TABLE OF CONTENTS

Chapter 1 **Report Overview……...2**

Chapter 2 **Historical Context…….5**

Chapter 3 **California's Public Long Term Care Programs…..14**

Chapter 4 **Options for Improving State Administration of Public Long Term Care Programs……...20**

Chapter 5 **Options for the Administration of Long Term Care Facility Licensure ……..…...30**

Chapter 6 **Conclusion……...49**

Appendix A **AB 1215 Questionnaire**

Appendix B **Inventory of Public Long Term Care Programs**

CHAPTER 1
REPORT OVERVIEW

AB 1215 (Chapter 322 Statutes of 1997) required the California Health and Human Services Agency (CHHSA) to prepare a report on the long term care (LTC) services in California. Specifically, the legislation required the report to include:

- An inventory of all LTC services provided to California adults, including the caseload statistics, funding sources, eligibility criteria, geographic availability, and client characteristics;

- Options for how the administration of LTC services at the state level could be better organized; and

- Options for how the Department of Health Services (DHS) Licensing and Certification (L&C) Program and the California Department of Social Services (CDSS) Community Care Licensing (CCL) Program could effectively be combined or in some way share resources to promote administrative efficiency and improved policy continuity.

LTC, as defined in AB 1215, refers to the continuum of preventive, diagnostic, therapeutic, rehabilitative, supportive and maintenance services that address the health, social, and personal care needs of older individuals and functionally-impaired adults who have restricted self-care capabilities. LTC services are provided in licensed nursing facilities, adult residential care facilities, residential care facilities for the elderly, and through a broad range of home and community-based services. It is important to note, however, that unpaid family members provide almost 80% of the non-institutional LTC.

An individual's need for LTC arises from chronic functional limitations which require supportive health and social services. LTC services should enable people to regain or maintain the highest level of function with the greatest degree of autonomy possible (*Chronic Care in America: A 21st Century Challenge, August 1996, p. 38).*

LTC services have frequently been categorized as either "medical" or "social" models of care. This typology, while traditionally useful in classifying types of services, negates the multi-dimensionality of LTC needs. Regardless of where LTC services are received, individuals with chronic care needs require some combination of both medical and social services.

In preparing this report, a set of principles was developed to evaluate the relative merits of the various alternative organizational options presented. These principles include:

- Promoting the provision of quality LTC services;

- Facilitating access to information on LTC programs and services;
- Promoting expanded consumer choice of LTC services, models, and options;
- Encouraging responsiveness to consumer needs;
- Supporting effective and flexible public oversight of LTC entities;
- Reducing fragmentation and duplication of programs and promoting effective coordination among LTC programs;
- Encouraging the personal responsibility and independence of the LTC consumer;
- Promoting future cost efficiency and effectiveness; and
- Supporting the development of appropriate incentives and models in the private marketplace.

To gain input from the many LTC stakeholders throughout the state, the CHHSA developed a written questionnaire that was sent to over 154 consumers, advocates, industry representatives, and legislators. Survey recipients were asked to identify problems with the current system and suggestions for improving the organization of these programs at the state level (the questionnaire is contained in Appendix A). This survey was an opportunity for stakeholders to provide input, but it was not intended nor designed for statistical analysis purposes. The CHHSA received approximately 236 returned questionnaires due to the document's broad secondary distribution.

While many of the survey responses dealt with the desire for increased service funding, which was not the legislative intent of this report, specific suggestions received that addressed the state administration of LTC programs/LTC licensing functions are reflected in the options presented in Chapters 4 and 5.

On September 1, 1998, the CHHSA also convened a public forum on AB 1215 and received additional written and oral input. Feedback from the forum was consistent with the written questionnaire responses.

AB 1215 requires this report to include options for improving the administration of LTC programs and licensure, but does not require specific recommendations. However, this report does provide a set of principles, based in part on input received, against which these and other options can be evaluated. These principles provide a framework with which the strengths and limitations of each of these and other options can be weighed. These options are not mutually exclusive and could be modified to attain various degrees of integration.

References

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CHAPTER 2
HISTORICAL CONTEXT

This chapter will first review the evolution of the CHHSA and the departments under its purview; then examine how the current state LTC organizational structure developed; it will describe the LTC demographic challenges ahead in California; and finally identify previous legislative efforts to address these issues.

The quest for the optimal state organizational model to administer the broad array of publicly funded health and social service programs has been ongoing since the mid-1960s. California, like many other states, moved from centralized, large departments to many smaller, specialized departments to ensure that the specialized needs of certain populations were appropriately met. Many states are now reconsolidating some programs to overcome the unintended fragmentation that can accompany a decentralized model.

In California, the executive organization currently known as the California Health and Human Services Agency was established in 1961. Prior to that time, departments were directly responsible to the Governor.

Chapter 2037, Statutes of 1961, established four agencies - Health and Welfare, Youth and Adult Corrections, Resources, and Highway Transportation - as statutory entities. Although the authorizing legislation stated that the Agency Administrators were to be directly responsible to the Governor, in reality the Administrators had limited power relating to investigations and hearings. The agencies had minimal staff as they had no direct administrative responsibilities.

In 1968, Governor Reagan stipulated that all state agencies would communicate directly through a statutory Agency Administrator. Although the number of agencies has changed since 1968 - and more departments report directly to the Governor - the agency concept as envisioned by Governor Reagan has endured as an organizational structure.

The departments under the CHHSA umbrella have expanded and contracted in response to changing socio-economic and political forces. Table 1 (next page) documents the most notable departmental changes relevant to this report.

TABLE 1: ORGANIZATIONAL CHANGES 1961 - 1999

1961	The newly established Health and Welfare Agency (HWA) assumes responsibility for three existing departments: Mental Hygiene, Public Health and Social Welfare.
1965	The California Medical Assistance Program (Medi-Cal) is established. The Office of Health Care Services, within the HWA, is designated as the entity to coordinate and supervise the activities of the various departments involved in the Medi-Cal program. The Office was also responsible for policy development, fiscal and management oversight, program planning and review, training assistance and federal program relations. The four state departments directly involved in the Medi-Cal program include: ▪ Mental Hygiene ▪ Public Health ▪ Rehabilitation ▪ Social Welfare
1968	CHHSA is replaced with the Human Relations Agency. Ten departments were included under the Agency's jurisdiction, among them: ▪ Department of Mental Hygiene ▪ Department of Public Health ▪ Department of Health Care Services ▪ Department of Rehabilitation; and ▪ Department of Social Welfare Administration of the Medi-Cal program is transferred to the Department of Health Care Services.
1972	The agency's name was changed back to Health and Human Services Agency. Department of Public Health, Mental Hygiene, and Health Care Services, as well as programs from Department of Social Welfare and Rehabilitation were consolidated into a single Department of Health (DoH). The purpose was to consolidate previously fragmented efforts thereby providing more efficient and cost effective services.
1973	The Department of Benefit Payments (DBP) was legislatively established, transferring the functions, positions, and funds of the Department of Social Welfare to the DBP. The audit, collections, and claims payment activities of the Departments of Health and Human Resources Development were consolidated into the new DBP. Program control remained with the respective program departments. This experiment in a functional rather than programmatic organization lasted only a few years.

1974	The Office of Aging was established with departmental status. *In 1976, the Office became the Department of Aging.*
1978	A significant reorganization occurred that reshaped the agency into its current configuration: ▪ DBP was abolished, replacing it with Department of Social Services; ▪ Fiscal and audit function of the DBP were returned to the program departments; ▪ Department of Health was reorganized. Major programs were divided into distinct departments in order to increase program visibility, improve program policy direction and increase administrative, legislative, and public accountability. The new departments included: • Department of Health Services, established with responsibility for public health activities, health facility licensure, and Medi-Cal, including the audit and collection function transferred from the DBP; • Department of Alcohol and Drug Abuse, combining the functions of the former Office of Alcoholism and substance abuse functions from the DoH; *In 1979, the name of this department was changed to the Department of Alcohol and Drug Programs;* • Department of Developmental Services, established to administer the Lanterman Developmental Disabilities Act and assure coordination of services to persons with developmental disabilities; • Department of Mental Health, established to develop and provide a continuum of mental health services; and • The Office of Statewide Health Planning and Development (OSHPD), established; transferring the former Health Planning Program and a portion of the Licensing and Certification Program from the DoH.

Since 1979	Department of Aging is one of four additional entities that have come under the HWA umbrella.
January 1999	The name of the HWA is changed to the California Health and Human Services Agency (CHHSA).

CHHSA Non-Departmental Functional Responsibilities

In addition to its departmental oversight functions, CHHSA has historically had non-departmental functional responsibilities assigned either legislatively or administratively to the Agency. Examples include a variety of activities from administering the Medi-Cal and the Multipurpose Senior Services Programs during their early years to substance abuse and mental health coordination roles.

Organizational Models

In the early 1970s, interest in alternatives to nursing home care lead to the state and federal government authorizing home and community based (HCB) services that might delay or prevent nursing home placement. Many of these individual pilots became permanent programs and expanded both in terms of the number of client served and geographic availability. What evolved was a loose, uncoordinated array of HCB services. As each was a stand-alone program, initially little attention was focused on creating a system out of these developing programs. As a result, each program had distinct eligibility, care planning, administrative, reporting and data systems.

The dispersion of these programs across several state agencies made it challenging to create a system from the various LTC programs. Often, in spite of a commitment to inter-departmental LTC collaboration, day-to-day program mandates, competing policy priorities, and the normal government planning process, geared toward departmental budgets and legislative proposals rather than broader administration initiatives, impede effective collaboration.

Historically, programs and services specifically targeted to seniors and adults with disabilities have been assigned to one of several different state departments based on the program's funding source,[1] compatibility with the department's overall mission, and the presence of other similar programs within that department.

As the above review of the California Health and Human Services Agency's evolution attests, there is an on-going debate as to whether a "functional" organizational structure (i.e., an agency that includes multiple like programs that supports a functional need of a broad population) or a "client-based" organizational structure (i.e., an agency that

[1] Federal law requires that the oversight for Medicaid funded programs must reside with the single state Medicaid agency, which in California is the Department of Health Services. Thus, if any other department administers a Medicaid funded program, the Department of Health Services must perform an additional level of oversight over and above that performed by the other department to meet Medicaid requirements.

includes various supportive programs based on the needs of the target population) is preferable. Currently, within the CHHSA, both models exist. CDA, DDS, and DMH are examples of "client-based" agencies; DHS and CDSS are examples of "functional" agencies. There are tradeoffs involved in both models.

Major strengths of the "functional" agency approach include:

(1) In organizing around broad general service areas (e.g., health services or social services), in-depth programmatic expertise can be developed about the focused number of funding sources, reporting requirements, and waiver or contract specifications involved; and
(2) Internal efficiencies can be achieved by consolidating identical (or very similar) tasks that many like programs must perform. For example, a sophisticated cluster of expertise can be developed to design payment rates based on previous industry cost trends. However, the "functional" agency model is inherently less predisposed to being able to efficiently integrate the broad array of LTC services consumers might require since a number of these services would potentially lie outside this single agency and its funding streams.

A "client-based" agency organizational structure that includes diverse services to meet the target population's needs should be more readily able to integrate services since presumably all, or the majority, of the needed services would be administered by a single agency. However, the potential disadvantages of the "client-based" agency model are:

(1) The difficulty of developing and maintaining detailed expertise in the broad array of programs and services the agency administers especially given the different funding sources and programmatic requirements involved; and
(2) Creating smaller, client-specific agencies may result in loss of economies of scale. For example, every department must perform the full range of administrative functions (personnel, budgets, accounting, information technology, etc.). However, the cost efficiency of these units must be evaluated in relation to the number of employees they support.

Some states have transferred all LTC services, including the administration of Medicaid funded programs, to new "client-based" departments focused on individuals with chronic disabilities. In these states, the new LTC departments must now perform the same program functions for the LTC population (e.g., rate development, eligibility determination, program monitoring, data reporting, facility licensing, etc.) that were performed by the "functional" health or social service department it left.

The Demographic Imperative

The evolution of the CHHSA and the departments under its umbrella speaks to the ongoing search for the best organizational structure and the most efficient and cost effective method for delivering LTC services. The tremendous demographic shift currently underway is increasing pressure at the state and federal level to develop the infrastructure and financing needed to support a rapidly aging society.

Today, there are almost 4 million Californians age 65 or over, and half a million of those are considered to be the "oldest old," i.e. those ages 85 or over. In 2010, just 12 years from now, the senior population is projected to grow by approximately 20% to 5 million. Between 2010 and 2020, the senior population is expected to increase by 30% to 7 million. California's senior population is also becoming racially and ethnically more diverse. By 2020, an estimated 40% of California's elders will be persons of color (*Torres-Gil and Hyde, 1990, pg.).*

The oldest old represents the fastest growing segment of California's population. Between now and 2010, Californians age 85 and over will increase by 33%. By 2020, there will be almost a million Californians age 85 or older (*CA Dept. of Finance, 1993).* The elderly, particularly the oldest old, represent the segment of the population most likely to require LTC assistance.

At the turn of the century, less than two years from now, an estimated 1.5 million Californians will require LTC assistance. While LTC assistance is linked to advanced age, approximately 42% of the LTC population in 2000 will be under age 65 *(Rice and LaPlante, 1988).* Advances in medical knowledge - screening, treatment, surgical interventions, and pharmaceuticals - has prolonged the lives of many people with disabling chronic conditions and increased the number of survivors of traumatic injury (*Chronic Care in America: A 21st Century Challenge, August 1996, pg. 14).* These demographic changes make it essential that California develop new strategies to finance and provide LTC in a manner that supports client independence, continued community involvement, quality assurance, and cost effectiveness.

The state must pursue multi-pronged strategies in responding to the projected increased demand for LTC services. This report focuses on how those programs are organized and administered at the state level. Another important state-level strategy that needs to be included is prevention. Diet, exercise, smoking cessation, and early detection/treatment of the diseases that lead to chronic long-term conditions can significantly decrease the need for LTC. Education efforts on these issues are an essential preventive component that should be incorporated into any LTC strategic planning effort.

Legislative and Administrative Efforts

Long Term Care Reform Act

The quest for a better state LTC organizational model has not been limited to the changes in the CHHSA structure. In 1982, the Torres-Feland Long Term Care Reform Act (Chapter 1453, Statutes of 1982) would have created the State Department of Aging and Long Term Care. The new department was intended to consolidate all Older Americans Act programs administered by the California Department of Aging (CDA) as well as selected LTC programs from the DHS and CDSS. However, the legislation became effective only if the necessary State Budget appropriations were made and federal waivers secured. Neither of these actions was pursued at the state level and consequently the Act was never implemented.

Residential Care Initiatives

Advances in medical technology, expanded Medicare coverage of home health care, and the increased use of hospice services have increased consumer preference for receiving needed services in their own home. Numerous pieces of legislation over the past decade have also helped make it possible for Californians to continue living in residential care facilities for the elderly (RCFEs) even if they develop certain health conditions. Facilities may seek two varieties of waivers. One permits a secured perimeter to prevent residents with Alzheimer's Disease from roaming away; the other allows residents who need hospice services to remain in the facility under certain conditions.

State legislation passed in 1985 added Article 7, Section 1569.70 to the Health and Safety Code. This legislation required the development of an implementation plan to establish three levels of care under the RCFE licensure category; however, implementation was subject to appropriations being made in the Budget that were never made. This legislation required the establishment of a supplemental rate and payment method for SSI/SSP recipients requiring nonmedical personal care (Level II) or health related assistance (Level III). RCFE providers would have been required to conduct a resident assessment, and to develop and implement a care plan for each resident. An interagency taskforce, under the auspices of the California Health and Human Services Agency, was to develop procedures for evaluating and monitoring the appropriateness of the level of care determinations and to formulate recommendations for the payment mechanism. In effect, this legislation would have created a public reimbursement for what is commonly termed "assisted living."

Although the RCFE Level of Care concept did not become operational, other statutory changes, reflecting consumer preference for non-institutional options, have made it possible for individuals with specific mobility or health conditions to be admitted to and remain in licensed residential care settings. As a result, many individuals in RCFEs require more assistance with activities of daily living and have more complex health care needs. Between 1992 and 1997, the number of licensed RCFEs increased by 36% compared to a 7% increase in licensed nursing homes during that period.

Long Term Care Integration Pilot Program

In 1995, the Wilson Administration budget called for the establishment of LTC integration pilot programs to test new models of financing and providing LTC services. Negotiations between the Administration, legislature, providers and advocates resulted in passage of the Long Term Care Integration Pilot Program (Chapter 875, Statutes of 1995). In essence, this demonstration program authorizes participating counties to integrate the delivery of all health and LTC services as well as to consolidate the funding of those services at the county level to improve the quality of care provided, increase consumer involvement, independence and choice, and encourage the most cost effective delivery of care. Cognizant of the fact that chronic health conditions result in not only LTC utilization but heavy use of primary and acute health care services, the LTCI Pilot Program went beyond requiring the integration of LTC services and called for establishing a seamless system of health and LTC. In combining these two systems,

incentives will be created to provide care at the most appropriate level and to invest in cost-effective preventive and rehabilitative care.

In an effort to better coordinate LTC services at the local level, several counties have reorganized their health and social services administrative structure(s). Support for AB 1215 came, in part, from these counties that recommended that the state departments administering LTC programs should undertake a similar restructuring effort.

The state effort to implement the Long Term Care Integration (LTCI) Pilot Program has already created a new level of state inter-departmental dialogue and coordination that is expected to increase as the participating counties begin implementing their integration efforts.

Older Californians Act Reauthorization

In 1996, the Mello-Grandlund Older Californians Act (OCA) (Chapter 1097, Statutes of 1996) made substantial changes in how California administers services funded through the Older Americans Act. Most home and community-based services formerly administered directly by the California Department of Aging were transferred to the local Area Agencies on Aging (AAAs). The impetus for this major change was the belief that this transfer of administrative responsibility would improve consumer access to services, permit better service coordination, and allow local communities flexibility in determining the services most needed in their area. To date, responsibility for many of the previously state-administered programs has been transferred to the AAAs.

Little Hoover Commission Report

In 1996, the Commission on California State Government Organization and Economy, most frequently referred to as the Little Hoover Commission, conducted a series of meetings to gain input on how the state could better meet the needs of Californians with LTC needs. Later that year, the Commission issued a report, *Long-Term Care: Providing Compassion Without Confusion*, making numerous recommendations. Among the proposals was that the State consolidate its LTC programs in a single state agency that can provide a coordinated continuum of care. The recommendations of this report were also a catalyst for AB 1215.

Like AB 1215, the Little Hoover report and the statutory changes discussed earlier in this chapter identified several common themes. These include:

- The importance of bringing together the program administration and funding for the major LTC programs to facilitate the development of systemwide LTC strategic planning, budgeting priorities, policy development, etc.

- The importance of implementing the key elements of an effective LTC system, (e.g., a strong information and referral program, use of a standard assessment instrument and client information system, care management, and nursing home preadmission screening) to increase client choice and options and potentially avoid the use of more costly services than the client needs or wishes;

- The importance of streamlining program administrative functions and requirements to reduce consumer confusion and to provide administrative relief to local agencies that must comply with these duplicative requirements; and

- The importance of improving consumer access to timely, responsive information. The multiplicity of LTC programs, eligibility requirements, and service limitations coupled with the lack of a clear, known source of information and referrals in a local community makes it very difficult for consumers to find their way to the appropriate services. Most often the need for these services is linked to an emergency, i.e. a hospital discharge, a loss of a primary caregiver, or a sudden downturn in health. Thus, the timeliness of services is critical.

While this chapter has focused on the historical evolution of departments within the CHHSA and efforts to improve the administrative organization of LTC services at the state level, the next sections will provide an inventory of existing public LTC programs and options for their improved administration.

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CHAPTER 3
CALIFORNIA'S PUBLIC LONG-TERM CARE PROGRAMS

This chapter will present aggregate information on the number of clients served and the costs associated with California's public LTC programs. All reported information is from FY 1996, the most recent period for which a full year's worth of data was available. Program specific information is available in Appendix B.

In FY 1996, California public LTC expenditures totaled approximately $4 billion, with $2 billion paid by the federal Medicaid program, $2 billion paid by State general funds, and $221 million paid by county funds. Non-medical out of home care for SSI recipients accounted for 11% of the total LTC expenditures while care in Intermediate Care or Skilled Nursing Facilities represented 50% of those costs.

In FY 1996, 69,000 adult SSI recipients lived in residential care facilities. Another 132,000 adults lived in either intermediate care (ICFs) or skilled nursing facilities (SNFs). Although institutional (i.e., ICF/SNF) care accounted for most of the public LTC expenditures, this amount reflects the higher cost of these services rather than the majority of the LTC population receiving institutional care. California's rate of institutionalization has actually declined slowly over the past decade (Office of Statewide Health Planning and Development, *Statewide Profile of Freestanding Long Term Care Facility Utilization, 1997*) for Medi-Cal and private pay residents. In 1996, for every 1,000 Californians age 65 and over, 30 resided in a nursing facility. Oregon, a state that has undertaken major innovations to develop alternatives to institutional care, had a comparable rate of 27 per 1,000 individuals. Overall, state ratios vary widely. For example, the comparable ratio of nursing home residents is 21/1000 in Hawaii, 19/1000 in Nevada, and 23/1000 in Florida. Minnesota, and North and South Dakota have a much higher ratio at 72/1000. (AARP Public Policy Institute *Across the States: Profiles of Long Term Care Systems 1998, pp. 30 and 162)*.

The Personal Care Services Program and the Residential In-Home Supportive Services Program represent the two largest home and community-based care programs, accounting for 22% of the total LTC expenditures ($950.5 million). Approximately 191,184 Californians received care through these two in-home support programs in FY 1996. These two statewide programs, combined with the growth of residential care options, are likely to have contributed significantly to the overall decline in nursing home utilization.

The tables included in this chapter present the LTC caseload and expenditure data for California adults in FY 1996. Disabled children are not included given the guidelines of AB 1215. While program caseload is included, an overall caseload is not calculated. This report was unable to calculate an unduplicated count of program participants because program data does not identify participants by a unique identifier.

It should also be noted that LTC waiver and pilot programs instituted since FY 1996 have been included to provide the most current inventory of the state's public LTC programs even if those programs do not yet have caseload or expenditures. Where waiver

participation has increased significantly since 1996, a notation is made of the current enrollment.

TABLE 2:
CALIFORNIA LONG-TERM CARE EXPENDITURES BY DEPARTMENT
FISCAL YEAR 1996

Department	County Funds	State General Funds	Federal Funds	Total Expenditures
Dept. of Aging	0	51,688,227	45,385,893	97,074,120
Dept. of Developmental Services	0	156,349,116	133,151,011	289,500,127
Dept. of Health Services	0	1,247,183,021	1,249,431,128	2,496,614,149
Dept. of Mental Health	0	5,542,000	0	5,542,000
Dept. of Social Services	221,000,000	665,369,381	549,628,197	1,435,997,578
Total	**221,000,000**	**2,126,131,745**	**1,977,596,229**	**4,324,727,974**

TABLE 3:
CALIFORNIA LONG-TERM CARE EXPENDITURES
CALIFORNIA DEPARTMENT OF AGING (CDA)
FISCAL YEAR 1996

Program	Number of Clients	State General Funds	Federal Funds	Total Expenditures
Adult Day Health Care	5,330	630,000	617,000	1,247,000
Adult Day Care/Health Care	2,913	253,429	1,039,715	1,293,144
Alzheimer's Day Care Resource Centers	2,448	2,491,000	0	2,491,000
Linkages	2,000	2,149,000	0	2,149,000
MSSP	8,014	11,042,000	10,764,000	21,806,000
OAA/Assist. Transportation	10,945	42,073	363,864	405,937
OAA/Case Management	27,850	78,574	3,295,483	3,374,057
OAA/Chore	3,039	9,221	94,355	103,576
OAA/Homemaker	21,420	238,139	2,436,778	2,674,917
OAA/Personal Care	4,150	80,791	826,698	907,489
OAA/Home Delivered Nutrition	53,576	5,729,000	16,043,000	21,772,000
OAA/Congregate Nutrition	153,779	26,931,000	7,236,000	34,167,000
Office of the State Long Term Care Ombudsman	171,415	2,014,000	2,669,000	4,683,000
Total	**N/A[2]**	**51,688,227**	**45,385,893**	**97,074,120**

[2] An unduplicated count of clients across programs could not be calculated.

TABLE 4:
CALIFORNIA LONG-TERM CARE EXPENDITURES
DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)
FISCAL YEAR 1996

Program	Number of Clients	State General Funds	Federal Funds	Total Expenditures
Alternative Residential Model (ARM)[3]	13,217	72,562,005	46,265,210	118,827,215
Independent Living Services (ILS)	8,977	21,253,158	21,428,495	42,681,653
Intermediate Care Facilities/Mental Retardation[4]	2,571	57,060,900	59,939,100	117,000,000
Supportive Living Services (SLS)	881	5,473,053	5,518,206	10,991,259
Total	**N/A[5]**	**156,349,116**	**133,151,011**	**289,500,127**

[3] Approximately 33% of these clients are under the age of 18. The figures shown reflect caseload and expenditures for the program's adult participants.
[4] Approximately 35% of these clients are under the age of 18. The figures shown reflect caseload and expenditures for the program's adult participants.
[5] An unduplicated count of clients across programs could not be calculated.

TABLE 5:
CALIFORNIA LONG-TERM CARE EXPENDITURES
DEPARTMENT OF HEALTH SERVICES (DHS)
FISCAL YEAR 1996

Program	Number of Clients	State General Funds	Federal Funds	Total Expenditures
AIDS Care Management	2,873	6,420,000	1,320,000	7,740,000
AIDS Medi-Cal Waiver	2,892	5,967,311	5,967,311	11,934,622
Alzheimer's Disease &Diagnostic Treatment Centers	3,033	2,615,040	0	2,615,040
CA Partnership for LTC	4,762	0	812,720	812,720
County Organized Health Systems (COHS)[6]	0	0	0	0
Dept. of Dev. Services Waiver	35,105	27,434,958	27,655,318	55,090,276
LTC Integration Pilots[7]	0	0	0	0
LTC Sub-Acute Services	1,312	75,775,727	75,827,272	151,602,999
Medi-Cal In-Home Medical Care Waiver	364	18,192,903	18,339,029	36,531,932
Medi-Cal Intermediate Care Facilities/Dev. Disabled	9,876	27,628,742	27,850,658	55,479,400
Medi-Cal Nursing Facility/Intermediate Care Facilities	122,255	1,059,495,000	1,068,005,000	2,127,500,000
Medi-Cal NF Waiver[8]	45	154,055	154,285	308,340
Model Waiver[9]	8	31,248	31,498	62,746
MSSP Waiver[10]	0	0	0	0
Personal Care Services[11]	0	0	0	0
Program of All Inclusive Care to the Elderly (PACE)	683	8,494,835	8,494,835	16,989,670
SCAN (Social/HMO Demo.)	11,000	14,973,202	14,973,202	29,946,404
Total	N/A[12]	1,247,183,021	1,249,431,128	2,496,614,149

[6] Data captured in Medi-Cal NF/ICF program category.
[7] Program underway in 1996, but pilots not yet begun.
[8] The NF Wavier had 279 participants, primarily adults.
[9] The Model Waiver had 57 participants, primarily adults.
[10] Data captured in CDA's MSSP program category.
[11] Data captured in DSS's Personal Care Services program category.
[12] An unduplicated count of clients across programs could not be calculated.

TABLE 6:
CALIFORNIA LONG-TERM CARE EXPENDITURES
DEPARTMENT OF MENTAL HEALTH (DMH)
FISCAL YEAR 1996

Program	Number of Clients	State General Funds	Federal Funds	Total Expenditures
Caregiver Resource Center	9,500	5,042,000	0	5,042,000
Traumatic Brain Injury Project	296	500,000	0	500,000
Total	N/A[13]	5,542,000	0	5,542,000

TABLE 7:
CALIFORNIA LONG-TERM CARE EXPENDITURES
DEPARTMENT OF SOCIAL SERVICES (DSS)
FISCAL YEAR 1996

Program	Number of Clients	County Funds	State General Funds	Federal Funds	Total Expenditures
Adult Protective Services (APS)[14]	57,256	0	0	0	0
Assistance to Blind and Visually Impaired	525	0	322,700	0	322,700
In-Home Supportive Services (IHSS) Residual[15]	71,448	110,000,000	205,000,000	0	315,000,000
Office of the Deaf	152,000	0	3,300,000	0	3,300,000
Personal Care Services Program[3]	119,736	111,000,000	205,500,000	319,000,000	635,500,000
SSI/SSP--Non-Medical Out-of-Home Care	69,071	0	251,246,681	230,628,197	481,874,878
Total	N/A[16]	221,000,000	665,369,381	549,628,197	1,435,997,578

[13] An unduplicated count of clients across programs could not be calculated.
[14] Services provided through Federal Title XIX Community Services Block Grant. Counties determine amount directed to their county APS.
[15] Data submitted reflects an annual average based on statewide monthly caseload. Counties contribute 18% of costs.
[16] An unduplicated count of clients across programs could not be calculated.

References

Graves, N. and Bectel, R. 1998. *Across the States: Profiles of Long Term Care Systems*, American Association of Retired Persons Public Policy Institute, Washington, D.C., pp. 30 and 162.

CHAPTER 4
OPTIONS FOR IMPROVING STATE ADMINISTRATION OF PUBLIC LONG-TERM CARE PROGRAMS

This chapter will describe organizational options for improving the state administration of LTC programs and identify the inherent challenges involved in integrating LTC services given the current organizational structure.

As discussed in Chapter 2, the LTCI Pilot Program calls for the integration of LTC services and the consolidation of funding at the local level to encourage improved care outcomes, greater client choice, and a more cost effective, efficient use of public resources. Programmatic integration and funding consolidation will require considerable interdepartmental commitment at the state level for this implementation to occur.

A number of counties seeking to implement LTCI have undergone administrative reorganization of their public health and social service agencies. These reorganization efforts have attempted to create a more seamless service system, to improve program outcomes, and to increase administrative efficiencies.[17] A key question is whether a similar reorganization at the state level, beyond the inter-departmental collaboration outlined above, would more quickly and simply advance the development of an effective LTC system.

Restructuring the state administration of LTC programs will not achieve the key policy objectives outlined above by itself. Resources must be secured, and the agencies involved must share a common vision in order to progress in developing and implementing a more effective LTC system.

Option A and B below suggest a partial or comprehensive LTC program consolidation that in some ways reflect the administrative reorganization underway in some counties and the programs being integrated in the LTCI pilot programs. Although the organizational options are presented as discrete options, they are not necessarily mutually exclusive. For example, Option A and C could both be selected for implementation.

[17] There are currently LTCI efforts underway in at least five counties. It is anticipated that one county will submit an administrative action plan for implementing its first integration steps to the DHS by December 31, 1998.

OVERVIEW OF OPTIONS FOR IMPROVING STATE ADMINISTRATION OF PUBLIC LTC PROGRAMS

OPTION A:

PARTIAL CONSOLIDATION OF LTC SERVICES

Potentially Includes:

- Medi-Cal LTC institutional
- IHSS
- Alzheimer's Day Care Resource Centers
- Respite programs
- Appropriate other Medi-Cal home & community based waiver programs
- Medi-Cal personal care services
- MSSP
- Linkages
- ADHC

OPTION B:

Comprehensive Consolidation of LTC Services

Includes all of Option A:

- Medi-Cal LTC institutional
- IHSS
- Alzheimer's Day Care Resource Centers
- Respite programs
- Appropriate other Medi-Cal home & community based waiver programs
- Medi-Cal personal care services
- MSSP
- Linkages
- ADHC

Additional programs….

All remaining CDA programs:

- Brown Bag
- Nutrition Services
- Senior Companion
- Other Supportive Services, such as transportation
- Foster Grandparent
- LTC Ombudsman
- Senior Community Services Employment

From DHS:

- LTCI program
- PACE
- Alzheimer's Disease Diagnostic & Treatment Centers
- Partnership for LTC
- Social HMO

From DMH:

- Caregiver Resource Center
- Traumatic Brain Injury Project

From DR:

- Habilitative Services
- State Independent Living Services

From CDSS:

- Adult Protective Services
- Office of Services to the Blind
- Office of Deaf Access

OPTION C:

Center for LTC Systems Development

Policy Center includes Directors of all departments administering LTC programs and possibly agencies providing other vital services (e.g., housing, transportation, etc.).

Option A: Partial Consolidation/Restructuring of Specific State LTC Programs

As counties participating in the LTCI Pilot Program implement their integration steps, the state can examine which core LTC programs are being integrated at the local level and evaluate the success of this programmatic integration. Based on these findings, the state can develop recommendations as to which programs should be clustered at the state level. Programmatic funding should be transferred with the program. LTC programs/services, which may be considered for inclusion, are the natural cluster of programs identified for service integration at the local level in the legislation implementing the LTCI pilots (Welfare and Institutions Code, Section 14139.32). These programs include:

- Medi-Cal long-term institutional care;
- Medi-Cal Personal Care Services Program;
- In-Home Supportive Services Program;
- The Multipurpose Seniors Services Program;
- Alzheimer's Day Care Resources Centers Program;
- Linkages Program;
- Respite Program;
- Adult Day Health Care Program; and
- Appropriate Medi-Cal home-based and community-based waiver programs;

This recommendation would require considerable additional refinement and analysis. Areas of further analysis include:

a. Completion of a thorough fiscal cost/benefit analysis that would include, but not be limited to the following: identification of the short term costs involved in securing space, moving and reclassifying employees, developing new administrative system, etc.; the additional on-going costs that may be incurred in duplicating administrative/programmatic functions provided by the prior department; and any long-term anticipated savings from merging administrative/programmatic functions.

b. Further exploration of federal requirements that could impact efforts to consolidate programs. Medicaid law clearly requires that a single state agency be identified to serve as the primary contact with the federal agencies, be responsible for the appropriate control and accounting of federal monies, and to be accountable for the health and welfare of the service beneficiaries. Even though a different state agency may have the day-to-day responsibility for a Medicaid-funded program's operation and administration, the single state agency must retain responsibility for health and welfare assurance as well as fiscal management.

c. A more in-depth review of other states' reorganization efforts that might be applicable to California should be undertaken. This study should identify similarities/dissimilarities of state's county structures; roles and responsibilities of

the Area Agencies on Aging; and the state's degree of success in creating a continuum of care options.

d. Detailed research on how the administrative aspects of the Medi-Cal program could be divided in order to separate Medi-Cal LTC services must be completed. Although it may be possible to agree on which services to classify as LTC, it is difficult to divide them from the larger Medi-Cal program because the clients themselves are not easily classified. Furthermore, LTC and non-LTC services are often closely linked. For example, an individual may require several days in a hospital for an acute illness and then be discharged to a SNF for several days of rehabilitation. It is difficult to identify where subacute and short-term skilled nursing care end and custodial LTC begins.

e. Recommendations must be developed on how to divide LTC programs that currently serve both children and adults given that a residual program would remain in the current department. Would both programs continue to use the same policies and procedures, program monitoring requirements, payment and data reporting systems or would new systems be developed by one or both groups?

Pros:

- An organizational structure based on the specific needs of the LTC population would potentially encounter fewer barriers in integrating services, resolving inconsistent program policies, and developing the tools of a LTC system (e.g., client information system, integrated intake/assessment process, MIS, etc.) since all of the major programs would be within that single department (with its own strategic planning, budget, and legislative process).

- The synergy[18] created in clustering these programs together should facilitate the development of program outcome measures appropriate in evaluating the quality of care being provided.

- The synergy created in clustering these programs together should encourage the adoption of "best practices" from one program to other appropriate programs and encourage the development of innovative models of care.

- In clustering the key LTC programs together, the needs of subpopulations not being addressed should become apparent more quickly and steps can be taken to incorporate these groups into existing programs or to establish specialized services if necessary.

- The synergy created in clustering these programs together should also facilitate the development of a "user-friendly" consumer information and referral process at the state and local level so individuals can receive appropriate and timely information on

[18] "Synergy" as used in this report refers to the phenomenon that can occur when the outcome of two (or more) entities working together is greater than the outcome either might independently achieve.

the options available to them. Several AB 1215 survey respondents identified consumers' inability to gain this information as a major client obstacle.

- As access to consumer information improves, this option potentially encourages increased personal responsibility and more informed consumer choices.

- Program efficiency should be realized as some program functions are streamlined and/or integrated.

- Local needs and solutions will be reflected in this restructuring option.

Cons

- If Medicaid programs are to be transferred, the Health Care Financing Administration (HCFA) must approve of this action. HCFA may not be willing to approve a department other than the Single State Medicaid Agency (DHS) to administer a specific program, or HCFA may continue to require DHS to conduct its own program monitoring in addition to that being done by a new entity. Such requirements would result in a new duplicative layer of program administration.

- Increases in administrative costs should be anticipated due to organizational changes that disrupt existing systems. Transferring programs will impact the budget, accounting, personnel, programmatic, and data sections of every department involved.

- This option is dependent on LTCI progress that will occur over a series of several years. Thus, tying implementation of state restructuring to the outcomes of the LTCI pilot efforts could significantly delay reorganization efforts.

- Extensive statutory changes would be necessary. Even if this reorganization were enacted by Executive Order, the plan must be submitted to both the Assembly and Senate and those bodies have 60 consecutive days of session to disapprove the plan. "Clean up" legislation would still likely be required to statutorily, at a minimum, transfer programs from one department to another whether it is transitioning to a new or existing department.

- If health and LTC programs are separated, as proposed under this option, further barriers in attempts to develop a seamless system of care that spans primary, acute and LTC services may be created;

- Simply relocating programs under a new roof will not magically create a system out of the existing LTC programs. Leadership at all levels must be committed to this goal and held responsible for achieving it.

- This alternative does not involve other critical long-term care programs (such as the Department of Mental Health's Caregiver Resource Centers).

Option B: Comprehensive Consolidation/Restructuring of State LTC Programs.

Once the outcomes of the organizational restructuring suggested in Option A can be measured, and presuming positive programmatic and fiscal results are found, it may be appropriate to consider a more comprehensive organizational restructuring. Option B represents the most broad restructuring likely to be considered. More modest program consolidation, beginning with several core programs, could also be considered. A great deal of coordination at the local level already occurs among these programs so they may constitute a natural cluster of services to consolidate. Programs appropriate for consolidation should have common program goals and respond to similar client needs.[19]

Option B includes all of the programs listed under Option A. The following additional programs could also be considered for inclusion:

1. All of the remaining programs from the existing CDA:

    - Brown Bag Program
    - Foster Grandparent Program
    - Nutrition Services, including Congregate Meals and Home-Delivered Meals (Older Americans Act Title II I-C)
    - Ombudsman/Elder Abuse Program
    - Senior Companion Program
    - Senior Community Services Employment Program
    - Supportive Social Services, including Adult Day Care/Health Care, Assisted Transportation, Case Management, Chore, Homemaker and Personal Care

2. From the existing DHS:

    - Alzheimer's Disease Diagnostic and Treatment Centers (ADDTCS)
    - California Partnership for Long Term Care

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[19] Department of Developmental Services (DDS) programs were not included in this option because the developmental services system currently provides, under the Lanterman Developmental Disabilities Act (Welfare and Institutions Code, Section 4500 et seq), a single point of entry in local communities and access to a wide range of residential, day, and support services regardless of the services' funding source or license status for persons with or at risk of developmental disabilities. Separating the LTC services provided to adults with developmental disabilities from those provided to children, as specified by AB 1215, would potentially dismantle the seamless single entry point for services in addition to fragmenting the services available. Another concern raised was that if a comprehensive reorganization included DDS, the entity created might be so large that it would be counter-productive (e.g., the "specific" organizational structure might be lost if it absorbs too many sub-populations or program areas).

- Long Term Care Integration Pilot Program
- Program for All-inclusive Care for the Elderly (PACE)
- Social Health Maintenance Program (S/HMOs)

3. From the existing DMH:

   - Caregiver Resource Center
   - Traumatic Brain Injury Project

4. From the existing Department of Rehabilitation (DR):

   - Habilitation Services
   - State Independent Living Services

5. From the existing CDSS:

   - Adult Protective Services
   - In-Home Supportive Services Program (including Personal Care Services Program)
   - Office of Deaf Access
   - Office of Services to the Blind

Pros:

- An organizational structure that includes not only the LTC programs but income support and other related programs would potentially encounter fewer barriers in integrating/coordinating services, resolving inconsistent program policies, and developing the tools of a LTC system (e.g., client information system, integrated intake/assessment process, MIS, etc.) since all of the major programs would be within a single department.

- The synergy created in clustering these programs together should facilitate the development of program outcome measures appropriate in evaluating the quality of care being provided.

- The synergy created in clustering these programs together should encourage the adoption of "best practices" from one program to other appropriate programs and encourage the development of innovative models of care.

- In clustering these programs together, the needs of subpopulations not being addressed should become apparent more quickly and steps can be taken to incorporate these groups into existing programs or to establish specialized services if necessary.

- The synergy created in clustering these programs together should also facilitate the development of a "user-friendly" consumer information and referral process at the state and local level so individuals can receive appropriate and timely information on

the options available to them. Several AB 1215 survey respondents identified consumers' inability to gain this information as a major client obstacle currently.

- As access to consumer information improves, this option potentially encourages increased personal responsibility and more informed consumer choices.

- Program efficiency should be realized as some program functions are streamlined and/or integrated.

- Local needs and solutions will be reflected in this restructuring option.

Cons:

- If Medicaid programs are to be transferred, the Health Care Financing Administration (HCFA) must approve of this action. HCFA may not be willing to approve a department other than the Single State Medicaid Agency (DHS) to administer a specific program, or HCFA may continue to require DHS to conduct its own program monitoring in addition to that being done by a new entity. Such requirements would result in a new duplicative layer of program administration.

- Increases in administrative costs should be anticipated due to organizational changes that disrupt existing systems. Transferring programs will impact the budget, accounting, personnel, programmatic, and data sections of every department involved.

- This option is dependent on LTCI progress that will occur over a series of several years. Thus, tying implementation of state restructuring to the outcomes of the LTCI pilot efforts could significantly delay reorganization efforts.

- Extensive statutory changes would be necessary. Even if this reorganization were enacted by Executive Order, the plan must be submitted to both the Assembly and Senate and those bodies have 60 consecutive days of session to disapprove the plan. "Clean up" legislation would still likely be required to statutorily, at a minimum, transfer programs from one department to another whether they are transitioning to a new or existing department.

- If health and LTC programs are separated, as proposed under this option, further barriers in attempts to develop a seamless system of care that spans primary, acute and LTC services may be created;

- Simply relocating programs under a new roof will not magically create a system out of the existing LTC programs. Leadership at all levels must be committed to this goal and held responsible for achieving it.

- The new entity would be required to incorporate a wide range of programs with varying missions, goals and objectives. If all the programs listed for potential

inclusion were incorporated, the size and scope of this entity may result in it becoming a new "generic" organization of another type.

Option C: Establish a Center for LTC Service Systems

This option would establish a Center for LTC Service Systems within the Governor's Cabinet or within the CHHSA to provide leadership in the development of a coordinated LTC system. The directors of the five departments serving individuals with LTC needs (the Departments of Aging, Developmental Services, Mental Heath, Health Services, and Social Services) would comprise the Center's leadership. The directors of the Housing and Community Development and Veterans Affairs could also be included since these departments have programs that finance and provide LTC services or impact the availability of supportive housing. This Center would work through an Executive Subcommittee, made up of top administrative program staff in those departments.

The Center's primary mission would be to provide leadership in developing a LTC system out of the current array of LTC programs. It would also develop public policy on how the licensing and certification functions related to LTC should be organized and administered. The Center would focus on the following:

- Identifying and implementing changes to streamline processes and share resources which would assist consumers in accessing and providers in developing responsive services and strengthen the monitoring of these services;

- Supporting improved resource and information sharing at the state and local level; and

- Developing priorities and strategies for enhancing the overall availability and quality of LTC services.

Pros:

- This alternative, although different in scope and approach than Options A and B, could provide a vehicle to address the overall LTC objectives articulated earlier in this chapter.

- Depending on where this entity was organizationally placed, it would elevate attention to LTC policy issues.

- Would establish a structure and forum for the on-going discussion of cross-cutting issues;

- Would facilitate an incremental approach to the policy development needed to identify state level changes necessary to support local efforts to build the LTC continuum of services;

- Could be implemented quickly, with little administrative cost.

Cons:

- If not appropriately configured and supported, the entity could create administrative confusion between departments and the Center. The Center could also be viewed as simply an additional administrative layer.

- Would require the ongoing participation of appropriate high-level departmental staff with the knowledge and authority to affect change;

- The need to address departmental priorities could distract participating agencies from focusing on the Center's efforts.

- The Center would be fundamentally an advisory body with no authority to enforce policy decisions unless it was granted that statutory authority.

CHAPTER 5
OPTIONS FOR THE ADMINISTRATION OF LONG-TERM CARE FACILITY LICENSURE

This chapter provides an introduction to the licensing process and presents options for integrating licensure functions for long-term health care facilities, community care facilities, and adult day health care facilities.

PART I: INTRODUCTION

The Licensing Process

The licensing process is among a variety of functions performed to assure the quality and availability of services to a range of populations. The licensing of long-term care and community care facilities is a state responsibility executed in response to state requirements established in statute and regulation. CDSS and DHS are the principle CHHSA departments responsible for licensing the community care and long-term care facilities that are the focus of this report. Other departments also play a role in licensing long-term care facilities. For example, DHS and CDA share responsibility for licensing adult day health care centers, while the Department of Mental Health (DMH) licenses psychiatric health facilities.

The licensing process focuses on assuring that minimum health and safety standards and protections are in place. Consumers look to the state to assure that needed services are accessible, that the services meet minimal standards, that providers will assist in achieving desired outcomes, and that an established point of contact will assist with service selection and the resolution of concerns. The enforcement and sanction functions involved in the licensing process have been augmented to include technical assistance to support providers in achieving outcomes and maintaining compliance. This process is consistent with national trends toward building a partnership between the consumer and the service provider that continually strives to achieve care quality. Quality cannot be assured simply by regulating processes; quality must become an integral part of an organizational mission focused on outcomes and consumer satisfaction.

There is significant overlap between the licensing process and the program departments' responsibility for establishing and maintaining a cost effective service system. Programs seek to build consensus between consumers and service providers with regard to outcomes and best practices. Because the licensing process focuses on health and safety protections, any separation of the licensing process from program development and support functions must guard against unnecessary duplication of effort, organizational conflicts, the application of different provider standards and expectations, and confusion for consumers.

While this chapter focuses on the licensing process as it pertains to long-term care and community care facilities, this process also applies to agencies and individuals which

provide health and social services related to long-term care. All of the facilities licensed by CHHSA departments are responsible for providing a safe structure, care according to acceptable standards, and protection of personal rights. Oftentimes, there is also a program of some type that is tailored to the unique needs of the population being served. In addition, new or modified health facilities require clearance from the Facilities Development Division of the Office of Statewide Health Planning and Development (OSHPD). Clearance from OSHPD requires compliance with federal Life Safety Code requirements (similar to the state's fire clearance requirements) and with specific state building code requirements. For example, skilled nursing facilities and hospitals must comply with construction requirements contained in the building that are designed specifically for these types of facilities.

Agencies also may be licensed to deliver services both within and outside the licensed facility setting. For example, DHS licenses home health agencies and hospice agencies to provide the services of a visiting nurse or aide to persons in their homes and in facilities. Further, many of the individuals licensed under the Department of Consumer Affairs (DCA) or certified by DHS provide health services in private practice, or provide services in licensed facilities and/or agencies.

Licensed agencies and facilities must comply with the professional practice acts enforced by DCA. For instance, a skilled nursing facility cannot adopt a policy that permits unlicensed individuals to provide services that the Registered Nurse Practice Act permits registered nurses only to perform. Accordingly, it is necessary to have a high degree of enforcement coordination and joint policy development among the CDSS, DHS, and DCA with regard to how licensed professionals practice in facilities and agencies.

Certification for Federal Reimbursement

Community care and long-term care facility licensing is a state responsibility which involves the enforcement of state requirements. In addition, the DHS serves on the federal government's behalf to certify long-term care facilities for participation in the Medicare and/or Medicaid (Medi-Cal) programs. To certify these facilities, DHS uses processes and standards determined by federal statute and regulation and interpreted by the Health Care Financing Administration (HCFA). The certification process examines the administration and physical plant of the facility, and assesses the quality and adequacy of the care being provided to residents. DHS uses the same staff to enforce federal certification requirements as it does state licensing requirements. State enforcement actions vary depending on whether the action is taken based on state or federal requirements.

Program Standards

State program departments also may establish additional requirements tailored to the specific needs of the populations receiving services from licensed entities. The application and enforcement of these standards is distinct from the licensing and certification process, and may be performed by a program department distinct from the

department responsible for licensing and certification. For example, the Department of Developmental Services (DDS) does not have any direct responsibility for facilities, agencies, or persons. However, DDS reviews and approves statutorily required program plans for intermediate care facilities serving the developmentally disabled. Through its 21 regional centers, DDS also vendors with residential care facilities and day care facilities to provide services to developmentally disabled persons. DDS may impose additional requirements on licensed caregivers, and may fund additional services and staffing to meet residents' needs.

LICENSING PROGRAMS AND LICENSED FACILITIES

CDSS and DHS are the CHHSA departments principally responsible for licensing facilities that provide long-term care to adults.

Community Care Licensing Mandate and Authority

The CDSS Community Care Licensing Division (CCLD) mandate is to protect the health and safety of persons who reside or spend a portion of their time in out-of-home care. CCLD is responsible for ensuring that community care facilities comply with applicable laws and regulations. The authority for all actions taken by CCLD is contained in the Health and Safety Code under three separate licensing acts and a fourth statute enacted in 1990. These are:

- The California Community Care Facilities Act enacted in 1973 for residential care facilities serving the children and adults (Section 1500 et seq.).

- The California Child Day Care Act enacted in 1984 for childcare centers and family day care homes serving children (Section 1596 et seq.).

- The California Residential Care Facilities for the Elderly Act enacted in 1985 for residential care facilities serving persons aged 60 and older (Section 1569 et seq.).

- Licensing laws for Residential Care Facilities for the Chronically Ill enacted in 1990 for residential care facilities serving chronically ill adults (Section 1568.01).

These four licensing laws are implemented through the development and enforcement of regulations in Title 22, Divisions 6 and 12 of the California Code of Regulations. Division 6 applies to residential care facilities. Division 12 applies to children's day care facilities.

Licensing and Certification Mandate and Authority

The DHS Licensing and Certification (L&C) Program mandate is to protect the health and safety of persons receiving services in licensed health facilities. All actions taken by L&C in the areas of licensing, certification and complaint investigation are based on

federal or state law, federal or state regulations, officially recognized federal or state instructions, or legal interpretations based on court decisions.

The authorities most commonly referenced by L&C are:

Federal Certification

- Titles XVIII (Medicare) and XIX (Medicaid/Medi-Cal) of the Social Security Act.
- The Code of Federal Regulations Title 42, Chapter IV.
- The State Operations Manual and State Agency Letters.

State Licensure

- Health and Safety Code, Division 2 (Licensing Provisions).
- California Code of Regulations, Divisions 3 and 5.
- The Licensing and Certification Policy and Procedure Manual.

The following tables provide an overview of the respective similarities and differences between each department's licensing program.

LICENSING PROGRAM	
CDSS	**DHS**
▪ Operate an effective regulatory enforcement program. ▪ Promote strategies to increase voluntary compliance. ▪ Provide technical assistance to and consult with care providers. ▪ Work collaboratively with clients, their families, advocates, care providers, placement agencies, related programs and regulatory agencies and others involved in community care. ▪ Train staff in all aspects of the licensing process. ▪ Educate the public about CCLD and community care options. ▪ Promote continuous improvement and efficiency throughout the community care licensing system.	▪ Operate a responsive, uniform enforcement program. ▪ Encourage provider-initiated compliance and quality of care improvement activities. ▪ Initiate changes to improve cost-effectiveness. ▪ Promote public and private health care partnerships to improve quality of care and access to new technologies, and to respond to California's changing demographics.

LICENSING PROCESS
▪ Review applications to determine applicants meet statutory and regulatory requirements. ▪ Oversee facility compliance through facility inspection. ▪ Promote provider compliance through technical assistance. ▪ Initiate enforcement actions when facility non-compliance with regulations is identified. ▪ Investigate complaints concerning care provided at facilities. ▪ Educate consumers and providers; promote provider compliance through technical assistance.

LICENSING PROGRAM ACTIVITIES	
CDSS	**DHS**
CCLD conducts seven major activities. They are: ▪ Licensing 18 categories of community care facilities ▪ Conducting background checks on licensed caregivers and their employees. ▪ Investigating complaints regarding alleged violations of licensing regulations. ▪ Providing technical assistance to providers to help them maintain compliance ▪ Initiating administrative action against licensees for failure to comply with licensing regulations ▪ Developing and enforcing state regulations. ▪ Certifying ARF and RCFE administrators annually.	L&C conducts six major activities that impact health care. They are: ▪ Licensing 30 different types of health care facilities and providers ▪ Certifying to the federal government the health care facilities and providers that are eligible for payments under the Medicare and Medicaid (Medi-Cal) programs. ▪ Investigating complaints regarding concerns expressed about care provided by health care facilities and agencies. ▪ Certifying that nurse assistants, home health aides and hemodialysis technicians can provide specific services and approving training programs for these health care workers. ▪ Educating consumers and providers to improve health care quality. ▪ Enforcing state and federal regulations.

OPERATIONAL OVERVIEW	
CDSS	**DHS**
CCLD consists of a Central Operations Branch in Sacramento, four Regional Offices and 22 District Offices. CCLD contracts with 44 counties to license foster family homes and eleven counties to license family childcare homes. Each District Office is responsible for licensing, enforcement and complaint investigation activities in a specific geographic area. Primary District Office activities include: ▪ Applications – processing applications for new facilities and changes in ownership; ▪ Enforcement – conducting annual on-site inspections of facilities. Issuing citations and developing plans of correction for follow-up, and initiating administrative actions against non-compliant facilities; and ▪ Complaints – conducting on-site investigation visits within ten days after receiving a complaint against a facility.	***L&C has 12 District Offices throughout California. In addition, L&C contracts with Los Angeles County that has another five offices that perform work on behalf of L&C in Los Angeles County. Each District Office is responsible for licensing, survey, and complaint activities in a specific geographic area. These activities include:*** ▪ Applications – processing applications for new facilities, changes in ownership, and additional service requests (L&C Program headquarters processes SNF/NF applications.); ▪ Enforcement – Issuing survey results, reviewing facility plans of correction, issuing citations and recommending termination from funding programs under federal law or revocation of license under state law; and ▪ Surveys – Conducting on-site inspections of health facilities for licensing and certification purposes.

The following table lists the various facilities licensed by CDSS or DHS to provide long-term care services to adults. Other CHHSA departments also may be involved in the licensure of these facilities, or for developing program standards to guide service to particular populations. These departments are noted as appropriate.

LICENSED LONG-TERM CARE FACILITIES IN 1998	
CDSS	**DHS**
ADULT DAY CARE FACILITY (ADCF) – a facility of any capacity which provides programs for frail elderly and developmentally disabled and/or mentally disordered adults in a day care setting. ▪ **564 Licensed Facilities** **ADULT DAY SUPPORT CENTER (ADSC)** – a community based group program designed to meet the needs of functionally impaired adults through an individual plan of care in a structured comprehensive program that provides a variety of social and related support services in a protective setting less than 24 hours per day. ▪ **42 Licensed Facilities** **ADULT RESIDENTIAL FACILITY (ARF)** – a facility of any capacity which provides 24-hour non-medical care for adults aged 18 through 59 who are unable to provide for their own daily needs. Adults many be physically handicapped, developmentally disabled and/or mentally disordered. These facilities may also have to meet DDS Regional Center vendorization requirements. Although ARFs are defined in statute as providing non-medical care, these facilities arrange for or provide incidental medical services which may be quite extensive. ▪ **4631 Licensed Facilities** **RESIDENTIAL CARE FACILITY FOR THE ELDERLY (RCFE)** – a facility of any capacity which provides non-medical care to persons aged 60 and over and other adults with compatible needs. Residents may require varying levels of care and supervision, protective supervision, or personal care. Although RCFEs are defined in statute as providing non-medical care, these facilities arrange for or provide incidental medical services which may be quite extensive. Hospice services may be provided in RCFEs only under specified circumstances. ▪ **5975 Licensed Facilities** **RESIDENTIAL CARE FACILITY FOR THE CHRONICALLY ILL (RCFCI)** – a facility with a licensed capacity of 25 or fewer which provides care and supervision to adults who have Acquired Immune Deficiency Syndrome (AIDS) or the Human Immunodeficiency Virus (HIV). ▪ **30 Licensed Facilities** **SOCIAL REHABILITATION FACILITY (SRF)** – any facility which provides 24-hour non-medical care and supervision in a group setting to adults recovering from mental illnesses who temporarily need assistance, guidance and counseling. ▪ **70 Licensed Facilities**	**ADULT DAY HEALTH CENTER (ADHC)** – an alternative to institutionalization for functionally impaired adults who are capable of living at home with the aid of appropriate health care or rehabilitative and social services. These facilities are licensed by DHS in cooperation with CDA, and certified for Medi-Cal reimbursement. ▪ **104 Licensed Facilities** **CONGREGATE LIVING HEALTH FACILITY (CLHF)** – a small residential home which provides inpatient care, including specific services for terminally ill or severely disabled patients. CLHF residents need skilled nursing care on a recurring, intermittent, extended or continuous basis. Care is generally less intense than that provided in a general acute care hospital, but more intense than care provided in a skilled nursing facility. ▪ 44 Licensed Facilities **INTERMEDIATE CARE FACILITY (ICF)** – a facility which provides skilled nursing and supportive care to patients who do not require continuous nursing care. ▪ **11 Licensed Facilities** **ICF/DEVELOPMENTALLY DISABLED (ICF/DD)** – a facility generally comprising 50 to 200 beds which provides 24-hour habilitation, developmental and supportive health services to developmentally disabled persons of any age whose primary need is for developmental services, and who have a recurring but intermittent need for skilled nursing care. DHS also certifies these facilities for Medi-Cal reimbursement. ▪ **18 Licensed Facilities** **ICF/DD – NURSING (ICF/DD-N)** – a small (6-to-15 bed) residential home for developmentally disabled persons who need nursing care. DHS also certifies these facilities for Medi-Cal reimbursement. ▪ **238 Licensed Facilities** **ICF/DD –HABILITATIVE (ICF/DD-H)** – a small (6-to-15) bed residential home for developmentally disabled persons who need habilitative care. DHS also certifies these facilities for Medi-Cal reimbursement. ▪ **706 Licensed Facilities** **PSYCHIATRIC HEALTH FACILITY (PHF)** – a 24-hour inpatient care facility for mentally disordered, incompetent, or other persons which includes among its basic services psychiatry, clinical psychology, social work, rehabilitation, drug administration and food services. DMH licenses these facilities; DHS certifies them for Medicare reimbursement. ▪ **16 Licensed Facilities** **SKILLED NURSING FACILITY/NURSING FACILITY (SNF/NF)** – these facilities provide continuous skilled nursing care to patients whose primary need is for the availability of skilled nursing care on an extended basis. In addition to 24-hour inpatient care, minimum services include physician, skilled nursing, dietary and pharmaceutical services and an activity program. DHS certifies these facilities for Medicare/Medi-Cal reimbursement. ▪ **1426 Licensed Facilities**

ISSUES

Over the past two decades, there have been dramatic changes in the way Californians receive health and long-term care services. New technologies, innovative models of care, reimbursement strategies, and standards of practice continue to evolve rapidly. Pressure has increased to provide care in the least institutional or least expensive setting in response both to cost containment strategies and to consumer preference. Government has often been slow to anticipate or respond to these changes. Professional licensing requirements determine the services a professional may perform in particular settings. The need for further examination of the licensing and certification functions arises from the following issues.

Fragmentation

Organizational and public policy fragmentation exists among the state government entities that regulate the standards for community care and long-term care facilities and related services. Furthermore, the process for promulgating regulations makes those regulations out-of-date nearly as soon as they become final. The public policy or responsible state government agency often varies, depending on the type of setting or type of service delivered. Fragmentation is confusing and costly to:

- Health care professionals, who must operate within their professional scope of practice regardless of the setting;
- Businesses wishing to provide long-term care services and trying to comply with often complex, duplicative and unnecessary requirements from multiple state government entities;
- Consumers, who are confused regarding which state government entity has jurisdiction over their questions or concerns, and are frustrated when two or more agencies are responsible for the same issue; and
- State government entities trying to track the multiple changes in long-term care and respond in a coordinated and timely fashion.

The historical reasons for multi-departmental licensing and certification authority may no longer apply. The continuing evolution of the regulated long-term care community suggests the need for alternative organizational models responsive to both long-term care consumers and providers.

Blurred Level of Care Distinctions

Long-term care in California traditionally has been biased toward institutional care using a medical model, largely in response to the public reimbursement available for institutional care. This tendency can result in care that is both more restrictive and more expensive than necessary. With the current emphasis on reducing health care costs, the

health services related to long-term care are being provided in settings where such care previously was prohibited.

RCFE residents are permitted to remain in the RCFE if they are able to provide self-care or if the facility has an appropriately licensed health care professional available to provide needed care. For instance, RCFE residents may receive home health or hospice services. RCFE residents often have chronic care conditions which are virtually indistinguishable from those experienced by SNF residents. In addition, the trend is for HMOs to contract with SNFs for surgical recovery and rehabilitation care. This care used to be provided in hospitals only.

Many consumers want to continue living in the least restrictive setting possible while receiving the services necessary to address their changing needs. Advances in medical technology have enabled the delivery of health services that formerly were considered acute in non-acute settings. In response both to consumer preference and the desire to control costs, the trend of more intense care being delivered in less restrictive settings is likely to continue. It is vital for state government to have the ability to determine that care is adequate, regardless of the setting in which it is provided.

Facility Specific Scope of Practice

Licensed facilities utilize a large number of employees who have similar responsibilities and may frequently work at more than one type of facility. The same individual may be allowed to perform different duties depending on the particular type of facility in which s/he works. This results in confusion and conflict for both staff and consumers regarding an employee's permissible duties in a particular facility type. For example, CDSS standards allow unlicensed staff in residential care settings (including Home Health Aides (HHA), and Certified Nurse Assistants (CNA) employed as unlicensed direct care staff) to assist residents in administering their own medications. By contrast, unlicensed staff in SNFs (including CNAs) are not permitted to assist with the "self-administration" of medications. This distinction often is confusing to both staff and consumers.

DHS certifies CNAs and HHAs, and instituted mandatory criminal background checks for CNAs and HHAs on July 1, 1998. However, statutory differences exist in the screening criteria that apply to community care facility personnel and those which apply to health facility personnel. Resolution of screening and scope of practice issues, coupled with the opportunity to address the level of care issues mentioned above, could promote consistency in the standards of practice for employees providing long-term care services.

Unnecessary Business Costs Arising from Multiple Jurisdictions

Currently, some types of facilities require "clearances" from more than one state agency in order to operate. For instance, certain facilities are required to meet building standards (Title XXIV) regulated by OSHPD. This is particularly true when renovating an existing building or constructing a new building. Architectural reviews and inspections are required. In addition, DHS must license the health facility through an entirely separate

application and inspection process. Overlap and duplication result in unnecessary costs to both business and government.

Consumer Frustration Arising from Multiple Jurisdictions

Consumers often are confused when attempting to find the appropriate state entity to answer questions or to resolve complaints. If a consumer is unhappy about the health care provided by an HMO, s/he could be directed to the Department of Corporations (DoC) (Knox-Keene) and DHS (if care was provided in a health facility). Similarly, a consumer concerned about the quality of care in an RCFE could be directed to CDSS or to DHS (if the care were provided by a home health agency). These overlapping jurisdictions are perplexing to citizens who may only have a vague understanding of state government organization.

AREAS OF POTENTIAL EFFICIENCY

The licensing (and certification) functions share elements that suggest areas of potential efficiency when considering options for the integration of licensing functions related to long-term care.

Common Processes

The licensing and certification of long-term care facilities involve certain key steps that present opportunities for enhanced efficiency through integration.

1) An application must be processed, and the facility must meet certain statutory and regulatory requirements before it can be licensed and/or certified. The purpose of this screening process is to eliminate causes of predictable harm through reviews such as fingerprint clearances, building inspections, and the submission of plans of operation.

2) The licensing agency must monitor, evaluate or inspect licensed facilities to assure that the licensee is providing services in a manner that protects public health and safety or that meets other standards for service delivery.

3) The other major function is enforcement. The licensing agency must have the ability to take action, sometimes immediate action, to assure public protection. The enforcement function often involves the Attorney General's office, the local district attorney's office, and the legal support arm of the particular licensing program.

Standardized licensure procedures could save time, money and be more responsive to the business community.

Common Skill Sets for Personnel

The human resources necessary for the state to be successful in performing its licensing obligations include staff that have various skill sets developed through formal education and training. The majority of the staff either are generalist analysts with various titles (e.g., Licensing Program Analysts, Health Facility Evaluators) or are nurses employed by DHS to perform inspections of health facilities. Specialized staff are fewer in number and perform particular functions. For example, community care licensing investigators investigate serious cases of abuse in residential care facilities; registered dieticians survey SNFs to identify non-compliance with regulations regarding resident nutrition.

Through integration, staff resources could be pooled to perform inspection and enforcement functions in a variety of facility types. This would promote the more efficient use of staff resources, while limiting duplicative on-site reviews. Data from on-site inspection activities could be aggregated in a centralized database and analyzed to support policy formulation, planning, and management decision making.

However, any plan for integration must take into account that CDSS and DHS have different resources available to implement significantly different regulatory requirements. The CDSS monitoring process is based on state statutes and regulations and supported through the state General Fund. By contrast, DHS long-term care facility surveys are driven by federal and state requirements, and supported by a combination of federal and state funds. The degree to which staff resources may be pooled will be influenced by significant differences in the scope and intensity of each department's monitoring activities. These differences derive from the statutory basis for these activities and the funds available to support them.

Common Data Bases and Administrative Support Functions

DHS and CDSS maintain separate statewide database tracking systems to identify former licensees with histories of poor compliance, complaints and other data elements. Each department also maintains a central, automated fingerprint clearance process. Both have central support functions in headquarters for activities such as fee collection and the payment of fines.

Integration would allow for the combination of multiple databases for more efficient tracking of licensees and better targeting of enforcement actions. Duplicative administrative support systems related to long-term care could be consolidated and streamlined.

Common Policies

Although each administrative agency may have very unique standards for its program, the primary objective is to provide safe and adequate care, in a manner that ensures fiscal integrity. Integration presents opportunities for the development of consistent policies for the provision of long-term care services, regardless of facility type. Integration would

support a clearer and more flexible definition of the continuum of care, and possibly result in the development of a greater array of care options for consumers.

PART II: OPTIONS FOR BETTER ADMINISTRATION OF LONG-TERM CARE FACILITY LICENSURE

Option A: Partial Consolidation

Consistent with the charge under AB 1215, Option A would consolidate into a single entity the licensure functions for all long-term care and community care facilities serving adults aged 18 and older. As the single state agency, DHS would continue to be responsible for certifying long-term care facilities for participation in the Medicare and Medicaid programs.

Facilities

Option A would consolidate licensure for the following facilities into a single entity. The departments in parentheses have programmatic responsibility for these facilities.

- Psychiatric Health Facilities (Department of Mental Health - DMH)
- Skilled Nursing Facilities/Nursing Facilities (DHS)
- Skilled Nursing Facilities/Institutes for Mental Disease (DMH)
- Congregate Living Health Facilities (DHS)
- Intermediate Care Facility for the Developmentally Disabled (DHS)
- Intermediate Care Facility for the Developmentally Disabled – Habilitative (DHS)
- Intermediate Care Facility for the Developmentally Disabled – Nursing (DHS)
- Residential Care Facility for the Chronically Ill (CDSS)
- Residential Care Facility for the Elderly (CDSS)
- Adult Residential Facility (CDSS)
- Adult Day/Support Care Centers (CDSS)
- Adult Day Health Care (CDA)
- Community Residential Treatment Systems (DMH)

Pros:

- Would enable businesses to apply to a single agency when seeking dual licensure as both a community care and long-term care facility;

- Creates the opportunity to simplify and standardize licensing of long-term care facilities;

- Offers consumers less fragmented access for resolving questions and complaints related to long-term care;

- Could enhance CDSS's and DHS's technical assistance and training functions by combining the strengths of their existing programs;

- Allows for more flexibility in developing teams to monitor facilities. Many community care facility clients have significant health issues, yet CDSS lacks health care professionals in sufficient numbers to address such issues;

- Reduces the need for consumers to contact multiple agencies for information regarding licensed long-term care facilities by placing the responsibility for licensing all long-term care facilities serving adults within one agency;

- Could realize efficiencies by streamlining the licensing process and reducing contacts with licensees seeking both community care and health facility licenses.

Cons:

- Could increase administrative costs due to organizational changes that disrupt existing systems. Reconfiguring licensing functions will impact the budget, accounting, personnel, programmatic and data sections of every department involved.

- Would perpetuate the duplication of staff and administrative support resources necessary for monitoring by separating regulatory functions related to licensing from those related to certification, and those related to long-term care facilities from those related to all other facility types;

- Would not be responsive to the fact that persons of all ages require a variety of health and social services which are provided in a multitude of settings;

- Could hinder the development of a long-term care continuum which serves the needs of persons of all ages by limiting consolidation to facilities serving adults age 18 and older;

- Would complicate management problems by separating the licensing function from the certification and criminal background check functions;

- Would continue administrative fragmentation by separating the licensing functions for long-term care facilities serving adults from those for community care facilities serving children.

- Would necessitate statutory changes to authorize the transfer of responsibility for licensing facilities from one entity to another.

Issues Requiring Further Development

- To foster the development of a care continuum, the new licensing entity could be given the authority to issue licenses for innovative models of care which may not correspond to existing licensing categories, and which would be exempt from the Administrative Law Process when promulgating regulations.

Option B: Functional Alignment

Option B would decentralize licensing and audit functions related to all long-term care facilities, and functionally align them with the department that has programmatic responsibility. For example, responsibility licensing ICF-DD facilities would move from DHS to CDDS. Similarly, the CDA would assume complete responsibility for licensing adult day health care centers; CDA currently shares this responsibility with DHS.

At this time, facility licensing and related certification activities for participation in the Medicare and Medicaid programs may be performed either by DHS when it also has programmatic responsibility, or by a separate department. This option would create within each department the authority and responsibility for assuring the availability of services to consumers that meet minimal standards and also reflect best practices. Each program department would be responsible for recruitment, screening, licensing, training, technical assistance, monitoring, and enforcement. While licensing functions may be distributed among the departments with programmatic responsibility, it would be difficult to reassign Medicare and Medi-Cal certification responsibility from DHS to other departments. Doing so could violate federal requirements for a single state agency to administer these programs, and likely would require federal waivers.

Licensing functions under this option would be distributed among program departments as indicated below.

Facilities

<u>CDA</u>

- Adult Day Health Care Centers

<u>DMH</u>

- Skilled Nursing Facilities/Institutes for Mental Disease
- Psychiatric Health Facilities
- Community Residential Treatment Systems

DDS

- Intermediate Care Facilities for the Developmentally Disabled
- Intermediate Care Facilities for the Developmentally Disabled – Nursing
- Intermediate Care Facilities for the Developmentally Disabled - Habilitative

CDSS

- Residential Care Facility for the Chronically Ill
- Residential Care Facility for the Elderly
- Adult Residential Facility
- Adult Day/Support Care Centers

DHS

- Skilled Nursing Facilities/Nursing Facilities
- Congregate Living Health Facilities
- Pediatric Day Health Care and Respite Care

Pros:

- The expertise to assure compliance with licensing requirements and to provide alignment with the administration of other programs and services would be in one agency;

- Consumers and service providers could address all inquiries regarding a particular service to a single agency.

Cons:

- Conflicts of interest could arise when program development and enforcement functions are within the same agency. The enforcement function may be compromised when the department responsible for program oversight also is responsible for placing consumers and managing their care. The enforcement agency may be reluctant to take an enforcement action if it would reduce available placement options or result in the loss of program funding;

- Could increase administrative costs due to organizational changes that disrupt existing systems. Reconfiguring licensing functions will impact the budget, accounting, personnel, programmatic and data sections of every department involved.

- Would fragment management responsibilities by separating the licensing function from the certification function;

- Interagency conflict could arise from the need to identify a program with lead responsibility for each service/consumer type;

- This option could be difficult to administer. In addition, licensing responsibility for community care facilities would be divided among departments responsible for different consumer populations. This would further complicate operations for facilities serving more than one consumer type;

- Each agency would need to perform functions that are currently centralized (e.g., fingerprint clearance, investigation, fiscal audits, fee collection and technical assistance activities to which a statutory amount of fee monies must be directed). This would result in costly duplication of administrative services;

- Would necessitate statutory changes to authorize the transfer of responsibility for licensing facilities from one entity to another.

- This option could result in the need for additional staff in some departments.

Issues Requiring Further Development

- Some residential providers serve persons from a number of programs. There will be a need to identify the program with lead responsibility and to develop ways to reduce overlap and duplication.

Option C: Consolidation

Option C would consolidate into a single entity the licensure and certification functions pertaining to the provision of health and long-term care services and certain associated professional services. These include licensing functions and certification functions currently housed in ADP, CDA, CDSS, DDS, DHS, DMH, and OSHPD.

Option C could resolve organizational policy fragmentation related to the regulation of health and long-term care facilities and services, resulting in streamlining the licensing and/or certification processes for businesses and state government. It would also provide better access for consumers with questions or complaints about long-term care services.

The following is a list of the licensing and certification functions that would be realigned under this option.

Facilities

- General Acute Care Hospitals (DHS)
- State Hospitals (DHS)
- Acute Psychiatric Hospitals (DHS)
- Ambulatory Surgery Centers/Surgical Clinics (DHS)
- Psychiatric Health Facilities (Licensed by DMH)
- Skilled Nursing Facilities/Nursing Facilities (DHS)
- Skilled Nursing Facilities/Institutes for Mental Disease (DMH)

- Congregate Living Health Facilities (DHS)
- Correctional Treatment Centers (DHS)
- End Stage Renal Dialysis/Chronic Dialysis Clinics (DHS)
- Intermediate Care Facility for the Developmentally Disabled (DHS)
- Intermediate Care Facility for the Developmentally Disabled – Habilitative (DHS)
- Intermediate Care Facility for the Developmentally Disabled – Nursing (DHS)
- Intermediate Care Facility for the Mentally Retarded (DHS)
- Chemical Dependency Recovery Hospital (DHS)
- Residential Care Facility for the Chronically Ill (CDSS)
- Residential Care Facility for the Elderly (CDSS)
- Adult Residential Facility (CDSS)
- Adult Day/Support Care Centers (CDSS)
- Adult Day Health Care (DHS with CDA)
- Pediatric Day Health and Respite Care (DHS)
- Primary Care/Community/Rural Health Clinics (DHS)
- Psychology Clinics (DHS)
- Rehabilitation Clinics (DHS)
- Mental Health Rehabilitation Centers (DMH)
- Residential Program Serving Adults with Alcohol and Drug Problems (ADP)
- Community Residential Treatment Systems (DMH)

Individual Providers

- Board of Examiners, Nursing Home Administrators (DHS)
- Certified Nurse Assistants (DHS)
- Home Health Aides (DHS)
- Hemo-Dialysis Technicians (DHS)
- Residential Care Facility for the Elderly Administrators (CDSS)
- Adult Residential Facility Administrators (CDSS)

Providers of Service

- Home Health Agencies (DHS)
- Hospice (DHS)
- Referral Agencies (DHS)
- Certified Nurse Assistant Training Programs (DHS)
- Narcotic Treatment Program (ADP)
- Outpatient Drug Free Program (ADP)
- Continuing Care Retirement Community Contracts (CDSS)

Other Related Functions

- Patient Trust Fund Audits (DHS)
- Patient Trust Fund Audits (DMH)

- Patient Trust Fund Audits (DDS)
- Facilities Development Division (OSHPD)
- Health Facility Data Division (OSHPD)

Pros:

- Would support the development of an integrated long-term care continuum for persons of all ages by reducing cross-agency fragmentation;

- Integrating licensing of long-term care and other facility types would facilitate the development of a care continuum which recognizes that people move in and out of long-term care;

- Would promote administrative efficiency by reducing duplication and streamlining administrative processes;

- Would reduce costs to business by consolidating the licensing and certification process, limiting the need for multiple contacts with a variety of administrative agencies;

- Would enhance consumer access to information regarding long-term care and other services provided in a facility setting, increasing consumers' ability to resolve issues and make informed long-term care decisions;

- Would promote expanded consumer choice through reconciliation of long-term care policy differences within a consolidated administrative structure;

- Would facilitate the leveraging of staff resources for more effective monitoring, enforcement, and quality improvement.

Cons:

- Could generate concern due to the perceived power of the consolidated agency. Further concern could proceed from the desire to maintain the continued distinction between medical and social approaches to long-term care;

- Could increase administrative costs due to organizational changes that disrupt existing systems. Reconfiguring licensing functions will impact the budget, accounting, personnel, programmatic and data sections of every department involved.

- The creation of a large government entity responsible for a variety of policy issues could be perceived as diluting the focus on long-term care, thereby complicating long-term care oversight;

- This option would continue the fragmentation of licensing functions, unless the licensing functions related to other programs regulated by CDSS also were integrated (e.g. Adoption Agencies, Child Care Centers, Family Day Care, Group Homes).

- Would necessitate statutory changes to authorize the transfer of responsibility for licensing facilities from one entity to another.

Issues Requiring Further Development

The following is a list of issues related to Option C that would require further development.

- The goals of this consolidation should be made clear, if not in statute, then by Executive Order.

- Should the new entity be separate from DHS, this option would necessitate a waiver of the federal government's requirement for a single state agency to regulate the Medicaid and Medicare programs;

- The benefits of continuing to license professionals using a board or bureau model need to be examined. The current process is cumbersome; lengthy delays are common in enforcement actions against licensees and in responding to consumer complaints and licensee concerns.

- Many of the programs to be consolidated have field offices. The locations and eventual consolidation of field offices would need to be studied.

CHAPTER 6
CONCLUSION

At the threshold of the 21st century, California faces major public policy challenges in developing a comprehensive long term care (LTC) system that supports family caregiving efforts, provides appropriate assistance in the least restrictive care setting, and exhibits responsible fiscal stewardship. To inform this policy development, this report has:

- Reviewed past efforts to reorganize California's health and human service departments and legislative steps to improve the administration of LTC services;
- Identified shortcomings in the current administrative structure; and
- Presents options for how the administration of LTC programs and licensure functions might be reorganized.

Each of the options has inherent potential benefits and limitations. Not all of the options are mutually exclusive. However, organizational re-structuring cannot be viewed as a panacea that will instantly create a system out of the current array of stand-alone LTC programs. Time and an investment in the tools necessary to build a system will also be required.

AB 1215 requires this report to include options for improving the administration of LTC programs and licensure, but does not require specific recommendations. However, this report does provide a set of principles, based in part on input received, against which these and other options can be evaluated. These principles provide a framework with which the strengths and limitations of each of these and other options can be weighed. These options are not mutually exclusive and could be modified to attain various degrees of integration.

In Chapter 1, principles that formed the criteria for developing restructuring options were articulated. Hopefully, any restructuring effort will be evaluated on its ability to:

- Promote the provision of quality LTC services;
- Facilitate access to information on LTC programs and services;
- Promote expanded consumer choice of LTC services, models, and options;
- Encourage responsiveness to consumer needs;
- Support effective and flexible public oversight of LTC entities;

- Reduce fragmentation and duplication of programs and promoting effective coordination among LTC programs;
- Encourage the personal responsibility and independence of the LTC consumer;
- Promote future cost efficiency and effectiveness; and
- Support the development of appropriate incentives and models in the private marketplace.

The timeframe for implementing changes in the administration of LTC programs or licensure would be dependent on the options selected. While all options would require statutory changes, certain options would require a longer implementation process since they involve significant administrative, fiscal, and programmatic changes.

APPENDIX A

AB 1215 QUESTIONNAIRE

APPENDIX B

LONG-TERM CARE PROGRAM INVENTORY

California Department of Aging Adult Day Health Care (ADHC)

Brief Program Description: A program providing a variety of health, therapeutic, and social services to those at risk of being placed in a nursing home.

What services are provided? ADHC required services include medical services (personal or staff physician); nursing services; physical therapy; occupational therapy; speech therapy; psychiatric/psychological services; social services; recreational activities; transportation to and from the center, if needed; noontime meal and nutritional counseling.

Is this provided through a federal waiver? No.

Funding Source(s)*:* ADHC providers are reimbursed by Medi-Cal for the ADHC services they have provided to participants. State Operations is General Fund - 50.5%; Reimbursements (Title XIX from DHS) - 49.5%.

Program eligibility criteria: Program serves frail elders and other adults with physically or mentally impairments.

Other client characteristics: The number and type of services provided to any single individual is based on assessments by the Center's multidisciplinary team.

Is enrollment capped? No.

Geographic availability: 100+ locations, but not in all counties.

FY 1996 (July 1995-June 1996) total program caseload: 5,330 Medi-Cal clients/713 private pay clients.

FY 1996 total program expenditures: $1,247,000, including $630,000 General Fund and $617,000 Title XIX reimbursements.

Other state departments this program interfaces with: Department of Health Services.

Does this program serve a significant portion of clients under age 18? No**.**

California Department of Aging

Older Americans Act Title IIIB – Adult Day Care/Health Care

Brief Program Description: Provision of personal care for dependent adults in a supervised, protective, congregate setting during some portion of a twenty-four hour day.

What services are provided: Typically include social and recreational activities, training, counseling and meals for adult day care, and services such as rehabilitation, medications assistance and home health aid services for adult day health.

Is this provided through a federal waiver? No.

Funding Source(s): State General Fund - 19.6%; Federal Funds (Older Americans Act, Title III-B) - 80.4%.

Program eligibility criteria: Participants must be 60+ years of age and assessed for problems and needs that can be met through program.

Other client characteristics: N/A.

Is enrollment capped? No.

Geographic availability*:* Statewide, although actual community availability may be limited by local priorities and available funds.

FY 1996 (July 1995-June 1996) total program caseload: 2,913 clients.

FY 1996 total program expenditures*:* $1, 293,144, including $253,429 - General Fund and $1,039,715 - Federal Funds.

Other state departments this program interfaces with: None.

Does this program serve a significant portion of clients under age 18? No.

California Department of Aging

Alzheimer's Day Care Resource Center (ADCRC)

Brief Program Description: Prevent premature or inappropriate institutional placement of persons with moderate to severe levels of impairment to Alzheimer's Disease and/or related dementia through the provision of specialized day care services; provide support and respite for caregivers; serve as models of optimum type and level of day care services needed by people with dementia; make training opportunities for professions providing care and treatment for dementia population; and increase public awareness and knowledge about Alzheimer's Disease and related dementia.

What services are provided: Participant care is designed to meet the specific physical, emotional and mental abilities and needs of those with dementia. Caregivers receive respite and support services such as counseling, training, resource materials and support groups to help prevent premature or inappropriate institutional placement.

Is this provided through a federal waiver? No.

Funding Source(s): General Fund.

Program eligibility criteria: Program is designed for individuals with Alzheimer's disease or related dementia, without regard to age or income.

Other client characteristics: N/A.

Is enrollment capped? No.

Geographic availability: 36 centers.

FY 1996 (July 1995-June 1996) total program caseload: 2,448 clients.

FY 1996 total program expenditures: $2,491,000.

Other state departments this program interfaces with: Departments of Health Services and Mental Health.

Does this program serve a significant portion of clients under age 18? No.

California Department of Aging Linkages

Brief Program Description: Designed to prevent or delay the premature or inappropriate institutionalization of frail older persons and adults 18 years of age or older with disabilities. Includes client case management as well as comprehensive information and assistance regarding appropriate community resources.

What services are provided: Brokerage of existing community services (e.g., transportation, meals, in-home support services, housing assistance and day care). In addition, Linkages focuses on obtaining assistive devices, medical equipment and special communications devices, in order to maximize individual independence and reduce the need for more costly alternatives.

Is this provided through a federal waiver? No.

Funding Source(s)*:* State General Fund and varying amounts of local funding, most notably from Handicapped Parking Fines monies. Percentages are unknown.

Program eligibility criteria: Frail older persons and adults 18 years of age and older with disabilities. Participants may or may not be eligible for Medi-Cal.

Other client characteristics: All clients served must be in need of case management assistance.

Is enrollment capped? No.

Geographic availability*:* 13 Sites; not statewide.

FY 1996 (July 1995-June 1996) total program caseload: 2,000 clients.

FY 1996 total program expenditures*:* $2,149,000 General Fund.

Other state departments this program interfaces with: None.

Does this program serve a significant portion of clients under age 18? No.

California Department of Aging

Multipurpose Senior Services Program (MSSP)

Brief Program Description: Provide optimum accessibility of various social and health resources for frail older individuals to maintain independent living for those with the capacity to do so.

What services are provided: Among the services provided through this program are case management, transportation, housing, escort, telephone reassureance, legal, emergency response systems, protective services, homemaker chore, meals, adult day care and nonmedical respite care services.

Is this provided through a federal waiver? Yes. Medicaid Title 1915 (c) Home and Community Based Waiver

Funding Source(s): General Fund - 50.6%; Reimbursements (Title XIX from DHS) - 49.4%.

Program eligibility criteria: All recipients must be 65 years of age and older, eligible for Medi-Cal without a share of cost, and be sufficiently impaired to qualify for nursing home placement based on Medi-cal criteria.

Other client characteristics*:* All clients served must be in need of case management assistance, e.g., the client cannot - and there is no caregiver to - make arrangements for needed services.

Is enrollment capped? Yes. Current waiver is capped at 6,000 client slots.

Geographic availability: 22 sites; not statewide at this time.

FY 1996 (July 1995-June 1996) total program caseload: 8,014 clients

FY 1996 total program expenditures*:* $21,806,000, including $11,042,000 General Fund and $10,764,000 Reimbursements.

Other state departments this program interfaces with: Departments of Health Services and Social Services.

Does this program serve a significant portion of clients under age 18? No.

California Department of Aging **Older Americans Act Title IIIB Assisted Transportation**

Brief Program Description: Provision of a means of transportation, including escort, for a person who has difficulties (physical or cognitive) using regular vehicular transportation.

What services are provided: Assistance, by trained staff, in getting in and out of homes, transportation vehicles, and the facilities to which the individual is being transported.

Is this provided through a federal waiver? No.

Funding Source(s)*:* State General Fund - 10.4%; Federal Funds (Older Americans Act, Title IIIB) - 89.6%.

Program eligibility criteria: Participants must be 60+ years of age and assessed for problems and needs that can be met through program.

Other client characteristics*:* N/A.

Is enrollment capped? No.

Geographic availability: Statewide, although actual community availability may be limited by local priorities and available funds.

FY 1996 (July 1995-June 1996) total program caseload: 10,945 clients.

FY 1996 total program expenditures*:* $405,937, including $42,073 - General Fund and $363,864 - Federal Funds.

Other state departments this program interfaces with: None.

Does this program serve a significant portion of clients under age 18? No.

California Department of Aging Case Management

Older Americans Act Title IIIB

Brief Program Description: Assistance either in the form of access or care coordination in circumstances where the older person and/or their caregivers are experiencing diminished functioning capacities, personal conditions or other characteristics which require the provision of services by formal service providers.

What services are provided: Activities of case management include assessing needs, developing care plans, authorizing services, arranging services, coordinating the provision of services among providers, follow-up and reassessment, as required.

Is this provided through a federal waiver? No.

Funding Source(s)*:* State General Fund - 2.3% and Federal Funds - (Older Americans Act Title IIIB) - 97.7%.

Program eligibility criteria: 60+ with physical and/or cognitive limitations requiring assistance.

Other client characteristics*:* N/A.

Is enrollment capped? No.

Geographic availability*:* Statewide, although actual community availability may be limited by local priorities and available funds.

FY 1996 (July 1995-June 1996) total program caseload: 27,850 clients.

FY 1996 total program expenditures*:* $3,374,057, including $78,574 - General Fund and $3,295,483 - Federal Funds.

Other state departments this program interfaces with: None.

Does this program serve a significant portion of clients under age 18? No.

California Department of Aging Older Americans Act Title IIIB-Chore

Brief Program Description: Provision of assistance to persons having difficulty with one or more of the following instrumental activities of daily living: heavy housework, yard work or sidewalk maintenance.

What services are provided: Provision of assistance to persons having difficulty with one or more of the following instrumental activities of daily living; heavy housework, yard work or sidewalk maintenance.

Is this provided through a federal waiver? No.

Funding Source(s)*:* State General Fund - 8.9% and Federal Funds (Older Americans Act Title IIIB) - 91.1%.

Program eligibility criteria: Participants must be 60+ years of age and assessed for problems and needs that can be met through program.

Other client characteristics*:* N/A.

Is enrollment capped? No.

Geographic availability*:* Statewide, although actual community availability may be limited by local priorities and available funds.

FY 1996 (July 1995-June 1996) total program caseload: 3,039 clients.

FY 1996 total program expenditures*):* $103,576, including $9,221 - General Fund and $94,355 - Federal Funds.

Other state departments this program interfaces with: None.

Does this program serve a significant portion of clients under age 18? No.

California Department of Aging **Older Americans Act Title IIIB-Homemaker**

Brief Program Description: Provision of assistance to persons having difficulty with one or more of the following instrumental activities of daily living: preparing meals, shopping for personal items, managing money, using the telephone or doing light housework.

What services are provided: Provision of assistance with one or more of the following instrumental activities of daily living: preparing meals, shopping for personal items, managing money, using the telephone or doing light housework.

Is this provided through a federal waiver? No.

Funding Source(s)*:* State General Fund - 8.9%; Federal Funds (Older Americans Act Title IIIB) - 91.1%.

Program eligibility criteria: **Participants must be 60+ years of age and assessed for problems and needs that can be met through program.**

Other client characteristics*:* N/A.

Is enrollment capped? No.

Geographic availability*:* Statewide, although actual community availability may be limited by local priorities and available funds.

FY 1996 (July 1995-June 1996) total program caseload: 21,420 clients.

FY 1996 total program expenditures*:* $2,674,917, including $238,139 - General Fund and $2,436,778 - Federal Funds.

Other state departments this program interfaces with: None.

Does this program serve a significant portion of clients under age 18? No.

California Department of Aging **Older Americans Act Title IIIB-Personal Care**

Brief Program Description: Provision of personal assistance, supervision or cues for persons having difficulties with one or more of the following activities of daily living: eating, dressing, bathing, toileting, and transferring in and out of bed/chair, or walking.

What services are provided: Provision of personal assistance, supervision or cues for persons having difficulties with one or more of the following activities of daily living: eating, dressing, bathing, toileting, and transferring in and out of bed/chair, or walking.

Is this provided through a federal waiver? No.

Funding Source(s)*:* State General Fund - 8.9%; Federal Funds (Older Americans Act Title IIIB) - 91.9%.

Program eligibility criteria: Participants must be 60+ years of age and assessed for problems and needs that can be met through program.

Other client characteristics*:* N/A.

Is enrollment capped? No.

Geographic availability*:* Statewide, although actual community availability may be limited by local priorities and available funds.

FY 1996 (July 1995-June 1996) total program caseload: 4,150 clients.

FY 1996 total program expenditures*:* $907,489, including $80,791 - General Fund and $826,698 - Federal Funds.

Other state departments this program interfaces with: None

Does this program serve a significant portion of clients under age 18? No.

California Department of Aging

Older Americans Act Title IIIC-Nutrition, Home-Delivered

Brief Program Description: Provision, to an eligible client or other eligible participant at the client's place of residence, of a meal which complies with the Dietary Guidelines for Americans (published by the Secretaries of the US Departments of Health and Human Services and Agriculture) which provides a minimum of 33 and 1/3 percent of the current daily Recommended Dietary Allowances (RDA).

What services are provided: Meals/services are prepared and delivered by paid and/or volunteer staff.

Is this provided through a federal waiver? No.

Funding Source(s)*:* State General Fund - 20.9%; Federal Funds (Older Americans Act Title IIIC) - 58.6%; US Dept of Agriculture - 20.5%.

Program eligibility criteria: Participants must be 60+ years of age and assessed for problems and needs that can be met through program.

Other client characteristics*:* N/A.

Is enrollment capped? No.

Geographic availability*:* Statewide, although actual community availability may be limited by local priorities and available funds.

FY 1996 (July 1995-June 1996) total program caseload: 53,576 clients.

FY 1996 total program expenditures*:* $27,383,000, including $5,729,000 - General Fund; $16,043,000 Federal Funds (Title III); $5,611,000 - Federal Funds (USDA).

Other state departments this program interfaces with: None.

Does this program serve a significant portion of clients under age 18? No.

California Department of Aging **Older Americans Act**
Title IIIC-Nutrition, Congregate

Brief Program Description: (A) Provision, to an eligible client or other eligible participant at a nutrition site, senior center or some other congregate setting, of a meal which complies with the Dietary Guidelines for Americans (published by the Secretaries of the US Department of Health and Human Services and (B) provides a minimum of 33 and 1/3 percent of the current daily Recommended Dietary Allowance (RDA) as established by the Food and Nutrition Boar of the National Research Council of the National Academy of Sciences.

What services are provided: Meals, socialization activities, nutrition education and nutrition counseling.

Is this provided through a federal waiver? No.

Funding Source(s)*:* State General Fund - 11.7%; Federal Funds (Older Americans Act Title IIIC) - 69.6%; US Dept of Agriculture - 18.7%.

Program eligibility criteria: Age 60+, without regard to income.

Other client characteristics*:* N/A.

Is enrollment capped? No.

Geographic availability: Statewide, although actual community availability may be limited by local priorities and available funds.

FY 1996 (July 1995-June 1996) total program caseload: 153,779 clients.

FY 1996 total program expenditures*:* $38,702,000, including $4,535,000 - General Fund; $26,931,000 Federal Funds (Title IIIC); and $7,236,000 - USDA.

Other state departments this program interfaces with: None.

Does this program serve a significant portion of clients under age 18? No.+

California Department of Aging Office of the State Long-term Care Ombudsman

Brief Program Description: Investigation of complaints of elder abuse on behalf of the elderly and protection of the rights, health and safety of older residents in long-term care facilities. Complaints range from ones of theft or loss of personal possessions (including laundry) to those involving physical, emotional or fiduciary abuse.

What services are provided: Ombudsmen are charged with investigating complaints, attempting to resolve complaints by mediation between patients, family members or conservators, and staff of the particular facility. Cases in which there is the probability of elder abuse are referred to local investigative and law enforcement authorities.

Is this provided through a federal waiver? No.

Funding Source(s)*:* 29% from Federal funds, 28% General Funds, 25% local matching funds, 15% local non-matching funds, 1% grant related income.

Program eligibility criteria: N/A.

Other client characteristics: None.

Is enrollment capped? No.

Geographic availability*:* Statewide.

FY 1996 (July 1995-June 1996) total program caseload: 171,415 clients.

FY 1996 total program expenditures*:* $4,683,000: (GF: $2,014,000 and FF: $2,669,000) (State Operations: $930,000; Local Assistance: $3,753,000).

Other state departments this program interfaces with: Department of Health Services, Licensing and Certification; Department of Social Services, Community Care Licensing; Department of Developmental Services; and Department of Justice.

Does this program serve a significant portion of clients under age 18? No.

Department of Developmental Services Alternative Residential Model (ARM)

Brief program description: This program oversees the licensed community care facilities that serve individuals with developmental disabilities. It develops the regional center rate supplement that regional centers pay beyond SSI to residential providers for services and supports to regional center consumers.

What services are provided: Facilities under this program provide residential services to both children and adults with developmental disabilities. The Department's function includes rate development, approval of rate exceptions, and resolving placement issues.

Is this provided through a federal waiver? Yes. Consumers who reside in ARM facilities may be certified as eligible for the home and community based services (HCBS) waiver and the funding of their services through the waiver.

Funding sources: The rates for ARM are 24% GF and 76% waiver funded (waiver split is 51.23% federal/48.77% GF)

Program eligibility criteria: Must be a person with a developmental disability as defined in the Lanterman Developmental Disabilities Act and be a client of a regional center for the developmentally disabled.

Other client characteristics: The residence in an ARM facility has been agreed upon in the consumer's individual program plan (IPP) as the most appropriate and least restrictive placement to meet the consumer's needs.

Is enrollment capped? There is no cap on the number of consumers who may reside in ARM facilities in the state. The total HCBS waiver cap is 35,000, which includes individuals with developmental disabilities in a variety of out-of-home living arrangements.

Geographic availability: Available statewide.

FY 1996 (July 1995-June 31, 1996) total program caseload: 13,217 adults.

FY 1996 total program expenditures: $118,827,215 The rates for ARM are 24% GF [$28,518,392] and 76% federal waiver funded [$90,308,824]. The waiver is split 51.23% federal [$46,265,210] and 48.77% GF[$44,043,613].

Other state departments this program interfaces with: Department of Social Services, Community Care Licensing.

Does this program serve a significant portion of clients under age 18? Yes (33%)

Department of Developmental Services Intermediate Care Facilities / Mental Retardation (ICF/MR)

Brief program description: The Department's role in this program is to approve the program plans for persons who wish to provide ICF/MR services; provide technical assistance to new and existing providers and liaison with the Department of Health Services on issues concerning ICF/MR facilities.

What services are provided? (See description above.)

Is this provided through a federal waiver? No.

Funding sources: 51.23% federal and 48.77% GF.

Program eligibility criteria:. Clients must be diagnosed as developmentally disabled and the level of care determination is related to the individual health and active care treatment needs. In an "H" facility, the need must be such that skilled nursing care is needed on an on-going and intermittent basis. For "Ns," the resident must need recurring but intermittent skilled nursing services. All clients must be able to participate and gain from an active treatment program that leads to a lessening dependence on others in carrying out daily living activities or in preventing regression or in ameliorating developmental delay.

Other client characteristics: It should be noted that level of care determination can also involve the client's previous placement and how the previous placement fits into the less restrictive hierarchy.

Is enrollment capped? No.

Geographic availability: Program is available statewide.

FY 1996 (July 1995-June 31, 1996) total program caseload: 2,571 adults.

FY 1996 total program expenditures: $117,000,000 ($59,939,100 federal/$57,060,900 GF)

Other state departments this program interfaces with: DHS Licensing and Certification Division.

Does this program serve a significant portion of clients under age 18? Yes (35%)

Department of Developmental Services Supportive Living Services (SLS)

Brief program description: SLS, are paid for by Regional Centers and provided by a SLS vendor to assist consumers efforts to: (a) live in their own home; (b) participate in community activities to the extent appropriate given the consumer's interests and capacity; and (c) realize their individual potential to live integrated, normal and productive lives.

What services are provided? The following categories of services are provided: (a) personal support (e.g., eating, dressing, bathing, housing cleaning, medical appointments, etc.) (b) training and habilitative services (e.g., finding a home/roommate, transportation use, budgeting and bill paying, self advocacy, etc. (c) 24-hour emergency assistance (e.g., securing and using emergency notification equipment, etc.)

Is this provided through a federal waiver? Yes. HCBS waiver.

Funding sources: 2% GF and 98% waiver funds (51.23% federal/48.77% GF).

Program eligibility criteria: N/A.

Other client characteristics: N/A.

Is enrollment capped? Although the HCBS waiver is capped at 35,000 beneficiaries, there is no cap on this service. Services will be paid through the waiver or with regional center purchase of service funding.

Geographic availability: This program is available statewide.

FY 1996 (July 1995-June 31, 1996) total program caseload: 881 clients.

FY 1996 total program expenditures: $10,991,259 GF=$219,825/waiver=$10,771,433 (federal=$5,518,205, GF=$5,253,227).

Other state departments this program interfaces with: Departments of Health Services, Mental Health, Rehabilitation, and Social Services

Does this program serve a significant portion of clients under age 18? No.

Department of Health Services

AIDS Case Management Program (CMP)

Brief program description: Provides comprehensive home and community based case to persons with AIDS or symptomatic HIV in lieu of placement in a nursing facility or hospital. The purpose of the program is to maintain clients in their homes and avoid costly hospitalizations.

What services are provided? Case management (nurse and social worker); skilled nursing; benefits counseling; psychosocial counseling; infusion therapy; DME; non-emergency transportation; attendant care; homemaker; nutritional counseling; food supplements; housing assistance; hospice care.

Is this provided through a federal waiver? No.

Funding sources: Ryan White CARE Act: Title II (17%); State General Funds (83%).

Program eligibility criteria: Diagnosis: adults with AIDS or symptomatic HIV who have a rating on the Karnofsky Performance Scale of 70 or less, and HIV positive children at any state. There are no income criteria.

Other client characteristics: N/A.

Is enrollment capped? No.

Geographic availability: 42 sites (community-based organizations or local government entities) serving 53 counties.

FY 1996 (July 1995-June 31, 1996) total program caseload: 2,873 clients served.

FY 1996 total program expenditures: Title II Federal Funds: $1.32 million (17%); General Fund: $6.42 million (83%).

Other state departments this program interfaces with: None.

Does this program serve a significant portion of clients under age 18? No.

Department of Health Services AIDS Medi-Cal Waiver (MCWP)

Brief program description: Provides comprehensive nurse case management; home and community based care to person with mid- to late-stage HIV/AIDS. Services provided in lieu of placement in nursing facility or hospital to maintain clients in their homes.

What services are provided? Case management (team of nurse and social worker); attendant care; homemaker; skilled nursing; benefits counseling; psychosocial counseling; infusion therapy; DME; non-emergency transportation; nutritional counseling and nutritional supplements; Medi-Cal supplements for infants and children in foster care.

Is this provided through a federal waiver? 1915(c) Federal Waiver.

Funding sources: State General Fund - 50%; Federal Fund: 50%.

Program eligibility criteria: Diagnosis: AIDS or symptomatic HIV; Nursing facility level of care or above; adults: rating on Karnofsky Performance Scale of 60 or less; children: meet criteria based on CDC system. Must be on Medi-Cal.

Other client characteristics: Cannot be on AIDS Case Management Program or Medi-Cal.

Is enrollment capped? 7,400 clients.

Geographic availability: 33 agencies (community-based organizations or local government) serving 53 counties.

FY 1996 (July 1995-June 31, 1996) total program caseload: 2,892 clients.

FY 1996 total program expenditures: $11,934,623 (50% State; 50% Federal)

Other state departments this program interfaces with: None.

Does this program serve a significant portion of clients under age 18? No.

Department of Health Services

Alzheimer's Disease Diagnostic & Treatment Centers (ADDTC's)/Alzheimer's Disease Program (ADP)

Brief program description: The ADP established and administers nine ADDTC's located at university medical centers in California. The ADDTC's provide diagnostic and treatment (research) services, conduct research directed toward the cause and cure of AD and provide training and education for professionals and family caregivers.

What services are provided? Comprehensive assessment of memory problems, diagnosis and treatment, information and referral, support groups for caregivers, training and education for both professional and lay audiences.

Is this provided through a federal waiver? No.

Funding sources: State General Fund – 100%.

Program eligibility criteria: Any individual with symptoms of memory loss, disorientation and confusion is eligible.

Other client characteristics: Clients may be self-referred or referred by family, private physician, or community agency.

Is enrollment capped? No.

Geographic availability: Nine sites in FY 95-96: 1 in Sacramento County; 3 in the San Francisco Bay Area; 1 in Fresno County; 1 in Orange County; 2 in Los Angeles County; 1 in San Diego County.

FY 1996 (July 1995-June 31, 1996) total program caseload: 1,016 new clients; 2,017 re-assessments.

FY 1996 total program expenditures: $2,615,040

Other state departments this program interfaces with: California Department of Aging; Department of Mental Health; and California Department of Social Services.

Does this program serve a significant portion of clients under age 18? No.

Department of Health Services

County Organized Health Systems (COHS)

Brief program description: The COHS provides Medi-Cal services to nearly all beneficiaries in counties designated. Institutional long term care is provided in specific counties based on contractual agreements. The services vary by county and will be described below.

What services are provided? In COHS which have long term care "carved in", the Plan pays the long term care daily facility rate. This includes room and board and ancillary services. For those COHS where the services are "carved out", eligible beneficiaries would receive all other medical services and certain ancillary services.

Is this provided through a federal waiver? All COHS are based on a Federal Waiver. In general, this is defined as Medicaid County Organized Health Insuring Organizations.

Funding sources: The Plans receive Medi-Cal dollars on a 50-50 State/Federal match.

Program eligibility criteria: To participate in a COHS long term care program, a beneficiary must be in a COHS designated county, be Medi-Cal eligible, and meet the Plan's criteria for long term care.

Other client characteristics: N/A.

Is enrollment capped? No.

Geographic availability: In the COHS in Santa Cruz, Solano, Napa and Santa Barbara, services are "carved in" and are currently ongoing. Orange County services are anticipated to be "carved in" effective June 1, 1998. For San Mateo, long term care is carved out (room and board and certain ancillary services are not provided).

FY 1996 (July 1995-June 31, 1996) total program caseload: These data are not available, because of the structure of the data reporting system. The four Medi-Cal aid codes specific to long term care beneficiaries are not all-inclusive. There are beneficiaries in other aid codes which are in long term care facilities. Likewise, those codes are not exclusive.

FY 1996 total program expenditures: Please see comment above.

Other state departments this program interfaces with: Department of Developmental Services.

Does this program serve a significant portion of clients under age 18? No.

Department of Health Services

Developmentally Disabled Services (DDS) Waiver

Brief program description: Home and community-based services including nursing, personal care, and other services enabling developmentally disabled beneficiaries to remain at home.

What services are provided? An array of community-based services. Institutional deeming rules are available for those who are medically eligible, but who would otherwise not be eligible for Medi-Cal in the community.

Is this provided through a federal waiver? Yes, DDS Waiver (HCBS).

Funding sources: State General Fund – 49.8%; Federal Funds - 50.2%.

Program eligibility criteria: Medi-Cal eligibles who are developmentally disabled and are regional center clients.

Other client characteristics: Services must be medically necessary.

Is enrollment capped? Yes, 35,105 currently.

Geographic availability: Statewide through network of regional centers and regional center providers.

FY 1996 (July 1995-June 31, 1996) total program caseload: 35,105 clients.

FY 1996 total program expenditures: $550,902,765.

Other state departments this program interfaces with: Department of Developmental Services by Interagency Agreement.

Does this program serve a significant portion of clients under age 18? Yes.

Department of Health Services Subacute Care Services

Brief program description: To provide access to quality medical care for a subgroup of Medi-Cal beneficiaries requiring medically necessary services beyond the capability of the nursing facility level of care in a fiscally prudent manner through a system of provider contracts.

What services are provided? Tracheostomy care with suctioning and room air mist or oxygen and/or continuous mechanical ventilation; continuous IV therapy; tube feeding; inpatient physical therapy (PT), occupational therapy (OT), and/or speech therapy (SP); inhalation therapy; debridement, packing and medicated irrigation with or without whirlpool treatment.

Is this provided through a federal waiver? No.

Funding sources: State General Fund - 49.83%; Federal Funds - 50.17%.

Program eligibility criteria: The patient meets Medi-Cal eligibility criteria for long term care; the patient's medical criteria is that the patient's condition warrants 24-hour nursing care by a registered nurse; and tracheostomy care as listed above; and administration of any three of these items: IV therapy, tube feeding, inhalation therapy, inpatient PT, OT or SP therapy, and debridement.

Other client characteristics: None.

Is enrollment capped? No.

Geographic availability: The program is available throughout the state by contracting with DHS. Any Distinct Part or Free-standing Nursing Facility throughout the State of California may contract with DHS for these services. Current contracts exist in the following areas: Sacramento, Bay Area, Los Angeles, San Bernardino, Orange, San Diego and Fresno. There are a total of 66 subacute providers.

FY 1996 (July 1995-June 31, 1996) total program caseload: 1,312 clients.

FY 1996 total program expenditures: $151,603,000 (State General Fund - 49.83%: Federal Funds – 50.17%.

Other state departments this program interfaces with: Department of Developmental Services.

Does this program serve a significant portion of clients under age 18? No.

Department of Health Services

Medi-Cal In-Home Medical Care (IHMC) Waiver

Brief program description: Nursing and other Medi-Cal services previously provided as an alternative to acute level of care. (New applicants request Nursing Facility and Subacute waiver level of services.)

What services are provided? Nursing and related services.

Is this provided through a federal waiver? Yes, IHMC Waiver.

Funding sources: Medi-Cal funding: State General Fund – 49.8%; Federal Funds – 50.2%.

Program eligibility criteria: Must be Medi-Cal eligible.

Other client characteristics: Many are residents of Congregate Living Health Facilities and are technologically dependent.

Is enrollment capped? 200 clients at any given time.

Geographic availability: Statewide.

FY 1996 (July 1995-June 31, 1996) total program caseload: 364 unduplicated clients.

FY 1996 total program expenditures: $36,531,932 (State General Fund – 49.8%; Federal Funds - 50.2%).

Other state departments this program interfaces with: None.

Does this program serve a significant portion of clients under age 18? No.

Department of Health Services Medi-Cal Intermediate Care Facilities (ICF)/Developmentally Disabled (DD) Institutional Services

Brief program description: ICF levels of institutional care specific to needs of ICF/DD (ICF-DD), DD-Habilitative (ICF-DDH), and DD-Nursing (ICF-DDN).*

What services are provided? Institutional services specific to needs of DD population: active treatment, social services, supervision, nursing based on need.

Is this provided through a federal waiver? No.

Funding sources: State General Fund – 49.8%; Federal Funds – 50.2%.

Program eligibility criteria: Medi-Cal eligible and designed to be developmentally disabled by Department of Developmental Services (DDS)/DDS Regional Centers.

Other client characteristics: Need care, supervision, and medical services at ICF level of care.

Is enrollment capped? No.

Geographic availability: Statewide.

FY 1996 (July 1995-June 31, 1996) total program caseload: 9,876 clients.

FY 1996 total program expenditures: $554,794,000 (State General Fund – 49.8%; Federal Funds – 50.2%).

Other state departments this program interfaces with: Department of Developmental Services (DDS) and DDS Regional Centers.

Does this program serve a significant portion of clients under age 18? Yes.

Department of Health Services
Nursing

Nursing Facility-A (NF-A) &

Facility-B (NF-B); Medi-Cal (Institutional)

Brief program description: Services provided in a health care facility, license by the state to be at NF-A or NF-B level.

What services are provided? Nursing and other services which are Medi-Cal benefits.

Is this provided through a federal waiver? No.

Funding sources: Medi-Cal: State General Fund – 49.8%; Federal Funds – 50.2%.

Program eligibility criteria: Medi-Cal categorically or medically eligible.

Other client characteristics: Services must be medically necessary.

Is enrollment capped? No.

Geographic availability: Statewide.

FY 1996 (July 1995-June 31, 1996) total program caseload: 122,255 clients.

FY 1996 total program expenditures: $2,127,500,000 (State General Fund – 49.8%; Federal Funds – 50.2%.

Other state departments this program interfaces with: None.

Does this program serve a significant portion of clients under age 18? No.

Department of Health Services

Medi-Cal Model Waiver (Replaced by Nursing Facility Model Waiver)

Brief program description: Nursing and other services medically necessary to maintain a person at home as an alternative to institutionalization. Makes Medi-Cal eligibility available to patients who would be ineligible for Medi-Cal in the community. Uses institutional deeming rules.

What services are provided? Range of services that are alternative to health care institution at the appropriate level (Nursing Facility or Subacute Level). Personal care services are available if medically justified.

Is this provided through a federal waiver? Yes, Section 1915(c) HCBS.

Funding sources: Medi-Cal: State General Fund – 49.8%; Federal Funds – 50.2%.

Program eligibility criteria: Medi-Cal eligible in the community through institutional deeming rules.

Other client characteristics: Nursing and other services must be medically justified and be less costly than institutional care.

Is enrollment capped? Yes, 200 clients.

Geographic availability: Statewide and where providers are available.

FY 1996 (July 1995-June 31, 1996) total program caseload: 8 clients.

FY 1996 total program expenditures: $62,746 (State General Fund – 49.8%; Federal Funds - 50.2%).

Other state departments this program interfaces with: California Department of Social Services/In Home Supportive Services Program.

Does this program serve a significant portion of clients under age 18? No.

Department of Health Services

Medi-Cal Skilled Nursing Facility (SNF) Waiver (SNF Waiver has been replaced by Nursing Facility: NF Waiver)

Brief program description: Nursing and other services medically necessary to maintain a person at home as an alternative to institutionalization.

What services are provided? Range of services that are alternative to health care institution at the appropriate level (NF or Subacute). Personal care services are available if medically justified.

Is this provided through a federal waiver? Yes, HCBS, Section 1915(c).

Funding sources: Medi-Cal: State General Fund – 49.8%; Federal Funds - 50.2%.

Program eligibility criteria: Medi-Cal eligible either categorically or medically needy with share of cost.

Other client characteristics: Nursing and other services must be medically justified and be less costly than institutional care. Hours capped at 27 hours per month. (Annual capped hours not applicable to current NF Waiver.)

Is enrollment capped? Yes, 200 clients.

Geographic availability: Statewide and where providers are available.

FY 1996 (July 1995-June 31, 1996) total program caseload: 45 clients. New waiver 7/1/96.

FY 1996 total program expenditures: $307,340 (State General Fund – 49.8%; Federal Funds – 50.2%).

Other state departments this program interfaces with: California Department of Social Services/In-Home Supportive Services Program.

Does this program serve a significant portion of clients under age 18? No.

Department of Health Services

Program of All-Inclusive Care for the Elderly (PACE)

Brief program description: A comprehensive, integrated health and long term care service delivery and financing strategy replicating the model developed by On Lok Senior Health Services in San Francisco.

What services are provided? Full range of Medicare and Medicaid services.

Is this provided through a federal waiver? Yes, Medicare, Section 222.

Funding sources: State General Fund - 50%; Federal Funds - 50%.

Program eligibility criteria: Minimum 55 years of age; certified eligible for nursing home care; resides in a defined geographic service area.

Other client characteristics: None.

Is enrollment capped? On Lok—500 client; Sutter Senior Care—250 clients; Center for Elder Independence—260 clients; AltaMed—200 clients.

Geographic availability: San Francisco; Sacramento; Oakland; and Los Angeles.

FY 1996 (July 1995-June 31, 1996) total program caseload: 683 clients.

FY 1996 total program expenditures: $16,989,671 (State General Fund - 50%; Federal Funds - 50%).

Other state departments this program interfaces with: California Department of Aging (Adult Day Health Care Component).

Does this program serve a significant portion of clients under age 18? No.

Department of Health Services SCAN Health Plan

Brief program description: In 1992, SCAN was designated as one of four sites in the HCFA Social Health Maintenance Organization (S/HMO) demonstration program. The demonstration sought to test whether the HMO concept, successful in controlling rising health care expenditures for younger, healthier populations, could be extended to effectively manage the care needs of the elderly, particularly those with chronic health conditions resulting in long term care needs.

What services are provided? Traditional services provided by Medicare HMOs including hospital inpatient; emergency room care; skilled nursing care; physician services; home health; ambulance and medical transportation; durable medical equipment (DME) and prosthetic devices; hospice care; prescription drugs; optometric; hearing; and chiropractic services. The S/HMO also includes extended home care services which include: personal care and homemaking; adult day care; home delivered meals; emergency response meals; in-home respite; wheelchair vans; non-medical DME; nutritional; supplemental; and incontinent supplies; electronic monitoring; and institutional respite care and short-term custodial care in a skilled nursing facility. Optional services: expanded dental care.

Is this provided through a federal waiver? Yes, Section 1115 Waiver.

Funding sources: State General Fund - 50%; Federal Funds - 50%.

Program eligibility criteria: Must reside in SCAN's catchment area and must be a Medicare or Medi-Cal beneficiary. Medi-Cal eligibility criteria: SSI, blind, aged or disabled.

Other client characteristics: N/A.

Is enrollment capped? Yes, Medi-Cal enrollment is capped at 3,000 clients.

Geographic availability: Los Angeles, Riverside and San Bernardino Counties.

FY 1996 (July 1995-June 31, 1996) total program caseload: 11,000 Medicare enrollees; 625 Medi-Cal only enrollees.

FY 1996 total program expenditures: Total Medi-Cal expenditures: $29,946,404 (State General Fund - 50%; Federal Funds - 50%).

Other state departments this program interfaces with: None.

Does this program serve a significant portion of clients under age 18? No.

Department of Health Services

California Partnership for Long Term Care

Brief program description: Increase the number of middle-income Californians who purchase long term care (LTC) insurance coverage. Private insurance companies market policies that meet the standards and requirements established by the California Partnership. Every dollar of benefits paid out by the policy translates into an additional dollar Medi-Cal would disregard were the policyholder to apply for Medi-Cal. Program providers consumer education and agent forums on LTC risks and costs and special features of Partnership-certified policies; collects and analyzes insurer data on policyholders; and advocates for LTC insurance benefit improvements that increase consumer protection/choice.

What services are provided? Two types of policies are available: (1) Comprehensive policy that provides home and community based care; care in a residential facility; and care in a skilled nursing facility; (2) care in a residential and skilled nursing facility. Policies are purchased in terms of dollar amounts which equate to one to five years of coverage.

Is this provided through a federal waiver? No. In 1993, HCFA granted DHS a Medicaid State Plan Amendment to allow private insurance payments for residential facility care; adult day health care; and person care to count toward the Medi-Cal asset disregard.

Funding sources: Original program support came from a multi-year Robert Wood Johnson Foundation (RWJF) grant and federal financial participation.

Program eligibility criteria: Must be a California resident age 18 or over to purchase a Partnership-certified policy and meet the insurer's health underwriting criteria. The eligibility criteria for policy benefits are two out of six activities of daily living (bathing; dressing; toileting; transferring; eating; and continence) or cognitive impairment.

Other client characteristics: The program's target group is Californians age 50 – 74 years of age with assets between $30,000 - $250,000.

Is enrollment capped? No.

Geographic availability: Available statewide.

FY 1996 (July 1995-June 31, 1996) total program caseload: 2,892 policyholders; five policyholders using insurance benefits.

FY 1996 total program expenditures: $812,720 Robert Wood Johnson Fund Grant; $812,720 Federal Funds.

Other state departments this program interfaces with: California Department of Social Services; California Department of Aging; and Department of Insurance.

Does this program serve a significant portion of clients under age 18? No.

Department of Health Services

Long-term Care Integration Pilot Program

Brief program description: In 1995, California State legislation was enacted to authorize and implement the Long Term Care Integration (LTCI) Pilot Program for adults. The legislation defined the pilot sites as single, multi-, or sub-county units. The program's primary goals are: (a) provide a continuum of social and health services that fosters independence and self reliance; maintain individual dignity; and allow consumers of LTC services to remain an integral part of their family and community life; (b) encourage as much consumer self direction as possible, given their capacity and interest; and involve them and their family members as partners in developing and implementing the pilot project; and (c) test a variety of models intended to serve different geographic areas, with differing populations and available services.

To achieve these program goals, pilot projects will consolidate funding sources and administration of social, supportive, and health programs to build an integrated system replacing the currently uncoordinated services available. This consolidation is intended to overcome cost shifting incentives in the current system and to provide needed services in the most appropriate setting and cost effective manner.

What services are provided? Programs and services to be consolidated into a system that provides a full continuum of care services including In-Home Supportive Services; Multipurpose Senior Services Program; Linkages; Respite Care; Adult Day Health Care; Alzheimer's Day Care Resource Centers; and all Medi-Cal and Medicare covered services.

Is this provided through a federal waiver? Counties will require waivers to implement the program. Specifically which waivers are currently not known.

Funding sources: Will include county, state and federal funding. Specific amounts unknown at this time.

Program eligibility criteria: Medi-Cal eligible adults requiring long term care services.

Other client characteristics: N/A.

Is enrollment capped? No.

Geographic availability: Counties must choose to participate in the program.

FY 1996 (July 1995-June 31, 1996) total program caseload: 0 clients.

FY 1996 total program expenditures: $0

Other state departments this program interfaces with: California Department of Aging; Department of Developmental Services; Department of Mental Health; and California Department of Social Services.

Does this program serve a significant portion of clients under age 18? No.

Department of Mental Health Caregiver Resource Centers

Brief program description: Provide an array of services to family caregivers providing care for adult family members with chronic or degenerative brain disorders.

What services are provided? Family consultation and care planning; specialized information counseling; support groups; psycho-educational groups; education and training; legal and financial planning; respite care; and other mental health interventions.

Is this provided through a federal waiver? No.

Funding sources: 100% State General Funds.

Program eligibility criteria: Family member being cared for must be 18 years of age or over and have a chronic degenerative brain disorder.

Other client characteristics: Client is the caregiver and services are to support the caregiver in maintaining the family member at home.

Is enrollment capped? No.

Geographic availability: Statewide, regionally based with 11 regions. Some Caregiver Resource Centers have a central office with satellite offices; others are central offices with toll-free telephone numbers.

FY 1996 (July 1995-June 31, 1996) total program caseload: 9,500 clients.

FY 1996 total program expenditures: $5,042,000 (100% State General Fund)

Other state departments this program interfaces with: Department of Health Services; Alzheimer's Diagnostic and Treatment Centers; and California Department of Aging.

Does this program serve a significant portion of clients under age 18? No.

Department of Mental Health Traumatic Brain Injury Project

Brief program description: This is a demonstration project to establish post-acute systems of care for persons with acquired traumatic brain injury.

What services are provided? Case coordination (case management); functional assessment; structured living arrangements; day programs; supported employment and vocational opportunities.

Is this provided through a federal waiver? No.

Funding sources: Penalty Assessment Fund.

Program eligibility criteria: Age 18 and over, with an acquired traumatic brain injury as a result of an external force to the head; 50% of the clients must be Medi-Cal eligible or have no income.

Other client characteristics: N/A.

Is enrollment capped? No.

Geographic availability: Four sites: Sacramento; Long Beach; Orange County; Santa Cruz County.

FY 1996 (July 1995-June 31, 1996) total program caseload: 296 clients.

FY 1996 total program expenditures: $500,000

Other state departments this program interfaces with: Department of Rehabilitation.

Does this program serve a significant portion of clients under age 18? No.

California Department of Social Services Adult Protective Services (APS)

Brief program description: APS is a state-mandated Title XX service program for investigation and evaluation of abuse, neglect or exploitation of dependent and elderly adults.

What services are provided? Reporting; investigation; needs assessment; crisis intervention; emergency shelter; adult respite care; and referral services.

Is this provided through a federal waiver? No.

Funding sources: Federal Title XIX Community Services Block Grant (CSBG).

Program eligibility criteria: Be an adult aged 65 or older, or a dependent adult aged 18 – 64 years of age.

Other client characteristics: There are no income or resource limitations or requirements.

Is enrollment capped? No.

Geographic availability: Statewide availability administered by county welfare departments.

FY 1996 (July 1995-June 31, 1996) total program caseload: 57,256 active cases.

FY 1996 total program expenditures: The CSBG is $17.4 million; each county decides on how much funding and what services should be provided. No information on each county's expenditures is available.

Other state departments this program interfaces with: California Department of Aging regarding cross-reporting of abuse complaints when a victim is a resident of a community care facility.

Does this program serve a significant portion of clients under age 18? No.

California Department of Social Services Office of Services to the Blind

Brief program description: Assistance to blind and visually impaired persons.

What services are provided? Information and referral; public information and awareness; Assistance Dog Special Allowance.

Is this provided through a federal waiver? No.

Funding sources: State General Fund – 100%.

Program eligibility criteria: Person is blind or visually impaired. For the Assistance Dog Special Allowance, person must be blind/visually impaired; deaf/hearing impaired; or disabled and receiving SSI/SSP; In-Home Supportive Services or Personal Care Services Program benefits.

Other client characteristics: N/A.

Is enrollment capped? No.

Geographic availability: Available statewide by contacting the office located in Sacramento.

FY 1996 (July 1995-June 31, 1996) total program caseload: 525 clients in State FY 1996/97.

FY 1996 total program expenditures: State FY 1996/97: $322,700

Other state departments this program interfaces with: None.

Does this program serve a significant portion of clients under age 18? No.

Department of Social Services (IHSS)

In-Home Supportive Services

Residual Program

Brief program description: A state/county funded component of the IHSS program which provides assistance to aged, blind and disabled persons so they can remain in their own homes.

What services are provided? Domestic and related services; heavy cleaning; transportation; paramedical; respite; teaching and demonstration; non-medical personal care; and protective supervision.

Is this provided through a federal waiver? No.

Funding sources: State General Fund – 65%; County Funds - 35%.

Program eligibility criteria: (1) SSI/SSP eligibility criteria except for income limits; (2) have a need for the services; and (3) live in his/her own home or abode of own choosing.

Other client characteristics: Persons who meet SSI/SSP criteria except for income; pay a share of cost.

Is enrollment capped? No.

Geographic availability: Statewide availability with administration by each county.

FY 1996 (July 1995-June 31, 1996) total program caseload: 71,448 clients (12-month average).

FY 1996 total program expenditures: State FY 1996/97: State General Fund - $205 million; County Funds - $110 million.

Other state departments this program interfaces with: None.

Does this program serve a significant portion of clients under age 18? No.

California Department of Social Services SSI/SSP – Non-Medical Out-of-Home Care (NMOHC)

Brief program description: A payment rate category for SSI/SSP-eligible individuals who live in a licensed residential care facility for the elderly (RCFE) or in the home of a relative.

What services are provided? A higher SSP payment in addition to Medi-Cal services.

Is this provided through a federal waiver? No.

Funding sources: Same as for SSI/SSP.

Program eligibility criteria: Same as for SSI/SSP.

Other client characteristics: N/A.

Is enrollment capped? No.

Geographic availability: Available statewide via Social Security Administration field offices.

FY 1996 (July 1995-June 31, 1996) total program caseload: 69,522 clients (12-month average).

FY 1996 total program expenditures: March 1998 costs: $52.4 million (Federal Funds - $32.5 million; State General Fund - $19.9).

Other state departments this program interfaces with: Department of Health Services regarding Medi-Cal program.

Does this program serve a significant portion of clients under age 18? No.

California Department of Social Services In-Home Supportive Services (IHSS) Personal Care Services Program (PCSP)

Brief program description: A component of IHSS program with different funding and eligibility requirements.

What services are provided? Services are the same as for the Residual IHSS Program.

Is this provided through a federal waiver? No.

Funding sources: Federal Funds - 50%; State General Funds - 31.5%; County Funds – 17.5%.

Program eligibility criteria: (1) disability expected to last 12 months or more or to end in death; (2) require at least one personal care service; (3) provider of services cannot be parent or spouse; (4) can not be receiving advancement payment for services; and (5) provider of services is an enrolled Medi-Cal provider.

Other client characteristics: N/A.

Is enrollment capped? No.

Geographic availability: Statewide availability with administration by each county.

FY 1996 (July 1995-June 31, 1996) total program caseload: 119,736 clients (12-month average).

FY 1996 total program expenditures: State FY 1996/97: $635.5 million: Federal Funds - $319 million; State General Fund - $205.5 million; County Funds - $111 million County Funds.

Other state departments this program interfaces with: Department of Health Services regarding Medi-Cal program.

Does this program serve a significant portion of clients under age 18? No.