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California's Medi-Cal Home & Community Based Services Waivers, Benefits & Eligibility Policies, 2005-2008

Report

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OVERVIEW

Introduction

Health and long term care services and practices constitute a continuum of care, but one that is highly compartmentalized. These compartments are varyingly defined: sometimes by the setting (e.g., hospital, nursing home), sometimes by the provider (e.g., primary care physician, social worker), sometimes by body system or disease (e.g., dementia, congestive heart failure), or by severity of the conditions (e.g., disability, nursing home certifiable, terminal). Compartmentalization has been reinforced by, and in turn has influenced, the means of financing and regulating these different levels and types of care. There have been persistent demarcations between hospital and custodial nursing home care, and between nursing homes and community services. Transitions between providers and/or settings are a particularly problematic aspect of compartmentalization. This can disrupt the "continuity of care" for individuals. Another consequence is cost shifting from one payer to another. All of these factors contribute to sub-suboptimal delivery system effectiveness. Fragmentation of funding, with Medicare being the primary public payer for acute health care and Medicaid being the predominant public payer for long term care, some times impairs continuity of care for those dually eligible for both programs. The complexity of service use and expenditures across levels of care and funding sources can also limit the ability to assess how the efforts to control use or access in one component of the delivery system may affect other components and payers.

California, through Medi-Cal (i.e., Medicaid) and other public funding sources, has developed a number of programs over the past 30 years to serve low income aged and adults with disability who need long term care services. These include, among others: nursing homes, personal care services in community settings, adult day health care, and care management. The oversight of these programs is distributed among several state departments and between state and county governments. The costs of these programs have been growing rapidly, and demand is expected to continue growing with the aging of the population. These trends raise two key questions for California policy makers and program stakeholders. What is the relationship between participation in home and community-based services, and the use of institutional settings? Does participation in home and community-based programs reduce the number of emergency room, hospital stays, nursing home stays, and total Medi-Cal and Medicare expenditures?

The SCAN Foundation and the California Department of Health Care Services have funded the California Medicaid Research Institute (CaMRI) at the University of California to address these and a variety of other health service questions. This study *The Comprehensive Analysis of Home and Community-Based Services Project*, is informally known as the HCBS Evaluation. The centerpiece of the HCBS Evaluation is a longitudinal database comprised of Medi-Cal claims, Medicare claims; and nursing home and personal care program assessments. It includes all persons aged 18 and older who received a Medi-Cal reimbursed long-term care service (e.g., home care/personal care assistant, adult day health care, care management, nursing home) at any time during 2005 through 2008. At the initiation of the project, 2008 was the date for which the most recent Medicare and Medi-Cal claims were available. The project seeks to have at least three years of claims and assessment data on most of the study population so that it can better assess changes over time and movements between levels of care and payers.

This report is intended to inform the project about Medi-Cal's home and community-based care waivers and state plan programs providing long term care services. It describes the benefits and eligibility criteria for each of California's HCBS Medicaid waiver programs operating during 2005-2008. [1] Also described are three programs within California's Medi-Cal State Plan. These are Adult Day Health Care (ADHC), the personal care program known as In-Home Supportive Services (IHSS), and Targeted Case Management (TCM). This background will be used in considering trends in recipient participation and expenditures over the study period. The data are drawn predominantly from California's Medi-Cal State Plan, Centers for Medicare & Medicaid Services (CMS) approved HCBS §1915(c) waiver applications, and CMS 372 forms reporting waiver expenditures for each study year.[2]

State Plan and Home & Community Based Waiver Programs

The Medicaid statute offers states broad authority under which to offer HCBS to beneficiaries with LTC needs, either through a Medicaid state plan benefit or through a §1915 waiver program. The Medicaid state plan refers to the part of the Medicaid program that generally follows, with exceptions, certain program benefit rules outlined in the statute. These rules require states to cover certain benefits under the traditional Medicaid state plan program (i.e., mandatory benefits) and give states the option to cover others (i.e., optional benefits). With respect to state plan benefits, federal law requires states to meet the following guidelines:[3]

- Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. States may place appropriate limits on a service based on such criteria as medical necessity or functional level-of-care;
- Within a state, services available to certain groups of enrollees must be equal in amount, duration, and scope. These requirements are called the "comparability rule";
- With certain exceptions, the amount, duration, and scope of benefits must be the same statewide, also referred to as the "statewideness rule"; and
- With certain exceptions, beneficiaries must have "freedom of choice" among Medicaid participating health care providers and managed care entities.

Figure 1 summarizes three of California's state plan community-based services programs: Adult Day Health Care, In-Home Supportive Services, and Targeted Case Management.

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[1] A §1115 demonstration waiver known as the IHSS Plus program was also operational between 2005 and 2009 as an adjunct to the state plan personal care program known as In-Home Supportive Services (IHSS). We have not separately described this waiver as it was operated with the same eligibility criteria and benefits as the IHSS program. Its notable difference was that it allowed federal financial participation in the reimbursement of legally responsible relatives (spouses, and parents of minor children) employed as personal care workers to IHSS program recipients. IHSS Plus was incorporated under §1915(i) into the State Plan program in 2009. Employment of legally responsible relatives was permitted under IHSS prior to 2005, but these providers were until then funded by state and county general funds, with no federal financial participation.

[2] These sources were supplemented with comments from state officials, sections from other state documents, and the report by Mollica, R & Hendrickson, L. (2009), *Home and Community-Based Long Term Care: Recommendations to Improve Access for Californians*. Portland, ME: National Academy for State Health Policy.)

[3] Stone, Julie, "Home and Community-Based Services Under Medicaid," Congressional Research Service, Washington, DC, January 19, 2011.

Figure 1
Medi-Cal Selected State Plan Community Based Programs
Operational during 2005-2008

Adult Day Health Care (ADHC)

Adult day health care began as a §1115 demonstration waiver in 1977. It became a state plan benefit in 1982 ***and*** serves individuals age 18 years or older having one or more chronic or post-acute medical, cognitive or mental health conditions; with functional impairments in two or more activities of daily living (ADLs) or instrumental activities of daily living (IADLs) requiring assistance or supervision in performing these activities; and lacking adequate family or caregiver support (Welfare and Institutions Code, §14525). The program is intended to serve beneficiaries at risk of institutionalization, including, but not limited to a nursing facility, emergency room, general acute care hospital, or intermediate care facility. ADHC provides one meal per day of attendance, and has both medical and social components, serving a mix of short-term, post acute and longer-term clients. Core services include the provision of one or more professional nursing services, personal care services or social services, and therapeutic activities provided by trained ADHC personnel (e.g., facilitated participation in group/individual activities for those whose frailty or cognitive functioning level precludes them from active participation in scheduled activities; group or individual activities to enhance the social, physical, or cognitive functioning of the participant). Other specialty services can also be provided in these settings. Among these are physical therapy, occupational therapy, mental health services, registered dietician services, speech therapy, and transportation services. ADHC centers are licensed by the California Department of Public Health and certified for Medi-Cal participation by the California Department of Aging. The total cost of the program was $397.9 million in 2005 and $430.2 million in 2008. It served between 55,500 and 58,400 individual beneficiaries annually (40,200 to 41,800 average monthly users) through approximately 300 centers during this period. Several attempts have been made since 2004 to reform the ADHC program, including a moratorium on new centers, tightening up eligibility criteria, unbundling the daily rate package, and limiting the days of services. These attempts have not achieved desired results or have been stayed by court action. As of August 2011, litigation is still pending. The approved fiscal year 2011-2012 state budget terminates funding for the Medi-Cal ADHC State Plan benefit beginning December 1, 2011.

*In-Home Supportive Services (IHSS)**

In-Home Supportive Services (IHSS) is the name used by the California Department of Social Services to describe the Personal Care Service Program (PCSP) funded and operated as an optional benefit under California's Medi-Cal State Plan. The IHSS program is administered by county social service programs and the California Department of Social Services to provide eligible participants with assistance with activities of daily living (ADL) (e.g., bathing and dressing) and instrumental activities of daily living (IADL) (e.g., preparing meals and shopping). PCSP was established nationally in 1975, allowing states through their Medicaid state plans to provide assistance with ADLs and IADLs. IHSS was incorporated into California's Medicaid state plan in 1993. IHSS (like all state plan programs) is offered on a statewide basis, and is available to all age and population groups who meet the need criteria established by the state. Unlike §1915(c) HCBS waivers and ADHC, IHSS need not be limited to persons eligible for institutional services. In 2008, the IHSS program served 408,112 individuals growing from 344,569 persons in 2005. The program provided about 31 million hours of services monthly. Total expenditures were about $4.4 billion in 2008.

Targeted Case Management (TCM)

The Targeted Case Management (TCM) Program is an optional Medi-Cal Program funded by federal and local funds. The TCM Program provides specialized case management services to Medi-Cal eligible individuals in a defined target population to gain access to needed medical, social, educational, and other services. TCM services include: Needs assessment, Development of an individualized Service Plan, Linkage and Consultation, Assistance with accessing services, Crisis assistance planning, and Periodic review of service effectiveness. TCM program target populations are adult probation, outpatient clinics, linkages, public guardian, public health, and community. The program benefits persons defined as high-risk, those who have language or other comprehension barriers, persons on probation, those who exhibit an inability to handle personal, medical, or other affairs, those abusing alcohol or drugs, adults at risk of institutionalization, or at risk of abuse or neglect. Recipients of HCBS waiver reimbursed case management are not eligible. In 2005 about 47,100 persons were served in TCM, this number remained stable in 2006 & 2007, but increased to 61,400 in 2008.

* Three parts of the IHSS program (about 10% of all IHSS participants) were not eligible for federal matching funds in 1993 (principle among these was paying legally responsible relatives as personal care providers). Recipients of these components were paid for solely by state and county funds until 2004 when these components were converted to an IHSS Plus program under a §1115 (of the Act) demonstration waiver, and Medicaid began to share costs. The Deficit Reduction Act of 2005 subsequently allowed states to offer services provided by "legally responsible relatives" under the §1915(j) self-directed personal assistance services benefit. California exercised this option and IHSS Plus was integrated into the state plan program in 2009. The Patient Protection and Affordable Care Act (PPACA) of 2010 extended this authority to §1915(i) & 1915(k) programs.

Medicaid waivers allow states to provide benefits outside of some of these preceding program and eligibility rules. For example, waivers allow states to extend services that are, among other things, neither comparable across groups nor statewide. The most commonly used waiver authority states use to provide HCBS to Medicaid beneficiaries is the §1915(c) authority. Individuals served under this waiver live in community-based setting but require the level-of-care offered in an institution. Some states also use the waiver authority in §1115 (Research and Demonstration Projects) to cover HCBS services. Together, these benefit and waiver authorities constitute an inventory of options states have in designing their HCBS benefit packages for LTC beneficiaries.

Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state, and local public programs as well as the supports that families and communities provide. Among the program features available through a waiver, states can request:

- Geographic Limitations, allow waiver programs to target areas of the state where the need is greatest, or perhaps where certain types of providers are available, rather than being statewide.
- Subgroup or Condition Targeting, to limit waiver services to persons meeting narrow needs criteria, e.g., being at risk of institutionalization. Services under a waiver do not have to be available to the Medicaid population at large. States have used this authority to target subgroups of the elderly, technology-dependent children, persons with mental retardation or developmental disabilities, and persons with specific disease or conditions, such as Acquired Immune Deficiency Syndrome (AIDS).

Figure 2 summarizes California's HCBS waivers operational during 2005 and 2008. These are authorized under provisions of §1915(c) of the Social Security Act. Six of these waivers were in operation in fiscal year 2009. Not all of these were in continuous operation during 2005-2008: three were initiated during this period. Two of these, newly named, consolidated three previously operating waivers. The third waiver was initiated after having previously operated as a pilot project.[4]

[4] California operated 18 other waivers during some portion of the period of 2005-2008. These were targeted to such things as pregnancy protection, children's dental services, county organized health systems, mental health, and inpatient hospital stay reviews. They do not include home and community-based care for the aged or non-aged adults.

Figure 2
Medi-Cal HCBS §1915(c) Waivers Programs*
Operational in 2005-2008

AIDS Waiver *(applications of interest 2002-2006; 2007-2011)*

The California Department of Public Health's Office of AIDS administers the AIDS waiver. Individuals must meet the nursing home qualifications, income eligibility qualifications, have an active diagnosis of AIDS and live in a setting where in-home services can be provided. The waiver provides case management, homemaker, environmental modifications, skilled nursing, transportation, specialized medical equipment and supplies, attendant care, psychosocial counseling, nutritional supplements, home-delivered meals and nutritional counseling. The AIDS waiver began in California in 1994 with 2,538 adults and children and has continued to serve approximately the same number of persons each year, although enrollment has declined in recent years. In 2005, there were 2,882 waiver participant and total expenditures of $11.9 million. By 2008 these numbers declined to 2,209 and $8.6 million respectively.

Assisted Living Waiver (ALW) *(application of interest 2005-2008)*

The Department of Health Care Services administers ALW. This waiver, initiated in 2006, allows case management, skilled nursing services, and an enhanced level of personal care and homemaker services in licensed Residential Care Facilities for the Elderly (RCFEs). These serve older adults and adults with physical disabilities. State regulations, absent this waiver, do not permit state funded IHSS services or HCBS waivers to be used by RCFE residents. The waiver also allows the offering of assisted care services for eligible residents in publicly subsidized housing. Eligibility requires meeting clinical qualifications for admission to a nursing home, income eligibility, and being at least 21 years of age. Since 2008, the waiver has a limited at least one-third of new participants to individuals who are transitioning from a nursing home. Applicants residing in an institutional setting may be eligible for nursing facility transitional care coordination. If they are relocating to a PSH setting, they may be eligible for funds for environmental accessibility adaptations. The waiver covers skilled nursing, and personal care and homemaker services as supplements to the RCFE's usual care or IHSS if in PSH)-- paid through an Assisted Living Services daily rate (Level 1, $52; Level 2, $62; Level 3 $71; Level 4, $82); care coordination, $200/month; nursing facility transition services (mostly care coordination available only to those relocating from a nursing facility), $1,000 per lifetime; environmental accessibility adaptations (limited to those in PSH), $1,500 lifetime maximum. Participation was initially limited to 50 providers in three counties. ALW is being incrementally expanded (at two counties annually between 2009-2013). The waiver served 186 individuals in 2006, at a cost of $1.3 million; and 875 participants with expenditures of $14.5 million in 2008.

Developmentally Disabled (DD) Waiver *(application of interest 2001-2011)*

The Department of Developmental Services through 21 regional centers administers the DD waiver. These are located throughout the state. Since 1983, this waiver has served individuals with DD (who have mental retardation, cerebral palsy, epilepsy, autism, or other related neurological conditions diagnosed before age 18) who must meet the clinical criteria for admission to an intermediate care facility for the mentally retarded or the developmentally disabled (ICF/DD), ICF/DD for habilitation, ICF/DD nursing, or skilled nursing facility. The waiver covers over 100 different types of services, including most of the services included as entitlements under California's Lanterman Developmental Disabilities Services Act. Some services provided under the Act are not covered by the waiver (e.g., day care) or are not billable under the waiver because the person resides in an institution or community care facility with greater than 15 beds. Generally, DD waiver services include coverage for: chore services, homemaker, home health aide services, respite care, habilitation, environmental accessibility adaptations, skilled nursing, transportation, specialized medical equipment and supplies, personal emergency response systems, family training, adult residential care, adult foster care, assisted living, supported living services, vehicle adaptations, communication aides, crisis intervention, nutritional consultation, behavior intervention services, specialized therapeutic services, transition/set up expenses, room & board for selected living in caregivers. The DD waiver grew from 2,976 individuals served in 1986 to 60,571 individuals served in calendar year 2005 with program expenditures of $1.3 billion. These increased to 70,211 recipients and $1.76 billion expenditures by 2008.

In-Home Medical Care (IHMC) Waiver *(application of interest 2003-2006)*

The Department of Health Care Services administered the IHMC waiver, operational since 1986. This waiver provided HCBS to severely disabled individuals with a catastrophic illness, and included persons who might be technology dependent, had a risk for life-threatening incidents, and who would otherwise require care in an acute care hospital for a minimum of 90 days. Services included home health aide, respite care, environmental assessment and adaptation, personal emergency response system, private duty nurse, family training, waiver service coordination, and transitional care coordination. The IHMC waiver grew modestly between 1986 and 1996 when it reached its highest enrollment of 348 persons. The program was statewide, but enrollment declined to 69 persons by calendar year 2005 and 63 in 2006, its last year of operation. Expenditures in those two years were $11.7 million and $10.6 million respectively. IHMC was consolidated effective January 1, 2007 into the Nursing Facility Acute Hospital (NF/AH) and the In Home Operations (IHO) waivers.

Figure 2 (continued)

In-Home Operations (IHO) Waiver *(application of interest 2007-2011)*
The Department of Health Care Services administers the IHO waiver. It was established effective January 2007. This waiver grandfathered a small population of the Medi-Cal beneficiaries who were previously enrolled in the Nursing Facility A/B Level of Care waiver, the Nursing Facility Sub Acute waiver or the In-Home Medical Care (IHMC) waiver. These IHO recipients did not meet the cost neutrality requirements of the new Nursing Facility/Acute Hospital waiver, which consolidated the older waivers in 2007. Recipients in the IHO waiver (and the former waiver programs) receive direct care services primarily provided by a licensed nurse and case manager. Additionally, the IHO waiver offers the same services as the NF A/B and NF SA waivers, and adds habilitation and community transition services. IHO waiver services include environmental accessibility adaptations, case management, respite care (home and facility), personal emergency response systems (PERS), PERS installation and testing, community transition services, home health aide services, habilitation services, family training, waiver personal care services, transitional case management, medical equipment operating expenses and private-duty nursing, including shared services. The planned enrollment in 2007 was 210 individuals, but due to the timing of the conversion process, actual enrollment was 188 with $16.2 million in total expenditures. Enrollment in 2008 was 180 with expenditures of $16.1 million. Enrollment in IHO continues to go down due to participant attrition.
Multipurpose Senior Services Program (MSSP) Waiver *(application of interest 2001-2009)*
The California Department of Aging administers the MSSP waiver through 41 regional contractors. This waiver began in 1983. To be eligible, individuals must be 65 or older, reside in a county with a MSSP provider, meet Medi-Cal income qualifications, and be certifiable for Nursing Facility (NF) level of care. Program services includes adult day care, case management, housing assistance, chore/personal care, protective supervision, respite, transportation, meal service, and protective services. About three fourths of MSSP expenditures are for case management. Most MSSP participants are usually jointly participating in IHSS (a state plan program). MSSP declined from 13,871 recipients in calendar year 2005 to 13,143 in calendar year 2008, while program expenditures increased from $43.1 million to $46.99 million.
Nursing Facility Acute Hospital (NF/AH) Waiver *(application of interest 2007-2011)*
The Department of Health Care Services administers the NF/AH waiver. This waiver was implemented in January 2007. NF/AH (along with the IHO) consolidates three previous waivers: Nursing Facility Level A/B, Nursing Facility Sub Acute 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, sub acute facility, or an acute care hospital. Services include case management, community transition services, environmental accessibility modifications, facility respite, family training, habilitation, home respite, medical equipment operating expenses, personal care services, personal emergency response systems (PERS), PERS installation and testing, private duty nursing (including shared services), transitional case management. The NF/AH waiver allocates 250 slots for transitioning individuals from a nursing facility. Enrollment was 1,095 in 2007 and 1,464 in 2008. Expenditures were $48.6 million and $63.9 million respectively.
Nursing Facility A/B (NF/AB) Waiver *(application of interest 2002-2006)*
The Department of Health Care Services administered the Nursing Facility A/B (NF/AB) waiver. This statewide program served physically disabled Medi-Cal beneficiaries who, in the absence of this waiver and as a matter of medical necessity, required care in an inpatient nursing facility for at least 365 consecutive days, and who needed assistance with personal care and/or needed skilled nursing care. Case management was a central component of this program, but it included coverage for several other services: community transition services, personal care services, home health aide services, respite care (both in home and in licensed facilities), environmental accessibility adaptations, personal emergency response systems, private duty nursing, family training, utility coverage, and waiver service coordination. Historically, this waiver had a small enrollment. Between 2001 and 2005 it ranged in size from 538 to 663, decreasing to 645 participants in 2006. Expenditures in 2005 were $16.2 million decreasing to $14.2 million in 2006. There was a waiting list of 649 individuals at the waiver's expiration in 2006. The NF/AH waiver replaced it in 2007. Continuing recipients were transitioned into the NF/AH waiver.
Nursing Facility Sub Acute (NF/SA) Waiver *(application of interest 2002-2006)*
The Department of Health Care Services administered the NF/SA waiver through 2006. This statewide program provided services to seriously ill, high-cost recipients who would otherwise have received adult or pediatric nursing facility services at a sub acute level of care for 180 days or more. It also supported the relocation of persons from nursing facilities to the community or diverted persons from entering a nursing facility. Services covered include case management, home health aide services, certified home health aide services, waiver personal care services, respite care, environmental accessibility adaptations, personal emergency response systems, private duty nursing (including shared nursing services), family training, transitional case management services, utility coverage, and waiver service coordination. Services available through the NF/SA waiver generally paralleled those available in the NF/AH waiver. NF/SA had an enrollment of 503 in calendar year 2005 and 505 in 2006. Like the In-Home Medical Care (IHMC) waiver, NF/SA was combined into the NF/AH and IHO waivers in 2007. About half (240) of the NF/SA participants transferred to the NF/AH Waiver, most of the others were enrolled in the In-Home Operations (IHO) Waiver. Expenditures in 2005 were $30.6 million and $29.6 million in calendar year 2006.

* Reference is to §1915(c) of the Social Security Act. Unless otherwise indicated information was obtained from the CMS approved waiver applications noted for each waiver in this Figure and CMS Form 372 reports for the calendar years shown.

Eligibility & Need Criteria

Medicaid is a means-tested, state-operated program providing health and long-term services and supports (LTSS) to certain people who are unable to afford private insurance or pay out-of-pocket for services. Under federal law, Medicaid has approximately 50 distinct eligibility groups; some are mandatory, meaning that states participating in Medicaid must cover them, while others are optional. People aged 65 and over and certain persons with disabilities are among the population groups who may qualify. Eligibility groups are differentiated, in part, by their income and asset thresholds. These financial thresholds are set by states within federal guidelines. The groups and thresholds that states cover determine who has access to Medicaid in that state and who does not.[5]

Under federal law, states have the authority to apply different eligibility rules for Medicaid's state plan and waiver services; allowing them to limit access to the waiver for selected populations. For example, if a state chooses to offer the medically needy eligibility pathway, it must use these rules to allow access to all Medicaid state plan applicants who meet the pathway's standards. Waiver authority, however, allows states to limit access to those who are categorically eligible for Medicaid, not allowing spend down to Medically Needy eligibility. States may also apply more generous eligibility criteria for access to waivers than for most state plan services, such as using the more generous standards of spousal income and resource protections. In later sections of this report, the major eligibility pathways that California uses to enable access to state plan and waivers for LTC are described.

California's HCBS waivers have in common the criteria of serving beneficiaries who are eligible for placement and care within nursing facilities or other institutional settings. They also share (with the exception of the AIDS waiver) similar Medi-Cal post-eligibility requirements, namely they permit the separation of spousal income and assets.[6] These provisions contrast with those of state plan programs (i.e., IHSS and Adult Day Health Care), which are not limited to persons meeting the needs for nursing home level of care, and do not allow for the separation of spousal income and assets.[7]

Figure 3 summarizes the eligibility criteria applicable to each of the waivers. All these programs use criteria for the determination[8] of nursing home eligibility, however, they each have specific criteria for level of care determination criteria--the basis for the type and amount of services authorized under the waiver. Later sections of this report provide a more extensive discussion of each program's eligibility and determination of need requirements.

[5] Stone, Julie. "Medicaid Eligibility for Persons Age 65+ and Individuals with Disabilities: 2009 State Profiles," Congressional Research Service, Washington, D.C., June 28, 2011.

[6] Provisions of the Patient Protection and Affordable Care Act (PPACA) of 2010 require states (for the period January 1, 2014 through December 31, 2018) to apply spousal impoverishment protections in all 1915(c) waivers, including the AIDS waiver.

[7] California sought to implement nursing home eligibility criteria for ADHC participation in 2009, but this change was denied.

[8] These criteria are elaborated in Appendix 1.

Figure 3
Medi-Cal HCBS §1915(c) Waivers Summary of Eligibility and Need Criteria
2005-2008

Waiver	AIDS	Assisted Living	DD	In-Home Medical Care	In-Home Operations	MSSP	Nursing Facility Acute Hospital	Nursing Facility A/B	Nursing Facility Sub Acute
Years in Period	**2005-2008**	**2006-2008**	**2005-2008**	**2005-2007**	**2007-2008**	**2005-2008**	**2007-2008**	**2005-2006**	**2005-2006**
SSI/SSP and 100% FPL	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Medically Needy[a]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
No Spousal Impoverishment	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Target group	HIV/AIDS	aged/ disabled	MR/DD	disabled	aged/disabled medically fragile/ tech dependent pediatrics	65+	aged/disabled medically fragile/ tech dependent pediatrics	physically disabled	disabled
Need criteria same as NF	Yes, or hospital	Yes	Same as ICF-MR	Yes, or hospital	Yes	Yes	Hosp or NF dist part of sub acute	Yes	Yes
Other criteria	MDS & 60 on CFA instrument	Uses MDS	Uses CDER assessment	hosp for 90 days+, chronic condition, IV, fluids, 2 Tx shift, LN	NF distinct part or sub acute	MSSP tool	hosp for 90 days+ chronic condition, IV, fluids, 2 Tx shift, LN	NF TAR request	NF sub acute includes pediatrics
Reassessed	Every 60 days	6 months	12 months	6 months	6-12 months	6 months	6-12 months	6 months	12 months
Other requirements	Not receiving CMP or other services	No IHSS except in PSH	Can receive IHSS/ADHC	Can receive IHSS/ADHC	Can receive IHSS/ADHC[b]	Can receive IHSS/ADHC	Can receive IHSS/ADHC	Can receive IHSS/ADHC	Can receive IHSS/ADHC
Max average cost/participant	100% of inst. costs	100% of NF Costs	ICF-MR cost	cost of hosp care	100% of inst. costs	100% of NF costs	cost of care by facility type	limit to 100% of NF costs	NF sub acute costs
Other requirements	No	No	No	No	No	<120% NF cost >3 mo	No	No	No
Geographic limit	Yes	Yes	No	No	No	Yes	No	No	No
Location of services	At home RCFE-CLHF Foster Care	RCFE or PSH	Not in hosp, NF, or ICF/MR	At home	At home	Not in hosp, NF, or ICF/MR	At home or in CLHF	At home or foster care	At home or in CLHF
Maximum slots	3,560 to 4,250	1,300-3,700	75,000-95,000	200-400	170 down to 140	16,335	2,392-3,032	450 to 890	905-1,105

Listing excludes waivers implemented after 2009, among these are the Pediatric Palliative Care and DD Continuous Nursing Care

ADHC=adult day health care, CDER=Client Development Evaluation Report, CFA= Cognitive and Functional Ability Scale, CLHF=congregate living health facility, CMP=Case Management Program, FPL=federal poverty level, MDS=minimum data set, NF=nursing facility, PSH=publicly subsidized housing, RCFE=residential care facility for the elderly

[a] Medically Needy eligibility determination uses the Institutional income and resources rules for all the HCBS waivers.

[b] Personal care provided by waiver funds prohibit using paid family members as providers.

Waiver Recipients & Expenditures

Tables 1-4 show the recipient counts and Medicaid expenditures for each HCBS and nursing facility-related waiver during the period 2005 through 2008. The tables are organized alphabetical by the name of the waiver. These data have been adapted from CMS form 372 reports. This is a standard federal reporting form for waiver data. The data represent an unduplicated number of persons who use waiver services, and the associated program expenditures during the operating period. States send CMS an "initial " 372 six months after the end of the reporting period and a "lag" report approximately 12 months after the end of the reporting period. The data presented here were obtained from the 12-month lag reports, and then compiled into calendar years. This was done to adjust for the variety of start and end dates for the waivers. The services shown for each waiver have also been consolidated into common categories to facilitate comparison.[9]

The AIDS waiver experienced a downward trend in both enrollment and expenditures going from 2,882 recipients in 2005 to 2,209 in 2008 and $11.9 million to $8.6 million expenditures. The Assisted Living waiver was initiated in 2006 with 186 recipients ($1.3 million expenditures) and doubled annually to 2008, with 875 recipients and expenditures of $14.5 million. The DD waiver, the largest and most expensive of the HCBS waiver programs, experienced annual variability. However, there was an overall growth in recipients across the period: 60.6 thousand in 2005 to 70.2 thousand in 2008. Expenditures reflected a similar growth rising from $1.3 billion to $1.76 billion during the period. MSSP, the second largest of the HCBS waivers, reduced enrollment during the period, going from 13.9 thousand recipients in 2005 to 13.1 thousand in 2008. Total expenditures increased from $43.1 million to $47.0 million. The NF A/B, NF SA, and IHMC waivers had relatively stable enrollments in between 2005 and 2006 (their last full calendar years of operation). The recipients combined among these waivers totaled 1235 and 1213 respectively in these two years. Combined expenditures totaled $58.5. The waiver covers the following services, paid largely million and $54.4 million in these years. The combined recipient counts continued at relatively similar levels in the 'new' NF AH and IHO waivers (1,161 recipients in 2007), but then grew in 2008 (1,644 recipients). Expenditures, combining these waivers, grew from $61.1 million in 2007 to $80.0 million in 2008.[10]

Technically there are no waiting lists for California's HCBS waivers (as shown in a comparison between approved program caps (last row of Figure 3) and the recipient counts shown in the following tables. However, several factors affect the time between waiver application and the actual receipt of services. This includes verification of Medi-Cal and waiver eligibility; the participant assessment (including home visits to assess the applicant's functional limitations and safety of the living environment); developing the individual's service plan; having the applicant select services from the waiver's specific Menu of Services, selection and lining up appropriate providers; and authorizing services within the waiver's cost cap.

[9] Appendix 2 shows a cross walk between the form 372 service categories and the consolidated listings shown in Tables 1-4.

[10] Figure 9, which appears in a later section, shows the services among these five waivers and the changes in specific services covered as a consequence of the waiver consolidation.

Other limitations also can create waiting lists for applicants in some waiver and HCBS state plan benefits. Among these are

- The finite number of state or local staff assigned to operate each waiver or HCBS program, and the impact that travel restrictions, hiring freezes, furloughs, and other cost saving measures have on their availability.
- Lack of the number or appropriate types of providers in various areas of the state, especially in rural areas.
- Changes in local program providers and the length of time it takes to enroll new providers selected by the waiver applicant may have also contributed to delays in program access. This has been a problem for the state plan benefit of Adult Day Health Care in several counties. Problems in finding or replacing personal care providers can cause service delays in IHSS.

Existing data systems do not readily permit the systematic tracking of time between program application and service initiation, or time between application and eligibility determination. Anecdotal reports suggest lags between MSSP application and enrollment, and between IHSS application and enrollment. Several HCBS waivers have provisions allowing for the temporary provision of personal care services until they are available through the state plan program. This provision applies to only those qualifying for the waiver, and who are able to find care providers.

Table 1
Medi-Cal HCBS Waivers, 2005
Services by Recipients and Expenditures

Waiver Number Title	183 AIDS	336 DD	348 In Home Medical Care	141 MSSP	139 Nursing Facility A/B	384 Nursing Facility Sub Acute
Start Date End Date	01/01/05 12/31/05	01/01/05 12/31/05	01/01/05 12/31/05	01/01/05 12/31/05	01/01/05 12/31/05	01/01/05 12/31/05
Waiver Services						
Adult Day Health				167		
				$408,733		
Assisted Living		23,407	11	5,858		16
		$597,871,157	$1,550,787	$1,814,360		$1,885,008
Case Management	2,877		59	13,856	436	369
	$5,850,124		$97,588	$33,168,724	$401,780	$336,740
Emergency Response		1,138		469	3	3
		$1,338,153		$239,833	$278	$858
Foster Care	7					
	$2,755					
Home Health		1,859			135	
		$15,756,047			$4,294,498	
Home Modification	88	73			4	2
	$13,618	$686,892			$13,289	$10,000
Homemaker	477	783				
	$1,316,166	$4,360,792				
Home Maintenance		4	1			
		$7,726	$153			60
Meals	1,164	425		1,858		$21,854
	$591,425	$190,208		$752,056		
Medical Supplies		1,496		7,399		
		$2,125,682		$1,672,005		
Mental Health Services	345	4,609				
	$433,812	$21,873,872				
Nursing	132	1,055	59		166	340
	$94,473	$2,770,784	$10,071,950		$7,328,306	$28,368,250
Nutrition	118	425				
	11711	$190,208				
Others					7	
					$1,327	
Personal Care	870			3,511	323	137
	$3,370,729			$2,229,075	$4,109,224	$3,042,483
Residential Habilitation		38,035				
		$450,475,846				
Respite		12,907		1,082		
		$40,696,267		$1,378,212		
Therapy		56				
		$3,139,032				
Trained Support		3,363			33	45
		$5,949,015			$3,930	$6,106
Transportation	1,278	35,582		3,789		
	$233,747	$90,710,550		$1,410,126		
Vocational Training		11,102				
		$58,842,545				
Total Recipients [a]	2,882	60,571	69	13,871	663	503
Total Expenditures	$11,918,560	$1,296,794,568	$11,720,477	$43,073,123	$16,152,632	$30,628,816

Source: Adapted from unpublished CMS 372 reports compiled by the California Department of Health Care Services. Data has been compiled into calendar years for all waivers.

[a] This is the unduplicated number of service users. Recipients may use more than one service.

Table 2
Medi-Cal HCBS Waivers, 2006
Services by Recipients and Expenditures

Waiver Number	183	431	336	348	141	139	384
Title	AIDS	Assisted Living	DD	In Home Medical Care	MSSP	Nursing Facility A/B	Nursing Facility Sub Acute
Start Date	01/01/06	01/01/06	01/01/06	01/01/06	01/01/06	01/01/06	01/01/06
End Date	12/31/06	12/31/06	12/31/06	12/31/06	12/31/06	12/31/06	12/31/06
Waiver Services							
Adult Day Health					156		
					$322,421		
Assisted Living		173	23,822	7	5,645		22
		$1,149,099	$644,952,999	$1,196,230	$1,753,748		$2,319,875
Case Management	2488	210		54	13,909	384	395
	$5,163,001	$170,253		$75,935	$35,072,509	$299,778	$314,412
Emergency Response			1,254		479	2	2
			$2,088,281		$268,580	$272	$376
Foster Care	4						
	$4,946						
Home Health			1,834			102	
			$16,694,211			$3,258,636	
Home Modification	85		74			1	1
	$10,584		$546,930			$2,500	$5,000
Homemaker	394		968				
	$1,131,575		$5,296,958				
Home Maintenance			10				43
			$28,533				$18,345
Meals	873				1,767		
	$520,885				$741,198		
Medical Supplies			1,705		7,740		
			$2,258,179		$1,750,982		
Mental Health Services	275		5,578				
	$315,582		$33,187,904				
Nursing	83		1,037	58		135	365
	$103,618		$3,131,031	$9,289,910		$5,748,092	$26,943,750
Nutrition	94		466				
	$7,039		$194,093				
Others						5	
						$640	
Personal Care	732				3,783	350	187
	$2,631,202				$2,359,658	$4,929,891	$4,485,791
Residential Habilitation			39,699				
			$484,968,205				
Respite			15,572		913		
			$55,201,050		$1,136,431		
Therapy			45				
			$2,979,005				
Trained Support			3,673			23	32
			$6,625,981			$2,611	$3,405
Transportation	1,096		36,952		3,890		
	$215,294		$101,122,890		$1,512,657		
Vocational Training			11,007				
			$62,855,404				
Total Recipients [a]	2,495	186	64,063	63	13,916	645	505
Total Expenditures	$10,103,726	$1,319,352	$1,422,131,654	$10,562,074	$44,918,184	$14,242,420	$29,605,163

Source: Adapted from unpublished CMS 372 reports compiled by the California Department of Health Care Services. Data has been compiled into calendar years for all waivers.

[a] This is the unduplicated number of service users. Recipients may use more than one service.

Table 3
Medi-Cal HCBS Waivers, 2007
Services by Recipients and Expenditures

Waiver Number Title	183 AIDS	431 Assisted Living	336 DD	457 In-Home Operations	141 MSSP	139 Nursing Facility Acute Hospital
Start Date **End Date**	01/01/07 12/31/07	01/01/07 12/31/07	01/01/07 12/31/07	01/01/07 12/31/07	01/01/07 12/31/07	01/01/07 12/31/07
Waiver Services						
Adult Day Health					141	
					$361,727	
Assisted Living		583	24,401		6,158	
		$6,237,418	$720,064,114		$2,029,907	
Case Management	2,348	583		60	13,962	694
	$4,719,297	$758,972		$82,141	$38,795,120	$528,991
Emergency Response			1,727		534	2
			$4,466,886		$379,689	$338
Foster Care	3					
	$3,374					
Home Health			1,766			
			$18,094,627			
Home Modification	94		92			
	$13,606		$703,128			
Homemaker	419		1,008			
	$1,060,597		$6,757,879			
Home Maintenance			8			
			$87,947			
Meals	1,056				1,725	
	$562,825				$833,672	
			1,872			19
Medical Supplies			$2,672,611		8,222	$4,274
Mental Health Services			6,324		$1,926,984	
			$41,470,233			
Nursing	88		1,636	72		498
	$120,636		$3,347,598	$12,363,060		$36,586,170
Nutrition	53		465			
	$4,286		$224,741			
Others						
Personal Care	647				4,198	606
	$2,283,406				$2,561,037	$11,483,885
Residential Habilitation			47,079			
			$52,968,463			
Respite			17,973		921	39
			$71,600,195		$1,377,276	$7,995
Therapy			48			
			$3,359,304			
Trained Support			3,411			
			$7,113,566			
Transportation	1,082		38,720		4,017	
	$217,157		$121,048,164		$1,670,183	
Vocational Training			10,866			
			$74,046,858			
Total Recipients [a]	2,339	583	67,650	66	13,975	1,095
Total Expenditures	$9,296,041	$6,996,390	$1,604,686,315	$12,445,201	$49,935,593	$48,611,653

Source: Adapted from unpublished CMS 372 reports compiled by the California Department of Health Care Services. Data has been compiled into calendar years for all waivers.

[a] This is the unduplicated number of service users. Recipients may use more than one service.

Table 4
Medi-Cal HCBS Waivers, 2008
Services by Recipients and Expenditures

Waiver Number	183	431	336	457	141	139
Title	AIDS	Assisted Living	DD	In-Home Operations	MSSP	Nursing Facility Acute Hospital
Start Date	01/01/08	01/01/08	01/01/08	01/01/08	01/01/08	01/01/08
End Date	12/31/08	12/31/08	12/31/08	12/31/08	12/31/08	12/31/08
Waiver Services						
Adult Day Health					133	
					$326,085	
Assisted Living		875	24,949		5,598	
		$13,001,027	$801,803,408		$1,464,468	
Case Management	2,206	875		155	13,137	800
	$4,339,347	$1,487,955		$152,046	$37,612,534	$652,568
Emergency Response			1,971		494	3
			$4,478,631		$329,679	$469
Foster Care	6					
	$5,227					
Home Health			1,701	40		
			$19,137,564	$2,022,902		
Home Modification	96		112			3
	$14,444		$952,289			$9,650
Homemaker	410		1,111			
	$1,201,081		$7,458,668			
Home Maintenance			7			
			$17,847			
Meals	860		483		1,645	
	$506,431		$229,873		$735,030	
Medical Supplies			1,890		7,918	28
			$3,131,385		$1,897,797	$8,712
Mental Health Services	243		6,854			
	$300,968		$55,205,015			
Nursing	64		1,550	122		651
	$89,399		$3,591,786	$12,024,083		$44,059,209
Nutrition	53		483			
	$7,720		$229,873			
Others						
Personal Care	532			68	3,804	934
	$1,923,958			$1,861,670	$2,126,828	$19,205,320
Residential Habilitation			43,273			1
			$569,507,434			$3,010
Respite			20,101		790	
			$88,390,734		$1,124,043	
Therapy			67			
			$3,323,720			
Trained Support			4,092			35
			$9,856,333			$2,303
Transportation	941		37,355		3,688	
	$184,114		$120,122,328		$1,372,899	
Vocational Training			10,408			
			$70,796,035			
Total Recipients [a]	2,209	875	70,211	180	13,143	1,464
Total Expenditures	$8,572,689	$14,488,982	$1,758,003,051	$16,060,701	$46,989,364	$63,941,241

Source: Adapted from unpublished CMS 372 reports compiled by the California Department of Health Care Services. Data has been compiled into calendar years for all waivers.

[a] This is the unduplicated number of service users. Recipients may use more than one service.

Part 2

Medi-Cal Income & Financial Eligibility

Introduction[11]

Access to Medi-Cal LTC benefits in California and all other states, begins with eligibility for Medicaid. This is a complex topic. In this section we review the several ways in which such eligibility is obtained. This is challenging reading, but it is important background for later sections that review the eligibility criteria used for the HCBS waivers and state plan benefits. Most of the waivers allow for more generous qualifying income levels (these are described later as the Institutional income and resource standard) and protections of spousal income and resources, than is true for state plan services. These distinctions are fundamental, and could well determine who enters a nursing home vs. who is able to remain in the community. They may also influence who is eligible for the array of other services available to Medicaid recipients—some of which may prove to be protective against more expensive services and avoidable health or even long term care service outcomes.

To qualify for Medi-Cal, an individual must meet both categorical and financial eligibility requirements. Categorical eligibility requirements relate to the age or other characteristics of an individual. People aged 65 and over and certain persons with disabilities are among the categories of individuals who may qualify.[12] According to federal law, Medi-Cal's financial eligibility requirements place limits on the amount of income and resources, or assets, individuals may possess and still be eligible for Medi-Cal.

Federal law specifies both mandatory and optional eligibility pathways; each of which has distinct income and asset limits. Among the mandatory groups covered in California are those eligible for Supplemental Security Income (SSI). California also covers those with income from the State Supplemental Payments (SSP). Other optional groups covered under Medi-Cal include those having a monthly income up to 100% of the Federal Poverty Level (FPL) and people who qualify as medically needy.[13] For medically needy, if medical expenditures are high enough, one can spend down an applicant's income to the medically needy income standard. Since at least 2001, California has set the medically needy income standard (net after paying health care expenditure) at $600 for individuals ($934 for aged, blind or disabled couples).

In addition to categorical and financial requirements, individuals in need of LTSS may be required to meet level-of-care eligibility criteria that demonstrate difficulty performing activities necessary for self-care and independent living.[14] Medi-Cal eligibility is reflected in

[11] The following sources provide readable and expanded detail of the information presented here: http://www.disabilitybenefits101.org/; also see the Medi-Cal resource page in particular; California Department of Health Care Services County Welfare Directors Letters (these are online); Health Consumer Alliance (HCA) brochures on Medi-Cal and an *Overview of the Medi-Cal System* jointly published with Protection and Advocacy, Inc. This document includes references to laws, regulations and decisions on Medicaid and Medi-Cal.

[12] Stone, Julie. "Medicaid Eligibility for Persons Age 65+ and Individuals with Disabilities: 2009 State Profiles," Congressional Research Service, Washington, DC., June 28, 2011.

[13] Other mandatory groups are pregnant women, infants, children age 1-5 (all with FLP up to 133%); , children age 6-18 (up to 100% FLP). Among other optional categorically needy groups are those in the 250% Working Disabled Program,

[14] Stone, Julie, "Medicaid Eligibility for Persons Age 65+ and Individuals with Disabilities: 2009 State Profiles," Congressional Research Service, Washington, DC., June 28, 2011.

numerous Aid Codes (summarized in Appendix 3). These are used in conjunction with the Medi-Cal Eligibility Verification System (EVS). The EVS verifies a recipient's eligibility, the Aid Code and the corresponding services for which they are eligible. If a recipient has an unmet Share of Cost (SOC), an aid code is not returned. A recipient can have more than one aid code over time, and may be eligible for multiple programs and services.

Supplemental Security Income (SSI)/State Supplemental Payments (SSP)[15]

Individuals 65 years or older or persons with a qualifying level of disability[16] are automatically eligible for Medi-Cal (with no pre-eligibility spend-down obligation) if their resources and income qualify them for the federal SSI program. The SSI income standard for aged and disabled adults living alone ranged from $579 to $674 per month between 2005 and 2009. Asset resource[17] limits during this period were $2,000 (excluding a principal place of residence, car necessary for transportation, clothing, and household goods). For couples where both partners were either aged or disabled, monthly income limits ranged from $869 to $1,011 during this same period. Resource limits were $3,000.[18] Resource limits have been at this level since 1989 (increasing by about $150 for each additional person in the household).

SSI payments function to bring total monthly income to these minimum levels. In other words, SSI is not a fixed payment. SSI income standards for 2005 to 2009 are shown in Table 5. SSI increased modestly annually. The standards are lower when the individual or couple lives in the household of another, and that household provides room & board as an in-kind contribution. SSI standards remain the same for individuals and couples whether the individual (or couple) lives in a unit with or without cooking facilities, or when room & board is not provided in-kind. Also constant is that couples have the same payment standard regardless of whether they are both aged or disabled; both blind; or a mix between blind, disabled, or aged.

States have the authority to offer a State Supplemental Payment (SSP) to the SSI payment (Code of Federal Regulations, Title 42, §12000). SSP is added to the SSI payment and generally increases the Medi-Cal no-share-of-cost income eligibility to this new level. California provides differential SSP payments according to the individual's or couple's living arrangements shown in columns of Table 5. From this table it can be seen that SSI increased modestly each year; whereas SSP payment standards, within the population subgroups, aged/disabled, blind, disabled minor children remained relatively constant over these years.[19]

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[15] Source: Medi-Cal Eligibility Division, Pickle Handbook, Section 16-Payment Standards, and Disability Benefits 101 SSI Program Description.

[16] Disability for adults means that the individual is unable to do any substantial, gainful activity (e.g., work for wages beyond a minimum level per month) because of a mental or physical impairment that is expected to last for a continuous period of at least 12 months or that will result in death. Proof of disability is reviewed & confirmed by the Social Security Administration (SSA). Blind means that the person is statutorily blind as determined by SSA.

[17] Income includes anything received in cash or in-kind that be used or sold to meet needs for food, shelter, and clothing. Resources are cash or other property than can be converted to cash (e.g., stocks, bonds, bank accounts, boats, land).

[18] See California State Plan, Supplement 2, Attachment 2.6A for the full listing of resource levels by household size.

[19] Currently, California's average SSP is $168. The average SSP is $125 in the 15 states having federally administered SSI payments. (Social Security Administration. (2010). *Annual Statistical Supplement*, Table 7.B3, December 2009.)

Table 5
SSI/SSP Payment Standards
2005-2009

	Independent Living			Household of another			Independent Living, No cooking facilities			NMB/C[b] or Relative HH No In-Kind room/board		
	Total	**SSI**	**SSP**	**Total**	**SSI**	**SSP**	**Total**	**SSI**	**SSP**	**Total**	**SSI**	**SSP**
2005												
Individual												
Aged or Disabled	$812	$579	$233	$620	$386	$234	$896	$579	$317	$991	$579	$412
Blind	$877	$579	$298	$701	$386	$315				$991	$579	$412
Disabled Minor[a]	698	$579	$119	$494	$386	$108				$991	$579	$412
Couple[c]												
Aged &/or Disabled	$1,437	$869	$568	$1,175	$579	$596	$1,605	$869	$736	$1982	$869	$1,113
Both Blind	$1,664	$869	$795	$1,402	$579	$823				$1,982	$869	$1,113
Blind/Disabled/Aged	$1,579	$869	$710	$1,316	$579	$736				$1,982	$869	$1,113
2006												
Individual												
Aged or Disabled	$836	$603	$233	$636	$402	$234	$920	$603	$317	$1,015	$603	$412
Blind	$901	$603	$298	$717	$402	$315				$1,015	$603	$412
Disabled Minor	$722	$603	$119	$510	$402	$108				$1,015	$603	$412
Couple												
Aged &/or Disabled	$1,472	$904	$568	$1,198	$603	$596	$1,640	$904	$736	$2,030	$904	$1,126
Both Blind	$1,699	$904	$795	$1,425	$603	$823				$2,030	$904	$1,126
Blind/Disabled/Aged	$1,614	$904	$710	$1,339	$603	$737				$2,030	$904	$1,126
2007												
Individual												
Aged or Disabled	$856	$623	$233	$649	$415	$234	$940	$623	$317	$1,035	$623	$412
Blind	$921	$623	$298	$730	$415	$315				$1,035	$623	$412
Disabled Minor	$742	$623	$119	$523	$415	$108				$1,035	$623	$412
Couple												
Aged &/or Disabled	$1,502	$934	$568	$1,218	$623	$596	$1,670	$934	$736	$2,070	$934	$1,136
Both Blind	$1,729	$934	$795	$1,445	$623	$823				$2,070	$934	$1,136
Blind/Disabled/Aged	$1,644	$934	$710	$1,359	$623	$737				$2,070	$934	$1,136
2008												
Individual												
Aged or Disabled	$870	$637	$233	$659	$425	$234	$954	$637	$317	$1,049	$637	$412
Blind	$935	$637	$298	$740	$425	$315				$1,049	$637	$412
Disabled Minor	$756	$637	$119	$533	$425	$106				$1,049	$637	$412
Couple												
Aged &/or Disabled	$1,524	$956	$568	$1,233	$637	$596	$1,692	$956	$736	$2,098	$956	$1,142
Both Blind	$1,751	$956	$795	$1,460	$637	$823				$2,098	$956	$1,142
Blind/Disabled/Aged	$1,666	$956	$710	$1,374	$637	$736				$2,098	$956	$1,142
2009												
Individual												
Aged or Disabled	$907	$674	$233	$683	$449	$234	$991	$674	$317	$1,086	$674	$412
Blind	$972	$674	$298	$764	$449	$315				$1,086	$674	$412
Disabled Minor	$793	$674	$119	$557	$449	$108				$1,086	$674	$412
Couple												
Aged &/or Disabled	$1,579	$1,011	$568	$1,270	$674	$596	$1,747	$1,011	$736	$2,172	$1,011	$1,142
Both Blind	$1,806	$1,011	$795	$1,496	$674	$823				$2,172	$1,011	$1,142
Blind/Disabled/Aged	$1,721	$1,011	$710	$1,411	$674	$737				$2,172	$1,011	$1,142

Source: Medi-Cal Eligibility Division, Pickle Handbook, Section 16-Payment Standards. SSI payment standards are adjusted annually. SSP standards are sometimes adjusted twice annually. In 2005 & 2006 they were adjusted in January and April; in 2008 this adjustment occurred in January and June. Payment standards shown in the table are those of April in each year.

[a] Independent living for a disabled minor means living in the parent's home. Household of another is used if both the disabled minor and parent live in the household of someone else (e.g. grandparent).

[b] NMB/C refers to nonmedical board & care licensed facility

[c] Couple refers to a married couple where both partners are either aged, blind, or disabled

Not shown in Table 5 is that SSP standards for the aged were reduced in January 2006 and increased in 2008 for portions of the year--in both cases returning to 2005 levels. The blind and disabled minor children experienced similar reductions in this period. In contrast, individuals living in a unit with no cooking facilities and in board & care received increases in SSP levels

(individuals and couples respectively, $407 & $1,045) in 2009. Couples in licensed housing also received a modest increase to $1,161.[20]

California policies continue eligibility for a transitional period when there is a cost of living or other adjustment affecting the beneficiary's SSI/SSP eligibility. This would have continued eligibility for the current beneficiaries during these short periods of changing payment levels. The more enduring effect of the relatively constant SSP standards is that more persons would enter Medi-Cal through spend down or special income standards. Whether this affected access and constancy in HCBS is unknown at this time.

Special Income Levels

The aged or disabled may be eligible for Medi-Cal programs through a special income standard known as Aged & Disabled Federal Poverty Level (A&D FPL). This compares the individual's or household's income relative to the applicable federal poverty level. Persons qualifying for Medi-Cal eligibility through a special income standard (e.g., 100% FPL) receive Medi-Cal with no share of cost, i.e., there is no post-eligibility payment requirement.

The Department of Health & Human Services issues the poverty level guidelines annually. FPL guidelines vary by household size in accordance with §1902(m)(3) under Title XIX of the Social Security Act.[21] California's Welfare and Institutions Code, §14005.40 requires that the A&D FPL be the greater of SSI/SSP or 100% of the FPL plus an income disregard of $230 for an individual or $310 for couples. Specific programs may have different standards of income as a percent of the poverty level. One example of these special standards is the California 250% Working Disabled Program—this refers to income up to 250% of the federal poverty level (FPL). Unlike many states, California does not have a special income standard (e.g., 300% of SSI) for persons in nursing homes.

Table 6 shows changes in the Federal Poverty Levels and Maintenance need levels for individuals and couples between 2005 and 2009. Income above the MMNL (or the $35 personal needs allowance for persons in nursing homes) is applied to care costs. California's income disregard levels of $230 for an individual and $310 for couples remained constant between 2005-2009. In years when SSI/SSP exceeded the combined FPL and the standard federal income disregard, then the difference between the SSI/SSP income level and FPL determined the effective qualifying income.

[20] In 2006 the SSP was reduced to $209 for individuals living independently and $533 for couples, returning back to 2005 levels in April 2006. SSP remained at that the 2005 level until May of 2008, when it was increased (e.g., to $251 and $602 respectively for individuals and couples living independently) until the end of the calendar year. SSP standards again returned to the 2005 level in January 2009, and were reduced again effective May 2009 for individuals and couples living independently (e.g., $196 & $513 respectively) or in the household of another (e.g., $209 & $559 respectively).

[21] Poverty guidelines for all family sizes back to 1965 are available in Table3.E8 of the *Annual Statistical Supplement of the Social Security Bulletin*. Annual levels are also published in the *Federal Register*.

Table 6
Federal Poverty Level & Net Maintenance Need Level/Medically Needy Level
2005-2009[a]

	Individuals		Couples	
Year	**100% FPL**[b] **Monthly**	**MMNL**[c] **Monthly**	**100% FPL**[b] **Monthly**	**MMNL**[c] **Monthly**
2005	$798	$600	$1,070	$934
2006	$817	$600	$1,100	$934
2007	$851	$600	$1,141	$934
2008	$867	$600	$1,116	$934
2009	$903	$600	$1,215	$934

Source: FPL adapted from Table 3.E8, *Annual Statistical Supplement of the Social Security Bulletin*, 2009.

[a] Effective April of each year.

[b] FPL refers to Federal Poverty Level, which increases as the household size increases. 100% FPL applies to Qualified Medicare Beneficiary Program, Children age 6 to 19, aged and disabled, and §1931 applicants. Other FPL standards are applied to selected groups, e.g., 133% children age 1 to 6, 200% pregnant women and infants to age 1, and 250% for Working Disabled Program and Healthy Families Program.

[c] MMNL refers to the net Minimum Maintenance Need Level income qualifying for the Medi-Cal Medically Needy Program. The levels shown are applicable when at least one of the adults in the household is aged, blind, or disabled. Additional income levels are defined for households of up to 10 members. These generally increase MMNL by about $150 for each additional family member. MMNL has been unchanged since 1989. See California State Plan, Supplement 1 to Attachment 2.6A for the full listing.

Comparing Table 6 with Table 5, for individuals the FPL and the standard income disregard shows the minimum income levels across the period. For couples, SSI/SSP provided higher income levels, and consequently more income disregard than the standard disregard of $310. The difference between the FPL and standard income disregard and SSI/SSP methodologies were minor over time (e.g., $57 in 2005, $54 in 2009).

Medically Needy/Share of Cost

California's Medically Needy eligibility has a resource limit, but no income cap. In other words, the person can start with any income level and still become eligible if their health care expenses are large enough. The share of cost payments are not specific to a particular Medi-Cal program and can be met in payments for a combination of Medi-Cal received services. Share of cost payment obligations are on going and need to be achieved monthly to retain Medi-Cal eligibility, i.e., before service payments are eligible for Medi-Cal reimbursement. Table 6 shows the net MMNL or Medically Needy income requirements for 2005-2009. The amounts shown are inclusive of $517 for individuals ($800 for aged, blind or disabled couples), and an $83 income disregard for individuals ($134 for couples). The resource limits applicable to SSI were constant between 2005-2009 at $2,000 for individuals and $3,000 for couples, incrementing by $150 for each additional household member.

Separation of Spousal Income and Assets

Separation of spousal income and assets can be an important consideration in Medi-Cal eligibility. Per §1924(h) of the Social Security Act, long term care beneficiaries, under specific

circumstances (e.g., when one spouse enters a nursing home or assisted living or various Medicaid waivers), may allocate a portion of the household income and economic assets (e.g., primary house and automobiles) for use of community dwelling spouse. These can be excluded in calculating eligibility for as long as the spouse remains living in the house.

Typically, the spouse remaining in the community receives an allocation of the joint assets and income to help assure that s/he retains sufficient financial resources for living expenses. The remaining income and assets are subject to spend down requirements needed to reach the income Levels discussed previously. The federal maximum allocations of monthly income and property caps for Spouses are shown in Table 7. The first row is the income level used by the Medi-Cal program in determining the minimum amount of income a LTC beneficiary can allocate to a community dwelling family member. The second row reflects the maximum spousal monthly maintenance need allowances under the *Medicare Catastrophic Coverage Act.* These were added to Medicaid starting in 1988. Row three is the federal ceiling for allowed resources. These income and resource allowances may make it easier for an individual in a nursing home or assisted living to qualify for Medi-Cal without impoverishing the other Medically Needy/Special Income eligible spouse. States can choose an amount within the income range reflected between rows 1 and 2 as the income that can be protected for the community spouse. California has, in the period shown, elected to use the federal standards.

Table 7
Monthly Income & Resource Allocation Amounts
Community Dwelling Spouses of Long Term-Care Beneficiaries
2005-2009

	2004	2005	2006	2007	2008	2009
Maximum Monthly Income[a]	$1,562	$1,604	$1,650	$1,712	$1,750	$1,822
Monthly Maintenance Needs[b]	$2,319	$2,378	$2,489	$2,541	$2,610	$2,739
Spouse Resource Allowance[b]	$92,760	$95,100	$99,540	$101,640	$104,400	$109,560

[a] Income levels effective July 1 of each calendar year
[b] Income and resource allowance caps under the Medicare Catastrophic Coverage Act. These are effective January 1 of each calendar year.

California's Medi-Cal program allows separation of spousal income and assets for long-term care facility residents, and 1915(c) HCBS waiver participants, except those in the AIDS waiver. However, California does not use separation of spousal income and assets for beneficiaries using State Plan HCBS Benefits like Adult Day Health Care and In-Home Supportive Services.

Implications of Financial Eligibility on Participants in HCBS Waivers

Under federal law, States may cover institutionalized beneficiaries with income up to 300% of the federal SSI standard. When using this special income standard states are not required to cover the same person in the community—although some states do. In California, to meet the financial eligibility criteria for §1915(c) waivers, applicants must receive SSI, SSP, meet the

Medi-Cal Medically Needy standards, or have income below 100% of the Federal Poverty Level (plus the allowable income disregard). However, the standard of 300% of SSI is not used.

Table 8 shows the estimated number of Medi-Cal eligibles by Aid code in California during a one-month snap shot in 2008, and how these cross walk with Medicare eligibility. Of the alternative routes into Medi-Cal eligibility, SSI/SSP and Medically Needy predominate. Any one beneficiary can have up to four aid codes recorded in any given month. The counts in the table reflect only the primary code for the period.

Table 8
Estimated Number of Medi-Cal Eligibles by Selected AID Codes
Percent with Medicare Eligibility

Eligibility Category	Number Eligible	% Eligible w/Medicare
100% Poverty	93,223	0.0%
133% Poverty	126,316	0.0%
200% Income Disregard/AC 76	110,957	0.0%
MI Adult	1,990	0.4%
MI Child	204,910	0.0%
Medically Needy		
Aged	107,049	95.5%
Blind	237	53.2%
Disabled	95,360	61.6%
Families	2,026,488	0.6%
SSI/SSP/ Special Needs/TANF		
Aged	285,434	99.0%
Blind	19,061	54.6%
Disabled	823,672	38.5%
Families	1,202,490	0.1%
Long-Term Care	7,705	71.2%
QMB - only	5,026	100.0%
Refugees	154	0.0%
Total	5,109,918	15.5%

Source: Unpublished Medi-Cal eligibility data compiled by the Department of Health Care Services. The numbers shown are for July 2008 and include those who are categorically eligible and those with a monthly share of cost obligation (the Medically Needy), regardless of whether the obligation was met that month. Not included are those in aid codes assigned to undocumented aliens, those considered a "Qualified" Alien under the Personal Responsibility and Work Opportunity Act or a PRUCOL alien, persons enrolled in the Breast and Cervical Cancer Program, Dialysis, Tuberculosis, Total Parental Nutrition and Minor Consent Programs.

Individuals in states with a Medically Needy program are more likely to be eligible if they are living in an institution than in the community. This occurs for two reasons. First, the persistent cost of a nursing facility can more quickly deplete the income and resources of low/moderate income individuals. Secondly, a separation of income and assets between the nursing facility recipient and the community dwelling spouse used to protect spousal resources, may also make

it easier for a nursing home resident to reach the share of cost limits needed for Medically Needy eligibility. In contrast, the service hours and monthly costs of HCBS are usually less than for nursing facilities; and further spousal income and resource protections may not extend to state plan services. HCBS spending, unless coupled with other qualifying health care costs, may be unlikely to continually meet Medi-Cal 'spend down' requirements and the larger array of benefits this makes available. This disadvantage for HCBS participation in California might be somewhat addressed by having a 300% special income eligibility standard for both nursing facilities and waiver programs, and by allowing a separation of spousal income and assets for the state's major Medi-Cal personal care program: In-Home Supportive Services (IHSS).

Part 3

SELECTED STATE PLAN COMMUNITY-BASED PROGRAMS

Introduction

California's Medi-Cal program provides a wide array of health care related services and programs for low-income individuals and families, including the elderly, persons with disabilities, those with specific diseases, and children with special medical needs. The majority of these services are articulated within a *State Plan Under Title XIX of the Social Security Act, Medical Assistance Program.* This plan is periodically reviewed by the federal Centers for Medicare & Medicaid Services (CMS). Among other things, the plan describes the mandatory and optional Medicaid (i.e., Medi-Cal in California) benefits available in the state. Most of the provisions of California's State Plan have been in place since 1989, although some provisions (such as additional benefits or more restrictive eligibility) have been modified through amendments and waivers since then. Figure 4 lists the services available under the state plan during 2005-2009.

This section will focus in detail on three of these, Adult Day Health Care Services, In-Home Supportive Services, and Targeted Case Management. These are optional benefits, but they are keystones to the state's home and community-based long-term care programs. Part 4, later in the report describes several additional home and community-based services. These are offered through waivers to the Medicaid program, and generally supplement or coordinate with the state plan programs.

State plan services are generally available on a statewide basis, available to all persons qualifying for Medicaid and meeting the levels of need appropriate to the services offered. There are however, a number of programs specific to pregnant women, prenatal care, and some preventive health screening that have less restrictive financial eligibility criteria than for regular Medi-Cal eligibility. See Appendix 4 for a listing of these Medicaid eligibility codes. Many of those with less restrictive eligibility also have restrictive benefits.

Figure 4
Services Available through California's Medi-Cal State Plan
2005-2009

Inpatient Services	**Physician Services**
Hospital Inpatient (other than for those provided in an institution for mental diseases)	Physician Services (home, office, hospital, NF, elsewhere)
Nursing Facility Services (other than for those provided in an institution for mental diseases)	Sign Language and Interpreter (in connection w/physician services
Sanitoria, Christian Science	Medical/Surgical services by a dentist
Institutions for Mental Diseases	**Other Licensed Health Care**
Inpatient Hospital/Psychiatric Facility (ages <22, 65+)	Chiropractor
Skilled Nursing Facility (age 65+)	Dentist
Intermediate Care Facility (all ages)	Optometrist
Outpatient & Clinic Services (Hospital or Other)	Podiatrist
Emergency Hospital Services	Other Practitioners
Hospital Outpatient Services	**Nursing Services**
Clinics (includes rural, Federally Qualified Health Centers, & Others)	Mid-Wife
Early Periodic Screening, Diagnostic, and Treatment services (EPSDT) for those under age 21	Nurse Practitioner (family & pediatric)
Family Planning	Private Duty
Local Education Agency Services	Christian Science Nurse services
Prenatal Care	**Home Health Services**
Preventive Services	Home Health Nurse
Tuberculosis Related Services	Home Health Aide
Therapies	Home Health Medical Supplies
Audiology Services	**Hospice Care**
Occupational Therapy	Inpatient
Physical Therapy	Outpatient
Speech Therapy	**Home & Community-Based Care**
Medications & Appliances	Adult Day Health Care*
Dentures	Case Management
Eyeglasses	Personal Care*
Prescription Drugs	**Laboratory & X-Ray**
Prosthetic and Orthotic Devices	**Medical Transportation**

Source: California State Plan

* indicates a service allowed by Medicaid, but that can be selected at the option of the state. This contrasts with services that are required to be in the state plan.

In-Home Supportive Services

In Home Supportive Services (IHSS) is the name used by the California Department of Social Services to describe the Personal Care Service Program (PCSP) funded and operated as an optional benefit under the Medi-Cal state plan. CMS historically has reimbursed the state at the Federal Medical Assistance Percentage (FMAP) rate of 50% for PCSP expenditures. Of the balance, the state of California pays 65% of the nonfederal share of costs through State General Funds, and counties pay the remaining 35% of the nonfederal share.[22] To be eligible for this program one must meet either the categorical or Medically Needy (share of cost) requirements

[22] The American Recovery and Reinvestment Act increased California's FMAP from 50% to 61.59% for calendar year 2010. This temporarily reduced the state and county shares.

for Medi-Cal eligibility and be unable to perform needed functional tasks. Unlike the HCBS waiver programs described later, IHSS recipients cannot gain Medi-Cal eligibility (or protect spousal income) through the separation of income and assets among spouses when both partners are living in the community. Nor can recipients of IHSS use institutional income and asset standards in determining Medically Needy eligibility.[23]

IHSS was initiated as a state and county funded program in the late 1970s. The program was incorporated into the Medi-Cal State Plan under the optional Personal Care Service Program (PCSP) in 1993. Components of the original program (e.g., services provided by legally responsible relatives and services provided to undocumented aliens) not eligible for federal matching at that time, were continued with the state and county funding 100% of these service costs. This portion of the program came to be known as the IHSS Residual Program.

In 2004 the vast majority of the IHSS Residual Program was transferred into a §1115 waiver. This was known as IHSS Plus. Between 2004 and into 2009 IHSS operated under two authorities—the Medi-Cal state plan and the Social Security Act §1115 demonstration authority. IHSS Plus generated FMAP for the following services and providers. Prior to this waiver, these features were not eligible for federal share of costs under the state plan: [24]

- IHSS payments to legally responsible relatives (parents of minor children and spouses) for personal care
- Protective supervision (mostly applicable to persons with cognitive and memory limitations)
- Domestic and related services
- Restaurant meal vouchers and advance payments (funds paid in advance to support timely payments to providers who serve severely impaired participants).

A Medicaid State Plan Amendment was submitted to CMS (and approved) in 2009 converting the IHSS Plus §1115 demonstration to a §1915(j) authority within the state plan. The amendments became effective under this new authority in October 2009. This authority continues program provisions for employing legally responsible relatives and offering the services noted above.

Services and Service Hours Guidelines

IHSS social workers have caseloads of 300-500 recipients. Social worker roles conduct assessments and service authorizations. They do not provide ongoing case management. IHSS is delivered by personal assistance service providers. All family members (including parents of minor children, spouses), as well as non-relatives are all potentially eligible to be paid providers.

[23] The PPACA require states to apply spousal impoverishment protection rules to applicants for LTC under §1915(i). This applies to both Categorical and Medically Needy eligibles. These provisions are effective from 1/1/ 2014 through 12/31/2018.

[24] Newcomer R. & Kang T. (2008), *Analysis of the California In-Home Supportive Services (IHSS) Plus Waiver Demonstration Program.* A report prepared under sub contract 5-312-208826 from the Research Triangle Institute, Research Triangle Park, NC. Retrieved on 6-20-10: http://aspe.hhs.gov/daltcp/reports/2008/ihssplus.pdf.

The vast majority of IHSS workers are independent providers, 'hired, supervised, and fired' by the IHSS recipients themselves. Direct payments to independent providers are made based on time sheets submitted and signed by both the providers and the recipients. IHSS workers (except those employed through agencies) have Public Authorities (PA) as their employer of record. This is for the purpose of negotiating local wages and benefits, and maintaining local registries of eligible workers. PAs are local community or county-based operations, and generally independent of county government. PAs have some responsibility for facilitating worker training, but they do not supervise or monitor IHSS providers.

Figure 5 shows the services and the time (in hours per week) that may be authorized for specific personal care tasks and for meal preparation and cleanup. Time for domestic and household-related tasks is reduced if there is more than one person in the household capable of performing these tasks. These guidelines have been in effect since 2006.[25] Prior to that, county social workers had more discretion in authorizing service hours. Currently, social workers use the guidelines in evaluating how the recipient's functional ability is ranked in the assessment. Waivers for extra hours of assistance can be authorized, but the social worker has to document why the consumer needs hours outside the suggested range.

Figure 5
IHSS Services and Authorized Hours Guideline

Services	Authorized Hours (hours per week)	Services	Authorized Hours (hours per week)
Domestic Services	Up to 1.5	Bowel and bladder care[d]	.58-8.0
Laundry if in building	Up to 1.0	Feeding[e]	.7-9.33
Laundry, outside building	1.0-1.5	Routine bed baths	.5-3.5
Grocery shopping	Up to 1.0	Bathing, oral hygiene, grooming	.5-5.1
Other errands	.5	Dressing & undressing	.56-3.5
Meal preparation	3.02-7.0	Repositioning[f]	.75-2.8
Meal clean-up[a]	1.17-3.5	Transfer[g]	.5-3.5
Ambulation/mobility[b]	.58-3.5	Assistance w/prosthesis[h]	.47-1.12
Protective Supervision[c]	variable	Routine menstrual care	.28-.8

Source: http://www.disabilitybenefits101.org/ca/programs/health_coverage/medi_cal/ihss/faqs.htm#_q702.

[a] General cleaning of refrigerator, stove, oven, counters, sink is included under domestic services.

[b] Includes moving from place to place within home, moving or retrieving assistive devices (e.g., walker, cane, wheelchair), assistance from front door to vehicle, and from vehicle to medical appointments or alternative resources.

[c] Includes supervision due to memory, orientation, judgment limitations. Time may be allocated into specific tasks or as protective supervision.

[d] Help getting to and from the bathroom is covered under ambulation; to and from commode in the same room is covered under transfer; enemas, catheters, suppositories, digital stimulation, colostomy and similar tasks are covered under paramedical.

[e] Cutting up or pureeing food is covered under meal preparation.

[f] Includes rubbing of skin and turning in bed. Care of pressure sores (decubiti) is covered under paramedical services.

[g] Includes help going from standing, sitting, prone to another position or to and from bed, chair/stairglide/walker, couch, etc. in the same room. Help on or off commode is covered under 'bowel and bladder.'

[h] Includes assistance with and care of brace, hearing aid, glasses; and assistance with medications.

[25] CDSS Manual of Policies and Procedures, §30-757 and following, effective September 2006.

California allows a maximum of 283 hours of IHSS paid services in a month. Individuals with complex or very high service needs must qualify for one of the HCBS waivers to receive additional personal care services. This means that they have to meet California's long-term facility level of care criteria. The total hours provided by coupling IHSS benefits with augmented services available through HCBS waivers are not regularly reported, but our analysis of 2005 Form 372 data (shown earlier in Table 1) reveals that 4,841 waiver recipients (less those in IHSS Plus and the DD waiver) received personal care paid by HCBS waivers. This was in addition to IHSS services that were not shown. Mean monthly expenditures for the waiver personal care was $219 (about 27 hours assistance) for those receiving this added benefit. Excluding the MSSP waiver recipients from the other HCBS recipients reduces to 1,330, the number receiving the waiver paid personal care, but per recipient expenditures increased to $657 per month.[26]

The average number of paid IHSS hours in 2008 was 86 per month or 21.4 per week.[27] This compares with the national average hours of assistance with ADLs and IADLs per week of about 31.4 hours. This latter statistic includes both paid and unpaid hours of care. Average IHSS hours only include paid services.[28] About 6% of IHSS participants received 200 or more hours of paid service in December 2008. Using single month data, CDSS estimates that the average authorized hours of IHSS service grew from 83.5 in 2005 to 86.0 in 2008.

Eligibility and Relationship to HCBS Waivers

The relationships between IHSS and the other HCBS programs, and IHSS and nursing homes (and perhaps with residential care) will emerge as a focus in longitudinal analyses. Because IHSS is a state plan benefit, it is possible to couple IHSS provision with services/hours funded by the HCBS waivers. Additionally, to the extent that IHSS may be effective in enabling recipients to remain in community settings rather than having them enter nursing homes, the growth and case mix changes in IHSS may be reflective of long-term nursing facility care placements that have been deferred or prevented. If this is occurring, analyses could also consider whether expenditures in IHSS are offset from nursing homes placement savings. Analyses of claims data (work to be reported in subsequent reports), combining all HCBS services, and adjusting for case mix, will be able to compare differences and inter-relationships between the service use and frailty mix among those in HCBS vs. those in nursing home, and health care expenditures in both Medi-Cal (and Medicare when applicable).

One expected complication in comparative analyses between nursing facility residents and other beneficiaries is that community-based recipients with share of cost Medi-Cal eligibility may have more variability from month to month in their eligibility and in the units of Medi-Cal reimbursed service than persons in nursing facilities with share of cost—where expenses are much more constant.

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[26] These counts differ substantially from those reported in Newcomer R. & Kang T. (2008), Table 26, page 76 in an analysis using data from 2005 Medi-Cal claims.

[27] Unpublished data from the California Department of Social Services, cited in Mollica & Hendrickson, 2009.

[28] LaPlante, MP, Harrington, C, Kang, T. (2002) Estimating paid and unpaid hours of personal care assistance in activities of daily living provided to adults living at home. *Health Services Research,* 37(2): 397-415.

Another complication affecting placement and community care retention is that both nursing homes and HCBS waivers use higher income standards and spousal separation of assets. This is not true for IHSS and ADHC recipients. This may favor easier access to Medi-Cal eligibility for nursing facility residents and those in HCBS waivers.

Level of Care Determination

The general standard for measuring individual need for IHSS services is an inability to perform needed functional tasks (see Welfare and Institutions Code §12300).[29] County IHSS social workers use a uniform instrument to assess functional capacity of applicants and to authorize services. They are responsible for conducting assessments and reassessments. The assessment is conducted in the applicant's home at progam application, and at approximately 12-24 month intervals afterwards.

Based on the assessment, the worker determines the type of services for which the recipient is eligible, and the hours of service to be authorized per month. Hours are adjusted based on the individual's living arrangements. The recipient is entitled to receive the services needed to enable them to remain safely in an abode of their choosing, and/or to establish and maintain an independent living arrangement (importantly, residents of licensed housing such as Residential Care Facilities for the Elderly are not eligible for IHSS services). There are 'time for task' guidelines built into the computerized assessment instruments used by the social workers. The authorized hours, however, may be negotiable up to a limit based on the time it takes a provider to do the authorized tasks. No time is authorized for services that are solely for the 'comfort' of the IHSS recipient.

A maximum of 283 hours per month can be authorized, but average utilization tends to be substantially less than the maximum. A 2008 study, for example, using data from 2005 showed that the average IHSS participant used substantially fewer than the maximum hours allowed by policy, ranging from approximately 60 hours to 115 hours, depending on the recipient's age and physical and cognitive limitations, and the expertise of the IHSS participant's caregiver.[30]

IHSS serves individuals who need assistance with activities of daily living (ADLs) like bathing and grooming, dressing, eating, using the toilet and transferring; instrumental activities of daily living (IADLs) like meal preparation and clean up, housework, laundry, shopping and errands, mobility inside the home; require assistance with respiration or maintenance of breathing equipment; or require protective supervision associated with limitations in memory, orientation, and/or judgment. The need for the services is authorized based on ability in each of these areas. Ability is evaluated and scored on a 1 to 5 (some on 6) point scale.[31]

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[29] IHSS program eligibility is extensively described in a May 4, 2007 DSS letter to the counties. It can be retrieved at http://www.dss.cahwnet.gov/lettersnotices/entres/getinfo/acl06/pdf/06-34E2.pdf.

[30] Newcomer & Kang (2008), Table 6, page 52.

[31] Laundry is scored as 1, 4 or 5; shopping & errands as 1, 3 or 5; eating as 1, 5 or 6; breathing as 1, 5 or 6; memory, orientation and judgment as 1, 2 or 5. Meal preparation and eating both include a 6 point score.

1 Independent—able to perform functions without human assistance though recipient may have difficulty; and completion of the task with or without a device poses no risk to safety of the recipient.

2 Able to perform, but needs verbal assistance such as reminding, guidance, or encouragement.

3 Can perform but needs some human help, e.g., direct physical assistance from the provider.

4 Can perform with a lot of human assistance.

5 Cannot perform function at all without human assistance.

6 Paramedical services needed

The IHSS program calculates a "Functional Index" (FI) score for each person. It is based on the weighted average of the individual's needs in performing 11 of 14 ADL and IADL functional tasks (memory, orientation, and judgment tasks are not included). This is distinct from a rank on each single activity.[32] A weighted average varies from 1 to 5. The FI score in combination with the individual's special needs/circumstance (e.g., the number of persons living in the home, the home environment, etc.) is used to determine the hours of service that are authorized. According to analysis conducted by the Department of Social Services[33] using a June snap shot for June from 2005 to 2008, there was no consistent pattern of change in the percentage of new IHSS participants having Functional Index scores greater than 3.0 during the period. An average score of 3.0 or more indicates a recipient requiring at least direct physical assistance from a provider in performing ADL/IADL tasks.

Table 9
Distribution of the Functional Index (FI) Scores Among New IHSS Recipients

FI Score Interval	% Cases June 2005	% Cases June 2006	% Cases June 2007	% Cases June 2008
1.00-2.00	17.09	16.26	17.99	17.37
2.01-3.00	57.79	57.15	59.49	59.32
3.01-4.00	24.02	25.13	23.08	24.74
4.01-5.00	3.67	4.65	4.87	4.92

Adapted from Table 14, Mollica & Hendrickson, 2009, page 25. The percentages total to more than 100% in each year. This result is in the original data, and seems to be greater than errors associated with rounding.

Consistent with the FI stability, there has been a relative consistency in recipient characteristics. For example, from July 2001-2008, the age distribution of the IHSS recipient population was roughly: 1% age 6 and younger, 4% age 7-18, 12% age 19-44, 25% age 45-64, 32% age 65-79, and 26% age 80 and older. The proportion of females was about two-thirds; and the proportion of developmentally disabled participants was also stable. These patterns are present even

[32] California Department of Social Services. (July 1, 2008), Social Services Standards: Service Program No. 7: In Home Support Services, Division 30, § 30-756. Retrieved on 6/20/2010: http://www.dss.cahwnet.gov/ord/PG310.htm.

[33] Reported in Mollica & Hendrickson, 2009; Table 14, page 25.

while the program has grown at a steady rate in the average monthly recipient caseload (344,569 to 411,706), average utilized hours (83.46 to 86.01), and average monthly total expenditures ($267 million to $367.6 million during the seven year period).[34]

The program growth and expenditure trends, coupled with the state budget deficits from 2004 forward have helped make the IHSS program a target for budget cuts. These have taken form in proposals to reduce provider wage rates, and limiting or targeting the program to recipients with mid-range or higher FI scores; however, no such policy changes were implemented during the 2005-08 study period. Beyond the policy debate, the program in 2005-06 conducted extensive trainings with IHSS social workers. The purpose was to obtain more uniformity in how the assessments were administered and scored. These trainings may have improved inter-rater reliability and to reduce variability in assessment data and service hours authorized, but there have been no follow-on quality assurance studies to confirm or assess this.

Adult Day Health Care

Services

Adult Day Health Care (ADHC) was implemented in California as a Medicaid §1115 demonstration in 1977. Then, as now, the program was intended to serve beneficiaries at risk of being institutionalized, although it has not been limited to those meeting nursing home eligibility criteria. ADHC became a state plan benefit in 1982. ADHC has both medical and social components, serving a mix of short-term, post-acute, and longer-term clients. Core services are shown in Figure 6. They include a mix of nursing and social services.

Specialty services can also be provided in ADHS settings. Among these are physical therapy, occupational therapy, speech and language pathology services, mental health services, and registered dietician services. ADHC centers are licensed by the California Department of Public Health and certified for Medi-Cal participation by the California Department of Aging.

Historically, a single per diem rate covered the entire range of ADHC services. The same rate has been used statewide, and has been calculated at 90% of a nursing facility level 'A' rate since 1993. It did not decrease during the 2005-2008 period. The per diem rate covered core ADHC services (i.e., skilled nursing, medical social services, planned recreational and social activities, and transportation), and specialty services (e.g., physical and occupational therapy, nutrition services, psychiatric and psychological services, speech and language pathology services) (CCR, title 22, §54309).

In the past decade, legislative actions have attempted to modify ADHC eligibility, service, and reimbursement criteria. Senate Bill 1755, chaptered in 2006, was implemented in February 2008. This law continued the practice of paying for ADHC core services on a per diem rate, but made changes in the minimum required ADHC services, and required new eligibility criteria,

[34] Reported in Mollica & Hendrickson, 2009; Tables 19, page 20, Tables 11 & 12, page 22.

new medical necessity criteria, and new provisions for the participant's personal health care provider. Other provisions excluded speech and language pathology services and required that specialty services be billed separately, outside of the per diem rate, on an as provided basis. However, SB117 (Chapter 165, Statutes of 2009) delayed implementation of the specialty services reimbursement and other changes in the reimbursement methodology until August 2012.[35] The entire ADHC benefit package with a statewide single bundled payment rate and single procedure code was the norm for the 2005-08 study period. (The approved fiscal year 2011-2012 state budget terminates funding for the Medi-Cal ADHC program beginning December 1, 2011.)

Figure 6
Core Adult Day Health Care Services

Professional Nursing Services	
Observation, assessment & monitoring of participant's general health status & changes in his/her condition, risk factors & specific medical, cognitive or mental health condition or conditions upon which admission to ADHC was based	Monitoring & assessment of the participant's medication regimen, administration & recording of the participant's prescribed medications & intervention as needed based on the assessment and the participant's reaction to his or her medications.
Oral or written communication with the participant's personal health care provider, other qualified health care or social service provider, or the participant's family or other caregiver, regarding changes in the participant's condition, signs or symptoms	Provision of skilled nursing care & intervention within scope of practice to participants as needed, based on the assessment of the participant's ability to provide self care while at the ADHC center and any health care provider orders
Supervision of the provision of personal care services for the participant & assistance	
Personal Care Services/Social Services	
Care coordination	Supervision of, or assistance with, ADLs or IADLs
Observation, assessment, and monitoring of the participant's psychosocial status	Protective group supervision and interventions to assure participant safety and to minimize the risk of injury, accident, inappropriate behavior or wandering
Group work to address psychosocial issues	
Therapeutic Activities Provider by Trained ADHC Personnel	
Group or individual activities to enhance the social, physical or cognitive functioning of the participant	Facilitated participation in group/individual activities for those whose frailty or cognitive functioning level precludes them from active participation in scheduled activities
One Meal Per Day of Attendance	

In January 2008, as allowed by SB 1755, the minimum required ADHC services became the "core services" shown previously in Figure 6 (professional nursing services, therapeutic activities, personal care services and/or social services, and a meal). Core services must be provided to each ADHC center participant, each day of attendance. New eligibility and medical necessity criteria tightened the requirements necessary for the participant to be approved for ADHC services and the subsequent reimbursement to the ADHC centers. These criteria were

[35] Other changes were proposed by AB X4 5 (Trailer Bill Language; Chapter 5 Statutes of 2009). Implementation was enjoined by a restraining order issued regarding a lawsuit demanding that ADHC services not be capped at three days a week and that the certain proposed new criteria not be implemented. As of August 2011, these causes of action remain in litigation.

intended to allow only those participants most likely to require institutionalization in the absence of ADHC services to be program participants. New provisions for the participants' personal health care providers sought to make them the lead in all services provided to the participant and to decrease the incidence of conflict of interest in owning an ADHC center.[36]

ADHC providers between 2005 and 2008 were reimbursed for a day of attendance or under procedure codes. "Procedures" include a comprehensive multidisciplinary evaluation or initial assessment; screening to determine the appropriateness of consideration of an individual for participation in a specified program, treatment protocol, per encounter; and for transition days. Up to three days per year may be billed for assessment days (no prior authorization is required). A participant must receive covered services at the center for a minimum of four hours, excluding transportation time, in order to bill for a day of attendance.

The centers are open a minimum of six hours a day, five days a week. Some are open six or seven days per week. Different centers may serve different categories of participants (e.g., cognitive impairments or mental illness, etc.). The focus on particular types of ADHC participants did not affect the per diem rate during the study period. The reimbursement rate was the same for all centers regardless where they were located or the category of participants being served.[37]

There were approximately 320 ADHC centers beginning calendar year 2009 (dropping to 315 in 2010), with an estimated capacity to serve about 45,400 persons daily. Just over half (170) of ADHC center are located in Los Angeles County. The number of centers had been increasing annually until a moratorium on certification of new centers was imposed in 2004.[38] Under this moratorium new centers could be licensed, but they could not be certified for participation in the Medi-Cal program.

Table 10 aggregates individual Medi-Cal claims records to obtain annual expenditures in the ADHC program and an unduplicated count of recipients. Annual expenditures remained grew by about 7.6% between 2005 and 2008. Most of that change occurred between 2007 between and 2008. During the four year period there was a 2.4% drop in unduplicated participation, although average monthly participation remained relatively constant. The fluctuation in enrollment may be associated with changes and reductions in the number of centers. The fluctuation in average monthly per user costs is perhaps explained by more frequent ADHC attendance, or more assessments. The daily reimbursement rate was unchanged.

[36] Prior to February 2008 the criteria for a Treatment Authorization Request (TAR) were specified in CCR, 22, §54209; starting in February 2008 the TAR criteria are those specified in SB 1755.

[37] When the new reimbursement methodology is implemented in August 2012, rates will differ from center to center depending on the location, its size, its costs as reported to the department.

[38] The moratorium was imposed after Audits and Investigation conducted an audit of claims that found instances of inappropriate billings, lack of medical necessity documentation to support the requested services, and services not being provided as listed on the Individual Plan of Care. ADHC centers were placed on temporary suspension and their monthly revenue was withheld until a settlement could be reached.

Table 10
Medi-Cal Adult Day Health Care Expenditures, 2005-2008

Calendar Year	Unduplicated Participants In Year	Total Annual Expenditures	Average Participants Monthly	Average Participant Monthly Cost
2005	58,367	$397,886,775	41,809	$792
2006	56,854	$405,993,558	40,750	$830
2007	55,502	$417,226,521	40,151	$866
2008	56,953	$430,225,301	41,542	$879

Source: Unpublished Medi-Cal claims data. ADHC services are defined as Vendor code 01 Adult Day Health Care Centers or Vendor code 77 with the procedure codes '00006' ADHC regular service day, '00007' ADHC initial assessment with subsequent attendance, '0008' ADHC initial assessment without subsequent attendance, '0009' ADHC transition day.

Eligibility

ADHC serves Medi-Cal beneficiaries who:

- Are age 18 or older
- Have one or more chronic or post-acute medical, cognitive or mental health conditions requiring monitoring, treatment or intervention, without which the participant's condition will likely deteriorate and require emergency department visits, hospitalization or other institutionalization
- Have limitations in the performance of two or more ADLs or IADLs and a need for assistance or supervision in performing the activities
- Do not have a network of non-ADHC center supports sufficient to maintain the individual in the community without ADHC assistance.[39]
- Require all of the ADHC cores services each day of attendance.

ADHC often serves beneficiaries who receive other Medi-Cal services. For example, a review of paid Medi-Cal claims found that at least 60% also received IHSS services.[40] In such cases ADHC is used to reduce the number of hours that IHSS needs to authorize, or supplements IHSS for participants who need more hours than can be authorized under IHSS, or provides skilled services that are not available through IHSS. Over 80% of the participants are age 65 and older.

[39] The insufficiency of available supports is demonstrated by one or more of the following: (a) The participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision; (b) The participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the participant; (c) The participant has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the participant; (d) A high potential exists for the deterioration of the participant's medical, cognitive or mental health condition or conditions in a manner likely to result in emergency room visits, hospitalization or other institutionalization if adult day health care services are not provided.

[40] Unpublished Medi-Cal data reported by Mollica & Hendrickson, 2009

Level of Care Determination

ADHC centers receive referrals from physicians, other medical professionals, family members, friends and prospective participants. Participants receive an assessment from a Multidisciplinary Health Care Team (MDT) that includes the participant's physician or a staff physician, or both, a registered nurse and a social worker. The MDT may include other members—physical therapist, occupational therapist and other qualified consultants with skills in recreational therapy, speech language pathology or dietary assessment if needed. The MDT assesses the medical, psychosocial and functional status and needs of the participant, documents its assessment via check boxes and problem statements, and then develops an individual plan of care (IPC) based on the findings. The IPC addresses the problems that are preventing the participant from maintaining independence in the community, including what the treatment will be, how often the treatment will be performed, and the results expected from the treatments.[41] The IPC is a 15-page document that outlines all of the eligibility and medical necessity criteria required for authorization of the Treatment Authorization Request (TAR). The needs determination criteria did not change between 2005-2008.

The ADHC submits the IPC and the TAR to the DHCS field office in Los Angeles, where they are reviewed and adjudicated by a nurse evaluator in consultation with a physician. TARs must be renewed every six months if services and treatments are to be continued.

Targeted Case Management (TCM) Program[42]

The Targeted Case Management (TCM) Program is an optional Medi-Cal benefit. It is authorized under the California's Welfare and Institutions Code, §14132.44, 14132.47, 14132.48 and 14132.49. Regulations governing the TCM Program are contained in Title 22 of the California Code of Regulations (22CCR), Division 3, Chapter 3. In addition, the Department periodically issues Policy and Procedure Letters regarding the Program. The TCM Program provides specialized case management services to eligible Medi-Cal recipients. The program attempts to ensure that the changing needs of the Medi-Cal eligible person are addressed on an ongoing basis and appropriate choices are provided among the widest array of options for meeting those needs. Case management services are intended to assist in gaining access to needed medical, social, educational and other services. The TCM program served 47,000 adults in

[41] As reported by Mollica & Hendrickson, 2009, page 64, CMS has advised California officials that it risks denial of state plan ADHC reimbursements because CMS does not consider ADHC, as implemented, a rehabilitation service as required by federal state plan service regulations. CMS has suggested two options—a §1915(c) HCBS Waiver or a §1915(i) HCBS state plan service waiver. Converting to a §1915(c) Waiver would limit participants to beneficiaries meeting institutional level of care criteria. It is estimated that at least 20% of the current participants would not meet the criteria and would lose service. ADHC is an eligible service under the §1915(i) HCBS state plan option. The challenge here, according to the department, is that the existing ADHC assessment (and the TAR process used to administer ADHC) may not meet the requirement to conduct independent assessments as required by §1915(i). To meet this requirement the state or local programs may have to contract with independent entities to conduct the assessment. As of April 2011, these issues were resolved.

[42] The program description was obtained from http://www.dhcs.ca.gov/tcm

2005. This number held relatively steady (46,900 in 2006, 49,100 in 2007), but increased sharply to 61,400 in 2008.

TCM Services are provided by Local Governmental Agencies (LGAs). Most case manager-client contacts are face-to-face, but telephone contacts are possible when environmental considerations preclude a face-to-face encounter. For the Public Guardian target population, the encounter may be with persons acting on behalf of the Medi-Cal beneficiary. Client case follow-ups occur at least every 6 months.

LGAs have responsibilities in addition to case management. Among other things they certify the availability and expenditure of 100% of the nonfederal share of the cost of providing TCM services to Medi-Cal beneficiaries from the LGA's general fund or from any other federally approved source (public funds only). They also identify the total allowable cost of all TCM services, and certify that the TCM services are provided pursuant to Welfare and Institutions Code, §14132.44, and do not duplicate services provided under any other home and community-based services waiver, and that claims for the same services have not been made to public agencies or private entities under other program authorities. The costs of providing TCM to Medi-Cal beneficiaries are reimbursed at the federal medical assistance percentage (FMAP).

Services

TCM services include the following case management functions and supports. The program does not offer reimbursement for direct care services.

- **Service Plan Development.** Based upon the assessed needs (and in consultation with the beneficiary), the plan includes: the actions required to meet the identified service needs, the community programs, persons and/or agencies to which the individual will be referred, and a description of the nature, frequency and duration of the activities and strategies to achieve the service outcomes. The service plan is not constrained by specific funding sources.

- **Linkage and Consultation** for the beneficiary primarily involves referrals to providers of service and placement activities. Case managers are supposed to follow-up with the beneficiary and/or provider of service within 30 days of the service to determine whether the services were received and meet the needs of the beneficiary.

- **Assistance to the beneficiary with Accessing Services** identified in the service plan is another major functions. This includes: arranging appointments and/or transportation to medical, social, educational and other services; arranging translation services to facilitate communication between the beneficiary and the case manager, or providers of service.

- **Crisis Assistance Planning** includes evaluating, coordinating, and arranging immediate services or treatments needed in situations that appear to be emergent or which

require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation. For outpatient clinics, crisis assistance planning is restricted to non-medical situations.

- **Periodic Reviews** are conducted by the case manager to re- evaluate the beneficiary's progress toward achieving the objectives identified in the service plan. These are completed at least every six months. They are conducted by the case manager in consultation with the beneficiary (to the extent of the beneficiary's capacity), and/or the beneficiary's family.

Eligibility

This program is available to Medi-Cal eligible individuals who meet one or more of the following criteria.

- High risk
- Have language or other comprehension barriers (i.e., are unable to understand medical directions because of language or comprehension barriers) or have no community support system to assist in follow-up care at home.
- 18 years of age or older on probation and have a medical/mental condition, have exhibited an inability to handle personal, medical, or other affairs and/or
- 18 years of age or older under conservatorship of person and/or estate or are in frail health and need assistance to access services in order to prevent institutionalization.
- A member of a public health, outpatient clinic, linkages, public guardian, adult probate, or community program target population.

These target groups are further described as follows.

Public Health. The aim of this emphasis is to assist "high risk persons" who have failed to take advantage of necessary health care services or do not comply with their medical regimen or who need coordination of multiple medical, social and other services due to the existence of an unstable medical condition in need of stabilization, substance abuse or because they are victims of abuse, neglect or violence. Target populations include women, infants, children and young adults to age 21, Persons with HIV/AIDS, Persons with reportable communicable diseases, Pregnant women, Persons who are technology dependent, Persons who are medically fragile, Persons with multiple diagnoses.

Outpatient Clinics. Targeted individuals are those in need of outpatient clinic medical services and who need case management in connection with their treatment because they are unable to access or appropriately utilize services themselves, including the following: Persons who have demonstrated non-compliance with their medical regimen, Persons who are unable to understand medical directions because of language or other comprehension barriers, Persons with no community support system to assist in follow-up care at home Persons who require

services from multiple health/social service providers in order to maximize health outcomes.

Public Guardian/Conservator. Medi-Cal eligible individuals, 18 years or older who have exhibited an inability to handle personal, medical or other affairs, who are under conservatorships of person and/or estate or a representative payee are the target group.

Linkages services are available for those Medi-Cal eligible individuals, 18 years or older, in frail health and in need of assistance to access services in order to prevent institutionalization.

Adult Probation. Medi-Cal eligible persons, 18 years or older, on probation who have a medical and/or mental condition and are in need of assistance in accessing and coordination of medical, social and other services is another target group.

Community. Targeted are Medi-Cal eligible adults and children at risk of abuse and unfavorable developmental, behavioral, psychological, or social outcomes including the following individuals: Persons abusing alcohol or drugs, or both, Persons at risk of physical, sexual, or emotional abuse, Persons at risk of neglect.

Level of Need Determination

The initiation of TCM services begins with a documented assessment of needs. This identifies the individual's needs and the selection of activities and assistance necessary to meet those needs. The assessment includes a review of the

- Medical and/or mental conditions
- Training needs for community living, Vocational and educational needs
- Physical needs (food, clothing)
- Social and/or emotional status
- Housing/physical environment, and
- Familial/social support

Assessments are conducted by the LGAs. There is no centralized filing system for these data.

Part 4

MEDI-CAL HOME & COMMUNITY BASED-SERVICES (HCBS) WAIVER PROGRAMS

Introduction

In this Part we return to the Medicaid Home and Community-Based Services (HCBS) waiver programs that were introduced in Part 1. The presentation elaborates the description of each waiver's benefits, eligibility and level of need determination process. Particular attention is given to changes, if any, in eligibility and services between 2005 and 2008; and to how these programs supplement or complement the HCBS programs available through California' Medicaid state plan benefits.

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program gives the Centers for Medicare & Medicaid Services (CMS) the authority to allow a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid long-term care institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population; universal among waivers is being at risk of long-term care institutionalization. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state, and local public programs as well as the supports that families and communities provide.

Waivers, as distinct from Medicaid State Plan requirements, allow states to limit the availability and program expenditures. Such flexibility allows states the opportunity to incrementally introduce, and perhaps expand programs as they gain experience with them. Among the program features available through a waiver, states can request:

- Geographic Limitations, to allow waiver programs to target areas of the state where the need is greatest, or perhaps where certain types of providers are available, rather than being statewide.

- Subgroup or Condition Targeting, to limit waiver services to persons meeting narrow needs criteria. Services under a waiver do not have to be available to the Medicaid population at large. States have used this authority to target subgroups of the elderly, technology-dependent children, persons with mental retardation or developmental disabilities, and persons with specific disease or conditions, such as Acquired Immune Deficiency Syndrome (AIDS).

- Special Income Standards and Resource Rules, to either narrow or expand the criteria for Medicaid eligibility. For example, waivers can be limited to those who are categorically eligible for Medicaid, not allowing spend down to Medically Needy eligibility. Also possible is more generous eligibility criteria, such as tying HCBS waiver eligibility to income standards applied to those in nursing homes, or using the standards of spousal resource protection available to those whose spouse is in a nursing home for couples where one individual is receiving HCBS services in the home

Figure 7 summarizes the HCBS-related waivers operating at sometime during 2005-2008.

Figure 7
Selected Home & Community-Based Care Medi-Cal Waivers, 2005-2008[a]

1115 Demonstration Project Waivers

Title	Description	Waiver Term[b]
In Home Supportive Services Plus (IHSS Plus) [c]	Provided aged, blind and disabled individuals an array of self-directed personal care assistance and delivery options (including payment to legally responsible relatives) similar to the State Plan Personal Care Services Program known as In Home Supportive Services (IHSS)	8/04–9/09

1915(c) Home and Community-Based Services (HCBS) Waivers

Title	Description	Waiver Term
Acquired Immune Deficiency Syndrome (AIDS Waiver)	Provides home and community-based services (HCBS) to Medi-Cal beneficiaries with mid- to late-stage HIV/AIDS as an alternative to nursing facility or hospital care.	1/05–12/11
Assisted Living Waiver (ALW)	Provides HCBS as an alternative to long-term nursing facility placement to Medi-Cal beneficiaries over the age of 21 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.	1/06—12/08
Home and Community-Based Services Waiver for the Developmentally Disabled (DD Waiver)	Provides HCBS to Regional Center consumers with developmental disabilities, enabling them to living in the community rather than in an intermediate care facility for the developmentally disabled (ICF/DD).	10/04–9/11
In-Home Operations (IHO) ***Former related waivers*** ***Nursing Facility A/B*** ***Nursing Facility SubAcute***	The In-Home Operations waiver was established effective January 2007. This waiver retained a subset of Medi-Cal beneficiaries who were previously enrolled in the Nursing Facility A/B Level of Care waiver or the Nursing Facility SubAcute waiver. Both of these latter waivers were replaced with the IHO and Nursing Facility/Acute Hospital waivers (see below). Recipients in the IHO and the former programs require direct care services primarily provided by a licensed nurse. Also included are those who have been receiving continuous care in a hospital for 36 months or more with physician orders for direct care services that are greater than those available in the Nursing Facility/Acute Hospital Waiver.	1/07–12/09 2/02-12/06 4/02-2/07
Multipurpose Senior Services Program (MSSP)	Provides HCBS, primarily case management, to Medi-Cal beneficiaries who are 65 or over and disabled who require the Nursing Facility (NF) level of care. Individuals shall only be enrolled in one HCBS waiver at any time, but are usually enrolled in IHSS and/or ADHC.	7/09–6/14
Nursing Facility / Acute Hospital (NF/AH) ***Former related waivers*** ***In-Home Medical Care (IHMC)*** ***Nursing Facility A/B*** ***Nursing Facility SubAcute***	The NF/AH waiver was implemented in January 2007. It 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, or subacute facility, or an acute care hospital.	1/07–12/11 7/02-12/06 2/02-12/06 4/02-2/07

[a] Two new HCBS programs--the Developmentally Disabled Continuous Nursing Care waiver (10/09-9/12) and the Pediatric Palliative Care waiver (4/09-4/12)--were initiated during calendar year 2009, outside the study period. California operated 18 other waivers during some portion of the period of 2005-2008. These are not included here as they were targeted to pregnant women, children's dental services, county organized health systems, mental health, and inpatient hospital stay reviews.

[b] Waiver term refers to the authorized periods during the study period. Year varies for each waiver since operational periods are based on the 12-month period approved by the Centers for Medicare & Medicaid Services (CMS); and may at times be a calendar year or California's fiscal year July 1-June 30 or the federal fiscal year (October 1-September 30). More than one approved waivers may have covered portions of this period.

[c] Transitioned to a 1915(j) State Plan Option benefit in 2009

Acquired Immune Deficiency Syndrome (AIDS) Waiver[43]

The AIDS Waiver serves adults and children who meet income eligibility qualifications for Medi-Cal, have a diagnosis of mid-to-late-stage HIV disease or AIDS, and live in a setting where in-home services can be provided. It is limited to 43 of the state's 58 counties, and targets individuals who would otherwise go to hospitals (as defined in 42 CFR §440.10), emergency rooms, and nursing facilities (defined in 42 CFR §440.40 and 42 CFR §440.155). The intention is to allow recipients to remain in their homes, stabilize and maintain health status at an optimal level, improve their quality of life, and avoid costly institutional care. Special emphasis is given to those populations who are institutionalized.

The Department of Public Health/Office of AIDS (OA), HIV Care Branch, administers this program. The OA contracts with agencies to implement the HIV/AIDS waiver at the local level. Until August of 2009, OA also provided comprehensive nurse and social work case management program (CMP) to persons with mid-to-late-stage HIV/AIDS who did not qualify for the AIDS Medi-Cal Waiver program. The programs were exclusive of each other. Clients eligible for MCWP could not be enrolled in CMP. CMP support was eliminated due to a reduction of state General Funds. CMP agencies subcontracted with qualified providers to render direct care services.[44]

Services

Any service provided under the AIDS waiver must be a part of the recipient's service plan prior to the provision of that service. The waiver covers the following services:

- Case management
- Homemaker services
- Home Health Aide Services/Attendant care
- Psychotherapy
- Medi-Cal supplements for infants and children in foster care
- Nonemergency medical transportation
- Nutritional counseling
- Nutritional supplements
- Home delivered meals
- Skilled Nursing (registered nurse/licensed vocational nurse)
- Specialized medical equipment/supplies
- Minor physical adaptations to the home.

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[43] Source: California Department of Health Care Services, Application for a §1915 (c) HCBS Waiver Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Medicaid Home and Community-Based Services Waiver, Effective January 2007.

[44] CMP was funded through state general fund revenue and the Federal Ryan White HIV/ADIS Program. CMP expenditures appear as non-EDS claims.

Case management is available to all AIDS waiver recipients (billed at a flat rate to the program). At enrollment the case manager initiates a comprehensive assessment of the recipient's health status, including psychosocial, nutritional, financial, environmental, and risk status; which then forms the basis for the recipient's service plan. The service plan includes identified problems or needs, goals and objectives, and services and interventions to be provided.

An Interdisciplinary Team Case Conference is an integral part of the model of care in the waiver. The interdisciplinary team consists of those individuals participating in the process of assessing the multi-service needs of recipients, planning for the provision of services to meet those needs, and evaluating the effectiveness and ongoing need for interventions as identified in the service plan. The team consists of the recipients and/or his/her legal representative, the qualified case managers, the attending physician or primary care practitioner, and the parent or guardian (if the recipient is a child). Interdisciplinary case conferences are held at least every 60 days or whenever significant changes in the recipient's condition occur. Service plans are modified as needs change.

Case management and attendant care services are available to waiver recipients living in the community as well as those in licensed residential care facilities or foster care (both facility types are subject to §1616(e) of the Social Security Act). These services can supplement, not replace, the basic services provided by these facilities. Unlike many of the other waivers (and the state plan personal care IHSS Plus Option), *AIDS waiver payments cannot be made to legally responsible relatives*. One reason for this is that attendant care must be provided by a Home Health Aide who is a Certified Nursing Assistant (CNA). CNA's are certified by the California Department of Public Health and supervised by a licensed nurse. CNAs are allowed to feed the recipient; take vital signs; measure and record height and weight; and assist with bedpan, urinal, and commode; collect urine, stool , and sputum specimens; and assist with bowel and bladder retraining. Homemaker services under this waiver are in addition to, not a replacement for the personal care benefits available through state plan services. Skilled nursing (registered nurse/licensed vocational nurse, specialized medical equipment/supplies, minor physical adaptations to the home offered through the AIDS waiver are also extensions or supplements to the coverage available for similar services under the state plan.

The state provides services under this waiver up to the maximum allowable annual cap per recipient. The individual recipient cost cap under the AIDS waiver has been $13,209 since 1996. It continued at this level at least through 2009. Fewer than 3% of the recipients reached this annual cap annually in any year between 2000 and 2008. Those reaching this limit are disenrolled from the waiver and may be provided services from other available funding sources. (Prior to 2009, those reaching the cap may have been enrolled in CMP.) The participant, if still otherwise eligible, can be re-enrolled in the AIDS waiver in the new calendar year.

The waiver provides for the entrance of all eligible persons up to the annual statewide cap on the number of recipients. Enrollment is monitored statewide; a specific number of slots are not allocated to the participating local/regional entities. The number of persons served under the AIDS waiver peaked at 3,021 in 1996. At the time of the AIDS waiver submission in 2006,

projections were made for further growth (i.e., 3,560, 3,720, and 3,890 recipients from 2007-2009, respectively).

Enrollment and expenditures between 2005-08 are shown earlier in Part 1 (Table**s** 1-4). Waiver enrollment has fallen well below the projected levels. This is thought by department representatives to be decreasing due to a combination of the following factors, however, these have not been formally investigated:

- Share of cost issues; recipients often cannot afford to pay or obligate their full monthly SOC, so they do not become eligible for reimbursement of services.
- Low reimbursement rates; waiver agencies cannot find providers who will accept rates.
- Payment reductions; services are being eliminated when agencies cannot afford them.
- Waiver agencies are pulling out of the program due to the loss of the General Funded CMP program; agencies used the two programs to leverage their funds.
- Improved client health and/or improved pharmacy funding under Medicare.

Waiver recipients continue to be in the early-chronic and chronic stages of disease. Average days of service are increasing because the recipients are living longer with new treatments. Increases in the average days of service and the cost per recipient suggest that the AIDS waiver program may be taking care of persons with serious medical needs.

Eligibility

Waiver recipients must be Medi-Cal eligible on the date of enrollment. Their Medi-Cal Aid Code must have: 1) federal financial participation, and 2) full benefits (excluding those in Long Term Care or those who are restricted to emergency room services or pregnancy-related services only). The following Medi-Cal eligibility groups can receive services under the AIDS waiver:

- Low income families with children as provided in §1931 of the Act;
- SSI & SSP recipients;
- Optional categorically needy aged and disabled who have income at 100% of the FPL;
- Medically Needy – the state received a waiver to §1902(a)(10)(C)(i)(III) of the Act to use institutional income and resource rules in determining Medically Needy eligibility.

Spousal impoverishment protection rules under §1924 of the Act or 42 CFR §435.726 are *not* available to recipients. AIDS waiver recipients may be dually enrolled in Medi-Cal Managed Care Plans.

Level of Care Determination

Level of care is based on a consideration of medical, nursing, psychosocial, financial, and home environment dimensions. The first order criterion is that the applicant has a written diagnosis from his/her attending physician of HIV Disease or AIDS with current symptoms related to HIV Disease, HIV Disease treatment, or AIDS. Secondly, the AIDS waiver applicant must be certified

to meet the Nursing Facility Level of Care (NF LOC) or the Acute Level of Care (ALOC) (as described in Title 22, California Code of Regulations, §51124-51335). Third the applicant must have an attending physician willing to accept full professional responsibility for his/her medical care. Additionally, health status must be consistent with in-home services; and the home setting must be safe for both the recipient and the service providers.

The instrument used for institutional placement determination in the AIDS waiver differs from that used for those in institutional care. In the latter case, under the state plan, the Minimum Data Set (MDS) is used. For waiver recipients, the assessment includes both the Nursing Facility Level of Care and waiver-specific assessments/reassessments. Contained within the assessments is the Cognitive and Functional Ability Scale (CFA) scale, which is used to measure the person's condition. The CFA adapts the Karnofsky Performance Scale to be more specific to adults with HIV or AIDS. Qualified case managers use observation and interview to complete the CFA. Within the CFA, a person's condition can be rated on a scale from 100 (totally independent) to 0 (totally dependent). Spaced in increments of 10 points each, one-sentence descriptions define certain levels of the person's health status during a progressively fatal disease.

Individuals 13 years and older must have a CFA score of 60 or less; pediatric clients under 13 years of age do not require a CFA score at this time. A score of 60 on this scale, identifies a person as "early chronic." These individuals are unable to carry on normal activity or to do active work. They may require occasional assistance, but are able to care for most of their own care needs. The recipient's CFA score may change over time due to improved or more compromised health. The recipient's service plan changes as his or her needs change. These LOC criteria did not change over the 2005-2008 period.

Initial assessments are conducted prior to or within 15 days of enrollment. Reassessments are conducted every 60 days (except home environment reassessments, which are performed annually or when the recipient changes residence). The LOC determination includes:

- Nursing Assessment. This includes a comprehensive medical review that (1) identifies the recipient's care needs; (2) evaluates health condition; (3) assists with formulation of service plan; and (4) assists with coordination of care.
- Nursing Facility Level of Care Certification per Title 22 of the California Code of Regulations, §51124 and 51335.
- Psychosocial Assessment provides information about the recipient's status in the following areas: social, emotional, behavioral, mental, spiritual, financial and environmental. It also assists with formulation of the service plan and with coordination of care.
- CFA Assessment, as described above, with a score of 60 or less to be eligible for the waiver.
- Financial Reassessment reviews information regarding the recipient's ongoing financial

status. It addresses income and expenditures, including those for housing, utilities, food, transportation, medical care, clothing, entertainment, tobacco/alcohol, and other expenses.

- Resource Evaluation provides information regarding the recipient's ongoing eligibility for benefits and/or entitlements being received or for which the recipient may be potentially eligible.
- Home Environment Reassessment determines whether or not environmental conditions could lead to the endangerment of the recipient or health care providers.

Some factors exclude participation in the waiver. Among these is that recipients cannot be simultaneously enrolled in another HCBS Waiver or the Medi-Cal Hospice Program; however, they may be simultaneously enrolled in the Medicare Hospice program. Within the AIDS waiver, recipients cannot simultaneously receive State Plan Targeted Case Management services or use CMP funds to supplement AIDS program funds.

Assisted Living Waiver (ALW)[45]

This waiver, first initiated in 2006 as a pilot project, allows California to offer case management and an enhanced level of personal care and homemaker services in licensed residential settings to older adults and adults with physical disabilities. State regulations, absent this waiver, do not permit the use of state-funded IHSS services or HCBS waivers to be used by residents of licensed supportive housing. The focus of the waiver has been recipients in licensed Residential Care Facilities for the Elderly (RCFEs).

The waiver also authorizes a bundle of assisted living services for eligible residents in publicly subsidized housing (PSH). These residents are currently able to use IHSS benefits, and are eligible for the assisted living services if they are delivered by a home health agency. Through 2008 this benefit has seldom been used.

The Department of Health Care Services administers ALW, but care coordination is done via local area contracts. To be eligible for the ALW, applicants must meet the clinical qualifications for admission to a nursing facility (Level A or B), meet income and resource eligibility qualifications for Medi-Cal, and be age 21 or over. ALW requires that recipients have private rooms even in RCFEs, unless they agree to share a room. Room and board costs, whether in residential care or PSH, are paid by the beneficiary—usually through SSI/SSP payments. Family contributions are possible under some circumstances, such as helping to pay for the incremental cost for a private vs. a shared occupancy room.

Applicants residing in an institutional setting may be eligible for nursing facility transitional care coordination. Those relocating to a PSH may be eligible for funds for environmental accessibility

[45] The information reported here was taken largely from the California Assisted Living Waiver Application, effective March 1, 2009. It was submitted under the authority of §1915(c) of the Social Security Act (the Act) by the California Department of Health Care Services.

adaptations. These latter benefits would be available as early as 180 days prior to relocation.

The ALW program is geographically limited and with a small enrollment. It was initiated in three counties, and had 186 recipients in 2006. Enrollment grew to 875 by 2008. With the waiver renewal in 2009 the ALW Pilot Project was renamed the Assisted Living Waiver (ALW). The renewed program is projected to add two counties annually each year between 2009 and 2013, and incrementally grow to a target enrollment of 1,000 to 3,700 average monthly participants by 2013. Beginning in 2008 and continuing with the waiver renewal in 2009, ALW case finding focuses on the goal that one-third of new waiver participants will be relocating from nursing facilities.

The size and growth of the program is also affected by provider eligibility, their willingness to participate, and the time it takes to orient and train providers in the program. There are two types of providers—Care Coordination Agencies and service providers (RCFEs and HHAs for participants in PSH). Care Coordination Agencies are paid to for finding, evaluating, placing, and monitoring ALW participants. Service providers are reimbursed based on tiered rates. These reflect the individual participant's level of need. The tiered daily rates increment from Level 1, $52; Level 2, $62; Level 3, $71; through Level 4, $82.. This payment is in addition to the SSI/SSP payments for room and board (about $30/day). As of 2009, the maximum annual reimbursement available for a Medi-Cal reimbursed nursing home resident was about $140/day. These costs do not include other state plan services used by nursing facility or assisted living residents.

Services & Benefits

The benefits available under ALW, especially as applied to participants in licensed residential care facilities, should be seen in the context that room and board costs are paid by the beneficiary—usually through SSI/SSP payments. The waiver includes an increase in provider per diem reimbursement over that available through their SSI/SSP payment, which is about $30/day. In principle the waiver's package of assisted living services covers care coordination (including translation and interpretation services and consumer education) and enhanced personal care and homemaker services at levels beyond the usual care within a RCFE, or those permitted under IHSS for those in PSH.

RCFE's, under the terms of their license and their usual per diem payment rates are expected to include: 24-hour awake staff to provide oversight and meet the scheduled and unscheduled needs of residents;, including personal and supportive services (assistance with ADLs and IADLs); health-related services (e.g., medication management services); social services; recreational activities; meals, housekeeping and laundry; and transportation. (For enrolled ALW recipients living in qualified PSH, the bundle of assisted living services is included and funded in the daily ALW reimbursement to the home health agency.) In addition to the Homemaker and Personal Care Services paid to service providers through the Assisted Living Services per diem rate, the waiver covers the following:

- Care Coordination, $200/month;
- Nursing Facility Transition Services (mostly care coordination) - $1,000 life time, available only to those relocating from a nursing facility;
- Environmental Accessibility Adaptations (limited to those in PSH), $1,500 annual maximum.

The number of recipients and expenditures in the ALW are shown earlier in Part 1 (Tables 2-4).

Eligibility

The following Medi-Cal eligibility groups can receive services under this waiver:

- SSI/SSP recipients.
- Optional categorically need aged and disabled who have income at 100% of the FPL
- Medically Needy, with the state electing to use institutional income and resource rules under §1902(a)(10)(C)(i)(III) of the Act for single individuals.
- Special home & community based waiver groups under 42 CFR §435.217 and §1924 of the Act and 42 CFR §435.726. These permit the state to use Spousal impoverishment rules to determine the eligibility of individuals with a community. This allows the couple to separate their incomes and resources, with the non-recipient partner being able to retain a personal care allowance (this is inclusive of the income standard and the amount of the income disregard).

Level of Care Determination

Care Coordination Agencies assess applicants to the ALW using an instrument that differs from that used for determining NF eligibility, but the NF risk factors are included in the instrument used by ALW. This allows ALW to use LOC criteria based on the CCR §51120 (Intermediate Care Services, NF-A) and §51124 (Nursing Services NF-B) and to include additional items that allow assignment into the level of care tiers used for ALW participant reimbursement. Persons eligible for the ALW are determined to meet the LOC by the electronically scored Assessment Tool. LOC is connected to assistance with ADLs/IADLs, cognitive patterns, behavioral symptoms, continence, medications, and skin conditions. More specifics on the NF criteria, and on the scores or combination of factors affecting assignment into each of the ALW daily rate tiers will be provided at a later time.

Reassessments are conducted every six months. Should a participant's LOC needs improve and sustain for 60 days at a level that no longer qualifies for the ALW, then the individual is disenrolled from the waiver.

Developmentally Disabled (DD) Waiver[46]

Community-based services for individuals with developmental disabilities are provided through a statewide system of 21 private, non-profit corporations known as regional centers. Regional centers, as established by the Lanterman Developmental Disabilities Services Act, provide fixed points of contact in the community for persons with developmental disabilities and their families. According to a 2008 report,[47] California spends about twice as much on community services for persons with developmental disabilities (covering about more than 200,000), as on institutional care (which serves about 10,000 annually).

Regional centers are responsible for the provision of outreach; intake, assessment, evaluation and diagnostic services; preventive services, and case management/service coordination for persons with developmental disabilities and persons who are at risk of becoming developmentally disabled. The centers also fund the provision of preventive services through contracts with private vendors. In addition, to funding a wide range of services and supports to implement the individual program plans (IPP) for consumers, regional centers also conduct quality assurance activities in the community, and maintain and monitor a wide array of qualified service providers. Any consumer receiving care through a regional center receives an assessment known as the Client Development Evaluation Report (CDER). The CDER provides the basis for development, monitoring, and updating consumers' care plans.

The Department of Developmental Services (DDS) administers a §1915c home and community-based services waiver known as the Developmental Disability waiver. The DD waiver, first approved in 1983, provides federal financial support for an extensive array of otherwise state-funded services for persons with developmental disabilities. The DD waiver is implemented by regional centers in accordance with Medicaid law and the State's approved waiver application. DD waiver services are available to regional center consumers who are Medi-Cal eligible and meet the level of care requirements for an intermediate care facility serving individuals with developmental disabilities. Both in terms of enrollment and expenditures, this is the largest of the California's Medi-Cal home and community-based services waivers. It had annual expenditures of about $1.8 billion in 2008.

California's Lanterman Developmental Disabilities Services Act, Welfare and Institutions Code, §4512(a) defines "developmental disability" as a disability, which originates before an individual reaches age 18, that can be expected to continue indefinitely, and constitutes a substantial disability. Developmental disability includes mental retardation, cerebral palsy, epilepsy, autism, and other neurological disabling conditions closely related to mental retardation. The definition does not include disabling conditions that are solely physical in nature.

[46] The information reported here was taken largely from the Home and Community-Based Services Waiver for the Developmentally Disabled, October 2006 – September 2011. It was submitted under the authority of §1915(c) of the Social Security Act (the Act) by the California Department s of Health and Developmental Services.

[47] Burwell B, Sredi K, Eiken S (2008). *Medicaid LTC Expenditures in FY 2007*. Thomson Reuters; cited by Mollica R & Hendrickson L. (2009). *Home and Community-Based Long-Term Care: Recommendations to Improve Access for Californians.* Portland, ME: National Academy for State Health Policy.

The DD waiver serves developmentally disabled Medi-Cal beneficiaries who, in the absence of this waiver, would otherwise require care in any one of the following types of facilities. These facilities meet the federal requirements of an Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150):

- Intermediate care facility services for the developmentally disabled (ICF/DD), pursuant to Title 22, California Code of Regulations (CCR), §51343; or
- Intermediate care facility services for the developmentally disabled-habilitation (ICF/DD-H), pursuant to Title 22, California Code of Regulations (CCR), §51343.1; or
- Intermediate care facility services for the developmentally disabled-nursing (ICF/DD-N), pursuant to Title 22, California Code of Regulations (CCR), §51343.2.

Services

Approximately 241,000 persons received services in the California DDS system in 2008. Of these, approximately 197,000 persons have a diagnosis of developmental disability, with the remaining 44,000 persons being family or other responsible parties. Fewer than half of those with developmental disabilities are participants in the DD waiver, primarily because they are not eligible for Medi-Cal, or, if eligible, do not meet the ICF/MR level of care criteria.

California's Lanterman Developmental Disabilities Services Act entitles persons with developmental disabilities to receive a broad scope of services, depending upon their individual needs. All services funded through the DD waiver are included under Lanterman; but some services provided under the Act are not covered by the waiver (e.g., day care) or are not billable under the waiver because the person resides in an institution or community care facility with greater than 15 beds. DD waiver services include coverage for:

- Case management available to waiver recipients, but this service is provided through the Targeted Case Management benefit contained in California's Medicaid State Plan and is not billed directly to the DD waiver.
- Chore services (includes heavy cleaning and minor repairs)
- Homemaker (short term or temporary service)
- Home health aide services (provided as a supplement to state plan benefit)
- Respite care (provided in a range of settings: individual's or family member's home, licensed residential setting, Adult or Child Day Care Facility, Community Recreational Setting, such as YMCA, Sports Club, Community Parks & Recreation, Licensed Preschool
- Habilitation
  -- Residential habilitation for children services
  -- Day habilitation
  -- Prevocational services
  -- Supported employment services
- Environmental accessibility adaptations
- Skilled nursing
- Transportation

- Specialized medical equipment and supplies
- Personal Emergency Response Systems
- Family training
- Adult Residential Care
  -- Adult foster care
  -- Assisted living
  -- Supported living services
- Vehicle adaptations
- Communication aides
- Crisis intervention
  -- Crisis intervention facility services
  -- Mobile crisis intervention
- Nutritional consultation
- Behavior Intervention services
- Specialized Therapeutic Services
- Transition/Set Up Expenses
- Room & Board, limited to that portion of the rent and food attributed to the live-in personal caregiver who resides in the same household with the waiver recipient, when the caregiver is unrelated to the individual receiving care. Federal Medicaid financial participation is not available for rent and food for a live-in caregiver in the circumstance that the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services.[48]

Waiver services to individuals under the age of 21 include only services otherwise not covered under the authority of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services program, pursuant to §1905(r) of the Social Security Act. DD waiver consumers can continue to access IHSS, other Medi-Cal state plan benefits or other regional center programs. Persons residing in a State Developmental Center are also ineligible for waiver enrollment.

Tables 1-4 in Part 1 (see pages 11-14) show unduplicated recipient counts and expenditures for DD waiver services for years 2005-2008. These expenditures are specific only to waiver reimbursed services. Services and expenditures funded by Medi-Cal state plan services (including IHSS and targeted case management among many others), state or county general funds, or other sources are not included in this table.

The DD waiver caseload expanded substantially after 1992, growing from 3,300 to more 35,000 by 1997. It expanded again from 42,000 to 61,000 between 2002 and 2005. Subsequent enrollment was expected to continue growing from 70.2 thousand in 2008 to about 95,000 by 2011.[49] One factor contributing to this growth is that the state has an unambiguous incentive and basis for comparing the cost neutrality of the DD waiver with institutional alternatives (i.e., the state developmental centers and ICF-DD facilities). According to the state's CMS 372 form

[48] Appendix G-3 of the DD waiver includes an explanation of the method by which room and board costs are computed.
[49] Mollica R & Hendrickson L. (2009), page 37.

for 2006, for example, the state estimated a savings of $43,700 per waiver recipient relative to the cost of care in a developmental center.[50] Another factor documented in the 372 reports is the trend of an increasing average number of day waiver participation days.

Eligibility

The following Medi-Cal eligibility groups can receive services under this waiver:

- Low income families w/children as described in § 1931 of the Social Security Act;
- SSI recipients (SSI Criteria States and 1634 States);
- State supplement recipients;
- The special home and community-based waiver group under 42 CFR 435.217. This includes individuals who would be eligible for Medicaid if they were in an institution, and who are covered under the terms of this waiver. California has elected to treat HCBS waiver participants with community spouses under the §1924 spousal impoverishment post-eligibility rules. Accordingly, California (42 CFR 435.726) uses the federal rules for spousal post-eligibility. Payment for home and community-based wavier services are reduced by the amount remaining after deducting the waiver recipient's personal needs allowance; and
- Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330).

Level of Care Determination

To be eligible for the DD waiver a person must have 1) a qualifying developmental disability [defined above] that originated before age 18 and is expected to continue indefinitely and present a substantial disability as defined in § 4512 of the California Welfare and Institutions Code,[51] and 2) have a clinical condition that qualifies the person for admission to an intermediate care facility for the mentally retarded (ICF/MR). Eligibility is established through diagnosis and CDER assessments performed by regional centers. There is an annual redetermination of need. Any reassessment of substantial disability for purposes of continuing eligibility uses the same criteria under which the individual was originally made eligible.

The consumer must have, at a minimum, two qualifying conditions in any one area or a combination of areas (see Figure 8). Determination that a qualifying condition exists is based on an evaluation that the condition significantly affects the consumer's ability to perform activities of daily living and/or participate in community activities. The areas shown correspond with the revised CDER (effective in 2008). The revised CDER combines some prior CDER evaluation elements and eliminates or re-names others. Evaluation of each consumer's level-of-care is

[50] Mollica R & Hendrickson L. (2009), page 42.

[51] "Substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person. Self-care, Receptive & expressive language, Learning, Mobility, Self-direction, Capacity for independent living, Economic self-sufficiency.

based on his/her ability to perform activities of daily living and community participation, not strictly on CDER scores. Using the revised CDER does not change the process of making level-of-care determinations nor does it restrict waiver eligibility.[52]

Figure 8
Need Determination Criteria for the Developmentally Disabled Waiver[a]

Skills Demonstrated in Daily Life	**Challenging Behaviors**
• Walking • Using a Wheelchair • Taking prescription medication • Eating • Toileting • Bladder and Bowel control • Personal care • Dressing • Safety awareness	• Disruptive social behavior • Aggressive social behavior • Self-injurious behavior • Emotional outbursts • Destruction of property • Running or wandering away
Medical or Physical Conditions Requiring ongoing intermittent nursing care or observation	
• Apnea monitoring • Oxygen therapy includes continuous positive airway pressure (CPAP) with or without artificial airway. • Gastrostomy feeding, requires at least one or all dietary needs via gastric/gastrostomy tube, or oral feedings supplemented with nasal/gastric tube feedings • Tracheostomy care and suctioning • Colostomy/ileostomy requires direct care and treatment by another person or close supervision	• Diabetic testing on a daily and regular basis • The consumer needs special feeding assistance. (Special eating utensils) • Medical condition requires at least daily or weekly injections; Seizures controlled by medications • Medical condition requires daily medications to control the progression of the disease • Sensory deprivation (deaf and /or blind). Consumer requires constant reminders, supervision or partial assistance in independent living/self-help domain activities & safety awareness of environment

[a] The revised CDER excludes "substantial limitations in rolling and sitting, crawling and standing, smearing." Bladder and bowel control are now a single element, bathing and hygiene became part of the personal care element and cannot be counted as separate qualifying conditions. Smearing refers to the spreading of substances (including bodily substances) by the client as a reaction to a situation or as a means of expressing hostility, frustration, aggression.

[52] Department of Developmental Services, Community Operations Division (December 2007) Program Advisory: Level of Care Determination Using the Revised CDER for Home and Community-Based Services (HCBS) Waiver Consumers

In Home Operations (IHO) Waiver[53]

The IHO Waiver was initiated in 2007 and renewed in 2010. It replaced components of three prior waivers: the Nursing Facility A/B waiver (NF A/B), Nursing Facility Subacute (NF SA) Services, and the In-Home Medical Care (IHMC) waiver (all subsequently discussed). The IHO waiver offers the same services and providers approved by CMS for the NF A/B and NF SA waivers, and adds habilitation and community transition services. IHSS Public Authorities are authorized as a provider under IHO.

Services

IHO Waiver services include environmental accessibility adaptations, case management, respite care (home and facility), personal emergency response systems (PERS), PERS installation and testing, community transition services, home health aide services, habilitation services, family training, waiver personal care services, transitional case management, medical equipment operating expenses and private-duty nursing, including shared services.[54] Legally responsible relatives can be paid to provide many of the services under this waiver. A notable exception is waiver-funded personal care. Recipient counts and expenditures for the services are shown previously in Part 1 (Tables 1-4, pages 11-14).

Eligibility

This waiver serves beneficiaries who are Medi-Cal eligible and who, in the absence of this waiver, and as a matter of medical necessity (pursuant to California Welfare and Institutions (W&I) Code, §14059), otherwise require care in an inpatient nursing facility (NF) providing the following types of care:

1. Nursing Facility Distinct Part services pursuant to W&I Code §1409.21(c)(1), and California Code of Regulations (CCR), Title 22, CCR, §51124 and 51335;
2. NF Level B Pediatric services pursuant to Title 22, CCR, §51124 and 51335 and the participant is under the age of 21;
3. NF Subacute services, pursuant to Title 22, CCR, §51124.5; or
4. NF Pediatric Subacute services, pursuant to Title 22, CCR, §51124.6.

Income eligibility is determined either through categorical income/resource standards that meet the criteria for SSI/SSP (see Medi-Cal eligibility section), optional categorically needy for aged and/or disabled (based on income at 100% of Federal Poverty level income), low income families with children as provided in §1931 of the Act, and all other mandatory and optional eligibility groups under the Medi-Cal state plan, including all individuals in the special home and community-based waiver group under 42 CFR §435.217. The state has elected a waiver to

[53] The primary sources of the information reported here was obtained for the approved IHO waiver applications *Application for a §1915c HCBS waiver* submitted December 15, 2006; and *Application for a §1915c HCBS waiver* submitted January 1, 2010.

[54] These services are described in Appendix C-3 of the IHO waiver application.

§1902a(10)(C)(i)(110) of the Act to allow the use institutional income & resources rules for determining Medically Needy eligibility for this waiver. Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. These are based on an allowance of the personal needs of the waiver participant.

Enrollment in this waiver is contingent on the waiver participant's acceptance of the enrollment requirement that establishes their current level of expenditure for the waiver and State plan services as described on their most recent *Plan of Treatment* (POT) as their individual cost limit. This limit is determined by an assessment of the amount (i.e., type of care, hours, frequency) of state plan and waiver services needed to assure health and safety in the community in comparison to the cost of institutional care. Costs exceeding those in institutional care are not authorized.

Level of Care Determination

Level of care need is determined by criteria set forth in Title 22, CCR, §51344(a) and (c). It includes the following, which applies to new and reevaluated recipients. These criteria are unchanged between 2007 through 2010 as reflected in the renewed waiver application:

- Physically disabled, no age limit;
- Medically Fragile, and/or Technology dependent;
- Meet the criteria for inpatient nursing facility care for 365 consecutive days or be receiving continuous services in an acute hospital for 36-months or more (the same instrument is used for assessing the need for the waiver as is used in assessing institutional level of care);
- Have an identified and available support network, including a primary care physician who oversees the participant's home care program;[55] and
- Have primary care physician ordered direct care services that are in excess of the NF/AH Waiver for the participant's LOC.

The waiver assumes that all participants receive case management. The two primary services are private-duty nursing and waiver-funded personal care. Recipients can never receive more the 24-hours/per day of personal care, regardless of the funding source(s). Modest amounts of family training and respite are also provided. The waiver includes transitional case management. DHCS staff report that approximately 79% of the IHO participants also receive IHSS services. No change in the services were authorized in the 2010 renewal of this waiver.

[55] See Appendix B-1: http://www.dhcs.ca.gov/SERVICES/MEDI-CAL/Pages/IHOMedi-CalWaiver.aspx#eligibility. Participants served under the IHO Waiver need to have an identified support network system available to them in the event the HCBS provider of direct care services is not able to provide the total number of hours approved and authorized by CDHS/IHO. The support network system may consist of care providers, community-based organizations, family members, primary care physicians, home health agencies, a member of the participant's medical team, licensed foster parent or any other individual that is part of the participant's circle of support. The participant's circle of support may consist of family members, legal representative/legally responsible adult, and any other individual named by the participant.

The CDHS/IHO NE uses the Case Management Acuity System to determine the periodicity of level of care (LOC) re-evaluations and the intensity of the required participant case management. Information collected during the initial evaluation and later reevaluations for LOC is documented in the Case Report and is used to determine a participant's level of case management. IHO Waiver participants are assigned a level of case management from one to four, which is based on factors such as a participant's medical stability, compliance with the POT, issues affecting participant health and safety, and availability and adequacy of staffing for waiver services (see below for a description of each level). The CDHS/IHO NE conducts on-site home visits based upon the level of case management acuity, or as necessary, to assess the effectiveness of the home program in ensuring the participant's health and safety and adherence to the POT. The LOC evaluation records and reevaluations are maintained in a participant's case record file with the assigned CDHS/IHO NE.

- Participants assigned ***Level 1*** are reevaluated at least once every 365 days. Level 1 participants are medically stable, have not recently been hospitalized for emergency care, and have no eligibility or staffing issues.

- ***Level 2*** participants are reevaluated more often, at least every 365 days, and up to every 180 days. Participants have minor staffing or durable medical equipment issues, which are addressed by the HCBS provider responsible for rendering waiver case manager services. The waiver case manager maintains regular contact with the CDHS/IHO NE, providing updates to the POT and/or documentation of the issues, corrective actions taken, and outcomes.

- ***Level 3*** participants are reevaluated at least every 180 days. Participants assessed at Level 3 can be dependent on medical technology, elected to have non-licensed providers render all of their direct-care services, have high turnover of waiver providers, have had four or more unscheduled hospitalizations in the previous 12 month period, and/or had difficulty in obtaining primary care physician ordered medically-necessary services. The CDHS/IHO NE will assist the participant and/or his/her legal representative/legally responsible adults and/or circle of support and waiver case manager in identifying areas of concern and taking corrective actions, and will monitor the outcome.

- ***Level 4*** participants are reevaluated at least once every 180 days or more frequently. Level 4 participants are at an elevated risk and require frequent monitoring and interventions by the CDHS/IHO NE to address issues that affect their health and safety. Participants evaluated at level 4 may have related issues suspected or reported domestic violence, abuse, neglect, or exploitation, or a lack of providers to meet their medical care needs and ensure their health and safety. The CDHS/IHO NE conducts frequent on-site visits to work with the participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support and the HCBS provider responsible for rendering waiver case manager services in response to issues requiring a plan of correction and follow-up.

Tables 4 & 5 in Part 1 (pages 13 & 14) shows the IHO recipient counts and expenditures for 2007-08. The program was planned during this period with an annual cap of 210 recipients. The cap is projected to be reduced incrementally starting in 2010 to 170, 162, 154, 147, 140 over the ensuing years.

The IHO Waiver is managed by DHCS. Registered nurses complete an assessment, determine the level of care, and review the plan of treatment or service plan as well as the Treatment Authorization Request (TAR). A CDHCS/IHO medical consultant also reviews the level of care determinations. Members of the support network providing direct care services in the absence of the authorized HCBS waiver provider will be identified on the Plan of Treatment (POT). The participant's primary physician must sign the POT. For purposes of the HCBS IHO Waiver, the primary physician is the physician that oversees the participant's home program. All primary care physician-ordered services must be in place at the time of discharge from the acute hospital to ensure the participant's health and safety.

The type, frequency and amount of the participant's authorized waiver and State plan services are documented in the Menu of Health Services (MOHS) worksheet and provided to the participant and/or his/her legal representative/legally responsible adult prior to enrolling in the HCBS IHO Waiver. The MOHS is a planning instrument used by the participant and/or his/her legal representative/legally responsible adult, circle of support, HCBS IHO Waiver Case Manager, and the CDHS/IHO NE to ensure the costs of the participant's selected services do not exceed the participant's cost limit. The MOHS summarizes all the waiver services and provider types available through the HCBS IHO Waiver. The MOHS enables the participant and/or his/her legal representative/legally responsible adult(s) and/or his/her circle of support to select a combination of waiver services best suited to meet his/her medical care needs and ensure his/her health and safety and ensure the costs of the services do not exceed the participant's cost limit.

In-Home Medical Care (IHMC) Waiver[56]

The In-Home Medical Care (IHMC) waiver was consolidated effective January 1, 2007 into the Nursing Facility/Acute Hospital (NF/AH) and the In-Home Operations waiver. IHMC was intended to provide home and community-based services to severely disabled individuals with a catastrophic illness, and included persons who might be technology dependent, had a risk for life-threatening incidents, and/or who would otherwise require care in an acute care hospital for a minimum of 90 days. It was intended to provide services to persons who would otherwise have received inpatient services from an acute or mental health hospital. This was a small waiver with high cost per case. The Medi-Cal Operations Division (MCOD), the Medical Care Coordination and Case Management Branch (MCCCMB), and the In-Home Operations Section (IHO) oversaw the implementation of the IHMC waiver services in the home for Medi-Cal

[56] The primary source of the information reported here was obtained for the approved In-Home Medical Care (IHMC) waiver Application for a §1915c HCBS waiver submitted July 1, 2003.

beneficiaries, and determined if the provided services were appropriate, medically necessary, and cost neutral.

Program enrollment varied over its history. It grew modestly between 1986 and 1996 when it attended to its highest enrollment of 348 persons. The program was statewide. It serves a small enrollment of high-cost persons. They have tended to stay long term on the waiver, averaging 356 days during FY 2006.[57] Enrollment was 69 persons in 2005 and 63 in 2006.

Services

Services included in the IHMC waiver were home health aid, respite care, environmental assessment & adaptation, personal emergency response system, private duty nurse, family training, waiver service coordination, transitional care coordination. This list was somewhat expanded in 2007 when the IHO waiver replaced the IHMC, see Figure 9.

IHMC Waiver services could be provided in a beneficiary's or primary caregiver's own residence (i.e., neither location licensed as health facility). If the home setting was not medically appropriate or available, residence could include congregate living situations or facilities licensed as congregate living health facilities (CLHF), pursuant to Title 22, CCR §51173.1. Tables 1 & 2 in Part 1 (pages 811& 12) provides recipient counts and expenditures for 2005-2006. The primary service was private-duty nursing either at home or in a congregate living health facility. Recipients were also eligible for IHSS. IHSS use is reported outside waiver expenditures.

Eligibility

Individuals receiving services under this waiver must have been Medi-Cal eligible under one or more of the following eligibility group(s) in the State plan:

- Low-income families with children as described in §1931 of the Social Security Act;
- SSI recipients;
- State supplement (SSP) recipients;
- Optional categorically needy aged and disabled who have income at 100% of the Federal poverty level (FPL);
- Medically Needy spend down to institutional level income (42 CFR 435.320, 435.322, 435.324 and 435.330); and/or
- All other mandatory and optional groups under the state.

Home and community-based waiver recipients found eligible under §435.217 are subject to post-eligibility calculations. California exercised its option of also including those eligible under §435.726 and §435.735 in post-eligibility calculations. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual, i.e., the amount that an individual is liable to pay for the cost of waiver services.

[57] Mollica & Hendrickson (2009)

Figure 9
Comparison of Services Covered by Prior & Consolidated HCBS Waivers

	Prior Waivers			Current Waivers	
Service Categories	IHMC	NF A/B	NF Subacute	IHO	NF/AH
Audiology Therapy	•				
Case Management	•	•	•	•	•
Community Transition Services	•	•	•	•	•
Congregate Living Health Facility-Private-Duty Nursing	•				
Environmental Accessibility Modifications	•	•	•	•	•
Facility Respite				•	•
Family Training	•	•	•	•	•
Habilitation				•	•
HCBS Personal Care					
Home Health Aide		•	•		
Home Health Aide-Shared	•		•		
Certified Home Health Aide-Shared	•				
Home Respite				•	•
Medical Equipment Operating Expenses				•	•
Personal Care Services		•			
Personal Emergency Response Systems	•	•	•	•	•
Personal Emergency Response Systems Installation & Testing				•	•
Private-Duty Nursing		•	•		
Private-Duty Nursing-Shared	•	•	•		
Private-Duty Nursing Services	•				
PDN-Including Shared Services				•	•
Private-Duty Nursing Supervision	•	•			
Respite	•	•	•		
Transitional Case Management	•		•	•	•
Utility Coverage		•	•		
Waiver Personal Care Services			•	•	•
Waiver Service Coordination		•	•		
Number of Services in Each Waiver	14	13	14	13	13

Source: Mollica & Hendrickson, 2009,Table 37, page 58

Under §435.726 and §435.735, states must provide an amount for the maintenance needs of the individual. This amount is based upon a 'reasonable assessment' of the individual's needs in the community. For recipients living with their spouse, or if the recipient is living in a community care facility and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. California elected to use the federal post-eligibility rules applicable to 42 CFR 435.726 to set the maximum deduction**.**

If the recipient's spouse is not living in the recipient's home, no maintenance amount is protected for that spouse's needs. If other family members are living with the recipient, an additional amount of income is protected for their needs. This amount was limited by the AFDC

need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size**.**

The spousal protection rules also provide for protecting a personal needs allowance (PNA) described in §1902(q)(1) for the needs of the institutionalized individual. This is an allowance "which is reasonable in amount for clothing and other personal needs of the individual while in an institution." For institutionalized individuals this amount could be as low as $30 per month, but must be a reasonable amount for clothing and other personal needs of an individual while in an institution. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. Therefore, the $30 PNA may not be a reasonable amount when the waiver recipient is living in the community. California, which elected to treat home and community-based services waiver participants with community spouses under the §1924 spousal impoverishment post-eligibility rules, also elected to use the personal needs allowance that was elected under 42 CFR 435.726 or 42 CFR 435.735.

Level of Care Determination

All new individuals applying for IHMC Waiver services were evaluated by the MCODIHO Intake Unit (comprised of Registered Nurses who assessed health-related needs and a licensed social worker who assessed non-physical care services and needs). The Social Worker worked with the individual's case manager in the development of the Plan of Treatment (POT). The POT includes health and non-physical care services and needs, providers, and expected outcomes. It was not limited to IHMC funded services. The Intake Unit was responsible for reviewing documentation supporting the need for the waiver. The individual, primary care physician, other health care entities and/or legal representative could submit documentation. IHMC does not appear to be as heavily reliant on the primary care physician as the IHO in developing the POT. Case management was usually the responsibility of a program based RN, but this could vary for recipients with private duty nursing or home health.

This waiver served physically disabled Medi-Cal beneficiaries who, in the absence of this waiver, and as a matter of medical necessity, pursuant to Welfare and Institutions (W&I) Code, §14059, met criteria for care in a hospital for at least 90 consecutive days. Additionally, beneficiaries served under this waiver had substantial care needs over a 24-hour period that required the presence of a licensed nurse to provide periodic assessment and interventions based upon a prescribed Plan of Care/Plan of Treatment, for the traumatic or acquired neuromuscular impairment and/or complex debilitating illness. In addition, the beneficiary had to have three or more of the following:

- Dependent on life-sustaining medical technology for more than 50% of the day;
- Total Parenteral Nutrition (TPN) at a minimum of three (3) times a week;
- Daily tube feeding (nasogastric or gastrostomy);
- Continuous IV therapy involving administration of therapeutic agents or IV therapy necessary for hydration or daily IV drug administration via a peripheral and/or central line without continuous infusion;
- Two or more medical treatments every shift with a minimum of six (6) treatments per 24-hour period (i.e. respiratory treatment, wound care, intermittent catheterization, ostomy care, tracheostomy care); and/or
- Need for a licensed nurse assessment at a minimum of every eight (8) hours for the administration of *Pro Re Nata* (PRN) medications.

In addition, all requests for IHMC Waiver services had to meet the criteria set forth in Title 22, California of Regulations (CCR), §51344 and 51173.1, as appropriate for institutional care.

Multipurpose Senior Services Program (MSSP) Waiver[58]

MSSP is administered by the California Department of Aging (CDA) through 41 regional contractors. This covers all but eight of California's 58 counties. The MSSP program converted from a state-funded demonstration to a §1915(c) Waiver in 1983. Care management is the core feature, accounting for about 80% of per enrollee Medi-Cal expenditures under this waiver (the available expenditures data do not include funds contributed by local program operators, many of which are said to contribute significant cash and in-kind resources to meet the MSSP staffing and program requirements). Care managers are responsible for enrollment assessments and reassessments, the development of a care plan, monthly contact with recipients to check on their condition, and verification of the adequacy and effectiveness of the care plan services. The care plan is not limited to the services directly funded by the waiver. In providing services to MSSP clients, care managers must first fully utilize any and all other funding sources (e.g., State Medicaid Plan, Older Americans Act) before authorizing expenditure of waiver funds. Accordingly, care managers assist clients in gaining access to waiver and other Medi-Cal State Plan services, as well as other medical, social, and other services. Services funded by the waiver include supplements or short-term coverage for state plan services as well as services, such as respite, that are not covered by state plan services. When an MSSP client makes their own arrangements for hiring or otherwise receiving any in-home services, including personal care, MSSP care management staff is not responsible for the monitoring or supervision of the service provider.

The waiver allows case managers to serve MSSP participants for up to 180 days prior to returning home if they are admitted to a hospital or nursing facility. However, according to a 2006 report by the Assessment/Transition Work Group of the Olmstead Advisory Committee,

[58] California Department of Health Care Services. (2004). §1915(c) Home & Community-Based Services Waiver Application: Multipurpose Senior Services Program (MSSP) Medicaid Reimbursement of Home and Community-Based Services July 1, 2004 – June 30, 2009. Sacramento: Department of Health Care Services.

this benefit appears to have been seldom used. Among the reasons noted were that the waiver program was operating at full capacity and did not have the resources needed to provide transitional care planning services to residents of nursing facilities.[59] The report also noted that additional training on transition coordination would be needed, should resources be available. (When these services are provided they are billed against the waiver on the date of discharge. If the beneficiary dies before discharge, all services provided may be charged to the waiver under Administrative Case Management. If the individual is not discharged, or is ineligible for MSSP upon discharge to the community, all services provided while in the institution are billed against the waiver under Administrative Case Management.)

The historical financial constraints on MSSP, coupled with administration proposals for substantial budget cuts in 2008 and 2009 may have destabilized the program. In 2008, seven county MSSP sites submitted notice to the CDA of their intent to cancel their contracts, citing rising costs, stagnant or decreasing program funding and increased need for county financial support. CDA was able to procure new contracts to continue the program in all but one of these counties. In 2008, funding for Medi-Cal providers was reduced by 10%. This included MSSP providers who, commensurate with the reduced funding, were allowed to reduce the number of clients served in the program by 10%. In 2009, an additional funding reduction of 50% was proposed for MSSP, but not enacted.

Services

The MSSP waiver services are listed in Figure 10. The number of recipients for these services and the expenditures during the 2005-2008 period are shown in Tables 1-4 of Part 1 (pages 11-14). Between 95%-98% of MSSP waiver participants also receive personal care services through the state's IHSS program. This has the effect of making MSSP case management available to a subgroup of high-risk IHSS recipients. Except through home- and community-based waivers like MSSP, case management is not otherwise available in the IHSS program. An estimate of the combined spending for those jointly receiving IHSS and MSSP is not currently available, but it should be noted that fewer than 4% of all IHSS recipients receive MSSP. MSSP provides a few unique benefits as well as additional hours of state plan services.

[59] Assessment/Transition Work Group (September 15, 2006), Assessment/Transition Work Group Policy Priorities. Olmstead Advisory Committee Meeting Presentation to Full Committee, Sacramento, CA. Retrieved on 12-12-08: http://www.chhs.ca.gov/initiatives/Olmstead/Documents/Assessment%20Transition%20Work%20Group%20Policy%20Priorities-%209-15-06.pdf.

Figure 10
Services Available under the MSSP Waiver

- Adult Day Support Center/Adult Day Care
- Housing Assistance:
  - -- Minor Home Repairs and Adaptive Equipment
  - -- Nonmedical Home Equipment and Supplies
  - -- Emergency Move
  - -- Utility Service
  - -- Temporary Lodging
- Chore & Personal Care[60]
- Health Care[61]
- Protective Supervision
- Professional Care Assistance, AKA home health aide
- Care Management:
  - -- Site-Provided Care Management
  - -- Purchased Care Management
  - -- Transitional Care Management also called Deinstitutional Care Management
- Respite:
  - -- In-Home
  - -- Out-of-Home
- Transportation:
  - -- Hour
  - -- One-Way Trip
- Meal Services:
  - -- Congregate Meals
  - -- Home-Delivered Meals
  - -- Food
- Protective Services:
  - -- Social Reassurance
  - -- Therapeutic Counseling
  - -- Money Management
- Communication Services/Personal Emergency Response Systems
  - -- Communication/Translation
  - -- Communication/Device

Eligibility

The MSSP waiver serves persons who meet clinical qualifications for nursing facility admission, as well as income eligibility qualifications for Medi-Cal, i.e., if beneficiaries receive SSI, SSP, are Medically Needy (42 CFR 435.320, 435.322, 435.324 and 435.330), or have income below 100% of the FPL. They must also be age 65 and older and reside in a county with an MSSP provider,[62] and have projected Medi-Cal expenditures that do not exceed those expected to be incurred if they were a nursing facility resident. The income and resource standards used for Medically Needy are approved by a waiver of §1902(a)(10)(C)(i)(III) of the Act. MSSP uses the Medically Needy income and resource rules applicable to those receiving institutional care for to those in the waiver. Accordingly, in applying these post eligibility rules, payment for home and community-based waiver services are reduced by the amount remaining after deducting the preceding amounts from the waiver recipient's income and resources. The State uses the post-eligibility rules of §1924 of the Act to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. This allows the couple to separate their incomes and resources. The non-recipient partner is able to retain a personal care allowance of their income standard and the applicable income disregard.

[60] Available only when the recipient is not eligible for IHSS, such as when the beneficiary is institutionalized and payment is made to retain the services of the care provider; or when the level of need exceeds the services authorized by IHSS. Family members are not eligible for waiver personal care payments.

[61] Service included here are those provided by authorized individuals when such care is prescribed or approved by a physician, and the service cannot otherwise be paid for under the state plan. Services may include pharmacists/pharmacy consultations; registered nurses or licensed vocational nurses; nutritionists/registered dietitians; occupational, physical, or speech therapists; other health professionals specific to the identified need of the client such as art, dance, exercise, massage, music, and recreation therapists.

[62] A listing of eligibility requirements is available at http://www.dhcs.ca.gov/services/medi-cal/Pages/MSSPMedi-CalWaiver.aspx#eligibility.

Enrollment in MSSP peaked in FY 2003 with 14,182 participants and declined slightly to 13,840 in FY 2006. It remained flat into 2008. MSSP is funded on a fixed rate per participant slot. As a consequence direct services compete with care management and other administrative support in the budget. This payment level was held constant from 1988 to 1998 and not increased again until 2006 when it was raised from $3,776 per participant to $4,285. Since 2005 the average cost per recipient was $3,382. During this period there were declines in the average number of waiver days. The average number of waiver days in FY 2006 was 293, down from the peak of 325 in FY 2003. The 2005-2006 data show a decline of 12% in the average number of days a person stays on the waiver and a drop of about 544,000 days of service from 4,448,074 in 2005 to 3,984,345 in 2008. This could be a consequence of fixed budgets and competing costs for direct service and administrative support.

Level of Care Determination

Potential clients are initially screened to determine the appropriateness for participation in MSSP. The Screening forms or tools vary somewhat from site to site, however, they are consistent within a site. The initial screening can be performed by telephone, in an acute care hospital, nursing facility, or the person's place of residence. The initial screening is to determine if the individual is age 62 or older; receiving Medi-Cal under an appropriate aid code and resides within the area defined by the MSSP site's contract.

Those determined to be eligible through the screening process receive face-to-face comprehensive health and psychosocial assessments to determine specific problems, resources, strengths, needs, level of care, and preferences. Nurse and social work care managers conduct these assessments. These assessments include, as appropriate, contact with the family and other informal supports; contact with the client's physician and other health providers (if any); as well as a review of the client's health/medical/psychosocial history. Based on both the health and psychosocial assessments, the nurse care manager then makes a level of care (LOC) determination. In the individual meets a nursing facility (NF) level of care, then they are eligible for MSSP. Assessments or reassessments are generally conducted in the client's place of residence. The health and psychosocial assessment uses a standardized set of forms. These cover a wide range of domains outlined below. Information on how these are weighted or combined to determine eligibility and authorize levels of care was not provided:

- Medical history & diagnoses
- Medications
- Nutritional Assessment & dietary habits
- Review of body systems
- Family & Social Network
- Living Arrangement/Environmental Safety
- Financial & other resources
- Psychological assessment
- Memory
- Orientation
- Judgment
- Anxiety
- Combative, Abusive, Hostile Behavior
- Depression
- Delusions, Hallucinations
- Paranoid Thinking, Suspiciousness
- Wandering
- Suicidal
- Functional Needs Assessment
- Formal Services

Reassessments are completed at least annually by either the nurse or the social work care manager. Clients may be terminated from MSSP for any one of the following reasons: death, moved out of the area, no longer desires services, no longer certifiable for placement in a nursing facility, no longer Medi-Cal eligible, institutionalization, high cost (service costs exceed or are expected to exceed 120% of "benchmark" for more than three consecutive months), no longer MSSP/Medi-Cal eligible (may be eligible for Medi-Cal, but no longer with an aid code that qualifies for MSSP, including unable to meet share of cost requirement through In-Home Supportive Services), or, unable/unwilling to follow their care plan.

Nursing Facility/Acute Hospital (NF/AH) Waiver

The NF/AH Waiver is a statewide program. It is intended for Medi-Cal beneficiaries having long-term medical conditions, and who have level of care (LOC) needs meeting the criteria for acute hospital, adult or pediatric subacute nursing facility, distinct-part nursing facility, adult or pediatric Level B (skilled) nursing facility, or Level A (intermediate) nursing facility (NF). The waiver seeks to: 1) facilitate a safe and timely transition of Medi-Cal eligible beneficiaries from a medical facility to his/her home and community utilizing NF/AH Waiver services; and 2) offer beneficiaries, residing in the community (but who are at risk of being institutionalized within the next 30-days) the option of utilizing NF/AH Waiver services to develop a home program that will safely meet his/her medical care needs. The waiver renewal gives priority enrollment to individuals who are in an acute facility and meet the NF/AH Waiver requirements.

The California Department of Health Care Services, In-Home Operations (CDHS/IHO), administers the NF/AH waiver. This waiver is a renewal of the previously operating Nursing Facility Level A and B (NF A/B) Waiver. It also incorporates the previously operating Nursing Facility Subacute (NF/SA) waiver, and retained some enrollees in the previously operating In-Home Medical Care (IHMC) waiver. The NF/AH Waiver offers the same services previously approved by CMS for the NF A/B, NF SA, and IHMC waivers; and it includes two new services: community transition services and habilitation services**.** The IHMC and NF/SA waivers were terminated effective the last day of the month preceding the initiation of the NF/AH (approximately February 28, 2007). The NF/AH Waiver expanded its capacity pursuant to California W&I Code 14132.99, to add 500 slots (up from 740 in the prior year) for individuals at the NF A/B level of care. The planned unduplicated number of waiver participants for the fiscal year 2007-08 through 2011-2012 is shown below (Table 11). Enrollment into the NF/AH Waiver is limited to the maximum number of waiver slots authorized for each waiver year. Of this number 250 are reserved for residents residing in facilities and transitioning to a community setting. The Department, through CDHS/IHO, maintains a waiting list of individuals eligible for potential enrollment in the NF/AH Waiver. It is used when there are no available waiver slots. Waiver slots that become available are filled on a first come first serve basis from a risk prioritized waiting list.[63]

[63] Available waiver slots are filled on a rotating basis. The first opportunity for waiver enrollment is offered to an individual at the top of the list of individuals residing in a health care facility wishing to transition to the community. The second opportunity for enrollment is offered to the individual at the top of the list of individuals residing in the community. The third opportunity is offered to the individual at the top of the list of individuals residing in a health care facility, and so forth. If an

Table 11
Projected Number of NF/AH Participants by Level of Care, 2007-2012

Waiver Year	Nursing Facility A/B LOC	Nursing Facility Subacute LOC	Hospital LOC	Total
2007-08	1240	852	300	2392
2008-09	1350	902	300	2552
2009-10	1460	952	300	2712
2010-11	1570	1002	300	2872
2011-12	1680	1052	300	3032

Source: Application for a §1915 (c) HCBS Waiver Nursing Facility/Acute Hospital, Appendix B, Table B-3-a

Enrollment in the NF/AH Waiver as projected above was to be up to 10 times the combined enrollment of the three consolidated waivers. This rate of growth did not materialize in 2007 or 2008, the initial operational years of the NF/AH waiver (see Tables 3 & 4 in Part 1, pages 13 & 14). In 2008, 90 nursing facility residents were said to have transition to the community through the waiver.[64] The enrollment in the later years have not yet been reported.

Organizationally, CDHS/IHO has a northern and southern California regional office, each responsible for conducting initial waiver LOC evaluations and reevaluations, and ongoing administrative case management activities. Waiver participants must have a current Plan of Treatment (POT) signed by the participant and/or legal representative/legally responsible adult, the participant's primary care physician and all HCBS Waiver providers that describes all the participant's care services, frequency and providers of the identified services that ensure his/her health and safety in a home and community setting.

Services

Waiver services are delivered through Medi-Cal HCBS waiver providers, such as home health agencies, durable medical equipment companies, individual nurse providers, licensed clinical social workers, marriage and family therapists, personal care agencies, and Waiver Personal Care Service providers. The waiver participant has the option of selecting the provider of waiver services that are appropriate to his/her care needs. [65]

The hours of service authorized are monitored to assure that expenditures for this assistance will not exceed the Medi-Cal expenditures for institutional care. The 2007 approved waiver shows the State approved annual waiver budget expenditure authority for the following institutional alternatives:

individual is unable to accept or declines waiver enrollment, the open waiver slot will be offered to the individual at the top rank in the order of rotation. CDHS/IHO may reserve waiver slots for priority enrollment beneficiaries to prevent interruption of existing home and community-based services or prevent unnecessary nursing facility placement.

[64] DHCS staff report cited by Mollica & Hendrickson, 2009, page 56.

[65] See: http://www.dhcs.ca.gov/services/medi-cal/Pages/NFAHMedi-CalWaiver.aspx.

- NF-A, $29,548
- NF-B, $48,180
- NF-Subacute, Adult, $180,219
- NF-Subacute, Pediatric, $240,211
- Acute Hospital, $305,283
- NF-Distinct Part, $77,600
- NF-B, Pediatric, $101,882

Figure 9 (page 57) shows the services in NF/AH and the predecessor waivers. This comparison reveals that in combination, a generally similar set of services continued to be available to participants. Most of the changes reflect the regrouping or new labels of services, for example, waiver personal care, home hospice, medical equipment operating expenses, personal emergency response system installation, and private duty nurse-shared services were added. Services seemingly dropped include audiology therapy, home health aides, and private duty nurse supervision**.** Tables 1-4 in Part 1 (pages 11-14) show that if recipients and expenditures were combined among the relevant waivers, that all services continue to have similar recipient counts and expenditures. In 2008 about 55% of NF/AH participants received case management, 44% used some form of nursing, and about 64% used waiver personal care services – an encounter rate separate from IHSS use.

Eligibility

The following shows the Medi-Cal eligibility groups that can receive services under this waiver:

- Low income families with children as provided in §1931 of the Act;
- SSI recipients;
- SSP recipients;
- Optional categorically need aged and disabled who have income at 100% of the FPL;
- Medically Needy, with the state electing to use institutional income and resource rules (This is consistent with IHO and the prior waivers.); and/or
- All other mandatory and optional eligibility groups under the Medi-Cal state plan, including those under 42 CFR §435.217 special home & community based waiver groups.

In addition to these basic income and resource eligibility standards, the state uses Spousal impoverishment rules under §1924 of the Act and 42 CFR §435.726 to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. This allows the couple to separate their incomes and resources.

Level of Care Determination[66]

A distinction is made in the level of care determination between persons qualifying for acute

[66] The information reported here is drawn from Appendix B-1 of the NF/AH waiver application, as amended July, 2007.

hospital and nursing facility level of care; however, eligibility can be broadly stated as the following:

- Persons with disabilities, no age limit
- Medically Fragile
- Technology Dependent

These criteria are similar to those used for the IHO waiver, and retain the LOC criteria used by the prior, but now consolidated waivers. Criteria are added for the assessment of potential participants at the NF-B level of care who meet the NF Distinct Part or NF Pediatric facility alternative. The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan. The criteria used for waiver LOC is determined by criteria established in Title 22, CCR Division 3, §51173.1 51120, 51124, 51124.5, 51125.6, 51334 and 51335 as well as information submitted on Treatment Authorization Requests (TARs). These support medical necessity for the services as defined in Title 22, CCR §51003. Together this information is used during the initial and ongoing reevaluations of all waiver services provided through the NF/AH Waiver.

The CDHS/IHO NE uses the Case Management Acuity System to determine the periodicity (minimum of every 6 months up to every 12 months) of LOC reevaluations and the intensity of the required participant case management. Information collected during the initial evaluation and later reevaluations for LOC is documented in the Case Report and is used to determine a participant's level of case management. NF/AH waiver participants are assigned a level of case management of 1-4, which is based on factors such as a participant's medical stability, compliance with the POT, issues affecting participant health and safety, and availability and adequacy of staffing for waiver services. These processes are the same as those used by the IHO waiver. See that section for a description of the four levels.

Beyond the LOC needs, participants served under either the NF/AH and IHO waivers need to have an identified support network system available to them in the event the HCBS provider of direct care services is not able to provide the total number of hours approved and authorized by California Department of Health Care Services (CDHS), In-Home Operations (IHO) in the plan of treatment. The support network system may consist of care providers, community-based organizations, family members, primary care physicians, home health agencies, members of the participant's medical team, licensed foster parent, or any other individual who is part of the participant's circle of support. The participant's circle of support may consist of family members, legal representatives or legally responsible adults, and any other individual named by the participant. Members of the support network providing direct care services in the absence of the authorized HCBS waiver provider will be identified on the Plan of Treatment (POT). The participant's primary care physician must sign the POT. For purposes of the NF/AH Waiver, the primary care physician is the physician overseeing the participant's home program.

Acute Hospital LOC. Hospital is defined in 42 CFR §440.10. Individuals must meet the criteria for hospital level of care (LOC) for 90 consecutive days or greater and the medical care criteria

defining medically fragile or technology dependent listed in the approved waiver pursuant to Title 22, CCR, §51344 and 51173.1:

- Traumatic or acquired neuromuscular impairment and/or a complex debilitating illness;
- Have substantial skilled nursing medical care needs over a 24-hour period; and
- Require the presence of a licensed nurse to provide continuous evaluation and administration of 3 or more skilled nursing interventions (i.e., dependent on life-sustaining medical technology for more than 50% of the day, evaluation for and administration of supplemental oxygen as needed, and a need for suctioning at least 3 times every 8 hours), total Parenteral Nutrition (TPN) a minimum of 3 times a week, tube feeding (nasogastric or gastrostomy) continuously or intermittently 3 or more times a day, continuous IV therapy involving the administration of therapeutic agents or IV therapy necessary for hydration, or daily IV drug administration via a peripheral and/or central line without continuous infusion, 2 or more medical treatments every shift with a minimum of 6 treatments per 24-hour period (i.e., respiratory treatment with prescribed medications, stage 3 and 4 wound care, intermittent catheterization, ostomy care, tracheostomy care), need for evaluation by a licensed nurse and the administration of *Pro Re Nata* (PRN) medications at minimum of every 8 hours per day.

For each reevaluation, the participant must continue to meet the criteria as described in the cited CCR and W&I Code, in addition to the other criteria outlined in the waiver application.

Nursing Facility LOC. NF/AH and IHO waiver participants qualifying under this component of the program require care for 90 consecutive days or greater in an inpatient nursing facility (NF). Nursing Facility is defined in 42 CFR §440.40 and 42 CFR §440.155 with additional limits as to subcategories of the nursing facilities established by California in the approved waiver. All requests for NF waiver services must meet the criteria set forth in Title 22, CCR, § 51344 (a) (c); and have an LOC need consistent with that provided in the following types of facilities:

- NF Level A - Intermediate Care Services pursuant to Title 22, CCR, §s 51120 and 51334.
- NF Level B includes three types of facilities Title 22, CCR, §s 51124 and 51335 - Skilled Nursing Facility Services, and the waiver participant is 21 years of age and older; Pediatric NF and the participant is under age 21; or Distinct Part NF, and the waiver participant is currently residing in or has been discharged from a Distinct Part Facility, having spent 30 consecutive days or greater and was referred to the waiver within 90 days after discharge.
- NF Subacute Level of Care, pursuant to Title 22, CCR, § 51124.5, or
- NF Pediatric Subacute Care Services, pursuant to Title 22, CCR, § 51124.6, and the waiver participant is under the age of 21.

At each reevaluation, the participant must continue to meet these to remain in the program.

Nursing Facility A/B (NF/AB) Waiver

The NF/AH Waiver replaced this waiver in 2007. NF/AB was operated statewide. It served physically disabled Medi-Cal beneficiaries, whom as a matter of medical necessity, required care in an inpatient nursing facility providing the following types of care for at least 365 consecutive days, and who needed assistance with personal care and/or needed skilled nursing care:

- Nursing Facility Level A services, pursuant to Title 22, California Code of Regulations (CCR), §51120 and 51334, or
- Nursing Facility Level B services, pursuant to Title 22, CCR, §51124 and 51335

Historically, NF/AB had a small enrollment. There were 645 participants,[67] and a waiting list of 649 individuals at the time of the waivers expiration in 2006.[68] Its continuing recipients were transitioned into the NF/AH Waiver in 2007. The Medi-Cal Operations Division (MCOD), In-Home Operations (IHO) of DHCS, administered NF/AB.

Services

NF A/B covered services are listed below. Figure 9 (page 57) compares these services to those provided in the on-going NF/AH waiver. Tables 1 & 2 in Part 1 (pages 11 & 12) summarize the expenditures and recipient counts for the waiver services for 2005 and 2006. More than half the participants received case management and similar proportions used personal care. Approximately 40% of the funds were spent on private-duty nursing, and about 25% on home health aides. Recipient counts were well below the participation planned at the time of the waiver application submission in 2002. The expected unduplicated count for 2004-05 was for 15 Level A and 882 Level B (897 combined) eligible recipients, and 17 and 990 (1007 combined) eligible recipients for 2005-06.[69] Enrollment was about 60% of these projected levels. The following services were covered under this waiver:

• Case management	• Personal Emergency Response Systems
• Community Transition Services	• Private duty nursing/shared nursing services
• Personal care services	• Family training
• Home Health Aide services	• Utility Coverage
• Respite care (in home and in licensed facilities)	• Waiver Service Coordination
• Environmental accessibility adaptations	

[67] Unpublished CMS 372 data, see Tables 1-2, page 8 & 9 of this report.

[68] California Department of Health Services (October, 2006), Money Follows the Person Rebalancing Demonstration: California Community Transitions. Sacramento, CA., p. 8. Retrieved on 12-12-08: http://www.dhcs.ca.gov/services/ltc/Documents/MFP_Demo_CCT_Application.pdf.

[69] Appendix G-2, Request for a New Application for Nursing Facility Waiver A and B Level of Care for Medicaid Reimbursement of Home and Community-Based Services, Effective date January 1, 2002

Case management was a central component of this program. Responsibilities included assessing, care planning, authorizing, locating, coordinating and monitoring a package of long-term care services for community-based clients. The planning and monitoring responsibilities included the services in the individual's plan of care/plan of treatment (POT) and those paid through the waiver's "Menu of Home and Community-Based Services Waiver Service" (MOHS). Case managers (and other providers) also assisted waiver recipients in gaining access to other State Plan services, as well as needed medical, social, educational, and other services--regardless of their funding source. Case management services could begin up to 180 days prior to discharge from an institution. All transitional services provided were billed against the waiver on the date of discharge.

Because the primary needs of the NF A/B recipient were medical in nature, it was generally preferable to have the case management function performed by a person with a medically based background. However, these services could be provided by an entity or organization of trained professionals or by a State licensed individual provider.

NF A/B waiver services were provided in a beneficiary's or primary caregiver's own residence. However, if the home setting was not medically appropriate or available, then the use of congregate living situations or facilities licensed as congregate living health facilities-Type "A" (CLHF-A) pursuant to Title 22, CCR, §51173.1, or a specialized foster care home, pursuant to W&I Code, §1773.1 were permitted.

Eligibility

Individuals receiving services under this waiver were eligible for Medi-Cal. Consistent with the State Plan, this eligibility could be obtained through any of the several means listed here:

- Low income families with children as described in §1931 of the Social Security Act;
- SSI recipients (Federal 1624 Rules);
- State Supplemental Payment (SSP) recipients;
- Eligible for Medicaid if they were in a medical institution and needed HCBS to remain in the community.
- Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330) based on institutional income and resource rules for the medically.
- All other mandatory and optional groups under the plan are included.

Post-eligibility determinations were required for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and needed home and community-based services in order to remain in the community (§435.217). The enrollment of beneficiaries for HCBS services under this method of determining eligibility was capped for each fiscal year. For individuals whose eligibility is not determined under the spousal rules (§1924 of the Social Security Act), the State used the regular post-eligibility rules at §435.726 and §435.735. For persons found eligible for Medicaid using the spousal impoverishment rules, the State used the Federal spousal post-eligibility rules under §1924.

Level of Care Determination

The NF A/B waiver target population consists of Medi-Cal eligible disabled persons whom the attending primary care physician and the Medi-Cal consultant (i.e., physician or registered nurse) agreed would, as a practical matter, in the absence of the waiver, be expected to require at least 365 consecutive days of the level of service provided in a nursing facility at the NF-A (intermediate care) and/or NF-B (skilled care) level of care. The determination of medical eligibility was based on a completed NF A/B waiver services assessment. This provided the following:

- Identification of an attending physician who provides beneficiary-specific written orders;
- A complete and accurate written medical record, including diagnoses, history and physical assessment, treatment plan and prognosis;
- Documentation that a medical need exists for the level of services requested; and
- A determination that the services to be provided will maintain program cost neutrality.

Also, as with the other HCBS waivers described in this report, NF A/B recipients needed to have a support network system available to them in the event the HCBS provider of care services was not able to provide the total number of authorized hours. To the extent that a support network care system could not be identified and/or implemented then waiver services would not be authorized.

The State refused to offer home and community-based services to any person for whom it could reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of institutional care appropriate the determined level of care needed. Re-evaluations for the level of care were completed every six months by DHCS-MCOD staff. These involved visits to the beneficiary's place of residence.

Nursing Facility Subacute (NF/SA) Waiver

This waiver operated until 2007 as a statewide program to provide services to persons who would otherwise have received adult or pediatric nursing facility services at a subacute level of care for 180 days or more. It also supported the relocation of persons from nursing facilities to the community or diverted persons from entering a nursing facility. Like the In-Home Medical Care (IHMC) waiver, NF/SA was intended to serve seriously ill, high-cost recipients. This waiver was combined into the NF/AH and IHO waivers effective in 2007. It had an enrollment of over 560 persons at the time of transition, up from 505 in 2006. When this waiver was discontinued, participants were individually reviewed with about half (240) transferred to the NF/AH Waiver. Most of the others were enrolled in the In-Home Operations (IHO) Waiver.[70]

NF/SA was operated directly by the Medi-Cal Operations Division (MCOD), In-Home Operations (IHO) of the Department of Health Care Services (DHCS). All initial cases were evaluated by the

[70] DHCS staff report cited by Mollica & Hendrickson, 2009, page 49.

MCOD-IHO Intake Unit, which was comprised of registered nurses. The Intake Unit was also responsible for the review of documentation submitted by the recipient's primary care physician and the provider of service that supports the need for requested services.

Ongoing case management was provided by MCOD-IHO to ensure that the home program set up for the delivery of waiver services remains appropriate and medically necessary, and that the home remained a safe environment for the beneficiary. There was planned coordination between the case managers and any home health or consulting nurses engaged in oversight of particular services. Case management included: home visits to the beneficiary at prescribed intervals; annual review of service(s); telephone contact with the physician as warranted; review of Plan of Treatment (POT) and Menu of Health Services (MOHS) during on-site visits, and upon any change in medical condition, or as additional services were requested; review and authorization of waiver and State Plan services according to state regulations; and working with related persons and entities involved with the beneficiary's care.

Services

Listed below are the services available through the NF/SA waiver. As seen in Figure 9 (page 57), these generally parallel those available under the on-going NF/AH waiver. One subtle difference is that waiver personal care services under NF/SA were supplemental to the state plan IHSS benefit, and available only to those receiving IHSS.

- Case management
- Home health aide services, also includes shared Certified Home Health Aide services
- Waiver Personal care services - available only if the beneficiary was receiving personal care services through the State Plan personal care program known as IHSS; the combined service hours could not total in excess of 24 hours in one day.[71]
- Respite care
- Environmental accessibility adaptations
- Personal Emergency Response Systems
- Private duty nursing to include shared nursing services
- Family training
- Transitional Case Management (TCM) Services
- Utility Coverage
- Waiver Service Coordination

Enrollment, service use and expenditures for this waiver for years 2005-2006 are shown in Tables 1 & 2 in Part 1 (pages 11 & 12). About two-thirds of the participants received case

[71] The Waiver Personal Care Service definition differs from that of the state plan. In the waiver Personal Care refers to companions. They can provide non-medical care, supervision, and socialization to a functionally impaired adult. The personal care companions could assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The personal care companion could also perform light housekeeping tasks that incidental to the care and supervision of the individual. Whether these distinctions had a practical consequence or daily task difference with the IHSS personal care provision is unknown.

management and about three-fourths received private-duty nursing. About one-third received supplemental personal care services through the waiver. Use of personal care through IHSS was required.

Enrollment into the NF/SA Waiver was limited to the maximum number of waiver slots authorized for each waiver year. When there were no available waiver slots, the Department, through MCOD-IHO, maintained a waiting list of individuals eligible for potential enrollment in the NF/SA Waiver. Priority enrollment into the NF/SA Waiver was given to individuals meeting all the following criteria:

- A current Medi-Cal beneficiary 21 years of age or older during the current waiver year;
- Receiving private duty nursing services under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) at the NF SA level of care in the month prior to enrollment in the NF SA Waiver;
- The beneficiary had submitted a completed HCBS Waiver Questionnaire; and
- The beneficiary was eligible for placement into the NF SA Waiver.

If there were available NF/SA waiver slots after applying the above rules then priority was given to beneficiaries residing in a medical facility at the time of submission of the HCBS Questionnaire to MCOD-IHO. To assist in the transition to home and community based services, individuals residing in a medical facility who were offered waiver slots were encouraged to enroll into the NF/SA Waiver so that they could receive Transitional Case Management (TCM) services prior to discharge. TCM services could begin up to 180 days prior to discharge from an institution in order to coordinate services such as housing, equipment, supplies, and transportation that may be necessary to leave the facility. MCOD-IHO could hold waiver slots 60 days for priority enrollment beneficiaries to prevent interruption of home and community based services. If waiver slots still remained then individuals otherwise meeting the NF/SA criteria would be selected on a first come first served basis.

Eligibility

The following shows the Medi-Cal eligibility groups who could receive services under this waiver.

- Low income families with children as provided in §1931 of the Act;
- SSI recipients;
- SSP recipients;
- Optional categorically need aged and disabled who have income at 100% of the FPL;
- Medically Needy, with the state electing to use institutional income and resource rules (This is consistent with IHO and the NF/AH waivers); and/or
- All other mandatory and optional eligibility groups under the Medi-Cal state plan, including those under 42 CFR §435.217 special home & community based waiver groups.

In addition to these basic income and resource eligibility standards, the state used spousal impoverishment rules under §1924 of the Act and 42 CFR §435.726 to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. This allowed the couple to separate their incomes and resources, with the non-recipient partner being able to retain a personal care allowance.

Level of Care Determination

This waiver (pursuant to Welfare and Institutions (W&I) Code, §14059), served physically disabled Medi-Cal beneficiaries who as a matter of medical necessity, required care in an inpatient nursing facility providing the following types of care. It was limited to persons with a disability meeting the level of care needs appropriate for placement in one of the following types of facilities with a medical prognosis that their debilitating condition(s) will last at least 180 consecutive days.

- Subacute services, pursuant to Title 22, California Code of Regulations (CCR), § 51124.5(a), which states "Subacute level of care means a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a skilled nursing facility." or

- Pediatric Subacute care services pursuant to Title 22, CCR, § 51124.6(a) that states "Pediatric subacute care services are the health care services needed by a person under 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function…"

All requests for NF SA Waiver services also had to meet the criteria in Title 22, CCR, §51344(c).

NF/SA waiver services were generally provided in a beneficiary's or primary caregiver's residence. If the home setting was not medically appropriate or available, a congregate living situation or facilities licensed as congregate living health facilities,[72] or a specialized foster care home could be used. Another element of eligibility was that individuals served under the NF/SA waiver was that recipients had to have an identified support network system available to them in the event the HCBS provider of care services was not able to provide the total number of authorized hours. If this was not available or could not be maintained, then the individual would not be eligible for the waiver. This is similar to the plan of treatment requirements in the on-going NF/AH waiver. Both waivers place responsibility on case managers for monitoring the viability of the support network. Both waivers also use(d) the MCOD-IHO Case Management Acuity System to determine the level of intensity for programmatic case management and periodicity for the initial and periodic Level of Care redeterminations. This acuity system ranges from 1-4, 4 requires the most intensive follow-up and technical assistance from program staff. (See the discussion of the NF/AH waiver for details.)

[72] Licensed in accordance with the California Health and Safety Code §1250(i), 1267.12, & 1267.13, 1267.16, 1267.17, & 1267.19

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Appendices

Appendix 1
Nursing Home Eligibility Requirements for Long-Term Care

Described here are the functional eligibility requirements for nursing facility and intermediate care facilities. This material is taken from Title 22 of the California Administrative Code http://government.westlaw.com/linkedslice/default.asp?SP=CCR-1000. The words "functional eligibility" refer to the medical, physical and mental conditions of persons that make them eligible to receive the services offered to persons who meet that level of care condition.

Skilled Nursing Facility Services Subsection (j). In order to qualify for skilled nursing facility services, a patient shall have a medical condition which needs visits by a physician at least every 60 days and constantly available skilled nursing services. The following criteria together with the provisions of §51124 will assist in determining appropriate placement: (1) Need for patient observation, evaluation of treatment plans, and updating of medical orders by the responsible physician; (2) Need for constantly available skilled nursing services. A patient may qualify for nursing home services if the patient has one or more of the following conditions or care needs. The general criteria identified below are not intended to be either all-inclusive or mutually exclusive. In practice, they should be applied as a total package in evaluation of an approved admission:

Condition which needs therapeutic procedures. Conditions such as the following may weigh in favor of nursing home placement.

- Dressing of postsurgical wounds, decubiti, e.g., ulcers, etc. Severity of the lesions and the frequency of dressings are determining factors in whether they require nursing home care.
- Tracheostomy care, nasal catheter maintenance.
- Indwelling catheter in conjunction with other conditions. Its presence without a requirement for other skilled nursing care is not a sufficient criterion for nursing home placement.
- Gastrostomy feeding or other tube feeding.
- Colostomy care for initial or debilitated patients. Facilities shall be required to instruct in self-care, where such is feasible for the patient. Colostomy care alone should not be a reason for continuing nursing home placement.
- Bladder and bowel training for incontinent patients.

Condition which needs patient skilled nursing observation. Patients whose medical condition requires continuous skilled nursing observation of the following may be in a nursing home-- dependent on the severity of the condition. Observation must, however, be needed at frequent intervals throughout the 24 hours to warrant care in a nursing home. Among the on-going nursing evaluations:

- Regular observation of blood pressure, pulse, and respiration is indicated by the diagnosis or medication and ordered by the attending physician
- Regular observation of skin for conditions such as decubiti, edema, color, and turgor
- Careful measurement of intake and output is indicated by the diagnosis or medication and ordered by the attending physician.

Patient needs medications which cannot be self-administered and requires skilled nursing services for their administration. Nursing home placement may be necessary for reasons such as the following:

- Injections administered during more than one nursing shift. If this is the only reason for nursing

home placement, consideration should be given to other therapeutic approaches or the possibility of teaching the patient or a family member to give the injections

- Medications prescribed on an as needed basis. This will depend on the nature of the drug and the condition being treated and frequency of need as documented. Many medications are now self-administered on a PRN basis in residential care facilities
- Use of restricted or dangerous drugs, if required more than during the daytime, requiring close nursing supervision
- Use of new medications requiring close observation during initial stabilization for selected patients. Depending upon the circumstances, such patients may also be candidates for intermediate care facilities.

Physical or mental functional limitation.

- Physical limitations. The physical functional incapacity of certain patients may exceed the patient care capability of intermediate care facilities. a. Bedfast patients. b. Quadriplegics, or other severe paralysis cases. Severe quadriplegics may require such demanding attention (skin care, personal assistance, respiratory embarrassment) as to justify placement in nursing homes. c. Patients who are unable to feed themselves.
- Mental limitations. Persons with a primary diagnosis of mental illness (including mental retardation), when such patients are severely incapacitated by mental illness or mental retardation. The following criteria are used when considering the type of facility most suitable for the mentally ill and mentally retarded person where care is related to his mental condition. (a) The severity of unpredictability of the patient's behavior or emotional state; (b) The intensity of the care, treatment, services or skilled observation that his condition requires; (c) The physical environment of the facility, its equipment, and the qualifications of staff; and (d) The impact of the particular patient on other patients under care in the facility.

§ 51343.2. Intermediate Care Facility Services for the Developmentally Disabled-Nursing. The beneficiary's medical condition shall be determined on an individual basis by the Department's Medi-Cal consultant. In determining the need for ICF/DD-N services the following conditions shall be met:

- A regional center has diagnosed the beneficiary as being developmentally disabled, or has determined that the beneficiary demonstrates significant developmental delay that may lead to a developmental disability if not treated.
- The beneficiary's medical condition is such that 24-hour nursing supervision, in accordance with Title 22, California Code of Regulations, §73839(a) personal care, and developmental services are required. The stability of the beneficiary's medical condition and frequency of required skilled nursing services shall be the determining factors in evaluating whether beneficiaries are appropriate for ICF/DD-N placements.
- Each beneficiary shall have a physician's certification that continuous skilled nursing care is not required and that the beneficiary's medical condition is stable. Beneficiaries convalescing from surgical procedures shall be stable enough that only intermittent nursing care is needed.
- The beneficiary needs a level of developmental, training and habilitative program services and recurring but intermittent skilled nursing services which are not available through other small (4–15 bed) community-based health facilities.
- The beneficiary's condition is such that there is a need for the provision of active treatment services as described at §73801, thereby leading to a higher level of beneficiary functioning and a lessening dependence on others in carrying out daily living activities or in the prevention of regression or in ameliorating developmental delay.
- The beneficiary shall have two or more developmental deficits as measured on the Client

Developmental Evaluation Report prescribed by the Department of Developmental Services in any one or combination of the following three domains:
-- Self-help domain (Eating, Toileting, Bladder control, Dressing)
-- Motor domain (Ambulation, Crawling and standing, Wheelchair mobility, Rolling & sitting)
-- Social emotional domain (Aggression--has had one or more violent episodes causing minor physical injury within the past year, or has resorted to verbal abuse and threats but has not caused physical injury within the past year)

- Self-injurious behavior--behavior exists but results only in minor injuries which require first aid.
- Smearing feces--smears once a week or more but less than once a day.
- Destruction of property.
- Running or wandering away.
- Temper tantrums, or emotional outburst.
- Unacceptable social behavior--positive social participation is impossible unless closely supervised or redirected.

The beneficiary must have a need for active treatment, defined at §73801, Title 22, California Code of Regulations, and intermittent skilled nursing services such as:

- Apnea monitoring
- Colostomy care
- Gastrostomy feeding and care
- Naso-gastric feeding
- Tracheostomy care and suctioning
- Oxygen therapy
- Licensed nurse evaluation on an intermittent basis
- Catheterization
- Wound irrigation and dressing
- The beneficiary needs special feeding assistance.
- Needs repositioning to avoid skin breakdown which would lead to decubitus ulcers & contractures.
- Intermittent positive-pressure breathing

Conditions which would exclude beneficiaries from placement in an ICF/DD-N are as follows:

- Beneficiaries shall not have any of the following extreme developmental deficits in the social-emotional area, i.e.,
  -- Aggression--has had violent episodes causing serious physical injury in the past year.
  -- Self-injurious behavior--causing severe injury requiring physician treatment at least once per year.
  -- Smearing--smears at every opportunity.
- Beneficiaries shall not be admitted to or approved for service in an intermediate care facility for the developmentally disabled-nursing if those beneficiaries have a decubitus ulcer at the third or fourth stage of development as defined in Title 22, California Code of Regulations, §73811.
- Beneficiaries shall not be admitted with clinical evidence of an active communicable disease (i.e., reporting required in accordance with §2500, Title 17, California Code of Regulations).

§ 51334. Intermediate Care Services. A need for a special services program for the developmentally disabled or mentally disordered is not sufficient justification for a beneficiary to be placed in an intermediate care facility. In order to qualify for intermediate care services, a patient shall have a medical condition which needs an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration. Intermediate care services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encouragement of individual patient independence to the extent of his ability. The following factors may assist in determining appropriate placement:

- The complexity of the patientí's medical problems is such that he requires skilled nursing care or observation on an ongoing intermittent basis and 24-hour supervision to meet his health needs.
- Medications may be mainly supportive or stabilizing but still require professional nurse observation for response and effect on an intermittent basis. Patients on daily injectable medications or regular doses of PRN narcotics may not qualify.
- Diet may be of a special type, but patient needs little or no assistance in feeding himself.
- The patient may require minor assistance or supervision in personal care, such as in bathing or dressing. The patient may need encouragement in restorative measures for increasing and strengthening his functional capacity to work toward greater independence.
- The patient may have some degree of vision, hearing or sensory loss.
- The patient may have some limitation in movement, but must be ambulatory with or without an assistive device such as a cane, walker, crutches, prosthesis, wheelchair, etc.
- The patient may need some supervision or assistance in transferring to a wheelchair, but must be able to ambulate the chair independently.
- The patient may be occasionally incontinent of urine; however, patient who is incontinent of bowels or totally incontinent of urine may qualify for intermediate care service when the patient has been taught and can care for himself.
- The patient may exhibit some mild confusion or depression; however, his behavior must be stabilized to such an extent that it poses no threat to him/herself or others.

§ 51343.1. Intermediate Care Facility Services for the Developmentally Disabled Habilitative. Covered services shall be limited to individuals who are defined as developmentally disabled in Welfare and Institutions Code, §4512. In determining the need for intermediate care facility services for the developmentally disabled habilitative, the following criteria shall be considered:

- The complexity of the beneficiary's medical problems is such that skilled nursing care on an ongoing but intermittent basis is needed. Individuals shall be placed in an ICF-DDH only if their predominant skilled nursing needs are predictable and advance arrangements can be made for licensed nurses to provide needed services at prescribed intervals. Individuals who require skilled nursing procedures on an "as needed basis" are not candidates for ICF-DDH placement.
- Medication may be mainly supportive or stabilizing but still requires professional nurse evaluation on an intermittent basis.
- The beneficiary needs specialized developmental, training and habilitative program services which are not available through other levels of care.
- The extent to which provision of specialized developmental, training and habilitative program services can be expected to result in a higher level of beneficiary functioning and a lessening dependence on others in carrying out daily living activities or in the prevention of regression.
- The beneficiary must have two or more developmental deficits as measured on standardized evaluation forms prescribed and furnished by the Department of Developmental Services in any one of the following two domains:
  -- Self-help domain (Eating, Toileting, Bladder Control, Dressing)
  -- Social-emotional domain (Aggression--has had one or more violent episodes causing minor physical injury within the past year, or resorted to verbal abuse and threats, but has not caused physical injury within the past year).
- Self-injurious behavior -behavior exists but results only in minor injuries which require first aid.
- Smearing feces--smears once a week or more but less than once a day.
- Destruction of property.

- Running or wandering away.
- Temper tantrums, or emotional outbursts.

Unacceptable social behavior-positive social participation is impossible unless closely supervised or redirected.

- Beneficiaries shall not have any of the following extreme developmental deficits in the socio-emotional area:
  -- Aggression--has had violent episodes which have caused serious physical injury in the past year.
  -- Self-injurious behavior--causes severe injury which requires physician attention at least once per year.
  -- Smearing -smears at every opportunity.
- Beneficiaries shall not be admitted to or approved for service in an intermediate care facility for the developmentally disabled habilitative if those beneficiaries have a decubitus ulcer.
- Beneficiaries shall not be admitted with clinical evidence of an active communicable disease that is required to be reported in accordance with §2500 of Title 17 of the California Administrative Code.
- Beneficiaries shall not be admitted to an ICF/DDH for purposes of respite care with the exception of clients enrolled in a federally approved home and community-based care program under §1915(c) of the Social Security Act.

§ 51343. Intermediate Care Facility Services for the Developmentally Disabled. Services shall be covered only for developmentally disabled persons as defined in §51164. Intermediate care services for the developmentally disabled are limited to those persons who require and will benefit from services provided pursuant to the provisions of §76301 through 76413 of Title 22 of the California Administrative Code. The Manual of Criteria for Medi-Cal Authorization, published by the Department, shall be the basis for the professional judgments of Medi-Cal consultants in their decision on authorization for services provided pursuant to this section. In determining the need for intermediate care facility services in institutions for the developmentally disabled, the following factors shall be considered:

- The extent of psychosocial and developmental service needs.
- The need for specialized developmental and training services which are not available through other levels of care.
- The extent to which provisions of specialized developmental and training services can reasonably be expected to result in a higher level of patient functioning and a lessening dependence on others in carrying out daily living activities.
- The individual's score on an assessment form approved by the Department of Developmental Services for the determination of intermediate care facility/developmentally disabled eligibility.
- Whether the patient has a qualifying developmental deficit in either a self-help area or social-emotional area as follows:
  -- A qualifying developmental deficit shall be determined in the self-help skill area if the patient has two moderate or severe skill task impairments in eating, toileting, bladder control or dressing skill task; or
  -- A qualifying developmental deficit shall be determined in the social-emotional area if the patient exhibits two moderate or severe impairments from a combination of the following assessment items (Social behavior, Aggression, Self-injurious behavior, Smearing, Destruction of property, Running or wandering away, Temper tantrums, or emotional outbursts)

Appendix 2

Figure 11
Service Coding Currently Active HCBS 1915(c) Waivers

AIDS		Assisted Living		DD		In Home Operations		MSSP		Nursing Facility Acute Hospital	
State Reported Service	**UCSF Coded Service**	**State Reported Service**	**UCSF Coded Service**	**State Reported Service**	**UCSF Coded Service**	**State Reported Service**	**UCSF Coded Service**	**State Reported Service**	**UCSF Coded Service**	**State Reported Service**	**UCSF Coded Service**
Case Management	Case Management	Care Coordination	Case Management	Adult Residential Care	Assisted Living	Case Management	Case Management	Adult Social/ Health Day Care	Adult Day Health	Case Management	Case Management
Skilled Nursing RN	Nursing	Transition Care Coordination	Case Management	Behavior Intervention	Mental Health Services	CLHF- Private Duty Nursing	Nursing	Care/Case Management	Case Management	Family Training	Respite
Skilled Nursing LVN	Nursing	Assisted Living Bundled Service	Assisted Living	Chore Services	Home Maintenance	Private Duty Nursing Services	Nursing	Housing Assistance	Assisted Living	Medical Equip't Operating cost	Medical Supplies
Attendant Care	Personal Care	State Reported Service	UCSF Coded service	Communication Aides	Medical Supplies	Private Duty Nursing - Shared	Nursing	IHSS	Personal Care	P.E.R	Emergency Response
Psychosocial Counseling	Mental Health Services			P.E.R./Crisis Intervention	Emergency Response			Meal Service	Meals	Private Duty Nursing	Nursing
Homemaker Service	Homemaker			Day/Residential Habilitation	Residential Habilitation			Protective Svcs/ Supervision	Emergency Response	Respite - Home	Respite
Minor Home Adaptations	Home Modification			Environmental/ Vehicle Mods	Home Modification			Respite Care	Respite	Waiver Personal Care	Personal Care
Supplements for Foster Care	Foster Care			Family Training	Trained Support			Special Communication	Therapy		
Non-Emergency Medical Transportation	Transportation			Homemaker	Homemaker			Transitional Care/Case Management	Case Management		
Nutritional Counseling	Nutrition			Home Health Aide	Home Health			Transportation	Transportation		
Nutrition Supplements/ Home Meals	Nutrition			Nutritional Consultation	Nutrition						
				Prevocational/ Supported Emp.	Vocational Training						
				Respite Care	Respite						
				Skilled Nursing	Nursing						
				Medical Equip't/ Supplies	Medical Supplies						
				Therapeutic Services	Therapy						
				Transportation, Non-Medical	Transportation						

State reported service was obtained from the CMS 372 forms. UCSF coded service reflects a consolidation of low frequency services into aggregations of related services.
P.E.R. = personal emergency response, IHSS=in home supportive services, CLHF= congregate living facility, Transitional Care includes transitional deinstitutional care

Appendix 3

Figure 12
Service Coding Recently Inactive HCBS 1915(c) Waivers

In Home Medical Care		Nursing Facility A/B		Nursing Facility Subacute	
State Reported Service	**UCSF Coded Service**	**State Reported Service**	**UCSF Coded Service**	**State Reported Service**	**UCSF Coded Service**
Case Management	Case Management	Case Management	Case Management	Case Management	Case Management
Private Duty Nursing	Nursing	Environmental Accessibility Adaptations	Home Modification	Environmental Accessibility Adaptations	Home Modification
		Family Training	Training	Family Training	Training
		Home Health Aide	Home Health Aide	HCBS Personal Care Benefit	Personal Care
		Personal Emergency Response System	Emergency Response	Personal Emergency Response System	Emergency Response
		Private Duty Nursing	Nursing	Private Duty Nursing	Nursing
		Utility Coverage	Miscellanous	Utility Coverage	Miscellanous
		Waiver Personal Care Services	Personal Care		

State reported service was obtained from the CMS 372 forms. UCSF coded service reflects a consolidation of low frequency services into aggregations of related services.
CLHF= congregate living facility

Appendix 4
AIDS CODES MASTER CHART

The Aid Codes Master Chart was developed for use in conjunction with the Medi-Cal Eligibility Verification System (EVS). Providers must submit an inquiry to the EVS to verify a recipient's eligibility for services. The eligibility response returns a message indicating whether the recipient is eligible, and for what services. The message includes an aid code if the recipient is eligible. If a recipient has an unmet Share of Cost (SOC), an aid code is not returned, since the recipient is not considered eligible until the Share of Cost is met. A recipient may have more than one aid code, and may be eligible for multiple programs and services.

The aid codes in this chart (revised as of May 2008) are meant to assist providers in identifying the types of services for which Medi-Cal and Public Health Program recipients are eligible. The chart includes only aid codes used to bill for services through the Medi-Cal claims processing systems and for other non Medi-Cal programs that need to verify eligibility through EVS.

Note: Unless stated otherwise, these aid codes cover United States citizens, United States Nationals and immigrants in a satisfactory immigration status. Satisfactory immigration status includes lawful permanent residents, Permanently Residing in the U.S. Under Color of Law (PRUCOL) aliens and certain amnesty aliens.

Code	Benefits	SOC	Program/Description
C1	Restricted to pregnancy and emergency services	No	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Aid to the Aged – Medically Needy.
C2	Restricted to pregnancy and emergency services	Yes	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Aid to the Aged – Medically Needy, SOC.
C3	Restricted to pregnancy and emergency services	No	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Blind – Medically Needy.
C4	Restricted to pregnancy and emergency services	Yes	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Blind – Medically Needy, SOC.
C5	Restricted to pregnancy and emergency services	No	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. AFDC – Medically Needy.
C6	Restricted to pregnancy and emergency services	Yes	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. AFDC – Medically Needy SOC.
C7	Restricted to pregnancy and emergency services	No	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Disabled – Medically Needy.
C8	Restricted to pregnancy and emergency services	Yes	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Disabled – Medically Needy, SOC.

Code	Benefits	SOC	Program/Description
C9	Restricted to pregnancy and emergency services	No	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. MI – Child. Covers medically indigent persons under 21 who meet the eligibility requirements of medical indigence. Covers persons until the age of 22 who were in an institution for mental disease before age 21. Persons may continue to be eligible under aid code 82 until age 22 if they have filed for a State hearing.
D1	Restricted to pregnancy and emergency services	Yes	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. MI – Child SOC. Covers medically indigent persons under 21 who meet the eligibility requirements of medically indigent.
D2	Restricted to pregnancy and emergency services	No	OBRA Aliens – Not PRUCOL and Unverified Citizens – Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the OBRA and IRCA section in this manual. Aid to the Aged – Long Term Care (LTC). Covers persons 65 years of age or older who are medically needy and in LTC status. Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).
D3	Restricted to pregnancy and emergency services	Yes	OBRA Aliens – Not PRUCOL and Unverified Citizens – Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the OBRA and IRCA section in this manual. Aid to the Aged – Long Term Care (LTC), SOC. Covers persons 65 years of age or older who are medically needy and in LTC status. Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).
D4	Restricted to pregnancy and emergency services	No	OBRA Aliens – Not PRUCOL and Unverified Citizens – Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the OBRA and IRCA section in this manual. Blind – Long Term Care (LTC). Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).
D5	Restricted to pregnancy and emergency services	Yes	OBRA Aliens – Not PRUCOL and Unverified Citizens – Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the OBRA and IRCA section in this manual. Blind – Long Term Care (LTC), SOC. Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).

Code	Benefits	SOC	Program/Description
D6	Restricted to pregnancy and emergency services	No	OBRA Aliens – Not PRUCOL and Unverified Citizens – Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the OBRA and IRCA section in this manual. Disabled – Long Term Care (LTC). Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).
D7	Restricted to pregnancy and emergency services	Yes	OBRA Aliens – Not PRUCOL and Unverified Citizens – Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the OBRA and IRCA section in this manual. Disabled – Long Term Care (LTC), SOC. Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).
D8	Restricted to pregnancy and emergency services	No	OBRA Aliens and Unverified Citizens – Pregnant Woman. Covers eligible pregnant alien women who do not have satisfactory immigration status and unverified citizens. MI – Confirmed Pregnancy. Covers persons aged 21 years or older, with confirmed pregnancy, which meet the eligibility requirements of medically indigent.
D9	Restricted to pregnancy and emergency services	Yes	OBRA Aliens and Unverified Citizens – Pregnant Woman. Covers eligible pregnant alien women who do not have satisfactory immigration status and unverified citizens. MI – Confirmed Pregnancy SOC. Covers persons aged 21 or older, with confirmed pregnancy, which meet the eligibility requirements of medically indigent but are not eligible for 185 percent/200 percent or the MN programs.
E1	Restricted to pregnancy and emergency services	No	Unverified Citizens. Covers eligible unverified citizen children. One-Month Medi-Cal to Healthy Families Bridge. Pregnancy and Emergency Services Only. Covers services only to eligible children ages 0 to 19, who are unverified citizens.
Code	**Benefits**	**SOC**	**Program/Description**
0A	Full	No	Refugee Cash Assistance (RCA). Covers all eligible refugees during their first eight months in the United States, including unaccompanied children who are not subject to the eight-month limitation. This population is the same as aid code 01, except that they are exempt from grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.
0C	HF services only (no Medi-Cal)	No	Access for Infants and Mothers (AIM) – Infants enrolled in Healthy Families (HF). Infants from a family with an income of 200 to 300 percent of the federal poverty level, born to a mother enrolled in AIM. The infant's enrollment in the HF program is based on their mother's participation in AIM.

0L	Restricted	No	Breast and Cervical Cancer Treatment Program (BCCTP) Transitional Coverage Until the County Makes a Determination of Medi-Cal Eligibility. Covers: • BCCTP recipients formerly in aid code 0U, without satisfactory immigration status, who are no longer in need of treatment, and/or have creditable health coverage and are not eligible for state-funded BCCTP. • BCCTP recipients formerly in aid code 0V, without satisfactory immigration status, who have turned 65 years of age, have other health coverage, and/or are no longer in need of treatment and have exhausted their 18-month (breast cancer) or 24-month (cervical cancer) time limit. • BCCTP recipients formerly in aid code 0X with creditable health coverage who have exhausted their 18 months (breast cancer) or 24 months (cervical cancer) of state eligibility. • BCCTP recipients formerly in aid code 0Y, age 65 or older who have exhausted their 18 months (breast cancer) or 24 months (cervical cancer) of state eligibility. Recipients eligible only for transitional federal emergency, pregnancy-related and state-only Long Term Care (LTC) services.
0M	Full	No	BCCTP – Accelerated Enrollment (AE). Provides temporary AE for full-scope, no Share of Cost (SOC) Medi-Cal for eligible females younger than 65 years of age who have been diagnosed with breast and/or cervical cancer. Limited to two months.
0N	Full	No	BCCTP – AE. Provides temporary AE for full-scope, no SOC Medi-Cal while an eligibility determination is made for eligible females younger than 65 years of age without creditable health coverage who have been diagnosed with breast and/or cervical cancer.
0P	Full	No	BCCTP. Provides full-scope, no SOC Medi-Cal for eligible females younger than 65 years of age who are diagnosed with breast and/or cervical cancer and are without creditable insurance coverage. They remain eligible while still in need of treatment and meet all other eligibility requirements.
0R	Restricted Services	No	BCCTP – High Cost Other Health Coverage (OHC). State-funded. Provides payment of premiums, co-payments, deductibles and coverage for non-covered cancer-related services for eligible all-age males and females, including undocumented aliens, who have been diagnosed with breast and/or cervical cancer, if premiums, co-payments and deductibles are greater than $750. Breast cancer-related services covered for 18 months. Cervical cancer-related services covered for 24 months.
0T	Restricted Services	No	BCCTP – State-Funded. Provides 18 months of breast cancer treatments and 24 months of cervical cancer treatments for eligible all-age males and females 65 years of age or older, regardless of citizenship, who have been diagnosed with breast and/or cervical cancer. Does not cover individuals with expensive, creditable insurance. Breast cancer-related services covered for 18 months. Cervical cancer-related services covered for 24 months.
0U	Restricted Services	No	BCCTP – Undocumented Aliens. Provides emergency, pregnancy-related and Long Term Care (LTC) services to females younger than 65 years of age with unsatisfactory immigration status who have been diagnosed with breast and/or cervical cancer. Does not cover individuals with creditable insurance. State-funded cancer treatment services are covered for 18 months (breast) and 24 months (cervical). Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).

0V	Restricted Services	No	Post-BCCTP. Provides limited-scope no SOC Medi-Cal emergency, pregnancy-related and Long Term Care (LTC) services for females younger than 65 years of age with unsatisfactory immigration status and without creditable health insurance coverage who have exhausted their 18-month (breast) or 24-month (cervical) period of cancer treatment coverage under aid code 0U. No cancer treatment. Continues as long as the woman is in need of treatment and, other than immigration, meets all other eligibility requirements. Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).
0W	Full	No	BCCTP Transitional Coverage. Covers recipients formerly in aid code 0P who no longer meet federal BCCTP requirements due to reaching age 65, are no longer in need of treatment for breast and/or cervical cancer, or have obtained creditable health coverage. Recipients in aid code 0W will continue to receive transitional full-scope Medi-Cal services until the county completes an eligibility determination for other Medi-Cal programs.
0X	Restricted	No	BCCTP Transitional Coverage. Covers recipients formerly in aid code 0U who do not have satisfactory immigration status, have obtained creditable health coverage, still require treatment for breast and/or cervical cancer and have not exhausted their 18 months (breast cancer) or 24 months (cervical cancer) of coverage under state-funded BCCTP. Recipients eligible only for transitional emergency, pregnancy-related and state-only LTC services, and co-pays, deductibles and/or non-covered breast and/or cervical cancer treatment and related services.
0Y	Restricted	No	BCCTP Transitional Coverage. Covers recipients formerly in aid code 0U who do not have satisfactory immigration status, have reached 65 years of age, still require treatment for breast and/or cervical cancer and have not exhausted their 18 months (breast cancer) or 24 months (cervical cancer) state-funded BCCTP. Recipients eligible only for transitional emergency, pregnancy-related and state-only LTC services, and state-funded cancer treatment and related services.
01	Full	No	Refugee Cash Assistance (RAC). Covers all eligible refugees during their first eight months in the United States, including unaccompanied children who are not subject to the eight-month limitation.
02	Full	Y/N	Refugee Medical Assistance/Entrant Medical Assistance. Covers eligible refugees and entrants who are not eligible for Medi-Cal or Healthy Families and do not qualify for or want cash assistance.
03	Full	No	Adoption Assistance Program (AAP). Covers children receiving federal cash grants under Title IV-E to facilitate the adoption of hard-to-place children who would require permanent foster care placement without such assistance.
04	Full	No	Adoption Assistance Program/Aid for Adoption of Children (AAP/AAC). Covers children receiving cash grants under the state-only AAP/AAC program.
06	Full	No	Adoption Assistance Program (AAP) Child. Covers children receiving federal AAP cash subsidies from out of state. Provides eligibility for Continued Eligibility for Children (CEC) if for some reason the child is no longer eligible under AAP prior to his/her 18th birthday.
08	Full	No	Entrant Cash Assistance (ECA). Covers Cuban/Haitian entrants during their first eight months in the United States who are receiving ECA benefits, including unaccompanied children who are not subject to the eight-month provision.

1E	Full	No	Craig v. Bonta Aged Pending SB 87 Redetermination. Covers former Supplemental Security Income/State Supplementary Payment recipients who are aged, until the county redetermines their Medi-Cal eligibility.
1H	Full	No	Federal Poverty Level – Aged (FPL-Aged). Covers the aged in the Aged and Disabled FPL program.
1U	Restricted to pregnancy and emergency services	No	Restricted Federal Poverty Level – Aged. Covers the aged in the Aged and Disabled FPL program that do not have satisfactory immigration status.

1X	Full	No	Aid to the Aged – Multipurpose Senior Services Program (MSSP). Allows special institutional deeming rules (spousal impoverishment) for MSSP transitional and non-transitional services for individuals 65 years of age or older.
1Y	Full	Yes	Aid to the Aged – MSSP. Allows special institutional deeming rules (spousal impoverishment) for MSSP transitional and non-transitional services for individuals 65 years of age or older.
10	Full	No	Aid to the Aged – SSI/SSP.
13	Full	Y/N	Aid to the Aged – Long Term Care (LTC). Covers persons 65 years of age or older who are medically needy and in LTC status.
14	Full	No	Aid to the Aged – Medically Needy.
16	Full	No	Aid to the Aged – Pickle Eligibles.
17	Full	Yes	Aid to the Aged – Medically Needy, SOC.
18	Full	No	Aid to the Aged – In-Home Support Services (IHSS).
2A	Full	No	Abandoned Baby Program. Provides full-scope benefits to children up to 3 months of age who were voluntarily surrendered within 72 hours of birth pursuant to the Safe Arms for Newborns Act.
2E	Full	No	Craig v. Bonta Blind – Pending SB 87 Redetermination. Covers former Supplemental Security Income/State Supplementary Payment recipients who are blind, until the county redetermines their Medi-Cal eligibility.
2H	Full	No	Blind – Federal Poverty Level – covers blind individuals in the FPL for the Blind Program.
2V	Full	No	Trafficking and Crime Victims Assistance Program (TCVAP). Refugee Medical Assistance (RMA). Covers non-citizen victims of human trafficking, domestic violence and other serious crimes.
20	Full	No	Blind – SSI/SSP – Cash.
23	Full	Y/N	Blind – Long Term Care (LTC).
24	Full	No	Blind – Medically Needy.
26	Full	No	Blind – Pickle Eligibles.
27	Full	Yes	Blind – Medically Needy, SOC.
28	Full	No	Blind – IHSS.
3A	Full	No	California Work Opportunity and Responsibility to Kids (CalWORKs), Timed-Out, Safety Net – All Other Families.
3C	Full	No	CalWORKS Timed-Out, Safety Net – Two-Parent Families.
3D	Full	No	CalWORKS – Pending, Medi-Cal Eligible.
3E	Full	No	CalWORKS – Legal Immigrant – Family Group.
3G	Full	No	CalWORKS – Zero Parent Exempt.
3H	Full	No	CalWORKS – Zero Parent Mixed.
3L	Full	No	CalWORKs – Legal Immigrant – Aid to families.
3M	Full	No	CalWORKs – Legal Immigrant – Two Parent.
3N	Full	No	Aid to Families with Dependent Children (AFDC) – 1931(b) Non-CalWORKS.
3P	Full	No	CalWORKS – All Families – Exempt.

3R	Full	No	CalWORKS – Zero Parent – Exempt.
3T	Restricted to pregnancy and emergency services	No	Initial Transitional Medi-Cal (TMC). Provides six months of coverage for eligible aliens without satisfactory immigration status who have been discontinued from Section 1931(b) due to increased earnings from employment.
3U	Full	No	CalWORKs – Legal Immigrant – Two Parent Mixed.
3V	Restricted to pregnancy and emergency services	No	AFDC – 1931(b) Non CalWORKS. Covers those eligible for the Section 1931(b) program who do not have satisfactory immigration status.
3W	Full	No	Temporary Assistance to Needy Families (TANF) Timed-Out, Mixed Case.
30	Full	No	CalWORKS – All Families.
32	Full	No	TANF Timed out.
33	Full	No	CalWORKS – Zero Parent.
34	Full	No	AFDC – Medically Needy.
35	Full	No	CalWORKS – Two Parent.
36	Full	No	Aid to Disabled Widow(er)s
37	Full	Yes	AFDC – Medically Needy SOC.
38	Full	No	Edwards v. Kizer.
39	Full	No	Initial Transitional Medi-Cal (TMC) (6 months). Provides six months of coverage for those discontinued from CalWORKs or the Section 1931(b) program due to increased earnings or increased hours of employment.
4A	Full	No	Out-of-State Adoption Assistance Program (AAP). Covers children for whom there is a state-only AAP agreement between any state other than California and adoptive parents.
4F	Full	No	Kinship Guardianship Assistance Payment (Kin-GAP) Cash Assistance. Covers children in the federal program for children in relative placement receiving cash assistance.
4G	Full	No	Kin-GAP Cash Assistance. Covers children in the state program for children in relative placement receiving cash assistance.
4K	Full	No	Emergency Assistance Foster Care. Covers juvenile probation cases placed in foster care.
4M	Full	No	Former Foster Care Children (FFCC).
4V	Full	Yes	TCVAP – RMA. Covers non-citizen victims of human trafficking, domestic violence and other serious crimes.
40	Full	No	AFDC-Foster Care. Covers children on whose behalf financial assistance is provided for state only foster care placement.
42	Full	No	AFDC-Foster Care. Covers children on whose behalf financial assistance is provided for federal foster care placement.
44	Restricted to pregnancy-related services	No	200 Percent FPL Pregnant (Income Disregard Program – Pregnant). Provides eligible pregnant women of any age with family planning, pregnancy-related and postpartum services if family income is at or below 200 percent of the federal poverty level.
45	Full	No	Foster Care. Covers children supported by public funds other than AFDC-FC.

46	Full	No	Interstate Compact on the Placement of Children (ICPC) Child. Covers foster children placed in California from another state. Provides eligibility for CEC if for some reason the child is no longer eligible under foster care prior to his/her eighteenth birthday. Also provides eligibility for the Former Foster Care Children (FFCC) program (aid code 4M) at age 18.
47	Full	No	200 Percent FPL Infant (Income Disregard Program – Infant). Provides full Medi-Cal benefits to eligible infants up to 1 year old or continues beyond 1 year when inpatient status, which began before first birthday, continues and family income is at or below 200 percent of the federal poverty level.
48	Restricted to pregnancy-related services	No	200 Percent FPL Pregnant Omnibus Budget Reconciliation Act (OBRA) (Income Disregard Program – Pregnant OBRA). Provides eligible pregnant aliens of any age without satisfactory immigration status with family planning, pregnancy-related and postpartum, if family income is at or below 200 percent of the federal poverty level.
5E	Full	No	Healthy Families to the Medi-Cal Presumptive Eligibility (PE) program. Provides immediate, temporary, fee-for-service, full-scope Medi-Cal benefits to certain children under the age of 19.
5F	Restricted to pregnancy and emergency services	Y/N	OBRA Alien – Pregnant Woman. Covers eligible pregnant alien women who do not have satisfactory immigration status.
5J	Restricted to pregnancy-related and emergency services	No	SB 87 Pending Disability Program.
5K	Full	No	Emergency Assistance (EA) Foster Care. Covers child welfare cases placed in EA foster care.
5R	Restricted to pregnancy-related and emergency services	Yes	SB 87 Pending Disability Program.
5T	Restricted to pregnancy and emergency services	No	Continuing TMC. Provides an additional six months of emergency services coverage for those beneficiaries who received six months of initial TMC coverage under aid code 3T.
5V	Full	No	TCVAP. Covers non-citizen victims of human trafficking, domestic violence and other serious crimes.
5W	Restricted to pregnancy and emergency services	No	Four-Month Continuing Pregnancy and Emergency Services Only. Provides four months of emergency services for aliens without satisfactory immigration status who are no longer eligible for Section 1931(b) due to the collection or increased collection of child/spousal support.
50	Restricted to CMSP emergency services only	Y/N	County Medical Services Program (CMSP). OBRA/Out of County Care.
53	Restricted to LTC and related services	Y/N	Medically Indigent – Long Term Care (LTC) services. Covers eligible persons age 21 or older and under 65 years of age who are residing in a Nursing Facility Level A or B with or without SOC. For more information about LTC services, refer to the County Medical Services Program (CMSP) section in this manual. Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).
54	Full	No	Four-Month Continuing Eligibility. Covers persons discontinued from CalWORKs or Section 1931(b) due to the increased collection of child/spousal support.

55	Restricted to pregnancy and emergency services	No	OBRA Not PRUCOL – Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the OBRA and IRCA section in this manual. Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).
58	Restricted to pregnancy and emergency services	Y/N	OBRA Aliens. Covers eligible aliens who do not have satisfactory immigration status.
59	Full	No	Continuing TMC (6 months). Provides an additional six months of TMC for beneficiaries who had six months of initial TMC coverage under aid code 39.
6A	Full	No	Disabled Adult Child(ren) (DAC) Blind.
6C	Full	No	Disabled Adult Child(ren) (DAC) Disabled.
6E	Full	No	Craig v. Bonta Disabled – Pending SB 87 redetermination. Covers former Supplemental Security Income/State Supplementary Payment recipients who are disabled, until the county redetermines their Medi-Cal eligibility.
6G	Full	No	250 Percent Working Disabled Program.
6H	Full	No	Disabled – FPL. Covers the disabled in the Aged and Disabled Federal Poverty Level program.
6J	Full	No	SB 87 Pending Disability. Covers with no SOC beneficiaries ages 21 to 65 who have lost their non-disability linkage to Medi-Cal and are claiming disability.
6N	Full	No	Former SSI No Longer Disabled in SSI Appeals Status.
6P	Full	No	PRWORA/No Longer Disabled Children.
6R	Full	Yes	SB 87 Pending Disability (SOC). Covers with an SOC those ages 21 to 65 who have lost their non-disability linkage to Medi-Cal and are claiming disability.
6U	Restricted to pregnancy and emergency services	No	Restricted Federal Poverty Level – Disabled. Covers the disabled in the Aged and Disabled FPL program who do not have satisfactory immigration status.
6V	Full	No	Department of Developmental Services (DDS) Waivers (No SOC).
6W	Full	Yes	DDS Waivers (SOC).
6X	Full	No	Medi-Cal In-Home Operations (IHO) Waiver (No SOC).
6Y	Full	Yes	Medi-Cal In-Home Operations (IHO) Waiver (SOC).
60	Full	No	Disabled – SSI/SSP – Cash.
63	Full	Y/N	Disabled – Long Term Care (LTC).
64	Full	No	Disabled – Medically Needy.
65	Full	Y/N	Katrina-Covers eligible evacuees of Hurricane Katrina.
66	Full	No	Disabled – Pickle Eligibles.
67	Full	Yes	Disabled – Medically Needy SOC.
68	Full	No	Disabled – IHSS.
69	Restricted to emergency services	No	200 Percent Infant OBRA. Provides emergency services only for eligible infants without satisfactory immigration status who are under 1 year of age or beyond 1 year when inpatient status, which began before 1st birthday, continues and family income is at or below 200 percent of the federal poverty level.

7A	Full	No	100 Percent Child. Provides full benefits to otherwise eligible children, ages 6 to 19 or beyond 19 when inpatient status began before the 19th birthday and family income is at or below 100 percent of the federal poverty level.
7C	Restricted to pregnancy and emergency services	No	100 Percent OBRA Child. Covers emergency and pregnancy-related services to otherwise eligible children, without satisfactory immigration status who are ages 6 to 19 or beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the federal poverty level.
7F	Valid for pregnancy verification office visit	No	Presumptive Eligibility (PE) – Pregnancy Verification. This option allows the Qualified Provider to make a determination of PE for outpatient prenatal care services based on preliminary income information. 7F is valid for pregnancy test, initial visit, and services associated with the initial visit. Persons placed in 7F have pregnancy test results that are negative.
7G	Valid only for ambulatory prenatal care services	No	Presumptive Eligibility (PE) – Ambulatory Prenatal Care. This option allows the Qualified Provider (QP) to make a determination of PE for outpatient prenatal care services based on preliminary income information. 7G is valid for Ambulatory Prenatal Care Services. Persons placed in 7G have pregnancy test results that are positive. QP issues paper PE ID Card.
7H	Valid only for TB-related outpatient services	No	Tuberculosis (TB) Program. Covers eligible individuals who are TB-infected for TB-related outpatient services only.
7J	Full	No	Continuous Eligibility for Children (CEC). Provides full-scope benefits to children up to 19 years of age who would otherwise lose their no Share of Cost Medi-Cal.
7K	Restricted to pregnancy and emergency services	No	Continuous Eligibility for Children (CEC). Provides emergency and pregnancy-related benefits (no Share of Cost) to children without satisfactory immigration status who are up to 19 years of age who would otherwise lose their no Share of Cost Medi-Cal.
7M	Valid for Minor Consent services	Y/N	Minor Consent Program. Covers eligible minors at least 12 years of age and under the age of 21. Limited to services related to Sexually Transmitted Diseases, sexual assault, drug and alcohol abuse, and family planning. Paper Medi-Cal ID Card issued.
7N	Valid for Minor Consent services	No	Minor Consent Program. Covers eligible pregnant minors under the age of 21. Limited to services related to pregnancy and family planning. Paper Medi-Cal ID card issued.
7P	Valid for Minor Consent services	Y/N	Minor Consent Program. Covers eligible minors at least 12 years of age and under the age of 21. Limited to services related to Sexually Transmitted Diseases, sexual assault, drug and alcohol abuse, family planning, and outpatient mental health treatment. Paper Medi-Cal ID card issued.
7R	Valid for Minor Consent services	Y/N	Minor Consent Program. Covers eligible minors under age 12. Limited to services related to family planning and sexual assault. Paper Medi-Cal ID card issued.
7T	Full	No	Express Enrollment – National School Lunch Program (NSLP).
7V	Full	Yes	TCVAP. Covers non-citizen victims of human trafficking, domestic violence and other serious crimes.
7X	Full	No	One-Month Medi-Cal to Healthy Families Bridge.
71	Restricted to dialysis and supplemental dialysis-related services	Y/N	Medi-Cal Dialysis Only Program/Medi-Cal Dialysis Supplement Program (DP/DSP). Covers eligible persons of any age who are eligible only for dialysis and related services.
72	Full	No	133 Percent Program. Provides full Medi-Cal benefits to eligible children ages 1 up to 6 or beyond 6 years when inpatient status, which began before 6th birthday, continues and family income is at or below 133 percent of the federal poverty level.
73	Restricted to parenteral hyperali-mentation-related expenses	Y/N	Total Parenteral Nutrition (TPN). Covers eligible persons of any age who are eligible for parenteral hyperalimentation and related services and persons of any age who are eligible under the Medically Needy or Medically Indigent Programs.

74	Restricted to emergency services	No	133 Percent Program (OBRA). Provides emergency services only for eligible children without satisfactory immigration status who are ages 1 up to 6 or beyond 6 years when inpatient status, which began before 6th birthday, continues and family income is at or below 133 percent of the federal poverty level.
76	Restricted to 60-day postpartum services	No	60-Day Postpartum Program. Provides Medi-Cal at no SOC to women who, while pregnant, were eligible for, applied for, and received Medi-Cal benefits. They may continue to be eligible for all postpartum services and family planning. This coverage begins on the last day of pregnancy and ends the last day of the month in which the 60th day occurs.
8E	Full	No	Accelerated Enrollment. Provides immediate, temporary, fee-for-service, full-scope Medi-Cal benefits to certain children under the age of 19.
8F	CMSP acute inpatient services only	Y/N	CMSP Companion Aid Code. Used in conjunction with Medi-Cal aid code 53. Aid Code 8F will appear as a special aid code and will entitle the eligible client to acute inpatient services only while residing in a Nursing Facility Level A or B. For more information about Long Term Care (LTC) services, refer to the County Medical Services Program (CMSP) section in this manual.
8G	Full	No	Severely Impaired Working Individual (SIWI).
8H	Family Planning	N/A	Family PACT (FPACT). Comprehensive family planning services for low income residents of California with no other source of health care coverage. HAP Card Issued.
8N	Restricted to emergency services	No	133 Percent Excess Property Child – Emergency Services Only. Provides emergency services only for eligible children without satisfactory immigration status who are ages 1 up to 6 or beyond 6 years when inpatient status, which began before 6th birthday, continues, and family income is at or below 133 percent of the federal poverty level.
8P	Full	No	133 Percent Excess Property Child. Provides full-scope Medi-Cal benefits to eligible children ages 1 up to 6 or beyond 6 years when inpatient status, which began before 6th birthday, continues, and family income is at or below 133 percent of the federal poverty level.
8R	Full	No	100 Excess Property Child. Provides full-scope benefits to otherwise eligible children, ages 6 to 19 or beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the Federal poverty level.
8T	Restricted to pregnancy and emergency services	No	100 Percent Excess Property Child – Pregnancy and Emergency Services Only. Covers emergency and pregnancy-related services only to otherwise eligible children without satisfactory immigration status who are ages 6 to 19 or beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the Federal poverty level.
8U	Full	No	CHDP Gateway Deemed Infant. Provides full-scope, no Share of Cost (SOC) Medi-Cal benefits for infants born to mothers who were enrolled in Medi-Cal with no SOC in the month of the infant's birth.
8V	Full	Yes	CHDP Gateway Deemed Infant SOC. Provides full-scope Medi-Cal benefits with a Share of Cost (SOC) for infants born to mothers who were enrolled in Medi-Cal with a SOC in the month of the infant's birth and SOC was met.
8W	Full	No	CHDP Gateway Medi-Cal. Provides for the pre-enrollment of children into the Medi-Cal program who are screened as probable for Medi-Cal eligibility. Provides temporary full-scope Medi-Cal benefits with no SOC.
8X	Full	No	CHDP Gateway Healthy Families. Provides for the pre-enrollment of children into the Medi-Cal program who are screened as probable for Healthy Families eligibility. Provides temporary full-scope Medi-Cal benefits with no SOC.
8Y	CHDP services only	No	CHDP. Covers CHDP eligible children who are also eligible for Medi-Cal emergency, pregnancy-related and Long Term Care (LTC) services.
80	Restricted to Medicare expenses	No	Qualified Medicare Beneficiary (QMB). Provides payment of Medicare Part A premium and Part A and B coinsurance and deductibles for eligible low income aged, blind or disabled individuals.
81	Full	Y/N	MI – Adults Aid Paid Pending.

82	Full	No	MI – Child. Covers medically indigent persons under 21 who meet the eligibility requirements of medical indigence. Covers persons until the age of 22 who were in an institution for mental disease before age 21. Persons may continue to be eligible under aid code 82 until age 22 if they have filed for a State hearing.
83	Full	Yes	MI – Child SOC. Covers medically indigent persons under 21 who meet the eligibility requirements of medically indigent.
84	CMSP services only (no Medi-Cal)	No	MI – Adult. Covers medically indigent adults aged 21 and over but under 65 years that meet the eligibility requirements of medically indigent.
85	CMSP services only (no Medi-Cal)	Yes	MI – Adult. Covers medically indigent adults aged 21 and over but under 65 years, which meet the eligibility requirements of medically indigent.
86	Full	No	MI – Confirmed Pregnancy. Covers persons aged 21 years or older, with confirmed pregnancy, which meet the eligibility requirements of medically indigent.
87	Full	Yes	MI – Confirmed Pregnancy SOC. Covers persons aged 21 or older, with confirmed pregnancy, which meet the eligibility requirements of medically indigent but are not eligible for 185 percent/200 percent or the MN programs.
88	CMSP services only (no Medi-Cal)	No	MI – Adult – Disability Pending. Covers medically indigent adults aged 21 and over but under 65 years that meet the eligibility requirements of medically indigent and have a pending Medi-Cal disability application.
89	CMSP services only (no Medi-Cal)	Yes	MI – Adult – Disability Pending SOC. Covers medically indigent adults aged 21 and over but under 65 years that meet the eligibility requirements of medically indigent and have a pending Medi-Cal disability application.
9A	Cancer Detection Programs: Every Woman Counts only	No	The Cancer Detection Programs: Every Woman Counts recipient identifier. Cancer Detection Programs: Every Woman Counts offers benefits to uninsured and underinsured women, 25 years and older, whose household income is at or below 200 percent of the Federal poverty level. Cancer Detection Programs: Every Woman Counts offers reimbursement for screening, diagnostic and case management services. Please note: Cancer Detection Programs: Every Woman Counts and Medi-Cal are separate programs; however, Cancer Detection Programs: Every Woman Counts relies on the Medi-Cal billing process (with few exceptions).
9H	HF services only (no Medi-Cal)	No	Healthy Families Child. Provides a comprehensive health insurance plan for uninsured children from 1 to 19 years of age whose family's income is at or below 200 percent of the Federal poverty level. HF covers medical, dental and vision services to enrolled children.
9J	GHPP	No	GHPP-eligible. Eligible for GHPP benefits and case management.
9K	CCS	No	CCS-eligible. Eligible for all CCS benefits (i.e., diagnosis, treatment, therapy and case management).
9M	CCS Medical Therapy Program only	No	Eligible for CCS Medical Therapy Program services only.
9N	CCS Case Management	No	Eligible for CCS only if concurrently eligible for full-scope, no SOC Medi-Cal. CCS authorization required.
9R	CCS	No	CCS-eligible Healthy Families child. A child in this program is enrolled in a Healthy Families plan and is eligible for all CCS benefits (i.e., diagnosis, treatment, therapy and case management). The child's county of residence has no cost sharing for the child's CCS services.
9U	CCS	No	CCS-eligible Healthy Families child. A child in this program is enrolled in a Healthy Families plan and is eligible for all CCS benefits (i.e. diagnosis, treatment, therapy and case management). The child's county of residence has county cost sharing for the child's CCS services.

Special Share of Cost (SOC) Case Indicators: These indicators, which appear on a recipient's SOC Case Summary Form, are used to identify the following:

IE – Ineligible: A person who is ineligible for Medi-Cal benefits in the case. An IE person may only use medical expenses to meet the SOC for other family members associated within the same case. Upon certification of the SOC, the IE individual is not eligible for Medi-Cal benefits in this case. An IE person may be eligible for Medi-Cal benefits in another case where the person is not identified as IE.

RR – Responsible Relative: An RR is allowed to use medical expenses to meet the SOC for other family members for whom he/she is responsible. Upon certification of the SOC, an RR individual is not eligible for Medi-Cal benefits in this Medi-Cal Budget Unit (MBU). The individual may be eligible for Medi-Cal benefits in another MBU where the person is not identified as RR.

For more information, refer to the Share of Cost (SOC) section of the Part 1 manual.

Appendix 5
Overview of Medi-Cal Programs and Services

Following is a list of related programs and health care services for low-income individuals and families, for the elderly, personal care, specific diseases and children with special medical needs.

- Access for Infants and Mothers Low-cost health coverage for pregnant women.
- American Indian Infant Health Initiative Provide extensive home visiting/case management services to high-risk Indian families.
- Assisted Living Waiver (ALW) The ALW is the Medi-Cal program that pays for specific Assisted Living benefits provided to eligible beneficiaries residing in Sacramento, San Joaquin, Los Angeles, and in mid 2010, Sonoma, Fresno, San Bernardino and Riverside Counties.
- Breast and Cervical Cancer Treatment California provides free cancer screening for breast and cervical.
- CalMEND California Mental Health Care Management Program.
- Cancer Screening and Detection Program Free cancer screening for some types of cancer.
- California Children's Services Treatment for children with chronic/life threatening health conditions/diseases.
- Child Health and Disability Prevention Preventive health program for low-income children and youth.
- Children's Medical Services Provides a comprehensive system of health care for children through preventive screening, diagnostic, treatment, rehabilitation, and follow-up services.
- Community-Living Support Benefit Waiver Pilot Project (AB 2968) Requires DHCS to provide a new Medi-Cal community-living support benefit to increase access to needed health-related and psychosocial services for persons residing in the City or County of San Francisco.
- Coordinated Care Management Coordinated Care Management is for eligible Medi-Cal Seniors and Persons with Disabilities; identifies high risk and expensive chronic conditions and provides care management, education, support, and assistance finding and accessing health resources.
- Denti-Cal Dental Services are currently provided as one of the many benefits under the Medi-Cal program. The beneficiary services department within the Medi-Cal Dental Program offers a variety of Services for program beneficiaries.
- Disease Management Disease Management (DM) has a pilot program for eligible FFS Medi-Cal beneficiaries with select, chronic medical conditions. The DM program provides: telephonic Nurse Advice services; patient and provider education; and assistance to access appropriate medical care.
- Home and Community-Based Services for the Developmentally Disabled The Home and Community-Based Services for the Developmentally Disabled (HCBS-DD) Waiver authorizes home and community-based services for developmentally disabled persons who are Regional Center consumers.
- Estate Recovery Recovers Medi-Cal expenditures from the estates of certain deceased Medi-Cal beneficiaries for services received on or after the individual's 55th birthday.
- Fair Hearing Complaints about how benefits/services are/were handled, or if services have been denied or modified.
- Family Planning, Access, Care & Treatment are available to eligible low income men & women.

- Genetically Handicapped Persons Program Treatment for specific genetic diseases.
- Gynecologic Cancer Information Program The Gynecologic Cancer Information Program (GCIP) was established in statute (California Health and Safety Code 138.4) within the Office of Women's Health to increase awareness and education regarding gynecologic cancers.
- Health Care Program for Children in Foster Care Provides public health nurse expertise in meeting the medical, dental, mental and developmental needs of children and youth in foster care.
- Health Insurance Premium Payment Health Insurance Premium Payment Program is a program that pays private health insurance premiums for certain high cost Medi-Cal beneficiaries.
- Health-e-App (Provider Information only)
- Healthy Families Low cost insurance for children and teens. It provides health, dental and vision coverage to children who do not have insurance and do not qualify for free Medi-Cal.
- Healthy Kids Healthy Kids is a low-cost health care program available in many counties for children who are not eligible for full Medi-Cal or Health Families.
- High Risk Infant Follow-Up Limited diagnostic services for children up to three years of age.
- In Home Operations In-Home Operations (IHO) is a section oversees the development and implementation of home- and community-based programs under Medi-Cal.
- IHSS Plus Waiver Personal care and domestic services to persons who are aged, blind or disabled and who live in their own homes.
- Indian Health Program Improve the health status of American Indians/Alaska Natives (AI/AN) living in urban, rural, and reservation/rancheria communities throughout California.
- Intermediate Care Facility for the Developmentally Disabled-Continuous Nursing (ICF/DD-CN) Pilot Project) The waiver requires the Department to commit to maintaining access to care, provision of quality services, adhering to cost effectiveness, and open access to emergency services for the target population eligible for services under the waiver.
- Legislative and Governmental Affairs This Office facilitates, coordinates and advocates for the development of legislation in the interest of public health.
- Long-Term Care Increases the number of middle-income Californians who have quality long-term care insurance that prevents or delays their dependence on Medi-Cal.
- Medi-Cal (Indivduals and Families) This is a public health insurance program which provides needed health care services for low-income individuals and families.
- Medi-Cal Eligibility Division The Medi-Cal Eligibility Division (MCED) is responsible for the coordination, clarification, and implementation of Medi-Cal regulations, policy, and procedures to assure that Medi-Cal eligibility is determined accurately and on a timely basis by the 58 county public social services agencies.
- Medical Case Management Medical Case Management (MCM) provides short-term case management for Medi-Cal recipients which require medically intensive services.
- Medi-Cal Managed Care Contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care.

- Medi-Cal Pharmacy Benefits Medi-Cal Pharmacy Benefits include Fee-For-Service Drug Program, Drug Rebate Program, Enteral and Medical Supplies Contracting, Drug Contracting, and Vision Care.
- Medi-Cal Waivers Medi-Cal Waivers are programs that demonstrate and evaluate new health care delivery systems. These programs focus on reducing costs and providing services in a community based setting.
- Medical Therapy Occupational Therapy (OT) and Physical Therapy (PT) for children with eligible conditions.
- Multipurpose Senior Services Program (MSSP) Waiver The MSSP waiver is targeted to those medically fragile individuals over the age of sixty-five and is administered through MSSP sites throughout the state, under the California Department of Aging.
- Newborn Hearing Screening Helps identify hearing loss in infants and guide families to the appropriate services needed to develop communication skills.
- Newborn Screening Testing for specific genetic disorders.
- Office of Clinical Preventive Medicine Strives to promote collaboration and understanding between public health authorities and health care providers.
- Office of Health Information Technology Medi-Cal Electronic Health Record Incentive Program.
- Office of Multicultural Health Reduce gaps in health status among and improve the quality of life of California's diverse populations.
- Office of Public Affairs The Office of Public Affairs is responsible for the overall communications and outreach activities.
- Office of Women's Health Improving the status of women's health.
- Overpayments The primary function of the Overpayments Unit is to recover funds due the Medi-Cal program.
- Program of All-Inclusive Care for the Elderly (PACE) The PACE model of care provides a comprehensive medical/social service delivery system using an interdisciplinary team approach that provides and coordinates all needed preventive, primary, acute and long term care services
- Personal Injury The Personal Injury Unit is responsible for the recovery of Medi-Cal expenditures in personal injury actions involving Medi-Cal beneficiaries.
- Presumptive Eligibility for Pregnant Women Allows Qualified Providers to grant immediate, temporary Medi-Cal coverage for ambulatory prenatal care and prescription drugs for conditions related to pregnancy to low-income, pregnant patients, pending their formal Medi-Cal application.
- Primary and Rural Health Care Improve the health status of special, targeted population groups living in medically underserved urban and rural areas of California.
- Senior Care Action Network (SCAN) SCAN Health Plan is a Medicare Advantage Special Needs Plan that provides all services in the Medi-Cal State Plan. Participants must be 65 years or older, Medi-Cal and Medicare eligible and reside in the SCAN service area.
- Subacute Care Program Specific reimbursement rates have been developed for providers of subacute care who have been licensed and certified by the DHCS' Licensing and Certification program.
- Women, Infants and Children (WIC) Nutrition program that helps pregnant women, new mothers and young children eat well and stay healthy.

- Workers Compensation Recovery Program Responsible for identifying and recovering Medi-Cal expenditures made on behalf of beneficiaries whose injuries are covered by Workers Compensation liability.

- Working Disabled Program Allows certain individuals to become eligible for Medi-Cal by paying low monthly premiums based on countable income.