

*WORKING PAPER: February 2006*

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***OLMSTEAD ISSUE BRIEFS***  
**OLMSTEAD ADVISORY COMMITTEE**  
**DIVERSION WORK GROUP**  
**FEBRUARY 2006**

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*The following Issue Briefs are a work-in-progress and reflect the priorities-to-date of the Olmstead Advisory Committee's Diversion Work Group. Additional issues will be considered on an ongoing basis as the work group continues to refine and develop priority issues.*

## **ISSUE 1: ENSURING CONTINUED STATE LEADERSHIP**

### **POLICY GOAL**

To develop a vision and institute a policy that affirms the state's commitment to *Olmstead* and accomplishes the following objectives: lessens the state's reliance on institutional care and services by increasing the use and capacity of home and community-based services; fosters and promotes an individual's informed choice as to his/her living arrangement; increases an individual's ability to participate, live and work in his/her community; and creates processes that divert individuals from institutions.

### **PROBLEM**

The development of efficient systems, supports and services in the community to promote community living for persons with disabilities is hindered by a lack of leadership and consistency across departments and agencies in developing and implementing *Olmstead*-related policy, as well as a lack of fiscal resources to promote systems change.

### **BARRIERS**

- Medicaid Institutional Bias: Medicaid law requires states to provide institutional services to all eligible persons as a mandatory benefit, and permits (but does not require) states to offer home and community-based services.
- Programs operate under multiple funding streams with varying requirements that may not conform with the *Olmstead* principles;
- Some agencies and departments may not be aware of or understand *Olmstead* and, therefore, are less likely to develop conforming policies.

## DIVERSION WORK GROUP POLICY PRIORITIES

1. **Review of Policies and Regulations:** One option to increase awareness and conform Olmstead policies across departments is for the Governor, through Executive Order, to call for an evaluation of Health and Human Service Agency departments' policies, programs, statutes, and regulations. A cross-department review could help determine whether any policies, statutes or regulations should be modified to improve the availability of community-based services for persons with disabilities. The review could focus on identifying affected populations, improving the flow of information about supports in the community, and removing any barriers that impede opportunities for either returning the individual to the community or promoting continued community living.

Federal Policy Precedent: In 2001, President Bush signed an Executive Order requiring, among other items, that the Attorney General, the Secretaries of Health and Human Services, Education, Labor, and Housing and Urban Development, and the Commissioner of the Social Security Administration review the policies, programs, statutes and regulations to determine their compliance with Olmstead. The Executive Order also led to the development of the New Freedom Initiative, providing grants for systems change, employment and other home and community-based service initiatives.

2. **Advancing Large-Scale Policies:** The Diversion work group places a high priority on efforts that advance large-scale policies that seek to rebalance fiscal incentives and prioritize the use of community-based services over institutionalization. For example, adopting a "Money Follows the Person" approach whereby resources follow individuals out of institutions could increase resources allocated to community-based services, and decrease the amount spent on institutionalization (See Assessment/Transition Work Group Issues). In addition, the state could explore options for strategically reducing nursing home beds and replacing with community-based services, as has been accomplished in other states. In California, Medi-Cal community-based long-term care funds account for 45% (FY 2004) of all Medi-Cal expenditures.

3. **Including the Needs of Seniors and Persons with Disabilities within Proposed Bond Initiatives:** The diversion work group supports

using the proposed bond initiatives to meet the needs of seniors and persons with disabilities, including housing and transportation issues.

## **EXAMPLES OF STATE INITIATIVES**

### **OREGON**

Legislative Commitment: In 1981, Oregon received the country's first home and community-based services waiver. Language in the original legislation to promote home and community-based services in Oregon laid out a vision for a new system of care that emphasized the transition to home and community-based long-term care. All programs focus on promoting diversion from nursing homes and relocation for nursing home residents who request care in the community. As a result, Oregon spends a relatively large portion of Medicaid long-term care funds for community-based care, accounting for 70 percent of all Medicaid funds.

### **VERMONT**

Establishing Targets for Shifting Long-Term Care Expenditures: A 1996 law required that the balance of the state's long-term care spending reduce the rate of growth for Medicaid nursing home expenditures and invest the savings in home and community-based supports. The initiative established specific targets for the level of savings to be achieved in each of the four years following its enactment, and generated savings were used to expand existing programs or to fund new programs. As a result of this legislation, Vermont successfully expanded community-based options, including new residential services, and offered greater opportunities for participants to self-direct their supports. In Vermont, Medicaid long-term care funds spent for community-based care accounts for 58 percent of all Medicaid funds.

### **WASHINGTON**

State Reorganization: Washington consolidated the administration of all long-term care supports for older people and people with physical disabilities in 1986. The agency has a single budget line item for both community and institutional long-term care and estimates that the cost of caring for people in nursing homes is equal to the cost of providing services for two to four people at home.

Diversion through the Comprehensive Assessment Reporting Evaluation (CARE) System: Washington's CARE system is used to assess and develop service plans for clients who receive long-term care services,

serving as a single point of entry and determines eligibility for home and community programs. The system places a high priority on ensuring that people at high risk of institutionalization receive information about long-term care options quickly. If a person is being discharged from a hospital or rehabilitation center, local staff must perform a face-to-face interview within one working day of the referral.

In Washington, the Medicaid home and community-based long-term care funds accounts for 55 percent of all Medicaid funds spent in the state.

## **ISSUE 2: INCREASING EDUCATION AND AWARENESS ABOUT HOME AND COMMUNITY-BASED OPTIONS**

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### **POLICY GOAL**

To provide consumers, caregivers, family members, and providers with readily accessible information and education about the availability of home and community-based services as an alternative to institutionalization.

### **PROBLEM**

Community-based options for long-term care are relatively unknown and misunderstood, resulting in a lack of awareness of available options that can lead to premature or inappropriate institutionalization.

### **BARRIERS**

- Resources: Educating the public requires investment in resources, including electronic, print and televised media to ensure individuals are educated about home and community-based alternatives.
- Cross-Program Coordination: While some programs engage in education and outreach activities, efforts are not coordinated and do not reach all consumers.

### **DIVERSION WORK GROUP POLICY PRIORITIES**

**1. Establish a Public Education Campaign:** The Diversion Work Group places a high priority on the development of a public education campaign as a way to increase public awareness and education about the alternatives to institutionalization and the availability of home and community-based services. The State campaign could educate the public, providers, state workers, advocates, family members, caregivers, and consumers about the Olmstead decision and an individual's right to home and community-based care as well as caregiver issues. The campaign could raise awareness of home and community-based alternatives to institutionalization, using print, digital and televised media resources and

seek out methods to reach isolated individuals. The initiative could include an evaluation of the outcome/impact of education and outreach efforts on consumers' ability to remain at home and avoid institutionalization. The effort could coordinate with existing education efforts, including those at the local levels with In Home Supportive Services, as well as the Department of Rehabilitation's public education campaign outlined in its State Plan for Independent Living.

**2. Develop Information Resources at the State and Local Levels:** The Diversion Work Group places a high priority on the development of information at the state level, including on-line resources, to help direct consumers, caregivers, and providers to appropriate community resources. The CalCareNet Portal Enhancement Project is currently developing recommendations to consolidate, enhance, and standardize CalCareNet ([www.calcarenet.ca.gov](http://www.calcarenet.ca.gov)), the state's aging and long-term care information website, to provide a comprehensive, easy-to-use, consistently updated system of care for all Californians. The final report will be available in the fall of 2006. The Work Group will track the recommends of the CalCareNet project, and will provide feedback to the Secretary upon the project's completion.

## **EXAMPLES OF STATE OUTREACH INITIATIVES**

### **PENNSYLVANIA**

To make information readily accessible, Pennsylvania offers a 24-7 toll-free hotline for its *Community Choice Program*. An Elder Abuse Hotline, which already was in operation, now performs this extra function. Operators route calls about long-term care services to assessors who are on call to respond to inquiries and to conduct assessments for long-term care services.

### **VERMONT**

In 2002, Vermont mounted the "Options Education" campaign to publicize the availability of options for long-term care services. The Department of Aging and Disabilities developed a set of outreach materials that could be used statewide and locally and also conducted a statewide media campaign (through television ads, radio, and print media). These materials urged state residents to call the Senior HelpLine and talk with information assistance specialists. Grant funds were used to develop the materials and mount the initial campaign.

**WASHINGTON**

Washington conducted a community education campaign to help people become more familiar with the long-term care system and options to remain at home and avoid unnecessary institutionalization.



## **ISSUE 3: SUPPORTING PAID AND UNPAID CAREGIVERS**

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### **POLICY GOAL**

To improve the availability of and access to paid caregivers, and to support non-paid family caregivers through provision of respite services and other means of caregiver support.

### **PROBLEM**

Consumers are not aware of or cannot access public or private caregiver programs, often leading to premature or inappropriate institutionalization. In addition, family caregivers suffer from stress and burnout, impacting their ability to provide care for a loved one, and often leading to institutionalization for the care recipient.

### **BARRIERS**

- Lack of awareness of available caregiver services
- High demand for and short supply of paid and un-paid caregivers
- Difficulty accessing emergency back-up caregiver services

### **DIVERSION WORK GROUP POLICY PRIORITIES**

#### **1. Develop and/or expand local IHSS Emergency Services Programs:**

A major challenge in self-directed support is providing back-up support when a participant hires his or her own worker and that worker is absent. Some counties have developed programs providing emergency on-call caregiver services for individuals needing immediate assistance. The Diversion Work Group supports expansion of these efforts at the local levels.

**County Examples of IHSS Emergency Services Programs** (Source: Excerpt from the Centers for Medicare and Medicaid Services, *"Promising Practices in Home and Community Based Services, California –Local Programs Providing Back-Up Assistance,"* March, 2003).

Alameda County and San Francisco County offer temporary back-up services to individuals with disabilities that direct their own care. These

counties provide examples of contrasting models for providing back-up support.

Alameda County IHSS Emergency Services Program: Alameda County's Public Authority initially provided back-up assistance through a pilot program called Rapid Response. The pilot program was funded by a \$300,000, three-year grant awarded in 1997 by the Robert Wood Johnson Foundation and administered by the National Council on Aging, Inc.

The project provided home care workers on a short-notice and emergency basis for IHSS participants living in Oakland. The Public Authority contracted with a community service agency that employed eight home care attendants, a supervisor, and a dispatcher. The Public Authority expected a replacement worker to arrive at a participant's home within one hour of a telephone request. Visits were limited to three hours, and participants could not use back-up assistance more than four times per month. After the pilot's completion, the Alameda County Public Authority established a permanent program for back-up support.

San Francisco IHSS Emergency Services Program: The San Francisco Public Authority created a pool of attendants to meet most emergency needs. The Public Authority employs the attendants directly, and pays for hours in which the attendants provide back-up support. Currently 15 to 20 workers are available for back-up support. The workers receive \$14 to \$15 per hour, including reimbursement for travel costs. The program expanded its coverage to include non-emergency situations, in which participants call in advance to cover planned absences of regular workers.

**2. Open county IHSS registries for use by private pay entities:** The Diversion Work Group supports the expansion of IHSS registries to allow private-pay clients to hire IHSS caregivers and provide the services to persons currently not eligible for services. At present, three Public Authorities provide access to IHSS registry services for private-pay consumers (Alameda, San Francisco and Santa Barbara). These Public Authorities have established policies to allow private-pay consumers to receive a list of available IHSS workers from the local registry and the private-pay consumer pays a fee for the list. The fees are set on a sliding scale associated with the person's self-reported income. Once the private-pay consumer receives the list of available IHSS providers, the consumer

can select the worker and establish their own private relationship to determine hours, pay and scope of work. The private-pay consumer can receive updated or new lists of available workers for some time period (this differs among these three Public Authorities) as part of the service covered within their original fee paid to the Public Authority. Due to limited outreach and education, there is little knowledge about the availability of these services and utilization has been fairly low.

**Related Legislation:** AB 477 (Baca) would have required the Department of Social Services to establish a 4-year pilot project authorizing certain individuals who are not financially eligible to receive In-Home Supportive Services or Medi-Cal services, to purchase In-Home Supportive Services. The legislation limited the participants to persons at or below 300% of Federal Poverty Level. The Governor vetoed the bill, indicating that *“this measure, while worthy, may negatively impact the ability of persons with disabilities enrolled in the In-Home Supportive Services (IHSS) program to secure the services they require. Current IHSS consumers often report difficulty in locating, hiring, and retaining quality service providers. Increasing the number of consumers seeking services from IHSS providers may exacerbate these challenges.”*

**3. Institute a State Match for the National Family Caregiver Support Program (NFCSP):** The Diversion Work Group supports the provision by the state of the required state match for the National Family Caregiver Support Program, as way to expand local home and community-based resources and, in particular, to enhance the State’s support of family caregivers. At present, the local Area Agencies on Aging are required to pay the NFCSP program’s required state match, taking resources away from other programs and services provided at the local level. The National Family Caregiver Support program directs states, working in partnership with Area Agencies on Aging and local community-service providers, to provide a continuum of caregiver services, including information, assistance, individual counseling, support groups, training, respite, and supplemental services. These caregiver support services are available to adult family members, or other individuals who are informal providers of in-home and community care to older persons. The Department of Aging indicates that the 25% match requirement for the Title III E Caregiver program is approximately \$3.8 million.

## **ISSUE 4: INCREASING THE SUPPLY OF AFFORDABLE AND ACCESSIBLE HOUSING**

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### **POLICY GOAL**

To increase the supply of affordable and accessible housing in California, and to ensure that seniors and persons with disabilities who wish to remain at home and avoid institutionalization or transition out of institutions can access adequate housing and supportive service alternatives.

### **PROBLEM**

Seniors and persons with disabilities often face high housing costs or live in physically unsupportive environments that are disconnected from services. For persons who need more services and support than can be provided in their homes and apartments, there is an inadequate supply of affordable supportive housing options. Consequently, seniors and persons with disabilities are often faced with living in inadequate settings or moving to more institutionalized settings. In addition, persons wishing to transition out of an institution into the community often cannot do so due to lack of affordable and accessible housing options.

### **BARRIERS**

- Lack of accessible housing for persons with disabilities
- Lack of affordable housing, with waiting lists ranging from 18 months to three years
- Lack of access to services that are in close proximity to housing

### **DIVERSION WORK GROUP POLICY PRIORITIES**

1. **Include Affordable, Accessible Housing within Bond Initiatives:**  
The inclusion of affordable, accessible housing in proposed bond initiatives can help to meet the housing needs of seniors and persons with disabilities. This policy option could also be achieved through

establishment of a permanent and dedicated source of funding (recommendation 2).

2. **Establish an Affordable Housing Trust Fund:** Upon depletion of Proposition 46 Funds, a permanent funding source for affordable housing could be established through an Affordable Housing Trust Fund that would provide continued funding for affordable housing to meet the needs of seniors and persons with disabilities across the state. Efforts are underway throughout the state to include an initiative on the state ballot for an affordable housing bond.
3. **Expand Programs that Bring Services into Housing:** The Diversion Work Group supports the development of models that encourage the co-location of housing and services. A variety of models exist that serve as models for bringing services into housing, including the following:
  - HUD 202s with service coordinators (approximately 1/3 of sites in state)
  - Service packages brought in an organized fashion (*Well Elder* program in San Francisco)
  - Co-location of services: Housing built in proximity to a senior center or as complex, such as *Presentation Senior Housing* (Mercy Housing) in San Francisco where 60 of 90 Units are set-aside for skilled nursing facility eligible residents
  - Integrated Service Program such as *On Lok* or *Center for Elder Independence* (Programs for All Inclusive Care)
  - Continuing Care Retirement Communities at Home: a new approach using case management and prepaid expenses for a moderate-income population that are frequently the least served.
  - Beacon Hill Village Model, Boston, MA
  - Public Health Nursing Services in low-income housing complexes serving seniors and adults with disabilities.
4. **Develop Transition Funds:** The Diversion Work Group supports development of state and local “patch” funds to subsidize housing needs (including rental assistance) for individuals transitioning out of institutions until the individuals are eligible for other programs including Section 8 vouchers.

The Department of Rehabilitation has a transition funding program, *One-time Transition Costs for Deinstitutionalization*, to assist independent living centers with the one-time costs associated with assisting people with disabilities of all ages to transition from institutional settings to community settings. The Department of Rehabilitation provides up to \$4,000 to assist consumers in meeting the one-time costs associated with moving from nursing facilities and similar settings to the community - generally, the individuals' homes or apartments. The average cost per consumer since implementation is approximately \$2,450.

## **ISSUE 5: INCREASING ACCESS TO TRANSPORTATION**

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### **POLICY GOAL**

To increase access to transportation alternatives that help individuals remain at home and in the community by, among other things, connecting consumers to medical, supportive, and employment services.

### **PROBLEM**

A lack of coordination and silos of funding between programs spanning across the Health and Human Services Agency departments and the Department of Transportation has contributed to a fragmented human services transportation system. The system fragmentation can lead to difficulty accessing services for seniors and persons with disabilities.

### **BARRIERS**

- Multiple funding streams operating across departments
- Lack of resources necessary to meet demand for services

### **DIVERSION WORK GROUP POLICY PRIORITIES**

**1. Improve Access to Medical Care Transportation:** The Diversion Work Group places a high priority on reforming the Medi-Cal Non-Emergency Transportation (NEMT) program to include a comprehensive strategy for managing non-emergency transportation to ensure access to medical appointments at a reasonable cost, including the use of transit passes. This policy would allow public transit as an eligible reimbursable transportation cost under Medi-Cal and include income-level as criteria for receipt of Medi-Cal reimbursement for Non-Emergency Medical Transportation.

#### **Background**

Title XIX of the Social Security Act and accompanying regulations require that in state Medicaid programs, states cover medical care and services and fulfill administrative requirements necessary to operate the Medicaid

program efficiently. Among these administrative requirements is the mandate that a State plan “specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers and describe methods that the agency will use to meet this requirement.” Transportation ensures that individuals can get to and from needed care and thus is necessary for the effective administration of Medicaid-funded health care services.

In California: Eligibility for transportation assistance under the Medi-Cal program is based on physical ability as opposed to economic need or the availability of transportation alternatives. To receive Medi-Cal reimbursement for transportation services, health professionals must certify that patients need a para-lift, a stretcher vehicle or an ambulance.

**Other States’ NEMT Policies:  
Transportation Brokers and Administrative Managers**

To respond to pressures of rising costs and lack of efficiency, a number of states have developed approaches to meet federal transportation requirements. For NEMT, these approaches include the use of transportation brokers and administrative managers, and a shift to capitated transportation services. Transportation brokerages are entities created to coordinate transportation services for Medicaid recipients, including screening of recipients, determination of eligibility and arrangement and payment of actual transportation. Administrative managers are state Medicaid agency staff that assumes the position of gatekeeper in arranging or contracting out the administrative responsibilities. Capitated services involve the transfer of responsibility for transportation to the managed care provider.

The Diversion Work Group supports testing the use of bus and transit passes, and the use of transportation brokers with a goal of improving access to routine care for more people and to reduce expenditures for acute care and emergency care.

The California Association for Coordinated Transportation has recommended that California conduct pilot programs in several jurisdictions to test approaches to reducing the total cost of medical care by increasing the transportation options for recipients. The options could include:

- Using bus passes



- Using bus passes in combination with a brokerage model
- Using bus passes in combination with a brokerage model and capitated rates

### **Feedback from the Department of Health Services**

While acknowledging that other states have had some success with similar NEMT programs, the Department of Health Services does not support this proposal, due to projected increased costs and other key issues surrounding implementation, operations, management, fraud, and abuse. DHS indicates that expansion of Medi-Cal services to cover NEMT would significantly increase Medi-Cal program costs with no proven savings potential.

The Department notes that California currently meets the federal requirement to assure transportation to Medi-Cal approved medical services, pursuant to 42 Code of Federal Regulations, Section 431.53, through the provision of medical transportation and through reliance on free or low cost public transportation and transportation provided by friends and families of Medi-Cal beneficiaries.

Citing a 1995 Alaska Medicaid Agency survey of all state Medicaid agencies in which 36 states responded (not including California), the Department indicates that states report a wide range of transportation services, payment methodologies, and authorization methods. A summary of some of the 1995 Alaska report findings follows:

- Eighty-four percent of reporting states had policies that allowed all eligible recipients to obtain transportation to medically necessary services. Some states exclude certain groups, e.g., medically needy.
- The majority (81%) cover public transportation, either through contractual arrangements, by distribution of tokens, passes and vouchers, or by reimbursement to recipients.
- Local and county offices are responsible for administration in most states (57%).
- Prior authorization of services is the utilization control method used in 78% of responding states.
- Some states perform post payment review of claims and some limit the number of trips per year.

- 81% of states reimburse individuals for transportation costs. Reimbursement for mileage is the most common form of direct reimbursement.
- 57% of responding states pay for transportation through claims submitted by enrolled providers.
- Most states manage transportation through a variety of methods, such as contracts, grants, vouchers, passes and tokens.
- At the time of the survey, five states, including Washington and Oregon, were using or implementing a broker model.
- Most states cover transportation as a service, some as an administrative expense, and some as both.

The Department of Health Services summarizes the reported problems encountered by states, as identified in Alaska's 1995 survey:

- Lack of uniformity in benefits
- Overly-generous reimbursement (thereby creating an excess of providers)
- "No shows" and cancelled appointments
- Cumbersome, staff-intensive reimbursement process
- Provider fraud and abuse, including double-billing
- Rapidly escalating costs in most states
- Lack of consistency in local office administration

Key issues that the Department of Health Services foresees in California include the following:

- Cost: Based on Oregon's 1997 figure of 1.6 percent (*non-emergency medical and non-medical* transportation costs as a percent of their total Medicaid costs), extrapolated to California, the estimated annual cost for providing transportation coverage for medical appointments would be approximately \$544 million. However, since California already spends \$96 million for non-emergency medical transportation, the actual additional cost accrued would be \$448 million.
- Sub-contractors would need to be Medi-Cal certified providers
- Limited state resources and potential barriers associated with conducting a pilot (staff including an actuary, Federal Medicaid Waiver, evaluation contractor, procurement/bidding process, etc.)
- Potential for abuse/over-utilization

- The Centers for Medicare and Medicaid Services is shifting away from bundled rates
- The broker model requires an actuary calculation for brokerage services

**2. Address Mobility Management and Coordination Issues:**

Establishment of California Mobility Council, comprised of representatives of the Business, Transportation and Housing Agencies and the Health and Human Services Agency could help to address state-level transportation coordination issues. This entity would provide a forum to address laws, regulations, and programs related to human services transportation-funding programs, and would set clear guidance for improving human services transportation within the state.

**The United We Ride Grant Program**

In the fall of 2005, the Department of Transportation, with support from the Health and Human Services Agency departments, applied for a federal United We Ride implementation grant. A key component to the proposal centers on establishment of a Mobility Council, an interagency body represented by leaders of the Department of Transportation and Health and Human Services Agency that will set clear guidance or mandates for improving human services transportation within the state. The grant seeks to improve human services coordination by providing greater access to funding, creating a more cost-effective use of resources, meeting currently unmet service needs, and providing more centralized management of existing resources.

**Other States' Coordination Efforts**

Most states have established formal coordination structures. Typically, the Departments of Transportation lead the coordination efforts, with direct participation from the Health & Human Service Agency Departments.

**3. Increase Access to Transit and Paratransit Services:** Seniors and persons with disabilities who do not drive need low-cost mobility options in order to access health, social, and other community services. Public transportation could be an option for these individuals, but the housing and service facilities often are not located on transit routes. The Diversion Work Group supports amending social service funding and licensing application eligibility criteria to include consideration of direct access to transit in the location of all service facilities.

**4. Enhance Paratransit Funding:** Many seniors and persons with disabilities who do not drive require specialized paratransit services. Federal law requires public transit to provide, or contract for, ADA-complementary paratransit service within  $\frac{3}{4}$  miles of existing fixed routes. Historically, most transit agencies have provided funds for services on a more regional basis. However, as revenues have been diminishing, many transit agencies are now restricting funding ADA trips to those both starting and finishing within the  $\frac{3}{4}$  mile fixed route limit. In addition, transit agencies have been cutting “nonproductive” routes, often in areas having large concentrations of disabled individuals and seniors. Once the route is cut, the transit agency no longer pays for ADA complementary service to those areas. The Diversion Work Group places a priority on the provision of additional resources be placed towards paratransit services.

**5. Amend the CTSA Law:** The Diversion Work Group supports providing Consolidated Transportation Service Agencies (CTSAs) with the authority to act as mobility managers and develop local coordination plans requiring public transit to evaluate the impacts of route and service cuts on disabled individuals and seniors. Additionally, public transit agencies should be encouraged to work closely with CTSAs, paratransit providers, and consumer advocacy groups to ensure services are continued.

### **Background**

State law designates CTSAs to consolidate and coordinate social service transportation services. State law does not mandate the establishment of CTSAs in all regions, nor does statute mandate that the existing entities carry out specific mobility management functions. Due to a lack of incentives to coordinate or improve services, mobility management is not a function of most CTSAs.

## **ISSUE 6: DEVELOPING A COMPREHENSIVE SERVICE DELIVERY SYSTEM THAT INTEGRATES SERVICES**

### **POLICY GOAL**

To design a comprehensive assessment system and coordinated system of care that integrates the full continuum of both acute and long term care financing and service delivery that emphasizes home and community-based services in lieu of institutional placements.

### **PROBLEM**

California's acute and long term care system has long been impacted by system fragmentation stemming from a multiplicity of funding streams, assessment procedures, and lack of coordination between the medical and social systems of care. This fragmentation can lead to higher-than-necessary rates of hospitalization, nursing home expenditures, with a lack of coordination between primary, acute, long term care systems.

### **BARRIERS**

- Multiple funding streams and silos of services
- Lack of coordination between medical and social systems of care

### **DIVERSION WORK GROUP POLICY PRIORITIES**

1. **Access Plus Community Choices - The Administration's Integration Proposal:** The work group supports integration and is interested in the Governor's proposal to integrate the acute and long term care services as outlined in the Access Plus Community Choices proposal. The Work Group will provide additional guidance and recommendations after reviewing the proposal in more detail.
2. **Establish Home and Community-Based Services as Part of the State Medicaid Plan:** Opportunities are presented by the Federal Deficit Reduction Act to develop home and community-based services that are

part of the state Medicaid plan, rather than the waiver. The Deficit Reduction Omnibus Reconciliation Act of 2005 authorizes a new home and community-based services (HCBS) initiative. Under the agreement, states will be able to submit a state plan amendment to cover home and community based services (HCBS), effective January 1, 2007. This new option will offer the flexibility of a 1915 (c) waiver and the benefits of using the state plan. The Act allows states for the first time to offer home and community-based services under the state plan but with the flexibility available in 1915 (c) waivers. In addition, the agreement separates the tie between HCBS and nursing home level of care. Under the Act, HCBS eligible individuals do not have to meet the level-of-care criteria for admission to a nursing home, a hospital, or an ICF-MR (Source: the National Academy for State Health Policy, January 2006). The Diversion Work Group recommends that the state monitor the implementation of this provision and analyze the potential for streamlining and integrating existing waivers into the state plan.

**3. Address the Institutional Bias and Revisit California's**

**Realignment System:** The Work Group places a high priority on establishment of policy options that would address the institutional bias at the local level and provide incentives to counties for diversion and transition efforts. Under the current realignment system, counties are required to pay a 17.5% match for IHSS services, the state pays 32.5%, and the federal government pays 50%. For nursing facility services, however, counties do not pay a share-of-cost; the state pays 50% and the federal government pays 50% of the cost of services under Medicaid. This policy may give counties a fiscal incentive to institutionalize IHSS consumers, as the counties bear no financial responsibility for institutionalized consumers. The state could develop incentives for counties who work to transition people out of nursing homes as has been done in other states.

**Other States**

In Wisconsin, the state provides an incentive to counties that assist individuals in transitioning out of nursing facilities. The state adds an amount to the county's allocation of HCBS waiver funds for each occupied nursing facility bed closed in which the person moves into the community. The state increases the county's allocation by the amount necessary to meet the needs of each person who leaves a nursing facility while using the HCBS waiver funds. Once this person no longer needs waiver services, the

funds will remain available for other people in that county who need home and community based services. This earmarked relocation funding is an incentive for counties to seek out people in institutions wishing to relocate. At the same time, the state budget for Medicaid nursing facility residents is reduced, so the result is a transfer of funds from nursing facilities to home and community-based services.

4. **Monitor implementation of the Federal Medicare Modernization Act:** The Medicare Modernization Act of 2003 specifies that beginning in 2006, prescription drug coverage (Part D coverage) will be available for Medicare beneficiaries. The Diversion Work Group is concerned about the impact Part D implementation may have on diversion issues, as individuals are susceptible to institutionalization if unable to access appropriate medications.

## **ISSUE 7: IMPROVING ACCESS TO AND INCREASING FUNDING FOR HOME AND COMMUNITY-BASED SERVICES**

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### **POLICY GOAL**

To design a long term care system that prioritizes the delivery of home and community-based services over institutional care, and ensures that consumers and caregivers can access an array of services in the community.

### **PROBLEM**

Consumers and caregivers often cannot access the necessary services and supports that promote community living, resulting in premature or unnecessary institutionalization.

### **BARRIERS**

- **Medicaid Institutional Bias:** Medicaid law requires states to provide institutional services to all eligible persons as a mandatory benefit, and permits (but does not require) states to offer home and community-based services.
- **Inadequate Funding Formulas:** Resources dedicated to home and community-based services often cannot keep pace with increasing costs and static rate structures do not take into account
- **Lack of Case Management Services Available on Statewide Basis:** Case management assists consumers with accessing the services and supports that help them remain in the community. Medi-Cal does not offer case management as an optional state plan benefit; some home and community-based waivers offer these services, but the availability of services varies throughout the state.



## **DIVERSION WORK GROUP POLICY PRIORITIES**

1. **Rate Reform for MSSP:** The Work Group supports rate reform for the MSSP program to adjust the funding formula and enable providers to keep up with rising program costs.

### **Background**

Forty-one Multipurpose Senior Service Program (MSSP) sites provide social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who choose to live at home with MSSP support. The goal of the program is to prevent or delay premature nursing home placement of these very frail clients. The program has operated under a federal Medicaid 1915 (c) waiver since 1983. MSSP clients are 35% less costly to the State than those living in skilled nursing facilities (Under federal rules, cost must not exceed 95% of nursing home costs). The program can serve up to 11,789 clients per month.

Clients eligible for the program must be 65 years of age or older, live within a site's service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, currently eligible for Medi-Cal, and certified or certifiable for placement in a nursing facility. MSSP site staff make this certification determination based upon Medi-Cal criteria for placement. The services that may be provided with MSSP funds include:

- Adult Day Care / Support Center
- Housing Assistance
- Chore and Personal Care Assistance
- Protective Supervision
- Care Management
- Respite (includes supervision and care of a client while the family or other individuals who normally provide full-time care take short-term relief)
- Transportation
- Meal Services
- Social Services
- Communications Services

**Need for Rate Reform:** Administrative and waiver-related obstacles prohibit flexibility in how waiver funds are used in the program. The diversion work group supports reforming the MSSP rate structure to allow for increased flexibility and increased program effectiveness.

Additionally, MSSP programs report an urgent need for funding to enable sites to continue offering services to frail elders. MSSP has had one funding increase since its inception in 1983 whereas nursing facilities have received a rate increase each year resulting in a 96% increase over the past 15 years. An ever-increasing number of elders served by MSSP have very complex medical and psychosocial needs requiring an intense level of service. The ability of the program to continue to address these needs has been shrinking due to stagnant funding and annually increasing health care and labor costs.

## **2. Include Targeted Case Management for Nursing Homes in**

**State Medicaid Plan:** The Targeted Case Management (TCM) can provide critical case management services for residents of skilled nursing facilities to transition into the community, when beyond the scope of existing discharge planning services available at the skilled nursing facility. The work group supports providing services to institutionalized persons, for up to 180 days prior to discharge, as allowed under CMS rules. These services could be used to work with SNF residents identified as having an interest in returning to the community.

### **Background**

Targeted Case Management is case management to assist Medi-Cal recipients in gaining access to needed medical, social, educational and other services. Covered activities include assistance in obtaining services covered under the Medi-Cal State Plan, such as home health, IHSS, and durable medical equipment, as well as through other public and private providers, such as emergency food and housing. Covered activities also include assessment, service/support planning, and monitoring services and supports to ensure they are meeting a beneficiary's needs. In California, TCM is offered through local governmental agencies (LGA) that provide services directly or by contracting with non-governmental entities or the University of California. The State Department of Health Services

assists local governments in processing claims and monitoring. TCM is reimbursed through the Medi-Cal State plan on a 50% local government, 50% federal dollar matching basis. This policy would shift TCM to the state for provision of the TCM services in SNFs as a statewide benefit.

The Center for Medicare and Medicaid Services (CMS) clarified that TCM can be furnished as a service to institutionalized persons, for up to 180 days prior to discharge, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, educational and other services in the community.

**3. Develop and Implement Two Diversion Pilot Programs:** The Diversion work group supports the establishment of two pilot programs that would focus on diverting individuals at risk of institutionalization in licensed skilled nursing facilities. The Diversion Pilot Programs could be established in two areas of the State (note: this concept was proposed in California's Real Choice Systems Change grant in 2005. The grant was not approved by the Centers for Medicare and Medicaid Services). The programs could provide a single point of contact with home and community-based programs for individuals at risk of nursing home placement (primarily those in hospitals at risk of institutionalization). The programs could target individuals who are at risk of nursing home placement, but could also act as an educational resource for the local communities to provide information and referrals on home and community-based services *before* a crisis situation occurs.

**4. Restructure Medicaid In-Home Nursing Care Waiver:** The Nursing Facility A/B waiver will be renewed and merged with the two other IN-Home Medical Care waiver programs (Subacute, and In-Home Medical Care). The Diversion work group supports restructuring the waiver based on need, both current and potential. The need can be estimated by using the Minimum Data Set, the findings of the Money Follows the Person research, Laguna Honda transition information, and the current transition programs operating in Santa Rosa and Los Angeles. Further, the Work Group recommends that the waiver and its cost caps be constructed so as

to meet needs while preserving cost neutrality – as opposed to the \$35,000 cap now in place for the NF A/B waiver.

**5. Implementation of Mental Health Services Act/Proposition 63:**

Monitor the Act's implementation to ensure that all funded proposals are consistent with the Policy Statement of the Olmstead Advisory Committee, specifically with regard to self-determination and consumer choice; foster and promote an individual's informed choice as to his/her living arrangement; increases an individual's ability to participate, live and work in his/her community, and creates processes that divert individuals from institutions.

**ADDITIONAL ISSUES TO EXPLORE FOR FUTURE DISCUSSION:  
THE FOLLOWING PROPOSALS WILL BE DISCUSSED AND  
CONSIDERED BY THE DIVERSION WORK GROUP:**

1. Expand Lanterman outside of DD population
2. Funding for systems advocacy (per Independent Living Centers)
3. Waiver assessments should not be centralized, should be localized
4. Equity in programs
5. Implementation of Mental Health Services Act/Proposition 63
6. ADHC program restructuring and implications
7. Employment issues
8. Work force capacity – with particular attention to direct service providers

