AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER TONY THURMOND, CHAIR

MONDAY, MARCH 9, 2015

1:30 P.M. - STATE CAPITOL ROOM 444

ITEMS TO BE HEARD

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LIST OF PANELISTS IN ORDER OF PRESENTATION

4170 DEPARTMENT OF AGING
4260 DEPARTMENT OF HEALTH CARE SERVICES
5180 DEPARTMENT OF SOCIAL SERVICES

ISSUE 1: COORDINATED CARE INITIATIVE OVERSIGHT

- **Sarah Steenhausen**, Senior Policy Advisor, The SCAN Foundation
- **Amber Cutler**, Senior Staff Attorney, Justice in Aging
- **Denise Likar**, Vice President, Independence at Home a division of SCAN Health Plan
- **Deborah Doctor**, Legislative Advocate, Disability Rights California
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Ed Long,** Deputy Director, California Department of Aging
- **Yang Lee** and **Scott Ogus,** Department Of Finance
- **Felix Su**, Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

ISSUE 2: COMMUNITY-BASED ADULT SERVICES OVERSIGHT

- **Laurel Mildred**, Consultant, California Association of Adult Day Health Care
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Ed Long**, Deputy Director, California Department of Aging
- **Yang Lee,** Department Of Finance
- **Scott Ogus,** Department Of Finance
- **Rashi Kesarwani**, Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: LICENSING & CERTIFICATION PROGRAM ESTIMATE & PROPOSALS

- **Jean Iacino,** Deputy Director, Center for Health Care Quality, CDPH
- **Scott Vivona,** Acting Assistant Deputy Director, Center for Health Care Quality, CDPH
- **Maria Gutierrez,** Chief, Resource and Operations Management Branch, Center for Health Care Quality, CDPH
- **Kimberly Harbison**, Finance Budget Analyst, Department of Finance
- **Jamey Matalka**, Principal Program Budget Analyst, Department of Finance
- **Shawn Martin**, Managing Principal Analyst, Legislative Analyst's Office
- **Public Comment**

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: SKILLED NURSING FACILITY QUALITY ASSURANCE FEE

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Yang Lee**, Department of Finance
- **Scott Ogus**, Department of Finance
- **Felix Su**, Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

4170 CALIFORNIA DEPARTMENT OF AGING

ISSUE 1: PROGRAM AND BUDGET REVIEW

- **Lora Connolly**, Director, and **Ed Long**, Deputy Director, California Department of Aging
- **Clay Kempf**, Executive Director, Seniors Council of Santa Cruz and San Benito
- **Karen Jones**, Coordinator, San Luis Obispo Ombudsman Program and Past President, California Long-Term Care Ombudsman Association
- **Rashi Kesarwani**, Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **John Silva**, Department of Finance
- **Public Comment**

ITEMS TO BE HEARD

4170 DEPARTMENT OF AGING
4260 DEPARTMENT OF HEALTH CARE SERVICES
5180 DEPARTMENT OF SOCIAL SERVICES

ISSUE 1: COORDINATED CARE INITIATIVE OVERSIGHT

PANELISTS

- **Sarah Steenhausen**, Senior Policy Advisor, The SCAN Foundation
- **Amber Cutler**, Senior Staff Attorney, Justice in Aging
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- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Yang Lee,** Department Of Finance
- **Scott Ogus,** Department Of Finance
- **Felix Su**, Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

BUDGET PROPOSAL

The Governor's budget includes a net General Fund savings of $173.8 million in 2015-16 as a result of the Coordinated Care Initiative (CCI), including General Fund savings from the sales tax on managed care organizations. Without the tax revenue, CCI would have a General Fund cost of $399 million in 2015-16. Additional fiscal detail is provided in the table below.

Coordinated Care Initiative (CCI) Savings Analysis		
	2014-15	2015-16
(In thousands)	General Fund	General Fund
Local Assistance Costs/Savings Total	**$453,828**	**$201,958**
Payments to Managed Care Plans	$2,851,779	$5,632,869
Transfer of IHSS Costs to DHCS	-$723,243	-$1,456,769
Savings from Reduced Fee for Service Utilization	$1,674,708	-$3,974,142
Payment Deferrals Total	**-$345,729**	**-$74,443**
Defer Managed Care Payment	-$382,473	-$91,688
Delay 1 Checkwrite	$36,744	$17,245
Revenue Total	**-$375,061**	**-$572,871**
Increased MCO Tax from CCI (All Revenue)	-$86,111	-$194,418
Increased MCO Tax from non-CCI (Incremental Increase from tax rate of 2.35 to 3.93 percent as part of 2013 agreement with CMS on managed care tax)	-$288,950	-$378,453
State Administrative Costs	**$34,132**	**$22,893**
Department of Social Services- IHSS County MOE	**$175,064**	**$248,593**
Department of Social Services- IHSS County MOE, Costs Related to Fair Labor Standards Act	$62,646	$109,897
Net Impact to State	**-$57,766**	**-$173,870**

BACKGROUND

The 2012 budget authorized the CCI, which expanded the number of Medi-Cal enrollees who must enroll in Medi-Cal managed care to receive their benefits. The CCI is being implemented in seven counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara).

The CCI has the following three major components:

1. **Cal MediConnect Program**: A three-year demonstration project for persons eligible for both Medicare and Medi-Cal (dual eligibles) to receive coordinated medical, behavioral health, long-term institutional, and home-and community-based services through a single organized delivery system (health plan). No more than 456,000 beneficiaries would be eligible for the duals demonstration in the eight counties. This demonstration project is a joint project with the federal Centers for Medicare and Medicaid Services (CMS).

2. **Mandatory Enrollment of Dual Eligibles and Others into Medi-Cal Managed Care.** Most Medi-Cal beneficiaries, including dual eligibles, partial dual eligibles, and previously excluded seniors and persons with disabilities (SPDs) who are Medi-Cal only, are required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits.

3. **Managed Long-Term Supports and Services (MLTSS) as a Medi-Cal Managed Care Benefit**: CCI includes the addition of MLTSS into Medi-Cal managed care. MLTSS includes nursing facility care (NF), In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), and Community Based Adult Services (CBAS). This change impacts about 600,000 Medi-Cal-only enrollees and up to 456,000 persons eligible for both Medicare and Medi-Cal who are in Cal MediConnect.

The purpose and goal of the CCI is to promote the coordination of health, behavioral health, and social care for Medi-Cal consumers and to create fiscal incentives for health plans to make decisions that keep their members healthy and out of institutions (given that hospital and nursing home care are more expensive than home and community-based care). See table below for enrollment summary information.

CCI Enrollment Summary as of January 1, 2015		
County	**Cal MediConnect**	**Medi-Cal-Only Managed Care for MLTSS***
Los Angeles	56,240	350,000
Orange	-	51,000
Riverside	14,536	48,000
San Bernardino	14,398	50,000
San Diego	19,683	64,000
San Mateo	10,226	14,000
Santa Clara	7,825	31,000
Total	**122,908**	**608,000**

*Medi-Cal-only enrollees will receive only Medi-Cal benefits from the health plan, including MLTSS. These enrollees include full dual eligibles excluded from Cal MediConnect, partial dual eligibles, and senior and persons with disabilities.

Factors Affecting the Fiscal Solvency of CCI. SB 94 (Committee on Budget and Fiscal Review), Chapter 37, Statutes of 2013, requires the Department of Finance to annually determine if there are net General Fund savings for the CCI. If the CCI is not cost-effective, all components would cease operation. As part of the budget, the Administration identified the factors below that have occurred since the 2012 enactment that may jeopardize the fiscal solvency of this initiative. According to DOF's current analysis, if these factors do not improve, there would be a net General Fund cost, and consequently, the CCI would cease operating effective January 2017. The Administration indicates that it remains committed to implementing the CCI to the extent that it can generate program savings.

The following changes have occurred since enactment of the 2012 Budget Act:

- More than 100,000 participants were exempted, including Medicare Special Needs Plans and certain categories of Medi-Cal beneficiaries based on age or health condition.

- Passive enrollment was delayed until 2014, and Alameda County will no longer participate in the demonstration due to concerns regarding one of the health plan's readiness. Orange County will not begin passive enrollment until August 2015.

- Medicare and Medicaid savings were intended to be shared 50:50 with the federal government; however, the federal government reduced the amount of savings California was allowed to retain to approximately 25 to 30 percent.

- The federal government allowed a 3.975 percent tax on managed care organizations through June 30, 2016 which is attributable to the state's participation in the demonstration. However, recent federal guidance indicates that this tax will not be allowed to continue in its current form.

- As of November 1, 2014 approximately 69 percent of eligible participants opted out of Cal MediConnect compared to initial projections of approximately 33 percent. Of the 69 percent that have opted-out, about 80 percent of these individuals are In-Home Supportive Services (IHSS) beneficiaries.

- Due to revised federal Fair Labor Standards Act (FLSA) regulations, IHSS providers are entitled to overtime compensation. Because the CCI established a maintenance-of-effort (MOE) funding formula for IHSS, the state's IHSS fiscal exposure has significantly increased. It should be noted that since the Governor's budget was released, a federal district court ruled that the FLSA regulations be vacated; consequently, it is unclear how this change impacts the CCI.

Higher Than Expected Cal MediConnect Opt-Out Rate. The Governor's budget warns that if certain issues are not resolved, the CCI and all of its parts, would cease to operate pursuant to current law. Of the key issues cited by the Administration negatively affecting the CCI, the issue with which the Administration has the greatest ability to have an impact—without statutory changes or changes in the agreement with CMS—is the higher than expected opt-out rate for Cal MediConnect.

DHCS indicates that it is currently undertaking a study as to the demographics of those who have opted-out including trying to get a better understanding for the reasons these individuals opted out of the demonstration. For example, DHCS is trying to assess why 80 percent of those who opted-out are IHSS beneficiaries and why there are geographical differences in the opt-out rate. Cal MediConnect plans have committed significant financial and other resources to the success of this program. Ensuring a certain level of plan enrollment is critical not only to the success of the demonstration but potentially to the financial viability of the plans. It is essential that the Administration evaluate and address the reasons for the higher than expected opt-out rate. An

essential component of this is the enrollment process as there have been anecdotal reports of missing or inaccurate information.

Uniform Assessment Tool. Pursuant to CCI statute, DHCS, DSS, and CDA are to develop a Universal Assessment Tool (frequently referred to as Uniform Assessment Tool) to assess Medi-Cal beneficiary's need for Home and Community Based Services. The goal is to enhance personalized care planning under CCI and create a mechanism that home and community based providers, who are currently using different programmatic based tools, can standardize, communicate and coordinate with each other on beneficiary's assessments and care needs. Under CCI, the long-term services and support which includes home and community-based services (CBAS, IHSS, MSSP) are benefits of the managed care plans. The latter are also required to conduct assessments, care planning, authorizing services and coordinating service delivery with their provider networks, physicians, hospitals, CBAS, County IHSS, NF, MSSP, and other medical services. The Universal Assessment is to create a common tool that can be used by all involved in the care of beneficiaries who need home and community based long-term care services.

DHCS is working closely with CDSS and CDA, creating a stakeholder workgroup (advocates, consumers, county IHSS, CBAS, MSSP, legislative staff, and health plans) and a process that facilitates the development of this tool. The workgroup has been meeting with the goal to establish a draft tool by 2014-15, to be piloted in no more than four CCI counties in 2015-16 and for adoption in 2016 by providers and health plans. SCAN Foundation is funding the effort of the stakeholder workgroup which also involves also UCLA, USC and UCSF researchers.

Evaluations of the CCI. If CCI is to continue, it will be important for the Legislature to have the data and metrics available to evaluate if CCI is meeting its goals of improved care coordination and improved health outcomes. Regardless of the trigger language that ceases operations of CCI if there is a net General Fund impact, the Legislature should consider CCI's overall value to the state and Medi-Cal enrollees. For example, if health outcomes are dramatically improved because health plans are aggressively using interdisciplinary care teams and providing care plan option services and there are modest increases in General Fund costs, it may be worthwhile to continue the CCI. For example, DHCS points out that 90% of Cal MediConnect enrollees have chosen to stay in the program thus far, rather than choosing to dis-enroll, which they can do at any time.

While the Administration and the federal CMS plan to evaluate measures such as these as part of its overall evaluation of Cal MediConnect, this information is needed on a more immediate/real-time and public basis to understand if CCI is meeting its goals and how improvements can be made on a timely basis. Other entities, such as The Scan Foundation, will be conducting evaluations.

Most of the focus for the CCI has been on the component related to the duals demonstration project, Cal MediConnect. However, the integration of MLTSS into Medi-Cal Managed Care affects over 600,000 Medi-Cal enrollees. The state has yet to develop an evaluation plan or metrics to assess how and if managed coordination of

long-term supports and services is improving the health outcomes for Medi-Cal only individuals.

IHSS IN THE CCI

Background. In the CCI demonstration, IHSS, other home and community based services, and nursing home care funded by Medi-Cal will be administered under managed care. The IHSS program will essentially operate as it does today, except authorized IHSS benefits and costs will be included in managed care plan capitation rates. The fundamental structure of the IHSS program is intended to remain the same, with eligibility determination, assessment of hours, and program administration conducted by county social workers and administrative staff. The health plans are charged with care coordination that includes IHSS providers and collaboration with the counties as outlined in memorandums of understanding.

IHSS consumers in the seven pilot counties (Los Angeles, Orange, Riverside, San Bernardino, Santa Clara, San Diego and San Mateo) will receive their Medicare benefits and LTSS through their Medi-Cal plan. CCI statute authorized managed care health plans to provide IHSS as a benefit and to contract with certain agencies for the provision of IHSS in the CCI counties. In order for an agency to enter such a contract, they must first become certified as a Qualified Agency. DSS, in consultation with DHCS are required to create and manage the certification, re-certification, and continuing monitoring of these Qualified Agencies.

County IHSS MOE. CCI statute also established a county maintenance-of-effort (MOE) funding formula for the IHSS program. Historically, for almost all IHSS recipients, 50 percent of program costs were paid for by the federal government, with 32.5 percent paid by the state and 17.5 percent by the counties. CCI statute altered the historical county contribution by enacting an MOE, which replaces the county contribution of 17.5 percent with a requirement that counties generally maintain their 2011-12 expenditure level for IHSS beginning in 2012-13, to be adjusted annually for inflation beginning in 2014-15.

Statewide Collective Bargaining. Additionally, the CCI established a Statewide Authority for purposes of collective bargaining with respect to the wages and benefits for IHSS providers in the CCI counties. The Statewide Authority for collective bargaining begins in a CCI county when enrollment into CCI is completed in the county. San Mateo was scheduled to transition to the Statewide Authority in February 2015, followed by Los Angeles, Riverside, San Bernardino and San Diego in July 2015. Santa Clara is anticipated to transition January 2016, and finally Orange in August 2016.

IHSS Opt-Out Rates. As mentioned previously, the opt-out rates for IHSS consumers thus far have been very high. As of January 2015, in Los Angeles County, which started enrollment in July 2014, the IHSS opt-out rate was 66 percent and the disenrolled rate was 13 percent as of January 2015, with an overall (all Mediconnect enrollments) opt-out rate of 55 percent. In San Diego, for the same time period, the IHSS opt-out rate was 53 percent and the disenrolled rate was 17 percent.

Issues in Monitoring and Oversight. Managed care plans are required to include county IHSS social workers in their interdisciplinary team care planning process to create individualized care plans under the CCI. Upon their own determination, CCI plan enrollees can include their IHSS providers in this interdisciplinary team care planning process. This effort is intended to improve the communication, quality of care plans, and care coordination among county IHSS eligibility workers, IHSS providers, enrollees' physicians, and other medical and service providers involved in the care of the CCI plan enrollees, making achieving health maintenance and reduction of utilization of hospitals and nursing facilities possible. As implementation continues, the Subcommittee will ask to track this activity along with other quality metrics to understand the effectiveness of these intended practices to increase the quality of care for IHSS and other consumers under the CCI.

Administration Request and Other Issues in IHSS. There is a Budget Change Proposal (BCP) in DSS regarding the extension of positions related to the CCI. This request will be heard, along with all IHSS issues, at the Subcommittee hearing on March 11, 2015. The CCI issues related to IHSS have been covered more thoroughly here, so there will be no panel on these issues in that hearing.

MSSP IN THE CCI

Background. The Multipurpose Senior Services Program (MSSP) provides social and health care management services for frail, elderly clients who wish to remain in their own homes and communities. Clients must be aged 65 or older, eligible for Medi-Cal, and certified (or certifiable) as eligible to enter into a nursing home. Teams of health and social service professionals assess each client to determine needed services, and then, work with the clients, their physicians, families, and others to develop an individualized care plan. Services provided with MSSP funds include: care management; adult social day care; housing assistance; in-home chore and personal care services; respite services; transportation services; protective services; meal services; and, special communication assistance.

CDA currently oversees operation of the MSSP program statewide and contracts with local entities that directly provide MSSP services to approximately 12,000 individuals. The program operates under a federal Medicaid Home and Community-Based, Long-Term Care Services waiver. The MSSP operates in 48 counties.

MSSP Slots Affected by the CCI. Under CCI, Medi-Cal beneficiaries will be required to join a participating Medi-Cal managed care health plan to receive their Medi-Cal health benefits, including MSSP. For recipients in non-demonstration counties, the MSSP program's current eligibility process and programmatic requirements will continue without changes. The MSSP sites in the CCI counties will continue to provide waiver services to clients for 19 months after the transition to managed care. The chart on the next page includes the 2014-15 MSSP funded slots broken out by the CCI and non-CCI counties. It is important to note that slots are not directly equivalent to "persons" or "cases."

MSSP Slots in CCI and Non-CCI Counties

CCI COUNTIES	
	Slots
Los Angeles	2,952
Orange	455
Riverside	248
San Bernardino	276
San Diego	550
San Mateo	160
Santa Clara County	375
Subtotal CCI County Slots	**5,016**
NON-CCI COUNTIES	
Alameda	377
Amador, Calaveras, Mariposa and Toulumne	80
Butte, Glenn and Tehama	160
Contra Costa	160
El Dorado	60
Fresno and Madera	251
Humboldt	104
Imperial	160
Kern	167
Kings and Tulare	163
Lake and Mendocino	240
Lassen, Modoc, Shasta, Siskiyou and Trinity	160
Marin	80
Merced	160
Monterey	160
Napa and Solano	160
Placer, Sacramento and Yolo	276
San Francisco	446
San Joaquin	160
Santa Barbara	160
Santa Cruz	160
Sonoma	160
Stanislaus	160
Ventura	160
Yuba	52
Subtotal Non-CCI County Slots	**4,376**
Unallocated Slots	**51**
TOTAL MSSP SLOTS	**9,443**

The chart below tracks the cutover of slots pursuant to the expected timeline of the implementation of the CCI.

		Cal MediConnect		MLTSS	CCI MSSP
		Passive Enrollment Begins	MSSP Clients cutover and Benefit into CMC	MSSP Clients enrollment into Medi-Cal managed care and Benefit in Medi-Cal managed care	MSSP 19 month ends and is no longer a waiver benefit
County	Plans	Start Date (based on birth month)	Start Date (all in one month)	Start Date (all in one month)	End Date (county by county based on earliest date)
Los Angeles	**Healthnet**	4/1/2014*	10/1/2014	10/1/2014	4/30/2016
	LA Care	4/1/2014*	10/1/2014	10/1/2014	4/30/2016
	Care 1st	4/1/2014*	10/1/2014	N/A	N/A
	Care More	4/1/2014*	10/1/2014	N/A	N/A
	Molina	4/1/2014*	10/1/2014	N/A	N/A
Orange	**Cal Optima**	8/1/2015	8/1/2015	8/1/2015	2/28/2017
Riverside	**IEHP**	4/1/2014	10/1/2014	10/1/2014	4/30/2016
	Molina	4/1/2014	10/1/2014	10/1/2014	4/30/2016
San Bernadino	**IEHP**	4/1/2014	10/1/2014	10/1/2014	4/30/2016
	Molina	4/1/2014	10/1/2014	10/1/2014	4/30/2016
San Diego	**Care 1st**	4/1/2014	10/1/2014	10/1/2014	4/30/2016
	CHGP	4/1/2014	10/1/2014	10/1/2014	4/30/2016
	Healthnet	4/1/2014	10/1/2014	10/1/2014	4/30/2016
	Molina	4/1/2014	10/1/2014	10/1/2014	4/30/2016
	Kaiser	N/A	N/A	10/1/2014	4/30/2016
San Mateo	**HPSM**	4/1/2014	4/1/2014	7/1/2014**	10/31/2015
Santa Clara	**Anthem Blue**	1/1/2015	1/1/2015	10/1/2014	4/30/2016
	SCFP	1/1/2015	1/1/2015	10/1/2014	4/30/2016

Footnotes:

* - this is the beginning of Voluntary Enrollment

** - Full Duals will receive MLTSS benefits 4/1/14

Transition of MSSP to Managed Care Benefit. A key piece of MLTSS is the transition of MSSP as services provided under a federal home- and community- based waiver into managed care benefit in the CCI counties. This transition would occur 19 months after a county enrolls MSSP beneficiaries into a managed care plan pursuant to CCI or when federal approval is received, whichever is later. For example, since Los Angeles County began enrolling MSSP beneficiaries into managed care pursuant to CCI in

October 2014, the transition in Los Angeles County would occur April 2016 (or when the state received federal approval).

As part of this transition, DHCS, the Department of Aging, and the Department of Managed Health Care are required to submit a transition plan to the Legislature on how this transition would occur. The plan is required to incorporate the principles and standards of MSSP in the managed care benefit, and provisions to ensure seamless transitions and continuity of care. Managed care health plans are required, in partnership with local MSSP providers, to conduct a local stakeholder process to develop recommendations that the department is to consider when developing the transition plan. This transition planning process has not yet begun. Although the state is about one year away from this transition, as the state learned when CBAS became a Medi-Cal managed care benefit in 2012, ensuring a smooth transition requires significant efforts to establish program standards and consensus on processes between the plans and providers. Consequently, it is important that the Administration commence this planning process in a timely manner and not rush or expedite this valuable planning process.

Due to the delays in the CCI since its authorization, the administration has formally notified the Legislature that it intends to provide statutorily-required MSSP reports describing the transition plan and the stakeholder process to the Legislature on May 1, 2015, and the finalized transition plan will be submitted February 1, 2016.

Issues Raised by Advocates. Advocates have discussed asking for an extension of the 19-month timeline to 36 months, aligning with the three-year timeline of the CCI upon implementation (which began April 2014). They remark on substantial work that has yet to commence or be completed to plan for the effective transition of MSSP to managed care plans. The MSSP Site Association is represented on the panel of speakers and can address these issues.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the administration provide reactions to the concerns and issues raised by the advocates and stakeholders on the panel, and respond to the following:

1. Please provide a brief explanation of the cost/saving situation with the CCI, and the resulting potential for being required to cease operating the program.

2. Please provide a summary of the various evaluations under way, or expected, and their timelines.

3. Please explain how DHCS ensures that plans are providing high-quality care coordination to both Cal MediConnect beneficiaries and non-Cal MediConnect beneficiaries.

4. Stakeholders allege that the state has already passively enrolled seniors who should not have been enrolled, including seniors who did not receive timely

notices, residents of ICF/DD facilities, and regional center clients. Please explain how DHCS is addressing this problem, particularly in the current environment wherein increasing enrollment is critical to the future of the program.

5. How is sufficient access being defined for MLTSS?

6. How is the IHSS service faring under the CCI for affected consumers?

7. How is the MSSP service faring under the CCI for affected consumers?

Staff Recommendation: No action is recommended at this time.

ISSUE 2: COMMUNITY-BASED ADULT SERVICES OVERSIGHT

PANELISTS

- **Laurel Mildred**, Consultant, California Association of Adult Day Health Care
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Ed Long**, Deputy Director, California Department of Aging
- **Yang Lee,** Department Of Finance
- **Scott Ogus,** Department Of Finance
- **Rashi Kesarwani**, Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

This is an oversight issue and there is no specific budget request or issue related to Community-Based Adult Services (CBAS) in the Governor's proposed budget.

BACKGROUND

The CBAS program developed out of the December 2011 *Darling et al. v. Douglas et al.,* Settlement Agreement (Case No. C-09-03798-SBA) and the April 2012 approval to the 1115 Medi-Cal Bridge to Reform (BTR) Waiver Amendment, following the elimination of Adult Day Health Care (ADHC) as a State Plan benefit via AB 97 (Committee on Budget), Chapter 3, Statutes of 2011. State operations authority was granted to operate the CBAS program through the end of the Settlement Agreement on August 30, 2014.

SB 1008 (Committee on Budget and Fiscal Review), Chapter 22, Statutes of 2012, and SB 1036 (Committee on Budget and Fiscal Review) Chapter 45, Statutes of 2012 (regarding implementation of the CCI) provide that CBAS is a managed care plan benefit, thus, requiring CBAS benefits to continue past the August 2014 end date by amending the 1115 Waiver and establishing positions needed to support this ongoing managed care effort.

The CBAS program developed from the elimination of ADHC as a Medi-Cal benefit, when the Governor signed AB 97 on March 24, 2011. The Center for Medicare and Medicaid Services (CMS) approved DHCS' State Plan Amendment to eliminate the ADHC benefit effective September 1, 2011. However, in June 2011, ADHC participants filed a motion in federal court to enjoin the elimination of ADHC "unless and until adequate replacement services were in place," asserting that the elimination of the benefit would place beneficiaries at risk of unnecessary institutionalization. The parties reached a settlement before further court action (Settlement Agreement). The

Settlement Agreement allowed the elimination of the ADHC program as an optional Medicaid benefit on February 29, 2012, and required establishment of the CBAS program on March 1, 2012 (subsequently moved to April 1, 2012) to provide similar services in outpatient facilities (CBAS Centers) to seniors and adults with disabilities who met the eligibility criteria defined in the Settlement Agreement and Waiver.

CBAS Access

The California Association for Adult Day Services (CAADS) reports that 51 (17 percent) of CBAS/ADHC centers have closed since ADHC was eliminated in 2011, thereby significantly reducing access to this service. CAADS also states that at least 9,454 people have lost CBAS/ADHC services since 2011, leaving the current CBAS caseload at 28,777. Center closures are primarily a reflection of rate cuts. ADHC providers were not a party to the lawsuit that secured an injunction for the AB 97 (2011) 10 percent Medi-Cal rate cuts, and therefore was one of the first provider groups to experience this reduction. CAADS is requesting relief from the AB 97 rate cut for all CBAS centers as well as the reinstatement of a rate floor. These proposals will be discussed in more detail at the Subcommittee's hearing on Medi-Cal rates on April 20th, 2015.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the administration provide an overview of CBAS, and provide a comparison of CBAS with the former ADHC Medi-Cal benefit in terms of numbers served, participating centers, and overall quality of the services. Please also respond to the following:

1. How does DHCS monitor and measure access for CBAS?

2. How many of the almost 10,000 Medi-Cal beneficiaries who lost ADHC/CBAS services since ADHC elimination have moved to skilled nursing facilities?

Staff Recommendation: No action is recommended at this time.

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: LICENSING & CERTIFICATION PROGRAM ESTIMATE & PROPOSALS

PANELISTS

- **Jean Iacino,** Deputy Director, Center for Health Care Quality, CDPH
- **Scott Vivona,** Acting Assistant Deputy Director, Center for Health Care Quality, CDPH
- **Maria Gutierrez,** Chief, Resource and Operations Management Branch, Center for Health Care Quality, CDPH
- **Kimberly Harbison**, Finance Budget Analyst, Department of Finance
- **Jamey Matalka**, Principal Program Budget Analyst, Department of Finance
- **Shawn Martin**, Managing Principal Analyst, Legislative Analyst's Office
- **Public Comment**

BUDGET PROPOSALS

Licensing & Certification (L&C) Program Estimate

The Governor's budget proposes no changes to L&C funding for 2014-15, and increased funding of $30.3 million for 2015-16, as described in detail below and shown in the chart below:

L&C Program Funding & Positions Current Year & Budget Year			
Funding Source	**2014-15 Budget Act**	**2015-16 Proposed**	**Budget Act to Budget Year Change**
General Fund	$3.7	$3.7	0
Federal Funds	$77.2	$86.8	$9.6
L&C Special Fund	$92.5	$121.0	$28.5
Reimbursement Funds	$14.8	$6.4	$(8.4)
Special Deposit Fund	$6.5	$7.1	$0.6
Total Funds	**$194.7**	**$225.0**	**$30.3**
Field Positions – Health Facilities Evaluator Nurses	456.2	600.2	144.0
Field Positions – Other	380.1	466.1	86.0
Headquarters Positions	241.0	251.0	10.0
Total L&C Positions	**1,077.3**	**1,317.3**	**240.0**

This year's L&C estimate reflects the proposed increase in resources, detailed below, and the following three changes to the methodology:

1. Standard Average Hours: In the past, L&C calculated standard average hours using only time spent in the nursing or other facility. Now, L&C includes the additional time spent in the office to complete the investigation work.

2. New Workload Projection for 2015-16: L&C built this year's estimate based on federal data of all complaints received in prior years, rather than only the complaints and entity-reported incidents (ERIs) that were actually worked on, as was the case in prior years.

3. Workload Carried Over from Prior Years: L&C added a new component to this year's estimate to reflect all open complaints and ERIs as of June 30, 2014 in order to capture workload that was incomplete from the prior year that needs to be addressed.

The Governor's budget includes the following estimates for L&C accounts:

L&C Accounts *(In Thousands)*			
	State Health Facilities Citation Penalties Account	**Federal Health Facilities Citations Penalties Account**	**Internal Departmental Quality Improvement Account**
Beginning Balance	$11,272	$3,880	$14,654
Revenues	$2,661	$1,002	$3,892
Expenditures	$3,337	$937	$2,292
Fund Balance	**$10,596**	**$3,909**	**$16,254**

State Health Facilities Citation Penalties Account - Used primarily to pay for temporary managers and/or receivers for SNFs. Funds ($1.2 million) from this account are also used to support the Department of Aging's Long Term Care Ombudsman programs.

Federal Health Facilities Citations Penalties Account - Used to fund innovative facility grants to improve the quality of care and quality of life for residents of SNFs or to fund innovative efforts to increase employee recruitment or retention subject to federal approval.

Internal Departmental Quality Improvement Account - Used to fund internal L&C program improvement efforts. Funded by administrative penalties on hospitals.

Budget Change Proposals

The Governor's budget includes the following four requests related to the L&C program:

1. ***L&C Workload*** - An increase of $19.8 million in 2015-16 for 173 permanent positions and 64 two-year, limited-term positions, for a total of 237 positions (123 positions will become effective July 1, 2015 and 114 positions will begin on April 1, 2016), and an increase in expenditure authority of $30.4 million in 2016-17 from the L&C Special Fund to address the licensing and certification workload. This request attempts to address the L&C's past failures to complete its survey workload and close/complete complaint investigations. The additional staffing would be used to:

a) Reduce the number of open complaints and entity-reported incidents;

b) Decrease the average number of days to close complaint and entity-reported incident investigations;

c) Increase the percent of immediate jeopardy complaint and entity-reported incident investigations that are investigated within 24 hours (those constituting an immediate jeopardy to the health or safety of a patient).

2. ***L&C Quality Improvement Projects*** – An increase of $2 million in 2015-16 from the Internal Departmental Quality Improvement Account to implement quality improvement projects recommended by Hubbert Systems Consulting for the Licensing and Certification Program.

3. ***Los Angeles County Contract*** - An increase in expenditure authority of $9.5 million from the L&C Special Fund to augment the Los Angeles County contract to perform licensing and certification activities in Los Angeles County. This proposal includes $2.6 million to fully fund the current contract positions at current Los Angeles County salary rates, and $6.9 million to fund 32 additional Los Angeles County positions to enable the county to address both aging and current long-term care facility complaints and entity-reported incidents (Tier 1 and Tier 2 federal workload).

4. ***Los Angeles County Contract Monitoring*** – An increase of $378,000 from the L&C Special Fund and three positions to provide on-site oversight and perform workload management, training, and quality improvement activities to improve the efficiency and effectiveness of the Los Angeles County contract licensing and certification activities. In order to begin the on-site oversight immediately, the department plans to administratively establish three positions in 2014-15.

BACKGROUND

The California Department of Public Health's (DPH) Licensing and Certification Program (L&C) is responsible for regulatory oversight of licensed health facilities and health care professionals to ensure safe, effective, and quality health care for all Californians. L&C fulfills this role by conducting periodic inspections and compliant investigations of health facilities to ensure that they comply with federal and state laws and regulations. L&C licenses and certifies over 7,500 health care facilities and agencies in California, such as hospitals and nursing homes, in 30 different licensure and certification categories.

The federal Centers for Medicare and Medicaid Services (CMS) contracts with L&C to evaluate facilities accepting Medicare and Medicaid (Medi-Cal in California) payments to certify that they meet federal requirements. L&C evaluates health care facilities for compliance with state and federal laws and regulations, and it contracts with Los Angeles County to license and certify health care facilities located in Los Angeles County.

L&C's field operations are implemented through district offices, including over 1,000 positions, throughout the state, and through the contract with Los Angeles County.

In addition, L&C oversees the certification of nurse assistants, home health aides, hemodialysis technicians, and the licensing of nursing home administrators.

Long-Standing Problems with L&C

There have been long-standing concerns about the L&C program. Multiple recent legislative oversight hearings, an audit released by the California State Auditor in October 2014, and media reports have highlighted significant gaps in state oversight of health facilities and certain professionals that work in these facilities.

CMS Concerns

On June 20, 2012, CMS sent a letter to DPH expressing its concern with the ability of DPH to meet many of its current Medicaid survey and certification responsibilities. In this letter, CMS states that its analysis of data and ongoing discussions with DPH officials reveal the crucial need for California to take effective leadership, management, and oversight of DPH's regulatory organizational structure, systems, and functions to make sure DPH is able to meet all of its survey and certification responsibilities.

The letter further states that "failure to address the listed concerns and meet CMS' expectations will require CMS to initiate one or more actions that would have a negative effect on DPH's ability to avail itself of federal funds." In this letter, CMS acknowledges that the state's fiscal situation in the last few years, and the resulting hiring freezes and furloughs, has impaired DPH's ability to meet survey and certification responsibilities.

As a result of these concerns, CMS set benchmarks that DPH must attain and is requiring quarterly updates from DPH on its work plans and progress on meeting these benchmarks. The state was in jeopardy of losing $1 million in federal funds if certain benchmarks were not met. (Ultimately, $138,123 in federal funding was withheld.)

State Auditor Concerns

In October 2014, the State Auditor released a report regarding the L&C program. The findings from this report include:

- DPH's oversight of complaints processing is inadequate and has contributed to the large number of open complaints and entity reported incidents. For example, the Auditor found more than 11,000 complaints and entity-reported incidents open for an average of nearly a year.
- DPH does not have accurate data about the status of investigations into complaints against individuals.
- DPH has not established formal policies and procedures for ensuring prompt completion of investigations of complaints related to facilities or to the individuals it certifies.
- DPH did not consistently meet certain time frames for initiating complaints and ERIs.

Hospital Complaint Investigations & Staffing Ratios

While the focus of recent audits, reports and media coverage has been on nursing homes, DPH acknowledges that they also face a backlog of complaint investigations that are hospital-based. Moreover, DPH explains that DPH only investigates a hospital's compliance with statutorily-required staffing ratios when they receive a complaint about the hospital. DPH states that the staffing/resources request included in the Governor's budget would address the full spectrum of workload and backlogs within L&C, including complaint investigations for both nursing homes and hospitals. DPH also states that these resources will enable L&C to do licensing surveys of hospitals every three years, as is statutorily-required.

Health Facility License Fees

Existing statute requires the L&C Program to annually publish a Health Facility License Fee Report (DPH Fee Report) by February of each year. The purpose of this annual DPH Fee Report is to provide data on how the fees are calculated and what adjustments are proposed for the upcoming fiscal year.

Licensing fee rates are structured on a per “facility” or “bed” classification and are collected on an initial license application, an annual license renewal, and change of ownership. The fees are placed into a special fund—the Licensing and Certification Special Fund.

The fee rates are calculated as follows:

- Combining information on projected workload hours for various mandated activities by specific facility type (such as skilled nursing home, community-based clinic, or hospital).
- Calculating the state workload rate percentage of each facility type in relation to the total state workload.
- Allocating the baseline budget costs by facility type based on the state workload percentages.
- Determining the total proposed special fund budget cost comprised of baseline, incremental cost adjustments, and credits.
- Dividing the proposed special fund cost per facility type by the total number of facilities within the facility type or by the total number of beds to determine a per facility or per bed licensing fee.

The department proposes to:

1. Increase fees by 20 percent on those facilities that would have received an increase as a share of their percentage of the state’s total workload.
2. Keep fees at 2014-15 level for those facilities that would have had decreased fees as a share of their percentage of the state’s total workload.

For each of the last two years, L&C credited health facilities with over $11 million from the special fund reserve instead of using these funds to address the problems with this program. Although L&C fees are to be used to support the work associated with enforcing state laws and requirements, DPH was resistant to using this resource to hire more staff to improve its oversight of health facilities.

License Fees by Facility Type			
	Fee Per Bed or Facility	FY 2014-15 Fee Amounts	FY 2015-16 Proposed Fee Amounts
Acute Psychiatric Hospitals	Bed	$266.58	$319.90
Adult Day Health Centers	Facility	$4,164.92	$4,997.90
Alternative Birthing Centers	Facility	$2,380.19	$2,380.19
Chemical Dependency Recovery Hospitals	Bed	$191.27	$229.52
Chronic Dialysis Clinics	Facility	$2,862.63	$2,862.63
Community Clinics	Facility	$718.36	$862.03
Congregate Living Health Facilities	Bed	$312.00	$374.40
Correctional Treatment Centers	Bed	$573.70	$688.44
District Hospitals Less Than 100 Beds	Bed	$266.58	$319.90
General Acute Care Hospitals	Bed	$266.58	$319.90
Home Health Agencies	Facility	$2,761.90	$2,761.90
Hospices (2-Year License Total)	Facility	$2,970.86	$2,970.86
Hospice Facilities	Bed	$312.00	$374.40
Intermediate Care Facilities (ICF)	Bed	$312.00	$374.40
ICF - Developmentally Disabled (DD)	Bed	$580.40	$696.48
ICF - DD Habilitative	Bed	$580.40	$696.48
ICF - DD Nursing	Bed	$580.40	$696.48
Pediatric Day Health/Respite Care	Bed	$150.41	$180.49
Psychology Clinics	Facility	$1,476.66	$1,771.99
Referral Agencies	Facility	$2,795.53	$2,795.53
Rehab Clinics	Facility	$259.35	$311.22
Skilled Nursing Facilities	Bed	$312.00	$374.40
Surgical Clinics	Facility	$2,487.00	$2,984.40
Special Hospitals	Bed	$266.58	$319.90

Data Source: FY 15-16 Licensing Fees Chart

2014-15 Budget

In an effort to provide transparency and accountability of the L&C program, the Legislature adopted trailer bill language that required L&C to:

- Report metrics, beginning October 2014 and on a quarterly basis, on: 1) investigations of complaints related to paraprofessionals certified by DPH; 2) long-term care health facility complaints, investigations, state relicensing, and federal recertification surveys; and 3) vacancy rates and hiring within L&C.

- Report by October 2016 the above information for all facility types.

- Assess the possibilities of using professional position classifications other than health facility evaluator nurses to perform licensing and certification survey or complaint workload by December 1, 2014.

- Hold semiannual meetings, beginning August 2014, for all interested stakeholders to provide feedback on improving the L&C program to ensure that Californians receive the highest quality of medical care in health facilities.

The quarterly data reported by DPH in response to this requirement shows the following trends:

- A slight increase in the number of complaints received by L&C;
- A slight increase in the number of complaint investigations completed by L&C; and
- A decrease in the average number of days L&C completes complaint investigations from 57 percent within 90 days in 2011 to 70% within 90 days in 2014. DPH largely attributes this increase to the implementation and eventual elimination of state worker furloughs during these years.

The 2014 budget also included:

1. One-time funding of $1.4 million from the Internal Departmental Quality Improvement Account to conduct business process improvement projects for its Central Applications Unit and Professional Certification Branch and contract for a project manager and consultant to facilitate and coordinate the multi-year implementation of the Hubbert System Assessment recommendations; and

2. 18 two-year limited-term positions and $1,951,000 (Licensing & Certification Special Fund) to support timely investigations of allegations/complaints filed against certified nurse assistants (CNAs), home health aides (HHAs), and certified hemodialysis technicians (CHTs).

In response to CMS' concerns, highlighted above, L&C contracted with Hubbert System Consulting for an organizational assessment of its effectiveness and performance. This assessment includes 21 recommendations for program improvement.

Los Angeles County Contract

For the past 30 years, DPH has contracted with Los Angeles County to provide federal certification and state licensing surveys and investigate complaints and entity reported incidents for approximately 2,500 health facilities in Los Angeles County. In July 2012, the contract was renewed for a three year period with an annual budget of $26.9 million to fund 178 positions. However, due to a salary increase negotiated by Los Angeles County nurses, the current budget only funds 151 of the authorized positions.

As revealed in March 2014, facing a backlog of hundreds of health and safety complaints about nursing homes, Los Angeles County public health officials told inspectors to close cases without fully investigating them. According to an April 21, 2014 letter from the federal CMS, the state was in jeopardy of losing federal funding if certain performance and management benchmarks regarding the L&C's investigation of complaints and L&C's oversight of the Los Angeles contract were not met. (Ultimately, $251,515 in federal funding was withheld.)

L&C used its state staffing model to assess Los Angeles County's long-term care and non-long term care workload. L&C determined that to complete state licensing and federal certification activities, and investigate aging complaints and entity-reported incidents, Los Angeles County would require approximately $41.3 million and 281 positions. This proposal focuses on a portion of the total assessed workload. Once Los Angeles County has hired and trained the additional positions requested in this

proposal, L&C may request additional resources for Los Angeles County to complete additional workload. This incremental approach gives Los Angeles County time for recruitment and training. It takes 12-14 months for a newly hired nurse surveyor to complete all required training and become proficient.

L&C's review determined that 32 additional positions and $6.9 million in additional funds are necessary to meet required responsibilities within reasonable timelines for completing Tier 1 and Tier 2 federal workload, including investigating long-term care complaints, and aging long-term care complaints and entity-reported incidents. In 2015-16, costs for the requested additional positions and to fully fund all current contracted positions salaries is $9.5 million. The state has recently entered into contract negotiations with Los Angeles County regarding the renewal of this contract, which expires June 30, 2015.

Los Angeles County Concerns & Request

Los Angeles (LA) County supports the Governor's budget proposal for an increase in the funding to be included in a new contract with the county, however also explains that the amount proposed is insufficient to effectively address the workload and actual costs for the county. LA County states that 33 percent of the health care facilities in California are located in LA County, yet the county does not receive 33 percent of the state's L&C budget, receiving only approximately 15 percent. LA County also explains that the current staffing model used by DPH to determine the County's allocation increase does not reflect current County salary rates, employee benefits, indirect costs, or staff classifications, which, they say, accounts for the funding shortfall. In light of these issues, LA County is requesting an additional $4.8 million over Governor's budget, as well as a long-term funding commitment from the state to address the ongoing funding shortfall.

DPH acknowledges that their methodology did not account for salary increases that LA County negotiated with labor and explains that they utilized the cost data that is based on their contract with LA County. DPH is in the process of negotiating a new contract with LA County since the current contract expires June 30, 2015. DPH explains that the current contract has no provisions on how to address increasing costs over time, and that they intend to include such provisions in the new contract. DPH states that salaries in LA County are significantly higher than for state employees, such as by approximately 22 percent for nurses. However, LA County has a lower turn-over rate for staff as compared to the state.

Legislative Analyst

The LAO recommends approval of the proposals regarding Los Angeles County Contract Monitoring and L&C Quality Improvement Projects. The LAO withholds recommendation on the proposals regarding the Los Angeles County Contract and L&C Workload pending receipt of information on the ability of using professional position classifications other than Health Facility Evaluator Nurses (HFENs) to perform licensing and certification survey or complaint workload. Additionally, the LAO recommends the Legislature require the department to incorporate meaningful performance measures and benchmarks into the Los Angeles County contract and impose withholds of funding if the county fails to achieve these measures. The LAO further recommends that the

contract, up for renewal in July 2015, be renewed for a one-year period in order to allow for annual adjustments to the performance measures and benchmarks. The LAO believes this approach to structuring the Los Angeles County contract will improve the county's accountability to the state and incentivize improvements in quality, efficiency and effectiveness.

Stakeholder Trailer Bill Proposal

Disability Rights California (DRC) is requesting consideration of trailer bill that requires L&C to complete complaint investigations involving death within 90 days and investigations involving serious bodily harm within 120 days. DRC states that these timeframes will ensure that the most egregious incidents (those presenting a risk of imminent danger of death or serious harm) are completed more quickly and thereby remediate issues that jeopardize the health, safety or security of patients or residents.

While state law requires L&C to initiate investigations within statutory timeframes, there is no statutorily-imposed time limit for the completion of complaint investigations. It is not uncommon – even for cases that have caused serious injury, disability or death – for years to lapse before L&C completes investigations and issues a citation, thereby requiring the facility to take appropriate corrective action.

DPH states that when L&C receives a new complaint, that identifies the risk of imminent danger, death, or serious harm to one or more patients, L&C is required to visit the facility within the statutorily-required number of days to initiate the investigation. Prior to leaving the facility, L&C often will request immediate corrective actions to be taken by the facility, and also will indicate the department's intent to issue a citation. In other words, although it may take years for a complaint investigation to be completed and closed, the department takes action steps throughout the process to ensure the safety of patients.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present an overview of the L&C program and estimate, present the budget change proposals included in the Governor's budget, and respond to the following:

1. A substantial number of the requested positions are limited-term, yet it takes a substantial investment of time and resources to train these workers. Given the size of the backlog of complaints within L&C, and the extent of the program deficiencies, would it not be more prudent to make these positions permanent?

2. Please provide an overview and update on the program's progress on implementing recommendations included in the assessment done last year.

3. 2014 trailer bill requires DPH to assess the possibilities of using professional position classifications other than Health Facility Evaluator Nurses to perform L&C survey or complaint workload by December 1, 2014. The Legislature has yet to receive this report; when should the Legislature expect to receive it?

4. Is it not reasonable to think that LA County should receive approximately 33 percent of the L&C budget given that 33 percent of the facilities are in LA County?

5. The Governor's budget proposes increased funding for LA County, but only for the highest priority workload; please explain how the rest of the workload will be addressed.

6. How can the state address cost changes and state budget changes within the context of a 3-year contract?

7. Please describe stakeholder involvement with L&C, and specifically with the LA County contract.

Staff Recommendation: Staff recommends holding this item open to allow for further consideration and public input.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: SKILLED NURSING FACILITY QUALITY ASSURANCE FEE

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Yang Lee**, Department of Finance
- **Scott Ogus**, Department of Finance
- **Felix Su**, Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

BUDGET PROPOSAL

The Governor's budget reflects trailer bill being proposed by DHCS to:

1. Change the sunset date on the AB 1629 rate setting methodology, Quality Assurance Fee (QAF), and Quality Accountability Supplemental Payment (QASP) programs from July 31, 2015 to July 31, 2020;

2. Set the annual increase in the weighted average Medi-Cal reimbursement rate at 3.62 percent; and

3. Set QASP program payments at the 2014-15 level of approximately $90 million per year.

Existing law, which sunsets on July 31, 2015 provided for a 3-percent increase in reimbursement rates for freestanding skilled nursing facilities (SNFs) subject to the QAF and a one percent set-aside for the QASP in the 2013-14 and 2014-15 rate years.

BACKGROUND

AB 1629 (Frommer, Chapter 875, Statutes of 2004) imposes a QAF on SNFs and requires using these funds to leverage a federal match in the Medi-Cal program to provide additional reimbursements to certain nursing facilities that support improvement efforts. The Legislature's goal with AB 1629 and the new reimbursement system was that it would result in improvements in individual access to appropriate long-term care services, quality resident care, wages and benefits for nursing home workers, a stable workforce, and provider compliance with all applicable state and federal requirements. Use of QAF revenue has enabled California to provide reimbursement increases to nursing homes without added General Fund support.

Legislative History

AB 1075 (Shelley, Chapter 684, Statutes of 2001) mandated, a facility-specific reimbursement methodology for Long Term Care SNF services to be implemented by August 1, 2004.

AB 1629 (Frommer, Chapter 875, Statutes of 2004) changed the methodology for calculating reimbursement rates for freestanding SNF level-B and subacute units of those freestanding SNFs and allowed the DHCS to assess a QAF to provide a revenue stream to fund the higher payments under the new reimbursement methodology. AB 1629 contains provisions which negate the entire statute should DHCS cease to assess the QAF or cease to use the AB 1629 rate reimbursement methdology. AB 1629 delayed the AB 1075 requirement to implement a rate methodology from August 1, 2004, until August 1, 2005, and it allowed DHCS to implement the legislation via provider bulletin, avoiding a lengthy regulatory process.

AB 360 (Frommer, Chapter 508, Statutes of 2005) was a technical cleanup measure to AB 1629. AB 360 exempted pediatric subacute units and institutions for mental disease from the QAF and from the facility-specific rate methodology.

AB 203 (Committee on Budget, Chapter 188, Statutes of 2007) extended AB 1629's sunset provision for an additional year to July 31, 2009. This was necessary to allow DHCS to continue collecting the QAF and maintaining the facility-specific rate methodology. Further, AB 203 extended for one year the mandated report to the Legislature relative to SNF staffing levels, staffing retention, worker wages and benefits, state citations, and the extent to which SNF residents were able to return to the community.

ABx4 5 (Evans, Chapter 5, Statutes of 2009) changed the allowable increase for the weighted average Medi-Cal reimbursement rates for the 2009/10 rate year from five percent to zero percent over the weighted average Medi-Cal reimbursement rate in effect for 2008–09 fiscal year. ABx4 5 mandated that Medicare revenues received for routine and ancillary services and Medicare revenue received for services provided to residents under a Medicare managed care plan be included in the calculation of the QAF for the 2009/10 rate year by amending the definition of net revenue to gross revenue, with the inclusion of Medicare revenues.

SB 853 (Committee on Budget and Fiscal Review, Chapter 717, Statutes of 2010) extended the sunset provision by one year and mandated the following methodology changes: 1) lifted the rate freeze for the 2010/11 rate year; 2) issued a rate increase of up to 3.93 percent over the weighted average for the 2010/11 rate year; 3) authorized DHCS to trend revenue data forward using inflationary factors to increase the revenue base on which the QAF is calculated; 4) assessed the QAF on multilevel facilities; and, 5) established a quality and accountability supplemental payment system that allows DHCS to issue supplemental payments based upon quality measures.

AB 97 (Committee on Budget, Chapter 3, Statutes of 2011) implemented a 10 percent payment reduction to nursing facilities NFs and other long-term care facilities effective June 1, 2011.

ABX1 19 (Blumenfield, Chapter 4, Statutes of 2011) extended the sunset provision by one year and mandated the following methodology changes: 1) provide a rate cumulative increase of no more than 2.4 percent in the 2011/12 and 2012/13 rate years, 2) terminate the 10 percent reductions on August 1, 2012 for AB 1629 SNFs, 3) hold harmless facilities from rates that are less than their rate that was on file as of May 31, 2011, 4) provide a one-time supplemental payment in the 2012-13 rate year that is equivalent to the 10 percent reduction applied from June 1, 2011 to July 31, 2012 for Medi-Cal fee-for-service SNFs, 5) delay until rate year 2012-13 the set-aside to the Quality and Accountability Supplemental Payment System (QASP) of 1 percent of the AB 1629 facilities reimbursement rate, and 6) delay implementation of the QASP for one year.

AB 1489 (Committee on Budget, Chapter 631, Statutes of 2012) extended the sunset provision by two years, and provided a rate cumulative increase of no more than three percent, which included a one percent set-aside for the Skilled Nursing Facility Quality and Accountability special fund, in the 2013-14 and 2014-15 rate years.

Quality Accountability Supplemental Payment Program (QASP)

The QASP for SNFs is intended to encourage and incentivize SNFs to implement quality improvements. In the 2013-14 Rate Year, approximately $45.5 million was paid out to 447 facilities in the form of incentive award payments under the QASP program, with the average payment amount being roughly $83,000. The total payout for the 2014-15 Rate Year is estimated to be slightly over $90,000,000. The payments are made once per year, and are made on the basis of scoring methodologies which utilize certain Minimum Data Set measures.

Stakeholder Input

The California Association of Health Facilities (CAHF), an association of SNFs, supports the Governor's proposal citing the overall benefits of the QAF and rate methodology contained in AB 1629. CAHF also states that the proposed rate increase will help "move skilled nursing facilities much closer to covering their costs of care by 2020." CAHF states that AB 1629 has benefited: 1) the state by creating an approximate $500 million General Fund offset within Medi-Cal; 2) nursing homes by generating approximately $6.5 billion in increased General Fund and federal fund revenue and by stabilizing the reimbursement system; and 3) patients by increasing quality of care. CAHF states that despite these benefits, the AB 1629 methodology currently reimburses providers at an amount that is less than 93 percent of the benchmarked costs of their services, equating to a shortfall of approximately $14 per patient day.

The California Advocates for Nursing Home Reform (CANHR) opposes this proposal due to the fact that it does not increase mandatory staffing requirements. CANHR states that the current staffing ratios were put into law in 1999 and that even in 1999 they were considered by many to be inadequate. They request that the proposal provide annual increases in minimum nursing hours such that by 2019-20, each SNF would provide at

least 4.1 nursing hours per resident day, including at least 1.3 hours of care by licensed nurses, of which the Registered Nurse component would be at least 0.75 hours per resident day.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal and respond to the following:

1. Do the current Medi-Cal rates for SNFs fully cover the Medi-Cal costs for SNFs?

2. Has General Fund spending for SNFs increased since creation of the QAF (2004)? If so, please explain the reason for this given that the purpose of the QAF was to increase payments to SNFs without increasing General Fund.

3. When were SNF staffing ratios established and last increased? Does the administration (DHCS and DPH) think they are adequate or optimal?

4. Please describe any evidence of increases or decreases in SNF quality of care and patient safety since creation of the QAF.

Staff Recommendation: Staff recommends holding this item open to allow for further consideration and public input.

4170 CALIFORNIA DEPARTMENT OF AGING

ISSUE 1: PROGRAM AND BUDGET REVIEW

PANEL

- **Lora Connolly**, Director, and **Ed Long**, Deputy Director, California Department of Aging
- **Clay Kempf**, Executive Director, Seniors Council of Santa Cruz and San Benito
- **Karen Jones**, Coordinator, San Luis Obispo Ombudsman Program and Past President, California Long-Term Care Ombudsman Association
- **Rashi Kesarwani**, Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **John Silva**, Department of Finance
- **Public Comment**

Department Description. The California Department of Aging's (CDA's) mission is to promote the independence and well-being of older adults, adults with disabilities, and families through:

- Access to information and services to improve the quality of their lives;
- Opportunities for community involvement;
- Support to family members providing care; and
- Collaboration with other state and local agencies.

As the designated State Unit on Aging, the Department administers Older Americans Act programs that provide a wide variety of community-based supportive services as well as congregate and home-delivered meals. It also administers the Health Insurance Counseling and Advocacy Program. The Department also contracts directly with agencies that operate the Multipurpose Senior Services Program.

The Department administers most of these programs through contracts with the state's 33 local Area Agencies on Aging (AAAs). At the local level, AAAs contract for and coordinate this array of community-based services to older adults, adults with disabilities, family caregivers and residents of long-term care facilities.

Overview of Department's Major Areas

- **Nutrition.** The Nutrition Program provides nutritionally-balanced meals, nutrition education and nutrition counseling to individuals 60 years of age or older. In addition to promoting better health through improved nutrition, the program focuses on reducing the isolation of the elderly and providing a link to other social and

supportive services such as transportation, information and assistance, escort, employment, and education.

- **Senior Community Employment Services.** The federal Senior Community Service Employment Program, Title V of the Older Americans Act, provides part-time subsidized training and employment in community service agencies for low-income persons, 55 years of age and older. The program also promotes transition to unsubsidized employment.

- **Supportive Services.** This program provides supportive services including information and assistance, legal and transportation services, senior centers, the Long-Term Care Ombudsman and elder abuse prevention, and in-home services for frail older Californians as authorized by Titles III and VII of the Older Americans Act. The services provided are designed to assist older individuals to live as independently as possible and access the programs and services available to them.

- **Community-Based Programs and Projects.** This program includes the community-based Health Insurance Counseling and Advocacy Program (HICAP). HICAP provides personalized counseling, community education and outreach events for Medicare beneficiaries. Volunteer counselors assist individuals understanding their rights and health care options. HICAP is the primary local source for accurate and objective information and assistance with Medicare benefits, prescription drug plans and health plans.

- **Medi-Cal Programs.** This program includes oversight of the Multipurpose Senior Services Program (MSSP) and Community-Based Adult Services (CBAS) program. Both of these programs are administered by CDA through interagency agreements with the Department of Health Care Services (DHCS). CBAS is a community-based day health program that provides services to adults 18 years of age or over who are at risk of needing institutional care due to chronic medical, cognitive, or mental health conditions and/or disabilities. CDA certifies CBAS centers for participation in the Medi-Cal Program. Under a 1915 Medicaid home and community-based services waiver, MSSP provides health and social care management to prevent premature and unnecessary long-term care institutionalization of frail adults aged 65 or older who otherwise would be placed in a nursing facility. (MSSP issues in the Coordinated Care Initiative are discussed in another Issue in this agenda.)

Historical Budget Reductions. Between July 2007 and June 2012, the CDA budget was reduced by approximately $30.1 million in General Fund. These recessionary cuts eliminated any state support for program funding that had previously complemented federal funds received for aging services, including state funds that had supported most of the Community Based Services Programs in the Older Californians Act, including Foster Grandparent, Brown Bag, Alzheimer's Day Care Resource Centers, Senior Companion, Linkages, Respite Purchase of Services, and the Long Term Care Ombudsman programs. These cuts also eliminated General Fund supporting the federal Senior Community Services Employment and reduced state funds supporting the federal senior congregate and home-delivered nutrition programs.

Fiscal Overview (With Dollars in Thousands)*:*

Fund Source	2013-14 Actual	2014-15 Projected	2015-16 Proposed	BY to CY Change	% Change
General Fund	$31,545	$32,335	$30,454	(1,881)	(5.8%)
State HICAP Fund	2,475	2,483	2,487	(4)	(0.16)
Federal Trust Fund	139,551	150,754	150,107	(647)	(0.4)
Special Deposit Fund	1,187	1,193	1,193	-	-
Reimbursements	10,146	13,301	8,313	(4,988)	(37.5)
Skilled Nursing Facility Quality and Accountability Fund	1,900	1,900	1,900	-	-
Total Expenditures	**$186,804**	**$201,966**	**$194,454**	**(7,512)**	**(3.7%)**
Positions	101.0	117.8	114.5	(3.3)	(2.8)

INVESTMENT PROPOSALS IN AGING

The Subcommittee has received proposals for state funds for aging programs. These include the following:

C4A Request. The California Association of Area Agencies on Aging (C4A) is requesting consideration of a cumulative proposal of $37 million General Fund for various programs. C4A cites the following statistics:

- 1,000 Californians are turning 65 every day.
- 75% of health care costs are spent on eight percent of the population, most of whom are seniors.
- 47% of all older Californians do not have enough income to meet basic needs.
- 15% of older Californians (675,000) will use a nursing home this year.
- Seniors with poor nutrition are 2.33 times more likely to have health problems.
- Long-term services and support increase the quality of life of seniors, combat elder abuse, and control or reduce medical costs.

The proposal includes the following components:

- Access to and Coordination of Services ($14 million General Fund). This amount would be used to invest in access to and coordination of services. $5 million would be used for information and assistance services and $9 million for case management through the AAAs. C4A states that investing in access to and coordination of services can reduce the cost of senior health care by $95 million annually.

- Senior Nutrition ($6 million General Fund). This amount would be used to provide additional meals and nutrition support through the Brown Bag program ($1 million) and Home-Delivered Meals ($5 million). C4A states that boosting Senior Nutrition programs can prevent heart attacks, depression, asthma and congestive heart failure, in addition to saving $25 million by reducing hospital use.

- Caregiving and Family Support ($7.5 million General Fund). This amount would be used to provide support to three programs that support caregivers: $5 million for Alzheimer's Day Care, $900,000 for Respite Purchase of Services, and $1.6 million for Senior Companion. C4A states that an estimated 5 million Californians are caregivers providing unpaid assistance and support to older persons and disabled adults. Investing $7.5 million in caregiver support allows family members to continue providing an estimated $35 billion of unpaid labor.

- Elder Abuse Protection ($9.5 million). This amount includes $5 million for Adult Protective Services (APS) and $4.5 million for the California Long-Term Care Ombudsman Program. The APS proposal will be heard on the March 11 Subcommittee agenda and the California Long-Term Care Ombudsman proposal is discussed in more detail below. C4A states that California seniors experience over $500 million in health expenditures and suffer financial losses of nearly $300 million due to elder abuse each year. Older adults who are victims of violence have additional health problems and add over $5.3 billion to the national annual health expenditures.

Long-Term Care Ombudsman Request. The California Long-Term Care Ombudsman Association (CLTCOA) is requesting $4.2 million. This breaks down as follows:

- $2,784,150 to enable the program to conduct unannounced monitoring visits to all long-term care facilities in California through the addition of 45 positions.
- $1,128,177 to enable the program to investigate 6,000 more complaints per year, through the addition of 18 positions.
- $351,331 to enable the program to recruit, supervise, and train volunteer Ombudsmen.

CLTCOA states that despite the important work of the LTCOP, Governor Schwarzenegger eliminated all $3.8 million in the General Fund for local LTCOPs from the program's annual budget in 2008. Since the General Fund elimination, Ombudsman representatives have worked tirelessly to secure alternative funding, streamline services and create systems that are more efficient. Total allocated local assistance funding for the program in 2015 stands at $6.7 million compared to $11.2 million in 2007-08. In response to this drastic cut in funding, California's local LTCOPs were required to reduce operating days and hours and scale back services to residents in long-term care. Since the cuts to their budget, the local LTCOPs have had to greatly reduce the number of long-term care facilities they visit quarterly. There were 5,769 facilities in California that did not receive regular quarterly visits from an Ombudsman in 2012-13. This left approximately 100,000 residents in those facilities without an

advocate and at increased risk of suffering from abuse and neglect. The requested funding will allow the LTCOP to once again meet their federal and state mandates, and will be an important first step to rebuilding the State's commitment to protecting vulnerable residents of LTC facilities.

Subcommittee staff has requested more information on the status of fund balances from the State Health Facility Citation Penalties Account and the possibility of using any of this funding to further support the Ombudsman program. Currently $1.2 million from this fund is used to support the program; it appears there is a $10.6 million fund balance in the State Health Facilities Citation Penalties Account and a $16.2 million fund balance in the Internal Departmental Quality Improvement Account. Statute requires any funds greater than $10 million in the State Health Facilities Citation Penalties Account be reverted to the General Fund. In 2012-13, 2013-14, 2014-15 (projected), and 2015-16 (projected), the fund balance of this account was greater than $10 million and; consequently, state penalties were deposited into the General Fund.

Aging and Long-Term Care Committee. The Subcommittee is additionally in receipt for a letter from the Chair of the Assembly Aging and Long-Term Care Committee, Assemblymember Cheryl Brown, requesting consideration of the following proposals, with the justification stated in brief from the correspondence. The letter also supports the aforementioned Long-Term Care Ombudsman program request, the APS proposal, Alzheimer's Day Care Resource Centers (but at a lower amount of $4 million), and the Senior Nutrition proposal (but at a higher amount of $7 million).

- Caregiver Resource Centers (CRC) ($8 million General Fund). In 2009, CRC funding was cut by 74 percent. The CRC total allocation has gone from $10.5 million to the current funding level of $2.9 million.

- Establish a Blue-Ribbon Caregiver Council ($500,000 General Fund). This Blue Ribbon panel would identify necessary steps required to move forward to provide decision-makers the guidance and insight necessary to address the growing senior population.

- Establish a Blue-Ribbon Panel on Elder and Dependent Adult Abuse ($1 million General Fund). This Blue Ribbon panel would conduct a five-year effort to assess, analyze, and then make recommendations to improve California's various systems of support, care, and oversight to assure the most dignified mechanisms to promote security and safety among older and functionally impaired adults.

- MSSP Rate Increase ($5.1 million General Fund). Advocates have stated that an increase like this for MSSP would create an additional 2,762 slots for MSSP clients. MSSP sustained reductions in 2008-09 and in 2010-11, with funding cuts of 10% and 11% respectively. The letter contends that MSSP saves the state an estimated $117 million by decreasing nursing home placement and that with restored capacity, MSSP could save the state $146 million annually.

Staff Recommendation: Staff recommends holding all issues in CDA open.