Master Plan for Aging LTSS Subcommittee
Recommendations for Immediate Action/Consideration in this Legislative Cycle
August 4, 2020

The LTSS Subcommittee was tasked with reviewing and advising the Department of Health Care Services on its Long-Term Care at Home proposal. As this work progressed, the LTSS Subcommittee decided that it had to do more than respond to the LTC at Home proposal because it did not appear that that proposal could achieve the goal of decompressing nursing facilities in the short term and it needed more time and development.

Given the grave situation with COVID-19 and the very real need to save the lives of older adults and people with disabilities, who are at high risk of dying from COVID, the LTSS Subcommittee committed to producing a list of items that could be quickly implemented, used existing HCBS infrastructure, and would keep people out of nursing homes and other congregate facilities. We worked to create solutions that can be targeted as needed to the communities most at risk. We worked to maximize use of Medi-Cal funded programs, but also provided solutions for those who do not qualify for Medi-Cal.

This packet provides information about 10 of our recommendations. Please note, the proposals below are not listed in priority order. The page numbers are cross-referenced and hyperlinked to each individual proposal.

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As a first step, a rapid assessment of each county LTSS system must be completed to identify local priorities and organizational steps to take to address impacts of COVID-19 on older adults and people with disabilities who are most at-risk for COVID-19. The rapid assessment must include establishing a rapid response team and response plan in order to: 1) identify and assess people in need of transition and diversion supports, 2) scope available services and mitigate gaps in services, and 3) evaluate workforce capacity. The rapid response team and plan should include LTSS providers, Community Based Organizations, hospitals, local government including Health & Human Services, Public Health, and other Access and Functional Needs taskforces**.** These rapid assessments should also look at disability-specific needs when possible, like those for blind and visually impaired, deaf and hard of hearing, and those with developmental disabilities. Together, these stakeholders will allow each local jurisdiction to collaboratively mitigate, prepare for, respond to, and effectively divert individuals from going into a nursing home and transition individuals back to the community. The rapid response plan will help identify which of the following specific recommendations are needed.

1. **California Community Transitions—Authorize in statute and develop state-only program)**

Program Overview: California's federal Money Follows the Person (MFP) Rebalancing Demonstration, entitled "California Community Transitions" (CCT) enables eligible Medi-Cal beneficiaries the opportunity to transition from a nursing facility setting to the community using support networks and providers to facilitate and monitor their transition. Eligible individuals of all ages must have resided in specified facilities for at least 90 days. Once transitioned, participants live in their own homes, apartments, or in approved community care facilities, receiving services at home and in the community according to their needs and preferences. CCT is a critical component of the state's continued efforts towards compliance with the U.S. Supreme Court's 1999 Olmstead Decision, and affirms California's commitment to ensure persons with disabilities have appropriate access to, and choice regarding, community-based services and placement options.

CCT and COVID Response Needs: High-needs individuals who reside in institutional settings are at significant risk for contracting and being hospitalized for COVID-19. It is critical that individuals residing in institutional settings have access to transition services to enable them to return to the most home-like setting possible. Because approximately 84% of nursing facilities residents stay in the facility for fewer than 90 days, it is imperative that we provide people needing shorter term stays with the ability to transition home so they do not end up staying in a facility longer than is necessary. The CCT program provides the necessary infrastructure to

transition individuals during this time of crisis. This program could be targeted to communities and facilities with high rates of COVID-19 infections.

Program Limitations: Based on the federal requirements, the CCT program is limited to Medi-Cal individuals who have resided at least 90 days in an institutional setting. This requirement prevents shorter-stay individuals from transitioning back to the community.

Recommendation: Amend SB 214 (Dodd) to codify the CCT program in statute while developing a state-only program that enables transition of individuals residing in institutional settings for fewer than 90 days.

2. **California Community Living Fund—Establish flexible fund to help prevent institutionalization**

Background: The COVID-19 crisis demands that California's older adults and people with disabilities who are either institutionalized or at-risk of institutionalization be enabled to remain in or transfer to a community setting.

According to the 2017 Long-Term Services and Supports Scorecard, almost 11 percent of California's 101,000 nursing home residents—or 11,000 --- are identified as having low-care needs. This means that these individuals could be cared for in the community as an alternative to institutionalization. But for many such individuals, the opportunities to transition either don't exist or these individuals and their families do not realize there are other alternatives. Surveys of nursing home residents reveal that a majority of residents do not want to remain in a nursing facility (NF), but thousands of Californians lack the appropriate services and resources necessary to transition. In particular, individuals often need flexible funds to assist with short-term costs including first and last month of rent, or other emergent needs for food, heaters, or related necessities.

COVID and Institutional Transitions/Diversion: The unprecedented COVID crisis requires flexible funding to meet emergent transition needs of institutionalized individuals as well as those who are at risk for institutionalization.

Recommendation: Establish the California Community Living Fund: The state should establish a California Community Living Fund that would serve as a "bridge" program to provide services to individuals moving from an institution to the community, as well as individuals residing in the community who are at-risk of institutionalization. The fund would address special circumstances that arise out of an eligible individual's need for certain goods or services, or other conditions on a non-recurring basis in order to transition individuals from institutional to community settings or to help individuals remain in the community and avoid institutionalization. This concept is modeled off the San Francisco Community Living Fund which helps individuals transition from institutions and remain in the community to avoid institutionalization. This fund is different than the CCT state-only program because it is not restricted Medi-Cal beneficiaries although they can receive goods and services if not paid for

through Medi-Cal, and it is not restricted to those transitioning out of nursing facilities. It is important to note, the Community Living Fund could be a complement or combined with the Department of Rehabilitation Transition Fund, which is a grant program provided pursuant to the State Independent Living Plan. The Community Living Fund could be used as a mechanism to provide grants for securing housing, housing modifications, assistive technology, in-home care, and other items necessary to enable persons with disabilities to transfer to home from a congregate setting or to remain in their own homes.

3. Rapid Response Intensive Care Management

Background: One of the barriers to successfully moving individuals from hospitals or nursing to facilities is the lack of targeted care management. California's current LTSS system often operates in programmatic silos which can make it difficult to both assess all of a person's needs as well as ensure that the services, supports and goods and services are available on the day of discharge. The end result are delays in discharge, something that we cannot afford to do during this pandemic.

Recommendation: Establish Rapid Response Intensive Care Management

Use existing HCBS or managed care programs with experience and capacity to create rapid response intensive care management "hubs." These hubs would work with discharge planners in hospitals to ensure patients can come up with the appropriate services and supports. These hubs would help ensure that coming home is a real option for people who would otherwise go to a nursing facility. The hub concept could be beta tested in a community/region where there is need, but also where there are strong HCBS programs and managed care involvement/interest.

4. Assisted Living Waiver—Increase slots and counties where available

Program Overview: California's Assisted Living Waiver (ALW) offers a range of health-related services, social services, and supportive services to eligible older adults and persons with disabilities who meet requirements for Medicaid coverage of nursing facility care, but who prefer to reside in a community-based setting. The program is offered in the following settings: Residential Care Facilities for the Elderly, Adult Residential Care Facilities or publicly subsidized housing. Eligibility is limited to Medi-Cal beneficiaries over the age of 21. Services include, but are not limited to: assistance with activities of daily living; health-related services including skilled nursing; transportation; recreational activities; and housekeeping.

The waiver operates in 15 counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, and Sonoma, with a cap of 5,744 enrollees.

Assisted Living Waiver and COVID Response Needs: High-needs individuals, including those meeting the Assisted Living waiver eligibility, are at significant risk for contracting and being

hospitalized for COVID-19. It is critical that waiver-eligible individuals residing in the community or in institutional settings have access to the services and supports in the most home-like setting possible, including Assisted Living. During the pandemic, ALWP staff are having extensive communication with Skilled Nursing facility staff to enable smoother transitions for existing clients re-enrolling into the ALWP after short-term rehabilitation stays as well as facilitating new enrollment in the program. ALW professionals are using telephone and telehealth modalities to continue to provide care including monthly visits, Initial Assessments and Reassessments, to keep people from moving into SNFs. Providing support in a range of residential facilities will ensure that those individuals with lower acuity will be able to avoid SNF enrollment and reduce exposure to COVID-19. It will ensure those currently in publicly subsidized housing remain in the community in non-congregate care while those already in RCFE and ARCF will remain with additional assessments, interventions and care to reduce exposure to unnecessary risk.

Waiver Waitlist: As of June 2020, the Assisted Living Waiver waitlist was 4,803 individuals.

Recommendation: Expand the Assisted Living Waiver by 10,000 slots and geographic reach widened, consistent with the intent of AB 2233 and AB 50 (Kalra 2018, 2019). Of this amount, 5,000 slots should be added by January 2021 and 5,000 slots added by January 2022. These slots can be targeted to communities and counties with high COVID-19 rates and could help solve housing for those who cannot return home or do not have a home to return to. Slots could be added quickly using the Appendix K flexibility provided by CMS.

5. **Home and Community-Based Alternatives Waiver—Increase slots and flexibility**

Program Overview: The Home and Community-Based Alternatives (HCBA Waiver) provides specified Medi-Cal beneficiaries the option of returning to the community from institutional settings and/or remaining in their homes or home-like community settings in lieu of institutionalization. Eligible individuals include Medi-Cal beneficiaries who are eligible for admission into, or who currently reside in, a Medi-Cal funded nursing facility, subacute facility, Intermediate Care Facility-Developmental Disabilities/Continuous Nursing (ICF-DD/CN) or acute hospital. The HCBA Waiver includes the following services:

- Private duty nursing including home health and shared services
- Waiver Personal Care Services (WPCS)
- Case management/coordination
- Habilitation
- Home respite
- Community transition
- Continuous nursing and supportive services
- Environmental accessibility adaptations
- Facility respite, family/caregiver training
- Medical equipment operating expense
- Personal Emergency Response System (PERS) -installation and testing

- Transitional case management for medically fragile and technology dependent individuals of any age

Prioritization for Slots and Waitlist: Eligible applicants who meet the waiver level of care criteria are automatically placed on a waitlist. As of March 2020, the waitlist for the HCBA waiver was 836 slots, despite having excess capacity of total waiver slots. The state reserves 60 percent of slots for people living in institutions over 90 days and for individuals turning 21 and aging out of the EPSDT program. In addition, children who need to be placed on the Waiver to become eligible for Medi-Cal (called "institutional deeming") receive priority review and are not placed on a waitlist. Slots are filled on a rotating basis, alternating between individuals residing in facilities and in the community.

HCBA Waiver and COVID Response Needs: High-needs individuals, including those meeting the HCBA waiver eligibility, are at significant risk for contracting and being hospitalized for COVID-19. It is critical that HCBA waiver-eligible individuals residing in the community or in institutional settings have access to the services and supports in the most home-like setting possible, regardless of age. These slots can be targeted to communities with high COVID-19 rates and could be especially valuable in keeping individuals with a great need for more personal care services hours living in the community. Slots could be added quickly using the Appendix K flexibility provided by CMS.

Recommendation: The HCBA waiver slots should be expanded by 5000 slots to ensure sufficient capacity to meet the needs of all individuals deemed eligible for placement on the waiver, regardless of age or residence in community vs. institutional setting. Priority shall not be assigned for one population over another. Instead, the waitlist should be entirely eliminated for community-residing and institutional transitions. The 5000 additional slots should be able to accommodate current and future need through the waiver's 2022 expiration.

6. In-Home Supportive Services (IHSS)—Expediting Services through Use and Expansion of Preliminary Assessments

Program Overview: The In-Home Supportive Services (IHSS) program provides eligible Medi-Cal beneficiaries with a range of services including personal care, domestic and related services, paramedical and protective supervision with the goal of allowing the person to stay safely in their own home. As the largest HCBS program in California, IHSS is integral to both keeping people out of congregate care and in helping people return to the community after a hospital or nursing home stay.

The IHSS program is administered by the Department of Social Services at the state level and by the county welfare departments at the local level. County welfare departments are responsible for determining whether an applicant is eligible for services as well as determining the number of hours each recipient will receive for each task. Currently, pursuant to MPP section 30-755.12, counties are required to provide a preliminary assessment to determine need for an applicant

who is being discharged from a hospital or nursing facility and who needs IHSS authorized before leaving the facility.[1] However, because of the requirement to assess applicants in-person and the tight timeline between the county learning of the discharge and the actual discharge this provision is under-utilized.

The Problem: People who are being discharged from hospitals and nursing facilities often experience delays between leaving the facility and getting assessed and beginning to use IHSS services. That delay puts people at risk of returning to the hospital or the facility because they do not have the assistance in place in order to remain safely in their own homes.

IHSS and COVID-19 Response: The IHSS program has made numerous changes to its processes and procedures in order to ensure IHSS recipients and applicants have access to the IHSS program during COVID-19. Two changes in particular can be used as a part of the solution described below to ensure individuals being discharged do not experience delays:

1. Pursuant to the section 1135 waiver granted to California, the Department of Social Services issued ACL 20-42 which allowed county welfare departments to conduct an initial assessment through videoconference in lieu of an in-person assessment until June 30, 2020. However, this authority was not extended for initial assessments.[2]
2. CDSS released ACL 20-29, which required counties to set-up emergency back-up provider registries. ACL 20-75 extended that requirement through December 31, 2020. In the same two guidance letters, CDSS established and extended a differential wage rate for emergency back-up providers through December 31, 2020.

Recommendation: California should use and expand the ability of county welfare departments to perform preliminary assessments for applicants who are going to be discharged from hospitals or nursing facilities to ensure IHSS services start immediately upon a return to home. To increase utilization of the preliminary assessment and to increase its effectiveness for recipients, the state should do the following:

1. Require counties to prioritize preliminary assessments requested before discharge.
2. Allow counties to conduct all preliminary assessments through videoconferencing so IHSS social workers do not need to enter hospitals or nursing facilities. The hospital or nursing facility should help facilitate this assessment, including providing the technology necessary for videoconferencing.

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[1] The Department of Social Services has released two All County Letters related to the subject of preliminary assessments before discharge: (1) ACL 02-68 which directs the county welfare departments to perform such assessments and (2) ACL 11-76 which allows IHSS to commence after discharge but before receipt of the health care certification form if the individual received a preliminary assessment. ACL 02-68 can found at: https://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2011/11-76.pdf and ACL 11-76 at https://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl02/pdf/02-68.pdf.

[2] This authority was extended for Program Integrity and Quality Assurance reassessments until December 31, 2020 in ACL 20-76. It also included telephonic methods of reassessments.

3. Allow preliminary assessments to remain in effect until at least December 31, 2020. This will give the recipient stability and provide the county with additional time before it must conduct the initial assessment.
4. The initial assessment should also be allowed to take place through videoconferencing or through the telephone.
5. Allow recipients being discharged to use the emergency back-up registry to find a provider, if the person does not already have someone they wish to work as their IHSS provider.
6. Allow any provider hired from the emergency back-up registry to be paid the differential wage until another provider is hired or until at least December 31, 2020.
7. Require the state to outreach to hospitals and nursing facilities to inform them of these changes.

7. Multipurpose Senior Services Program (MSSP)—Slot restoration and rate permanency

Program Overview: The Multipurpose Senior Services Program (MSSP) provides older adults whom are ***certified eligible for skilled nursing home placement*** and are 65 years and older with intensive in-home care management and care coordination services so they can remain living in the community. MSSP meets prescribed standards of care, as well as strict budget neutrality requirements while serving as the community negotiator to make sure that clients have access to community resources and other services even during COIVD. Without this intercession, these individuals or their families are left to navigate an increasingly complicated system of medical and social services alone. The majority of MSSP clients live alone, subsist on approximately $1000 per month or less, and have complex medical and psychosocial needs that require specialized medical and social support services. According to the California Department of Aging, the average amount of time in the MSSP program is four years.

MSSP providers deliver the following services in their communities:

- ***Personal Assessment and Care Planning:*** A registered nurse and social worker conduct a joint, comprehensive assessment to develop a living care plan linking medical and social service's needs. These professional staff identify appropriate community services for each client, ensure compliance with medication and prescribed therapies, and coordinate In Home Supportive Services (IHSS), home-delivered meals, transportation and other appropriate services. Additional services and purchases of goods not available through other programs but critical to helping the older adult remain safe in his or her home can be obtained through MSSP.
- ***Client Monitoring:*** All clients must be monitored by the MSSP Care Team, which entails review and evaluation of the effectiveness of each care plan. The health, safety, and social components of the client and their living arrangement are addressed through comprehensive monitoring.
- ***Waived Services Funding:*** MSSP sites spend up to 28 percent of their overall program allocation purchasing critical services and equipment needed by our clients when other

public or private resources are not available to meet their need. Examples include, appropriate nutrition and food resources, safety equipment, home modifications, and medical supplies, and helping clients make IHSS work for them and purchasing supplemental/gap filling care if needed.

The waiver operates in 43 counties: Alameda, Amador, Butte, Calaveras, Contra Costa, El Dorado, Fresno, Glenn, Humboldt, Imperial, Kern, Kings, Lake, Los Angeles, Madera, Marin, Mariposa, Mendocino, Merced, Monterey, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Sonoma, Stanislaus, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Siskiyou, Solano, Tehama, Tulare, Tuolumne, Ventura, Yolo, Yuba

Waiver Waitlist as of April 30, 2020: 1,465 individuals.

MSSP's Covid-19 Response: MSSP sites went into immediate action at the beginning of the pandemic and continue to seek opportunities to stay in touch with and support clients. Although social distancing requirements have curtailed required face-to-face visits, MSSP care teams have continued to reach out to clients and have provided an important bridge to needed services. Care managers have been assisting with governmental forms required for housing and food assistance, as an example and working with landlords to prevent potential eviction. CMS has recently allowed the purchase of tablets that will be used to conduct virtual interviews with clients, which will reduce isolation and allow the care manager to get a better sense of what is going on in the client's environment and to monitor health and safety such as medication management. These slots can be targeted to communities with high COVID-19 rates. Slots could be added quickly using the Appendix K flexibility provided by CMS.

Recommendation and Fiscal Impact: Medi-Cal funding for MSSP had been flat for more than 13 years and funding was reduced twice (FY 2008 and 2011) during the recession years. A one-time-only supplemental increase of $24.9 million (GF) over three budget years was appropriated in the 2020 California budget. This funding augmentation is set to expire at the end of the 2022 budget year. Given the impact of COVID on seniors, we must continue to keep our seniors safely at home and out of hospitals and nursing facilities by making this temporary supplement permanent while restoring the 2,497 MSSP slots that were lost in the prior years due to cuts. To increase lost MSSP slots, an additional $6.7 million dollars (GF) is needed for one year starting July 1, 2021. As of July 1, 2022, $15 million dollars (GF) will be required to make the one-time-only increase permanent and to fund the increase in slots for a total annual amount of $31.4 million (GF).

8. Community-Based Adult Services—Allow for emergency authorizations and rate permanency

Crisis Background: Responding to the Governor's emergency order for the public to shelter at home and for CBAS to stop providing regular congregate services, CBAS centers worked with the administration to quickly design Temporary Alternative Services (TAS) to continue serving and protecting roughly 37,000 participants, who, by definition, are at highest risk for COVID-19

and death. DHCS submitted an emergency request under Section 1135 of the Social Security Act (42 U.S.C. § 1320b-5 dated March 19, 2020, to CMS asking for approval of TAS, but final approval remains pending. Per CMS instructions, DHCS is now preparing an Appendix K document for CBAS separate from the Medi-Cal 2020 1115 waiver one-year extension request.

TAS Guidance and Implementation:

- DHCS All Plan Letters, CDA All Center Letters, and CDPH All Facility letters distributed during April and May describe the TAS framework and provide guidance to the centers and the Managed Care Plans.
- CBAS must have Plans of Operation for TAS, approved by CDA.
- CDA is conducting provider compliance surveys, using remote methods.
- Weekly training webinars for providers ~~were~~ designed and hosted by the California Association for Adult Day Services (CAADS) and the Alliance for Leadership and Education (ALE) began in March 2020 and will continue through January 2021. Managed care plans and state partners have participated and contributed TAS Guidance. CAADS and ALE continue to work closely with state partners and the provider community to successfully implement and refine CBAS TAS.

CBAS TAS Framework: Through TAS, CBAS is being provided via alternative modes, as described below, including in-center or in-home care, limited to what is deemed "essential" and can be safely delivered, due in part to the difficulty in accessing PPE for community providers.
CBAS TAS includes flexibility to:

- Reduce adult day health care center-based activities/gatherings for vulnerable populations
- Offer telephonic, telehealth or live video interactions for social/therapeutic visits, interventions and assessments
- Provide physical therapy or occupational therapy in the home
- Conduct doorstep deliveries of food, meals, supplies, activities, etc.
- Provide or arrange for home delivered meals to ensure nutritional security
- Continue per diem reimbursement in accordance with approved Individual Plans of Care (IPCs)

Barriers to Rapid Deployment of CBAS/TAS Resources:

- For dual eligibles not previously enrolled in managed care, the requirement of managed care enrollment as a condition for accessing CBAS is a barrier to care because of the length of time and specialized tasks required to enroll into Medi-Cal managed care (presently an added step for duals).
- The process for enrollment into Medi-Cal Managed Care is lengthy and complex, which significantly delays access to initiation of CBAS services.

Need for Additional Emergency Flexibility to Maximize Impact of CBAS TAS
New participants can be assessed by CBAS providers using means and methods other than face to face visits, then admitted, with MCP authorization.

- Additional capacity to serve beneficiaries is immediately available. The number of participants who can be served is no longer limited to the licensed capacity of the physical facility, so centers are able to serve participants daily based upon their assessed needs in order to reduce risks for participants and caregivers who are sheltering at home.
- Screened and experienced CBAS health providers are presently employed and working to carry out individually care planned services.

Solutions:

- To enable rapid emergency enrollment of people into CBAS who would otherwise be at risk for nursing home placement when discharged from a hospital to a nursing facility, or who choose to move out of a nursing facility, expedited and retroactive enrollment into Medi-Cal Managed Care and presumptive eligibility and retroactive reimbursement for CBAS is absolutely critical.
- The current CBAS eligibility criteria, which include nursing facility level of care, are sufficient to presumptively qualify a person for CBAS.
- Existing payment mechanisms through Medi-Cal Managed Care or Fee-for Service Medi-Cal can be utilized to authorize payment retroactively.
- CBAS Centers also have the experience and knowledge to provide complex care management to facilitate complex care transitions needed during this public health emergency, and can quickly work with managed care organizations to amend their existing contracts for the purpose of facilitating emergency care transitions.

9. Caregiver Resource Centers—Increase funding and flexibility for respite

Background: 80% of care is provided by unpaid family caregivers. During COVID these caregivers are now more socially isolated, are caring for children and parents, and have increased pressure to minimize chances of older adults going to hospital or SNF. More people are now aware of how isolating caregiving can be and are in need of comprehensive supports. LTC@ home cannot be successful without the statewide caregiver focused services as a core member of the Rapid Response Team (RRT). We have a nationally replicated statewide system with expertise of 30 years providing services to family/informal caregivers. The system would add a new core service, rapid response caregiver specialist (RR-CS) to each CRC statewide. They specialist will coordinate with CCT, MSSP, CBAS and IHSS.

Current Program Limitations: The current funding allocation for CRC's is set to expire in 2022. Currently, we have a high volume of referrals from hospital discharge planners. CRC's would need funding to expand staff to handle the increase in referrals for individualized long term caregiver case management (caregiver intake, assessment and care plan.) Because caregiver issues will not emerge immediately on discharge (beside those associated with setting up the patient/care receiver needs) this would be done 4-6 weeks post discharge, then we can have a more accurate assessment of the caregivers LTSS supports, education, training and emotional

support after discharge. This support includes respite care for unpaid caregivers which is currently paid for through the CRCs.

The coordination would be with the RRT pre-post discharge and since we have an HIPAA online portal we can integrate some aspects of the referral and discharge with discharge planner and all the CCT programs. During COVID the CRC's were able to transition all services and supports on-line within a week of the stay-at-home order because of the recent one-time funding to enhance CRC comprehensive service delivery model and provide innovative on-line access statewide. Also, the pandemic has highlighted new support requests to CRC's including housing assistance, food, PPE's, as well as increased need for respite for caregivers. (this is not a full list of needs). Providing these supplemental services would be part of the RR-CS expansion.

This specialized statewide RR-Caregiver Specialist (RR-CS) would require stable funding of $2.1 in 7/1/2021

Current Funding: Funding for CRC's had been flat for more than 13 years and funding was reduced twice (FY 2008 and 2011) during the recession years. A one-time-only supplemental increase of $30.0 million (GF) over three budget years was appropriated in the 2020 California budget. This funding augmentation is set to expire at the end of the 2022 budget year.

Recommendation and Fiscal Impact: Given the impact of COVID on seniors and the unpaid family caregivers that support them in the community, we must continue to keep our seniors safely at home and out of hospitals and nursing facilities by making this temporary supplement permanent. flexibility with respite funding to use for supplemental services and support to help caregivers assist with complex care needs associated with discharge referrals from crisis team. Additional funding would allow these cases to be prioritized for respite since all the CRC's have a waitlist for respite services.

Moreover, with the increase in LTSS needs, we need an additional $.9 million dollars (GF) for January-July 2021 and $1.8 million dollars (GF) is needed for one year starting July 1, 2021 to provide RRT-Caregiver Specialist (RRT-CS) and supplemental services expansion. As of July 1, 2022, $30 million dollars (GF) will be required to make the one-time-only increase permanent and to fund the RRT-CS for a total annual amount of $32.1 million (GF).

10. Program for All Inclusive Care for the Elderly (PACE): Supplemental Rate and Rapid Approval

Program Overview: Program of All-Inclusive Care for the Elderly is an integrated managed model providing Medicare and Medi-Cal covered benefits to eligible individuals who are age 55 or older, and who are certified to need nursing home care, but who are able to live safely in the community at the time of enrollment.
Required services include:

- Medical care provided by a PACE physician

- Adult day health care (nursing; meals; nutritional counseling; personal care physical/occupational/recreational therapies)
- Home health care and personal care in the home
- Prescription drugs
- Social services
- Medical specialty services, and hospital, plus nursing home care, when necessary

COVID Response Needs: High-needs individuals who reside in institutional settings are at significant risk for contracting and being hospitalized for COVID-19. It is critical that individuals residing in institutional settings have access to a full array of services, both health and social services, to enable them to return to the most home-like setting possible or avoid institutionalization. The PACE program provides the necessary infrastructure to transition individuals during this time of crisis.

Program Limitations: The PACE program currently is limited in the extent of transition services that can be provided for individuals leaving nursing homes or to help stabilize those in the community. Additionally, the rate for PACE programs needs to be adjusted to care for individuals with significant health impairments, such as those coming out of long-term care placement. Additionally, it can take several weeks to process and receive approvals for referrals to the PACE program at the State level, making it difficult to assist those with critical needs. It is also not currently possible to bill for services mid-month.

Recommendation: Approve an acuity based short term supplemental rate adjustment for those coming out of the hospital or skilled nursing facility. Allow for rapid approval (within several days) for PACE referrals at the local level with subsequent State approval for those individuals needing care due to COVID-19 impacts as well as allow for immediate billing for services.

11. Required COVID-19 Testing Before Hospital Discharge

Background: Currently, hospitals are not required to test patients for COVID-19 before discharging them to a congregate facility or to their home. This means that congregate settings do not know a resident's COVID status upon admission which could increase transmission in facilities. For those returning home, it means that family and other caregivers do not know what precautions need to be taken to keep everyone safe and healthy.

Solution: The state should require hospitals to test for COVID-19 before discharging whether discharging to a congregate facility, including a nursing facility or to home.

12. Ensure HCBS Providers Have Access to PPE

Background: At the beginning of the pandemic, it was difficult for community providers to receive the PPE they needed to safely provide services to seniors and people with disabilities. The State has made significant progress in addressing these concerns.

Recommendation: As HCBS services expand and communities re-open, it will be important to ensure that HCBS providers have sufficient access to PPE as programs are expanded. This will help limit the spread of COVID-19 to a highly vulnerable population and help ensure providers stay safe and healthy.