LTSS Advocacy Day 2018 Briefing Materials

California Collaborative for Long Term Services and Supports • 5337 – 10th Avenue, Sacramento, CA 95820
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CALIFORNIA COLLABORATIVE FOR LONG TERM SERVICES & SUPPORTS (CCLTSS)

2018 State Budget Priorities
To Support Long-Term Services and Supports
For California Seniors and People with Disabilities

Investments in Long-Term Services and Supports

- **LTSS Data Budget Proposal** - $3 million in one-time funds to collect and analyze LTSS needs of Californians.
- **MSSP Budget Proposal** - $4.7 million ongoing for a supplemental rate adjustment for the MSSP program.
- **PACE Budget Proposal** – No funding requested; budget language allowing new and expanded PACE programs to start up on a monthly basis.
- **IHSS Budget Proposal** – $300 million ongoing, to officially rescind the 7% service hour cut now backfilled by the MCO tax, making program funding independent of the uncertainties of the MCO tax.

Increasing Economic Security

- **Senior Nutrition Budget Proposal** - $17.5 million ongoing to serve meals to an additional 6% of at-risk seniors.
- **SSI/SSP Increase Budget Proposal** – Increasing the SSI/SSP grants by $100 per recipient.

Better Protection and Care

- **Alzheimer's Public Awareness Campaign Budget Proposal** - $2.2 million one-time funds for an early detection awareness campaign thru the Triple A's.
- **Ombudsman Budget Proposal** - $7.299 million ongoing to increase investigations, visits and volunteers.
- **Home Safe Budget Proposal** - $15 million one-time funds for an Adult Protective Services homeless prevention program for older & disabled adults who are victims of abuse and neglect.

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What Are Long-Term Services and Supports?

Long-Term Services and Supports (LTSS), also referred to as long-term care (LTC), include a broad range of services to assist people with limitations due to a physical, cognitive, or chronic health condition expected to last for at least 90 days. People with these limitations often need assistance with one or more activities of daily living (ADLs), such as bathing, dressing, eating, transferring, and walking, as well as instrumental activities of daily living (IADLs), such as meal preparation, money management, house cleaning, medication management, and transportation.

California's LTSS System

California administers several LTSS programs — institutional as well as home and community-based services (HCBS) — funded primarily by Medi-Cal and operated through several different state departments. Individuals and their families struggle to navigate a complex web of services, as California's system is plagued by fragmentation, limited access to information and supports, lack of data and accountability, workforce challenges and the absence of a comprehensive framework to plan for the population's needs. In an ideal world, the LTSS system would offer individuals seamless access to the necessary services in the setting of their choice.

PARTIAL LIST OF HCBS PROGRAMS BY MAIN FUNDING SOURCE

Program	What It Provides	State Department Oversight	Funding Source
In-Home Supportive Services (IHSS)	Provides in-home personal care assistance to low-income adults age 65 years and older, blind, or disabled, as well as children who are blind or disabled. Services include assistance with bathing, feeding, dressing, and/or domestic services such as shopping, cooking, and housework.	Department of Social Services	Medi-Cal
Community-Based Adult Services (CBAS) – (formerly referred to as Adult Day Health Care)	Provides a variety of person-centered health, therapeutic, and social services in a community-based setting that includes: nursing; physical, occupational and speech therapies; mental health; therapeutic activities; personal care; hot meals and nutritional counseling.	Department of Aging	Medi-Cal
Multipurpose Senior Services Program (MSSP)	Provides care management to high-need older adults to help them remain in community.	Department of Aging	Medi-Cal
Assisted Living Waiver	Provides an alternative to institutional care for older adults and adults with disabilities through Residential Care Facilities for the Elderly or publicly subsidized housing, including: assistance with ADLs; skilled nursing; transportation; recreational activities; and housekeeping.	Department of Health Care Services	Medi-Cal
Home and Community-Based Alternatives Waiver (formerly the Nursing Facility/Acute Hospital Waiver)	Provides a range of services in the home or in a home-like setting as an alternative to institutional care for individuals with long-term medical conditions who meet specified "levels-of-care" criteria. Services include: case management/care coordination; private duty nursing; environmental accessibility adaptations; caregiver training; habilitation services; supportive services; and more.	Department of Health Care Services	Medi-Cal
HCBS Waiver for Individuals with Developmental Disabilities (HCBS-DD)	Provides HCBS to developmentally disabled persons served by Regional Centers as an alternative to institutional care.	Department of Health Care Services	Medi-Cal

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Program	What It Provides	State Department Oversight	Funding Source
Coordinated Care Initiative (CCI)	A federal/state demonstration program in seven counties (Los Angeles, San Diego, Orange, Riverside, San Bernardino, San Mateo and Santa Clara), that seeks to better coordinate care for adults with Medicare and Medi-Cal (dual eligibles). The CCI has three components: 1. Cal MediConnect: A voluntary program for dual eligible individuals that combines Medicare and Medi-Cal benefits into one health plan; 2. Managed Long-Term Services and Supports (MLTSS): Requires Medi-Cal managed care plans to provide specified LTSS (CBAS, MSSP and nursing facility care); and 3. Mandatory enrollment into Medi-Cal managed care for dual eligible individuals for the above specified LTSS benefits.	Department of Health Care Services	Medi-Cal
Program of All Inclusive Care for the Elderly	Provides medical and supportive services to adults 55 and older who are certified to need nursing home care, but who are able to live safely in the community at the time of enrollment. Delivers interdisciplinary team care including medical care; adult day health care; home health care and personal care in the home; and social services.	Department of Health Care Services	Medi-Cal and Medicare
Independent Living Centers (ILCs)	Provides six core services to people with disabilities regardless of age, including: housing referrals; information and referral; peer counseling; personal assistant services; independent living skills training; and individual and systems change advocacy.	Department of Rehabilitation	Federal Rehabilitation Act, General Fund
Area Agencies on Aging (AAAs)	Manages local-level services for community-based adults age 60 and over, including: nutrition services (home-delivered and congregate meals); healthy aging and community involvement; access to employment opportunities; and caregiver support.	Department of Aging	Older Americans Act, General Fund
Caregiver Resource Centers (CRCs)	Provides information and referral; short-term counseling; respite care; education; training and support to families and caregivers of persons with Alzheimer's disease, stroke, Parkinson's disease, and others.	Department of Health Care Services	General Fund
Traumatic Brain Injury (TBI) Program	Provides persons suffering from TBI with the following: community reintegration, service coordination, family and community education, vocational support, and service coordination.	Department of Rehabilitation	Seat Belt Penalty Fund

Summary: The Need for Coordinated Systems of Care

California has long sought to develop programs that deliver LTSS in a more streamlined, coordinated manner while integrating services across the continuum of medical care, behavioral health and social services. Yet, the CCI demonstration is slated to sunset at the end of 2019, and coordinated service delivery programs like PACE are available only in limited areas of the state and to a specified population. California's policymakers play a critical role in addressing LTSS system challenges and outlining a clear pathway needed to serve individuals in a coordinated fashion. Older adults and people with disabilities deserve a clear commitment and well-articulated path so that we can all live with dignity, choice, and independence.

Solving California's Long-Term Services and Supports Crisis

A comprehensive policy platform can position the state to meet the needs of older adults, people with disabilities and caregivers through a three-pronged solution addressing 1) linkages to care, 2) access and 3) affordability.

THREE-PRONGED SOLUTION

Institute a comprehensive framework providing:

- Timely connections to information, care and supports
- Coordinated medical, social and mental health services
- Better data, information and technology

Support and develop local community options that:

- Promote statewide availability of home and community-based services
- Plan for workforce needs and develop strategies to recruit, support and retain staff.
- Increase access to transportation
- Increase the supply of affordable and accessible housing in rural, suburban and urban areas

Explore a mix of financing options accompanied by adequate protections for low and middle income Californians that:

- Maximize efficiency and sustainability of existing public and private funding sources
- Adequately and comprehensively deliver long-term services and supports statewide
- Maintain consumer choice and flexibility in the least restrictive setting without regard to age

CALIFORNIA REGIONAL COALITIONS FOR LONG TERM SERVICES AND SUPPORTS

CARING FOR CALIFORNIA:

ADDRESSING THE DEVELOPING CRISIS OF THE AGING AND DISABLED POPULATIONS

The rapid growth and unmet needs of California's aging and disabled populations will soon constitute a catastrophic crisis, not unlike climate change. California needs a Master Plan to address the crisis, including economic analysis and data that will reveal the extent of crisis and uncover many obvious solutions. Here are several steps the Legislature can take to begin to address this critical turning point and build a system of care for the 21st century. We can assist in developing specific legislation in all of these key areas:

- ***Infrastructure Investments Are Urgently Required***
  A system patched together when deinstitutionalization of the aging and disabled began in the 1960s will soon be required to serve millions of Californians in numbers that are growing exponentially. California's system of long term services and supports is unprepared for this population explosion. Reimbursement methods are antiquated and inadequate, capital investments are scarce, workforce development and caregiver supports are neglected. Serious planning and investment in a modern and effective LTSS infrastructure is essential.

- ***The Housing Crisis is a Health Crisis for the Aging and Disabled***
  Fifty-four percent of adults over age 65 live below 200% of federal poverty, and people with disabilities are twice as likely as others to live in poverty. Inability to find or sustain stable housing results in health system costs when people cannot transition from institutional care. Despite important progress on affordable housing, more needs to be done and specifically, California needs housing strategies that allow people to modify their home, access assisted living, health and supportive services, leverage Medicaid to access housing dollars and find housing after a health crisis are essential for older adults and people with disabilities.

- ***Essential to Improve Access, Coordination and Integration***
  Systemic inefficiencies are extremely costly while keeping people from getting the essential care and services they need. Cost-effective social services are rationed and result in an enormous price paid in health system costs. To accommodate the growing numbers who need services and serve them cost-effectively, we must improve access, coordination and integration of care, including further developing and improving the Cal Medi-Connect program.

- ***Care Needs of Middle-income Californians Must Be Addressed***
  Californians are woefully unprepared for aging; most people mistakenly believe that Medicare will cover the cost of their care when they are old. For most Californians, long-term care insurance is unaffordable. Without solutions to address the middle class, these individuals often must spend down all of their assets in order to be eligible for Medi-Cal to get long-term care services and health benefits – a bill that is then paid by the state and federal governments. Developing affordable access to services for these individuals would protect the state budget.

FOR IMMEDIATE RELEASE
March 12, 2018

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STATEWIDE POLL: Vast Majority of California Voters Favor Candidates for Governor with Plan to Serve State's Fast-Growing Senior Population

West Health and The SCAN Foundation Launch "We Stand With Seniors…Will You?" Awareness and Education Campaign

(San Diego, CA) – More than two-thirds of California voters feel the state is not prepared to address the health and social service needs of its fast-growing senior population, and that sentiment could sway votes in the race for governor, according to a new poll commissioned by two California-based senior-focused nonprofit organizations. California is heading for a crisis in caring for its older population if the state and next governor do not act now to create effective and cost-efficient policies.

In proportions rarely seen in statewide opinion research, more than 80 percent of California voters say that when it comes time to vote, they are more likely to support a gubernatorial candidate who has a plan for aging Baby Boomers and seniors that effectively addresses their growing demand for healthcare, dental and social services.

"Now is the time for California to stand with our rapidly growing senior population," said Shelley Lyford, CEO and president of West Health. "It's time for candidates running for governor and other statewide offices to develop a concrete plan to provide for the healthcare needs of vulnerable seniors. And it's time for voters to hold politicians accountable at the ballot box in November."

According to the Public Policy Institute of California (PPIC), the state's 65-and-older population is projected to grow nearly 90 percent, or by four million more people, by 2030, which spans the next three gubernatorial terms.

"In a time when we see so much political polarization, it's encouraging to see that California Democrats, Republicans and independent voters of all ages can all agree on one thing: We need to provide better care for our older adults," said Bruce Chernof, MD, CEO and president of The SCAN Foundation. "Now we must work together to enact policies and create an environment that reflects our shared commitment to the well-being of older Californians."

This poll comes as West Health and The SCAN Foundation launch "We Stand With Seniors…Will You?" a public awareness and education campaign on the specific challenges seniors and their families face in accessing high-quality, affordable healthcare, dental care and supportive services and the cost to the state if these challenges are not addressed.

In the months leading up to the election, the campaign will convene seniors, advocates and policy makers for educational forums throughout the state and conduct periodic surveys on how well the gubernatorial candidates are addressing the issues.

Summary of Poll Findings

- 67 percent of voters feel that **California is NOT prepared to care for its aging population.**
- 87 percent of voters agree that providing dental care for seniors is as important as access to healthcare.
- 83 percent of voters would be more likely to **support a gubernatorial candidate who has a vision and a long-term investment plan to address the increasing demand for senior services for California's aging population.**
- 82 percent of voters are more likely to **support a gubernatorial candidate committed to making high-quality healthcare for seniors more accessible and affordable.**
- 80 percent of voters **support the state investing in caregiver programs that assist those who care for senior family members.**
- 79 percent of voters **support the state making in-home healthcare service investments that allow seniors to age successfully in place, including medication delivery, telehealth and house calls.**

The poll also showed voters want state legislators to support seniors. Eighty-two percent are more likely to support legislative action that improves seniors' access to dental care, a benefit Medicare does not provide. Voters also want to see improvements in independent living services, mental and behavioral health and other senior services.

"California can lead the country on aging and senior issues, just as it has on so many other issues," said Tim Lash, chief strategy officer of West Health. "There is tremendous support for it across the state. Now we need a governor who will tap into that support and prioritize the needs of California's aging population now and into the future."

Survey Methodology

From Friday, January 12, 2018 through Sunday, January 15, 2018, J. Wallin Opinion Research conducted a telephone survey of voters throughout California. One thousand voters were interviewed using live, professional interviewers, speaking both English and Spanish languages and calling both mobile and landlines. The sample is stratified (the demographic composition of our results matches the demographic composition of the state's voting population) and has a margin of error of +/-3.1 percent (95 percent confidence interval).

About We Stand With Seniors

West Health and The SCAN Foundation's "We Stand With Seniors …Will You?" public awareness and education campaign focuses on the specific challenges seniors and their families face in accessing high-quality, affordable healthcare, dental care and supportive services and the cost to the state if these challenges are not addressed. Visit www.WeStandWithSeniors.org for more information. Keep up with #StandWithSeniors on social media via Facebook @WeStandWithSeniors and Twitter @WeStandWSeniors.

About West Health

Solely funded by philanthropists Gary and Mary West, West Health includes the nonprofit and nonpartisan Gary and Mary West Health Institute and Gary and Mary West Foundation in San Diego, and the Gary and Mary West Health Policy Center in Washington, D.C. These organizations are working together toward a shared mission dedicated to enabling seniors to successfully age in place with access to high-quality, affordable health and support services that preserve and protect their dignity, quality of life and independence. For more information, visit westhealth.org and follow @westhealth.

About The SCAN Foundation

The SCAN Foundation is an independent public charity dedicated to creating a society where older adults can access health and supportive services of their choosing to meet their needs. Our mission is to advance a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. For more information, visit www.TheSCANFoundation.org and follow @TheSCANFndtn.

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CALIFORNIA NEEDS A VISION AND PLAN FOR ITS DIVERSE AGING POPULATION

More than **80 percent** of California voters would **support a gubernatorial candidate** who has a vision and long-term investment plan for the state's older adults

Californians age 65+ will increase to more than 9 million by 2030—that's 20 times the growth rate of those younger than 65!

Californians age 85+ will increase to 1.2 million by 2030, a 56 percent increase

Given these trends, leaders must create a vision and actionable plan to prioritize state resources so that older Californians truly live with dignity and independence

THESE LEADING STATES HAVE A PLAN—AND USE IT

COLORADO

CONNECTICUT

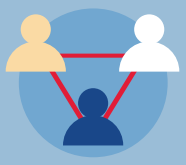
MINNESOTA

HERE ARE 5 ELEMENTS FOR PLAN SUCCESS

DECISIVE LEADERSHIP
Governor and legislators are invested

RATIONAL
Priorities are ranked and data-driven

COMPREHENSIVE
Financing, services, workforce, caregiver support, housing, and transportation included



STAKEHOLDER INVOLVEMENT
Consumers, providers, and policymakers work together

ACCOUNTABILITY
Reporting timelines are clear, with measurable outcomes

THE scan FOUNDATION

www.TheSCANFoundation.org

CALIFORNIA CAN DO BETTER!

Inclusion ***drives*** Innovation

NATIONAL DISABILITY EMPLOYMENT AWARENESS MONTH

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OFFICE OF DISABILITY EMPLOYMENT POLICY
UNITED STATES DEPARTMENT OF LABOR

dol.gov/odep

Supporting Older Americans' Basic Needs: Health Care, Income, Housing and Food

Older adults and their families strive each day to pay for health care and medicine, keep food on the table, have a roof over their heads, and meet other basic needs. In meeting these challenges, families are supported by a broad range of federal programs that provide Americans with the means to thrive as they grow older and remain at home and in their communities. Often, the combination of these programs is critical to their success--older adults whose only income is from Supplemental Security Income would not be able to afford sufficient groceries without the SNAP program, or to pay the rent without rental assistance, or to see the doctor without Medicaid. Below is an overview of these programs and how they work. A longer issue brief explores more deeply how these programs work together to provide older adults the opportunity to age with justice.

Health Care

To get the health and long-term care services they need while maintaining their economic security, low-income older adults rely on both Medicaid and Medicare.

Medicare

- Medicare is a primary source of health coverage for over 59 million seniors and individuals with disabilities.
- It covers essential services such as hospital stays, doctor's visits, and prescription drugs.

Medicaid

- Medicaid is the key to health care access for 6.5 million seniors who are dually eligible for both Medicaid and Medicare and 8.5 million Americans ages 50-64 who are not yet Medicare eligible.
- One in five Medicare beneficiaries relies on Medicaid to pay for Medicare premiums and co-pays.
- Medicaid also fills in the significant gaps in Medicare coverage, like oral, vision, and long-term care, for low-income seniors.
- Low- and moderate-income older adults who can no longer live independently rely on Medicaid to cover the long-term services and supports they need both at home and in nursing facilities.
- Medicaid plays a critical role in allowing older adults to age in place and live safely at home and in their communities by providing access to Home and Community-Based Services (HCBS) not available through Medicare.

Social Security and SSI Benefits

Social Security and Supplemental Security Income (SSI) provide cash benefits that are critical to older adults' ability to survive, and allow individuals to make choices about where their money is most needed.

Social Security

- Social Security ensures that millions of older adults have the cash income they need to pay for basic necessities, including food, shelter, clothing, and medicine.
- Without Social Security benefits, about 40% of Americans aged 65 and older would have incomes below the poverty line.

Supplemental Security Income (SSI)

- SSI provides a very basic income to older adults and people with disabilities who have little-to-no other income or resources.
- Over 8 million people, including 2.2 million older adults, rely on SSI benefits to pay rent and put food on the table.
- SSI is especially critical for women, who are more likely to have spent time out of the workforce caring for family, or working part-time or in industries where they were not able to contribute a portion of their paychecks to Social Security.
- In 2018, the maximum SSI federal benefit is $750 per month, or 74% of the federal poverty level, while the average benefit seniors receive is only $437.

Older Americans Act Programs

The Older Americans Act (OAA) funds a wide range of programs that help older adults remain connected to their families and communities. These programs provide millions of American seniors, many of whom are low-income, the resources necessary to reduce hunger and isolation while maintaining their dignity, health, and independence. OAA services include **Meals on Wheels, transportation services, access to legal assistance, elder justice and elder abuse prevention**, and many others.

Affordable Housing and Food Assistance

Federal housing assistance programs provide vital support to over 1.7 million households with older adults who would otherwise be unable to afford the cost of shelter. **Section 202 supportive housing** is focused specifically on older adults, while many other households with older adults also rely on broader rental assistance programs including **Housing Choice Vouchers, Section 8 Project-Based Rental Assistance (PBRA), and Public Housing**.

The **Supplemental Nutrition Assistance Program (SNAP)** is a federal program that helps ensure that over 4.8 million low-income older adults do not have to make the impossible decision of choosing between food and medicine, clothing, or shelter. Additionally, Meals on Wheels uses federal, state, and local funds to provide more than 2.4 million seniors with nutritious meals, social visits, and checks to ensure that they are safe.

Legal Assistance

Legal help is critical for low-income older adults who are denied needed health care, are at risk of losing their housing through eviction or foreclosure, or who are victimized by elder abuse, consumer scams, or financial exploitation. Both the **Legal Services Corporation** and the Older Americans Act provide federal funding to local legal services providers to address seniors' social and economic needs and help them stay independent in their homes and communities for as long as possible.

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California's Community of Constituents

Community Profiles • April 2018

The Community of Constituents initiative is a statewide movement of nearly 1,000 organizations, with more than 300 affiliated members, working together to transform the system of care so that all Californians can age with dignity, choice, and independence. This initiative includes the Sacramento-based California Collaborative for Long Term Services and Supports (LTSS) and 20 county-level Regional Coalitions. It unifies parts of the LTSS advocacy world that have historically worked separately: aging and disability, rural and urban, health plans and community-based organizations, and consumers and providers. In 2018, the California Collaborative and Regional Coalitions are advocating for an LTSS system that includes integrated care and service delivery, updated reimbursement processes, investments in workforce development and caregiver support, sustainable and stable housing strategies, and attention to the care needs of middle-income Californians. In addition, they are working to identify and engage future LTSS leaders. Together, they serve as a visible, organized, trusted, and consumer-focused voice for LTSS efforts.

For a full listing of coalitions, visit:
http://www.thescanfoundation.org/our-goals/dual-integration/community-of-constituents

Long-Term Services and Supports (LTSS) Data Budget Proposal
Fact Sheet
Updated 2/8/18

Proposal

Funds shall be appropriated to the Department of Health Care Services for the purpose of contracting with UCLA for collection and analysis of data on LTSS access and needs in California by incorporating questions on LTSS access and needs in the California Health Interview Survey (CHIS) in the 2019-20 and 2023-24 survey cycles.

Background

California currently has close to 8 million persons who are either seniors age 65 and over or are persons under age 65 who have disabilities (CA Department of Finance). This population is expected to grow significantly over the next decade, primarily due to the aging of the population, but also due to the growing number of persons with disabilities, including those with developmental disabilities, who are aging out of their systems of care or do not have systems in place but need support, and of those with traumatic injuries who are surviving their injuries due to advances in medical care. Concurrent with this will be a growing need for long-term services and supports (LTSS). The number of seniors with self-care difficulties who live in the community in California, for example, is projected to double by 2030 (PPIC, 2015).

Despite this unprecedented growth in needs for LTSS, California does not collect the data it needs to accurately track and plan for these needs. While national surveys collect data on the prevalence of disabilities and cognitive and functional impairments, they do not provide state and county level estimates of the population that needs and uses LTSS in California, nor assess the needs for LTSS by income level, age, type of disability, care setting, geographic region, or racial or ethnic group.

Studies show lack of access to long-term services and supports contributes to higher health care needs and increased utilization of health care services. For example, significant percentages of Med-Cal beneficiaries who have unmet LTSS needs indicate they have limited mobility, making it difficult to get to medical appointments and do household chores, they go without groceries, and they make medication mistakes (UCSF and UC Berkeley, 2017). Studies also show that most Medi-Cal beneficiaries experience high rates of utilization of health services before they begin accessing LTSS, which diminish after they begin receiving LTSS (CAMRI, 2014). Without data to identify populations and areas of the state that experience barriers to access to LTSS, the state lacks the ability to develop and target interventions that can improve health status and reduce state expenditures.

Arguments in Support

- A modest investment in developing better and more accurate state and county level data will enable the state to engage in better planning for the LTSS needs of its growing population of seniors and persons and disabilities;
- Better data will enable the state to determine the amount of funding necessary to address the needs of those who will require LTSS in the future, and to develop sustainable funding mechanisms that are not dependent upon the General Fund.

CALIFORNIA COLLABORATIVE FOR LONG-TERM SERVICES & SUPPORTS (CCLTSS)

February 9, 2018

Hon. Joaquin Arambula, MD
Assembly Budget Subcommittee 1 on Health and Human Services
State Capitol, Room 6026
Sacramento, CA 95814

Hon. Richard Pan, MD
Senate Budget Subcommittee 3 on Health and Human Services
State Capitol, Room 5019
Sacramento, CA 95814

Re: Long-Term Services and Supports Data Budget Proposal - SUPPORT

Dear Assembly Member Arambula and Senator Pan:

The California Collaborative for Long Term Services and Supports is comprised of 37 statewide aging and disability organizations that promote dignity and independence in long-term living. Our members include advocates, providers, labor and health insurers and collectively we represent millions of California seniors and people with disabilities, their caregivers and those who provide health, human services and housing.

We are writing in strong support of a budget augmentation to collect and analyze data on long-term services and supports (LTSS) needs and access to services, by incorporating questions about LTSS into the California Health Interview Survey.

Collecting better data is an essential step in planning for the needs of the growing population of California seniors and people with disabilities:

- In the next 15 years the number of Californians over 65 years will increase by 4 million, comprising one-fifth of the state population by 2030.
- Californians at least 85 years of age will increase by over 85%, to about 400,000. More and more, this population will be living alone.
- An increasingly aged population will include many more people with disabilities, some of whom will need supports and services to continue to live independently.
- This population notably includes persons at least 65 years old who are living with Alzheimer's. Medi-Cal costs for this population are expected to grow by nearly 60% in the next ten years. Appropriate home and community-based services are essential to manage these costs.
- The number of younger persons living with significant disabilities is also increasing. For example, the Department of Developmental Services caseload of adults with autism is projected to double in the next five years and triple in the next ten.
- Advances in medical care have increased the lifespan for persons with many disabilities, meaning these persons will require services for a longer period of time.

The state needs to better understand the populations who need LTSS and the geographic and other barriers to accessing services, in order to develop and target interventions to improve health status and reduce state expenditures, now and in the future. Collecting this data is also eligible for federal matching funds.

Understanding California's LTSS needs is an important step to developing the appropriate systems and supports that will allow Californians to live with dignity

- A portion of the costs of developing and analyzing the data can be matched with federal funds as an allowable Medicaid administrative cost.

Organizations in Support

AARP
The Arc of California
Alzheimer's Association
California Association for Adult Day Services
California Association of Area Agencies on Aging
California Collaborative for LTSS
California Commission on Aging
California Domestic Workers Coalition
California Foundation for Independent Living Centers
California LTC Ombudsman Association
CalPACE
Caring Across Generations
Congress of California Seniors
Disability Rights California
Disability Rights Education and Defense Fund
Hand in Hand: The Domestic Employers Network
Justice in Aging
LeadingAge California
Service Employees International Union (SEIU)
UDW/AFSCME Local 3930

Proposed Budget Language

$3 million shall be appropriated to the Department of Health Care Services to contract with the University of California, Los Angeles to incorporate questions on LTSS needs in the California Health Interview Survey (CHIS) in the 2019-20 and 2023-24 survey cycles. The questions shall be designed to gather data at the state and local level on the prevalence of disabilities, cognitive and functional impairment, need for and use of LTSS, unmet needs, and factors that mitigate or offset needs for LTSS, and shall be implemented pursuant to a methodology that ensures accurate representation of all persons with LTSS needs.

Funds appropriated pursuant to this item shall be used to continue the inclusion of questions on caregiver burdens, which are scheduled to be included in the 2019-20 survey cycle and funded by foundation sources, in the 2023-2024 survey cycle; for the analysis of data gathered in the 2019-20 survey cycle on LTSS needs; and to examine health and other impacts associated with LTSS needs.

The department shall seek federal Medicaid matching funds for data collection and analysis activities related to LTSS needs and usage by Medi-Cal beneficiaries.

Data obtained pursuant to this appropriation will be made available for public access through CHIS, to the Legislature, and to state departments for use in LTSS planning.

and independence despite age, disability or chronic conditions that would otherwise severely limit their daily lives.

We respectfully ask for your support for this proposal.

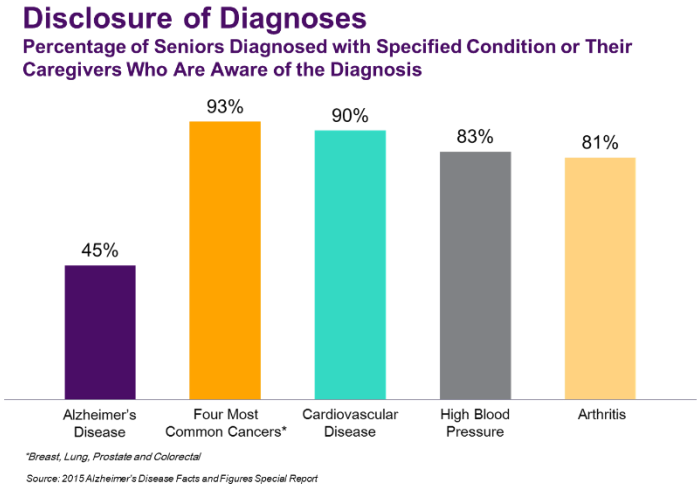
Sincerely,

Laurel Mildred, MSW
For the California Collaborative
Laurel.Mildred@mildredconsulting.com

cc: Hon. Phil Ting, Chair, Assembly Budget Committee
Hon. Jay Obernolte, Vice Chair, Assembly Budget Committee
Hon. Holly Mitchell, Chair, Senate Budget Committee
Hon. Jim Nielsen, Vice Chair, Senate Budget Committee
The Hon. Members of Assembly Budget Subcommittee 1
The Hon. Members of Senate Budget Subcommittee 3
Diana Dooley, Secretary, Health and Human Services Agency
Michael Cohen, Director, Department of Finance
Jennifer Kent, Director, Department of Health Care Services
Hon. Anthony Rendon, Speaker, California State Assembly
Hon. Brian Dahle, Assembly Republican Leader
Hon. Kevin de León, President pro Tempore, California State Senate
Hon. Patricia Bates, Senate Minority Leader

Alzheimer's Association budget proposal: $2.2 million one-time General Fund (GF) investment to launch a statewide, culturally and linguistically appropriate, public awareness campaign in partnership with participating Area Agencies on Aging (AAAs)

- 2.2 million Californians are either living with or caring for a loved one with Alzheimer's today.
- In 2015, Alzheimer's became the 3rd leading cause of death in California, tied with stroke.
- By 2025, California is projected to spend $4.9 billion on Medi-Cal beneficiaries with Alzheimer's.
- Quality care for persons with Alzheimer's disease and related dementias starts with an accurate diagnosis, disclosed to the patient, and documented in the medical record. This is the critical first step in chronic disease management.
- Evidence indicates that less than half of all Californians living with Alzheimer's and related dementias have not been diagnosed.



- A key barrier to diagnosis is stigma. According to a Harvard School of Public Health survey 25% of us fear developing this disease more than any other. California's Alzheimer's Disease State Plan: An Action Plan for 2011 – 2021 set as the number one statewide goal: **"Eliminate Stigma."** The leading recommendation is to *"heighten public awareness through culturally appropriate public education campaigns."*
- Stigma – among patients, families and clinicians, contributes to poor quality health outcomes. Even in 2018, consumers routinely find their concerns dismissed, deferred or ignored.
- Unlike other chronic health conditions that have benefited from public awareness campaigns (e.g. F.A.S.T. to recognize stroke or Know Your Numbers to prevent heart disease), Alzheimer's and related dementias continue to suffer from myth and misinformation. Accessing accurate health information is a statewide challenge, a challenge made more difficult for individuals who speak or read languages other than English and/or have low literacy levels.
- With age the greatest risk factor for Alzheimer's disease (1:10 at age 65; 1:3 by age 85), it is most strategic and efficient to target state resources on raising public awareness among older adults. In California, the Area Agencies on Aging (AAAs) are the primary source of public information, assistance and referral for seniors with agencies operating in 33 Planning and Service Areas (PSAs) throughout the state.

- AAAs have expressed interest in developing greater Alzheimer's competency and community capacity to better meet the growing demand for information, assistance and referral from community members impacted by dementia. By 2025, the number of individuals affected is projected to climb from 630,000 to 840,000, with African Americans, Latinos and women disproportionately impacted by higher prevalence rates.

- AAAs are at the front-line of their communities, offering information, assistance and referral to experts, e.g. California Alzheimer's Disease Centers, Caregiver Resource Centers, and specialty community-based organizations such as the Alzheimer's Association.

- With one-time GF support, participating AAAs would receive specialized training on Alzheimer's disease and related dementias, as well as start-up funding to produce materials to share with their community via in person, telephone and online assistance. An evidence-derived, field tested and evaluated campaign exists in multiple languages: Know The 10 Signs. Alternatively, the state may wish to create a unique campaign at additional expense.

CONTACT: Susan DeMarois, State Policy Director, Alzheimer's Association at 916-447-2731 or sdemarois@alz.org

CLTCOA
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The California Long-Term Care Ombudsman Association is requesting $7,299,680 in general funds for the Local Long-Term Care Ombudsman Programs

The California Long-Term Care Ombudsman Program

History

The Long-Term Care (LTC) Ombudsman Program provides advocacy services to protect the health, safety, welfare, and rights of residents of skilled nursing facilities (SNF) and residential care facilities for the elderly (RCFE) (also known as assisted living facilities) through investigation and resolution of individual resident complaints. Unannounced visits to facilities, not in response to a complaint, provide opportunities for Ombudsman representatives to observe conditions in facilities, identify problems and concerns of residents, and resolve these problems quickly and efficiently. The LTC Ombudsman Program is mandated by federal and State law to advocate for and protect the rights of residents living in long-term care facilities. California's LTC Ombudsman program started in 1979 with the passage of the Mello-Granlund Older Californian's Act.

Over the past three decades, the role of the LTC Ombudsman Program has greatly increased from the original intent of the Older Americans Act. In 1986, AB 3988 (Papan, Chapter 769, Statutes of 1986) made California Ombudsmen legally responsible for receiving and investigating reports of suspected abuse and neglect in long-term care facilities. California is one of only five states that require its Ombudsmen to investigate complaints of abuse and neglect.

Prevention is the hallmark of Ombudsman Programs. Regular visitation and observation of conditions in facilities is vital to identifying problems, which left unresolved, can result in serious quality of care and life concerns. For example, through their regular presence in facilities, Ombudsmen are able to detect issues such as overmedication/sedation of residents, insufficient staffing, negligent care, insufficient food supply, and unhygienic living conditions. Ombudsman can take steps to resolve these issues before residents are injured or suffer harmful consequences. Ombudsman services of advocacy and intervention help ensure the best possible opportunity for improving quality of care and quality of life for residents.

Although prevention through unannounced visits and investigations of abuse and neglect complaints are a major focus of California's LTC Ombudsman Program, Ombudsmen have several other roles to fill due to California mandates. When these mandates were enacted in the 1980's and 1990's, they were un-funded and continue to be severely under-funded.

- Cal. Probate Code 4675 – A representative of the Long-Term Care Ombudsman Program must witness the Advance Health Care Directive whenever it is executed in a skilled nursing facility.
- California law requires the Long-Term Care Ombudsman Program witness transfers of property in excess of $100 when transfer takes place in a long-term health care facility.
- AB 2100 – The Long-Term Care Ombudsman Program must report abuse cases to the local district attorney with consent of the resident or the resident's legal representative.
- Maintain and staff a 24-hour, 7-day per week crisis line.

Funding – Resources, Budget Cuts and Impact

The LTC Ombudsman Program is federally funded under Title III-B and VII of the Older Americans Act to cover the costs associated with the federal mandates as established in federal law. Despite the growing workload the 2017/18 federal funds for the program was reduced by $114,744. The U.S. Administration on Aging has disallowed the use of federal funds for "State-mandated" activities that a State Long-Term Care Ombudsman Program may have. i.e., witnessing Advance Health Care Directives (AHCD). The costs of California's Ombudsman mandates must be borne by the State.

In 2016/17 Ombudsman programs successfully witnessed 2,344 AHCDs. To maximize efficiency some programs have scaled back witnessing activities, to only on those occasions when an Ombudsman is in the facility in response to a complaint investigation. This has resulted in 40% of the local programs reporting 2 or more residents dying prior to an Ombudsman being available to meet with the resident. Because Ombudsmen activities are directed to living residents, we do not collect data on outcomes, due to the lack of a legally binding AHCD.

California has a state Ombudsman office and thirty-five regional programs. Due to the varied structures of the Ombudsman programs (either as a direct service provider or contracted service provider), funding levels for these programs vary from county to county and from one Area Agency on Aging to the next. Local funding is based on regional priorities. This causes competition for funding between services for elderly and pits Ombudsman activities against other programs for the aging and against services for children.

Local funding outside of the AAA (city, county and charitable donations) has had a steady decline in recent years, from a high of $3M in 2006 (LAO Budget Analysis: Improving Long-Term Care 2006) to last year's $1.8M. As local programs spend less time in the community, providing free educational events to the public on topics relating to resident's rights and best practices for long-term care they receive less exposure and less funding support.

With declining federal funds and inconsistency in local support, Ombudsman program activities are forced to rely on state funding as the primary source of program support.

Increasing funds to the local programs continues to prove to be a sound investment. In 2015, with the introduction of the additional $2.4M in the 2015/16 budget ($1M in general funds, $400k SNF bed fee and OTO $1M state SNF citations) unannounced visits to SNFs increased by 7%, RCFEs visits increased by 5% and an additional 1,200 complaint cases were investigated and resolved with a 71% resident satisfaction score.

Despite these increases in unannounced visits, a remaining 26% of SNFs and 56% of RCFEs did not receive the federal minimum standard of 1 visit per quarter. The decrease in number of eyes and ears in these facilities has had a direct impact on the state licensing agencies responsible for oversight with an increased work load.

Impact on State Licensing Agencies

The California Department of Social Services Community Care Licensing Division April 2016 reported receiving 15,746 complaints in RCFEs, a 19% increase since 2012.

The California Department of Public Health provided testimony during the 2016 legislative budget hearings and reported in their annual report a steady increase in the number of both jeopardy and non-immediate jeopardy complaints. Since 2013 the department has experienced a 21% increase in non-jeopardy complaints, with a 9% increase in 2016.

Historically non-immediate jeopardy complaints are responded to by the local Ombudsman program. While in the facility, Ombudsmen answer questions and resolve concerns of the residents and their family members. With fewer Ombudsmen in facilities, families must call the Ombudsman offices. With the reduction in office staff, complaint response time is increasing. The longer response times from an Ombudsman results in residents and family members turning to the licensing agencies for assistance.

Ombudsman Program Designation Standards

To ensure that local Ombudsman Programs meet federal and state requirements the program shall provide adequate personnel which include a full-time Program Coordinator. Local Programs are to have sufficient staff to

answer the calls in person during normal business hours. To respond to the 24hour CRISIS line a local Program Ombudsman must be available at all times. If the local LTCOP cannot provide immediate assistance, complaintants should be referred, as the situation dictates and with the consent of the resident or legal representative, to the local offices of the Department of Social Service, Community Care Licensing Division; the Department of Public health, Licensing and Certification program; the Department of Justice, Bureau of Medi-Cal Fraud and Elder Abuse; and /or local law enforcement.

Volunteers

Due to the flat funding in recent years, local programs have needed to rely more on volunteers to investigate abuse and neglect cases that full-time staff would normally handle. The California's Elder Abuse Investigators: Ombudsman Shackled by Conflicting Laws and Duties California Senate Office of Oversight and Outcomes 2009 study found that half of California's local ombudsman programs depend on volunteers to play a role in abuse and neglect investigations. The greater the number of complaints received by a local ombudsman program, the more likely the program is to allow volunteers to conduct the abuse and neglect investigations. In 2016 all but 5 Ombudsman programs utilize volunteers for elder abuse complaints.

In 2009, in response to the loss of general funds, local programs reduced staff by 50%. Remaining staff were moved from supervisory positions into field complaint investigators. The 2015-16 increase in funding was not used to replace those supervising positions but for field investigators to keep up with the growing number of complaints.

The on-going reduction in supervisors has resulted in a steady reduction in volunteer Ombudsmen. In 2004, the program had 1,300 certified volunteers. In July 2017, the state office reported that programs had 723 volunteers, the lowest number in the program's history. Last year 17 Ombudsman programs recruited 0 or 1 new volunteer. These programs reported difficulty in recruiting volunteers willing to investigate elder abuse complaints. An additional challenge with the lack of supervisors, program coordinators must delay responding to complaints to provide the required 36 hours of class room training and three weeks of supervised fieldwork. In comparison, the four programs with the greatest increase in volunteers have a staff person dedicated to volunteer recruitment, training and retention.

The ASK: The California Long-Term Care Ombudsman Association is requesting $7,299680 in general funds for Local Long-Term Care Ombudsman Programs.

A 1991 study by the Office of the Inspector General Successful Ombudsman Programs, Department of Health and Human Services (1991) states successful state Ombudsman programs share a number of characteristics (here after referred to as **The Study**):

Frequent visits to facilities

The Study states that the most successful state ombudsman programs make weekly visits to long term care facilities. The visits are proactive and enable the residents to become familiar with the ombudsmen. Ombudsmen use the visits to speak with residents and develop trust as well as identify complaints and violations. Their presence is two-fold: to identify and resolve complaints and prevent future problems.

Quarterly visits: hours required for 100% facility coverage: travel, time for Ombudsman initiated complaint investigations and documentation. Therefore, 16 hours per SNF per quarter x 1,252 facilities plus 8 hours per RCFE per quarter x 7,386 facilities for a total of 316,480 hours.

Currently 25% of work is completed by volunteers and 75% by paid staff. Volunteers will donate 79,120 hours and the remaining 237,360 hours of paid staff at $30 per hour will cost an estimated $7,120,800.

Effective in recruiting, training, and retaining volunteers

The Study demonstrates that states with top Ombudsman programs have good recruitment programs that attract the right volunteers. It is also shown that paid staff members are vital to the success of volunteer programs. Paid staff are needed to develop volunteer training programs and recruit, supervise and support volunteers.

Programs estimate that the staff hours needed for a recruit during their first year of service, initial recruitment, 36-hour class room training, 3 weeks of supervised field work, monthly on-going training, on-going documentation review and supervision = 100 hours per volunteer for the first year of a volunteer's service. Therefore, 100 hours x 10 new volunteers x 35 local programs= 350 new volunteers requiring an addition $1,050,000.

Programs estimate that the ideal number of staff hours needed to support, train and supervise after first year of service = 20 hours per volunteer per year. Creating a statewide need for 20 hours x 723 current volunteers for a total of 49,460 hours of paid staff at $30 per hour = $1,483,800.

A study funded by the California Health Care Foundation, California's Term Care Ombudsman Program: Assessing the Volunteer Experience (March 2007), found the need for greater preparation of volunteers. "Only 44 percent of volunteers (surveyed) felt 'very prepared' to function in their role because of the training and mentoring they received."

Programs know the need for training and supervision of volunteers is necessary for strong retention of volunteers. However, programs consistently focus limited resources on complaint management at the growing expense of less than ideal volunteer support.

Public Awareness

The Study states that successful Ombudsman programs are highly publicized and accessible in the community. This includes consultations and trainings to facility staff/administration, written materials, toll-free numbers, community outreach efforts and media exposure.

Staff hours needed to complete consultations and trainings to facilities, staff and administrators.
Per the 2015/16 Annual Report from the Office of the State Long-Term Care Ombudsman: Ombudsman completed 14,134 consultations at approximately 20 minutes each for a total of 430 staff hours. The report also states that Ombudsman provided 1,215 trainings at approximately 90 minutes each for a total of 1,823 hours.

Complaint Investigations

The Study continues, that the most successful state programs respond on-site to potentially life-threatening complaints within 24-48 hours. Higher rates of resolution of complaints are another indicator of successful Ombudsman programs. Per the Study, successful Ombudsman programs have 75% closure rate of complaints within 12 months.

The 2005 Legislative Analysis Report, Improving Long-Term Care calculates the cost per complaint for the LTC Ombudsman Program at $172. Programs estimate current expenditure per complaint is $188.

Conclusion

Adequately funded LTC Ombudsman programs would utilize volunteers for unannounced facility visits, individual consultations, most witnessing activities and non-elder abuse complaints investigations. Staff would complete the elder abuse investigations, communication with licensing and law enforcement agencies, facility consultations, community event trainings, volunteer support and recruitment activities and documentation review.

With a modest investment in General Funds, Governor Brown has an ideal opportunity to use the LTC Ombudsman Program in his efforts to fulfill California's promise of quality life and care for persons living within the long-term care system. With early Ombudsman intervention, costly state agency intervention can be avoided. With increased visits provided by more Ombudsman trained "eyes and ears" facilities residents will receive better care, allowing them to continue living in RCFEs, primarily paid through private funds thus avoiding unnecessary hospitalizations and the need for higher levels of SNF care, primarily funded via the Medi-Cal system.

The requested funding will allow the LTC Ombudsman Program to once again meet their federal and state mandates, will be an important step to rebuilding the State's commitment to protecting vulnerable residents of long term care facilities and begin the critical process of ramping up Ombudsman services considering the rapidly growing California senior population.

CLTCOA
California Long-Term Care Ombudsman Association

The California Long-Term Care Ombudsman Association is requesting $7,299,680 in general funds for the Local Long-Term Care Ombudsman Programs

- **$3,451680 will enable the local programs to conduct vital federally (Administration on Aging) recommended quarterly unannounced visits to all 8,842 long term care facilities in California** (Currently only 46% of all facilities receive these recommended visits.)
- **$420,0000 will enable the programs to focus on volunteer recruitment**
- **$1,128,000 will enable the programs to investigate 6,000 more complaints per year** (generated through the additional 4,476 quarterly unannounced facility visits.)
- **$2,300,000 to adjust the local annual program base to $100,000** (this $65,000 per program increase will ensure each of the 35 programs will have one full-time Ombudsman Program Coordinator and a staff person to focus on recruitment, supervision and retention of volunteers)

	Facilities currently not receiving quarterly visits	**Hours per visit (including travel & documentation)**	**Hours per year to visit once a quarter**
Quarterly Monitoring Visits of Skilled Nursing Facilities	318	16 hrs	20,352 hrs
Quarterly Monitoring Visits of RCFE Facilities	4,158	8 hrs	133,056 hrs
Total Hours Needed to Meet Quarterly Monitoring Visits			**153,408 hrs**

Additional hours needed to meet quarterly unannounced visit mandate	
Average volunteer to staff ratio	0.25
Volunteer Hours	38,352 hrs
Staff Hours	115,056 hrs
Average Hourly Wage and Benefits	$30
Additional staff salary needed to achieve quarterly visits to 8,638 LTC licensed facilities	**$3,451,680**
Staff hours needed to focus on volunteer recruitment	14,000 hrs
Staff salary to recruit/train/supervise volunteers	**$420,000**
Investigate resident and ombudsman reported complaints	6,000
Cost to investigate single complaints	$188
Cost to investigate additional complaints identified	**$1,128,000**
Cost to adjust local program base to $100k	**$2,300,000**
Cost to conduct quarterly unannounced facility visits, support volunteers, investigate additional complaints and other State and Federally Mandated Ombudsman activities	**$7,299,680**

For additional information please contact: Leza Coleman, Executive Director, 1230 N. Street #210 Sacramento, CA95814 Office (916)426-3697 or email: lcoleman@cltcoa.org

BUDGET FACT SHEET

Senior Hunger – A Policy Embarrassment

REQUEST

Provide an additional $17 million to increase funding for senior nutrition programs. The added dollars would provide for an extra 2 million meals per year, and serve over 12,500 older Californians.

HUNGER AMONG OLDER ADULTS IS A POLICY EMBARRASMENT

Over the last ten years, the percentage of the senior population age 60 and older that faces food insecurity has increased by 45% (Ziliak & Gunderson, 2015). Incredibly, studies show that the percent of older adults in California facing the threat of hunger is 16.33%. California has the eleventh highest rate of senior food insecurity in the nation (United Heath Foundation, 2015).

Food insecurity is linked to poor health status (Stuff et al, 2004) and malnutrition. Malnutrition can lead to loss of weight and strength, greater susceptibility to disease, confusion, diabetes, osteoporosis, stroke, and cancer (World Health Organization, 2015). Malnutrition also leads to increased visits to emergency rooms, increased lengths of hospital days, and discharges to higher levels of care (Charlton et al, 2012).

HUNGER NEEDS TO BE ADDRESSED

California is home to some 7.8 million older adults (California State Plan on Aging 2017-2021). In California, the percent of older persons facing the threat of hunger is 16.33 %. Subsequently, nearly 1.274 million adults over the age of 60 are considered food insecure.

No one in California should go hungry, especially our parents and grandparents. Forty percent of older Californians do not have sufficient incomes to make ends meet. About 50% of older persons suffer from malnutrition. Over one million are threatened by hunger each day. It is essential to provide a safety net of preventive nutrition that enables older adults to age well.

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Email: aging@c4a.info ✦ Website: www. c4a.info

THE BASICS OF SENIOR NUTRITION PROGRAMS

Nutrition programs serve numerous seniors through home delivered meals and congregate sites. Congregate sites reach out to low-income persons, those seeking social programs as well as the hidden homeless in the streets or in cars. Home delivered meal programs focuses on the home-bound, socially isolated, and most needy.

Home delivered meals are provided to older adults who are shut in and unable to get out of the house to go to a meal site. These seniors tend to be older, poorer and have multiple chronic conditions and suffer from isolation and loneliness. Nearly 11 million home-delivered meals are served annually - providing life-sustaining nutrition for some 55,000 older, frail Californians. Total cost of home delivered meals is about $79 million with federal and state dollars of nearly $39 million. On average, a recipient of home delivered meals receives 4 meals a week.

Congregate meals provide an opportunity for socialization (critical to health and well-being) and connection to community resources and social programs for those who attend. Congregate meals are provided in communal settings at various community-based sites. The positive impact of congregate meal programs is especially evident among the low-income respondents and those living alone. Approximately 7 million congregate meals are served every year to some 168,000 recipients. Total cost of the congregate meal program is about $98.6 million with federal and state dollars contributing some $54 million.

INCREASING NEED AMID FLAT FUNDING

Resolving the problem of 1.274 million older adults facing food insecurity is an enormous task. The task grows bigger considering that funding for nutrition has not been adjusted for the past 8 years.

Although approximately 223,000 seniors receive meals each year, over 1.051 million older Californians still face hunger every day. Attempting to feed those seniors not currently receiving meals would cost a whopping $1.39 billion per year.

California can provide aggressive leadership in battling senior hunger by augmenting existing programs with an additional $17 million for senior nutrition programs. These added dollars would provide for an additional 2 million meals per year, and serve over 12,500 new seniors with an average of three times per week for about $8.50 per meal.

STATE FUNDING IS A CRITICAL PIECE OF A REAL SOLUTION

Home-delivered Meals and Congregate Dining Centers provide real solutions to two key issues facing seniors; they combat hunger and food insecurity, and have the added advantage of reducing loneliness and isolation.

California's leadership can provide the momentum for local communities, private individuals and foundations to join forces in this battle and augment the state funding with additional resources to address this overwhelming crisis. Socially isolated seniors are often silent and even invisible to the general public, but their lack of visibility does not end their hunger. Nutritious meals improve health and sustain life. Food is easier to provide and more cost-effective than hospitalizations or placement in a skilled nursing facility, and improves the quality of life for our older adults and their children and grandchildren. A budget augmentation to Senior Nutrition Programs will send a clear message that California prioritizes promoting health and well-being for all ages, rather than hospitalization, institutionalization, or other drastic and more costly interventions.

The budget request is co-sponsored by the California Association of Area Agencies on Aging, California Commission on Aging, and the Congress of California Seniors. It is supported by numerous aging organizations, including Meals on Wheels California, and the California Collaborative for LTSS.

CALIFORNIA ASSOCIATION OF AREA AGENCIES ON AGING

Congress of California Seniors

CCoA

California Commission on Aging

... a citizens voice within government

Multipurpose Senior Services Program-- MSSP

Serving frail, nursing-home eligible Seniors at Home

Budget Request: Provide a Supplemental Rate Adjustment of $4.7 million (GF or Healthcare Treatment)

MSSP serves almost 12,000 frail Seniors (65+) in their homes, rather than institutions, and saves California $110 million or more annually yet Medi-Cal reimbursement still reflects recession-era cuts from 2008 and 2011 of 22.5 percent.

Our 38 non-profit sites throughout California ensure professional and Client-centered services for Seniors to live in their community. MSSP operates under a federal waiver and must meet prescribed standards of care, as well as strict budget neutrality requirements. Our request of $4.7 million (GF/Healthcare Treatment Fund) provides continued operations of MSSP at a cost of only $5,356 per Client, maintains all federal waiver requirements, and continues services to our Clients.

Our non-profit providers need a Medi-Cal supplemental rate adjustment to sustain MSSP services moving forward to provide the following:

- ***Personal Assessment and Care Planning***. An MSSP Registered Nurse and Social Worker conduct a joint, comprehensive assessment to develop a living Care Plan linking medical and social service's needs. The Client's choice and functional needs are reflected and included in the Care Plan. Linkage to IHSS, home-delivered meals, transportation and other appropriate services is provided. Additional needed items and services not available through other programs can also be obtained through MSSP.
- ***Client Monitoring.*** All Clients must be monitored at-least monthly by the MSSP Care Team. Monitoring entails review of each Care Plan problem statement and evaluating the effectives of the Care Plan. The health, safety, and social components of the Client and their living arrangement is addressed through comprehensive monitoring.
- ***Professional, Quality Staff.*** The federal CMS requires specific education and work experience for employment at an MSSP site. We must meet and sustain our valuable staff to continue to provide complex case management. No Medi-Cal reimbursement augmentations have been provided to reflect these workforce needs.

Who We Serve: Our Clients are 65 years and older who **are *certified eligible for skilled nursing home placement***. The majority of Clients live alone and have complex medical and psychosocial needs, requiring specialized medical and social support services. Our data reflects increased needs reflecting an array of serious chronic conditions and multiple comorbidities, along with behavioral health needs.

Justification of Cost-Benefit: Medi-Cal funding for MSSP has been flat and was then reduced during the recession years. However, the cost of professional staff and operations has increased considerably, including salaries, worker's compensation, staff training and development, rent and utilities.

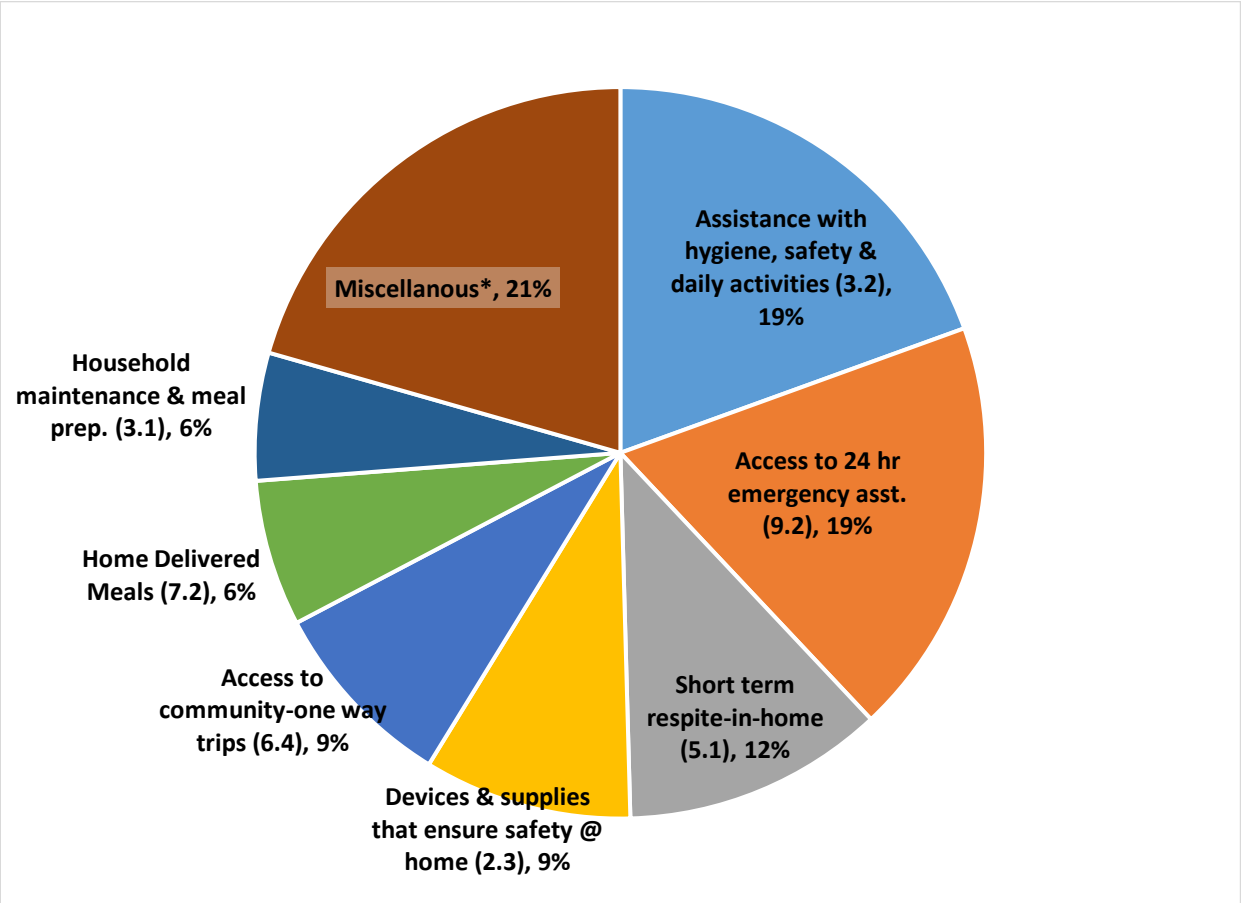
Additionally, MSSP sites spend up to 30 percent of their overall program allocation purchasing services and equipment (waiver services) needed by our Clients when other public or private resources are not available to meet their need (Please see the attached chart).

We are tremendously cost-beneficial to the Medi-Cal Program and desire to continue to serve our Clients.

Contact: Dustin Harper, MSA President at (415) 750-8790 or Erin Levi of Capitol Partners at (916) 930-0609.

Purchased Services Provided by MSSP Sites with Medi-Cal Waiver Funds

(March 2016 – April 2017)



*The Miscellaneous category includes:

Protective supervision

Minor home repair/Adaptive equipment

Staples for after hospitalization

Professional services (e.g. pharmacist, nutritionist)

Therapeutic counseling

Emergency utility service

Translation/Interpretation

Adult day care

Emergency move

Money management

Socialization & monitoring

Purchased care management

UDW The Homecare Providers Union
AFSCME Local 3930 / AFL-CIO

February 20, 2018

The Honorable Joaquin Arambula
Chair, Assembly Health and Human Services Budget Subcommittee 1
State Capitol, Room 5155
Sacramento, CA 95814

The Honorable Richard Pan
Chair, Senate Health and Human Services Budget Subcommittee 3
State Capitol, Room 5114
Sacramento, CA 95814

RE: Proposed FY 18-19 IHSS Budget

Dear Dr. Arambula and Dr. Pan,

UDW/AFSCME Local 3930 represents over 100,000 In-Home Supportive Services (IHSS) providers in 21 counties throughout California. The IHSS program provides vital in-home care services to eligible low-income seniors and people with disabilities.

We respectfully request the budget subcommittee adopt the following actions:

- **Rescind the 7 percent across the board cut to IHSS service hours**

Because of a legal settlement between UDW and other plaintiffs with the state of California, IHSS service hours were reduced by 8% for all recipients starting July 2013 - for a period of one year - with a 7% cut annually thereafter. Currently, the 7% cut is restored using proceeds from the state's Managed Care Organization (MCO) tax, which is set to expire on July 1, 2019. Per WIC Section 12301.02 (e), the 7% cut is suspended only if the MCO tax remains operative. The cut will be reinstated if the MCO tax becomes inoperative for any reason.

According to the LAO's 2018-2019 Fiscal Outlook, it is highly uncertain whether the federal government will provide the necessary approval for the MCO tax to be continued beyond July 1, 2019. If the 7% cut is reinstated, over 1,000,000 IHSS clients and their providers would be harmed by the loss of essential hours of service.

Multiple years of revenue growth have allowed the Legislature to significantly build our state's budget reserves. Now is time to make the IHSS program whole once and for all. We respectfully urge the Legislature to rescind the 7% cut. The state should continue to rely on MCO tax revenue to restore services, however in the event the tax expires we must ensure that cuts are not reinstated.

- **Oppose Electronic Visit Verification (EVV)**

The 21st century CURES Act requires every state that receives Medicaid funding for personal care services programs like IHSS to implement EVV beginning January 2019 or lose federal funding for these programs.

These new requirements are inherently burdensome. It is unclear how EVV would work in IHSS, which is already very complicated for providers and consumers to navigate. EVV almost certainly will make receiving services in the home more restrictive for seniors and people with disabilities. Imposing new reporting requirements on providers will make an already difficult job even more difficult.

- **Fund LTSS Data Collection and Analysis**

UDW requests a General Fund allocation of $3 million to fund the collection and analysis of data on long-term services and supports (LTSS) in California. We request the state use these funds to contract with the University of California, Los Angeles to incorporate specific questions on access to and need for LTSS in the California Health Interview Survey (CHIS) in the 2019-20 and 2023-24 survey cycles. A portion of the costs of developing and analyzing the data can be matched with federal funds as an allowable Medicaid administrative cost.

The Department of Finance estimates there are 8 million older adults and people with disabilities in California. This population is expected to grow significantly over the next decade. However, our state does not collect data to accurately track and plan for this growth. While national surveys collect data on the prevalence of disabilities and cognitive and functional impairments, these surveys do not provide state and county level estimates of the population needs and uses of LTSS. Additionally, the surveys do not assess the needs for LTSS by income level, age, type of disability, geographic region, or racial or ethnic group.

- **Expedite IHSS Provider Enrollment**

Currently, it can take anywhere from a few weeks to months before new IHSS providers are enrolled into the program and mailed their first timesheet. This delay is unacceptable. It has severely impacted the ability of IHSS consumers to recruit and retain new workers, who must wait weeks or months to get their first paycheck.

We are requesting a modest appropriation to expedite the provider enrollment process at the county level. We are currently in discussion with county representatives to determine

the amount of additional funding that would be needed to accomplish the following changes: 1) ensure prospective IHSS providers receive enrollment packets within three business days of applying for employment and 2) ensure prospective providers have access to the mandatory IHSS provider orientation within two weeks of submitting their application.

- **Fund Health Care Benefits and establish an Employer of Record (EOR) for Waiver Personal Care Services (WPCS) Providers**

UDW requests an appropriation to establish an employer of record and provide healthcare benefits for roughly 700 WPCS providers in California. Currently, WPCS providers are unable to receive health benefits because their hours are not covered by existing collective bargaining agreements. WPCS providers deserve the same right to health care benefits and labor protections as IHSS providers.

- **Paid Sick Leave Implementation**

The Governor's budget allocates $29 million to implement eight hours of paid sick leave for IHSS providers. While UDW is supportive of this allocation, we are very concerned that a provider back-up system for consumers has not yet been established. We request that the Legislature urge the Administration to develop a comprehensive provider back-up system as soon as possible. This is essential for the successful implementation of paid sick leave in IHSS.

We thank you in advance for your consideration of our budget recommendations.

Sincerely,

Doug Moore
Executive Director

cc: Members of Assembly Budget Sub Committee No. 1 on Health & Human Services
Members of the Senate Budget Sub Committee No. 3 on Health & Human Services

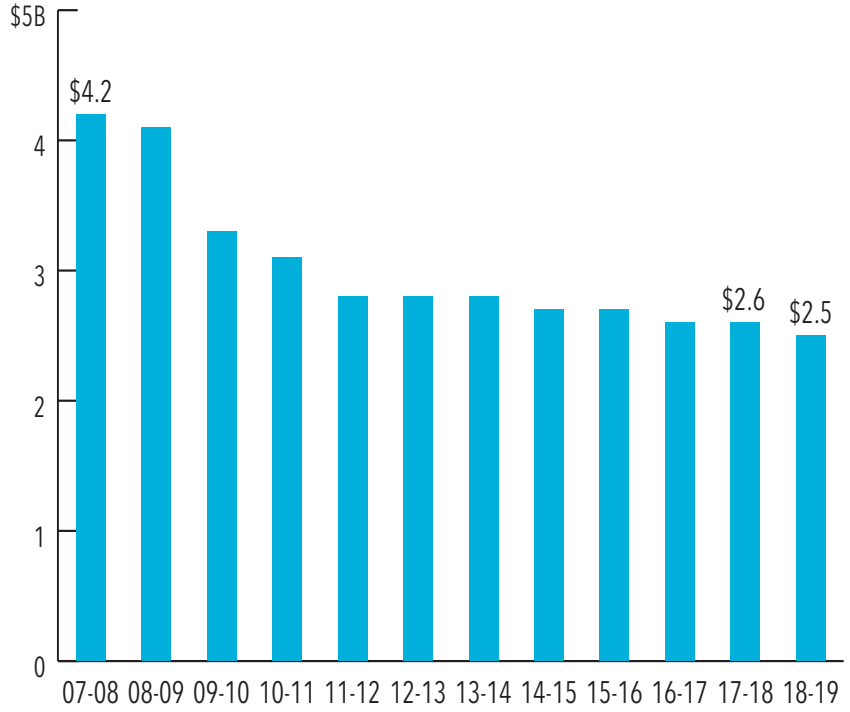
Data Hit

California Budget & Policy Center

FEBRUARY 2018 | BY SCOTT GRAVES

Due to Budget Cuts, State Spending for SSI/SSP Grants Is About 40% Below the 2007-08 Level

General Fund Expenditures in Billions, Inflation-Adjusted



Note: Figures are in 2018-19 dollars. All figures are state estimates except for 2018-19, which reflects the Governor's proposed expenditure level.
Source: Department of Social Services

- **Supplemental Security Income/ State Supplementary Payment (SSI/ SSP) grants are a critical source of basic income for low-income Californians.** SSI/SSP grants help well over 1 million seniors and people with disabilities pay for basic necessities such as housing and food. (People enrolled in SSI/SSP are not eligible for CalFresh food assistance.)

- **Deep cuts to the state's SSP portion – which largely remain in place – have reduced annual state support for SSI/SSP by more than $1 billion.** State spending on the SSP portion has dropped from $4.2 billion in 2007-08 to $2.6 billion in 2017-18, after adjusting for inflation. State spending would remain at recession-era levels in 2018-19 under the Governor's proposal.

- **State policymakers must decide whether to maintain recession-era spending.** State cuts generate well over $1 billion in annual General Fund "savings," but jeopardize the well-being of more than 1 million Californians.

CALIFORNIA BUDGET & POLICY CENTER
calbudgetcenter.org

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BUDGET FACT SHEET

Adult Protective Services (APS) Home Safe

January 29, 2018 | 2 Pages

Homelessness Prevention for Vulnerable Seniors

PROPOSAL

Provide one-time funding of $15 million General Fund in 2018-19 to establish Home Safe, a homelessness prevention demonstration grant program for victims of elder abuse and neglect served by county-run Adult Protective Services (APS). Across California, APS social workers are finding that seniors and adults with disabilities who are the victims of financial exploitation, physical abuse, or caregiver neglect are at risk of losing their housing and becoming homeless. APS programs are uniquely positioned to help individuals in a moment of crisis – but currently do not have the funding to prevent victims from becoming homeless. Home Safe would allow participating counties to help APS clients maintain their housing through services such as short-term rental or utility assistance, legal assistance, and expanded case management services.

VICTIMS OF ELDER AND DEPENDENT ADULT ABUSE, NEGLECT, AND EXPLOITATION AT RISK OF HOMELESSNESS

Victims of elder and dependent adult abuse and neglect are at unique risk of becoming homeless. New research shows that nearly half of the homeless adults over age 50 in Oakland are experiencing homelessness for the first time. These adults typically led "conventional" lives until a crisis led them directly to homelessness – a crisis such as being financially exploited by a scam artist or family member, or being left unable to care for themselves after the death of a spouse or caregiver.[1] These destabilizing events that lead to homelessness are instances of elder and dependent abuse and neglect that get reported to APS.

LIMITED FUNDING KEEPS APS PROGRAMS FROM PREVENTING HOMELESSNESS AMONG VICTIMS OF ABUSE

When APS receives a referral for an older or dependent adult who has been abused or exploited, APS social workers investigate those claims and create a plan to help the individual stabilize and recover. But, county social workers are finding that they are unable to provide the assistance necessary to help victims of abuse maintain their homes as they recover. This is because APS was originally designed to be a bare-bones program. With $126 million, it investigates 150,000 referrals and provides short-term services to 25,000 clients each year. In contrast, the child welfare system serves a population 4 times larger than APS, but receives 40 times the funding – $5 billion a year. Unlike child welfare, APS simply does not have the resources to provide a more in-depth intervention, especially during a housing crisis.

FACT SHEET | ADULT PROTECTIVE SERVICES-HOME SAFE

WITH HOME SAFE, APS PROGRAMS WOULD INTERVENE AT THE TIME OF CRISIS TO PREVENT HOMELESSNESS

A one-time $15 million General Fund investment to establish Home Safe would allow participating county APS programs to demonstrate over three years how intervening at the moment of crisis can prevent homelessness among victims of abuse and neglect. Home Safe counties would identify clients at risk of losing their homes and provide services including short-term rental and utility assistance, heavy cleaning, immediate mental health treatment, and intensive case management to ensure clients are able to maintain their homes. Home Safe builds on the best practices and evidence-based principles of homelessness prevention and rapid re-housing supported by the Legislature in recent years. Proven to be cost-effective and have better outcomes than many other housing models, these approaches prioritize intervening at the moment of crisis, maintaining individuals in permanent housing, providing short-term supports, and maximizing community-based resources to bolster housing stability.[2] Since APS already works with individuals in moments of crisis, the program is in a unique position to target assistance to those most likely to become homeless at the moment they need it most.

THERE IS NO MEDICINE AS POWERFUL AS HOUSING

As a three-year demonstration grant program, the one-time $15 million General Fund investment in Home Safe would include an evaluation component to evaluate the effectiveness of Home Safe at: reducing the risk of homelessness, preventing future incidents of elder abuse and neglect among California's older adults, and saving taxpayer dollars in the long run. A recent study demonstrated that providing modest financial assistance (about $1,000) to families most at risk of homelessness reduced their likelihood of becoming homeless within six months by 76 percent. These small investments lead to averted costs – and taxpayer savings – of well over $10,000 per person by reducing shelter costs, emergency room visits, and law enforcement calls.[3] Older and dependent adults who become homeless later in life are particularly at risk of falling ill and using high-cost emergency rooms instead of less costly primary care.[4] The health hardship of homelessness makes older homeless adults likely to die nearly 30 years earlier than similarly-situated adults who have housing.[1] By evaluating Home Safe, we will be able to test what the research strongly suggests: that preventing victims of elder and dependent abuse and neglect from becoming homeless will not only save tax payer dollars – it will save lives.

REFERENCES

[1] Brown, RT et al. Pathways to Homelessness among Older Homeless Adults: Results from the HOPE HOME Study. *PLOS One* (2016). http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0155065

[2] National Alliance to End Homelessness. Homelessness Prevention: Creating Programs that Work. (2009). http://www.endhomelessness.org/library/entry/homelessness-prevention-creating-programs-that-work

[3] Evans, WM et al. The Impact of homelessness prevention programs on homelessness. *Science* (2016). https://www.ncbi.nlm.nih.gov/pubmed/27516600

[4] Baggett, TP et al. Mortality among homeless adults in Boston: shifts in causes of death over a 15-year period. *JAMA Internal Medicine* (2013). https://www.ncbi.nlm.nih.gov/pubmed/23318302

This budget update was created by CWDA Staff. Direct questions to the contact at right.
For more information, visit: cwda.org

County Welfare Directors Association of California

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CALIFORNIA COMMUNITY TRANSITION PROGRAM (CCT)
BUDGET PROPOSAL

CCT to HCBA – How Transition Services are Eliminated

History

In January of 2007, the California Department of Health Care Services (DHCS) was awarded a special grant to participate in the Money Follows the Person Rebalancing Demonstration, known in California as the California Community Transitions (CCT) project. The goal of this project is to transition long-term nursing home residents back to community settings. The federal program expires September 30, 2020.

CCT Accomplishments

This project successfully demonstrated that the State is able to accomplish three goals simultaneously: (1) Medi-Cal beneficiaries living in skilled nursing institutions for longer than 90 days can be transitioned back into community living; (2) California can comply with the *Olmstead* decision requiring the State to enable people with disabilities to live in the most integrated setting possible; and (3) the State can realize savings since community living is more cost effective for the State.

To date, the CCT program has successfully transitioned 3,629 individuals from institutional settings to the community resulting in an average of approximately $ 60,000 in savings per participant per year.

CCT Termination

Beginning in January 2017, DHCS began implementing a two-year effort to terminate the CCT program. The last long-term care resident transitions will occur in December 2018. After that, post-transition work will continue in 2019 and end in 2020.

Separately from the CCT process, DHCS has renewed the Nursing Facility Acute Hospital (NF/AH) waiver, newly renamed the Home and Community Based Alternatives (HCBA) waiver, and intends to delegate administration of the waiver to contracted non-state providers called Waiver Agencies. DHCS asserts that the new HCBA Waiver will serve to replace the CCT program. However, the HCBA waiver cannot truly replace the CCT program because it does not accomplish the three goals outlined above.

The HCBA Waiver Does Not Adequately Replace the CCT Program

The HCBA waiver is neither capable of serving all those in need of transition services currently served by the CCT program or of providing the same level of services. The CCT program offers transitions services to all eligible individuals who utilize IHSS and other non-waiver services as well as those enrolled in all HCBS waivers in the community. In contrast, the HCBA waiver limits transition services to only those individuals enrolled in the HCBA waiver. Additionally, the transition services the HCBA waiver offers to this limited population are not at the same level as those offered by the CCT program as described below:

- **Staffing Costs Higher:** The HCBA requires that nurses fill care management positions and masters level social workers at a significantly higher cost than that required under the current CCT model, which allows transition coordinators without degrees with supervision from nurses or other clinical professionals to provide services. CCT has effectively used this model to transition individuals to the community so there is no demonstrated need for higher-level staff.
- **Ratio Requirement is Too High:** As structured, the caseload to staff ratio is too high under the HCBA waiver to adequately provide for the services necessary during the height of a transition.
- **Restricts Reimbursement for Pre-Transition Work:** Unlike the CCT program, the HCBA waiver only allows for reimbursement for pre-transition work if the transition to the HCBA Waiver takes place. If the individual dies, transitions to non-HCBA Waiver services, or otherwise does not complete the transition, there is no reimbursement for pre-transition work.
- **Unable to achieve required 60/40 ratio:** The HCBA waiver requires a 60 (institutional placements)/40 (community applicants) ratio for entrance from the waitlist. While this is intended to encourage transitions from institutions, the barriers to transition described here will in fact slow such transitions, which will impede entrance to the Waiver for all applicants who need Waiver services to be safe at home.
- **Limits Access to Transition Services:** The HCBA waiver only allows for transition service provision for 60% of waiver eligible participants at any given time. This limitation will slow the rate in which these services can be provided in sharp contrast to the CCT program, which provides transition services to individuals as soon as they are eligible for the program.

- **Reduces the Reimbursement for Transition Costs:** The HCBA waiver provides for just $5,000 in actual transition costs compared to $34,500 currently available under the CCT program as summarized in the following chart:

Service	CCT	HCBA Waiver Agencies
Enrollment: *Includes Initial interview, face-to-face assessment, care planning with transition team, development of transition plan*	Maximum $908.60	No specific payment for Enrollment. Per Member/ Per Month (PM/PM) rate of $33.50 to $562.01/mo. based on acuity level. Only if client is transitioned to HCBA Waiver
Pre-transition: *Includes identifying a community physician and managed care plan, securing the necessary long-term services and supports (LTSS), preferred housing, in-home supportive services (IHSS), waiver services, and other appropriate medical and social supports*	Maximum $4,543	No specific payment for Pre-Transition. PM/PM case management rate of $33.50/mo. to $562.01/mo. based on acuity level. Only if client is transitioned to HCBA Waiver
Transition: *Includes below*		$5,000 lifetime maximum Only if client transitions.
Home modification	Maximum $7,500	
Household set-up	Maximum $7,500	
Assistive devices	Maximum $7,500	$0.00
Vehicle adaptations	Maximum $12,000	$0.00
Habilitation	$45.43/hour as needed	PM/PM rate above only if client is transitioned to HCBA Waiver
Personal care services	$45.43/hour as needed	PM/PM rate above only if client is transitioned to HCBA Waiver
Family and informal caregiver training	$45.43/hour as needed	PM/PM rate above only if client is transitioned to HCBA Waiver
Post-transition: *Includes care management for a 365 day period following transition up to 50 hours*	Maximum $2,722	PM/PM rate above only if client is transitioned to HCBA Waiver

BUDGET PROPOSAL

CONTINUATION OF CALIFORNIA COMMUNITY TRANSITIONS PROGRAM

The Governor's proposed budget reduces the CCT program from $19.1m ($2.5 GF) in 2017-18 to $8m ($1.8 GF) in 2018-19 due to a phase out of the FFP, which ends September 30, 2020 when the program expires. See attached. We propose that on-going program costs budgeted at the 2017-18 appropriated amount ($19m) continue in 2018-2019 and thereafter. After September 30, 2020, no FFP would be available unless the federal Money Follows the Person Demonstration Program is reauthorized. GF would replace the loss of the FFP at the expiration of the federal program. Total program savings in 2018-2019 are estimated to be $28.2m ($14.1 GF). See attached. Continuing the program with GF beyond September 2020 will allow the program to continue in 18-19 and the first quarter of 19-20 without program reductions and FFP and continue to fund the Program thereafter and realize the full estimated savings to the GF from program continuation.

Disability Rights California

Justice in Aging

East Bay Innovations

Choice in Aging