Informational Hearing:
In Home Supportive Services (IHSS) Integration into Medi-Cal Managed Care: Policy Considerations

Senate Human Services Committee
March 27, 2012
2:00-4:00pm

Background Paper

California's In Home Supportive Services (IHSS) program is the state's primary community-based long-term service, providing in-home domestic and personal care services for 442,000 aged, blind or disabled individuals living at or below the poverty level. The purpose of IHSS is to enable seniors and persons with disabilities to remain safely in their homes through the provision of a specified number of assistance hours provided by a home care worker under the direction of the consumer. The program is administered locally by counties and county public authorities under the direction and regulation of the Department of Social Services.

The program was established in 1979 as an innovative alternative to institutional care, and evolved in the context of a growing "independent living" civil rights movement led by persons with disabilities.[1] The program expanded significantly following the U.S. Supreme Court decision Olmstead v. L.C. in 1999 which established the rights of persons with disabilities to receive services in the most integrated setting possible for the purpose of "providing individuals with disabilities opportunities to live their lives like individuals without disabilities"[2] under the American with Disabilities Act (ADA).

The long anticipated rise in demand for long term services and supports (LTSS) as the "baby boomer generation" ages is expected to continue the previous decade of growth in the program for the foreseeable future. The nationwide economic recession has further eroded the financial stability of millions of seniors[3] who are now entering public programs. There are now about 1.9 million seniors and persons with disabilities (SPDs) enrolled in Medi-Cal, for which IHSS is an optional benefit. IHSS is widely acknowledged as a community based LTSS that reduces overall costs to the Medi-Cal program by reducing institutionalizations in nursing homes and developmental centers and state mental hospitals.

IHSS serves multiple policy goals for the state. IHSS is both a keystone program in California's Olmstead plan and an essential component of ADA compliance and it is a primary LTSS that may lower health care costs for the Medi-Cal program and potentially improve quality of care.

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[1] http://www.cicaihss.org/ihss-public-authority-history

[2] Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.* June 22 2011. http://www.ada.gov/olmstead/q&a_olmstead

[3] California Budget Project. http://www.cbp.org/pdfs/2011/111101_A_Generation_of_Widening_Inequality.pdf

Additionally, IHSS is credited with reducing overall unemployment and bringing millions of federal dollars into the state economy.[4]

Significant Policy Changes Proposed in Governors 2012-2013 Budget

The Governor's 2012-2013 January budget proposes to expand the "Dual Eligibles Coordinated Care Demonstration," authorized pursuant to SB 208 (Steinberg, 2010), which permitted the establishment of pilot projects in four counties to create new health delivery models that coordinate Medi-Cal and Medicare benefits. The Governor's new plan would expand the pilot from four counties to as many as ten counties, and it would further expand the scope of the pilots to fully integrate, as opposed to coordinate, Long Term Services and Supports, including IHSS, Community Based Adult Services (CBAS), Multipurpose Senior Services Programs (MSSP), nursing facilities and 1915 (c) home and community based waiver programs into Medi-Cal managed care over a phased period of three years. In order to access these LTSS, Medi-Cal beneficiaries would be required to enroll in Medi-Cal managed care plans as opposed to "fee for service" Medi-Cal in which beneficiaries manage their own care without a managed care plan. The Department has stated that integrating financial risk for long term care into managed care contracts is expected to lead health plans to voluntarily increase LTSS in order to reduce overall costs.

The Department of Health Care Services and the Department of Social Services have yet to release bill language for the proposal and have stated that in the first year the program will remain largely unchanged; however, the future of the IHSS program beyond years 1-3 is unclear. Prior to embarking on significant policy changes the legislature may wish to seek greater clarity regarding the long term future of the program. An additional overarching question is whether the plans' financial incentives regarding IHSS will be sufficiently aligned with the states interests with respect to the Americans with Disabilities Act and Olmstead decision.

IHSS and Olmstead and Americans with Disabilities Act

In Home Supportive Services did not begin as a Medicaid program, currently its primary funding source, but as a social services program funded through Title XX of the Social Security Act. Historically, the goal of the program is to assist seniors and disabled individuals with activities of daily living in order to enable them to live at home safely.

On June 19, 1999, the United States Supreme Court issued the landmark Olmstead decision which held that the American with Disabilities Act (ADA) and the Rehabilitation Act requires public entities to administer services "in the most integrated setting appropriate" and to "make reasonable modifications in policies, practices, or procedures…to avoid discrimination on the basis of disability, unless [the state] can demonstrate that making the modifications would

[4] http://laborcenter.berkeley.edu/californiabudget/budget_solutions_jobs10.pdf

fundamentally alter the nature of the services, program or activity," such as requiring new expenditures or closing institutions.[5] Most integrated setting is defined as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." Though not based on Medicaid law, the Olmstead ruling and the resulting Department of Justice regulations have widespread implications for the Medicaid program as it has become the primary funding source for home and community based services.

Prior to the Olmstead ruling, the growth of home and community based care was constrained by waiver policies and procedures that limited eligibility and enrollment. These include limitations on the number of waiver slots available, reimbursement rates that cover housing and meal costs in institutional settings but not community-based settings, caps on service costs per person, and limitations on the scope of services. The resulting wait lists for waiver programs and shortage of home and community based services are credited with creating the environment for the Olmstead decision.[6]

In deciding Olmstead, the court established a framework intended to balance the obligation of states to provide services in the most integrated setting possible with the financial limitations of the states, stating that public entities are required to provide community based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community based treatment; and (c) community based services can reasonably be accommodated, taking into account the resources available to the state and the needs of others who are receiving disability services from the entity.

Recent Court Decisions

California, facing repeated looming budget shortfalls, has sought to significantly reduce expenditures on home and community based services. While Olmstead does not require states to fundamentally alter its existing programs in ways that increase overall spending, it does provide legal recourse against budget cuts that may place individuals with disabilities at risk of unnecessary institutionalization. Recent efforts to reduce community-based LTSS have faced repeated court challenges and thus far been enjoined or are awaiting final determinations. These include:

Oster v. Lightbourne; Douglas
SB 73 (Statutes of 2011) as part of the 2011-12 Budget Act, sought to implement a 20 percent across the board cut to authorized hours to IHSS recipients, and is subject to a preliminary injunction from the Ninth Circuit District Court. The ruling stated that:[7]

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[5] Olmstead v L.C.

[6] Desonia, Randy, "Is Community Care a Civil Right? The Unfolding Saga of the Olmstead Decision". National Health Policy Forum, George Washington University. March 12, 2003.

[7] http://www.disabilityrightsca.org/news/V.L.ND.DKT.417%20ORDER.pdf

> SB 73 raises serious questions of violations of Title XIX of the Social Security Act, 42 U.S.C. § 1396a ("the Medicaid Act"), the Americans with Disabilities Act of 1990, 42 U.S.C. § 12312 ("ADA") or Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 ("Section 504"), by placing IHSS recipients at imminent risk of unnecessary and unwanted out-of-home placement, including in institutions such as nursing homes, board and care facilities, and psychiatric hospitals; by discriminating on the basis of type of disability; and by using methods of administration that will exclude individuals with disabilities from IHSS. The potential for IHSS recipients to apply for relief from the reductions mandated by SB 73 does not cure these defects.

Esther Darling et. al. v. Toby Douglas
AB 97 (Statutes of 2011) sought to entirely eliminate ADHC as an optional Medi-Cal benefit. The court issued a preliminary injunction against the statute stating the "new legislation completely eliminates the very services that the Court has previously concluded would result in irreparable harm."[8] The case was settled, leading to the development of the new Community Based Adult Services program modeled on the previous ADHC program.

Brantley v. Maxwell-Jolly, (2009); *Cota v. Maxwell-Jolly*, (2010)
ABx4 5 (2009) implemented program alterations and cuts to the Adult Day Health Care (ADHC) program which were enjoined by the Ninth Circuit District Court. Both injunctions rested, in part, on a finding that the Departments proposed reductions in available ADHC services, without ensuring provision of sufficient replacement services, would place impacted ADHC recipients at risk of institutionalization in violation of the ADA.[9]

Dominguez et. al. v. Schwarzenegger et. al.
Senate Bill X3 6 (Chapter 13, Statutes of 2009) reduced the level of state participation in IHSS wages and health benefits, from $12.10 to $10.10 per hour, effective July 1, 2009. The Ninth Circuit District Court issued a preliminary injunction order on July 26, 2009 (and further clarifying injunctions) finding that the State had violated the federal Medicaid Act which requires the Department "to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[10] The court has now signed a stipulation and order staying the case pending disposition of *Douglas v. California Pharmacists Association.*[11]

Douglas v. Independent Living Center of Southern California
Consolidated with:

- *Douglas v. California Pharmacists Association*
- *Douglas v. Santa Rosa Memorial Hospital*

The United States Supreme Court agreed to review this case in which the Department of Health Care Services challenged the right of affected parties to sue to enjoin reductions in state payments

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[8] http://www.disabilityrightsca.org/advocacy/Darling-v-Douglas/2011-06-02-Order.pdf
[9] http://www.ada.gov/olmstead/documents/darling_soi.pdf
[10] 42 U.S.C. section 1396a(a)(30)(A)
[11] http://dockets.justia.com/docket/california/candce/4:2009cv02306/215313/

for Medicaid. As mentioned, previous reductions in provider rates for Medi-Cal services, including IHSS rates, had been repeatedly enjoined by the Ninth Circuit District Court. The Department argued that only the federal government has the authority to enforce the Medicaid program and thus to ensure that states comply with the requirements that law imposes on them. Prior to the Supreme Court reaching a determination, CMS acted to approve several of the proposed changes to California's Medicaid program that had previously been enjoined by the District Courts. The Department argued that CMS's approval demonstrated the cuts were consistent with federal law. On February 22, 2012, the Supreme Court returned the issue to the District Court for further review and did not make a determination on whether affected parties may sue to stop rate cuts. The decision further stated that CMS approval of the rate cuts may affect the outcome of those challenges but that it did not necessarily render them moot.[12]

Current Statute Governing IHSS program

Scope of Services

The scope of supportive services provided through IHSS is defined in statute to include "domestic and related services, heavy cleaning, personal care services, accompaniment to health-related appointments or to alternative resource sites, yard hazard abatement, protective supervision, teaching and demonstration directed at reducing the need for other supportive services, and paramedical services which make it possible for the recipient to establish and maintain an independent living arrangement." (WIC Section 12300)

Personal care services are further defined to include assistance with ambulation i.e. walking; bathing, oral hygiene, and grooming; dressing; care and assistance with prosthetic devices; bowel, bladder, and menstrual care; repositioning, skin care, range of motion exercises, and transfers; feeding and assurance of adequate fluid intake; respiration; assistance with self-administration of medications.

Welfare and Institutions Code allows IHSS providers to perform paramedical services that are ordered by a licensed health care professional which consumers could provide for themselves but for their functional limitations. Paramedical services include the administration of medications, puncturing the skin or inserting a medical device into a body orifice, activities requiring sterile procedures, or other activities requiring judgment based on training given by a licensed health care professional.

The legislature may wish to consider specifying whether and to what extent the Department, counties, managed care plans or other entities would be permitted to reduce or alter the scope of services mandated under current law.

Delivery of Care

Current law provides numerous consumer protection provisions and program requirements governing the IHSS program largely implemented by counties and county public authorities including timely notices of eligibility and eligibility changes, an accessible appeals process, regular reassessments, required provider orientation, provider background checks, and

[12] http://www.supremecourt.gov/opinions/11pdf/09-958.pdf

standardized provider timesheets. Current law provides a structure for local IHSS advisory committees to provide stakeholder input to counties. The legislature may wish to consider which of these consumer protections and program requirements are essential to preserve at the county level and which should be reflected in managed care contracts.

The current program provides recipients the right to "self-direct" their care, although not all recipients are cognitively able to do so. Among IHSS recipients, there is wide range in the functional needs and level of independence, making a one-size fits all model of care delivery impractical. Some recipients may have a physical or cognitive impairment, but are not otherwise medically needy. Such recipients rely on IHSS for assistance with activities of daily living that enable a typical lifestyle including employment, social and community activities, and an otherwise fully independent living arrangement. Other recipients may be medically needy, but are cognitively independent and capable of managing their own care under the direction of an aide. An increasing number of recipients are aging seniors who may have substantial cognitive and physical impairments combined with medical conditions that make care management particularly relevant. The legislature may wish to consider specifying a consumer's right to self-directed care in managed care contracts. Additionally, the issue of "self-directed care" may be an important consideration in the development of a uniform assessment tool, discussed below.

Existing law allows counties the option of utilizing a public authority or a nonprofit consortium to act as the employer of record, to establish local registries, perform provider background checks and other specified functions. All but two counties have opted to create a public authority for this purpose.

Existing law provides for the "contract mode" or the "individual provider mode" of service delivery, or a mix of the two, but requires counties with more than 500 recipients to offer an individual provider employer option. The "contract mode" refers to an arrangement where providers are employees of an agency that has a contract with the county to provide services. The contract agency is responsible for the hiring, supervision, and firing of contract providers although the recipient retains the right to recruit, select, train, reject, or change their provider. In contrast, the "individual provider mode" permits consumers to hire, fire, train and supervise their provider, in conjunction with the oversight and registry services provided by the public authority.

Recent Dual Demonstration applications submitted to the Department of Health Care Services by managed care plans outlined highly varied visions for how plans would change these elements of the program. The legislature may wish to specify whether existing statutes preserving existing service modes should be reflected in managed care contracts.

Uniform Assessment Tool

Current Assessment process
In 1988, the CDSS implemented a Uniform Assessment Tool (WIC Section 12309) on a statewide basis in order to assure that in-home supportive services were delivered in all counties in a uniform manner. This functional index tool applied only to IHSS, and is not integrated with other LTSS including CBAS, MSSP, and other waiver programs.

The functional index is measured on a 0-5 (or sometime 0-6) scale as established in Welfare & Institutions Code 12309, as follows:

Rank 1	Functioning is independent, and he or she is able to perform the function without human assistance, although the recipient may have difficulty in performing the function, but the completion of the function, with or without a device or mobility aid, poses no substantial risk to his or her safety.
Rank 2	Able to perform a function, but needs verbal assistance, such as reminding, guidance, or encouragement.
Rank 3	Can perform the function with some human assistance, including, but not limited to, direct physical assistance from a provider.
Rank 4	Can perform a function, but only with substantial human assistance.
Rank 5	Cannot perform the function, with or without human assistance.
Rank 6	Paramedical Services Needed

The “Functional Index Rank” is set for each task when the social worker evaluates the hours and type of care an IHSS consumer needs to remain independent. For example, a consumer can be ranked as a “3” for bathing and as a “4” for meal preparation. The “Functional Index Score” is the average of the Functional Index Rankings as determined by the social worker. As previously mentioned, efforts to achieve budgetary savings by reducing the functional index levels that qualified to receive services were enjoined by the courts on the basis of the ADA and Olmstead.

Additionally, Section 12301.2 of the Welfare and Institutions Code requires counties to use statewide hourly task guidelines, established by CDSS, when conducting assessments or reassessments in order to consistently assess and authorize service hours in a standard way. The guidelines specify a range of hours associated with each FI level (2-5) for each task.

According to regulations, when assessing time for services, the time authorized must be “based on the recipient’s individual level of need necessary to ensure his/her health, safety and independence based on the scope of tasks identified for service.” Regulations further state that, “in determining the amount of time per task, the recipient’s ability to perform the tasks based on his/her FI ranking shall be a contributing factor, but not the sole factor.”

Additionally, current law requires recipients to obtain a certification from a licensed health care professional declaring that the applicant or recipient is unable to perform some activities of daily living independently, and that without services to assist him or her with activities of daily living, the applicant or recipient is at risk of placement in out-of-home care.

Governor's Proposal for New Uniform Assessment Tool
The Governor calls for, as part of the Duals Demonstration proposal, the development of a new uniform assessment tool that would incorporate and consolidate the multiple assessments used for IHSS, MSSP, CBAS, the Nursing Facilities waiver program and the Home and Community Based Waiver program. According to the administration, the Department of Health Care Services, Department of Social Services, and Department of Aging would lead a stakeholder process for this purpose, starting June 2013, to be implemented upon completion of design, development, system testing, and training, no earlier than January 1, 2015.

The administration further states that the tool would be used by managed care health plans, county social service agencies for IHSS, CBAS providers, MSSP sites, other home and community-based providers, and institutional nursing facility providers to assess the need for LTSS. This tool would not replace the assessment process used by managed care plans when beneficiaries initially enroll.

On December 1, 2011, prior to release of the Duals proposal, California submitted a 58-page State Plan Amendment (SPA) in response to the Community First Choice Option waiver established by the federal government which includes a 6% increase in federal participation for the provision of community-based attendant services and supports. The waiver includes funding for the purpose of creating a new uniform assessment tool encompassing LTSS as well as a "No Wrong Door" approach to the provision of these services and offered the following guidelines for the development of the assessment tool:[13]

> We propose…that the assessment include information about an individual's health condition, personal goals and preferences for the provision of services, identified functional limitations, age, school participation status, employment, household, and other factors that are relevant to the authorization and provision of services, and support the finding for need of home and community-based attendant services and supports and development of the service plan and budget. We are currently working to determine universal core elements to include in a standard assessment for consistency across programs. As these elements are identified, it is expected States will incorporate these elements in the assessment of need to be used for Community First Choice.

The proposed changes to IHSS in California's CFCO SPA do not include the proposal to integrate IHSS into Medi-Cal managed care found in the Duals Demonstration proposal. The status of California's proposed SPA in accordance with the CFCO is unclear.

The content and application of the uniform assessment tool and functional index scoring system has been viewed in previous court decisions as an important element in determining whether the states obligations under the ADA, the Olmstead decision, and the Rehabilitation Act of 1973 are met. The legislature may wish to consider specifying the manner and process in which a new uniform assessment tool is established including specific principles and objectives for any new assessment tool.

[13] https://www.federalregister.gov/articles/2011/02/25/2011-3946/medicaid-program-community-first-choice-option#p-71

Other states, such as Wisconsin have been experimenting with uniform assessment tools since 2001 and in doing so engaged in extensive stakeholder processes that lasted in some cases as long as eight years. California may wish to investigate the feasibility of adapting and building upon these existing tools.

Measuring Outcomes and Assuring Quality

Currently, there are relatively few quality assurance measures for community based long term supports and services that are widely accepted, however such measurements have been identified as critical element for proposals that integrate community based LTSS into managed care since plans often lack experience managing social service programs.

Wisconsin has developed tools for measuring outcomes and quality in community based LTSS based on "Personal Experience Outcomes." Such outcome measurement tools seek to account for the wide variety of preferences and expectations that seniors and persons with disabilities may have for their care.

The project states[14]:

> In our long-term care system we strive to empower the individuals who receive services (participants, members, or consumers) to have choices—to have a "voice" or say about things that affect their quality of life and to make decisions as they are able. People with cognitive disabilities are supported to actively participate in the ways they are able, and their decision-makers (guardians or POA) keep their perspectives in mind for making decisions.
>
> People who participate in a long-term care programs need to feel they are 'citizens', not parts of a 'program' and that they are treated with respect. The focus of supports and services is to assist people in their daily lives, not to take them over or get in the way of the experience.

These personal experience outcomes are measured using some of the following statements:

- I decide where and with whom I live.
- I make decisions regarding my supports and services.
- I decide how I spend my day.
- I have relationships with family and friends I care about.
- I do things that are important to me.
- I am involved in my community.
- My life is stable.
- I am respected and treated fairly.
- I have privacy.
- I have the best possible health.
- I feel safe.
- I am free from abuse and neglect

[14] http://www.chsra.wisc.edu/peonies/personal-experience-outcomes.htm

Additionally, in the state of Wisconsin this tool is used by an External Quality Review Organization (EQRO) as part of the annual review process for their integrated long term care program.

Last year, the Department of Health Care Services began implementation of its plan to mandatorily enroll Medi-Cal eligible seniors and persons with disabilities (SPDs) into Medi-Cal managed care plans (MCPs) where available. The stated goal of the proposal is to provide SPD beneficiaries with a high-quality system of care that improves access and care coordination. However, recent hearings in the Senate and Assembly Budget Committees included testimony from advocacy groups and legal aid organizations which indicated that there may be implementation problems which may have significant impacts on the health and wellbeing of the population affected. Despite inclusion of a variety of patient protection measures, advocacy groups have stated that enforcement of those protections has been lacking. The legislature may wish to consider strengthening enforcement measures and increasing legislative oversight for this policy proposal.