CALIFORNIA COLLABORATIVE FOR LONG TERM SERVICES & SUPPORTS

Legislative Briefing Book 2017

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CALIFORNIA COLLABORATIVE FOR LONG TERM SERVICES & SUPPORTS

Legislative Briefing

MATERIALS

CALIFORNIA COLLABORATIVE FOR LONG TERM SERVICES & SUPPORTS
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AGENDA

January 27, 2017
California State Capitol, Room 444
Sacramento, CA
1:00 – 2:30 PM

1:00 PM **Welcome & Introductory Remarks**

- *Amber Christ*, Senior Staff Attorney, Justice In Aging

1:10 PM **Coordinated Care Initiative and Consumer Impacts**

- *Gary Passmore, Director, Congress of California Seniors*

Comments from California Collaborative Members

1:35 PM **Consumer Impacts of Health System Churn, Including the Repeal of the Affordable Care Act (ACA) and Potential Medicaid Block Granting**

1:50 PM **Critical Issues in Housing Policy**

- *Meghan Rose*, Director of Policy and Home and Community-Based Services, LeadingAge California

2:00 PM **Summary of LTSS Budget Requests**

2:05 PM **Q&A Discussion – Comments from Legislative Staff**

2:30 PM **Adjourn**

California Collaborative for Long Term Services & Supports
2017 MEMBERSHIP

AARP California

California Advocacy Network for Aging Latinos

California Assisted Living Association

California Association for Adult Day Services

California Association of Area Agencies on Aging

California Association of Caregiver Resource Centers

California Association of Health Facilities

California Association of Health Plans

California Association of Public Authorities

California Commission on Aging

California Council of the Alzheimer's Association

California Council of the Blind

California Elder Justice Coalition

California Foundation for Independent Living Centers

California Health Advocates

California Hospital Association

California In-Home Supportive Services Consumer Alliance

California Medical Association

California State Independent Living Council

Californians for Disability Rights

CalPACE

Coalition for Compassionate Care of California

Congress of California Seniors

Disability Rights California

Family Caregiver Alliance

Harris Family Center for Disability and Health Policy (HFCDHP)

Justice in Aging

LeadingAge California

LifeLong Medical Care

Multipurpose Senior Services Program Site Association

SEIU – California

The ARC California

UDW/AFSCME Local 3930

Mission and Principles of the California Collaborative for Long Term Services and Supports

Mission Statement

The California Collaborative advocates for the dignity, health and independence of Californians regardless of age who experience disabilities, functional limitations or chronic conditions and who use long-term services and supports. California needs a system of high-quality, cost-effective long-term services and supports that strengthen the person, his or her family, caregivers, circles of support, and the community at large. That system must promote the person's well-being and social participation, promote economic independence, prevent impoverishment and remove barriers to employment. The Collaborative will use several strategies, including public education and awareness, to further its mission.

Definition: Long-Term Services and Supports

Long-term services and supports refer to a wide range of personal, medical and social/financial assistance needed by persons with functional limitations over an extended time. The services may be publicly or privately financed, delivered in a wide range of settings, and may change as the needs of the individual who uses the services change.

Statement of Principles

The Collaborative Endorses a System of Long-Term Services and Supports Based on the Following Ten Principles:

1. **Dignity:** The services are grounded in respect for the person who uses them and driven by the preferences of that person.
2. **Choice:** Access to all types of services is provided on an equal footing.
3. **Flexibility:** The services are comprehensive and flexible enough to meet changing needs and incorporate new modes of service and supports.
4. **Quality:** Public funding and oversight that values and rewards high-quality care.
5. **Legality:** The services are consistent with the legal rights of individuals who use them.
6. **Cultural Competence:** The services are appropriate and responsive to the needs of unserved and underserved populations.
7. **Accessibility:** The services and information about them are easy to locate and use and are physically and programmatically accessible.
8. **Affordability:** The services are cost-effective for the person and the system.
9. **Inclusive:** The system recognizes and supports the crucial role of high-quality paid and unpaid caregivers, including family caregivers, and emphasizes the importance of workforce development and training.
10. **Independence:** The services support maximum independence, full social integration and quality of life.

Staffed by GACI ● 4535 Shady Oak Way ● Fair Oaks, CA 95628 ● info@gacinstitute.org ● 916.966.6643

CALIFORNIA COMMUNITY OF CONSTITUENTS INITIATIVE

2016-2017

The Community of Constituents initiative is a statewide project affiliated with the California Collaborative and funded by The SCAN Foundation. More than 700 member organizations and 850 local activists are working together to transform the aging and disability systems so that all Californians who need long-term services and supports can live with dignity, choice, and independence. Members include community-based organizations, aging and disability service and advocacy groups, as well as consumer and provider organizations. These advocates represent millions of Californians at the local, regional, and state levels who are working to improve the health care and supportive services for older adults and people with disabilities. Participating counties are highlighted below.

More information on the initiative is available at http://bit.ly/RCProfiles.

COALITION	LEAD REGIONAL CONTACT
Aging and Disability Coalition of Lake and Mendocino Counties *Serving Lake and Mendocino*	**Corrina Avila** corrina@mydslc.org
Aging Services Collaborative of Santa Clara County *Serving Santa Clara*	**Wendy Ho** wendyh@svcn.org
Bay Area Senior Health Policy Coalition *Serving Alameda, Contra Costa, Marin, Napa, San Francisco, Santa Clara, San Mateo, Solano, and Sonoma*	**Eileen Kunz** ekunz@onlok.org
Central Valley LTSS Coalition *Serving* Fresno, Kings, Madera, and Tulare	**Donald Fischer** castlekeepx@gmail.com
Community Living Implementation Council of Nevada County *Serving Nevada, Sierra, Sutter, and Yuba*	**Ana Acton** ana@freed.org
Contra Costa Advisory Council on Aging *Serving Contra Costa*	**Debbie Toth** dtoth@rsnc-centers.org
Diversability Advocacy Network *Serving Butte, Colusa, Glenn, Modoc, Plumas, Shasta, Sierra, Siskiyou, Tehama, and Trinity*	**Forest Harlan** forest@actionctr.org
Independent Living Workgroup of Kern County *Serving Kern*	**Jan Lemucchi** jan@ilcofkerncounty.org
Inland Empire LTSS Coalition *Serving Riverside and San Bernardino*	**Michael Knight** mknight@co.riverside.ca.us
Los Angeles Aging Advocacy Coalition *Serving Los Angeles*	**Brandi Orton** borton@sbssla.org
Monterey Bay Aging and Disability Resource Center Coalition *Serving Monterey, San Benito, and Santa Cruz*	**Clay Kempf** clayk@seniorscouncil.org
Orange County Aging Services Collaborative *Serving Orange*	**Cynthia Okialda** cynthia@ocagingservicescollaborative.org
Placer County Aging and Disability Resource Coalition *Serving Placer*	**Eldon Luce** elconsult@hotmail.com
San Diego Long Term Care Integration Project *Serving San Diego*	**Kristen Smith** kristin.smith@sdcounty.ca.gov
San Francisco Long Term Care Coordinating Council *Serving San Francisco*	**Mark Burns** mburns@homebridgeca.org
San Mateo County New Beginnings Coalition *Serving San Mateo*	**Michelle Makino** mmakino@smcgov.org
Santa Barbara County Adult and Aging Network *Serving San Luis Obispo, Santa Barbara, and Ventura*	**Jennifer Griffin** jgriffin@ilrc-trico.org
Senior Coalition of Stanislaus County *Serving Stanislaus*	**Dianna Olsen** dolsen.healthyaging@gmail.com
Senior Services Coalition of Alameda County *Serving Alameda*	**Wendy Peterson** wendy@seniorservicescoalition.org
Ventura County Hospital to Home Alliance *Serving Ventura*	**Sue Tatangelo** statangelo@camhealth.com
Yolo Healthy Aging Alliance *Serving Yolo*	**Sheila Allen** sheila.allen@yolocounty.org
Initiative Staff	**Sue North** snorthca@gmail.com
	Jack Hailey Jack@gacinstitute.org

THE HENRY J. KAISER FAMILY FOUNDATION

MEDICAID IN CALIFORNIA

January 2017

Medicaid and the Children's Health Insurance Program (CHIP) provide health and long-term care coverage to more than 12.2 million low-income children, pregnant women, adults, seniors, and people with disabilities in California. Medicaid is a major source of funding for safety-net hospitals and nursing homes. Federal policy proposals could fundamentally change the scope and financing of the program.

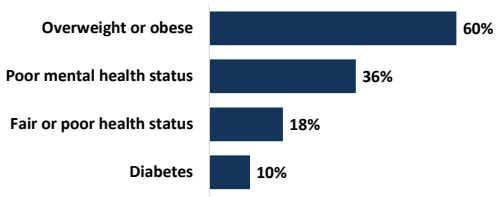
Snapshot of the California's population

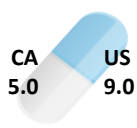
39.1 million people live in CA

33% of CA's population is low-income

Low-income: <200% FPL or $40,320 for a family of 3 in 2016

Adults in CA reporting:





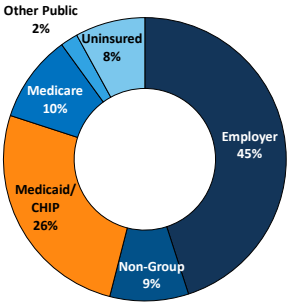
Opioid Deaths

HIV Diagnoses

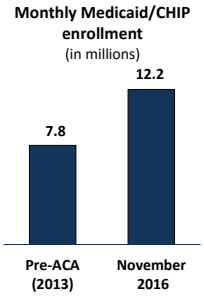
Per 100,000 population in 2014

How has Medicaid affected coverage and access?

In 2015, 26% of people in CA were covered by Medicaid/CHIP.



Since implementation of the Affordable Care Act (ACA), Medicaid/ CHIP enrollment has increased in CA.

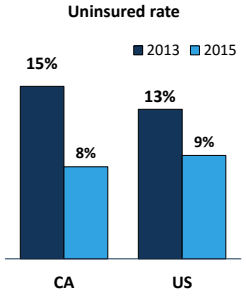


Did CA expand Medicaid through the ACA?

☑ Yes ☐ No

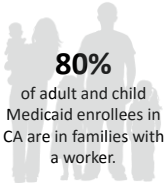
3.5 million adults
in the expansion group in Q1 of 2016

The uninsured rate in CA has decreased.



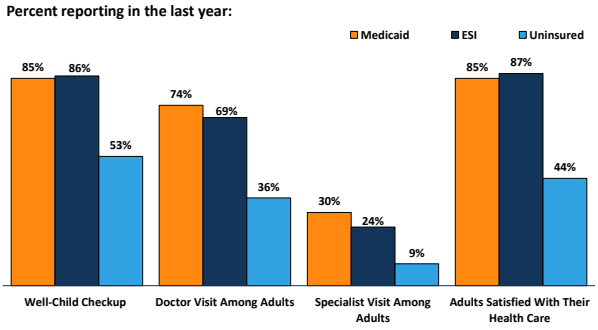
In CA, Medicaid/CHIP covers:

- 1 in 5 adults <65
- 1 in 2 low-income individuals
- 2 in 5 children
- 3 in 5 nursing home residents
- 1 in 2 people with disabilities



80%
of adult and child Medicaid enrollees in CA are in families with a worker.

Nationally, Medicaid is comparable to private insurance for access and satisfaction – the uninsured fare far less well.



Medicaid coverage contributes to positive outcomes:

- Declines in infant and child mortality rates
- Long-term health and educational gains for children
- Improvements in health and financial security

And…

>85%
of the public would enroll themselves or a child in Medicaid if uninsured.

How does Medicaid work and who is eligible?

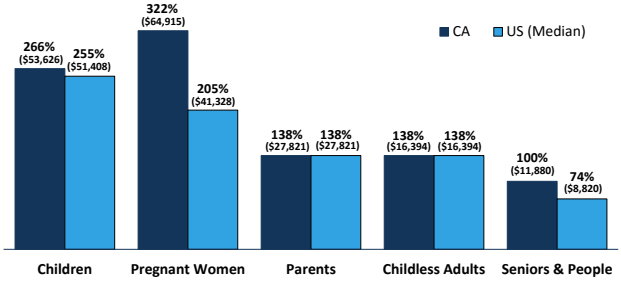
Each Medicaid program is unique:

Federal government sets core requirements, but states have flexibility regarding:

- **Eligibility** - All states have taken up options to expand coverage for children; many have opted to expand coverage for other groups.
- **Benefits** – All states offer optional benefits, including prescription drugs and long-term care in the community.
- **Delivery system & provider payment**– States choose what type of delivery system to use and how they will pay providers; many are testing new payment models to better integrate and coordinate care to improve health outcomes.
- **Long-term care** – States have expanded eligibility for people who need long-term care and are increasingly shifting spending away from institutions and towards community-based care.
- **State health priorities** – States can use Medicaid to address issues such as the opioid epidemic, HIV, Zika, autism, dementia, environmental health emergencies, etc.

Medicaid/CHIP eligibility levels are highest for children and pregnant women.

Eligibility Level as a Percent of FPL, as of January 1, 2017



Eligibility levels are based on the FPL for a family of three for children, pregnant women, and parents, and for an individual for childless adults and seniors & people w/ disabilities. Seniors & people w/ disabilities eligibility may include an asset limit.

How are Medicaid funds spent and how is the program financed?

Medicaid plays a key role in the U.S. health care system, accounting for:

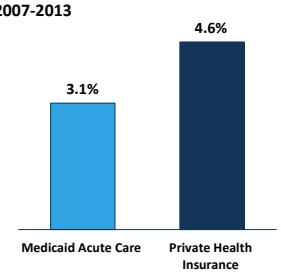
$1 in $6 dollars spent overall in the health care system

More than $1 in $3 dollars provided to safety-net hospitals and health centers

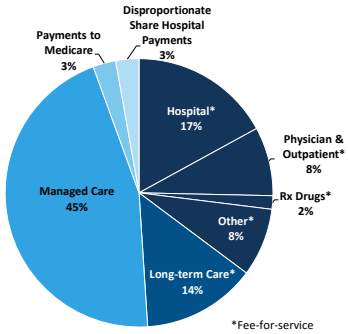
$1 in $2 dollars spent on long-term care

On a per enrollee basis, Medicaid spending growth is slower than private health care spending, in part due to lower provider payments.

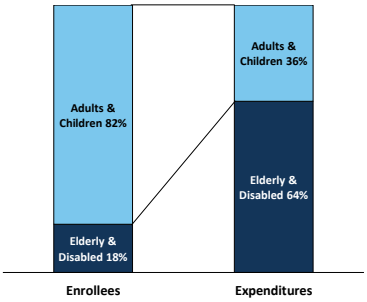
Per enrollee spending growth in the US, 2007-2013



In FY 2015, Medicaid spending in CA was $85.4 billion.



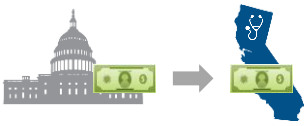
In 2011, most Medicaid beneficiaries in CA were children and adults, but most spending was for the elderly and people with disabilities.



Federal funding to states is guaranteed with no cap and fluctuates depending on program needs.

In CA the federal share (FMAP) is 50%. For every **$1** spent by the state, the Federal government matches **$1**.

Expansion states receive an increased FMAP for the expansion population. CA received **$28.0 billion** in federal funds for expansion adults from Jan 2014 – Sept 2015.



0.52
is the Medicaid-to-Medicare physician fee ratio in CA.

64%
of long-term care spending in CA is for home and community-based care.

85%
of beneficiaries in CA are in managed care plans.

1.3 million
Medicare beneficiaries (27%) in CA rely on Medicaid for assistance with Medicare premiums and cost-sharing and services not covered by Medicare, particularly long-term care.

34%
of Medicaid spending in CA is for Medicare beneficiaries.

19%
of state general fund spending in CA is for Medicaid.

58%
of all federal funds received by CA is for Medicaid.

What are the implications of reduced federal financing in a Medicaid block grant or a per capita cap?

Congress may soon debate proposals to reduce federal Medicaid funding through ACA repeal and federal caps.

The March 2016 Budget Resolution would reduce federal Medicaid spending by **41%** nationally over the 2017-2026 period.

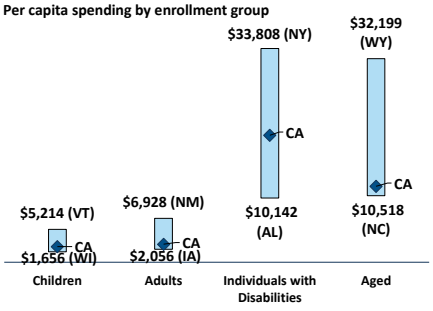
Total reduction in federal funds:
$2.1 trillion

The impact of a block grant or per capita cap will depend on funding levels, but could include:

- Increases in the number of uninsured
- Reduced access and service utilization, decreased provider revenues (to hospitals, nursing homes, etc.), and increased uncompensated care costs
- Increased pressure on state budgets
- Decreased economic activity

A per capita cap could lock in historical state differences or redistribute federal funds across states.

Per capita spending by enrollment group



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January 2017

CALIFORNIA COLLABORATIVE FOR LONG TERM SERVICES & SUPPORTS

FACT SHEET:
The Developing Crisis in Medicaid

OVERVIEW

- Medicaid is especially vulnerable in the current complex environment, because block granting Medicaid was part of the new administration's platform and is a top priority of the Speaker and the incoming Health and Human Services Secretary. It serves the poorest and does not have powerful constituencies to protect it.

- Cuts to Medicaid will likely be packaged as "reform" or "flexibility." *However, the current proposals would represent dramatic cuts.* In the case of block granting, Medicaid could be expected to lose 33% of its value in 10 years, with cuts deepening beyond that year-over-year.

- This would require rationing of care across Medicaid, but would land particularly hard on people whose lives depend on the program - vulnerable elderly and disabled people who require long term services in their daily lives.

- These populations include people with mental and developmental disabilities, dementia, the deaf, blind and otherwise seriously disabled, and frail elderly people who do not have resources to take care of themselves in serious illness so are forced into expensive nursing homes against their will.

- They have the highest needs and the highest costs. Even before Medicaid, their care was historically the responsibility of the state, which ran expensive and inhumane large-scale institutions.

- If the federal government walks away, frail elderly and disabled people will again become primarily the responsibility of state and local governments.

- This is occurring at the moment of a demographic boom of increased population that will become a nightmare scenario of enormous expense, homelessness and widespread human suffering if we do not take prudent actions.

- We have learned again and again that rationing appropriate and community-based care to these populations increases their costs. If the state rations care as a result of loss of federal funding, costs for emergency care, hospitalization, nursing homes, and other institutionalization will multiply exponentially.

Several Key Approaches to Navigate the Crisis

- Aged, blind and disabled populations are not "Medicaid as usual." They are unique populations with very high needs and must receive appropriate services to prevent escalating costs to state and local governments.
- To manage reduced federal funding and significant population growth at the same time, the state must develop and expand proven best practices that are known to result in lower per capita costs.
- These best practices include global budgeting to be able to provide the right services at the right time, utilizing efficient community-based services, improving crisis responses, diversion from institutions, discharge planning, coordination of care, transitional care, efficient analytics, and addressing social determinants of health.
- These best practices and models of care must be the cornerstone of efforts to manage costs, *because rationing care to this population will only result in higher costs.*
- These changes will likely occur very rapidly. California policymakers must prepare for a significant mindshift, understanding that in the current crisis, knee-jerk efforts to ration care to the aged, blind and disabled will backfire. The solution to the crisis of managing costs for the elderly and disabled is to aggressively develop and pursue the best practices and models of care that are known to be effective for providing appropriate care and controlling costs.

Prepared by Laurel Mildred, Laurel.Mildred@mildredconsulting.com and Sue North, SNorthCA@gmail.com

Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

November 30, 2016

Medicaid Block Grant Would Slash Federal Funding, Shift Costs to States, and Leave Millions More Uninsured

By Edwin Park

If confirmed, President-elect Trump's nominee for Health and Human Services Secretary — House Budget Committee Chair Tom Price — will be well-placed to advance a proposal that he's previously supported as part of recent House Republican budget plans to fundamentally change the structure of Medicaid by converting it into a block grant.[1] Trump[2] and House Speaker Paul Ryan[3] also have supported converting Medicaid into a block grant, which would likely eliminate the guarantee that everyone who's eligible and applies for its benefits would receive them and probably give states sweeping new authority to restrict eligibility, cut benefits, and make it harder for people to enroll. The incoming White House and Republican congressional leaders are reportedly planning to pursue such a block grant in 2017, in addition to repealing the Affordable Care Act (ACA).[4]

A Medicaid block grant would institute deep cuts to federal funding for state Medicaid programs and threaten benefits for tens of millions of low-income families, senior citizens, and people with disabilities. To compensate for these severe funding cuts, states would likely have no choice but to institute draconian cuts to eligibility, benefits, and provider payments. To illustrate the likely magnitude of these cuts, an analysis from the Urban Institute of an earlier block grant proposal from

[1] The past two House Republican budget plans crafted by Rep. Price included a Medicaid block grant, though the fiscal year 2017 budget plan included the option of states electing a "per capita cap" instead. See Edwin Park, "Medicaid Block Grant Would Add Millions to Uninsured and Underinsured," Center on Budget and Policy Priorities, March 15, 2016, http://www.cbpp.org/blog/medicaid-block-grant-would-add-millions-to-uninsured-and-underinsured and Edwin Park, "Proposed Medicaid Block Grant Would Add Millions to Uninsured and Underinsured," Center on Budget and Policy Priorities, March 17, 2015, http://www.cbpp.org/blog/proposed-medicaid-block-grant-would-add-millions-to-uninsured-and-underinsured.

[2] See President-elect Donald J. Trump's campaign website, https://www.donaldjtrump.com/policies/health-care/, accessed November 23, 2016.

[3] As part of his "Better Way" health plan he announced this year, Speaker Ryan proposed to give states the choice of either a Medicaid block grant or a per capita cap. In addition, past budget plans crafted by Speaker Ryan when he was chair of the House Budget Committee included a Medicaid block grant. See Edwin Park and Judith Solomon, "Per Capita Caps or Block Grants Would Lead to Large and Growing Cuts in State Medicaid Programs," Center on Budget and Policy Priorities, June 22, 2016, http://www.cbpp.org/research/health/per-capita-caps-or-block-grants-would-lead-to-large-and-growing-cuts-in-state and Edwin Park, "Ryan Block Grant Would Cut Medicaid by More than One-Quarter by 2024 and More After That," April, 4, 2014, http://www.cbpp.org/research/ryan-block-grant-proposal-would-cut-medicaid-by-more-than-one-quarter-by-2024-and-more.

[4] See, for example, Phil Galewitz, "Millions Could Lose Medicaid Coverage under Trump Plan," Kaiser Health News, November 9, 2016, http://khn.org/news/millions-could-lose-medicaid-coverage-under-trump-plan/.

Speaker Ryan found that between 14 and 21 million people would eventually lose their Medicaid coverage (on top of those losing coverage if policymakers repeal the ACA and its Medicaid expansion) and that already low provider payment rates would be reduced by more than 30 percent.

A block grant would cap federal Medicaid funding in order to achieve savings for the federal government. Under current law, the federal government picks up a fixed percentage of states' Medicaid costs: about 57 percent, on average (outside of the ACA's Medicaid expansion). In contrast, under a block grant, states would receive a fixed dollar amount, with states responsible for *all* Medicaid costs in excess of the cap. Because a Medicaid block grant is explicitly intended to produce significant federal budgetary savings, block grants are designed in ways that give states considerably less federal funding each year than they would receive under the current financing system. That is typically accomplished by basing a state's initial block grant amount on its current or historical spending and then increasing it annually at a considerably slower rate — such as general inflation — than the currently projected annual growth in federal Medicaid spending. The resulting federal funding cuts would thus grow steadily larger each year.

The likely magnitude of the federal funding cuts and resulting cost-shift to states would be very large. The House Republican budget plan for fiscal year 2017, for example, would have cut federal Medicaid funding by $*1 trillion* — or nearly 25 percent — over ten years, relative to current law, *on top of* the cuts the plan would secure from repealing the ACA's Medicaid expansion.[5] By the budget plan's tenth year (2026), federal funding for Medicaid and the Children's Health Insurance Program (CHIP) would have been $169 billion — or about *33 percent* — less than under current law (see Figure 1). The size of the cuts would have kept growing after 2026.

Moreover, the actual cut in federal funding for states, relative to current law, would be even greater in years when either enrollment or per-beneficiary health care costs rose faster than expected. For example, as people lose their jobs and access to employer-sponsored insurance during a recession, many become newly eligible for and enroll in Medicaid. In addition, developments in new treatments that improve beneficiaries' health but raise costs, and the onset of epidemics or new illnesses like Zika (or HIV/AIDS in the 1980s), can produce significant unexpected increases in medical costs.[6]

Currently, the federal government and states share in those unanticipated costs. Under a block grant, however, states alone would bear them. Furthermore, while all states would face substantial reductions in federal funding under a block grant, some would likely be hit particularly hard — such as states whose current Medicaid spending levels are already relatively low and states whose spending is expected to rise relatively quickly in future years due to demographic, economic, or other factors.[7]

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[5] See Park, *op cit.*

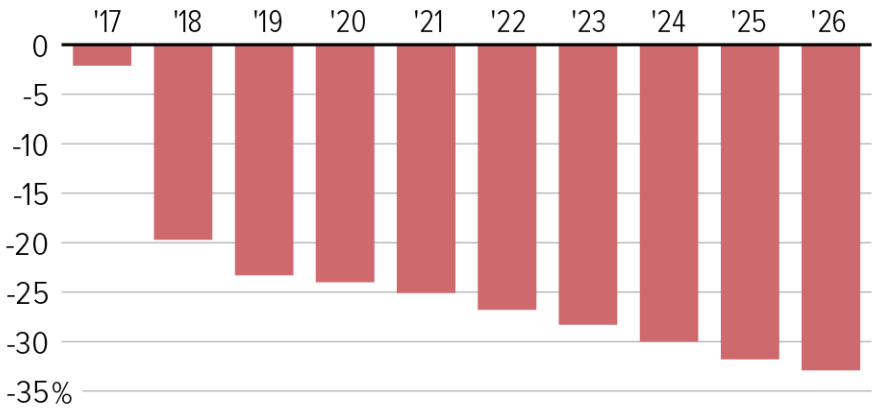
[6] See, for example, Edwin Park and Matt Broaddus, "Medicaid Block Grant Would Shift Financial Risks and Costs to States," Center on Budget and Policy Priorities, February 23, 2011, http://www.cbpp.org/research/medicaid-block-grant-would-shift-financial-risks-and-costs-to-states.

[7] See Edwin Park and Matt Broaddus, "Medicaid Block Grant Would Produce Disparate and Inequitable Results Across States," Center on Budget and Policy Priorities, March 10, 2011, http://www.cbpp.org/research/medicaid-block-grant-would-produce-disparate-and-inequitable-results-across-states and John Holahan and Matthew Buettgens, "Block Grants and Per Capita Caps: The Problem of Funding Disparities among States," Urban Institute, September 8, 2016, http://www.urban.org/research/publication/block-grants-and-capita-caps.

FIGURE 1

Medicaid Cuts Would Grow Over Time Under House Budget Committee Block Grant

Percent cut in federal Medicaid funds, relative to current law



Source: CBPP analysis using Jan. 2016 Congressional Budget Office Medicaid baseline and House Budget Committee documents.

CENTER ON BUDGET AND POLICY PRIORITIES | CBPP.ORG

Such a block grant would push states to cut their Medicaid programs deeply. To compensate for the federal Medicaid funding cuts a block grant would institute, states would either have to contribute much more of their own funding or, as is far more likely, use the greater flexibility the block grant would give them to make draconian cuts to eligibility, benefits, and provider payments. For example, Speaker Ryan's "Better Way" health plan would give states the choice of a block grant or a Medicaid per capita cap; both would appear to enable states to make sizeable cuts directly affecting beneficiaries that states can't make now. This could include using waiting lists or capping enrollment; under current law, all eligible individuals who apply for Medicaid must be allowed to enroll. States also could be allowed to no longer provide children with a comprehensive pediatric benefit known as EPSDT (Early Periodic Screening, Diagnostic, and Treatment), under which children enrolled in Medicaid receive both regular check-ups and coverage for all medically necessary treatments that the check-ups find a child needs.

In addition, states could be permitted for the first time to impose a work requirement and terminate coverage for people deemed non-compliant. This could result in people with various serious barriers to employment — such as people with mental health or substance use disorders, people who have difficulty coping with basic tasks or have very limited education or skills, and people without access to child care or transportation — going without health coverage.[8] States would also likely be able to begin charging significant premiums, deductibles, and co-payments at levels that research suggests would likely cause poor people to forgo coverage entirely or go without needed care.

[8] Hannah Katch, "Medicaid Work Requirement Would Limit Health Care Access Without Significantly Boosting Employment," Center on Budget and Policy Priorities, July 13, 2016, http://www.cbpp.org/research/health/medicaid-work-requirement-would-limit-health-care-access-without-significantly.

Medicaid is already efficient and innovative. Block grant supporters, including House Republican leaders, often argue that states could compensate for the substantial losses in federal funding they would experience under a block grant by using added flexibility to cut costs without harming beneficiaries. That claim doesn't withstand scrutiny. Medicaid costs per beneficiary already are far below those of private insurance, after adjusting for differences in health status, due to lower payment rates to health care providers and lower administrative costs, even though Medicaid provides more comprehensive benefits than private insurance at significantly lower out-of-pocket cost to beneficiaries. And over the past three decades, they have also grown much more slowly, on average, than private insurance per-beneficiary costs.[9] They are expected to continue growing more slowly than costs under private insurance in coming years, according to the Medicaid and CHIP Payment and Access Commission.[10]

In addition, states already have substantial flexibility in how they deliver Medicaid services. For example, they have dramatically expanded the use of managed care over the last two decades, instituted cost-containment strategies in areas like prescription drug spending, and in recent years, have adopted numerous innovative reforms in how they deliver care to Medicaid beneficiaries that improve quality of care while lowering costs.[11]

A Medicaid block grant would thus lead to draconian cuts to eligibility, benefits, and provider payment rates. As the Congressional Budget Office concluded in 2012 when analyzing a Medicaid block grant proposal from then-House Budget Committee Chairman Paul Ryan: "the magnitude of the reduction in spending . . . means that states would need to increase their spending on these programs, make considerable cutbacks in them, or both. Cutbacks might involve reduced eligibility, . . . coverage of fewer services, lower payments to providers, or increased cost-sharing by beneficiaries — all of which would reduce access to care."[12] The Urban Institute estimated that the 2012 Ryan proposal would lead states to drop between *14.3 million and 20.5 million* people from Medicaid by the tenth year (in addition to the effects of repealing health reform's Medicaid expansion).[13] That's an enrollment decline of 25 to 35 percent. Urban also estimated that the 2012 Ryan block grant would lead states to cut reimbursements to health care providers by more than *30 percent*, even though, as noted, provider payments are already much lower than what private insurance and Medicare pays. That could result in many fewer providers and health plans participating in Medicaid, making it far more difficult for beneficiaries to obtain needed care.

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[9] Edwin Park *et al.,* "Frequently Asked Questions About Medicaid," Center on Budget and Policy Priorities, updated August 10, 2016, http://www.cbpp.org/research/health/frequently-asked-questions-about-medicaid.

[10] Medicaid and CHIP Payment and Access Commission, "Report to Congress on Medicaid and CHIP," June 2016, https://www.macpac.gov/wp-content/uploads/2016/06/Trends-in-Medicaid-Spending.pdf.

[11] Hannah Katch, "States Are Using Flexibility to Create Successful, Innovative Medicaid Programs," Center on Budget and Policy Priorities, June 13, 2016, http://www.cbpp.org/research/health/states-are-using-flexibility-to-create-successful-innovative-medicaid-programs.

[12] Congressional Budget Office, "The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan," March 2012, http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-20-Ryan_Specified_Paths_2.pdf.

[13] John Holahan *et al.*, "National and State-by-State Impact of the 2012 House Republican Budget Plan for Medicaid," Kaiser Commission on Medicaid and the Uninsured, October 1, 2012, http://kff.org/health-reform/report/national-and-state-by-state-impact-of/.

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

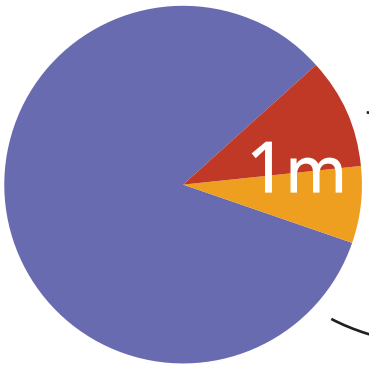
FACT SHEET

Repealing the ACA Threatens California Seniors

The repeal of the Affordable Care Act (ACA) without replacement threatens 7.6 million older adults living in California who rely on Medicare, Medi-Cal, and the ACA to see a doctor, receive care in their home, and pay for prescription drugs. Here are some of the dangers California seniors would face if the ACA is fully repealed.

1 million Californians age 55-64 would lose coverage.

The ACA expanded coverage for individuals age 55-64 through Covered California and through the expansion of Medi-Cal. If the ACA is repealed, these individuals would lose access to affordable coverage.

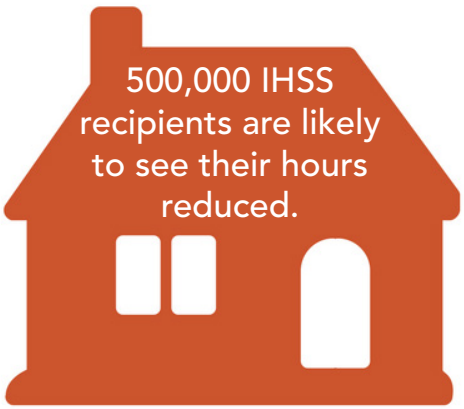


600,000 have obtained coverage through the Medi-Cal expansion.

Approximately 400,000 adults age 55-64 purchased health insurance through Covered California—93% of whom receive subsidies to purchase their coverage.

4.9 million Californians in total would lose coverage.

IHSS and other home and community-based services would be threatened.



The ACA increased critical support for programs that help keep seniors and people with disabilities in their homes and in the community through programs like the Community First Choice Option (CFCO).

If CFCO and other LTSS programs are repealed, 500,000 IHSS recipients could see their hours reduced. Home and community-based programs authorized under the 1115 waiver like the Community Based Adult Services (CBAS) program are also put at risk. Without these robust programs, more seniors would be forced to seek care in institutional settings like nursing facilities.

Seniors and people with disabilities would pay more in Medicare costs.

The ACA helped people with Medicare by closing the Medicare "donut hole" and providing free preventive services.

- One in four Medicare Part D enrollees has high enough prescription drug spending to fall into the Medicare "donut hole."

  This means 9 million seniors and people with disabilities would face higher prescription drugs costs.

- Since 2010, Medicare enrollees have saved $2,272 per person on prescription drugs.
- Seniors and beneficiaries would also see costs rise for Medicare preventive services.

More than 39 million Medicare enrollees benefited from free preventive care in 2015.

Dual eligibles would be at greater risk.

Cal MediConnect serves 113,000 dual eligibles.

The ACA allowed California to adopt innovative programs like Cal MediConnect that seek to improve care coordination for seniors. Cal MediConnect serves 113,000 dual eligibles.

A full repeal of the ACA would threaten the Cal MediConnect program, and other programs that California is currently implementing to better coordinate care including the Health Homes Program and Whole Person Care Pilots.

ACA repeal would destabilize all health care programs.

Medicare and Medicaid are bedrock programs that older adults rely on for care.

Fully repealing the ACA places both of these programs in greater financial peril and in danger of dramatic budget cuts, block grants, per capita caps, vouchers, and privatization. For example, California would lose $160.2 billion in federal funding if the ACA is repealed. To make up this enormous loss of federal funding, California would have to make drastic choices. Seniors can't afford these risks.

WASHINGTON
1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES
3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND
1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055

Repeal of the ACA—Without a Replacement—Threatens California Seniors

There are currently 7.6 million older adults living in California who rely on Medicare, Medi-Cal, and the Affordable Care Act (ACA) to see a doctor, receive care in their home, and pay for prescription drugs. The repeal of the ACA threatens these critical programs, jeopardizing the care seniors receive every day.

California has led the way in expanding health insurance coverage under the ACA, reducing the uninsured rate by over 50 percent. If the ACA is repealed, 4.9 million Californians will lose coverage, including over one million older adults ages 55-64. Repealing the ACA would also end programs that help keep seniors and people with disabilities living in their homes. For example, nearly 500,000 older adults and persons with disabilities could see reductions in their In-Home Supportive Services (IHSS) benefits if the ACA is repealed. Older adults in California will also face higher prescription drug costs when they fall into the Medicare "donut hole." Further, an ACA repeal without replacement puts both Medicare and Medi-Cal at greater risk for cuts in the coming year. This post describes just some of the dangers seniors in California will face if the ACA is repealed.

Eliminating coverage for adults 55-64

California increased coverage to adults ages 55-64 by offering marketplace plans through Covered California and through the expansion of Medi-Cal. Before the ACA, these older adults struggled to find and afford coverage. Now more than a million of those older adults are covered. Approximately 400,000 adults age 55-64 purchased health insurance through Covered California – 93% of whom receive subsides to purchase their coverage. Another 600,000 have obtained coverage through the Medi-Cal expansion. If the ACA is repealed, more than one million older adults in California will lose coverage and will not be able to afford needed medical care or prescription drugs.

Threatening IHSS and other home and community based services

In addition to expanding coverage for more than one million older adults, the ACA provides critical support for programs that help keep seniors and people with disabilities in their homes and in the community. The Community First Choice Option (CFCO) program increases federal funding for home and community-based services. California applied for CFCO in 2011 and now receives 6% more in federal funding for more than 50% of IHSS recipients—nearly 250,000. Consequently if the ACA is repealed, all 500,000 IHSS recipients, whether in the CFCO program

or other IHSS programs, are likely to see their hours reduced in order to make up for the loss in federal funding. These cuts would threaten IHSS recipients' ability to remain safely in their homes.

ACA repeal and changes in leadership at the Centers for Medicare and Medicaid Services could also impact California's 1115 waiver, "Medi-Cal 2020," which currently authorizes the provision of Community Based Adult Services (CBAS). CBAS is an important program that helps to ensure older adults can remain living in the community through the provision of skilled nursing care, social services, therapy, nutrition services, and more at adult day health care centers. Without these robust programs, more seniors will be forced to seek care in institutional settings like nursing facilities.

Increasing costs for seniors and people with disabilities

The impact of the ACA repeal would also likely lead to cuts in other health benefits and increased out-of-pocket costs for older adults. In total, California will lose $160.2 billion in federal funding under repeal. To make up this enormous loss of federal funding, California will have to make drastic choices. It could eliminate optional Medi-Cal benefits like dental coverage or begin charging premiums for Medi-Cal services. Older adults could be faced with paying for services out-of-pocket, forgoing treatment, or seeking services in emergency rooms.

The ACA also made Medicare more affordable for older adults in a number of ways. It eliminated the Medicare Part D "donut hole," which decreased high out-of-pocket prescription drug costs for seniors and adults with disabilities. According to MedPAC, if the ACA is repealed one in four Medicare Part D enrollees will fall back into the coverage gap. This means that older adults in California will again have to make the difficult choice between paying for necessities like rent or food and paying for their prescription drugs. The ACA also expanded the number of preventative services that individuals receive for free including yearly wellness exams, screenings for cardiovascular disease and diabetes, mammograms, and flu shots. If repealed, Medicare recipients will see out-of-pocket costs rise for these preventative services.

Diminishing innovation and protections for seniors

The ACA allowed California to adopt innovative programs that benefit seniors by improving care coordination. California adopted the Cal MediConnect program, which coordinates enrollees' Medicare and Medi-Cal benefits with the goals of improving quality of care, keeping people living in the community, and reducing health care spending. Early data shows that Cal MediConnect plans are helping enrollees remain living in the community and transition out of nursing facilities. Currently, the Cal MediConnect program serves approximately 113,000 dual eligibles. If repealed, dual eligibles would transition back into a fragmented system to navigate care on their own. Repeal would also threaten the Health Homes Program, which California is currently implementing to better coordinate care for people with chronic health care

conditions, and the Whole Person Care Pilots aimed at improving health outcomes for the sickest Californians through coordination of health, behavioral health, and social services.

Repealing the ACA puts California seniors' health at risk

California was a leader in ACA implementation to the enormous benefit of older adults. The repeal of the ACA, therefore, would be especially detrimental in California where millions of individuals have gained coverage and access to better and more affordable health care. The loss of both the federal funding and the expansion of innovative health programs provided by the ACA would be catastrophic to older adults in California who deserve a system which supports their health and well-being.

*An electronic version of this summary is available at http://www.justiceinaging.org/repeal-aca-without-replacement-threatens-california-seniors/

Meghan Rose, Esq.

Director of Policy, Housing and HCBS
LeadingAge California

Who We Are

LeadingAge California

- Founded in 1961, LeadingAge California is the state's leading advocate for quality, not-for-profit senior living and care.
- LeadingAge California represents more than 400 nonprofit providers of senior living and care – including affordable housing, continuing care retirement communities, assisted living, skilled-nursing, and home and community- based care.
- Our members serve more than 100,000 of the CA's older adults.

The Issue

California needs about 1.5 million more affordable rental homes to meet the needs of its lowest income residents. Of those who are in most need of rental assistance in California – those who pay more than half their income for rent – 35 percent are elderly or disabled households.

The Issue

There are not enough affordable housing units to house our growing older adult population.

- In less than 15 years, 1 in 5 people in the U.S. will be over age 65, and in 25 years, 1 in 8 will be over age 75.
- One third of adults (nearly 20 million people) aged 50 and over pay more than 30% of their income for housing. Of that group, nearly half pay more than 50% of their income for housing.
- The typical renter over age 65 can only afford two months of long-term services and supports, like assisted living.
- Of 3.9 million low-income older renters eligible for housing assistance in 2011, only 1.4 million actually received assistance.

What is Affordable Housing?

Housing is considered affordable when the tenant pays no more than 30% of their income toward housing costs.

- A person is considered “rent burdened” when they pay more than this.
- Senior housing often includes persons with disabilities.
- Need two financing streams to fund affordable housing:
    - Funding for construction; and
    - Funding for the ongoing subsidy or rental assistance.

Why Affordable Housing is Critical for Seniors

Housing IS Healthcare

- The rate of older adults experiencing homelessness is growing. The number of older adult experiencing homeless is expected to double between 2010 and 2050. Chronically homeless adults do not improve their health without housing.

- Older adults have a special set of housing needs that should be considered when drafting housing policy. For instance, despite a median age of 57, homeless older adults have health conditions and functional status similar to, or worse than, an average adult in his or her 70s or 80s.

- A small percentage of individuals use a large percentage of healthcare resources. Housing can reduce healthcare costs, reduce mortality, and improve quality of life.

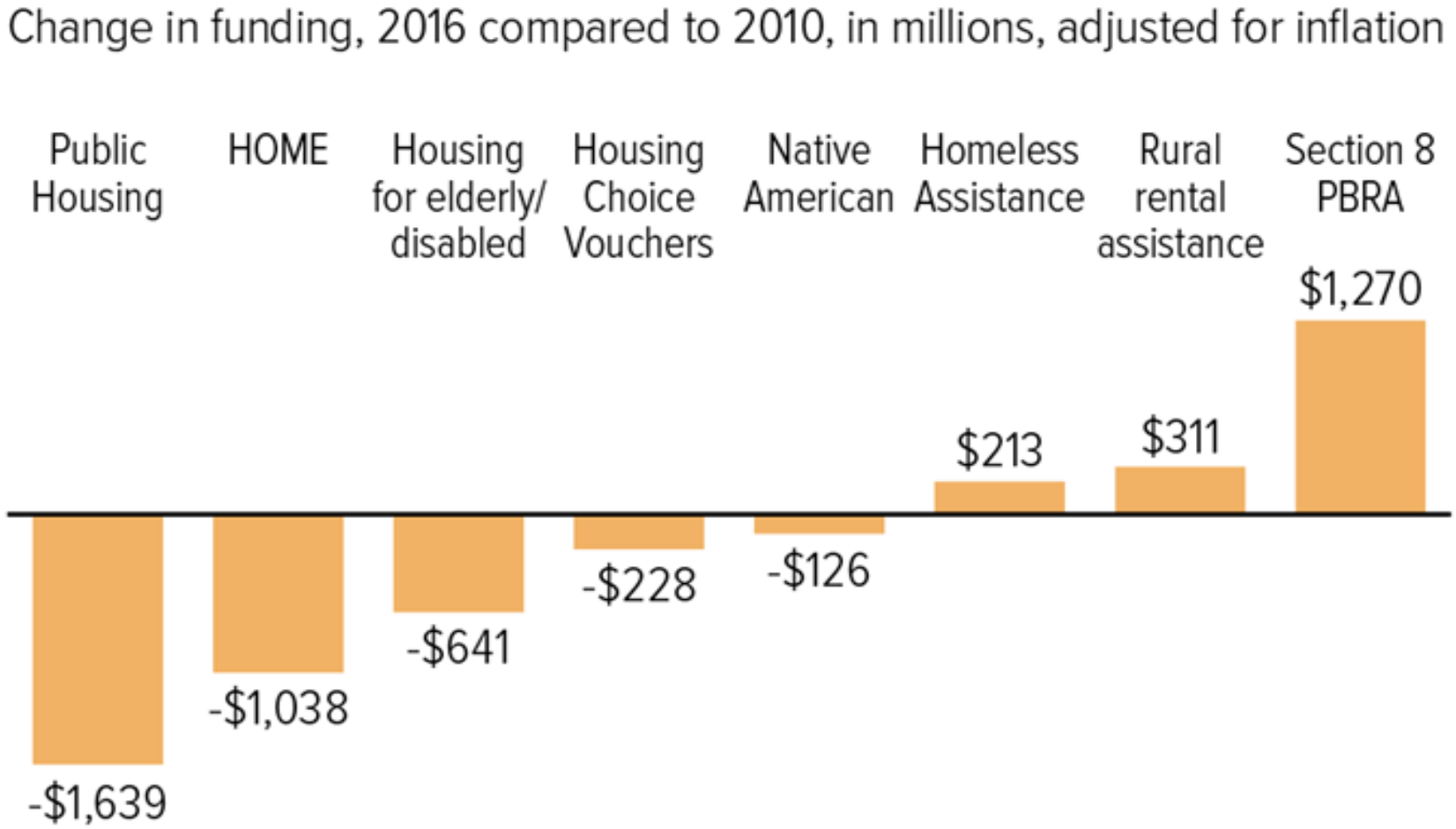
- Funding sources must allow for the creation of supportive housing – subsidized housing with onsite or closely linked social and health services. Supportive housing can reduce the size of government and improve health outcomes.

Financing New Units is Harder Than Ever

Three of four financing mechanisms have been eliminated or depleted:

- Redevelopment: In 2011, California eliminated funding to more than 400 redevelopment agencies.
- HUD 202: The same year, Congress eliminated capital advance grant funding for the HUD 202 program.
- Bond Financing: State investment through general obligation bonds (Prop. 46 (2002) and Prop. 1C (2006)) built, rehabilitated, or preserved 174,000 affordable apartments.
- All told, these cuts have reduced California's investment in the development and rehabilitation of affordable homes by more than $1.7 billion annually. State dollars that leverage federal and local funds and private investment is the lowest it has been in years.

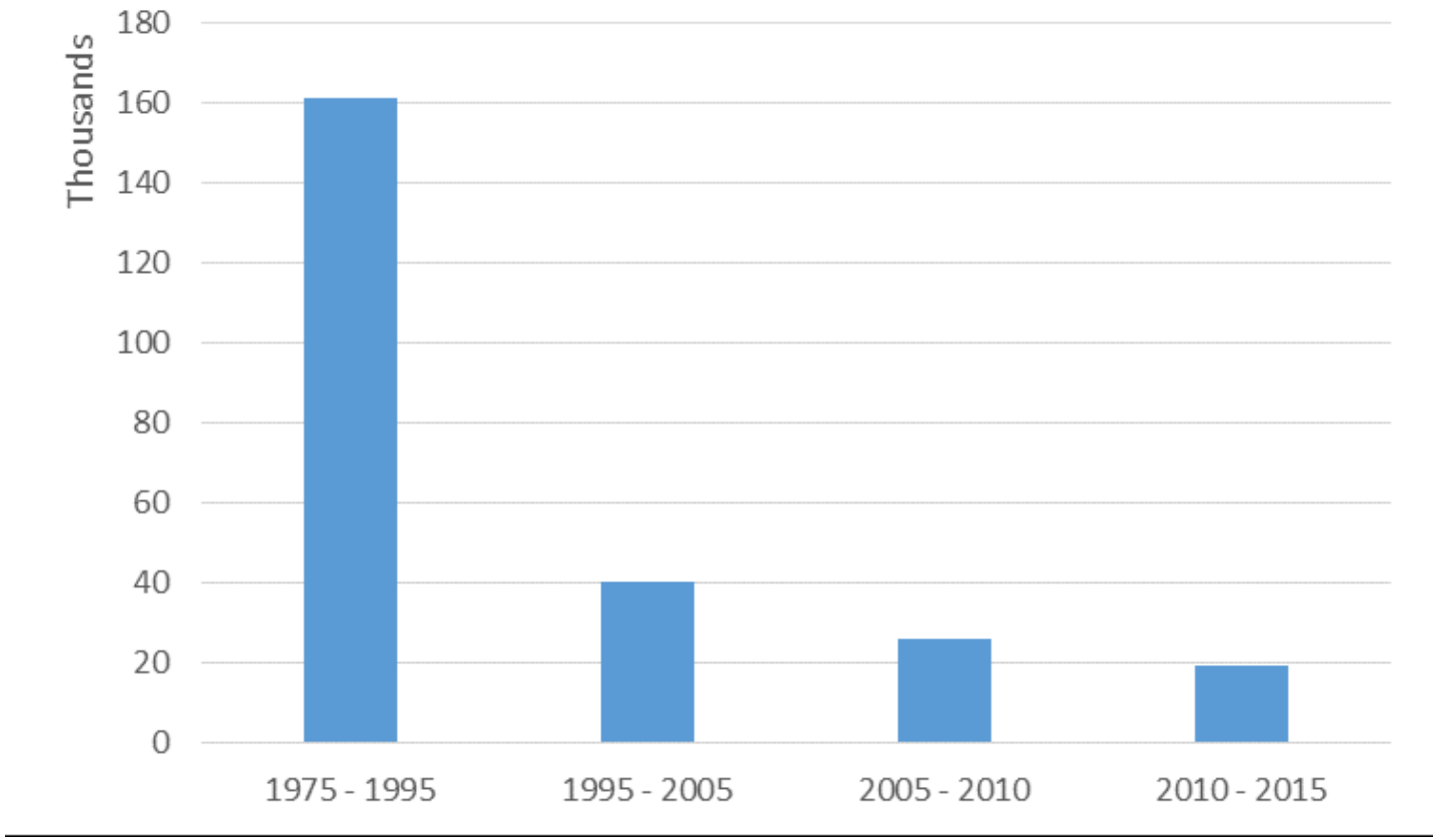
Cuts to Federal Housing Programs



Source: CBPP

Cuts to Federal Housing Programs

Rental assistance expansion has slowed drastically since the mid-1990s



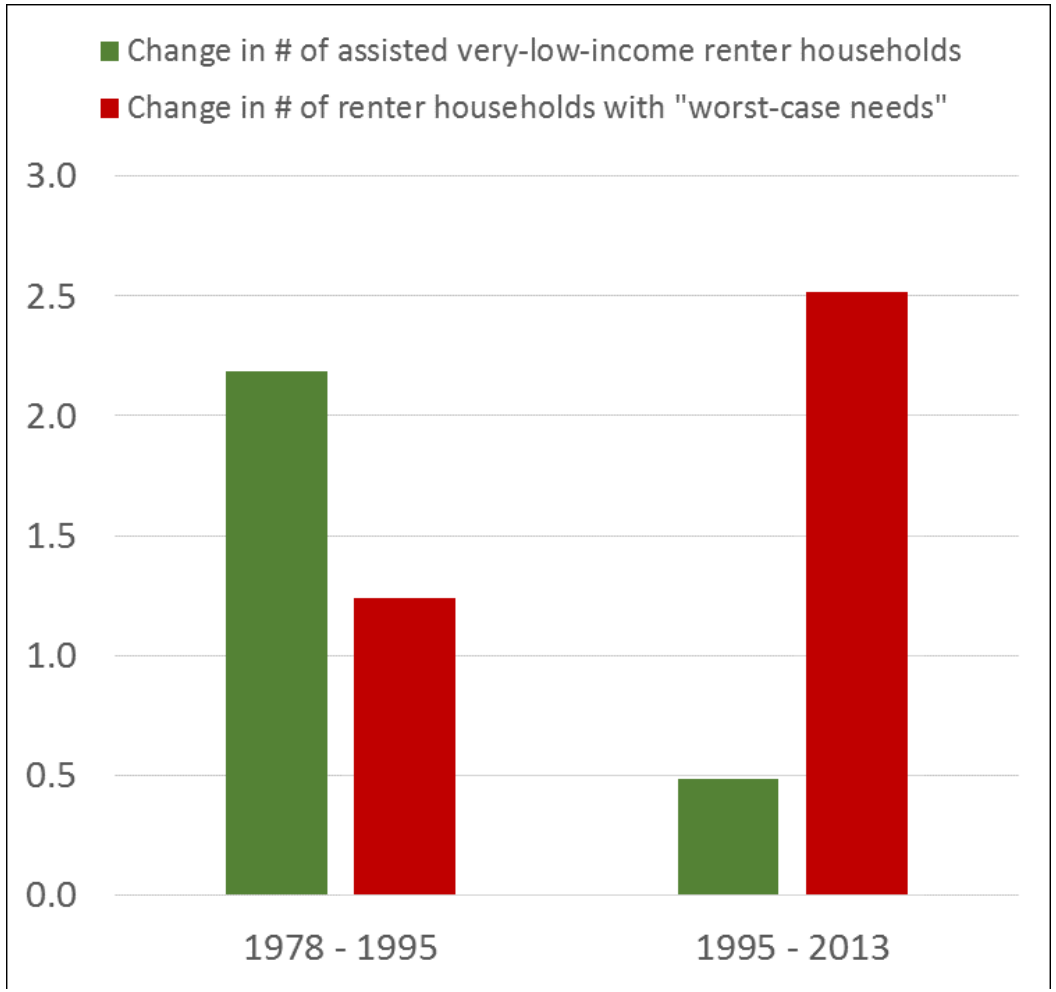
Source: CBPP

Cuts to Federal Housing Programs

Current federal assistance is far below 2010 levels

- As rental assistance expansion has slowed, growth in “worst-case housing needs” has accelerated.
- From 1995 to 2013, “worst-case needs” rose by 2.5 million households – about twice the size of the growth from 1978 to 1995 -- to 7.7 million households.

Source: CBPP



Cuts to Housing Programs

What does this mean?

- Unit production is at an all-time low and HUD has indicated that it is phasing out of the business of creating new units.
- Without the ability to create new units, HUD has to focus on preserving existing housing stock.
- This federal policy puts burden on states and LITHC programs to fund new development.
- HUD will require increase of more than $1 billion to sustain rental assistance for current contracts, cover expected decline in FHA receipts.

California Weighs In

Recent statewide efforts do not benefit seniors:

- Affordable Housing and Sustainable Communities Program (AHSC): Funded through cap and trade auction revenues. Due to recent action by the SGC, AHSC does not fund senior projects.

- No Place Like Home: $2 billion for supportive housing, exclusively for persons with severe mental illness who are chronically homeless. Does not apply to persons with cognitive impairment like dementia or Alzheimer's.

CA Legislation 2017

Recently introduced legislation that will help build housing:

AB 71 (Chiu) – The Bring California Home Act: This bill provides an ongoing state funding source for affordable housing by eliminating the state mortgage interest deduction on vacation homes. This deduction results in a revenue loss to the state of approximately $300 million annually. The funds saved as a result of eliminating the deduction would then increase the Low Income Housing Tax Credit (LIHTC) program by $300 million per year.

AB 72 (Santiago) – Increased Enforcement of Existing State Housing Laws: This bill appropriates funds to the Attorney General to enforce existing state housing laws.

AB 73 (Chiu) – Spur Production of High-density, Transit-oriented Housing: This bill spurs production of housing on infill sites around public transportation by incentivizing local governments to complete upfront zoning and environmental review and rewarding them when they permit housing.

CA Legislation 2017

Recently introduced legislation that will help build housing:

SB 2 (Atkins) – The Building Homes and Jobs Act: SB 2 is similar to last session's AB 1335. It seeks to fund construction of affordable homes on an ongoing basis through a modest recording fee on certain types of real-estate transactions, excluding home sales.

SB 3 (Beall) – The Affordable Housing Bond Act of 2018: SB 3 would authorize the issuance of general obligation bonds in the amount of $3,000,000,000. Proceeds from the sale of these bonds would be used to finance various existing housing programs, as well as infill infrastructure financing and affordable housing matching grant programs.

Questions?

Contact Meghan Rose

mrose@leadingageca.org

LeadingAge™ California
Formerly Aging Services of California

1315 I Street, Suite 100
Sacramento, CA 95814
Main 916-392-5111
Fax 916-428-4250
www.aging.org

ISSUE BRIEF

Increasing the Supply of Affordable Housing for Older Adults

BACKGROUND: Older adults are the fastest growing demographic in the United States. By 2035, 1 in 3 American households will be headed by someone aged 65 and older. As our older adult population grows, the demand for affordable, safe and supportive housing is growing as well. In California, 54 percent of adults 65 and older are living below 200 percent of the federal poverty threshold.

Our housing market has not supplied enough affordable homes to keep pace with demand, in part due to major cuts to federal and state housing programs:

- In 2002, California voters approved Proposition 46, which provided $2.1 billion for the development of affordable homes. At the time, this was the largest affordable housing ballot measure in U.S. history. Four years later, voters supported Proposition 1C, the Housing and Emergency Shelter Trust Fund Act, which provided $2.85 billion for the development of affordable homes and related infrastructure. In total, state investment through general obligation bonds built, rehabilitated, or preserved 174,000 affordable apartments. A decade later, funds available under Propositions 46 and 1C have run dry.

- In 2011, California eliminated funding to more than 400 redevelopment agencies within the State. Redevelopment funding was one of the few tools local governments had to support the development of affordable homes.

- The same year, Congress eliminated capital advance grant funding for the HUD 202 program – the government program that funds new construction of affordable homes for older adults.

All told, these cuts have reduced California's investment in the development and rehabilitation of affordable homes by more than $1.7 billion annually. This depletion of funding has created a dire financing situation for the development of affordable homes in California. State funding that leverages federal and local funds and private investment is the lowest it has been in years.

California needs about 1.5 million more affordable rental homes to meet the needs of its lowest income residents. Of those who are in most need of rental assistance in California – those who pay more than half their income for rent – 35 percent are elderly or disabled households.

Additionally, the Great Recession made the need for affordable housing even more urgent. The foreclosure crisis increased the number of renter households, driving up rents, while failing to make homeownership more accessible to low-income households. Median rents in California increased by over 20 percent from 2000 to 2012, while the median income dropped by eight percent.

The lack of affordable homes, coupled with the lack of funding for the development of new affordable housing, has created a dire situation for low- and moderate-income older adults - a population which is steadily increasing in number and living longer. The number of Californians age 85 and older is likely to more than double by the year 2030. Further, the average U.S. life expectancy is now age 78, up 10 years from 1950.

ISSUE: California needs to make a permanent investment in creating and sustaining affordable housing to keep pace with acute demand. The creation of a trust fund for the development, preservation, and rehabilitation of affordable homes will create jobs and spur economic growth.

RECOMMENDATION: Support SB 2 (Atkins), which seeks to fund construction of affordable homes on an ongoing basis through a modest recording fee on certain types of real-estate transactions, excluding home sales. In addition, bills like AB 71 (Chiu) and SB 3 (Beall) will help to increase the supply of affordable housing in California by expanding financing options.

CONTACT: Meghan Rose, Director of Policy – Housing and Home- and Community-Based Services, LeadingAge California, mrose@leadingageca.org, 1315 I Street, Suite 100, Sacramento, CA 95814, (916) 392-5111, (916) 428-4250 fax.

January 2017

CALIFORNIA COLLABORATIVE FOR LONG TERM SERVICES & SUPPORTS

FACT SHEET:
Poverty in California

General Poverty in California: The Nation's Worst Poverty Rate

- 14.9 percent of Californians live at or below the federal poverty threshold: a total of 5.78 million people. [October 2016] [WorldAtlas.com cites 15.8%]
- Using the Supplemental Poverty Measure, which factors in costs such as housing, the figure jumps to 20.6 percent, *the nation's highest poverty rate*. [October 2016, 20.6% = 7.99 million Californians; District of Columbia is the only region higher with rate of 22.2%]
- Within California, poverty hits some age groups harder: the youngest, the oldest, and those with disabilities have the highest poverty rates.

Sources: US Census, Current Population Survey, 2015 [using a three year average 2013-2015]; "Californians Have High Poverty, High Incomes," *Sacramento Bee*, December 2015; and "A Better Measure of Poverty Shows How Widespread Economic Hardship is in California," California Budget & Policy Center, October 2016

Poverty Among Seniors in California: The Nation's Worst and Not Improving

The "supplemental poverty measure" is a U.S. Census adjustment to reflect home owner status and regional housing costs, job-related expenses, tax credits and in-kind government benefits, and out-of-pocket costs for health care.

- **20.3 percent** of Californians age 65 and older have incomes below the supplemental poverty measure, the highest percentage for any state in the nation. [October 2016]
- The national average for states, using the supplemental poverty measure, is 15.1 percent of all seniors. [Three year average 2013-15]
- **Recovery is not reaching seniors**: poverty among California seniors increased 1 percent between 2009-11 and 2012-14. From 1999 to 2014 the rate increased by a total of 85 percent. This is more than double the rate of population growth among the elderly; in 2014-15 the state budget estimated that every day another 1,000 Californians would turn 65.

- Nearly a third of Latino seniors (32.8 percent) and nearly one quarter of other seniors of color (23.7 percent) live at or below the poverty line.

Sources: *A State-by-State Snapshot of Poverty Among Seniors*, Kaiser Family Foundation, May 2013; Poverty Among Seniors: An Updated Analysis of National and State Level Poverty Rates, Kaiser Family Foundation, June 2015; and "Poverty Rate Jumps Among California Seniors," *Sacramento Bee*, March 2016

Poverty and Employment Among Californians with Disabilities

A disability more than doubles your chance of living in poverty and more than halves your chance of getting a job.

California Disability Populations: 2014	Total
Working-age people with disabilities: poverty rate	27.1 percent
Working-age people with no disability: poverty rate	13.4 percent

- Of 1,914,600 adults of working age who have a disability, only 382,920 (20 percent) work full time, compared to more than half (52.8 percent) of the 20,825,700 million people in that age group who have no disability. [2014]
- In 2014, only 33.5 percent of individuals with a disability, ages 21 to 64, were working (either full- or part-time), compared to 75 percent of individuals without a disability. [74.7 percent was the exact figure]
- Only 13 percent of Regional Center clients, ages 18-65, receive wages – including those working part time and those paid a sub-minimum wage

Sources: 2013 Disability Status Report, Cornell University (published 2015); US Census Bureau 2011 analyzed by the State Council on Developmental Disabilities; and [Erickson, W., Lee, C., von Schrader, S. (2016). Disability Statistics from the 2014 American Community Survey (ACS). Ithaca, NY: Cornell University Yang Tan Institute (YTI). Retrieved Jan 11, 2017 from www.disabilitystatistics.org] Disability Statistics, Online Resource for U.S. Disability Statistics, Cornell University (website visited 2017)

Data on Government Programs and Payment

- SSI/SSP: enrolls 1.3 million California seniors and persons with disabilities
- SNAP: 4.4+ million Californians receive SNAP benefits, roughly 12 percent of the population

    - California Food Policy Advocates estimates that two million more Californians are eligible
- Government payments, especially Social Security, succeed at lowering the supplemental poverty rate for those over 64 from 48 percent to 21 percent.
- 33 percent of adults in California 65 and older in 2009-2011 lived below 200 percent of poverty; 33 percent was also reported for 2013. (Kaiser Family Foundation using U.S. Census data).
- 56 percent lived below 200 percent of the supplemental poverty measure in 2009-2011; 45 percent was reported for 2013.

Source: California Department of Finance; and, Kaiser Family Foundation using U.S. Census data

Additional Resources

U.S. Census Bureau, State by state comparison for 2013-15 of supplemental poverty measure versus federal poverty measure. Click on Table 4 of following: http://www.census.gov/library/publications/2016/demo/p60-258.html

"State Insights on Refining Integrated Care for Dually Eligible Beneficiaries," Center for Health Care Strategies (CHCS), December 2016. http://www.chcs.org/resource/state-insights-refining-integrated-care-dually-eligible-beneficiaries/

"Promising Practices to Integrate Physical and Mental Health Care for Medi-Cal Members," CHCS, June 2016.
http://www.chcs.org/media/BSCF-Brief_060716.pdf

"Poverty Among Seniors: An Updated Analysis of National and State Level Poverty Rates Under the Official and Supplemental Poverty Measures," The Henry J. Kaiser Family Foundation, June 2015
http://kff.org/report-section/poverty-among-seniors-issue-brief/

"Sequester Hurts the Most Vulnerable," The Spokesman-Review, May 4, 2013
http://www.spokesman.com/stories/2013/may/04/guest-opinion-sequester-hurts-the-most-vulnerable/

"Struggling to Get By: The Real Cost Measure in California in 2015," United Ways of California - *See report section on seniors in California; using the Elder Index the authors found that almost 1 in 3 (31 percent) of seniors in California are struggling to meet basic costs of living.* http://www.unitedwaysca.org/realcost

"The Hidden Poor: Over Three-Quarters of a Million Older Californians Overlooked by Official Poverty Line," UCLA Center for Health Policy Research, August 2015. http://healthpolicy.ucla.edu/publications/Documents/PDF/2015/HiddenPoor-brief-aug2015.pdf

Public Policy Institute of California, "The California Poverty Measure: A New Look at the Social Safety Net," October 2013. http://www.ppic.org/main/publication.asp?i=1070

"State Medicaid Managed Long-Term Services and Supports Programs: Considerations for Contracting with Medicare Advantage Dual Eligible Special Needs Plans," Center for Health Care Strategies, November 2016. http://www.chcs.org/media/State-MLTSS-Considerations-for-D-SNP-Contracting-FINAL-updated.pdf

Legislative Analyst's Office, "Disability Among California Seniors" http://www.lao.ca.gov/reports/2016/3509/disability-long-term-outlook-112816.pdf

Cornell's searchable data base for current statistics https://www.disabilitystatistics.org/

Annual Disability Statistics Compendium (various Federal databases used) http://www.disabilitycompendium.org/

Census data for 2015 using the Supplemental Poverty Measure http://www.census.gov/content/census/en/library/publications/2016/demo/p60-258.html

Prepared by Jack Hailey, Jack@gacinstitute.org

JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

CALIFORNIA HEALTH ADVOCATES
Medicare: Policy, Advocacy and Education

Disability Rights California

Disability Rights Education & Defense Fund DREDF

HCA
Health Consumer Alliance

WESTERN CENTER ON LAW & POVERTY

December 22, 2016

The Honorable Edmund Brown
Governor
State of California
State Capitol, Governor's Office
Sacramento, California 95814

Re: Coordinated Care Initiative

Dear Governor Brown,

The undersigned consumer advocacy organizations write to voice our concerns with the potential termination of California's Coordinated Care Initiative (CCI). The CCI is California's largest effort to transform its health care delivery system into a model that is integrated, coordinated, and person-centered, and the Cal MediConnect program is the largest dual demonstration project in the country.

The CCI has proven to be a substantial undertaking with no shortage of challenges. Under the program, over 1.2 million low-income seniors and persons with disabilities have gone through a significant transition in the way they receive their health care. That transition has been a difficult one for many beneficiaries and stakeholders. While early survey results show that many enrollees are satisfied with their care under the program, the program continues to face problems with providing better access to long-term services and supports and coordination of care.

Despite these challenges, consumer advocates are very concerned by the Governor's Budget Summary in January 2016 that if the program is not cost effective, it "would automatically cease operation in the following fiscal year." The dismantling of the program would represent yet another disruption in care to the 1.2 million beneficiaries enrolled in the program. It would only be appropriate to take such action after the state has worked with stakeholders to develop a thorough alternative plan to maintain continuity to benefits and providers that advances the goals of the CCI – a more coordinated, integrated, person-centered delivery system that shifts the delivery of LTSS from institutional to home and community based settings. Moving to

dismantle the CCI without such an alternative in place would be tantamount to repealing without replacing.

California's aging population is expected to nearly double by 2050, and poverty rates among seniors and persons with disabilities will continue to rise. The need for a fully integrated, person-centered delivery system is critical to providing quality health care and reducing health care spending. In the absence of any other plan or proposal that would attempt to advance these goals, California should commit to improving and strengthening the CCI program for existing enrollees not dismantling it.

Thank you for your consideration of this letter and our concerns. Please feel free to contact us to discuss in more detail.

Sincerely,

Kevin Prindiville, Executive Director
Justice in Aging

Gregory E. Knoll, Esq.
CCI Cal MediConnect Ombudsman Program

Tatiana Fassieux, Board Chair
California Health Advocates

Deborah Doctor, Legislative Advocate
Disability Rights California

Silvia Yee, Senior Staff Attorney
Disability Rights Education & Defense Fund

Gregory E. Knoll, Esq.
Health Consumer Alliance

Linda Nguy, Legislative Advocate
Western Center on Law & Poverty

Michael Cohen, Director, Department of Finance
Diana Dooley, Secretary, California Health and Human Services
Jennifer Kent, Director, Department of Health Care Services

CALIFORNIA COLLABORATIVE FOR LONG-TERM SERVICES & SUPPORTS

January 27, 2017

Hon. Philip Y. Ting
Assembly Budget Committee
State Capitol, Room 6026
Sacramento, CA 95814

Hon. Holly J. Mitchell
Senate Budget Committee
State Capitol, Room 5019
Sacramento, CA 95814

Re: 2017-18 Budget Requests for Aging and Disability Issues

Dear Assembly Member Ting and Senator Mitchell:

The California Collaborative for Long Term Services and Supports (CCLTSS) is a coalition of 31 aging and disability statewide organizations that promote dignity and independence in long-term living. We meet regularly to discuss policy and budget issues.

As we have communicated with the Legislature in the past, the Collaborative is concerned with the growing demographic of California seniors and people with disabilities and the lack of readiness of the systems and supports that enable them to live with dignity and independence in community-based settings, rather than in inappropriate and expensive institutional settings.

The looming changes in federal health care policy exacerbate these concerns, with aged, blind and disabled populations at high risk. The rapidly growing demographic of people with greater needs, combined with uncertainty around federal policy and a fragmented and unprepared state delivery system for long-term services and supports (LTSS), represents a perfect storm for some of our most vulnerable citizens.

<u>These are some of the demographic trends:</u>

- 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.

We believe that despite the uncertainties of the moment, we should not defer progress in improving and stabilizing our LTSS system. Kicking the can down the road isn't going to prepare us for the massive challenges ahead. As such, we are recommending several investments to strengthen and stabilize the LTSS system of care in the current year's budget.

Nutrition Services

There has been 57% growth in seniors who qualify for Medi-Cal since 2011, but California's nutrition services for elderly, isolated and homebound adults are not able to keep pace with needs, serving only 1.8% of seniors who are at risk of hunger. $12.5 million is needed to keep pace; this will provide services to approximately 6% of the burgeoning new senior population in Medi-Cal. A Brown University Study has estimated that every $25 spent by a state per person over the age of 65 on home-delivered meals, reduces the low-care nursing home population by 1%, so investments in nutrition are a cost-effective LTSS.

Multi-Purpose Senior Services Program (MSSP) Services

MSSP programs have over 30 years of experience serving frail, nursing-home eligible elders in their home instead of skilled-nursing facilities. This option is a significant cost-savings for taxpayers, avoiding high institutional costs. However, cuts have made the program increasingly precarious, with closure or turnover of 9 MSSP sites statewide since 2008. $4,046 million is needed to stabilize the program, backfill growing costs of doing business, close funding gaps and provide direct client services such as medical transportation, adaptive equipment, respite care and other supplemental services.

Ombudsman Services

The Long-term Care Ombudsman program coordinates volunteer advocates for residents of nursing homes, board and care homes and assisted living facilities, resolving problems, and providing information about finding quality care and facilities. There are two budget-related proposals this year that will strengthen

critical Ombudsman services; the first is a budget request to continue the annual allocation of $1 million from the Health Facility Citation Penalties account overseen by the California Department of Public Health.

The second proposal is to revise the 1989 Long-Term Care Ombudsman Funding Formula (Welfare and Institutions Code Section 9719.5) from the current allocation of $35k local program base to $100K local program base through an increase of $2.25 million in general funds. This change would ensure adequate management, staffing and volunteer staffing are available to handle an estimated 130% growth in the residential care population.

Medi-Cal Rate

When voters approved Proposition 56, they overwhelmingly agreed that funding the Medi-Cal rate should be the focus of spending for the funds. We urge that the $1.2 billion in revenue generated by the California Health care, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) should be directed for use for improving payments to providers in the Medi-Cal program. California health providers are still struggling with the 10 percent decrease in Medi-Cal payments implemented in 2013. Even prior to these cuts, California ranked among the lowest in the nation in payments to health providers. As a result, Medi-Cal patients are more likely to have difficulty accessing appropriate care, which can lead to unnecessary, costly emergency room visits, hospital re-admissions and inappropriate placement in skilled nursing facilities.

Ultimately, if the state does not provide the services and supports that enable people to continue to live in the community as they age or experience serious disability, they are likely to end up in expensive skilled nursing facilities, developmental centers or other institutions sooner and for a longer period. Investing in the infrastructure that will keep them in the community as long as possible will prove to be fiscally prudent.

The Collaborative stands ready to assist the Legislature in the critical policy conversations we anticipate are ahead. And in the current year's budget process, we call your attention to the need to support these investments in long-term services and supports that will continue to build capacity, meet the growing needs in the current year, and continue to prepare California's inadequate system of LTSS to respond to these challenges.

We respectfully ask for your support for these priorities.

Sincerely Yours,

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

cc: Hon. Richard Pan, Chair, Senate Budget Subcommittee 3
Hon. Joaquin Arambula, Chair, Assembly Budget Subcommittee 1
Diana Dooley, Secretary, Health and Human Services Agency
Michael Cohen, Director, Department of Finance
Lora Connolly, Director, Department of Aging
Jennifer Kent, Director, Department of Health Care Services
Will Lightbourne, Director, Department of Social Services
Hon. Kevin de León, President pro Tempore, California State Senate
Hon. Anthony Rendon, Speaker, California State Assembly
Hon. Members of the California State Senate and Assembly

CALIFORNIA ASSOCIATION OF AREA AGENCIES ON AGING

"Aging is All About Living"®

SUPPORT FOR REQUEST OF NUTRITION FUNDS

The Need

- Approximately 36% of California seniors, some 2.7 million, don't have enough income to meet their basic needs (Elder Economic Security Index), with more than 1 million threatened by hunger each day
- It is estimated that 1.3 million seniors in California are isolated, living alone
- 1.5 million seniors qualify for Medi-Cal

Poverty Implications

- Studies show that there is a direct relationship between poverty and poor nutrition
- 8.6% of California seniors have incomes below the federal poverty level
- There has been a 57% growth of our seniors who are eligible for Medi-Cal since 2011

Current Services

- The home-delivered meal program reaches out to the older, frail seniors that are invisible and living throughout the community in all types of neighborhoods
- Congregate mealsites serve numerous seniors, including the hidden homeless living in cars, etc., and provide health education and activities for all attendees, including the socially isolated, such as those who have recently lost a spouse.
- 7 million congregate meals are served every year
- Almost 11 million home-delivered meals are served annually
- Some 55,000 older, frail Californians are receiving home-delivered meals at an average of 4 meals a week.
- The average price of a home-delivered meal is $7.50.
- A congregate meal averages about $12.50 in costs (and adds socialization and other health-related activities and benefits).
- Home delivered meals are serving only 1.8% of the nutritionally at-risk seniors
- Congregate mealsites serve only 4% of the nutritionally at-risk seniors

980 Ninth Street, Suite 240 Sacramento, CA 95814 Phone (916)443-2800 Fax (916)554-0111

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

Request for Funds

- An additional $12.5 million is needed to maintain a service level of food for 6% of the at-risk population. That growth includes a half-million increase in the number of Calif. Seniors who are so poor that they qualify for Medi-Cal.

Cost Savings

Food-insecure seniors are 2.33 times more likely to report fair/poor health status and have a higher nutritional risk[1]. Food-insecure seniors are at greater risk for chronic health conditions and experience the following:

- 60 percent more likely to experience depression
- 53 percent more likely to report a heart attack
- 52 percent more likely to develop asthma
- 40 percent more likely to report an experience of congestive heart failure

A Brown University Study[2] estimated that every $25 spent by a state per person over the age of 65 on home-delivered meals, reduces the low-care nursing home population by 1%.

In addition to the cost benefits, meal programs need additional funding because no senior should have to go hungry in California. Being hungry, homeless, or ill does NOT have to be a condition of growing old in California.

[1] Lee JS, Frongillo, Jr. EA. (2001). Nutritional and health consequences are associated with food insecurity among U.S. elderly persons

[2] The Relationship between Older Americans Act Title III State Expenditures and Prevalence of Low-Care Nursing Home Residents;Kali S. Thomas, PhD, MA and Vincent Mor, PhD, MED

980 Ninth Street, Suite 240 ✦ Sacramento, CA 95814 ✦ Phone (916)443-2800 Fax (916)554-0111

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

Multipurpose Senior Services Program Site Association, Inc.

1107 9th Street, Suite 701, Sacramento, CA 95814

Phone: 916. 552. 7400 ~ Fax: 866. 725. 3123

MSSP Program Rate Restoration Request: $4,046,000 GF

REQUEST: MSA requests that the Legislature help create a sustainable safety net for frail, vulnerable Californians by restoring the MSSP program funding with a reinvestment of $4,046,000 in State General Funds. When matched with federal funds, the per-slot rate would increase from $4,285 to $5,142 per year. The MSSP sites are still operating on the budgets that were blue-penciled in 2008. This restoration would allow sites to serve 100% or more of the current MSSP participants and keep pace with rising costs. Compared to $83,364 annually for a nursing home, the investment of $5,142 per slot is a significant cost savings for tax payers.

Background

The Multipurpose Senior Services Program (MSSP) is a **complex case management program** for Medi-Cal seniors, 65 and older, who are certified eligible for skilled nursing placement. These seniors have complex medical and psychosocial needs, requiring specialized medical and social support services. Without MSSP support, clients and their family caregivers are unable to live at home safely. MSSP is a federal waiver program serving approximately 12,000 frail seniors in their homes, rather than institutions, saving California an estimated $110 million or more, annually.

In its 30+ year history, MSSP has received just two small cost of living adjustments (in 2000 and 2006), followed by **22.5% in funding cuts** in 2008 and 2011 due to state budget deficits. These cuts, along with annual cost increases, place MSSP's future in peril. MSSP providers cannot make up for program deficits by increasing or decreasing the number of people they serve, reducing program services, or serving private pay consumers. MSSP is a federal waiver with a cap on the number of persons served statewide and per provider and has a fixed allocation per slot. In addition, federal regulations require highly skilled and educated staff that is extremely expensive, and these regulatory requirements which are essential to program success, are also part of what causes costs to exceed the current rate structure.

Funding Challenges

While funding has been flat and then cut, the costs to do business have increased each year, including: worker's compensation premiums; health, life, dental, vision and other employee benefits; rent, utilities, and other operating costs; and staff development and training. The current rate is not adequate to maintain this essential safety net.

Additionally, MSSP sites spend up to 30% of their overall program allocation purchasing services and equipment (also known as "waived services") needed by frail clients living in home settings, when the client, family, and other existing healthcare, community and public resources are unable to meet the need. This is an important waiver provision which includes ability to make purchases such as supplemental transportation for medical appointments and essential non-medical trips, adaptive equipment, supplemental chore, personal care and respite care, and many more purchases to enable this complex, high need population to remain safely at home. The longstanding history of flat funding and funding reductions leaves MSSP providers in jeopardy of being unable to meet the waived services needs of MSSP clients due to insufficient funding.

Based on an industry-wide survey in 2015 with a 87% participation rate, 65% of sites reported being unable to serve 100% of their required slots at the current rate. This means sites, whether county sponsored or standalone nonprofits, must find funding elsewhere to fully fund the costs of MSSP, which is unsustainable. The closure and turnover of 9 sites since 2008 due to funding cuts have resulted in costly changes, loss of institutional knowledge and have negatively impacted the continuity of care for this very fragile population in communities throughout the state. If rates are not increased, this trend will continue, without any organizations able to take on insufficiently-funded programs. This will leave skilled nursing placement as the only viable option for these frail beneficiaries.

CONGRESS OF CALIFORNIA SENIORS

1230 "N" STREET, SUITE 201, SACRAMENTO, CA 95814 • (916) 442-4474 • (800) 543-3352 • FAX (916) 442-1877 • www.seniors.org

Laurel Mildred
Mildred Consulting
For CCLTSS

CCS budget proposals for FY 2017-18 for review by Collaborative members:

Dear Laurel:

The Congress of California Seniors has two budget requests to submit…both are in support of other organizations' proposals.

The first is in support of the $12.5 million proposal to increase funding for congregate and home delivered meals in the Department of Aging. Derrell Kelch is sending the one page summary for Collaborative members and we are strongly in support of the proposal.

The second proposal is for the CLTCOA and includes (1) a budget-related policy bill to re-design the funding formula used by CDA to allocate funds among ombudsman programs and (2) A budget request to continue the annual allocation of $1 million from the Health Facility Citation Penalties Account overseen by the California Department of Public Health.

I understand that the nutrition proposal has been submitted by C4A.

The proposals for the Long Term Care Ombudsman are attached.

Gary Passmore
Congress of California Seniors

1230 N St., Ste. 201
Sacramento, CA 95814
office: 916-375-3313
LColeman@CLTCOA.org
www.CLTCOA.org

January 2017

The California Long-Term Care Ombudsman Association (CLTCOA) on behalf of the 35 local Long-Term Care (LTC) Ombudsman Programs is pleased to provide information on our 2017/18 Ombudsman funding efforts. This year we are preparing a budget request and a policy bill. These two efforts conform to the actions of the 2016/17 Budget Conference Committee where Ombudsman had unanimous and bipartisan recommendations of additional support for the work of the Long-Term Care Ombudsman Programs.

2017/18 LTC OMBUDSMAN BUDGET FUNDING REQUEST:

$1 million from the State Health Facility Citation Penalties Account

for on-going support of

the local Long-Term Care Ombudsman Programs

History:

- 2011-2015 $1.1M State Health Facility Citation Penalties Account (STHFCPA) (total of $1.1M)
- 2015/2016 $1.1M on-going and $1M One Time Only from STHFCPA (total of $2.1M)
- 2016/2017 $1.1M on-going and $1M One Time Only from STHFCPA (total of $2.1M)

Budget Proposal:

CLTCOA is requesting the same dollar amount award of the last two years with the modification that the additional $1 million is made "on-going." We are also open to considering options to make these funds available for three years, or on-going unless/until the STHFCPA account fund falls below $6 million.

One-Time-Only (OTO) Concern:

We remain concerned that continuing to provide these funds as One Time Only (OTO) funding limits the ability of local Ombudsman programs to utilize these funds for sustainable infrastructure improvements and increased resident access to the Ombudsman program. Eliminating the OTO nature of the STHFCPA funds is vital to protecting facility resident health and welfare.

For additional information contact: Leza Coleman, Executive Director, at 916-426-3697 or lcoleman@cltcoa.org

CLTCOA
California Long-Term Care Ombudsman Association

LTC OMBUDSMAN POLICY BILL

Revise the 1989 Long-Term Care Ombudsman Funding Formula (Welfare & Institutions Code Section 9719.5) from the current allocation of $35k local program base to $100K local program base through an increase of $2.25 million in general funds.

History:

The funding allocation was established in 1989. LTCOPs receive $2.9M in Federal funds. These funds are allocated as follows:
$1.2M covers the current $35k base for 35 local Ombudsman programs. The $35k base was created to cover the cost of opening the local Ombudsman office (rent, utilities, staff, internet, equipment, etc.). **The base has not been updated for inflation in 27 years.**

The remaining $1.7M in Federal funds is combined with Ombudsman State funds, including:
$1M State General Funds
$1.9M Skilled Nursing Quality and Accountability Fund
$400k Public Health Licensing and Certification Program Fund

$ 5,000,000 allocated to local Ombudsman programs using the following formula:

- 50% based on the number of LTC facilities in the area
- 40% based on the number of facility beds in the area
- 10% based on the total square miles in the local Ombudsman program area in proportion to total of the state.

Increasing the program base will ensure that all 35 programs have a full time Ombudsman available to provide support to the staff and volunteer Ombudsmen. It allows us to employ the minimal levels of supervisory staff needed to use volunteers effectively. Current estimates indicate a 130% growth in residential care population. This will result in a need for significant growth in the number of staff and volunteer Ombudsman to provide services to those new facility residents.

This update of the Ombudsman funding formula addresses the program need for the training of new volunteers and employees. It recognizes that better oversight will generate more complaints and issues that must be tracked and resolved. It is a thoughtful proposal that protects the people who need our assistance. But in the long run, it saves the state money by reducing the greater expense of licensing and law enforcement personnel who must be deployed to make adversarial inspections, issue citations and initiate litigation.

For additional information contact: Leza Coleman, Executive Director, at 916-426-3697 or LColeman@cltcoa.org

California Medical Association
Physicians dedicated to the health of Californians

January 13, 2017
The Honorable Holly Mitchell
Chair, Senate Budget Committee
State Capitol, Room 5019
Sacramento, CA 95814

RE: CMA Position on Governor's Budget Proposal on Proposition 56

The California Medical Association (CMA), representing 43,000 physicians throughout California in all specialties and modes of practice opposes the Governor's proposal for expending Proposition 56 revenues in Medi-Cal.

Proposition 56 – Medi-Cal Expenditures—OPPOSE Spending Plan

CMA is disappointed that Governor Brown's budget ignored the will of voters who supported the California Health Care, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) by proposing to utilize the new tax revenues to offset general fund obligations rather than investing in the overburdened

Medi-Cal system. California now serves the nation's largest Medicaid population while paying providers the 2nd lowest rates in the country.

The growth in Medi-Cal enrollment has exceeded all expectations – the program is now estimated to serve 14.3 million individuals. This is up from 7.6 million individuals who were enrolled in the program in 2012 before the Medi-Cal expansion. With the successful passage of Proposition 56, voters made their support for the program and for increased provider payments clear in November. Citing an expected one time increase in Medi-Cal General Fund obligations, the Governor's proposal uses $1.2 billion from Proposition 56 funds toward existing health care costs in the Medi-Cal program that are General Fund obligations. The budget proposed using the Proposition 56 funds toward the state's existing General Fund obligations makes no new investments into a Medi-cal program that provides services to over one third of California's population.

We believe that the language of Proposition 56 is clear—and that voters voted to support improving payments for programs and providers to ensure patients can have access not just coverage.

California's low rates are not enough to enlist a sufficient number of providers to ensure that care and services are available, as required by federal statute. This fact was explored in a 2013-2015 study by the California Health Care Foundation (CHCF) and the University of California, San Francisco[3] (UCSF) in which physician participation in the Medi-Cal program was investigated. CHCF and UCSF found that California physicians are less likely to have Medi-Cal patients in their practices than privately insured or Medicare patients. Specifically, CHCF and UCSF report that between 2013 and 2015 physicians decreased the number of Medi-Cal patients in their practices by five percentage points; with the gap being wider for specialists, with a decrease of six percentage points. In summary, they report:

[3] Physician Participation in Medi-Cal. UCSF

- In California, 40% of physicians provide 80% of Medi-Cal visits.

- Physicians are more likely to report difficulty securing referrals to specialists for Medi-Cal patients than for privately insured patients.

- Low payment rates and program administration challenges are the most common reasons cited by physicians to explain the low number of Medi-Cal patients in their practices.

According to a 2014 California Healthcare Foundation Survey, 69% of physicians stated that they have Medi-Cal patients in their practice. Based on a 2016 estimate by the Kaiser Family Foundation that there are 103,363 California physicians in active practice, we estimate the number of physicians serving any Medi-Cal patients to be 71,320. [4]

California continues to rank 2nd lowest in physician payment rates among Medicaid programs.
Chronically low reimbursement rates have a direct effect on access to health care for Medi-Cal patients. Many providers find that they cannot continue to treat Medi-Cal recipients and maintain a viable practice. When physicians are unable to treat Medi-Cal recipients, patients cannot get timely access to care.

With more than 14 million Californians – over one in three – relying on Medi-Cal programs to provide basic and specialty care for serious diseases, the stakes are high. Californians voted for the tobacco tax to remove these barriers to reliable, quality care and require the state to make an investment in the health of its people. California cannot afford to continue starving this program by diverting Prop 56 revenues to cover the state's General Fund obligations.

We ask that you OPPOSE the Governor's proposal for expending Proposition 56 revenues in Medi-Cal.

Sincerely,
Janus Norman
Senior Vice President
Center for Government Relations California Medical
Association jnorman@cmanet.org

The Honorable Members of the Senate Budget Committee
The Honorable Members of the Assembly Budget Committee
Anita Lee, Higher Education Consultant, Senate Budget Committee
Mark Martin, Higher Education Consultant, Assembly Budget Committee
Peggy Collins, Health Consultant, Senate Budget Committee Andrea Margolis,
Health Consultant, Assembly Budget Committee

[4] Total Professionally Active Physicians, State Health Facts, Kaiser Family Foundation, September 2016. Accessed at: http://kff.org/other/state-indicator/total-active-physicians/?currentTimeframe=0.

AARP Real Possibilities in California

1415 L Street, #960 | Sacramento, CA 95814
1-866-448-3614 | Fax: 916-446-2223 | TTY: 1-877-434-7598
aarp.org/ca | caaarp@aarp.org | twitter: @aarpca
facebook.com/aarpcalifornia

January 19, 2017

The Honorable Edmund G. "Jerry" Brown, Jr.
Governor, State of California
State Capitol, First Floor
Sacramento, CA 95814

RE: Governor Brown's 2017-18 Proposed Budget

Dear Governor Brown:

On behalf of our 3.3 million AARP members in California, we applaud you for the fiscal stewardship you have provided our great state even as revenue projections have not met expectations and despite looming economic uncertainty.

AARP's overarching priority is promoting livable communities for Californians of all ages. AARP's research consistently shows that the vast majority of Californians 50 and over want to remain in their homes and communities for as long as possible. In order for this to be possible, we encourage the state to invest in the necessary community programs, services, and support systems. California's population of people 65 and over is estimated to double in the next 13 years, and with increasing rates of disability, as noted in the 2016 Legislative Analyst's Office report, we must begin planning for the resources that will be necessary to help seniors and persons with disabilities continue to live in their homes and communities.

We were disappointed to see that no new general fund expenditures will be allocated to help increase the inventory of affordable housing. The increasing cost of housing in California impacts residents of all ages-- those who are very low income and those who are middle income. At the same time, we strongly agree with your proposal to reduce regulatory barriers to construction and permitting policies at the local level, and incentivizing local jurisdictions through various mechanisms that spur the development of affordable housing stock. We were strong supporters of SB 1069, the legislation you enacted in 2016, that will streamline the permit process so homeowners can build an Accessory Dwelling Unit on their property.

AARP is concerned about the proposed major modification to the Coordinated Care Initiative, which currently has about 400,000 individuals, many of whom suffer from multiple chronic

conditions, cognitive impairments or live in uncertain housing situations. The change, which removes IHSS (In-Home Supportive Services) from capitated payments and shifts program costs back to the seven CCI counties, will create confusion for existing beneficiaries who already have challenges in their daily lives because they are elderly, low-income and have multiple chronic medical conditions.

Our chief concern is to ensure CCI beneficiaries are well informed about the change to their medical insurance plan with ample time for them to access affordable options for their care. In the coming months, we will be looking to you and the legislature to put forth a plan to properly and thoroughly inform program participants of the change and how to help them navigate this revised program. We anticipate receiving more information on how these changes to the program will be codified in law while protecting participants so that they can continue to live in their homes and communities.

Finally, we encourage you to enhance funding for Senior Nutrition programs ($12.5 million), the Long-Term Care Ombudsman program ($1 million in ongoing funds) and to continue funding Adult Protective Services staff training at the same level as in 2016-17 ($5 million). We hope that you will revisit these proposals and include them as part of your May Revise budget proposal. Each of these programs lower long-term costs to the state by reducing unnecessary institutionalization for seniors and persons with disabilities, while also keeping them in their homes and communities where they want to be.

As the budget process proceeds and proposals are more fully formed, AARP will continue to advocate in support of protecting programs that we believe are essential to creating livable communities for all ages.

If you have any questions about our comments on these proposals, please contact me at nmcpherson@aarp.org or directly at 626-585-2622.

Sincerely,

Nancy McPherson
State Director

Disability Rights California
California's protection & advocacy system

LEGISLATION & PUBLIC
INFORMATION UNIT
1831 K Street
Sacramento, CA 95811-4114
Tel: (916) 504-5800
TTY: (800) 719-5798
Toll Free: (800) 776-5746
Fax: (916) 504-5807
www.disabilityrightsca.org

COMMENTS REGARDING RENEWAL OF THE NURSING FACILITY/ACUTE HOSPITAL WAIVER

December 23, 2016

Disability Rights California is the federally mandated protection and advocacy agency for the State of California. We have worked on Home and Community-Based Services (HCBS) Waiver issues from the legislative, policy, and individual client perspectives for many years, to support the rights of people with disabilities, including seniors, to receive the services they need to live in integrated settings of their choice. Given the importance of this issue to our mission to assist our clients, Disability Rights California welcomes the opportunity to provide input into the Nursing Facility/Acute Hospital (NF/AH) Waiver renewal process.

The Waiver can and should conform with the Americans with Disabilities Act and the United States Supreme Court's *Olmstead* decision, giving people a real alternative to less desirable and generally more costly institutions.

We commend the Department of Health Care Services (DHCS) for adopting an aggregate cost limit, one of the recommendations contained in the earlier versions of AB 1518, which had the unanimous support of the Assembly and of the Senate Health Committee. We also welcome the potential for better care management for those Waiver participants who want that service.

Our detailed comments that follow are summarized here:

1 While the Waiver renewal application contains some promising elements, California still lacks a comprehensive plan to reduce reliance on nursing and other institutional facilities other than in the developmental disabilities system. We encourage the State, including DHCS, to develop targeted strategies to divert people from, as well as assist them to leave, long-term institutional placement. This approach must include providing appropriate, community-based services for people traditionally underserved by the Waiver, including people with mental health disabilities and brain injuries, and must anticipate the needs and preferences of the expanding aging population.

2 While increasing the number of Waiver slots is positive, the number of slots and the planned approach is inadequate to clear the waitlist and prevent harm to waitlisted people with disabilities.

3 The shift to local care management may be a very promising approach to improving access to appropriate and timely services. We look forward to further discussion regarding the questions below.

4 The Waiver does not include rate increases, and current rates for in-home nursing and other service constitute known barriers to access to services.

5 The Waiver does not address arbitrary restrictions on Waiver Personal Care Services which limit participant access to the Waiver.

6 We commend DHCS for the shift away from an Individual Cost Limit. We have many questions and look forward to further details about how this may impact Waiver applicants and participants.

7 We would like to see a plan for improving and expanding information and outreach about the Waiver.

8 We have some questions and concerns about excluding participants based on behaviors and would like more information about the basis for and intended implementation of this provision.

9 We have some concerns regarding the HCBS Transition Plan and would like clarification about the state's intended approach to assessment of services in private residences.

We had hoped that the Waiver application would more closely reflect the problems identified by and recommendations made by the Technical Expert Group and other stakeholders who have weighed in via the two hearings and the questionnaire, including:

--A significant increase in immediately available Waiver slots within the first year of Waiver renewal, and primarily relying on research and analysis for annual capacity increases, such as the number of IHSS users and different factors on IHSS users, current Medi-Cal spending, MDS Section Q, and the LTSS scorecard.

--Anticipating growth with the senior and AIDS and disabled population.

--Fixing the rates, which now limit the availability of needed services.

We appreciate the opportunity to comment on the actual Waiver Renewal application, which helps to answer some of the questions we raised in our June 27, 2016 comments to the June 10 Proposal. Since the Waiver Renewal application has already been submitted to CMS, we are copying these comments to CMS for consideration.

SPECIFIC CONCERNS, QUESTIONS, AND RECOMMENDATIONS:

1. Need for Comprehensive Plan to Reduce Reliance on Institutional Care

The NF/AH Waiver remains one of the primary programs through which Californians may be able to access the services they need leave or avoid institutional placement. Nevertheless, the program's small size, centralized operation, low funding levels and caps, state budget neutrality requirement, and limited array of services have inhibited its ability to achieve its stated purpose. We strongly encourage the State to look at the future of long term care needs and where they can best be met and where this Waiver fits into that picture. This effort should include a targeted approach to meeting the needs of people who have not traditionally been served on the Waiver, such as people with mental health needs and brain injuries, as well as

anticipating the needs and preferences of the aging population.

Our recommendations to the Waiver renewal proposal, below, reflect our concerns about the lack of significant progress in the areas of diversion from, and preventing long-term stays in institutional settings. In addition, we recommend that the State:

--Take necessary steps to ensure that provision of long-term services in the community are as readily available as institutional placement so that people are not unnecessarily placed in nursing facilities or other institutions because of the difficulty and the length of time it takes to secure community-based services.

--Improve its oversight of nursing homes' obligation to make referrals based on responses to MDS 3.0 Question Q.

--Develop a system of unified budgeting so people and budgets aren't separated by the location of their care (i.e., facility versus community).

--Create incentives for nursing homes to discharge residents who want to leave, including shutting down nursing facility beds upon discharge of residents.

2. Too Few Waiver Slots

Approximately 20,000 nursing home residents, at any one time, say they are interested in returning to the community, in answer to a question in the Minimum Data Set, which is administered quarterly in nursing homes. The AARP/SCAN scorecard showed there are about 10,000 people with low care needs in California nursing homes, whom they assume could be cared for outside the facilities. The current Waiver only has 3,964 slots to meet these needs (Proposal at 4), which is clearly insufficient. **According to DHCS, 1800 people—who have been determined likely to meet eligibility requirements for the Waiver and therefore are at imminent risk of nursing facility placement-- remain on a waitlist for two to three years.** (June 10, 2016 Waiver Renewal Proposal ["Proposal"] at 10).

The proposed increase in Waiver capacity will not solve this urgent problem. The renewed Waiver will increase the number of slots by up to 5,000 over the next five years. (Proposal at 10). And of those, 60%, or up

to 3,000, must be people being discharged from nursing facilities or children aging out of EPSDT. (Waiver Renewal Application at 27; Proposal at 10). Given the significant barriers to discharging people from nursing facilities (see comments below), we encourage a targeted approach to improving access to needed services to enable people to leave nursing facilities more easily.

However, moving people from the waitlist contingent on discharging people from nursing facilities is unfair and harmful to those who need, and would be able to access, services immediately. Prolonging their wait for Waiver services increases the risk that they will be placed in nursing facilities, lose their housing and community supports, and then be unable to leave even if Waiver services become available to them.

We are very concerned about the inadequate plan to "phase out" the waitlist (Proposal at 11). Rather, the state must take immediate steps to clear the waitlist given that so many individuals have been waiting months or even years to receive Waiver services. We are also concerned that the proposal to conduct an "interim review" in 2018 "to determine if additional slots should continue to be added post 2018" (Proposal at 4) raises the specter that even this minimal progress could be rescinded. The State should make a commitment to enlarging the Waiver and take necessary steps to remove barriers to filling available slots.

Questions Raised:

1. How did the state arrive at 5,000 slots over the lifetime of the Waiver (i.e., was this number related to any assessment of need?). DHCS has stated that despite the addition of the 5,000 slots, it intends to enroll no new consumers during the transition to the new model of care management, and not reach full capacity until the end of the waiver period. This will add more people to the waiting list and is disconnected from need.

2. Will the interim review in 2018 consider the potential slower pace of discharging people from nursing facilities initially due to startup of local care management functions and barriers to discharge such as lack of housing and nursing care (i.e., will the state consider not continuing to add slots if slots are available in 2018)?

Recommendations: The State must make an affirmative commitment to expanding the Waiver, including the following:

a) As set forth in AB 1518, immediately add at least 5,000 new Waiver slots, with a commitment to further additions annually based on need, as determined by several factors which are spelled out in AB 1518.

b) Immediate priority for new slots should be given to people currently on the waitlist, in conjunction with identifying nursing facility residents and others in institutional settings who can leave quickly.

c) Actualize expedited enrollment on the Waiver for those who are hospitalized or who are otherwise at imminent risk of institutional placement without Waiver services.

d) De-link the availability of Waiver services for people in the community, including people on the Waiver waitlist, from any connection to people moving from nursing facilities and aging out of EPSDT. These are all equal priorities and reflect people with equally urgent needs. No one should be placed at risk due to delays in receipt of adequate services.

3. Questions and Concerns about Local Care Management

We commend DHCS for consideration of local and diverse care management options. We support the aims of this approach, which, if implemented well, could improve Waiver participants' access to prompt, individualized, and high-intensity care management services. We are concerned, however, about the apparent failure to address the barriers to timely receipt of services which care management alone will not be able to fix (see comments below).

Waiver participants have widely diverse needs and preferences for care management services—some want none and some have a high need for frequent and intensive services. We hope that the requirements, expectations, and provider payment levels allow for this range of service levels, and that consumers will have a wide choice of providers (Page 13 of the Proposal suggests otherwise, as it says IHO participants will be

"assigned").

Moreover, in our experience, the process for becoming a Medi-Cal provider, and for providers to be paid, can be lengthy and cumbersome, disincentiving providers from participating. We hope that DHCS will look for ways to streamline these processes and provide assistance to new and non-traditional Waiver providers to avoid delays in receipt of services to Waiver participants.

In addition, there are currently significant problems with lack of information about the Waiver, no outreach by the State, and lengthy wait times for assessments. Shifting to a local care management approach could address these problems but only if those are specified, with deliverables, in contracts.

Finally, Waiver assessments and service planning must conform to federal person-centered planning requirements, which are in effect now. This means that:

--Consumers must lead the process, and they must be given the necessary information they need and in a manner they can understand in order to do so;

--The service plan must reflect the consumer's goals and strengths, and identify the services and supports the consumer needs to achieve those goals.

Questions Raised:

1. Will Waiver participants be required to accept care management services? How does DHCS intend to quickly build care management capacity to serve people with immediate needs?
2. How will the agencies be ready to provide services in the proposed time frame, which seems very ambitious? (The timelines shows that the new care manager provider agencies will receive their contracts in May 2017, be establishing provider networks in that same month, and that beneficiaries will transition to care management agencies two months later, in July 2017.)
3. Will there be more than one CMA available to each waiver participant? What will DHCS do if no CMAs apply to cover some areas of the state?

4. The Waiver Renewal application (p. 221) says that a consumer in an area without a CMA can hire an individual licensed provider to do case management, community transition and transitional case management. Does this also mean that the consumer could also hire an agency to do case management, even though the agency is not a CMA for the waiver?
5. In general, will consumer choice of providers be affected and specifically, will authorization for Waiver Personal Care Services be affected?
6. How will care management agencies provide 24-hour assistance to participants via means other than a "member" hotline or nurse advice line?
7. Will Waiver applicants and participants be able to choose from a range of case management agencies or will they be assigned?
8. How does the state decide eligibility if the care managers are performing the assessments?
9. What is the role of these new care managers vis-a-vis the managed care plans to which the participants may belong?
10. How quickly will current Waiver participants be reassessed under the new Waiver when their case management is switched to a CMA?
11. How will their current level of care be modified in the new Waiver since there will be fewer levels of care.
12. Will CMAs be expected to follow consistent procedural requirements (e.g., second level of review) per DHCS directive or guidance or will CMAs have latitude to conduct level of care assessments and make service determinations individually?
13. If a CMA does a reassessment before the annual reassessment is due, will the CMA be able to add medically necessary services based on the new aggregate cost limit? If so, will the potential for

additional services to be added include consideration of services other Waiver participants are receiving (in order to maintain cost neutrality within the CMA or more broadly?)

14. In areas with no CMA, when will current waiver participants be assessed using the new aggregate cost neutrality formula?

Recommendations: DHCS must further develop the care management agency proposal in conjunction with stakeholders to: 1) Include the broadest range of care management functions to meet Waiver participants' preferences and needs, 2) Work quickly to develop a local network of care management providers, including streamlining the application, approval, and payment processes; 3) Ensure that care management is person-centered, and that care management staff are fully educated, trained, and willing to provide person-centered services; 4) Provide resources and set expectations so that shifting to local care management agencies improves timely access to information, assessments and services, including development of an expedited process for approving Waiver applications and authorizing services for people when appropriate.

4. Lack of Solutions to Barriers to Timely Access to Services

We are concerned that DHCS does not intend to consider changes to currently available services, provider types, or provider rates. The current system leaves many people with disabilities languishing in costly institutions because of service barriers. If not addressed the Waiver will fail to deliver on its promise: care managers will not be able to help people with disabilities leave nursing facilities (and thereby phase out the waitlist), and provide effective care management. DHCS has been told that some home health agencies are dropping current clients and declining new ones because of the rates, which haven't increased in at least a decade. By contrast, the state has raised rates for nursing homes many times. This represents and perpetuates a bias towards institutional long term care.

In addition to arbitrary limits on Waiver Personal Care Services (discussed below), lack of access to nursing is a tremendous problem, as is the very limited number of supported living services agencies who are enrolled as

Waiver providers and able to serve people with brain injuries and/or who need less medical and more behavioral support. Serving a more diverse population will also require expanding the array of Waiver services to include services such as supported living, mental health services, more flexible budgeting (to allow for backup care, time for training of staff, etc.). We encourage further exploration of these concepts in conjunction with stakeholders.

Questions Raised: '

1. Given the difficulty waiver participants face in obtaining authorized services because of the Medi-Cal rates paid under the waiver, how will the state ensure access to needed services in the waiver renewal?
2. Will CMAs be authorized to spend more than the usual rate if that is needed to secure services?

Recommendations: We strongly encourage DHCS to work with stakeholders to develop immediate and longer-term solutions, such as: 1) expansion of service provider categories (e.g., supported living as a NF/AH Waiver service category, outreach to expand supported living provider pool); 2) raising rates for community nursing care; 3) exploration of other ways to improve access to nursing (e.g., payment for travel time and/or overtime, payment for hands-on training in the home for new nurses, etc.); 4) allowing for flexible budgeting to give Waiver participants more control over the services they receive.

5. Arbitrary Limits on Waiver Personal Care Services (WPCS)

The current Waiver includes unnecessary and arbitrary limitations on services that impair participants' ability to receive the care they need and to which they are entitled. In particular, restrictions on receipt of Waiver Personal Care Services (WPCS), particularly for backup care, pose serious problems for Waiver participants. Some of these arbitrary limitations are further described in participant letters directed to the Department, and are described below:

a) Need for Backup WPCS: Clients find it very difficult to find backup care to fill nursing shifts (which they need and which is required as a condition of Waiver participation). If nurses don't show up or the home health agency cannot staff certain shifts, clients are often left to rely on family members or friends to show up without notice and fill in uncompensated—or to go without needed care. Waiver budgets should be flexible enough to be able to enable Waiver participants to get the care they need.

Recommendation: Clients who have authorized hours for nursing care should be informed about and assisted to be able to use Waiver Personal Care Services when needed to provide backup for authorized nursing care.

b) 12-Hour Per Day Limitation: The Waiver prohibits WPCS providers from being compensated for more than 12 hours per day. While we understand that there are health and safety concerns if providers are overworked, the 12 hour limit is not based on objective data or the lives and needs of consumer and providers. This rule has only been recently enforced and it leaves some consumers in an extremely vulnerable position if they do not have someone to work the remainder of their authorized hours. Some providers will not remain on duty if they know they will not get paid, leaving the participant without needed care. Others, typically family members, will simply provide the care uncompensated.

Some Waiver participants have longtime caregivers who routinely work more than 12 hours a day, without undermining health or safety. Whether these hours are worked by choice or because of the inability of the participant to find enough caregivers, a blanket prohibition on workers being compensated for more than 12 hours per day—without any ability to seek even a temporary exception—is unfair and harmful to participants.

Recommendation: The renewed Waiver should remove the bar on caregivers being compensated for working more than 12 hours per day. Determinations about whether a provider can be authorized for more than 12 hours per day—even on a temporary basis—should be permitted on a case-by-case basis.

c) Prohibition on Spouse/Parent WPCS Providers: Parents and spouses who have a legal duty to provide care for a Waiver participant are

allowed, under certain circumstances, to provide some Waiver services. They are not, however, permitted to provide Waiver Personal Care Services. (Waiver Renewal Application at 180). This rule is inconsistent with IHSS and is simply not rational. Parents and spouses often must leave work, forgoing pay, to provide backup care to Waiver participants. They should be able to be compensated, just as they would be if the service to be fulfilled were nursing or habilitation (two of several services which are permitted to be provided by legally responsible individuals).

Recommendation: Allow parents of minors and spouses to provide Waiver Personal Care Services under the same circumstances in which they would be eligible to provide other Waiver services.

d) Bar on WPCS for Acute Hospital Level of Care: Waiver participants at the Acute Hospital level of care are prohibited from using Waiver Personal Care Services because of the complexity of their care needs. Because of the complexity of their care needs, such participants are especially in need of stable, trained caregivers to avoid hospitalization or even untimely death. However, these individuals are often left without backup care if their authorized nursing care needs cannot be met. Some individuals also prefer and have available trained and capable unlicensed caregivers who could adequately meet their care needs. These problems can be resolved by removing the ineligibility for WPCS for people at the acute hospital level of care and allowing an exception when backup needs cannot be met.

Recommendation: Allow Waiver participants at the acute hospital level of care to utilize WPCS when they prefer and have competent unlicensed caregivers available, and also to be permitted to use WPCS as backup care when needed to ensure that care needs will be met.

6. Questions Regarding Shift from Individual Cost Limit, New Levels of Care, Cost Neutrality and Cost Estimates

We applaud the state's decision to eliminate individual cost limit for Waiver services, a shift which comes after many years of advocacy and litigation challenging these arbitrary and harmful restrictions on access to Waiver services. We have questions however, about whether and how this change will improve Waiver participants' access to appropriate and sufficient

Waiver services. We would like further information about how this change will be implemented, including the change from eight levels of care to three.

We are also concerned that the state's monitoring through "frequent checks and balances to ensure [that] management of medically necessary services and cost neutrality are appropriately occurring" could have a chilling effect on authorization of services unless the criteria and expectations are clearly laid out.

Questions Raised:

1. What is the basis for the aggregate cost cap? Is it the actual institutional costs?

2. Will the basis increase when/if institutional costs increase?

3. With three levels of care, which institutional costs will be reflected in the aggregate?

4. We would like an explanation for the language, on page 11, which says there will be "no annual cost limit for medically needed services" but also says there will be "an individual cost limit that calculates cost neutrality in the aggregate across all Waiver Participants."

5. What are the underlying assumptions regarding utilization of services, institutional comparison costs, and population (including numbers of participants at each level of care)?

6. The timeline says that reassessments will start in January 2017. Are these reassessments different from the regular reassessments performed by DHCS?

7. Will state staff be reassessing current enrollees, placing them at one of the new levels of care and authorizing medically needy services beyond the former individual cost limits?

8. How will the change in levels of care differ from current procedures and eligibility criteria?

9. How will the new levels of care correlate to institutional level of care criteria?

10. How will services be authorized and/or limited, especially in the shift from state authorization to local care management agency authorization?

11. What criteria will be used to determine “medically necessary” services? How will DHCS inform Waiver participants, state staff, care management agencies, and Waiver service providers about this significant change?

12. Will DHCS keep data on the impact on services to Waiver participants and outcomes?

13. How will DHCS monitor and conduct “frequent checks and balances to ensure management of medically necessary services and cost neutrality are appropriately occurring”?

14. What is the expectation of CMAs to maintain cost neutrality (on an individual and/or aggregate basis?

15. If on an aggregate basis, is the aggregate comprised of this particular CMA’s consumers)?

16. If so, will similar consumers have different services offered depending on the cost neutrality requirements of the CMA which is responsible for that consumer?

17. How will CMAs be expected to maintain cost neutrality with existing Waiver participants?

18. What instructions (written or verbal), contracts, directives, or other guidance has been or will be provided to CMAs regarding cost controls/assurance of cost neutrality/individual or aggregate cost limits within each CMA?

19. What will DHCS oversight of CMAs be regarding cost neutrality? (Including frequency and description of how oversight will occur)

20. In areas with no CMA, how will aggregate cost neutrality be calculated?

21. If current state staff will be used as case managers in areas with no CMA, how are they being retrained to authorize services with no individual cost cap?

22. What dollar figures did DHCS use in the Waiver renewal for factor D for each level of care? (It appears that DHCS is using 2014 institutional costs, and not adjusting those costs upward for each Waiver year.) Please explain.

23. How are the usage estimates in Appendix J determined? Do they reflect any anticipated change in Waiver service usage? If based on actual Waiver costs, for what period of time?

Recommendations: DHCS must provide clear and understandable explanations as to the questions raised above, and others, regarding this important policy change. DHCS must also be transparent about the cost assumptions, and any resulting limitations on services, that will be anticipated or necessary as a result of this change.

7. Lack of Waiver Information From and To the State

Professionals who work in long term care, our clients, and attendees at the two stakeholder meetings, agree that information about the Waiver is hard to obtain and that currently the State does not publicize this alternative to institutionalization. Also, we have been told by transition agencies that they do not encourage qualified people to apply if their needs are unlikely to be met because of the cost limits and waiting lists, which means that otherwise eligible individuals remain in nursing facilities.

Recommendation: The State and its contractors must do outreach and ensure that information about the Waiver is provided, in appropriate formats and languages, to a wide range of people, including consumers and families, IHSS social workers, nursing home staff, transition agencies, managed care staff, hospital discharge planners and other service providers. The State must encourage transition providers to inform DHCS about potential clients whose needs cannot be met and why and those barriers must be addressed by DHCS.

8. Questions and Concerns about Excluding Participants Because of Behavior

The proposed termination of Waiver services based on a finding that the participant poses a threat or harm to others appears to be a workers' rights provision (also intended to protect roommates and families) but we are unclear what the participant's rights are related to what appears to be an emerging issue.

Questions Raised: What is the basis for adding this provision? How does it differ from current Waiver protections for participants and workers? What are the criteria for a determination that a participant should be terminated from the Waiver? Who makes the decision? What steps will DHCS take to avoid termination of the Waiver participant? What specific steps will be required of the local care agency to identify other Waiver services and other providers?

9. Concerns about HCBS Transition Plan

We are concerned about the State's broad approach to HCBS services provided in private residences, which we believe are still subject to

assessment for compliance with the HCBS rules. In addition, we do not believe that monitoring for compliance with the rules should rest solely with the care management agencies; rather, consumers must be integrally involved initially and on an ongoing basis in evaluation of the settings in which they live and reside, and through genuine person-centered planning, should be knowledgeable about the rules, their rights, and the choices that are available to them.

10. Other questions:

1. Why did the state choose to not make payment to legally responsible individuals for furnishing personal care or similar services?
2. We assume that are participant direction opportunities are available to participants who live in their own private residence even if they live with a non-family member? Please confirm.
3. On p. 271 of the Waiver Renewal application, the distribution of levels of care does not add up to the total unduplicated number of participants. Please explain.

We appreciate the opportunity to submit these comments and look forward to additional productive discussions with you and your staff.

CalMediConnect: Managed Care for Dual Eligibles

Since 2014, California has been working to transition people who are dually eligible for both Medicare and Medi-Cal into a simpler, streamlined, patient-centered health care delivery system of comprehensive, coordinated benefits and services under the Coordinated Care Initiative(CCI). Without this program, beneficiaries are forced to navigate a fragmented system of separate Medicare and Medi-Cal benefits, payers and providers. The new managed care delivery model, called Cal MediConnect, combines a full continuum of medical and community-based services into a single benefit package administered by and delivered through health plans. Studies show that beneficiaries are overwhelmingly satisfied with their care and care coordination. This program is overseen by the Department of Health Care Services.

WHAT IS MEDICARE?

A federal system that provides health coverage to those 65 and older and people with certain disabilities or medical conditions

Primary payer for many services:

- Hospital services
- Outpatient, physician, other provider services
- Skilled nursing facilities
- Home health care
- Dialysis
- Prescription drugs
- Durable medical equipment
- Hospice

WHAT IS MEDI-CAL? (California's Medicaid program)

A state-based system that provides health coverage to low-income Californians; covers certain services not covered by Medicare and helps beneficiaries pay some of their Medicare premiums, copays, and deductibles

Medi-Cal is the payer "of last resort" and covers duals':

- Medicare cost-sharing (Part A and B deductibles, Part B premiums and coinsurance, some prescription drug costs)
- Nursing home care
- Transportation to medical appointments
- Some home- and community-based services, personal care, home health care
- Some services and costs not covered by Medicare

DUAL ELIGIBILE = Someone who is eligible for health coverage through Medicare and Medicaid

30% younger people with disabilities

Current System is Fragmented, Confusing, and Inefficient

- Contradictory treatments
- Reimbursement disputes
- Medication interactions/errors
- Duplicative tests
- Overreliance on institutional care
- Unnecessary care settings
- Lack of care coordination
- No directory of providers
- Multiple phone numbers
- Multiple ID cards

Under the current system, people with Medicare and Medi-Cal are not connected to a unified system of health care delivery. The programs are administered separately with different benefits and providers, which can result in fragmented, confusing, and inefficient care for dual eligibles. Moreover, beneficiaries may be enrolled in a combination of traditional fee-for-service or managed care. This high-needs, high-cost population may receive delayed, duplicative, and even unnecessary care due to this lack of coordination.

Dual Eligibles are a High-Needs, High-Cost Population

On the whole, duals suffer from complex, high-cost medical conditions and take multiple prescription medications.

1.2 Million DUAL ELIGIBLES IN CALIFORNIA

55% have 3 or more chronic conditions

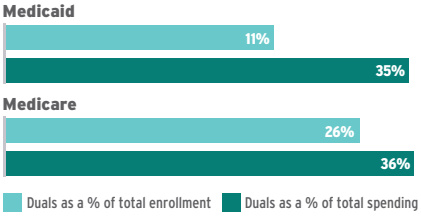
AVERAGE HEALTH CARE COSTS **$30,000** PER DUAL / PER YEAR

MORE THAN **HALF** OF DUALS have cognitive or mental impairments

1 IN 6 DUALS LIVES IN AN INSTITUTION

DUALS COST **4x MORE** than Medicare-only enrollees

Duals: Medicaid vs. Medicare



Costs for dual eligibles is roughly evenly split between the Medicare and Medi-Cal programs. However, Medi-Cal typically covers 80% of dual eligibles' long term care costs while Medicare pays for most of dual eligibles' inpatient and outpatient care.

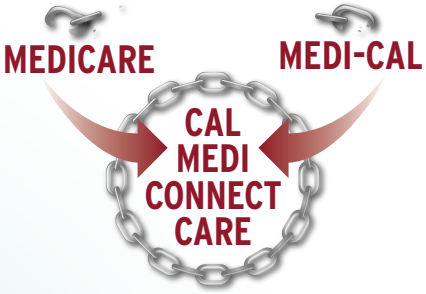
For more information, please go to www.calhealthplans.org

California Association of Health Plans

December 2016

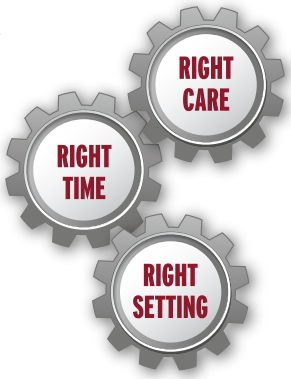
CalMediConnect: Managed Care for Dual Eligibles

How Cal MediConnect Works



Cal MediConnect health plans will manage Medicare and Medi-Cal benefits and services, including medical care, long-term supports and services, behavioral and mental health care services, and social supports. **The coordination helps ensure patients get the right care at the right time in the right setting.**

The managed care health plans will receive a fixed monthly payment to provide beneficiaries access to all covered, medically necessary services.
Monthly payments create strong financial incentives to ensure beneficiaries receive preventive care and home- and community-based services to avoid unnecessary hospital or nursing home admissions. Coordinated care will also reduce duplicative, unnecessary, or delayed care that increases costs. **The state anticipates a 20% reduction in hospitalizations and a 5% reduction in nursing home usage among Cal MediConnect enrollees.**



Benefits of Managed Care

- **Simplified, streamlined services:**
  - One point of contact for all covered benefits
  - One health plan membership card
  - One phone number to call for help
- **Improved access to home- and community-based services and reduced reliance on institutional settings**
- **Care and Setting Transition Teams**
- **Patient-centered care:**
  - Access to nurses, social workers, and a care coordination team
  - Beneficiaries and their families may participate in the care team
  - Continuity of care and care coordination between settings
- **Access to interpreters for non-English speakers and documents in their language**

Safeguards & Consumer Protections

- Can opt-out any time before or after passive enrollment
- Health plans required to ensure network adequacy
- Access to out-of-network Medicare providers for up to 6 months and out-of-network Medi-Cal providers up to one year
- Same standards for appeals and grievance processes for Medi-Cal and Medicare services, including fair hearing process for in-home supports and services
- Defined quality of care measures
- Right to hire, fire and train in-home supports and services workers
- Continual monitoring by Department of Health Care Services
- DHCS will enforce consumer protections
- DHCS can make changes to the program at any time
- Cal MediConnect will have a dedicated Ombudsman under DMHC

Up to 456,000 Dual Eligibles in 7 Pilot Counties

LOS ANGELES
(up to 200,000 duals)
- CareMore Cal MediConnect
- Care1st Cal MediConnect
- Health Net Cal MediConnect
- L.A. Care Cal MediConnect
- Molina Dual Options

ORANGE
- OneCare Connect (CalOptima)

RIVERSIDE
- IEHP DualChoice
- Molina Dual Options

SAN BERNARDINO
- IEHP DualChoice
- Molina Dual Options

SAN DIEGO
- Care1st Cal MediConnect
- CommuniCare Advantage (Community Health Group)
- Health Net Cal MediConnect
- Molina Dual Options

SANTA CLARA
- Anthem Blue Cross
- Santa Clara Family Health Plan

SAN MATEO
- CareAdvantage Cal Medi Connect (Health Plan of San Mateo)

For more information, please go to www.calhealthplans.org

California Association of Health Plans

December 2016

Program of All-Inclusive Care for the Elderly

About PACE

The Program of All-inclusive Care for the Elderly (PACE) model is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible. PACE serves individuals who are age 55 or older, certified by their state to need nursing home care, are able to live safely in the community at the time of enrollment, and live in a PACE service area. Although all PACE enrollees must be certified to need nursing home care to enroll in PACE, only about seven percent of PACE enrollees nationally reside in a nursing home. If a PACE enrollee does need nursing home care, the PACE program pays for it and continues to coordinate the enrollee's care.

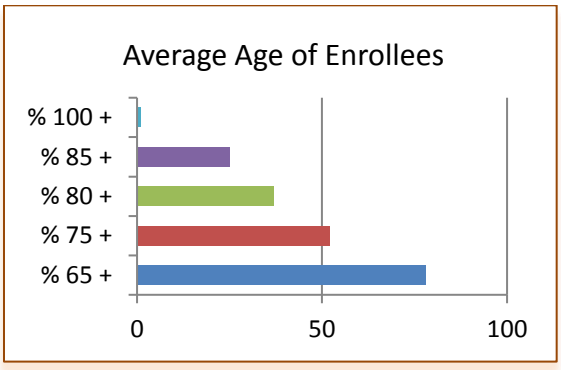
Total Enrollees Served

Since 2005, the operational PACE programs in California have served over 11,000 enrollees. As of July 2016, total enrollment statewide is 6,133 participants.

Enrollee Characteristics

This data is reported as of July 2016.

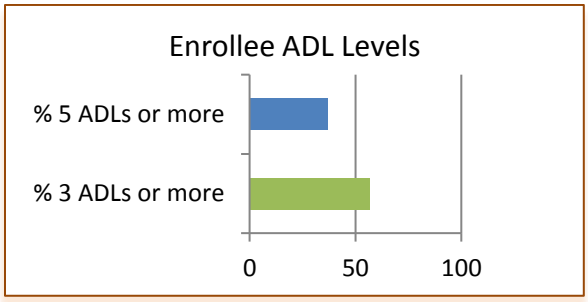
Age & Residency: The average enrollee age is 76. In California, 96% percent of PACE enrollees reside in the community, with only 4% living in nursing homes. PACE serves enrollees which are 65 years and above (78%) and 25% of the total population is aged 85 years and above.

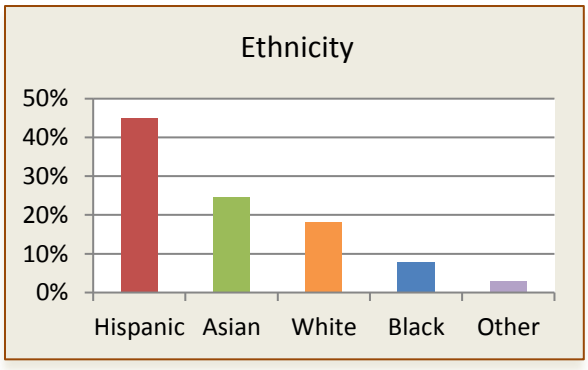


Multicultural & Multilingual: Primary languages spoken are Spanish (43%), English (31%), and Chinese (16%).

Eligibility for Medi-Cal & Medicare: 100% of enrollees are eligible for Medi-Cal. Currently 79% of enrollees are dually eligible for Medi-Cal and Medicare, and 21% are Medi-Cal eligible only.

Functional Status: The average Activities of Daily Living (ADL) level of PACE enrollees is 3.5.





CalPACE Program Characteristics

CalPACE, the California PACE Association, is a 501 (c)(6) association dedicated to the expansion of comprehensive health care services to the frail elderly though the Program of All-Inclusive Care for the Elderly (PACE). CalPACE was officially incorporated in August 2007 and is one of the first state-wide PACE Associations established in the United States.

As of 2016, our membership includes eleven operational PACE programs: AltaMed PACE, Brandman Centers for Senior Care (Los Angeles Jewish Home), CalOptima PACE, Center for Elders' Independence, Fresno PACE, On Lok Lifeways, Redwood Coast PACE, San Diego PACE, St. Paul's PACE, Sutter SeniorCare, and InnovAge PACE. CalPACE members provide services through 29 PACE centers and six alternative care sites in twelve counties—Alameda, Contra Costa, Fresno, Humboldt, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, and Santa Clara.

Enrollee Characteristics, Service Utilization & Satisfaction Measures

Enrollee Characteristics	
Average number of medical diagnoses	18
% with Alzheimer's or related dementia	41%
Average number of HCCs*	4.9
Average HCC score*	2.1
Average Risk score*	2.3
Utilization of Services	
Hospital admissions per 1,000	407
Average length of hospital stay (days)	5.3
Emergency Room visits per 1,000	485
Average PACE center days per participant per month	8.8
Enrollee Satisfaction Ratings	
% Very satisfied (% rating on overall PACE care)	93%
% Who would refer PACE to a close friend	93%

**Measures utilized by Medicare for number of chronic conditions*

CalPACE Location

1315 I Street, Suite 100
Sacramento, CA 95814

Contact Information

Peter Hansel
Chief Executive Officer
1315 I Street, Suite 100
Sacramento, CA 95814
(916) 469-3368
phansel@calpace.org
www.calpace.org

Jennifer Blankenship
Executive Assistant
1315 I Street, Suite 100
Sacramento, CA 95814
(916) 469-3386
jblankenship@calpace.org

Types of Adult Day Services in California

Adult day services are provided in two types of licensed settings:

1) **Adult Day Program (ADP)** facilities are licensed by the CA Department of Social Services
2) **Adult Day Health Care (ADHC)** licensed by the CA Department of Public Health. To serve and be reimbursed for the Medi-Cal population, a licensed ADHC must be certified as **Community Based Adult Services** center by the Department of Aging. CBAS is a mandated managed care plan benefit. CBAS participants meet strict eligibility requirements and are authorized for services by their Medi-Cal managed care plan.

Both ADPs and ADHC/CBAS centers serve adults with Alzheimer's disease or related dementias, complex physical, mental or developmental disabilities, cognitive impairments or other chronic disabling conditions. While providing person-centered individualized care, adult day services provide needed support for working caregivers, allowing them to maintain jobs and reduce the stress that often accompanies the responsibility of 24/7 care.

Alzheimer's Day Care Resource Center (ADCRC) is a specialized program within either the ADP or ADHC/CBAS setting. ADCRCs address the needs of persons with dementia by assisting each person to function at their highest level, while providing caregiver support and respite. State funding is no longer available for this service.

	ADP	ADHC/CBAS
General Description	Community-based facility or program for adults in need of personal care services, supervision, or assistance essential for sustaining the activities of daily living or for the protection of the individual on less than a 24-hour basis.	Organized day program of health services, therapeutic activities and social services for adults with chronic, disabling medical, cognitive or mental health conditions who are at risk for institutional placement.
Licensing Authority	CA Department of Social Services	CA Department of Public Health
Statutory Authority	H&S Code, Chapter 3	W&I Code, Chapter 7 H & S Code, Chapter 3.3
Medi-Cal Certification	Not funded nor certified by Medi-Cal	CA Department of Aging
Funding	Area Agencies on Aging; Regional Centers; Private Fees Community Donations	Medi-Cal Managed Care; Regional Centers; Private Fees Community Donations
Home Visit/Assessment	Optional	Required
Individual Plan of Care	Required	Required
Activity Program	Required	Required
Dietary Services	Required	Required
Meal/Snacks	Required	Required
Personal Care & Supervision	Required	Required
Transportation	Provide, arrange or assist	Provide or arrange
Medication	Assist with self-administration	Administration by RN
Social Services	Not required	Required
Skilled Nursing	Not required	Required
Physician Services	Not required	Required
Mental Health Services	Not required	Required
Occupational Therapy	Not required	Required
Physical Therapy	Not required	Required
Speech Therapy	Not required	Required

To learn more, visit www.caads.org or call California Association for Adult Day Services 916.552.7400.

How People with Intellectual and/or Developmental Disabilities (I/DD) Benefit from the Affordable Care Act (ACA)

The ACA made significant progress in expanding access to health care for individuals with intellectual and/or developmental disabilities. Access to consistent and reliable healthcare is imperative for individuals with I/DD, and the ACA created much-needed reforms to health insurance, addressed systemic discrimination, and expanded coverage.

Expansions of Health Coverage and Long Term Supports and Services

The Arc has a history of supporting expanding Medicaid to cover more low income individuals and provide more flexibility within the program.

- The ACA allowed states to extend their Medicaid programs to childless adults earning up to 138% of the federal poverty level. This change has provided coverage to millions of people, including individuals with I/DD and other disabilities and chronic health conditions who were not otherwise eligible for Medicaid.
- The ACA provided federal money to support Medicaid expansion. The additional federal contribution to expanding Medicaid has helped more people access health care without harming the existing programs that provide supports and services to people with I/DD.
- Several provisions of the ACA were designed to assist states to rebalance their long term supports systems and invest in the community instead of costly and outdated institutions. These include the Community First Choice Option (CFC) and the State Plan Home and Community-Based Services Option (also known as 1915(k) and 1915(i).
    - States utilizing 1915(k): California, Maryland, Montana, Oregon, Texas
    - States utilizing 1915(i): California, Colorado, Connecticut, Delaware, District of Columbia, Idaho, Indiana, Iowa, Louisiana, Maryland, Mississippi, Montana, Nevada, Oregon, Texas, Wisconsin

Selected Examples of Provisions of the ACA that Impact the Lives of Individuals with I/DD:

In addition to expansions of health coverage, the ACA provided important insurance requirements, nondiscrimination provisions, and long term supports and services expansions to ensure that everyone would have options for coverage.

1. Strong nondiscrimination provisions and health insurance reforms such as:
    - Banning the exclusion of people from health insurance coverage based on pre-existing conditions;
    - Preventing insurers from charging people with disabilities and health conditions significantly more for health insurance coverage; and
    - Eliminating annual and lifetime caps on health coverage.

2. Improving affordability of private health insurance through premium tax credits and cost-sharing assistance for low and moderate income individuals and eliminating medical underwriting;
3. Requiring a more comprehensive benefit package which includes rehabilitative and habilitative services and devices, mental health and substance abuse disorder services including behavioral health treatment, and critical prescription drug coverage;
4. Expanding access to health insurance in a number of important ways including:
    - Medicaid expansion to childless adults;
    - Expanding mental health parity provisions;
    - Requiring coverage for dependents until age 26;
    - Creating health insurance market places; and
    - Improving accessibility of medical diagnostic equipment; and
5. Expanding access to long term supports and services by:
    - Creating the Community First Choice Option allowing states to provide comprehensive participant-directed home and community based attendant services and supports as part of their state Medicaid plan;
    - Providing enhancements to the state plan home and community based services option;
    - Extending the Money Follows the Person Rebalancing Demonstration; and
    - Creating the Balancing Incentives Program to incentivize states to increase access to non-institutional LTSS.

Impact of ACA Repeal on Medicaid:

Repeal of the ACA would be devastating for all who have finally found coverage in the last seven years. In addition, repeal would undermine the basic health and long term supports provided by the Medicaid program.

- If the additional Medicaid expansion funding is repealed it will destabilize the Medicaid program in the 32 states that have expanded Medicaid.
- It will force states to make tough choices about eligibility and access to services and supports.
- It could cause substantial competition between diverse groups (children, people with disabilities, the elderly) for scarce resources.
- States would also be faced with how to finance the cost shift from the federal government to the states and may look to beneficiaries, family members, providers, and others to make up the difference.
- Significantly increased cost-sharing is not affordable for people with I/DD who receive Medicaid. Foregoing prescription drugs or other types of medical treatments will harm individuals and increase medical costs.

Maintain Access to Health Care

There are numerous other provisions in the ACA that are important to people with disabilities. The ACA has unquestionably improved access to care for people with disabilities and chronic conditions to help them live healthy, independent, and fulfilling lives. To eliminate the ACA or to eliminate the ACA without simultaneously replacing it with a functionally equivalent alternative, jeopardizes this progress and puts consumers' ongoing access to comprehensive, affordable coverage at risk. It is critical that the I/DD community is a part of any discussion about repeal and replace to ensure that any changes meet the needs of people with disabilities.

Multipurpose Senior Services Program Site Association, Inc.

1107 9th Street, Suite 701, Sacramento, CA 95814

Phone: 916. 552. 7400 ~ Fax: 866. 725. 3123

What is MSSP?—*The Multipurpose Senior Services Program (MSSP) is comprehensive care coordination model that:*

- Has operated under a federal Medicaid HCBS 1915(c) waiver since 1983 as an essential safety net provider
- Serves 12,081 chronically ill, disabled older adults annually in the home instead of a nursing home
- Provides patients with professional nursing, social work, and direct services necessary to remain safely at home: coordination with health care providers and family caregivers; in-home monitoring of health status and ensuring timely interventions—polypharmacy, pressure ulcers, signs and symptoms of acute cardiac, pulmonary, and neurological events; emergency response system rental; monitoring of medication adherence; transportation for health-related services; fall prevention interventions; supplemental personal & chore; protective supervision; temporary caregiver relief; linkage to dental care and mental health services, local food, clothing, non-medical equipment, incontinence supplies, donated household items, etc.
- Is comprised of a statewide network of 39 sites throughout California
- Is in the home and community, is a patient advocate and provides "eyes and ears" to the health care team
- MSSP has 30+ years of experience navigating and coordinating services in the community and building a relationship with medically complex patients to support their efforts to maintain independence.

Who does MSSP serve?—*MSSP patients are:*

- Sixty-five (65) years or older (average age is 85)
- Certified at nursing home level of care and *unable* to live at home safely without MSSP
- Medically and psychosocially complex, needing specialized medical and social support services
- The poorest community-dwelling elders—monthly income of $890 if single or $1496 for couples
- Heavily reliant on overwhelmed family caregivers or living alone with no family or friends to help.

MSSP and the Dual Eligibles Coordinated Care Initiative (CCI)

- MSSP is included in statute in the CCI demonstration counties. In non-demonstration counties, MSSP continues as a waiver program with providers under contract with the California Department of Aging
- The future of this program is uncertain in CCI and non-CCI counties. The funding mechanisms will be different, the sunset dates for the program in CCI counties are changing, and the decision to continue the program model in the CCI counties is unclear.

How is MSSP the SOLUTION for serving California's seniors?—*Total public costs of an MSSP patient are 47 percent LOWER than the cost of nursing facility placement*[1]

- MSSP saves the state an estimated **$110 million**[1] or more by decreasing nursing home placements, and cost savings are even greater with decreased use of emergency and acute care services
- Lowers healthcare costs—MSSP patients have multiple chronic conditions (MCC) and functional impairments—studies show these patients are the highest risk and highest cost health care utilizers in the absence of coordinated care such as MSSP
- Helps patients navigate the right level of healthcare services at the right time to prevent costlier care
- Helps patients identify and advocates for critically-needed services in a fragmented and shrinking safety net ensuring consumer protection
- The MSSP model provides patients with conflict-free care coordination—providers are charged with ensuring health and safety of patients served, and do not stand to gain from any other determination of need
- Maintains a network of providers through contracts with hundreds of small businesses throughout the state
- Health plan case management is typically telephonic and lacks: in-home assessment, frequent monitoring and purchased services; this model fails to adequately support frail Californians for safe community-living.

For more information, contact John Beleutz, MSA President at (831) 471-8010 or Erin Levi of Capitol Partners at (916) 930-0609.

[1]Based on data from CMS-372, Annual Report on Home and Community-Based Waivers (FY2010-11). This report compares annual average per capita Medicaid costs for HCBS for individuals in the waiver program with costs for institutionalized persons at the same level of care.