-based options.
- Funded grants to states to conduct *Olmstead* related activities aimed at overall systems change, including efforts through Medicaid to fund more home and community-based supports, increase the quality of those supports; and redesign those programs to include a client-directed philosophy.

Through these efforts, CMS has sought overall system wide state improvements that create:

- Strategies for transitioning persons residing in institutions back into the community and diverting persons with significant disabilities into home and community based supports;
- Interventions that affect not just one population (e.g., the developmentally disabled) but multiple disability subgroups; and,
- A "Money Following the Person" approach--a "system of flexible financing for LTC services that enables available funds to move with the individual to the most appropriate and preferred setting as the individual's needs and preferences change.

While acknowledging that the state's budget crisis limited the immediate action that could be taken, in 2003 the California Health and Human Services Agency released the state's first *Olmstead* Plan. This plan identifies 12 major areas to be addressed: state commitment, data, comprehensive service coordination, assessment, diversion (from institutional placement), transition (from institutions), community service capacity, housing, "Money Follows the Person" and other new funding options, consumer information, community awareness, and quality assurance.

C. Limitations of State's Current Organizational Structure

The CPR reorganization proposal is intended to improve the effectiveness of state government through restructuring. To assess its potential merit, it is important to first assess the limitations of the state's current organizational structure for the delivery of services to disabled and older adult populations. In conducting this type of assessment, it is possible to draw upon many of the same criteria the CHHSA has requested be used in assessing the CPR restructuring proposal itself (see Attachment 1).

1. What are current barriers to improving client service delivery and client outcomes?
2. What are the current barriers to coordination and integration of policy and programs?
3. Where do program and/or service duplications currently exist?
4. What are the current barriers to accountability at the local service delivery level and state level?
5. What opportunities exist to save or better use existing resources?
6. What impacts does the current organization of services have on other levels of government?

Limitations of the state's current organizational structure for delivery of services to disabled and older adult populations are briefly outlined below.

1. What are current barriers to improving client service delivery and client outcomes?
 - Current system reinforces institutional placement
 - Current system encourages cost-shifting
 - Eligibility requirements and processes vary widely across programs
 - Reimbursement rates hamper provider participation
 - Availability of programs varies by region
 - Federal financial participation requirements and state licensing requirements limit innovation
 - Lack of comprehensive information restricts service utilization and results in a duplication of client assessments
 - Absence of care planning results in service fragmentation
 - System does not provide a coordinated response to client needs
2. What are the current barriers to coordination and integration of policy and programs?
 - There is no overarching leadership structure that has responsibility for policy development, budget development, and program and system planning for home and community-based long-term care programs. As a result:

- No overarching structure promotes program coordination and holds programs accountable for improved client outcomes.
 - Individual departments and programs focus their limited resources on their programmatic responsibilities for their defined population groups. The emphasis on discrete silos of programs and services hinders service coordination and, when appropriate, service consolidation.
 - No mechanism is in place to promote comprehensive planning for a coordinated system of long-term care programs and services for all affected populations.
 - Points of entry into the local service delivery system for publicly funded programs are not coordinated.
 - No common client assessment instrument or process is utilized across programs, which results in a duplication of efforts and service fragmentation.
 - There is no coordinated data collection across programs, no organized data system across programs and very limited ability to share data across programs.
- Federal financial participation requirements and state licensing requirements often limit options.
 - Funding and resource levels vary widely between programs and are inconsistent across non-institutional programs.
 - Communication and coordination between programs is complicated by differing philosophical approaches to care.
 - Payer sources vary across programs.
 - Limits on program services vary widely by program, hampering service coordination.
3. Where do program and/or service duplications currently exist?
- Care coordination and case management activities are program specific instead of focusing on the array of programs and services available.
 - Some programs with complementary services have different funding sources and different eligibility rules, which complicates service delivery.
 - Current state and/or federal monitoring requirements duplicate efforts.
 - Public health projects are not utilized fully.
4. What are the current barriers to accountability at the local service delivery level and state level?
- The current structure emphasizes program-specific accountability for units of service versus accountability for improved client outcomes.
 - Required data are not always collected and reported.

5. What opportunities exist to save or better use existing resources?

Below are listed an array of options for better using existing resources. These options are intended to be complementary, not mutually exclusive.

- Organize home and community-based programs and services for disabled and older adults into a structure that recognizes the unique needs of different populations while it also focuses on promoting improvements in client functioning. As a part of this structure:
 - Seek opportunities to build toward service coordination and integration; minimize the reliance on stand-alone, uncoordinated program silos.
 - Promote development of a client-focused, seamless service delivery system with an emphasis on client outcomes.
 - Establish a quality assurance system for long-term care that is based on outcomes.
 - Develop a comprehensive assessment process and tool, to be used across the various programs, to enable the consumer to access appropriate services without needing to complete multiple applications and assessments.
 - Establish common program eligibility & data collection processes through the use of an Internet based, interactive system.
 - Provide information and comprehensive care coordination across all programs.
 - Establish pilot project authority for provider licensing that better facilitates testing projects that share resources or provide innovative alternatives in the community.
 - Investigate opportunities to pool resources and utilize managed care approaches that can leverage Medicare and promote the use of community-based services.
 - Utilize advisory councils/committees comprised of key stakeholders to provide input on program development and implementation and help guide decision-making processes.

- Promote further improvement in the delivery of home and community-based long-term care services through other complementary strategies. These include but are not limited to the following:
 - Expand the infrastructure for community-based services.
 - Require that long-term nursing facility services may only be used if community-based services cannot meet the needs of the individual.
 - Stabilize long-term care funding by fully funding mandated programs with adequate staff and resources.
 - Enhance consumer safety through education of the consumer, their caregivers and providers.

- Increase the use of computerized technology and reduce the dependency on paper.
 - Develop or acquire evidenced based criteria to determine services needed by the individual, in order to achieve their highest level of health and function.
6. What impacts does the current organization of services have on other levels of government?

Organization at the local level often reflects the organization at the state level. As a consequence, local programs tend to experience much of the same fragmentation that is experienced at the state level. Consequences of this fragmentation include, but are not limited to:

- Local program administrators struggle with the same categorical program rigidity that affects programs at the state level.
- County service providers must comply with reporting requirements that differ significantly with each program that they administer.

IV. Organizational Structure Proposed by CPR

In consideration of the limitations of the state's current organization of services for disabled and older adult populations, attention can be turned to the CPR reorganization proposal. Using the criteria requested by CHHSA, the following responses have been prepared.

1. Will the proposal improve service delivery and outcomes for clients?

The CPR proposal appears to move boxes organizationally, but it fails to offer a comprehensive approach for organizing home, community and institutional long-term care programs with the clients of those services in mind. Programs and services will likely continue to be difficult for consumers to identify and access and the other limitations of the state's current organizational structure will not be addressed.

2. Will the proposed organization promote better coordination and integration of policy and programs?

The CPR proposal does not identify any single organization or process to provide overarching leadership for policy development, budget development, and program and system planning for home, community, and institutional long-term care programs. Accordingly, there would be no real enhancement of coordination and integration than what exists with the state's current organizational structure. In some cases, the CPR recommended changes may result in lost opportunities. For example, CPR proposes to move aging programs to the Social Services Division, but In-Home Support Services,

the service most often used by aging clients, would be moved to the new Health Purchasing Division.

3. Does the reorganization proposal save money in terms of opportunities for less duplication of activities?

It is difficult to identify specific savings that would result from the proposed structure. While the array of home, community and institutional long-term care programs and services would be reorganized into different departments, they would still operate as separate categorical programs and services that are not coordinated.

4. Does the proposed organization provide better/clearer accountability?

There is no clear evidence that the proposed restructuring would improve programmatic accountability. Again, the proposed reorganization would result in the array of programs continuing to operate as separate categorical programs and services that are not coordinated.

5. Will the proposal save, or better use, existing resources?

There is no clear evidence that the proposed restructuring would save or better use existing resources for the reason stated in #3.

6. Are there any special state laws, federal laws, or court orders that need to be considered due to the proposed reorganization?

The CPR proposal does not specifically address requirements under the *Olmstead* decision and the primary purpose and delivery of long-term care services. The CPR proposes to place the State Independent Living Council (SILC) and the State Council on Developmental Disabilities (SCDD) under departments. According to Federal Regulations, which govern the councils, they may not be placed under or report to any department.

Further, the CPR proposal would place the Department of Rehabilitation under the new Department on Labor and Economic Development's Workforce Development Division, which would violate federal regulations. Pursuant to federal law, a "sole state agency" must be designated to administer the state plan for vocational rehabilitation services. In addition, the designated state agency (DSA) must be "an agency that is primarily concerned with vocational rehabilitation or with vocational rehabilitation and other rehabilitation of individuals with disabilities." Alternatively, the State can administer the vocational rehabilitation program through a "designated state unit" (DSU) that is a "bureau, division or other organizational unit" within the single state agency. (29 USC Section 721(a)(2)).

More study is required to determine what functions would be included under "Client Advocate & Access" within the HHS Department Secretary's Office. Ombudsman-like

functions should be co-located to create programmatic consistency and operational efficiencies. Placing these functions in the Secretary's Office would appear to ensure that the State Long Term Care Ombudsman (and other similar units within other current "departments" that receives complaints from facility residents) does not report to a manager that is also responsible for nursing home or residential care licensing functions. If such a reporting relationship were to occur, it could limit the Ombudsman's advocacy role established in the federal Older Americans Act.

7. Will the proposal have any impact on other levels of Government?

Locally operated programs will have to identify new contact points within the new state organization. This will cause a disruption in the interim until local program administrators become familiar with the new lines of authority and reporting relationships. Over time, this disruption should ease.

8. Will the proposal have any impact on other restructuring proposals contained in CPR?

The CPR proposed structure reshuffles the fragmentation of home, community and institutional long-term care programs that exists across an array of current state departments. However, this fragmentation would now be spread across five new divisions: Health Purchasing, Behavioral Health, Services to the Disabled, Social Services, and Public Health.

9. What major tasks need to be accomplished in order to facilitate the reorganization? What resources will be required to implement?

The following major tasks would need to be addressed as a part of any reorganization:

- Identify affected programs, their funding sources and current locations within state government.
- Provide strong leadership with clear designated responsibilities.
- Identify all regulations and guidelines associated with their respective responsibilities.
- Assess the need to inform and engage other levels of government (federal, county, city) and interested stakeholders in the dialogue.
- Develop a transition plan, identifying all parties that need to be involved and clarify their respective roles.
- Implement the transition plan.
- Reassess the transition.

10. How long would it take to implement the reorganization?

It is estimated that the physical reorganization proposed by CPR for the affected would take between 12 and 18 months. This timetable is dependent upon the extent to which the physical logistics of reorganization, such as the relocation of staff and equipment,

including data systems, is required. It is difficult to estimate how long it will take the affected programs and the new divisions to incorporate the affected programs into the policy frameworks of their divisions. It is also difficult to estimate how long it will take program providers and stakeholders to develop effective working relationships with their respective new divisions.

V. Improving Upon the CPR Restructuring Proposal – Create New “Division for Adult and Community Living”

In lieu of adopting the CPR recommendations for the organization of home, community and institutional programs serving older adults and adults with disabilities, it is recommended that the State establish a separate **Division for Adult and Community Living** that has responsibility for policy development, budget development, and program and system planning for home, community, and institutional long-term care programs. This new Division will contain a wide variety of related programs that the CPR recommended be placed in other new Divisions and will be guided by the vision and principles described below.

Vision Statement: California adults have dignity and choice and the opportunity to live and function independently in their communities.

Guiding Principles: The following principles will guide organizational change:

- The organizational structure will bring focused attention to the needs of persons with disabilities and older Californians.
- The structure will align fiscal, operational, and policy incentives to support program and policy development that promote the highest level of independent living for persons with disabilities and for older adults.
- The structure and the culture of the organization will focus on creating opportunities for and removing barriers to improving care coordination at the local level so that clients receive more responsive, timely, and cost effective services.
- The structure will align programmatic responsibilities in order to increase accountability for client outcomes.
- The structure will cluster expertise in given areas (e.g., aging, developmental disabilities, independent living, etc.) and facilitate innovation through cross population dialogue, cross-fertilization, and coordination (e.g. Medi-Cal waiver management, consumer directed care initiatives, consumer satisfaction activities, etc.).
- The structure will provide the opportunity to develop shared elements for client assessment tools used by individual programs in order to improve client referrals, service delivery and data reporting.

- The structure will provide the opportunity to create cohesive data reporting across programs so that local agencies and the state receive useful programmatic and administrative data that can be used to measure and analyze client outcomes, promote continuous quality improvement, and inform policy and program development.
- The structure will provide the opportunity to coordinate consumer information and referral throughout the state so the public knows what options are available, can plan for potential long-term care needs, and can make informed choices should they need supportive services.
- The structure will provide a focal point within the CHHS Department for coordination with other state departments in pursuing supportive housing, employment, “smart growth” initiatives and transportation alternatives.
- The structure will provide the opportunity to examine state level authorizations for nursing facility care, and related community-based alternatives, in order to promote opportunities for individuals to remain in community settings where desired and appropriate.

The new Division is designed to address the strategic goals the Administration has set forth as a part of CPR. The new Division will make government more accountable, put clients first, streamline existing structures and operations, and save money by using available resources in a more cost-effective manner.

Making Government More Accountable. The new Division will make government more accountable by providing a clearer line of accountability for achieving progress in the delivery of home, community and institutional services for older adults and adults with disabilities because most programs serving these clients will report to the same key decision makers. This means that policies and procedures will be consistent across Centers and across programs so that conflicting regulations, program eligibility, policy, financing and data issues can be addressed. Simplification of program policies and procedures will strengthen accountability.

Putting People First. The new Division will put older adults and adults with disabilities “first” by improving service delivery and outcomes for clients served by the Division. It will place under one “roof” the majority of programs and services offered by the federal and state governments to meet the needs of older adults and adults with disabilities. It will establish centers that contain programs dedicated to similar client needs. These centers will allow the unique aspects of these service needs or population needs to be addressed within the Division’s larger framework.

Streamlining Operations. The new Division will provide a framework for comprehensive planning to address the multiple needs of individuals based upon their functional needs. Having the various centers under the single Division will promote coordination and integration among programs, which will be enhanced to the extent that

the centers and the Division can be co-located. Program coordination, integration and simplification will be core operational values for the Division.

Saving State Dollars and Using Resources More Effectively. The new Division offers the opportunity to use current program resources in a more cost-effective manner. Program coordination, integration and simplification will reduce service fragmentation, service duplication and associated administrative costs. As a result, more “value” will be obtained from each service dollar. In addition, overhead costs associated with individual programs will be reduced as economies are achieved through co-location and consolidation of like functions and activities.

Moreover, a key charge of the Division will be to develop a core client data set across programs and a uniform mechanism for collecting and retrieving information at the state and local levels so that a client’s service needs can be identified and addressed through the array of existing programs and services. This effort will substantially reduce service fragmentation and duplication and their associated costs.

Implementation Issues and Next Steps

Each program will need to be assessed for current federal and state statutory requirements, including the requirements of the primary funding sources for each affected program. An assessment of major statutory and fiscal requirements associated with the programs to be included in the new Division has been completed. Based upon this assessment, it is recommended that the framework proposed for the new Division can meet these requirements. Separate state statute and associated state budget changes will be required to achieve the proposed reorganization.

Proposed Organization

(next page)

CALIFORNIA DIVISION OF ADULT AND COMMUNITY LIVING

► *Center for Adult and Aging Services*

- Older American's Act
- Older Californian's Act
- Multipurpose Senior Services Program
- Office of Long-Term Care Ombudsman
- In-Home Supportive Services and Personal Care Services Program (PCSP/Medi-Cal)
- Adult Protective Services
- Disability Evaluation
- SSI/SSP Administration

The Center would have policy and budget responsibility for all listed programs.

► *Center for Vocational Rehabilitation and Community Services*

- Vocational Rehabilitation
- Independent Living
- Services to the Blind
- Services to the Deaf

The Center would have policy and budget responsibility for all listed programs.

► *Center for Innovative Strategies and Planning*

- Home and Community Based Services (federal waivers)
 - In-Home Medical Care
 - Nursing Facility, Level A/B
 - Nursing Facility Subacute Level
- Adult Day Health Care and Adult Day Program
- Partnership for Long Term Care (LTC insurance)
- Alzheimer's Day Care Resource Centers
- Caregiver Resource Centers
- Traumatic Brain Injury program
- Integrated Medicare and Medi-Cal programs
- Programs of All-inclusive Care for the Elderly (PACE)
- Senior Care Action Network (SCAN Social HMO)
- Long Term Care Integration
- Money Follows the Person (federal grant)

The Center would have policy and budget responsibility for all listed programs. In addition, the Center would have overall planning responsibility for the Division, including data and policy development, program and system coordination and integration within the Division, and coordination with other Divisions, including the Division for Quality Assurance. Further, the Center would have responsibility for development of strategies to improve local service delivery, including but not limited to common data reporting, uniform client assessments, outcome measures, and linkages to other service delivery systems, such as mental health and alcohol and drug treatment programs.

► ***Center for Nursing Facility Policy***

- Skilled Nursing Facility Care (Medi-Cal)
- Intermediate Care Facility services (Medi-Cal)
- Subacute Skilled Nursing Facility Care services (Medi-Cal)

This Center would have responsibility for the nursing facility budget, for nursing facility policy and rate development, and for oversight and administration of the Treatment Authorization Request (TAR) process for skilled nursing services. The Center would enter into an interagency agreement with the Division of Health Purchasing for actuarial services (supporting nursing facility rate development), administration of nursing facility payments, and coordinated delivery of the TAR process with other Medi-Cal TAR processes.

► ***Center for Developmental Services***

- Regional Centers for the Developmentally Disabled
- Developmental Centers
- Developmentally Disabled home and community-based waiver program
- Intermediate Care Facilities for Developmentally Disabled
- Work Activity Program

The Center would have policy and budget responsibility for all listed programs.

Other Programs and Services (not included in Division)

The following related programs and functions would be retained by the Department Secretary and other proposed divisions.

Department of Health and Human Services

The following organizations would be retained and report their recommendations to the Governor, Administration and Legislature in the same manner as under current law (dotted-line reporting).

- State Council on Developmental Disabilities
- State Independent Living Council
- Commission on Aging

Social Services Division

Among other programs, this division would retain the following programs, as proposed under CPR:

- Cash Assistance Program for Immigrants
- California Veterans Cash Benefits Program

Health Purchasing Division

Among other programs, this division would retain the following programs, as proposed under CPR:

- Targeted Case Management (Medi-Cal)
- Medical Case Management (Medi-Cal)

Behavioral Health Division

This division would retain the following programs, as proposed under CPR:

- Community Mental Health Programs
 - Short-Doyle/Medi-Cal program
 - Adult Integrated Service program
 - AIDS Mental Health program
 - Community Mental Health Services
 - SAMSA/PATH program for the homeless

ATTACHMENT 1

HEALTH AND HUMAN SERVICES AGENCY CALIFORNIA PERFORMANCE REVIEW PROCESS

CRITERIA FOR REVIEW OF ORGANIZATIONAL PROPOSALS

The proposed reorganization of state government is expected to achieve efficiency, less duplication of administrative services and better integration of program delivery. In reviewing the organization proposals, workgroups are asked to consider the following questions in evaluating each proposed organization:

1. Will the proposal improve service delivery and outcomes for clients?
2. Will the proposed organization promote better coordination and integration of policy and programs?
3. Does the reorganization proposal save money in terms of opportunities for less duplication of activities?
4. Does the proposed organization provide better/clearer accountability?
5. Will the proposal save, or better use, existing resources?
6. Are there any special state, federal laws, or court orders that need to be considered due to the proposed reorganization?
7. Will the proposal have any impact on other levels of Government?
8. Will the proposal have any impact on other restructuring proposals contained in CPR?
9. What major tasks need to be accomplished in order to facilitate the reorganization? What resources will be required to implement?
10. How long would it take to implement the reorganization?

NOTE: Workgroups are asked to identify approaches to strengthening the proposals to further advance the intended outcomes.

Appendix E

SCAN Foundation Policy Brief No. 2

*A Summary of the Patient Protection and Affordable Care Act
(P.L. 111-148) and Modifications by the Health Care and Education Reconciliation
Act of 2010 (H.R. 4872)*



POLICY BRIEF • No. 2 • March 2010
**A Summary of the Patient Protection and Affordable Care Act (P.L. 111-148) and
 Modifications by the Health Care and Education Reconciliation Act of 2010 (H.R. 4872)**

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (H.R. 3590, P.L. 111-148), which was passed by the Senate on December 24, 2009 and by the House on March 21, 2010. Following closely on its heels was the Health Care and Education Reconciliation Act of 2010, which makes changes to the Patient Protection and Affordable Care Act. The reconciliation bill was passed by both houses of Congress on March 25, 2010 and signed into law by the President on March 30, 2010. This Policy Brief presents an analysis of the Patient Protection and Affordable Care Act, covering those elements that provide support for the continuum of care for seniors. The Health Care and Education Reconciliation Act of 2010 modified a few provisions in the health reform law specific to the continuum of care, and these modifications are noted where relevant.

The organizing framework for this analysis includes the following concepts about the continuum of care: 1) support the rebalancing of the long-term services and supports (LTSS) available to seniors toward home and community-based services; 2) improve the coordination of health and supportive services, especially for those with chronic illnesses; 3) improve access to medications and reduce the cost burden on seniors; 4) reinforce the existing workforce and establish initiatives to grow the workforce that serves seniors, including direct care workers; and 5) strengthen quality and consumer protections for seniors.

<p>Dates Introduced & Passed</p>	<p style="text-align: center;">The Patient Protection and Affordable Care Act (Public Law 111-148)</p> <p><i>Announced: November 18, 2009; Passed by Senate: December 24, 2009; Passed by House: March 21, 2010; Signed into Law: March 23, 2010</i></p>	<p style="text-align: center;">Health Care and Education Reconciliation Act of 2010 (H.R. 4872)</p> <p><i>Introduced March 18, 2010; Passed by House: March 21, 2010; Passed by Senate with Revisions: March 25, 2010; Revised Bill Passed by House: March 25, 2010; Signed into Law: March 30, 2010</i></p>
<p>1. Bolstering Supportive Services Delivered at Home and in the Community</p> <p>Community Living Assistance Services and Supports (CLASS) plan</p>	<p>Establishes a new public long-term care insurance program, to be known as the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations.</p> <ul style="list-style-type: none"> • Financed by voluntary payroll deductions or contributions from all eligible adults • Those eligible to enroll are actively employed (including self-employed) adults age 18 and older • Automatic enrollment with an opt-out option; if an employer does not elect to deduct and withhold premiums on behalf of an employee, an alternate payment mechanism will be available for an eligible individual • 5-year vesting period • Enrollees will be eligible for benefits after meeting specified disability criteria (functional and/or cognitive impairment that is expected to last for 90 days or more and is certified by a licensed health care practitioner) • Upon determination of eligibility, a cash benefit will be paid based on functional ability, averaging not less than \$50 per day, with no lifetime or aggregate limit • Secretary is required to establish premiums to ensure solvency for 75 years 	<p>No changes made.</p>

The Patient Protection and Affordable Care Act (Public Law 111-148)	Health Care and Education Reconciliation Act of 2010 (H. R. 4872)
<ul style="list-style-type: none"> • Medicaid enrollees receiving home and community-based services (HCBS) or Program for All Inclusive Care of the Elderly (PACE) would retain 50 percent of their cash benefit while living in the community • Medicaid enrollees in institutions would retain 5 percent of their cash benefit • Premium subsidies would be available for eligible individuals ages of 18 to 22 who are full-time students while working or for any individual with income below the poverty line • Self-employed individuals could enroll • The CLASS program will be treated in the same manner as a qualified long-term care insurance policy • No taxpayer funds (e.g., Federal funds from any source other than from premiums collected in the CLASS program) will be used to pay benefits under this provision. • The Secretary must establish an eligibility assessment system by January 1, 2012 and designate the benefit plan by October 1, 2012. (Title VIII, Sec. 8002) 	
<p>Community First Choice Option</p> <p>Establishes a Medicaid State Plan Option to provide a community-based attendant services and supports benefit to those who meet the state's nursing facility clinical eligibility standards.</p> <ul style="list-style-type: none"> • Provides 6 percentage point increase in FMAP to States choosing this option • States would be authorized to provide community transitions support (e.g., rent/utility deposits, first month's rent and utilities, bedding, basic kitchen supplies) to institutionalized individuals who meet the eligibility criteria. • Effective start date was October 1, 2010. (Title II, Subtitle E, Sec. 2401) 	<p>The Reconciliation Bill changed the implementation start date to October 1, 2011. (Title I, Subtitle C, Sec. 1205)</p>
<p>Removal of Barriers to Providing Home and Community-Based Services</p> <p>Amends Section 1915(f) of the Social Security Act to remove barriers to providing HCBS by giving States the option to provide more types of HCBS through a State Plan amendment to individuals with higher levels of need, rather than through waivers.</p> <ul style="list-style-type: none"> • Requires "State-wideness" of the HCBS State Plan benefit • Prohibits States from setting caps on the number of individuals who receive coverage for the benefit • Enables States to target benefits to individuals with selected conditions if the State wishes • Individuals receiving coverage under the State Plan are grandfathered into services if the criteria for eligibility are modified for as long as their condition meets the previous criteria. • Effective on the first day of the first fiscal year quarter that begins after the date of enactment of this Act. (Title II, Subtitle E, Sec. 2402) 	<p>No changes made.</p>
<p>Money Follows the Person Rebalancing Demonstration</p> <p>Extends the Money Follows the Person Rebalancing Demonstration, originally authorized in the DRA, through September 30, 2016. Modifies eligibility rules, which originally required that individuals reside in facility for not less than 6 months, by requiring that individuals reside in an inpatient facility for not less than 90 consecutive days. Amendments effective 30 days after enactment of this Act. (Title II, Subtitle E, Sec. 2403)</p>	<p>No changes made.</p>

The Patient Protection and Affordable Care Act (Public Law 111-148)		Health Care and Education Reconciliation Act of 2010 (H.R. 4872)
Protection for Recipients of Home and Community-Based Services Against Spousal Impoverishment	Requires States to apply spousal impoverishment rules to beneficiaries who receive HCBS. This provision would apply for a five-year period beginning on January 1, 2014. (Title II, Subtitle E, Sec. 2404)	No changes made.
Funding to Expand State Aging and Disability Resource Centers	Appropriates to the Secretary of HHS \$10 million for each of FYs 2010 through 2014 to carry out Aging and Disability Resource Center (ADRC) initiatives provided in the Older Americans Act. (Title II, Subtitle E, Sec. 2405)	No changes made.
Sense of the Senate Regarding Long-Term Care	Expresses the <i>Sense of the Senate</i> that during the 111th Congress, Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need, in the community as well as in institutions. (Title II, Subtitle E, Sec. 2406)	No changes made.
Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes	Creates the State Balancing Incentive Payments Program with new financial incentives for States to shift Medicaid beneficiaries out of nursing homes and into home and community-based services. <ul style="list-style-type: none"> • Eligible States are those that spend less than 50 percent of total expenditures for LTSS on services in the home or community • The Secretary may determine among the States that apply and qualify which will participate • Qualifying States with less than 25 percent of total LTSS expenditures for HCBS will receive a 5 percentage point increase in FMAP; States with 25-50 percent will receive a 2 percentage point increase • As part of this provision, States may increase the income eligibility for HCBS • Requires qualifying States to establish a statewide "No wrong door – single entry point system" to enable consumer to access LTSS • Requires qualifying States to develop case management services to assist in the development of a service plan for beneficiaries and for family caregivers; also provide case management to support the transition from institutional to community-based services • Allocates up to \$3 billion for Medicaid HCBS. (Title X, Subtitle B, Part I, Sec. 10202) 	No changes made.
2. Improving Coordination of Health Care and Supportive Services		
Building Infrastructure for Program and Policy Development		
Medicaid and CHIP Payment and Access Commission (MACPAC)	Clarifies the topics to be reviewed by the Medicaid and CHIP Payment and Access Commission (MACPAC) including: <ul style="list-style-type: none"> • Medicaid and CHIP enrollment and retention processes, coverage policies, quality of care, how interactions of policies between Medicare and Medicaid affect access to services, payments, and dually-eligible individuals, and additional reports of State specific data • Authorizes \$11 million to fund MACPAC for FY2010. (Title II, Subtitle J, Sec. 2801) 	No changes made.
Improved Coordination and Protection for Dual Eligibles	Requires the Secretary to establish a Federal Coordinated Health Care Office (CHCO) within the Centers for Medicare and Medicaid Services (CMS) by March 1, 2010. The purpose of the CHCO will be to bring together officials of the Medicare and Medicaid programs to: <ul style="list-style-type: none"> • More effectively integrate benefits under those programs, and • Improve the coordination between the federal and state governments for individuals eligible for 	No changes made.

	The Patient Protection and Affordable Care Act (Public Law 111-148)	Health Care and Education Reconciliation Act of 2010 (H.R. 4872)
<p>Establishment of Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services (CMS)</p>	<p>benefits under both Medicare and Medicaid (dual eligibles) to ensure that dual eligibles have full access to the items and services to which they are entitled.</p> <ul style="list-style-type: none"> • The goals of the CHCO are: <ul style="list-style-type: none"> ○ Provide dual eligibles full access to benefits to which they are entitled under Medicare and Medicaid; ○ Simplify the process by which dual eligibles access services; ○ Improve the quality of health and long-term care services for dual eligibles; ○ Increase dual eligibles understanding of and satisfaction with coverage; ○ Eliminate regulatory conflicts between Medicare and Medicaid; ○ Improve care continuity for dual eligibles; ○ Eliminate cost shifting between Medicare and Medicaid and among related health care providers; and ○ Improve the quality of performance of providers under Medicare and Medicaid. • Specific responsibilities include: <ul style="list-style-type: none"> ○ Provide States, Special Needs Plans, and providers with education and tools to align Medicare and Medicaid benefits; ○ Support State efforts to coordinate and align acute and long-term care services for dual eligibles; ○ Provide support for coordination, contracting and oversight by States and CMS with respect to integrating Medicare and Medicaid; ○ Consult and coordinate with MedPAC and MACPAC regarding relevant policies; ○ Study the provision of drug coverage for new full-benefit dual eligibles and monitor and report total annual expenditures, outcomes and access to benefits for dual eligibles; and ○ Submit an Annual Report to Congress with recommendations for legislation to improve care coordination and benefits for dual eligibles. • Effective March 1, 2010. (Title II, Subtitle H, Sec. 2602) 	<p>No changes made.</p>
<p>Accountable Care Organizations</p>	<p>Rewards Accountable Care Organizations (ACOs) that take responsibility for the costs and quality of care received by their patient panel over time.</p> <ul style="list-style-type: none"> • ACOs can include groups of health care providers (including physician groups, hospitals, nurse practitioners and physician assistants, and others) 	<p>No changes made.</p>
<p>Demonstration Programs and New Delivery Models</p>		
<p>Establishment of Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services (CMS)</p>	<p>Establishes within CMS a Center for Medicare & Medicaid Innovation. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. Dedicated funding is provided to allow for testing of models that require benefits not currently covered by Medicare as well as payment reform models. Successful models can be expanded nationally. Requires the Secretary to focus on models that both improve quality and reduce costs. Effective January 1, 2011. (Title III, Subtitle A, Part 3, Sec. 3021)</p>	<p>No changes made.</p>

The Patient Protection and Affordable Care Act (Public Law 111-148)		Health Care and Education Reconciliation Act of 2010 (H.R. 4872)
Payment Reform – Bundling	<p>organizations in helping individuals receive better access to care, providing information on clinical trials, and conducting outreach to health disparity populations. Authorizes \$3.5 million for FY2010 and allocating funds as needed for FY2011 through FY2015. (Title III, Part 3, Subtitle F, Sec. 3510)</p> <p>Directs the Secretary to develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models.</p> <ul style="list-style-type: none"> Covers Medicare beneficiaries who are hospitalized for one of ten conditions (a mix of chronic and acute) Requires the Secretary to establish this program by January 1, 2013 for a period of five years Before January 1, 2016, the Secretary is also required to submit a plan to Congress to extend the pilot program if doing so will improve patient care and reduce spending. (Title III, Subtitle A, Part 3, Sec. 3023) 	No changes made.
Extension of Special Needs Plan (SNP) Program	<p>Establishes a demonstration project, in up to eight States, to study the use of bundled payments for hospital and physicians services under Medicaid. The demonstration will begin by January 1, 2012 through December 31, 2016. (Title II, Subtitle I, Sec. 2704)</p> <p>Extends the SNP program through December 31, 2013 and requires SNPs to be National Committee for Quality Assurance (NCQA) approved.</p> <ul style="list-style-type: none"> Allows HHS to apply a frailty payment adjustment to fully-integrated, dual-eligible SNPs that enroll frail populations Requires HHS to transition beneficiaries to a non-specialized Medicare Advantage plan or to original fee-for-service Medicare who are enrolled in SNPs that do not meet statutory target definitions and requires dual-eligible SNPs to contract with State Medicaid programs beginning 2013 Also requires an evaluation of Medicare Advantage risk adjustment for chronically ill populations. (Title III, Subtitle C, Sec. 3205) 	No changes made.
Medicare Senior Housing Plans	<p>Allows demonstration plans that serve residents in continuing care retirement communities to operate under the Medicare Advantage program. Effective January 1, 2010. (Title III, Subtitle C, Sec. 3208)</p>	No changes made.
New Benefits Supporting Care Coordination		
Medicare Coverage of Annual Wellness Visit	<p>Provides coverage under Medicare, with no co-payment or deductible, for an annual wellness visit and personalized prevention plan services.</p> <ul style="list-style-type: none"> Such services would include a comprehensive health risk assessment A personalized prevention plan would take into account the findings of the health risk assessment and include elements such as: a five- to ten-year screening schedule; a list of identified risk factors and conditions and a strategy to address them; and health advice and referral to education and preventive counseling or community-based interventions to address modifiable risk factors such as physical activity, smoking, and nutrition. Effective January 1, 2011. (Title IV, Subtitle B, Sec. 4103) 	No changes made.

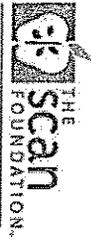
3. Improve Medicare Part D Access and Reduce the Medication Cost Burden		
<p>Reduction or Elimination of the Coverage Gap in Medicare Part D</p>	<p>Increases the initial coverage limit in the standard Part D benefit by \$500 for 2010, thus decreasing the time that a Part D enrollee would need to be in the coverage gap. This provision applies only to 2010; the initial coverage limit for subsequent years will be separately determined. (Title III, Subtitle D, Sec. 3315)</p>	<p>This section was repealed by the Reconciliation Bill. (Title I, Subtitle B, Sec. 1101)</p>
<p>Medicare Coverage Gap Discount Program</p>	<p>Requires drug manufacturers to provide a 50 percent discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap beginning July 1, 2010. (Title III, Subtitle D, Sec. 3301)</p>	<p>This section is further amended to include:</p> <ul style="list-style-type: none"> • Provides a \$250 rebate to Medicare beneficiaries who reach Part D coverage gap in 2010 (Effective January 1, 2010) • Gradually phases down the coinsurance rate in the Medicare Part D coverage gap from 100 percent to 25 percent by 2020 • For brand name drugs, requires pharmaceutical manufacturers to provide a 50 percent discount on prescriptions filled in the coverage gap (Effective January 1, 2011). In addition to federal subsidies of 25 percent of the brand-name drug cost by 2020 (phased in beginning January 1, 2013) • For generic drugs, provides federal subsidies of 75 percent of generic drug cost by 2020 for prescriptions filled in coverage gap (Phased in starting in 2011) (Title I, Subtitle B, Sec. 1101)
<p>Improved Assistance to Low-Income Subsidy (LIS) Beneficiaries</p>	<p>The following sections improve access to Medicare Part D plans for LIS beneficiaries and beneficiary outreach and education activities.</p> <ul style="list-style-type: none"> • Allows Part D plans that bid a nominal amount above the regional low-income subsidy (LIS) benchmark to absorb the cost of the difference between their bid and the LIS benchmark in order to remain a \$0 premium LIS plan. Effective January 1, 2011. (Title III, Subtitle D, Sec. 3303) • Allows the surviving spouse of an LIS-eligible couple to delay LIS redetermination for one year after the death of a spouse. Effective January 1, 2011. (Title III, Subtitle D, Sec. 3304) • Requires HHS, beginning in 2011, to transmit formulary and coverage determination information to subsidy-eligible beneficiaries who have been automatically reassigned to a new Part D low-income subsidy plan. Effective January 1, 2011. (Title III, Subtitle D, Sec. 3305) • Provides \$45 million for outreach and education activities to State Health Insurance Programs, Administration on Aging, Aging Disability Resource Centers and the National Benefits Outreach and Enrollment beginning FY2009. (Title III, Subtitle D, Sec. 3306) 	<p>No changes made.</p>

The Patient Protection and Affordable Care Act (Public Law 111-148)		Health Care and Education Reconciliation Act of 2010 (H.R. 4972)
Elimination of Part D Cost-Sharing for Selected Non-Institutionalized Dual Eligible Individuals	Eliminates Part D cost sharing for people receiving care under a home and community-based waiver who would otherwise require institutional care. (Title III, Subtitle D, Sec. 3309)	No changes made.
4. Enhancing and Revitalizing the Health and Supportive Service Workforce		
Demonstration Project to Address Health Professions Workforce Needs	<ul style="list-style-type: none"> Establish a demonstration program to offer low income individuals the opportunity to obtain training and education for occupations in the health care field that are expected to experience labor shortages or be in high demand. Requires the Secretary to establish demonstration programs in up to 6 States for no less than 3 years through competitive grants for purposes of developing core competencies, pilot training curricula, and develop certification programs for personal and home care aides. Appropriates \$85 million for 5 years (FY 2010-2014), no more than \$5 million per year (FY 2010-2012) allocated for the personal and home care aide demonstration (Title V, Subtitle F, Sec. 5507) 	No changes made.
Training Opportunities for Direct Care Workers	<ul style="list-style-type: none"> Establishes grants to eligible entities to provide advanced training opportunities for direct care workers employed in long-term care settings (including nursing homes, assisted living facilities, intermediate-care facilities, and home and community-based settings). Funds are to be allocated in the form of tuition or fee support for eligible individuals A condition of receiving assistance is that participating individuals agree to work in the fields of geriatrics, disability services, long term services and supports, or chronic care management for at least 2 years following completion of training This provision authorizes \$10 million for FY 2011-2013 for these grants. (Title V, Subtitle D, Sec. 5302) 	No changes made.
Expanding Physician Assistants' Role in Medicare	Authorizes physician assistants to order skilled nursing facility care. This provision is effective starting January 1, 2011. (Title III, Subtitle B, Part 1, Sec. 3108)	No changes made.
Payment Incentives for Selected Primary Care Services	<ul style="list-style-type: none"> Increases the Medicare payment rate by 10 percent to primary care practitioners for primary care services. Primary care practitioners are those with a family, internal, geriatric, or pediatric medicine and for whom primary care services account for at least 60 percent of allowed charges (Effective FY 2011-2016). (Title V, Subtitle F, Sec. 5501) 	No changes made.
Geriatric Education and Training; Career Awards; Comprehensive Geriatric Education	<ul style="list-style-type: none"> Authorizes \$10.8 million for FY 2011 to FY 2014 for geriatric education centers to support training in geriatrics, chronic care management, and long-term care for faculty in health professions schools, direct care workers, and family caregivers. Funds are allocated to develop curricula and best practices in geriatrics focusing on mental health, medication safety, and communication skills in dementia care These funds also expand the geriatric career awards to advanced practice nurses, clinical social workers, pharmacists, and psychologists; create a parallel geriatrics career incentive award program for Master's level candidates; and establish traineeships for individuals who are 	No changes made.

Health Workforce Evaluation and Assessment	<p>preparing for advanced education nursing degrees in geriatric nursing. (Title V, Subtitle D, Sec. 5305)</p> <ul style="list-style-type: none"> Establishes a national commission tasked with reviewing health care workforce and projected workforce needs. The overall goal of the Commission is to provide comprehensive, unbiased information to Congress and the Administration about how to align Federal health care workforce resources with national needs. Congress will use this information when providing appropriations to discretionary programs or in restructuring other Federal funding sources. Appointments to be made by September 20, 2010. (Title V, Subtitle B, Sec. 5101) Codifies existing national center and establishes several state and regional centers for health workforce analysis to collect, analyze, and report data related to Title VII (Public Health Service Act) primary care workforce programs. The centers will coordinate with State and local agencies collecting labor and workforce data and coordinate and provide analyses and reports on Title VII to the Commission. Authorizes \$7.5 million for each fiscal year 2010 through 2014 to carry out activities of the National Center. Also authorizes \$4.5 million for each fiscal year 2010 through 2014 to carry out the activities of the state and regional centers. (Title V, Subtitle B, Sec. 5103) 	No changes made.
<p>5. Strengthening Quality and Consumer Protections</p> <p>Improving Transparency of Information on Skilled Nursing Facilities, Nursing Facilities, and Other Long-Term Care Facilities</p>		
Required Disclosure of Ownership and Additional Disclosable Parties	<p>Requires skilled nursing facilities (SNFs) and nursing facilities (NFs) to disclose information on ownership and facility organizational structure and requires the Secretary of HHS to develop a standardized format for such information within two years of date of enactment. Final regulations must be promulgated within 2 years following the enactment of this Act. Information will be publicly available one year following the publication of final regulations. (Title VI, Subtitle B, Part 1, Sec. 6101)</p>	No changes made.
Accountability Requirements for SNFs and NFs	<p>Requires SNFs and NFs to operate compliance and ethics programs on or after the date that is 36 months after enactment. Directs the Secretary to develop a quality assurance and improvement program for SNFs and NFs no later than December 31, 2011. (Title VI, Subtitle B, Part 1, Sec. 6102)</p>	No changes made.
Nursing Home Compare Medicare Website	<p>Directs the Secretary to publish the following information on the Nursing Home Compare Medicare website: standardized staffing data, links to state internet websites regarding state survey and certification programs, the model standardized complaint form, a summary of substantiated complaints, and the number of adjudicated instances of criminal violations by a facility or its employee. Each informational element shall be published on the website one year after the date of enactment of the relevant subsection of the bill. (Title VI, Subtitle B, Part 1, Sec. 6103)</p>	No changes made.
Reporting of Expenditures	<p>Requires SNFs to separately report expenditures for direct care staffing services, indirect care services, capital assets, and administrative costs on cost reports for cost reporting periods.</p> <ul style="list-style-type: none"> Requires Secretary to redesign the SNF cost report to meet the needs of this section no later than 1 year following enactment Effective on or after two years following redesign of the cost report. (Title VI, Subtitle B, Part 1, Sec. 6104) 	No changes made.

		The Patient Protection and Affordable Care Act (Public Law 111-148)	Health Care and Education Reconciliation Act of 2010 (H. R. 4872)
Standardized Complaint Form	Directs the Secretary to develop a standardized complaint form for use by residents or a person acting on a resident's behalf in filing complaints with a State survey and certification agency and a State long-term care ombudsman program.	• States would also be required to establish complaint resolution processes.	No changes made.
Ensuring Staffing Accountability	Requires the Secretary to develop a program for facilities to report staffing information in a uniform format based on payroll data, and to also take into account services provided by any agency or contract staff. Effective two years after the date of enactment of this Act. (Title IV, Subtitle B, Part 1, Sec. 6106)	• Effective one year after the date of enactment of this Act. (Title IV, Subtitle B, Part 1, Sec. 6105)	No changes made.
GAO Study and Report on Five-Star Quality Rating System	Requires the Government Accountability Office to conduct a study on the Five-Star Quality Rating System which would include an analysis of the systems implementation and any potential improvements to the system. A Report to Congress is due two years after the date of enactment of this Act. (Title IV, Subtitle B, Part 1, Sec. 6107)		No changes made.
National Demonstration Projects on Culture Changes and Use of Information Technology in Nursing Homes	Requires the Secretary to conduct two facility-based demonstration projects that would develop best practice models in two areas: <ul style="list-style-type: none"> To identify best practices in facilities that are involved in the "culture change" movement, including the development of resources where facilities may be able to access information in order to implement culture change; and To develop best practices in information technology that facilities are using to improve resident care. The demonstration projects shall be implemented no later than one year following the date of enactment of this Act. The demonstration projects shall be conducted for a period not to exceed three years. (Title IV, Subtitle B, Part 2, Sec. 6114)		No changes made.
Dementia and Abuse Prevention Training	Permits the Secretary to require SNFs and NFs to conduct dementia management and abuse prevention training in pre-employment training programs, and, if the Secretary determines appropriate, as part of ongoing training. Effective one year after the date of enactment of this Act. (Title IV, Subtitle B, Part 3, Sec. 6121)		No changes made.
Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers	Establishes a national program for long term care facilities and providers to conduct screening and criminal and other background checks on prospective direct access patient employees. Authorizes an amount not to exceed \$160 million for the period FY2010 to FY2012. (Title IV, Subtitle C, Sec. 6201)		No changes made.
Other Quality Provisions			
Elder Justice	Establishes advisory capacity and grants to further elder justice providing for the following: <ul style="list-style-type: none"> An Elder Justice Coordinating Council within the Office of the Secretary that will make recommendations to the Secretary, coordinating with the Department of Justice and other 		No changes made.

	<p>The Patient Protection and Affordable Care Act (Public Law 111-148)</p> <p>relevant federal, state, local, and private agencies and entities related to elder abuse, neglect, exploitation and other crimes against elders</p> <ul style="list-style-type: none"> • Establishes an Advisory Board on Elder Abuse, Neglect and Exploitation to create strategic plans around elder justice in long-term care • Grants to eligible entities to establish elder abuse, neglect and exploitation forensic centers • Awards grants and carry out activities that provide greater protection to those individuals seeking care in facilities that provide long-term services and supports and provide greater incentives for individuals to train and seek employment at such facilities. (Title VI, Subtitle H, Sec. 6703) 	<p>Health Care and Education Reconciliation Act of 2010 (H.R. 4872)</p>
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Appendix F

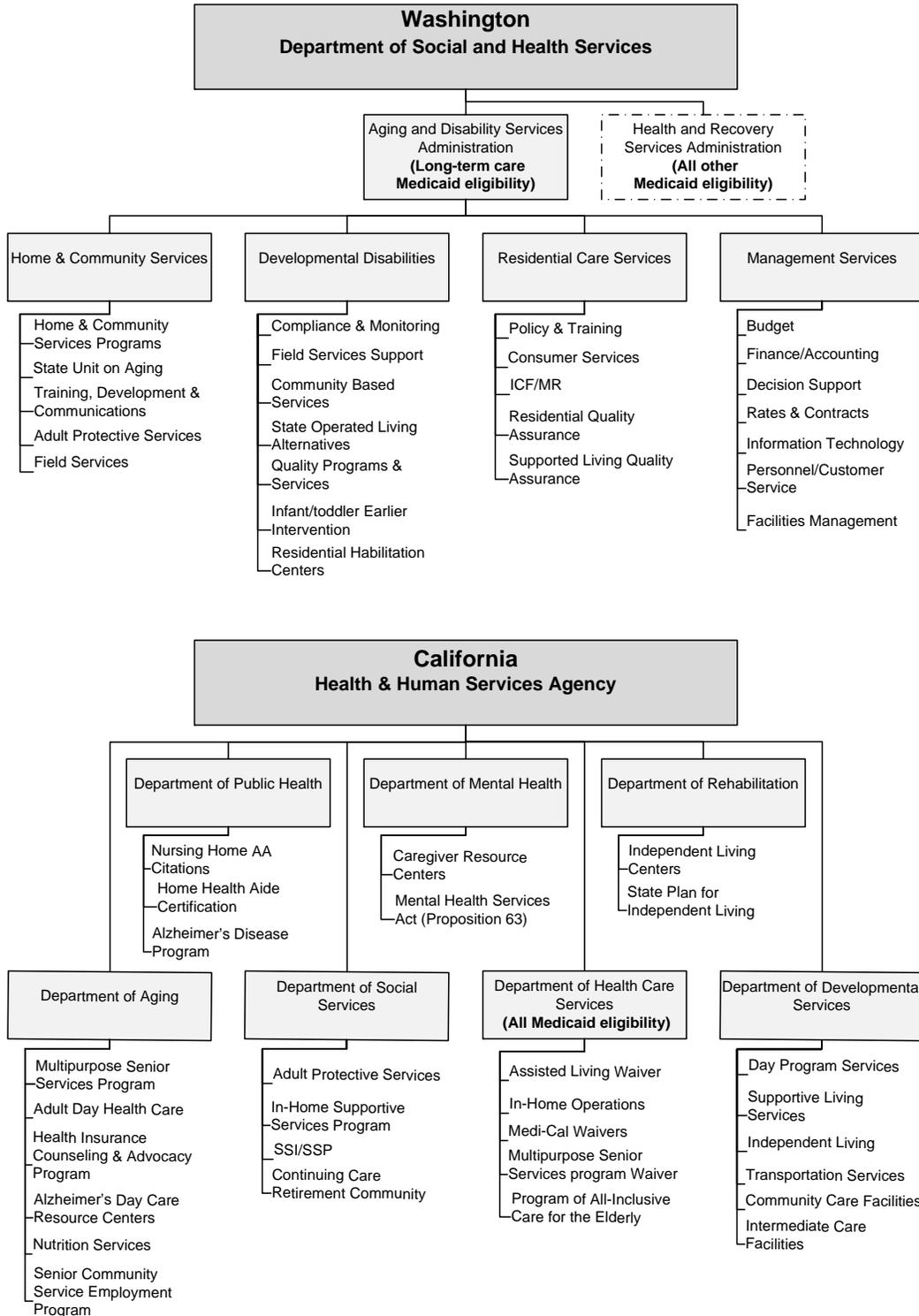
Oregon Department of Human Services Seniors and People with Disabilities Division

Service Priority Levels

1	Full Assist in Mobility (Ambulation <u>or</u> Transfer); and Eating; and Elimination; and Cognition (need 3 FA in cognition/behavior)
2	Full Assist in Mobility (Ambulation <u>or</u> Transfer) & Eating & Cognition (3 FA in cognition/behavior)
3	Full Assist in Mobility (Ambulation <u>or</u> Transfer); or Eating; or Cognition (3 FA in cognition/behavior)
4	Full Assist Elimination
5	Substantial Assist with Mobility (Ambulation inside <u>or</u> Transfer); and Assist with Eating; and Assist with Elimination (Toileting <u>or</u> Bowel <u>or</u> Bladder)
6	Substantial Assist with Mobility (Ambulation inside <u>or</u> Transfer); and Assist with Eating
7	Substantial Assist with Mobility (Ambulation inside <u>or</u> Transfer); and Assist with Elimination (Toileting <u>or</u> Bowel <u>or</u> Bladder)
8	Minimal Assist in Mobility (Ambulation only); and Assist with Eating; and Assist with Elimination (Toileting <u>or</u> Bowel <u>or</u> Bladder)
9	Assist with Eating and Elimination (Toileting <u>or</u> Bowel <u>or</u> Bladder)
10	Substantial Assist with Mobility (Ambulation inside <u>or</u> Transfer)
11	Minimal Assist in Mobility (Ambulation only); and Assist with Elimination (Toileting <u>or</u> Bowel <u>or</u> Bladder)
12	Minimal Assist in Mobility (Ambulation only); and Assist with Eating
13	Assist with Elimination (Toileting <u>or</u> Bowel <u>or</u> Bladder)
14	Assist with Eating
15	Minimal Assist in Mobility (Ambulation only)
16	Full Assist in Bathing; or Dressing
17	Assist in Bathing; or Assist with Dressing; or Full Assist with Grooming or Full Assist with Personal Hygiene
18	Independent SPL 1-17 <u>and</u> Requires structured living for supervision for complex medical problems <u>or</u> a Complex medication regimen

Appendix G

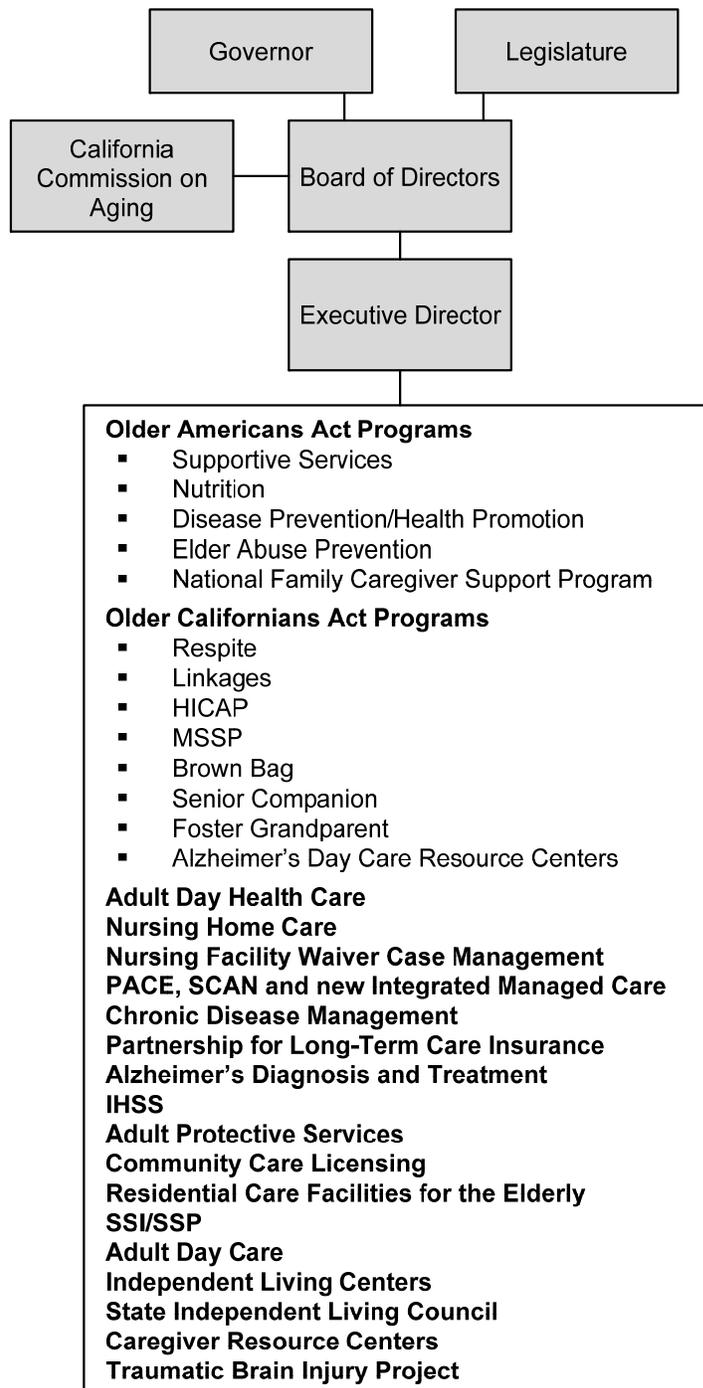
Organizational Chart Comparison Washington and California



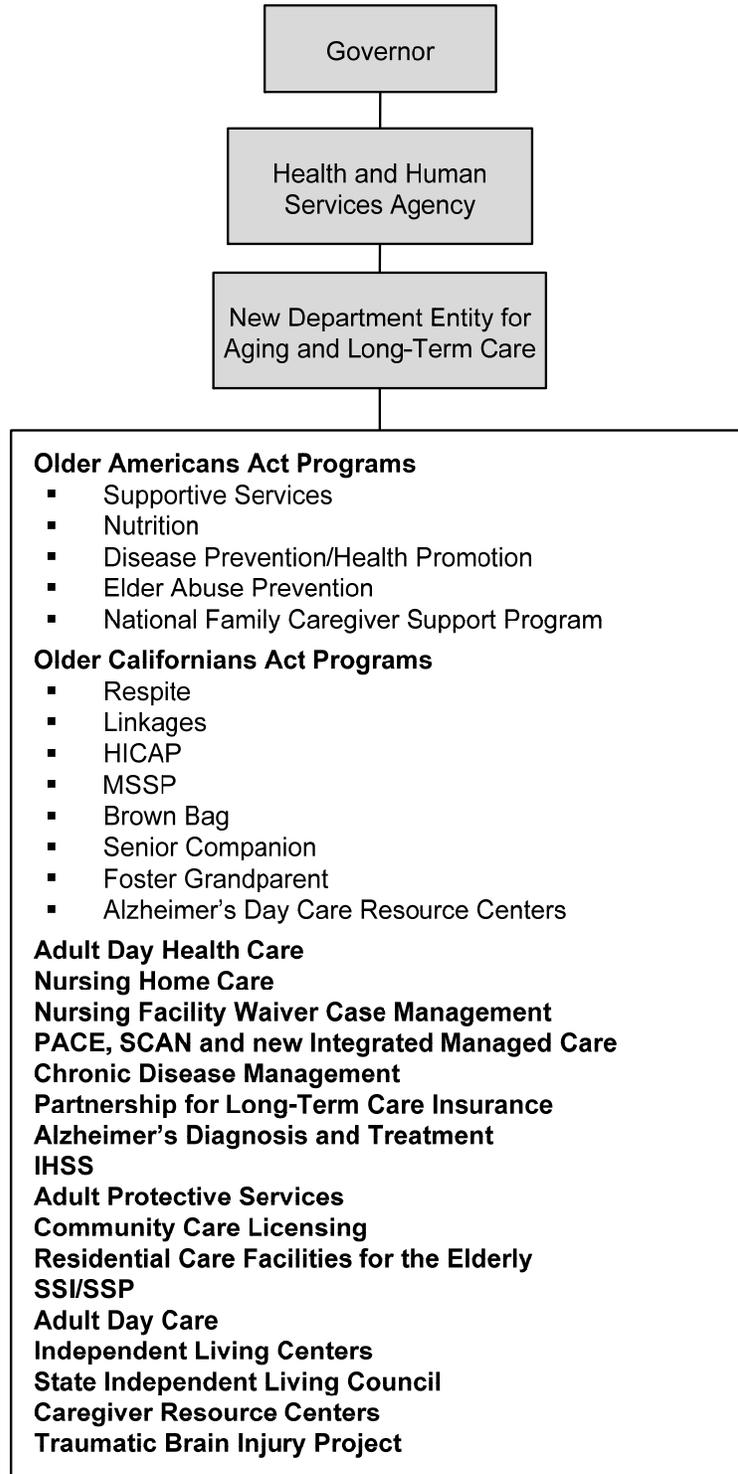
Appendix H

Organizational Charts for Proposed Consolidation Models

Model 1 – Quasi-Governmental Structure for Aging and Long-Term Care



**Model 2 – Traditional Department Structure
for Aging and Long-Term Care**



Source: Expert Panel to Review California Department of Aging Structure. September 2004.
"Planning for an Aging California Population: Restructuring the California Department of Aging
and Long-Term Care Services in California."

Appendix I

In-Home Supportive Services Program Reforms

The 2009 IHSS budget was \$5.46 billion, of which the federal government pays roughly half (currently 62 percent, adding in federal stimulus money), and the remaining cost is paid jointly by the state (65 percent of the remaining portion) and counties (35 percent of the remaining portion). In addition to budget reductions and threats of elimination, IHSS has been under fire in recent years for claims of fraud. Budget bill language in 2009 included the following reform provisions:

- Beneficiaries must be fingerprinted.
- Providers must be fingerprinted, required to complete a new enrollment form, pay for a background check and attend an orientation.
- Individuals are barred from being providers if convicted within the last 10 years of defrauding government health care or supportive services, felony child abuse or felony elder abuse.
- 78 county level positions were authorized to conduct program integrity actions, including unannounced home visits.
- Counties were authorized to investigate fraud and share data with state agencies.

Supporters of IHSS say that while some fraud exists in the program just as it does in Medi-Cal, CalWorks, or any other program with cash aid payments, the vast media attention and state money allocated in the governor's budget to combat fraud have been blown out of proportion during a year of competitive district attorney races. There has been no significant evidence produced to show fraud in the system, advocates say. As part of the anti-fraud measures, the administration recently proposed spending \$41.6 million over seven years to photograph and fingerprint IHSS beneficiaries; this included purchasing portable devices at \$5,000 each that would allow a social worker to photograph and fingerprint a beneficiary and upload the data to a statewide system. The Senate Budget Subcommittee on Health and Human Services blocked this expenditure on May 6, 2010 because IHSS staff had failed to show the benefit of the cost.

Source: California Healthline. May 11, 2010. "Senate Subcommittee Blocks \$41.6M Plan to Reduce IHSS Fraud."

Notes

1. California HealthCare Foundation. November 2009. "California Health Care Almanac: Long Term Care Facts and Figures."
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Little Hoover Commission Members

CHAIRMAN DANIEL W. HANCOCK (*D-San Ramon*) Appointed to the Commission by Assembly Speaker Cruz Bustamante in July 1997. Reappointed by Assembly Speaker Robert M. Hertzberg in January 2001, by Speaker Fabian Núñez in March 2006 and by Speaker Karen Bass in January 2009. Former president of Shapell Industries of Northern California. Chairman of the Commission since March 2007.

VICE CHAIRMAN EUGENE "MITCH" MITCHELL (*R-Carlsbad*) Appointed to the Commission by Governor Arnold Schwarzenegger in April 2004 and reappointed by Governor Schwarzenegger in December 2010. Regional vice president of external affairs for San Diego Gas & Electric Company. Vice chairman of the Commission since March 2007.

VICTORIA BRADSHAW (*R-Sacramento*) Appointed to the Commission by Governor Arnold Schwarzenegger in December 2010. Former secretary of the Labor and Workforce Development Agency and former deputy chief of staff and cabinet secretary to Governor Schwarzenegger.

MARILYN C. BREWER (*R-Newport Beach*) Appointed to the Commission by Governor Arnold Schwarzenegger in October 2006 and reappointed by Governor Schwarzenegger in December 2010. Recently served as a commissioner on the Orange County Transportation Authority. From 1994 to 2002, represented the 70th Assembly District in the California State Assembly.

VIRGINIA ELLIS (*D-Sacramento*) Appointed to the Commission by the Senate Rules Committee in January 2011. Former Sacramento bureau chief for the Los Angeles Times.

MARSHALL GELLER (*DTS-Los Angeles*) Appointed to the Commission by Assembly Speaker Fabian Núñez in March 2008. Senior managing director of St. Cloud Capital and director of a number of public companies. Former chairman and CEO of Geller & Friend Capital Partners and former senior managing director for Bear, Stearns & Company.

ASSEMBLYMEMBER ALYSON HUBER (*D-El Dorado Hills*) Appointed to the Commission by Assembly Speaker John Pérez in March 2010. Elected to the 10th Assembly District in 2008 to represent all of Amador County and portions of Sacramento, El Dorado and San Joaquin counties.

LOREN KAYE (*R-Sacramento*) Appointed to the Commission by Governor Arnold Schwarzenegger in March 2006 and reappointed by Governor Schwarzenegger in December 2010. President of the California Foundation for Commerce and Education. Former partner at KP Public Affairs. Served in senior policy positions for Governors Pete Wilson and George Deukmejian, including cabinet secretary to the governor and undersecretary for the California Trade and Commerce Agency.

SENATOR MICHAEL J. RUBIO (*D-East Bakersfield*) Appointed to the Commission by the Senate Rules Committee in February 2011. Elected to the 16th Senate District in November 2010 to represent all or portions of Fresno, Kern, Kings and Tulare counties.

DAVID A. SCHWARZ (*R-Beverly Hills*) Appointed to the Commission by Governor Arnold Schwarzenegger in October 2007 and reappointed by Governor Schwarzenegger in December 2010. Partner in the Los Angeles office of Irell & Manella LLP and a member of the firm's litigation workgroup. Former U.S. delegate to the United Nations Human Rights Commission.

JONATHAN SHAPIRO (*D-Beverly Hills*) Appointed to the Commission by the Senate Rules Committee in April 2010. Writer and producer for NBC, HBO and Warner Brothers. Former chief of staff to Lt. Governor Cruz Bustamante, counsel for the law firm of O'Melveny & Myers, federal prosecutor for the U.S. Department of Justice Criminal Division in Washington, D.C., and the Central District of California.

SENATOR MARK WYLAND (*R-Escondido*) Appointed to the Commission by the Senate Rules Committee in February 2011. Elected to the 38th Senate District in 2006 and re-elected in November 2010. Represents San Clemente and San Juan Capistrano counties and the cities of Carlsbad, Encinitas, Escondido, Oceanside, San Marcos, Solana Beach and Vista.

“Democracy itself is a process of change, and satisfaction and complacency are enemies of good government.”

*Governor Edmund G. “Pat” Brown,
addressing the inaugural meeting of the Little Hoover Commission,
April 24, 1962, Sacramento, California*