



Overview of Long-Term Care Programs in the Long-Term Care Division

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DEPARTMENT OF HEALTH CARE SERVICES

Webinar Overview



- Long-Term Care Programs
- Care Coordination and Payment Structures/Responsibilities
- Universal Assessment
- Future of Long-Term Care and Conclusion
- Questions?

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LTC Programs (Home and Community-Based Waivers)

List of Long-Term Care Programs

- **California Community Transitions (CCT)**
- **Assisted Living Waiver (ALW)**
- **Nursing Facility/Acute Hospitals (NF/AH)**
- **Developmentally Disabled (DD)**
- **HIV/AIDS**
- **In-Home Operations (IHO)**
- **San Francisco Community Living Support Benefit (SF-CLSB)**
- **Pediatric Palliative Care (PPC)**
- **1915(i) SPA: DD-RC**

California Community Transitions (CCT)

- **Federal grant funding to implement a Money Follows the Person (MFP) Rebalancing Demonstration program (known as CCT in California)**
 - Provides individuals living in a nursing home or other institution new opportunities to live in the community with the services and supports they need
 - In 2012, 432 CCT Transitions, capacity to double in 2015
 - CCT Project pre-transition services are available through September 30, 2016
- **Entry point for NF transitions to LTSS programs**

California Community Transitions (CCT)

- **Eligibility:**
 - Person must be a Medi-Cal beneficiary for at least one day
 - Person must be an SSI/SSP recipients
 - Person must have been living in an inpatient facility (freestanding NF or DP/NF, acute or ICF/DD) for 90 consecutive days not on Medi-Care
 - Person must continue to require the “level of care” provided in a health care facility to transition to an HCBS waiver

California Community Transitions (CCT)

- **Services provided**
 - Help access IHSS program
 - Search for affordable housing
 - Assist in training personal attendants
 - Assist in interviewing and hiring caregivers
 - Follow-up assistance: post-transition coordination
 - Home set-up: home and vehicle modifications
- **Provider Types:**
 - Independent Living Centers
 - Department of Developmental Services
 - Home Health Agencies
 - Other Community Organizations (e.g. SCAN, IOA, Rehabilitation Services of Northern CA)

California Community Transitions (CCT)

- **Individuals who are in CCT:**
 - Most have physical or developmental disabilities
 - Less elderly in CCT: challenging, tend to require more medical care, supervision and LTSS
 - Person with DD/ID
- **Geographic Service Area**
 - Northern region: Alameda, San Joaquin, Sacramento
 - Southern region: Los Angeles, Orange, San Bernardino

For list of all CCT counties, visit the DHCS website:

<http://www.dhcs.ca.gov/services/ltc/pages/CCT.aspx>

Overview of 1915(c) HCBS waivers

- **Must reside in HCB settings**
- **Must only be on one 1915(c) waiver**
- **Must be NF certifiable**
- **7 Assurances**
- **Waive – eligibility, statewideness, comparability**
- **In general, waiver slot is held for 30 days if admitted to institution and no payments made for holding slot**

Assisted Living Waiver (ALW)

- Provides HCBS as an alternative to long-term nursing facility placement for Medi-Cal beneficiaries in either of two settings: a Residential Care Facility for the Elderly or in Publicly Subsidized Housing with a Home Health Agency providing the assisted care services
- Assisted Living Waiver
 - Capacity: 3,000
 - Current # of participants: 2,500
- Eligibility
 - Person must be age 21 years and older
 - Person must be eligible for full-scope no share-of-cost or share-of-cost Medi-Cal
 - Person must require a nursing facility level of care
 - Person must be receiving SSI/SSP

Assisted Living Waiver (ALW)

- **Services**

- 24 hour oversight
- Personal care and assistance
- Health-related services: skilled nursing
- Arrange/provide transportation
- Social services

- **Provider Types**

- Care Coordination Agencies (CCA)
- Service Providers: Residential Care Facility for the Elderly (RCFE) and Home Health Agencies (HHA)
 - Visit the following link for more information about service providers:
<http://www.dhcs.ca.gov/services/ltc/pages/alwpp.aspx>

Assisted Living Waiver (ALW)

- **Geographic Service Area**
 - **Counties:** Fresno, Los Angeles, Riverside, San Diego, Sacramento, San Joaquin, Sonoma, Alameda and Contra Costa
- **Expanding to Santa Clara, San Mateo, Orange and San Bernardino retroactive to 3/1/2014**
- **NF Transition waiver**
 - 1 community to 1 NF transition
 - Housing afforded through waiver enrollment
- **Waitlist: None**

Nursing Facility/Acute Hospital (NF/AH)

- NF/AH waiver implemented in January 2007
- Consolidates the Nursing Facility A/B, Nursing Facility Subacute and the In-Home Medical Care waivers
- NF/AH offers services for individuals at home who would otherwise receive care for at least 90 days in a skilled nursing, intermediate care, subacute facility, or an acute care hospital
- Non residential, residential facility provider types
- Target Population:
 - Medically Fragile
 - Technology dependent
 - Aged (65 and older)
 - Physically disabled (under age 65)

Nursing Facility/Acute Hospital (NF/AH)

- **Eligibility**

- Person must have full scope Medi-Cal Eligibility
- Person must be physically disabled (No Age Limit)
- Person must meet the following levels of care:
 - Acute hospital (90 days +)
 - Adult or pediatric subacute nursing facility (180+ days)
 - Distinct-part nursing facility (180+ days)
 - Adult or pediatric Level B (skilled) nursing facility and Level A (intermediate) nursing facility (180+ days)

Nursing Facility/Acute Hospital (NF/AH)

- **Services**
 - Case management (e.g. transitional)
 - Home health aide services
 - Home modifications to enable improved access
 - Personal care
 - Medical equipment maintenance and recurring expenses
 - PERS (Personal Emergency Response service, installation and fees)
 - Respite care (both at home and in residential care on a temporary basis)
 - Skilled nursing services

Nursing Facility/Acute Hospital (NF/AH)

- **Geographic Service Area: Statewide**
- **Waiting list: Yes (for certain levels of care)**
- **Demographics**
 - **People admitted to NF tend to be older (65 years and older)**
- **Living arrangements**
 - **Over one-quarter of duals with extended stay NF admission were living alone prior to admission**
- **Reimbursement LOC cap amount: direct individual services monthly so not to exceed LOC cost cap**

Developmentally Disabled (DD) Waiver

- Provides HCBS to Regional Center consumers with developmental disabilities, enabling them to live in the community rather than in an intermediate care facility for the developmentally disabled
- Provider type: Regional Centers
 - Visit website for more information:
 - DHCS website: <http://www.dhcs.ca.gov/services/ltc/pages/dd.aspx>
 - DDS website: <http://www.dds.ca.gov/RC/Home.cfm>
- Diagnosis:
 - Persons in waiver diagnosed with developmental disability before the age of 18
 - Includes: cerebral palsy, epilepsy, autism, other neurological conditions
- Enrollment Cap (persons per waiver year)
 - 110,000 – 2013/14
 - 115,000 – 2014/15
 - 120,000 – 2015/16
- Current Enrollment: 100,000+

Developmentally Disabled (DD) Waiver

- **Eligibility**

- Person must be eligible or have full scope Medi-Cal
- Person must have a formal diagnosis of a developmental disability before the age of 18 (and expected to continue indefinitely)
- Person must be a Regional Center consumer
- Person must meet at a minimum the level of care of intermediate care for ICF/DD-type facilities

*Persons residing in a State Developmental Center are ineligible for waiver enrollment

Developmentally Disabled (DD) Waiver

- **Services include coverage for:**
 - **Case management (TCM benefit contained in CA State Plan and not billed directly to DD waiver)**
 - **Chore services**
 - **Homemaker**
 - **Home health aide services**
 - **Respite care**
 - **Habilitation**
 - **Environmental accessibility adaptations**
 - **Skilled nursing**
 - **Transportation**

Developmentally Disabled (DD) Waiver

- **Geographic Service Area:** Statewide
- **Waitlist:** None
- **Reimbursement:** DDS pays directly to Regional Centers on FFS basis and claims FFP from DHCS

HIV/AIDS Waiver

- Provide service alternatives to hospitalization or institutional care to persons living with HIV or AIDS
- Department of Public Health/Office of AIDS (OA) administers waiver program
- OA contracts with AIDS Waiver agencies to implement the waiver at local level
 - HIV/AIDS waiver provider CDPH website link:
<http://www.cdph.ca.gov/programs/aids/Pages/tOACareProviders.aspx>

HIV/AIDS Waiver

- **Eligibility**

- Person must be full-scope Medi-Cal
- Person must be eligible for Medical Assistance
- Person must be diagnosed with Symptomatic HIV or AIDS (foster kids or HIV/AIDS waiver)
- Person must meet the level of care needs for a Skilled Nursing Facility
- Person must meet financial requirements as determined by local County Assistance office
- Person may not be in a hospice program

HIV/AIDS Waiver

- **Services**

- Supplemental skilled nursing
- Supplemental home health aide
- Homemaker services
- Nutritional Consultations
- Durable Medical Equipment and Supplies
- Transitional Services
 - One time expense not to exceed \$4,000 per person
 - Expense is used to transition from institution to own home or in the community

HIV/AIDS Waiver

- **Provider Types:** AIDS Waiver Agencies (local non-profits; some county-based)
- **Geographic Service Area:** Regional (43 counties covered)
- **Enrollment limits:** None
 - Allowable cost limit for each waiver client is \$13,209 per calendar year
 - No waitlist
- **Currently enrolled:** 2,897
- **Reimbursement:**
 - FFS directly billed to DHCS
 - No bundled services
 - Waiver Agency provides case management and contracts for all direct services

In-Home Operations (IHO)

- Established in January 2007
- Serves Medi-Cal beneficiaries who require direct care services provided primarily by a licensed nurse and needed services in excess of that available through the NF/AH waiver
- Non residential provider types
- Eligibility
 - Person must have full-scope Medi-Cal Eligibility
 - Person must be physically disabled (no age limit), blind or over the age of 65
 - Person is unable to live safely at home without care
 - Person must meet certain financial requirements

In-Home Operations (IHO)

- **Target Populations:**
 - Individual from birth onwards who are Medically Fragile or Technology Dependent
- **Services**
 - Environmental Accessibility Adaptations
 - Case management
 - Respite Care (home and facility)
 - Personal Emergency Response System
 - Community Transition Services
 - Home Health Aide Services
 - Habilitation Services
 - Family Training



In-Home Operations (IHO)

- **Providers**
 - **HCBS Benefit Provider:** licensed psychologist, marriage and family therapist (MFT), Licensed Clinical Social Worker (LCSW)
 - **HCBS Waiver Nurse Provider - RN**
 - **Home Health Agency - RN**
 - **Independent Provider (IP)**
- **Geographic Service Area: Statewide**
- **Waitlist: None***
- **Reimbursement:**
 - **LOC cost cap = direct individual services not to exceed annual LOC cost cap**
- * **IHO Waiver has closed statewide and no longer accepts new applicants**



San Francisco-Community Living Support Benefit (SF-CLSB)

- Assist individuals to move into available community settings and increase independence
 - Eligibility
 - Person must be a resident of San Francisco
 - Person must be at least age 21 years or over
 - Person must be eligible for placement in an SNF or ICF
 - Person must be homeless and at risk of entering a nursing facility
 - Person is determined to benefit from supportive housing
- *Nurses from SF DPH determines eligibility for waiver
- *Waiver is limited to State-approved housing
- Adult Residential Facilities (ARFs)
 - Direct Access Housing (DAHs)



San Francisco-Community Living Support Benefit (SF-CLSB)



- **Services**

- **Care Coordination (Enhanced)**
- **Community Living Support Benefit in licensed settings**
- **Behavior Assessment and Planning**
- **Environmental Accessibility Adaptations**
- **Home delivered meals in housing sites**



San Francisco-Community Living Support Benefit (SF-CLSB)

- **Provider Type**
 - SF City and County staff
 - ARFs
- **Geographic Service Area:**
 - City and County of San Francisco, Alameda
- **Reimbursement:**
 - Through city and county of San Francisco and receive FFP from DHCS
- **Participants not in CCI as they are clients of city and county of San Francisco**



Pediatric Palliative Care (PPC) for Children

- Provide services to children with chronic, complex and/or life-threatening conditions and their families
- Target Population:
 - Children under 21 who are medically fragile and technology dependent
- Eligibility
 - Person must be under 21 years old
 - Person must have full scope Medi-Cal
 - Person must reside in participating county
 - Person must have a life-threatening medical condition
 - Person must meet level of care



Pediatric Palliative Care (PPC) for Children

- **Services**
 - Community-Based Care Coordination
 - Pain and symptom management
 - Expressive therapies (art, music, play, massage)
 - Respite care (in-home/out-of-home)
 - Family education
 - Bereavement support
- **Provider types**
 - Home Health Agencies
 - Local participating hospice agencies



Pediatric Palliative Care (PPC) for Children

- **Geographic Service Area**
 - Counties: Alameda, Monterey, San Diego, Santa Clara, Santa Cruz, Marin, Orange, San Francisco, Sonoma, Fresno, Los Angeles
- **Participants of PPC are not eligible for CCI due to minimum age requirement**



1915(i) SPAs (Developmentally Disabled – Regional Centers)



- **1915(i) State Plan Amendment (09-023A and 11-041)**
 - CMS approved 2013 DD services under State Plan
 - Targets DD individuals with a need for habilitation services
 - Extends Medi-Cal eligible coverage for existing specialized health and other HCBS provided to Medi-Cal eligible persons with DD
- **Projected Numbers of DD individuals to be served annually:**
 - 2012-13 = 46,000
 - 2013-14 = 48,000
- **Eligibility Criteria:**
 - Criteria for DD services must be less stringent than the institutional level of care criteria required under other Medi-Cal waivers



1915(i) SPAs (Developmentally Disabled – Regional Centers)

- **Eligibility**

- Person must be determined by RC to be in need of habilitation services
- Person must have impairment/condition resulting in three or more of major life activities:
 - Learning
 - Self-care
 - Mobility
 - Capacity for independent living and economic self-sufficiency



1915(i) SPAs (Developmentally Disabled – Regional Centers)

- **Services**
 - Habilitation (e.g. community living arrangement, day services, behavioral intervention)
 - Respite Care
 - Homemaker services
 - Home Health Aide (CBAS)
 - Personal Emergency Response Systems
 - Vehicle modification and adaptation
- **Provider Type:** Regional Centers, Foster Family Agency (FFA)-Certified Family Homes (children only), Group Homes (children only), Adult Residential Facilities (ARF), RCFEs
- **Geographic Services Area:** Statewide



1915(i) SPAs (Developmentally Disabled – Regional Centers)

- **Community Living Arrangement Services (CLAS)**
 - **Licensed/certified settings**
 - Includes assistance with acquisition, retention, or improvement in skills related to living in community
 - Services and supports include daily living activities, adaptive skills, social and leisure skill development
 - **Supported living services (provided in residences owned or leased by the recipients)**
 - Includes daily living activities, locating and scheduling medical services
 - Selecting and moving into a home
 - Training and hiring personal attendants

- **Waitlist: None**



Care Coordination and Payment Structures/Responsibilities



CCT Care Coordination

- **CCT Care Coordination:**
 - **Organizations work directly with eligible individuals and Medicaid State Agency**
 - Center for Independent Living (CIL)
 - Alternative Home Care (AHC)
 - Home and Health Care Management (HHCM)
 - Elder Options, Inc (EO)
 - **Team members work with participant to design personal service plan detailing health, social and supportive services needed to transition to community living**
 - **Monthly support meetings with DHCS LTCD**



CCT Payment Structure/Responsibilities

- **No Cost Cap**
 - Average cost varies by target population: \$18,000-\$101,000
 - Average cost for entire CCT population: \$48,000 per beneficiary per year
- **CCT lead organizations receive hourly reimbursement for providing transition coordination services, home set-up costs, home/vehicle modification costs and post transition care coordination**



CCT Payment Structure/Responsibilities

- CCT LOs bill Medi-Cal FFS and is carve out from CCI
- CCT and CCI care coordination:
 - Plan or CCT LO identifies NF transition with Plan RN and ICT to discharge and establish community care plan
 - CCT LO finds housing

CCT Data

CCT Participants by Target Population*

Elderly	PD	DD/ID	MH
23%	46%	29%	2%

* MFP/CCT Performance Data is reported to CMS biannually. The CCT Performance Data presented at the March 7, 2014 LTSS Advisory Committee Meeting only included the first 6 months of calendar year 2013. Updated data will be posted on the Community Choices website as it becomes available.

CCT Post-Transition HCBS

Informal Support	IHSS Only	NF/AH Waiver	Other Waivers**	ALW	DD Waiver
9%	35%	12%	1%	14%	29%

** Other Waivers = AIDS, MSSP, Specialty MH Consolidation Program (SMHCP)

CCT Data

Housing Outcomes by Target Population

Target Population	Home	Apartment	ALW	Group Home
Elderly	25%	37%	36%	2%
PD	22%	65%	12%	1%
DD/ID	6%	9%	2%	83%
MH	43%	38%	19%	0%
Total Population	18%	42%	15%	25%

1-year CCT Post-transition Status

Remained in the community for the entire 365-day Demonstration	Died	Re-institutionalized	Other (no longer Medi-Cal eligible, moved out of state, etc.)
80%	7%	8%	5%

CCT Data

Post-transition HCBS Cost***

Which costs are included?	Cost for all CCT Participants (post-transition) who completed 365-day Demonstration within CY 2012
Time Period	Jan. 1, 2012 through Dec. 31, 2012
Average Cost	\$48,222 per beneficiary
Low	\$18,000 per beneficiary
High	\$101,000 per beneficiary
Savings	20% of the annual cost of care in a long-term nursing facility

*** The average cost of post-transition services varies by target population



ALW Care Coordination

- **Care Coordination includes:**
 - Enrolling clients
 - Conducting assessments (using ALW Assessment Tool)
 - Determining Level of Care (based on tiers)
 - Help transition clients from nursing facilities to RCFEs or PH setting
 - Capacity: 3,000
 - Current # of participants: 2,500
- **NF Transition Care Coordination**
 - Contracted Care Coordinators may provide transition care coordination for up to 180 days prior to transitioning an individual from skilled nursing facility into ALW program



ALW Care Coordination

- **Home Health Agency in PSH**
 - Develop Service Plan for each resident
 - Provide personal care and assistance
- **RCFE:**
 - **Assisted Living Services**
 - Provided or coordinated by RCFE staff
 - RCFE staff develop Service Plan for each resident
 - Provide other services to meet individual special needs
- **ALW and MLTSS Care Coordination**
 - ALW care manager on Plan ICT to understand full medical picture and ensure daily care is delivered and person-centered



ALW Payment Structure/Responsibilities

- **Frequency**
 - Minimum of every 30 days face-to-face visit
 - Re-assessment conducted every 6 months
 - Individual is disenrolled if level of care needs improve and sustain for 60 days at a level that no longer qualifies for ALW
- **Payments**
 - CCA are paid for finding, evaluating, placing, and monitoring ALW participants
 - Service providers (RCFEs and HHAs) are reimbursed based at four levels of care, with daily rates ranging from \$52/day for Tier 1 to \$82/day for Tier 4, establishing Tier 5 at \$200/day for applied behavior needs
 - Payment is for services where RCFEs or landlords receive in addition to SSI/SSP payments for room and board (about \$35/day)



ALW Payment Structure/Responsibilities

- **RCFE's Care Coordination Cost: \$200/participant/month for care coordination services and for coordination of other benefits and services**
- **Additional funds:**
 - **\$1,000 lifetime benefit for Nursing Facility Transition Services for relocating from a nursing home**
- **Waitlist: None - assessed by Care Coordination Agency depending on level of care and availability**
- **ALW services are provided as a carve out to MLTSS**
- **ALW is not provided to Cal MediConnect members**



ALW Data

- **Age Range:** 85% are 65 and older
15% are ages 22-64
- **Average Cost Per Client:** \$17,356
- **Most Prevalent Diagnosis:** 60% Dementia
26% Alzheimer's
10% Schizophrenia
4% Traumatic Brain Injury
- **Average Length of Stay:** 247 days



NF/AH Care Coordination

- **NF/AH Care Coordination**
 - DHCS Northern and Southern California regional office conducts initial waiver LOC evaluations and reevaluations and ongoing case management activities
 - Waiver participants must have Plan of Treatment (POT) signed by representative, primary care physician and HCBS Waiver providers describing participant's care services, frequency, scope and duration
- **NF/AH and MLTSS Care Coordination**
 - NF/AH care manager on Plan ICT to understand full medical picture and ensure daily care is delivered and person-centered

NF/AH Payment Structure/Responsibilities

- **Level of Care annual waiver budget expenditures:**

Acute Hospital	\$ 305,283
NF Subacute Pediatric	\$ 240,211
NF Subacute Adult	\$ 180,219
NF B Pediatric	\$ 101,882
NF B DP	\$ 77,600
NF B	\$ 48,180
NF A	\$ 29,548
ICF/DD-CN (non-ventilator dependent)	\$ 140,678
ICF/DD-CN (ventilator dependent)	\$ 155,461

- **Individual cost cap amount depends on level of care**



NF/AH Payment Structure/Responsibilities

- Services are delivered through HHAs, DME companies, Nurse Providers, Licensed clinical social workers, WPCS providers
- Reimbursement:
 - NF/AH services are provided as a carve out to MLTSS
 - NF/AH is not provided to Cal MediConnect members



NF/AH Data

- **Age Range:** 67% are ages 22-64
20% are ages 65 and older
13% are ages 21 and under
- **Average Cost Per Client:** \$41,744
- **Most Prevalent Diagnosis:** 45% Cerebral Palsy
30% Muscular Dystrophy
15% Quadriplegia
10% Respiratory Failure
- **Average Length of Stay:** 339 days



DD Waiver Care Coordination

- **Care Coordination by Regional Centers**
 - Responsible for intake, assessment, evaluation, and diagnostic services, preventative services, and case management/service coordination
 - Fund provision of preventive services through contracts with private vendors and implement individual program plans (IPP)
 - Conduct quality assurance activities
 - Conduct assessment (Client Development Evaluation Report (CDER))
- **DD Waiver**
 - Capacity: 95,000 (since 2010)
 - Additional slots per year: 5,000
 - Current # of participants: 100,000+
- **DD Waiver and MLTSS Care Coordination**
 - DD care manager on Plan ICT to understand full medical picture and ensure daily care is delivered and person-centered



DD Waiver Payment Structure/Responsibilities

- **Client cost cap: No cost limit**
- **Reimbursement:**
 - DD services are provided as a carve out to MLTSS
 - DD waiver is not provided to Cal MediConnect members



DD Waiver Data

- **Age Range:** 62% are ages 22-64
34% are ages 21 and under
4% are ages 65 and older
- **Average Cost Per Client:** \$22,777
- **Most Prevalent Diagnosis:** 35% Mild Profound Mental Retardation
25% Autistic Disorder
20% Seizures
20% Cerebral Palsy
- **Average Length of Stay:** 339 days



HIV/AIDS Waiver Care Coordination

- **Care Coordination**

- **Case management programs (case managers)**

- Initiates comprehensive assessment of individual's health status (includes psychosocial, nutritional, financial, environmental and risk status) to develop a service plan
- Service plan includes individual's needs, goals/objectives, services and interventions to be provided

- **Licensed Home Health Aide who is a Certified Nursing Assistant (CNA)**

- CNAs are certified by CDPH and supervised by a licensed nurse



HIV/AIDS Waiver Care Coordination

- **Frequency of Care Coordination: Every 90 days** (performed by qualified case managers, face-to face)
- **HIV/AIDS Interdisciplinary Team (IDT)**
 - **ID Team:** the individual, his or her representative, qualified case manager, attending physician or primary care practitioner, parent or guardian
 - IDT Conferences are held at least every 60 days
 - IDT Goals:
 - To assess multi-service needs of recipients
 - Plan for the provision of services to meet those needs
 - Evaluate the effectiveness and ongoing need for interventions identified in the service plan



HIV/AIDS Waiver Care Coordination

- **HIV/AIDS Waiver and MLTSS Care Coordination**
 - **HIV/AIDS care manager on Plan ICT to understand full medical picture and ensure daily care is delivered and person-centered**
- **Persons with HIV/AIDSs may disenroll from Medi-Cal managed care at any time**



HIV/AIDS Waiver Payment Structure & Responsibilities

- **Cost Cap per member**
 - **Maximum allowable reimbursement**
\$13,200/client/year
 - If limit is reach, individual is disenrolled from waiver and may be provided services from other available funding sources
 - If individual is eligible, can be re-enrolled in waiver in the new calendar year
 - **DHCS pays waiver agencies for administrative and case management services based on flat fees per eligible client per month**
- **Agencies include: Licensed HHA; County health department; Community-based organizations**



HIV/AIDS Waiver Payment Structure & Responsibilities

- **Capacity: 3, 560**
 - Additional slots per year: 170-180
 - Current # of participants: 2,897
- **Waitlist: None**
 - Individual agencies can enroll as many clients as feasible until federally imposed limit is reach
- **Reimbursement:**
 - HIV/AIDS services are provided as a carve out to MLTSS
 - HIV/AIDS is not provided to Cal MediConnect members



HIV/AIDS Waiver Data

- **Age Range:** 85% are ages 22-64
34% are ages 21 and under
12% are ages 65 and older
- **Average Cost Per Client:** \$4,256.54
- **Most Prevalent Diagnosis:** 100% HIV
- **Average Length of Stay:** 302 days



1915(i) DD-RC Care Coordination

- **Regional Centers responsible for care coordination:**
 - Face to face assessment of individual's support needs and capabilities
 - Assist in developing service plan for each individual
 - Person-centered planning
- **Frequency: every 12 months or as needed**
- **Evaluations through Regional Centers**
 - Review current individual's current record (social, medical, psychological)
 - Review eligibility criteria (significant functional limitations)
- **1915(i) DD-RC and MLTSS Care Coordination**
 - 1915(i) DD-RC care manager on Plan ICT to understand full medical picture and ensure daily care is delivered and person-centered



1915(i) DD-RC Payment Structure & Responsibilities

- **Organized Health Care Delivery System (OHCDS) arrangement - DDS is the OHCDS**
 - Qualified providers submit claims to RC for services delivered to the beneficiary
 - RC reviews and submits claim of payment to DDS as the OHCDS
 - OHCDS reimburses RC for actual cost of services and submits claim for FFP to DHCS

* Costs for administrative activities are not billed as part of OHCDS payment (claimed separately)
- **Community Living Arrangement Services (CLAS)**
 - Payments in licensed/certified settings do not include cost for room and board
 - Payments do not include routine care and supervision that is expected to be provided by family
- **Reimbursement:**
 - DD services are provided as a carve out to MLTSS
 - DD waiver is not provided to Cal MediConnect members



Universal Assessment



Universal Assessment

- **Universal Assessment Tool**
 - In progress
 - Currently, each waiver has an individual assessment tool to determine person's need for level of care
 - Goal:
 - Create a universal standardized assessment tool for all waivers to be used by management, assessing individual care plans
 - Use assessment tool for CCI members rolling into the 8 CCI counties and for Medi-Cal managed care plans



Future of Long-Term Care

Future of Long Term Care Programs

- California has rebalanced its LTC services per Federal definitions
- California has focused HCBS programs on deferring NF placement
- Switch focus to NF transitions as CBO network can sustain high need, frail and/or elderly population
 - Affordable and sustainable housing
 - Streamline HCBS waiver programs (menu of providers and menu of services)
 - LTSS Advisory Committee
- HCBS future in managed care

GLOSSARY

ALW - Assisted Living Waiver

AHC: Alternative Home Care

ARF: Adult Residential Facilities

CBAS: Community-Based Adults Services

CCA: Care Coordination Agency

CCI: Coordinated Care Initiative

CCT - California Community Transitions

CDPH: California Department of Public Health

CIL: Center for Independent Living

CLAS: Community Living Arrangement Services

DAH: Direct Access Housing

DD - Developmentally Disabled

GLOSSARY

DD/ID: Developmental Disability/Intellectual Disability

DDS: Department of Developmental Services

DHCS: Department of Health Care Services

DP/NF: Distinct Part Nursing Facility

EO: Elder Options Inc.

FFA: Foster Family Agency

FFP: Federal Financial Participation

FFS: Fee-For-Service

HCBS - Home and Community-Based Services

HHA: Home Health Agency

HHCM: Home and Health Care Management

HIV/AIDS - Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

GLOSSARY

ICF/DD: Intermediate Care Facility/Developmental Disability

IHO: In-Home Operations

IHSS: In-Home Supportive Services

IP: Independent Provider

LCSW: Licensed Clinical Social Worker

LO: Lead Organization

LOC: Level of Care

LTC: Long-Term Care

LTSS: Long-Term Supports and Services

MFP: Money Follows the Person Rebalancing Demonstration

MFT: Marriage and Family Therapist

NF/AH: Nursing Facility/Acute Hospitals

OA: Office of AIDS

PPC: Pediatric Palliative Care

RC: Regional Center

GLOSSARY

RCFE: Residential Care Facility for the Elderly

SSI/SSP: Supplemental Security Income/State Supplementary Payment

SF-CLSB: San Francisco Community Living Support Benefit

SF DPH: San Francisco Department of Public Health

SNF: Skilled Nursing Facility

TCM: Targeted Case Management

QUESTIONS?

Please contact Michael Luu at
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