



REVISED EDITION, SEPTEMBER 2001

Understanding
Medi-Cal:
*Long-Term
Care*

The **Medi-Cal Policy Institute**, established in 1997 by the California HealthCare Foundation, is an independent source of information on the Medi-Cal and Healthy Families programs. The Institute seeks to facilitate and enhance the development of effective policy solutions guided by the interests of the programs' consumers. The Institute conducts and commissions research, distributes information about the programs and the people they serve, highlights the programs' successes, and identifies the challenges ahead. It collaborates with a broad spectrum of policymakers, researchers, providers, consumer representatives, and other stakeholders who are working to create higher-quality, more efficient Medi-Cal and Healthy Families programs.

Medi-Cal Policy Institute
476 Ninth Street
Oakland, California 94607
tel: 510/286-8976
fax: 510/238-1382
www.medi-cal.org

A project of the California HealthCare Foundation

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ISBN 1-929008-69-4

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Understanding Medi-Cal: *Long-Term Care*

Lucy Streett, M.P.H.



Methodology: Long-Term Care Data

The long-term care system in California, including the programs and services funded by Medi-Cal, is extraordinarily complex and fragmented. This system serves a diverse group of individuals with different needs (from frail elderly adults to chronically ill children), delivers care through a variety of providers (ranging from institutions like hospitals and nursing homes to in-home health care workers and community-based providers), receives funding from numerous private and public sources (including Medi-Cal, Medicare, and other federal and state funds), and is administered by multiple state agencies (including the California Departments of Health, Social Services, Aging, and Developmental Services).

As a result of this complexity, comparable participant data across the full range of long-term care programs is not available. Consequently it is difficult to draw comparisons about the relative size of different programs.

Whenever possible, this report presents **annual unduplicated counts** of participants. This format provides the most accurate depiction of the total number of people receiving a given service during the year. For services where annual counts are not available, **average monthly estimates** are presented. Average monthly estimates represent the average number of people receiving a service each month during the year. For those long-term care services provided on a temporary or intermittent basis (e.g., hospice, home health), the total number of participants over an entire year is likely to be much larger than average monthly estimates indicate. Finally, for nursing home services, a **point-in-time estimate** is presented. This number estimates the nursing home population on any given day during the year.

Introduction

When your elderly parents are no longer able to care for themselves in their own home, how will your family get assistance with nursing home costs? If your chronically ill child needs in-home care, where will you turn for help? When your disabled neighbor needs transportation to

Medi-Cal is the primary funder of public long-term care services in California, spending more than \$5 billion in 1998.

a doctor's appointment, how will she get there? For many people, the answer to these questions is *Medi-Cal*.

Although Medi-Cal is typically thought of as providing health care coverage to children and low-income families, one-quarter of the program's funds go toward long-term care services for low-income elderly, blind, and disabled individuals. In fact, Medi-Cal is the primary funder of public long-term care services in California, spending more than \$5 billion in 1998.

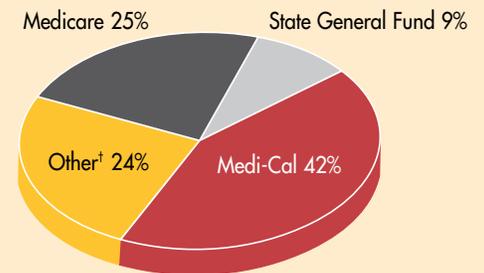
Medi-Cal pays for 64 percent of all nursing home days in California and accounts for 45 percent of total nursing home expenditures. In contrast, the Medicare program, which pays for no more than the first 100 days of a nursing home stay, covers only 9 percent of total nursing home days and 25 percent of total expenditures.

Beyond funding nursing home care, Medi-Cal covers a wide array of additional long-term care services, including personal care and chore services, in-home medical care, hospice, adult day health care, services for people with developmental disabilities, case management, and assistance with purchasing private long-term care insurance. Mental and behavioral health services, which are also funded by Medi-Cal and are sometimes considered to be long-term care services, are not discussed in this report.¹

This guide provides information on the following issues:

- What is Medi-Cal?
- What is long-term care?
- Who needs long-term care?
- Who is eligible for Medi-Cal long-term care?
- How is long-term care funded and administered?
- Which services are covered by Medi-Cal?
- What policy issues lie ahead?

Figure 1. Public Long-Term Care Spending in California by Payer, FY 1998*



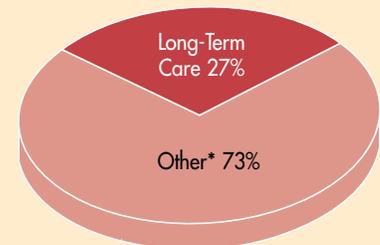
Total = \$11.9 billion

Source: Charlene Harrington et al. *The Role of Medi-Cal in California's Long-Term Care System*. Oakland: Medi-Cal Policy Institute, 2000.

*Excludes spending on mental health services.

†Includes Older Americans Act and Rehabilitation Act funding.

Figure 2. Long-Term Care as a Percentage of Medi-Cal Expenditures, FY 1998



Total = \$18.5 billion

Source: California Health and Human Services Agency.

*Includes acute care and administrative costs.

What Is Medi-Cal?

Medi-Cal, California's Medicaid program, provides health care coverage for low-income families and aged, blind, or disabled individuals. Jointly funded by the federal and state governments, Medi-Cal is the primary source of health care coverage for more than 5 million Californians.

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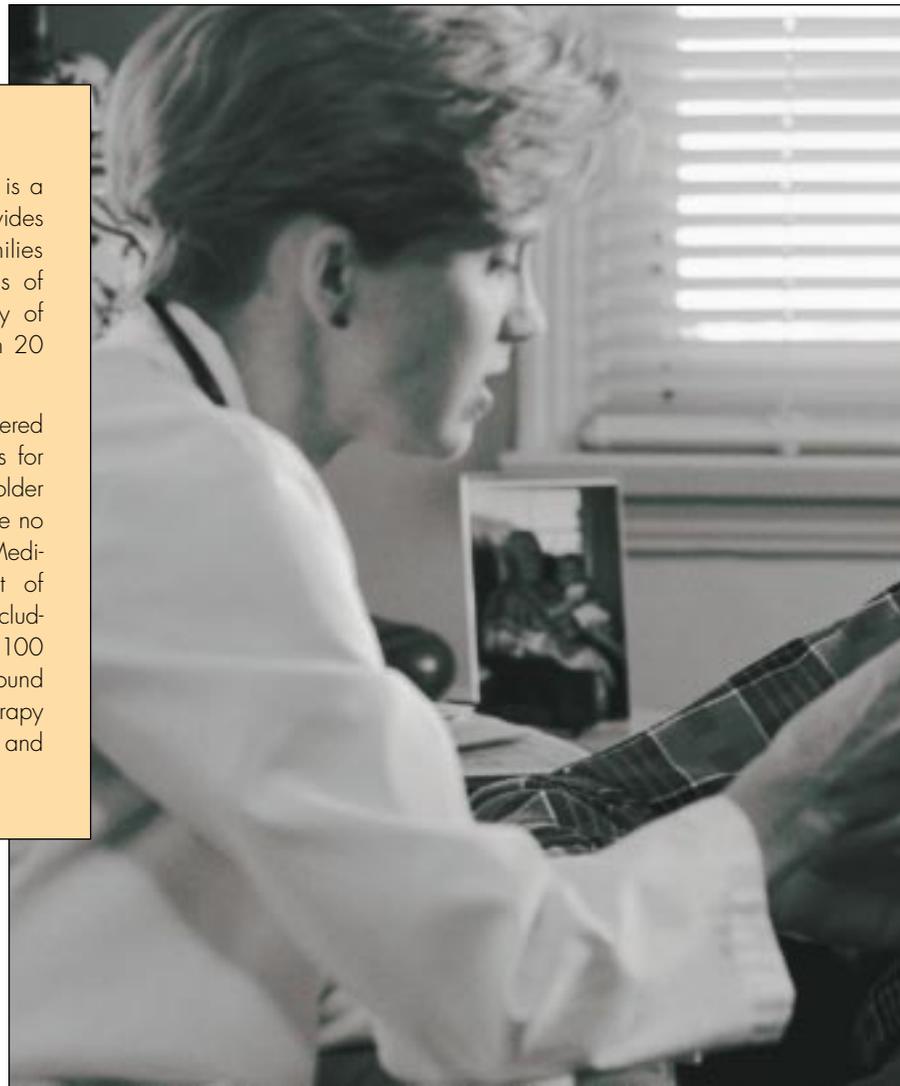
The federal government created the Medicaid program in 1965 through Title XIX of the federal Social Security Act. That same year, the California Legislature established the Medi-Cal program. Medi-Cal is administered by the California Department of Health Services (DHS) with federal oversight from the Centers for Medicare and Medicaid Services (CMS), formerly called the Health Care Financing Administration (HCFA).

Today's Medi-Cal program is different from the program established in 1965. Over time, the program has expanded to address unmet needs. For example, eligibility criteria have recently been expanded to make it easier for people with disabilities to return to work without losing their Medi-Cal coverage. The distribution of program expenditures has also changed over time, as services for aged, blind, and disabled beneficiaries have consumed a steadily increasing percentage of the total Medi-Cal budget.

Medi-Cal vs. Medicare

Medi-Cal, California's Medicaid program, is a joint federal and state program that provides health care coverage for low-income families and aged, blind, or disabled individuals of all ages. Medi-Cal covers a wide array of long-term care services through more than 20 different programs.

Medicare is a federally funded and administered program that pays for health care services for U.S. residents who are 65 years of age or older or who have long-term disabilities. There are no income eligibility criteria for the program. Medicare covers a much more limited set of long-term care services than Medi-Cal, including short-term nursing home care (for up to 100 days only), home health (limited to homebound individuals who need skilled nursing or therapy services on a part-time or intermittent basis), and hospice.



What Is Long-Term Care?

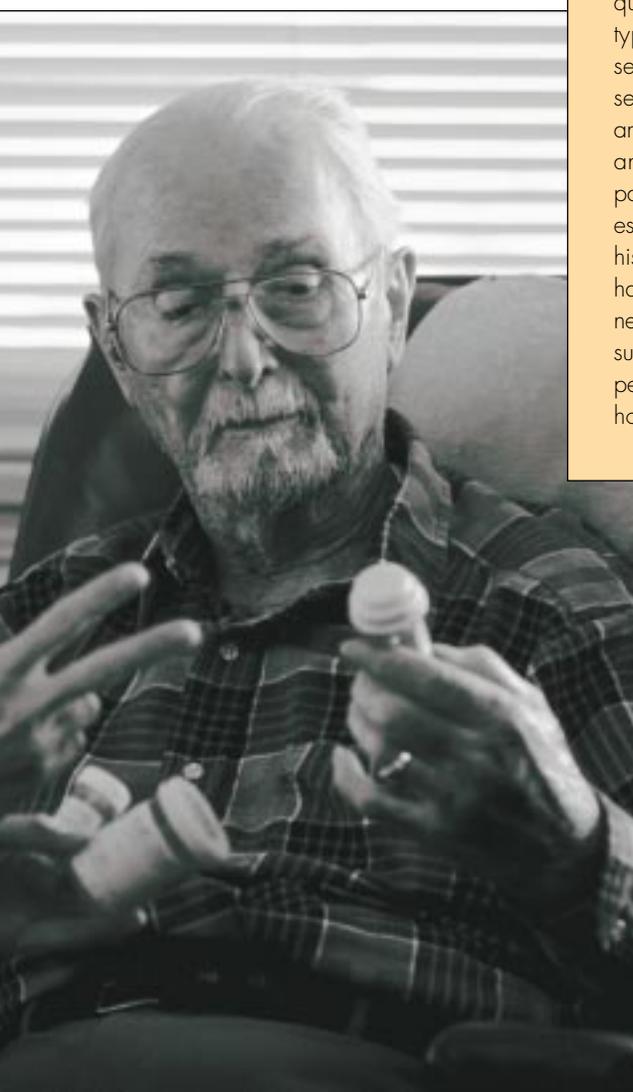
Many people associate the phrase *long-term care* with the care provided in a nursing home. In fact, long-term care encompasses much more than nursing home care. It refers to a wide range of services provided to elderly individuals and people with disabilities who need ongoing care due to chronic conditions. These services may include medical care, therapy, rehabilitation, case management, protective supervision, and assistance with “activities of daily living” such as eating, bathing, and toileting. Long-term care may also include assistance with “instrumental activities of daily living” such as meal preparation, shopping, and taking medication. Long-term care services are delivered by a variety of providers (medical professionals, trained workers, family, and friends) in a number of different settings (homes, community centers, and residential facilities).



Long-Term Care vs. Basic Health Services

The distinction between long-term care and basic health services is not always easy to make because many individuals use both types of services at the same time or frequently go back and forth between these types of services. Generally, basic health services include acute care, physician services, and other health maintenance and preventive health services. For example, an individual who suffers a stroke and becomes paralyzed will need immediate basic health services, such as hospital and physician care, to stabilize his or her medical condition. Once that individual has been medically stabilized, he or she is likely to need long-term care services on an ongoing basis, such as assistance with a catheter and help with personal services such as dressing, bathing, and household chores.

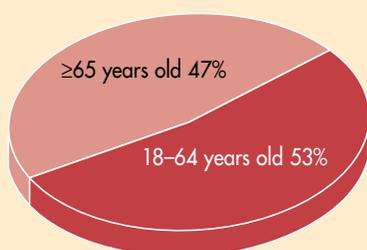
Long-term care services are delivered by a variety of providers (medical professionals, trained workers, family, and friends) in a number of different settings (homes, community centers, and residential facilities).



Who Needs Long-Term Care?

The need for long-term care services is commonly measured by the need for assistance with “activities of daily living” (ADLs) such as eating, dressing, and bathing, and “instrumental activities of daily living” (IADLs) such as preparing meals and taking medication. This need for assistance may stem from physical disability, developmental disability (such as mental retardation), chronic illness (such as HIV/AIDS or cancer), severe injury, progressive disease (such as multiple sclerosis), or the decrease in mobility and cognitive functioning that often comes with aging.

Figure 3. Non-Institutionalized Adults Needing Long-Term Care in the United States by Age, 1995



Total = 13.2 million

Source: M. P. LaPlante, C. Harrington, and T. Kang. *Estimating Paid and Unpaid Hours of Personal Assistance Services Provided to Adults Living at Home*. University of California, San Francisco, June 2000.

The population in need of long-term care is extremely diverse and requires a wide range of services and delivery options. This population is often divided into three groups:

- 1. Frail Elderly.** Rates of disability increase with age, and many frail elderly individuals have limitations in physical or cognitive functions that require ongoing assistance with health and personal care services.
- 2. Non-Elderly Adults with Disabilities.** These individuals often live many years with their disability, and may be raising children and working while needing ongoing care.
- 3. Children.** A substantial number of children with developmental disabilities and other disabling conditions require long-term care services.

The vast majority of people needing long-term care services receive them at home and/or at a non-residential community-based center. California data on this non-institutionalized population as a whole are not available. However, a national disability survey conducted between 1995 and 1997 found that an estimated 13.2 million adults in the United States who live

at home need help with one or more ADLs or IADLs.² Since California represents about 12 percent of the U.S. population, the number of non-institutionalized adults needing long-term care services in California is probably close to 1.6 million.

Nationally, the majority of non-institutionalized adults needing long-term care are female (65 percent), and nearly a quarter of them (24 percent) live alone. Fifty-three percent of those needing assistance are working-aged adults (18 to 64 years of age), while 47 percent are aged 65 and older. Data on the number of children living at home who need ongoing care are not available.

In addition to the non-institutionalized population, many people requiring long-term care reside in a nursing home, residential care facility, intermediate care facility, or state hospital. Demographic data on this population as a whole are not available.

Who Is Eligible for Medi-Cal Long-Term Care?

To be eligible for Medi-Cal's long-term care services, a family or individual must meet Medi-Cal's requirements for income, assets (real or personal property), residence, and citizenship. Medi-Cal eligibility is extremely complicated, but most of the eligibility categories relevant to long-term care can be grouped into one of two broad categories: (1) those who are categorically needy and therefore automatically qualify for Medi-Cal; and (2) those who are medically needy and may become eligible by incurring medical expenses each month.³ These categories include some low-income Medicare beneficiaries who are also eligible for Medi-Cal.

Categorically Needy

Low-income individuals who receive cash assistance through public programs like CalWORKs or Supplemental Security Income (SSI) automatically qualify for Medi-Cal. Other categorically eligible groups are those who meet appropriate financial eligibility criteria but are not receiving cash assistance, including individuals with specific health needs (e.g., dialysis); individuals who are in a long-term care institution; or individuals who would require the level of care provided in a hospital or nursing home if not for the provision of home and community-based long-term care services.

To be eligible for Medi-Cal's long-term care services, a family or individual must meet Medi-Cal's requirements for income, assets (real or personal property), residence, and citizenship.

Assets Rules

A family's assets help determine financial eligibility for Medi-Cal. Assets are considered to be the things a family owns, such as a car, a bank account, or a home. However, if a family lives in its home, the home cannot be counted toward the asset limit. There are limits on the value of countable assets a family can own and still qualify for Medi-Cal coverage. These limits vary by eligibility category and family size, but generally start at \$2,000 for one person.

Special Medi-Cal rules have been created to protect the assets of a spouse when his or her partner has been institutionalized in a nursing home or hospital for an extended period. In California, the spouse of an institutionalized person is allowed to keep a maximum of \$87,000 (as of January 1, 2001). This amount can be increased under certain circumstances—through a Fair Hearing or by a court order for support of the non-institutionalized spouse. The institutionalized partner is allowed to keep an additional \$2,000. These spousal protections are also applied to several of the home and community-based waiver programs (described on page 17), but they do not apply to individuals receiving any other Medi-Cal long-term care services.

The transfer of assets for less than fair market value, by an individual or spouse, within 30 months of applying for Medi-Cal is not allowed. Such action can result in nonpayment for nursing facility services for a period of time directly related to the value of the asset transferred. During this time, the individual is still eligible for all other Medi-Cal services.



Who Is Eligible for Medi-Cal Long-Term Care?

Medically Needy

California's Medically Needy program extends Medi-Cal eligibility to individuals with high medical expenses who may have too much income or property to qualify as categorically needy. However, they must meet the other requirements of the cash assistance programs (e.g., the SSI requirements of age, blindness, or disability) to be eligible for Medi-Cal. Those who receive

Supplemental Security Income (SSI)

SSI provides cash assistance to low-income aged, blind, and disabled individuals. Individuals who qualify for SSI are automatically eligible to receive Medi-Cal, and therefore financial eligibility for Medi-Cal is in large part tied to the eligibility rules for SSI. To be eligible for SSI, an individual generally must have an income below \$500 per month and countable assets of not more than \$2,000 (\$3,000 for a married couple). In 1998 more than 1 million aged, blind or disabled individuals in California received SSI. More than 7 percent (78,861) of those recipients were children under the age of 18.⁶

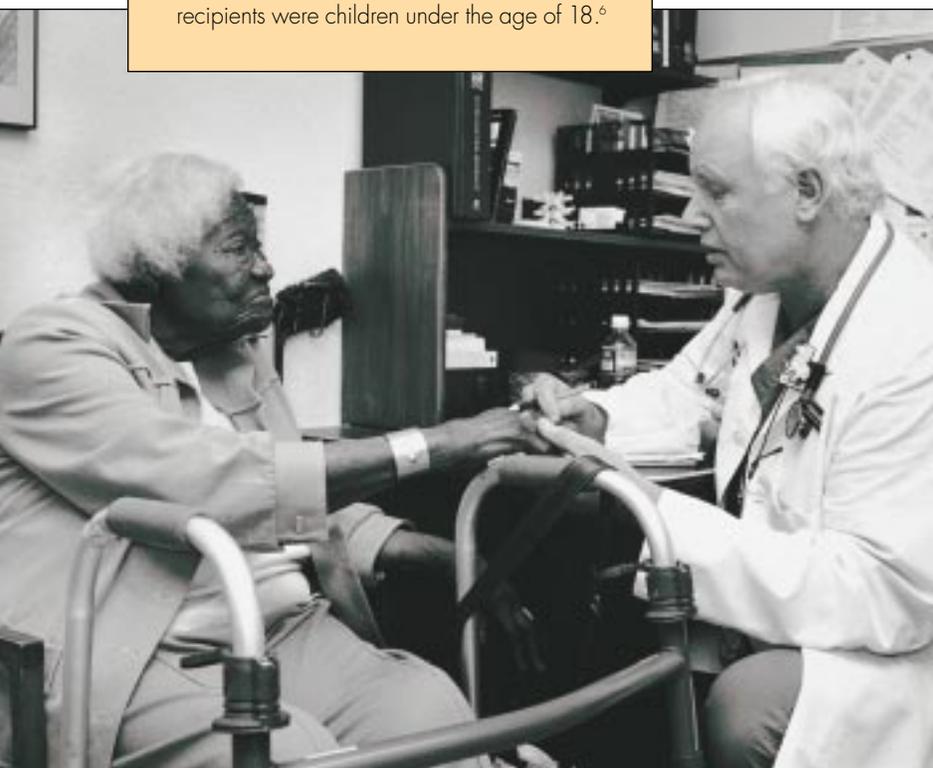
Medically Needy Medi-Cal may be eligible with or without a "share of cost." Sometimes called "income spend down," share of cost refers to the amount of health care expenses a recipient must incur each month before Medi-Cal begins to provide assistance. Whether or not a recipient has a share of cost, and how much it is, is determined by monthly family income.⁴ In March 2000 nearly 64,000 Medi-Cal long-term care beneficiaries had a share of cost. The average share of cost amount was approximately \$712 per month.⁵

Dual Eligibles

Some low-income individuals who are entitled to Medicare may also qualify for Medi-Cal because they are categorically or medically needy.

For these "dual eligibles," Medi-Cal helps pay for out-of-pocket Medicare costs like premiums and deductibles. Medi-Cal may also pay for benefits not covered under the Medicare program, including extended nursing home stays. In such cases, payments for any services covered by Medicare are made before any payments by Medi-Cal.

Individuals who qualify for Supplemental Security Income (SSI) are automatically eligible to receive Medi-Cal.



How Is Long-Term Care Funded and Administered?

Funding

Long-term care services in California are funded through both public and private sources. Public sources of funding include Medi-Cal, Medicare, the California State General Fund, federal

veterans' programs, federal and state aging programs, and county funds. Private sources include private health insurance, long-term care insurance policies, and out-of-pocket payments by individuals and their families. Nationally, public funds account for approximately 60 percent of all long-term care expenditures, while private payments account for the remaining 40 percent.⁷

Formal vs. Informal Care

In addition to the formal long-term care services paid for by Medi-Cal, Medicare, private insurance, and out-of-pocket payments, a large number of individuals receive informal or unpaid care in their homes from family members, friends, and neighbors. In fact, the California Health and Human Services Agency estimates that unpaid family members provide nearly 80 percent of all long-term care services delivered in the home and community.⁸

In FY 1998 Medi-Cal paid for 42 percent (\$5 billion) of all public long-term care expenditures in California. The Medi-Cal program, including its long-term care services, is jointly funded by the federal (51 percent) and California

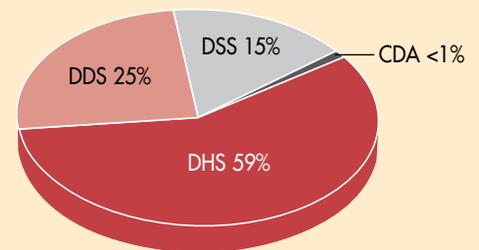
state (49 percent) governments. In FY 1998 payments for long-term care services represented approximately 27 percent of the Medi-Cal program's total budget of \$18.5 billion.

Administration

The Medi-Cal program is administered by the California Department of Health Services (DHS) with federal oversight from the Centers for Medicare and Medicaid Services (CMS), formerly called the Health Care Financing Administration (HCFA). DHS has the discretion, within federal guidelines, to decide who is eligible for Medi-Cal, what services are covered, how to administer the program, and what the payment rates are for different services.

Fifty-nine percent of Medi-Cal's long-term care expenditures goes to programs that are directly administered by DHS. However, Medi-Cal funds are also channeled into long-term care programs that are administered by other departments, including the California Department of Social Services (DSS), Department of Aging (CDA), and Department of Developmental Services (DDS). In addition, California's 58 counties play a significant role in operating many of Medi-Cal's long-term care programs, including the In-Home Supportive Services program. More detailed information about the administration and funding streams for individual long-term care services is provided in the next section.

Figure 4. Medi-Cal Long-Term Care Expenditures by Department, FY 1998



Total = \$5 billion

Source: California Health and Human Services Agency.

Which Services Are Covered by Medi-Cal?

When most people think of long-term care, they think first about nursing homes. Medi-Cal does play a significant role in covering nursing home care, paying for 64 percent of California's

long-term nursing home days at a cost of more than \$2 billion every year. However, Medi-Cal also covers a wide array of additional long-term care services that are provided in a variety of institutional and community-based settings.

By federal law, all state Medicaid programs are required to provide a basic package of benefits. This required benefits package includes long-term care services such as nursing home care for people aged 21 or over, and home health care for people who would otherwise be eligible for nursing home care. In addition, states may choose to provide up to 34 optional services. California offers 32 of these optional services through its Medi-Cal program, including long-term care services such as expanded home health care, personal care services, intermediate care facilities for people with developmental disabilities, nursing facility services for children under age 21, adult day health care, transportation services, and rehabilitation and physical therapy.

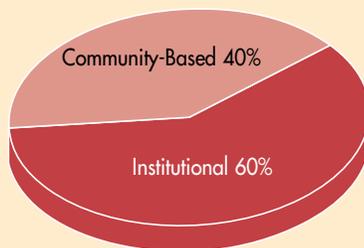
This section describes the long-term care services funded by Medi-Cal in the following areas:

- Nursing homes
- In-Home Supportive Services
- Home health and hospice
- Adult day health care
- Home and Community-Based Services Waiver programs
- Services targeted to people with developmental disabilities
- Services targeted to children
- Innovative models

Institutional Care vs. Home and Community-Based Services

Institutional long-term care is provided in places like nursing homes and intermediate care facilities. Home and community-based services, on the other hand, are provided in an individual's own residence, or in other settings such as adult day health care centers, to people who have an ongoing need for assistance but are able to remain in their own homes. Although a third more individuals used home and community-based services in FY 1998 than used institutional services, institutional services accounted for 60 percent of Medi-Cal's long-term care expenditures.

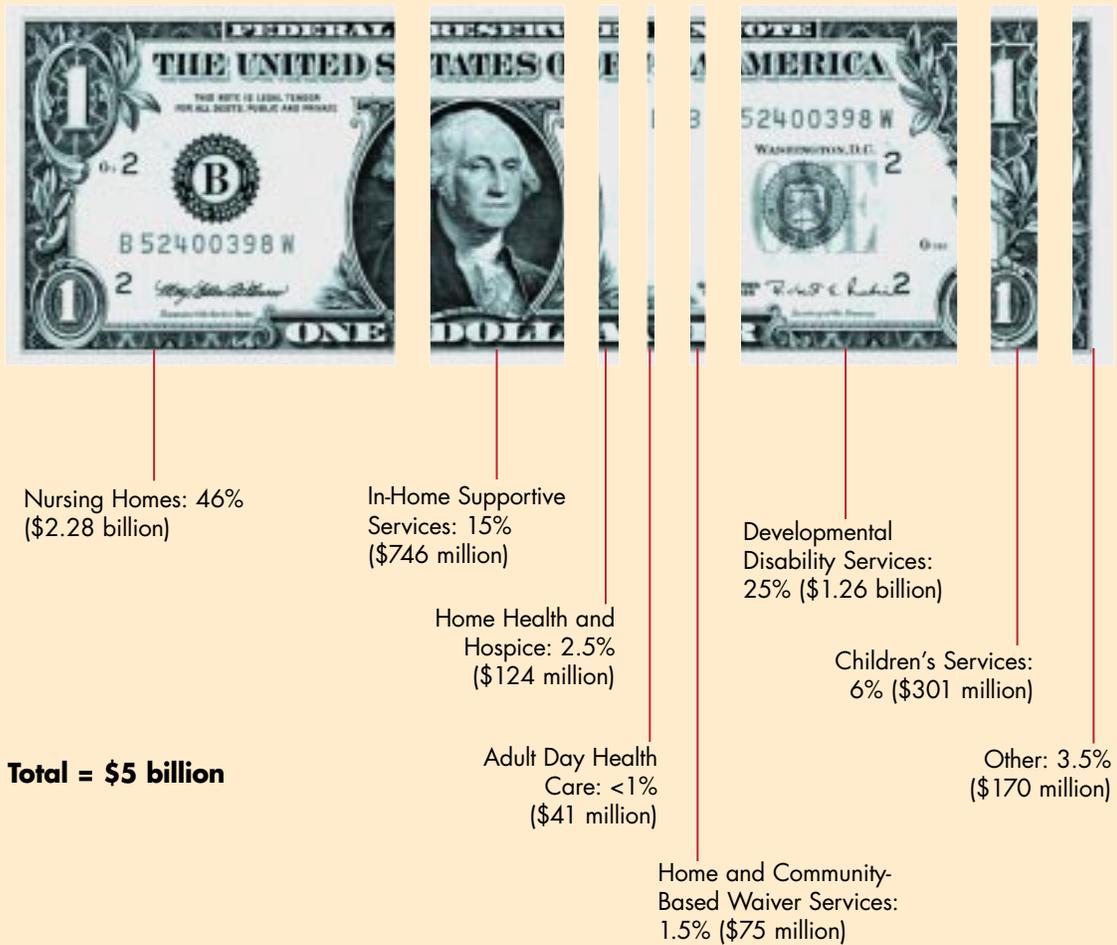
Figure 5. Medi-Cal Long-Term Care Expenditures: Institutional vs. Community-Based, FY 1998



Total = \$5 billion

Source: California Health and Human Services Agency.

Figure 6. Medi-Cal Long-Term Care Expenditures by Service, FY 1998



Source: California Health and Human Services Agency.

Which Services Are Covered by Medi-Cal?

Nursing Homes

Services

Nursing homes provide institutional care on a 24-hour basis to the frail elderly, the chronically ill, individuals recovering from a serious illness or accident, and people with disabilities. There are two types of nursing homes: Nursing Facilities (NFs) and Skilled Nursing Facilities (SNFs).⁹ NFs provide inpatient care to residents who have a recurring need for supervision and supportive care but do not require continuous skilled nursing care. NF services include assistance with activities

of daily living, monitoring and assistance with medication, and rehabilitation services. SNFs provide 24-hour inpatient care to patients whose primary need is extensive skilled nursing care. At a minimum, SNFs must provide physician care, skilled nursing, dietary assistance, pharmaceutical services, and an activity program.

Funding and Administration

Nursing homes are funded through a variety of sources, including Medi-Cal, Medicare (for short-term stays), private insurance, and out-of-pocket payments by individuals and their families. In California, Medi-Cal pays for approximately 64 percent of all nursing home days. Nursing homes that wish to receive Medi-Cal funding must be licensed and certified by the California Department of Health Services.

Providers

California has approximately 1,450 nursing homes with a total of 132,000 beds.¹⁰ As of February 2000, some 1,169 of those nursing homes were certified to provide services to Medi-Cal beneficiaries.¹¹ Nursing homes may be either freestanding or hospital-based. Roughly 18 percent of California's nursing homes are hospital-based facilities, whose residents typically have shorter stays than residents of freestanding facilities.

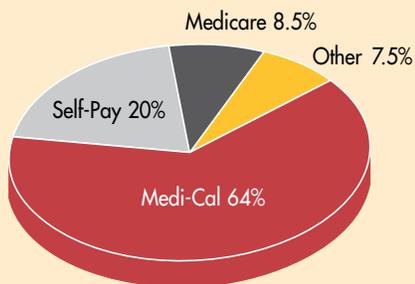
Beneficiaries and Expenditures

In 1998 an average of 65,000 Medi-Cal beneficiaries resided in a freestanding nursing home on any given day at a total annual cost of \$2 billion (or \$31,028 per beneficiary).¹² An additional 83,000 beneficiaries received services through hospital-based facilities at an annual cost of \$274 million, but many of these visits were less than three weeks and thus not considered to be long-term care.¹³

Key Issues

- The quality of California's nursing homes has been criticized by the U.S. General Accounting Office, which found in 1998 that nearly one in three nursing homes had serious or potentially life-threatening care problems.¹⁴ California nursing homes had twice as many reported deficiencies in 1998 as the U.S. average.
- Medi-Cal payment rates for nursing homes are a concern for many providers: In 1998 Medi-Cal's average freestanding nursing home daily payment rate was \$83.12, compared to a national average of \$95.72.¹⁵

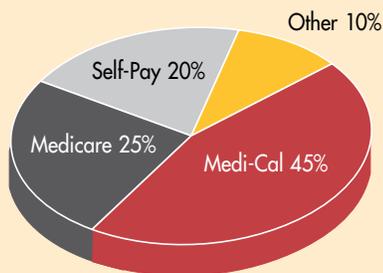
Figure 7. Total Nursing Home Days in California by Payer, CY 1998



Total = 39.8 million

Source: Office of Statewide Health Planning and Development. *Aggregate Long-Term Care Facility Financial Data Summary*. Sacramento, CA: reporting period December 31, 1997, through December 30, 1998.

Figure 8. Total Nursing Home Expenditures in California by Payer, CY 1998



Total = \$5.05 billion

Source: Office of Statewide Health Planning and Development (OSHPD). *Aggregate Long-Term Care Facility Financial Data Summary*. Sacramento, CA: reporting period December 31, 1997, through December 30, 1998. Net revenues calculated by OSHPD from gross revenues.

In-Home Supportive Services

Services

The In-Home Supportive Services (IHSS) program helps to pay for personal care and chore services for elderly individuals and people with disabilities who need assistance to remain safely in their own homes. Services range from domestic (e.g., housekeeping and meal preparation) to personal care (e.g., assistance with toileting, bathing, and mobility) to paramedical (e.g., wound care and assistance with medications). Individuals may receive a maximum of 283 hours per month of IHSS services.

Funding and Administration

The IHSS program is funded through Medi-Cal, the State General Fund, and county funds. Medi-Cal covers IHSS services through the Personal Care Services Program (PCSP). Under the PCSP benefit, Medi-Cal paid for 70 percent of the total cost of all services provided under the IHSS program in FY 1998. Unlike other Medi-Cal-funded programs, county funds pay for part of the PCSP program. Funding for the PCSP program is shared by the federal government (51 percent), the State General Fund (32 percent), and county funds (17 percent).

IHSS is administered at state and county levels. At the state level, the California Department of Social Services develops IHSS regulations, monitors county IHSS programs, and oversees the data and payroll systems. At the county level, each of California's 58 counties is responsible for the daily tasks of implementing and delivering the IHSS program, including establishing eligibility, assessing the need for and authorizing IHSS services, and ensuring that beneficiaries receive services in a timely manner.

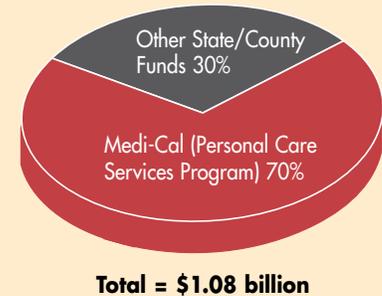
Providers

The majority of IHSS services are delivered by independent providers. Independent providers are hired individually by the IHSS participant and may include friends or family members. Nearly half of all independent providers are family members; however, IHSS services provided by the parent or spouse of the client are not covered by the Medi-Cal PCSP program, but are paid for with other state and county funds. In 1998 there were approximately 170,000 independent providers in California serving 95 percent of IHSS participants.¹⁶ The remaining 5 percent of IHSS participants received services from home care agencies with a county contract or directly from county employees.

Beneficiaries and Expenditures

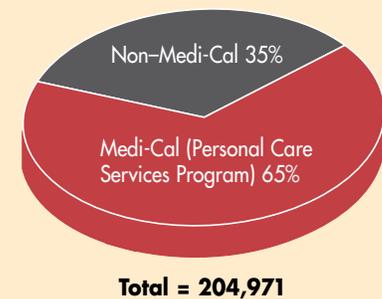
California's IHSS program is the largest home and community-based care program in the country, serving an average of 205,000 individuals each month with a total program cost of more than \$1 billion in FY 1998. Medi-Cal paid for 70 percent (\$746 million) of annual IHSS expenditures and covered 65 percent (134,277) of IHSS participants.¹⁷

Figure 9. Annual IHSS Expenditures by Payer, FY 1998



Source: California Department of Social Services.

Figure 10. Average Monthly IHSS Participants by Program, FY 1998



Source: California Department of Social Services.

Which Services Are Covered by Medi-Cal?

The In-Home Supportive Services (IHSS) program helps to pay for personal care and chore services for elderly individuals and people with disabilities who need assistance to remain safely in their own homes.

Key Issues

- Low reimbursement rates for independent IHSS workers (minimum wage) and a lack of health insurance and other benefits have been reported to result in high turnover rates. However, a 1999 state law (AB 1682) mandated that all counties must establish an entity to serve as the employer of record for independent IHSS providers by January 1, 2003, in order to provide a mechanism for collective bargaining over wages, hours, and benefits.
- Consumer advocates have raised concerns that the number of hours of care IHSS workers are authorized by the program to provide are often not sufficient to meet the needs of many beneficiaries. This situation may lead to inadequate care and costly hospital visits or nursing home stays.



Home Health and Hospice

Services

Home health care allows professional nursing and therapy services that are usually provided in a hospital or other health facility to be provided in the home. Medi-Cal covers home health services related to prevention, treatment, rehabilitation, and maintenance. Specifically, services may include nursing, personal care, physical and speech therapy, medical social services, and dietary counseling.

Hospice care is designed to enable patients with a terminal illness to live comfortably until their death. Hospice emphasizes pain relief and symptom control rather than aggressive curative treatments. The Medi-Cal hospice program provides physician and nursing services, physical and speech therapy, home health services, counseling, and pharmaceuticals. These services may be provided in the home, a hospice facility, or a nursing home.

Funding and Administration

Both home health and hospice care are optional Medicaid benefits that California has chosen to include as part of its Medi-Cal benefits package. In addition to Medi-Cal, both programs also receive funding through Medicare, private insurance, and out-of-pocket payments by individuals and their families. Medicare pays for the majority of publicly funded home health and hospice services in California (93 percent), while Medi-Cal pays for a much smaller share (7 percent). The Medi-Cal home health and hospice programs are administered by the California Department of Health Services.

Providers

In 1998 California had 1,101 licensed home health agencies, of which 711 were certified to participate in Medi-Cal. There were 36 licensed hospice agencies in 1998.¹⁸

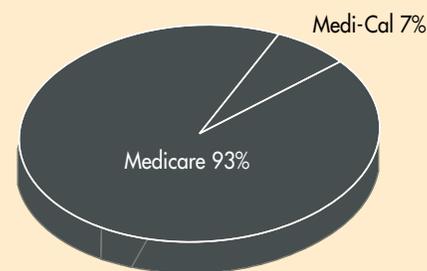
Beneficiaries and Expenditures

In CY 1998 Medi-Cal provided home health services to an average of 10,084 beneficiaries each month at a total annual cost of more than \$92 million, and provided hospice to an average of 1,125 beneficiaries each month at an annual cost of nearly \$32 million.¹⁹ In total, Medi-Cal spent more than \$124 million to provide home health and hospice services in 1998. In contrast, Medicare spent \$1.7 billion on these services in California in the same time period.²⁰

Key Issues

- Recent changes in Medicare that limit reimbursement and set new restrictions on utilization have resulted in the closure of some home health agencies in California. The ratio of home health agencies per 1,000 population aged 65 and over in California was 0.30 in 1998, which was lower than the U.S. ratio of 0.47.²¹

Figure 11. Home Health and Hospice Expenditures by Payer, CY 1998*



Total = \$1.8 billion

Sources:

1. California Department of Health Services, Medical Care Statistics Section. *Medi-Cal Services and Expenditures Month-of-Payment Report for January 1998 through December 1998*. Sacramento, CA: January 30, 1999.
2. U.S. Department of Health and Human Services. *Health Care Financing Review: Statistical Supplement, 1999*. Washington, D.C.: November 1999.

*Does not include private insurance or out-of-pocket payments.

Which Services Are Covered by Medi-Cal?

Adult Day Health Care

Services

Adult day health care (ADHC) provides a variety of health, therapeutic, and social services for frail elderly and functionally impaired adults and is designed to delay or prevent inappropriate nursing home placements. ADHC services include: medical services; nursing services; physical, occupational, and speech therapies; psychiatric and psychological services; social services; recreational and social activities; hot meals; nutritional counseling; laundry; bathing; and transportation to and from the ADHC center.

Funding and Administration

ADHC is funded by Medi-Cal and is administered by the California Department of Aging under an interagency agreement with the Department of Health Services. The Department of Aging works with 33 Area Agencies on Aging that are responsible for the coordination of ADHC services at the local level. Adult day health care centers are licensed by the Department of Health Services and are certified for Medi-Cal reimbursement by the Department of Aging.



Providers

As of June 2001, there were more than 200 ADHC centers in California.²² ADHC centers should not be confused with the more than 600 adult day care centers that are not funded by Medi-Cal and provide primarily socialization and recreational services in contrast to the nursing, medical, and rehabilitation services that are provided by ADHC centers.

Beneficiaries and Expenditures

In CY 1998 an average of 4,009 Medi-Cal beneficiaries used adult day health care services each month, at a total annual cost of \$41 million.²³

Key Issues

- The ADHC program has expanded rapidly during the past year and a half. This rapid growth has caused a number of problems, including an increase in the number of providers without a background in health or social services; an increase in centers targeting ethnic populations coupled with a shortage of bilingual staff; and concerns about the eligibility screening processes being used by these new centers.
- Some adult day health care providers have expressed frustration that insufficient daily payment rates prevent their centers from offering extended daytime hours. These limited hours can present problems for individuals who need a place to go during the day while their primary caregiver is at work.

Home and Community-Based Service Waivers

The home and community-based service (HCBS) waiver program was established by the federal government in 1981. The goal of the waiver program is to allow states to provide community-based care alternatives to institutional care by waiving certain Medicaid statutes and regulations. HCBS waiver programs are targeted to individuals who would otherwise need to be in an institution (e.g., a nursing home or hospital).²⁴

California has six Medi-Cal HCBS waivers: Nursing Facility (NF), Model-NF, In-Home Medical Care (IHMC), AIDS, Multipurpose Senior Services Program (MSSP), and Developmentally Disabled (DD). The first five waivers are discussed in this section, and the DD waiver is discussed in the next section.

Table 1. Medi-Cal HCBS Waivers, FY 1998

	NF	Model-NF	IHMC	AIDS	MSSP
Population Served	Individuals with disabilities	Children with disabilities	Individuals with disabilities who need acute care	Individuals with mid- to late-stage HIV/AIDS	Frail elderly
Services Included	Case management, skilled nursing, therapy services, and personal care services	Case management, skilled nursing, therapy services, and personal care services	Case management, skilled nursing, and therapy services	Case management, skilled nursing, attendant care, counseling, home-delivered meals, and transportation	Case management and a range of other home and community-based services and equipment
Funding	Medi-Cal	Medi-Cal	Medi-Cal	Medi-Cal	Medi-Cal
Administration	DHS In-Home Operations	DHS In-Home Operations	DHS In-Home Operations	DHS Office of AIDS	Department of Aging
Providers	Licensed and certified home health agencies	Licensed and certified home health agencies	Licensed and certified home health agencies	Local health departments, community-based organizations, home health agencies, and others	Local agencies provide case management and contract with private providers for other services
Geographic Area	Statewide	Statewide	Statewide	Available in 43 counties	Available nearly statewide
Beneficiaries*	348	24	243	2,511 [†]	7,890
Enrollment Cap	472	110	200	2,900 [†]	8,314
Expenditures	\$17 million	\$564,507	\$24.5 million	\$12.5 million [†]	\$20.7 million

Sources: 1. Department of Health and Human Services, Health Care Financing Administration. *Annual Report on Home and Community-Based Services Waivers, Form HCFA-372*. Washington, D.C.: reporting period July 1, 1997, through June 30, 1998.

2. California Department of Health Services, Office of AIDS. Personal communication, Jan Vick, December 4, 2000.

*Annual unduplicated counts.

[†]CY 1998 data.

Which Services Are Covered by Medi-Cal?

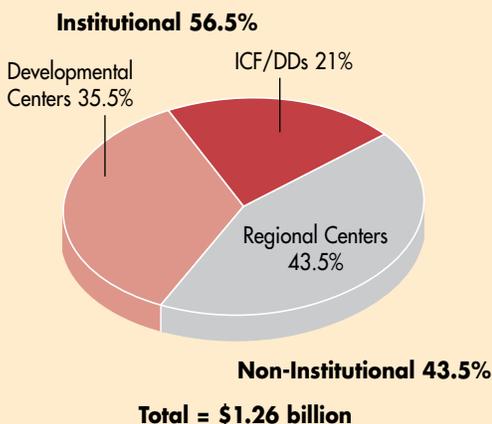
Key Issues

- Despite recent increases in enrollment caps for many of the HCBS waiver programs, they continue to have a limited number of slots and in some cases have long waiting lists. In December 2000, for example, the Nursing Facility and Model-NF waiver programs had waiting lists of approximately 160 and 50 respectively. Further, staff from the Department of Aging estimate that the MSSP program is only able to serve one in five people who might benefit from the program.²⁵
- The recent U.S. Supreme Court decision of *Olmstead v. L.C.* may increase interest in expanding and adding new HCBS waivers for California. This decision requires states to provide community-based alternatives to institutionalization for disabled individuals with long-term care needs.

Services Targeted to People with Developmental Disabilities

The California Department of Developmental Services administers several programs targeted specifically to individuals with developmental disabilities (DD). A developmental disability is a severe and chronic disability originating before the 18th birthday that stems from mental retardation, cerebral palsy, epilepsy, autism, or a disabling condition found to be closely related to mental retardation.²⁶ In addition to qualifying for the programs described below, people with DD may also qualify for other long-term care services described in this report.

Figure 12. Medi-Cal Expenditures on DD Services, FY 1998



Sources:

1. California Department of Health Services, Medical Care Statistics Section. *Medi-Cal Services and Expenditures Month-of-Payment Report for January 1998, through December 1998*. Sacramento, CA: January 30, 1999.
2. California Department of Developmental Services. *Fiscal Year 1998-99 Budget Act: Funding Summary*. Sacramento, CA: August 21, 1998.

Services

Services for people with developmental disabilities are offered both in institutions and in the community. Institutions, including privately operated Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs) and state-run Developmental Centers, provide medical care, nursing, and developmental training to individuals who require 24-hour supervision in a structured environment. ICF/DDs are a type of nursing home for individuals with developmental disabilities, and Developmental Centers are state-administered programs that are certified as ICF/DDs.

Community-based services are provided through Regional Centers and include assessments, case management, counseling, education, monitoring of care programs, and a full spectrum of treatment and habilitation services that are purchased by Regional Centers from community providers.

Funding and Administration

The Developmental Center program is funded through Medi-Cal, out-of-pocket payments, Medicare, and the State General Fund. Developmental Centers are overseen by the Developmental Centers Program in the California Department of Developmental Services. Private ICF/DDs are funded through Medi-Cal and licensed and certified by the Licensing and Certification Division of the California Department of Health Services.

Regional Centers are funded through Medi-Cal, the State General Fund, and other state agencies. Medi-Cal funding is provided primarily through a home and community-based services (HCBS) waiver program. In addition, case management is provided through the Department of Health Services' Medi-Cal Targeted Case Management program, and Medi-Cal general funds are used for other Regional Center services. The Regional Centers are under contract with the California Department of Developmental Services and are operated by community boards of directors.

Table 2. Medi-Cal Beneficiaries, Expenditures, and Providers, 1998*

	Medi-Cal Beneficiaries	Medi-Cal Expenditures (in millions)	Number of Facilities	Geographic Area
Developmental Centers	3,857 [†]	\$448.9	5	Los Angeles, Orange, Santa Clara, Sonoma, and Tulare Counties
ICF/DDs	5,931 [†]	\$263	1,026	Statewide
Regional Centers			21	Statewide
Medi-Cal Waiver	34,212 [‡]	\$424.3		
Targeted Case Management	46,176 [‡]	\$83.5		
Other Medi-Cal	NA	\$44.4		

Sources: 1. California Department of Health Services, Medical Care Statistics Section. *Medi-Cal Services and Expenditures Month-of-Payment Report for January 1998 through December 1998*. Sacramento, CA: January 30, 1999.
 2. California Department of Developmental Services. *Fiscal Year 1998–99 Budget Act: Funding Summary*. Sacramento, CA: August 21, 1998.
 3. Department of Health and Human Services, Health Care Financing Administration. *Annual Report on Home and Community-Based Waivers, Form HCFA-372*. Washington, D.C.: reporting period October 1, 1997, through September 30, 1998.

*The expenditures presented in this table represent only a portion of DDS's total expenditures.

[†]Average monthly estimate.

[‡]Annual unduplicated count.

Key Issues

- Despite a recent effort to de-institutionalize individuals with developmental disabilities, more than 10,000 people continue to live in Developmental Centers and ICF/DDs. The Developmental Center program consumes more than 35 percent of Medi-Cal's total spending on DD programs to support less than 5 percent of its DD population.
- In 1998 CMS (formerly HCFA) placed an enrollment freeze on the Medi-Cal HCBS waiver for Regional Centers due to quality and management problems. However, by the year 2000, CMS removed 12 Regional Centers from the enrollment freeze and granted partial removal for the remaining centers. One lingering concern is that there may not be sufficient funds and services to ensure high quality of care in the waiver program.

Which Services Are Covered by Medi-Cal?

Services Targeted to Children

With the exception of a few programs, children may qualify for most of the long-term care services described in this report. In addition, DHS administers two programs targeted specifically at children with special health care needs: California Children Services (CCS) and the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program.

Services

CCS provides treatments and specialized medical care, case management, and rehabilitative and therapy services for children under age 21 who have serious physical disabilities. Eligibility is based on income and for those with qualifying conditions such as genetic disease, cancer, severe injury, chronic illness, or disability.

EPSDT is primarily a preventive health program for Medi-Cal–eligible children from birth to age 21. However, EPSDT also provides supplemental long-term care services such as in-home skilled nursing services and pediatric day health services for medically fragile children.

Funding and Administration

Medi-Cal pays for CCS services for children who are enrolled in Medi-Cal. CCS services for children who are not eligible for Medi-Cal are paid for through other state and county funds. EPSDT is funded entirely through Medi-Cal. Both CCS and EPSDT are administered by the Department of Health Services.

Providers

CCS services are provided in large part by “special care centers” located in children’s hospitals and academic medical centers. These centers are composed of multidisciplinary, multispecialty providers organized around a specific condition. EPSDT supplemental nursing services in the home are provided by licensed vocational nurses or a higher level of professional nurse when medically necessary.

Beneficiaries and Expenditures

In CY 1998 an average of 21,642 children received CCS services each month, at a total annual cost of \$602 million.²⁷ While specific data on the long-term care component of these costs were not available from the state, it is estimated that roughly 50 percent of beneficiaries (10,821) and expenditures (\$301 million) were related to long-term care. The EPSDT supplemental (long-term care) program served a monthly average of 48 beneficiaries at a total annual cost of \$378,314.²⁸

Key Issues

- Although the state is establishing a new statewide eligibility system as part of an automation effort for CCS case management and claims payment systems, methods for early identification of children eligible for CCS and for the coordination of their care remain a challenge.
- CCS has historically operated on a fee-for-service basis. However, 1994 state legislation authorized a limited number of pilot projects to test the feasibility and cost-effectiveness of treating CCS conditions for Medi-Cal beneficiaries in managed care models. Due to a lack of state funds, however, these pilot projects have not been launched.

Innovative Models

- **Program of All-inclusive Care for the Elderly (PACE).** PACE, a nationwide model which pools Medicaid, Medicare, and private dollars, is a fully integrated managed care system for frail elderly and disabled people eligible for nursing homes. The program provides comprehensive medical, social, and long-term care services in day health centers, homes, hospitals, and nursing homes. Most services are coordinated out of PACE sites (nonprofit adult day health centers) where a multidisciplinary team of specialists provides case management and other services. There are four PACE sites in California: Los Angeles, Oakland, Sacramento, and San Francisco. In FY 1998 PACE served an average of 930 Medi-Cal beneficiaries each month at a total annual cost of \$24.7 million.²⁹
- **Senior Care Action Network (SCAN) Health Plan.** SCAN is one of four health plans in the United States participating in a federal demonstration project designed to test the integration of acute care services and a limited set of long-term care services. To be eligible for SCAN, individuals must reside in Los Angeles, Orange, Riverside, or San Bernardino Counties, and must qualify for Medicare. (Unlike PACE, SCAN participants do not need to be nursing home eligible.) For individuals who qualify for both Medicare and Medi-Cal, services are paid for through the Medi-Cal program. In FY 1998 SCAN served an average of 1,003 Medi-Cal beneficiaries each month at a total annual cost of \$5.8 million.³⁰
- **California Partnership for Long-Term Care.** This public-private partnership between Medi-Cal and private long-term care insurance companies provides the opportunity for middle-income consumers to purchase high-quality, affordable, and private long-term care insurance rather than depend on Medi-Cal to pay for their long-term care. The California Partnership is designed to reduce reliance on Medi-Cal by avoiding or significantly delaying the need to enroll in the Medi-Cal program. As of December 1998, a total of 8,552 Californians held Partnership insurance policies. The program's total budget in FY 1998 was \$1.2 million, of which Medi-Cal paid \$524,835.³¹
- **County Organized Health Systems (COHS).** COHS is a county-based Medi-Cal managed care model that provides a full range of Medi-Cal acute and long-term care services in Monterey, Napa, Orange, Santa Barbara, Santa Cruz, Solano, and Yolo Counties. The COHS in San Mateo County does not currently cover long-term care facility charges, but does pay for medical services for members who reside in such facilities. The long-term care portion of the COHS budget is estimated to be 16 percent of total expenditures, or roughly \$110 million in FY 1998.³²



- **Medical Case Management and Targeted Case Management.** The California Department of Health Services offers two case management programs for Medi-Cal beneficiaries. Medical Case Management targets individuals with chronic and/or catastrophic conditions who require medically intensive services. Targeted Case Management coordinates care for a defined group of Medi-Cal beneficiaries to assist them in gaining access to needed medical, social, educational, and other services. In FY 1998 the Medical Case Management program provided services to an average of 2,163 beneficiaries each month at a total annual cost of nearly \$16 million,³³ and the Targeted Case Management program spent \$14.4 million on non-developmental disability clients.³⁴
- **Assisted Living Demonstration Project.** AB 499, approved by the governor in September 2000, authorizes a Medi-Cal assisted living demonstration project. Assisted living facilities offer meals, health and personal services, and 24-hour supervision in a residential setting, and are appropriate for individuals who do not require the intensive medical and nursing care provided in a nursing home. AB 499 requires the Department of Health Services to develop a federal waiver program to test the efficacy of an assisted living benefit in the Medi-Cal program by January 1, 2003.

Related Services

Medi-Cal also provides a number of services that are not always considered to be long-term care. These services include non-emergency medical transportation, durable medical equipment, prosthetics, hearing aids, therapy, and dialysis. Though not necessarily long-term care services, these Medi-Cal benefits are often provided to individuals with chronic long-term care needs.



Table 3. Medi-Cal Long-Term Care Beneficiaries and Expenditures, FY 1998

	Medi-Cal Beneficiaries	Medi-Cal Expenditures
Department of Health Services		
Institutional Services		
Nursing Facilities—Freestanding	64,748 ^{*†}	\$2,009,019,137
Nursing Facilities—Hospital-Based [‡]	83,436 [•]	\$274,138,419
Non-Institutional Services		
Home Health	10,084 ^{†§}	\$92,464,337 [†]
Hospice Services	1,125 ^{†§}	\$31,948,998 [†]
Nursing Facility Waiver (NF)	348 [#]	\$16,988,534
Model Waiver	24 [#]	\$564,507
In-Home Medical Care (IHMC)	243 [#]	\$24,479,649
AIDS Waiver	2,511 ^{†#}	\$12,500,000 [†]
California Children Services (CCS)	10,821 ^{†§}	\$301,148,617 ^{†**}
EPSDT Supplemental (LTC)	48 ^{†§}	\$378,314 [†]
PACE	930 [§]	\$24,689,743
SCAN	1,003 [§]	\$5,816,060
California Partnership LTC	NA	\$524,835
COHS	NA	\$109,787,824 ^{††}
Targeted Case Management	NA	\$14,400,000
Medical Case Management	2,163 [§]	\$15,749,131
Department of Social Services		
Non-Institutional Services		
In-Home Supportive Services (IHSS)	134,277 [§]	\$746,000,000
Department of Aging		
Non-Institutional Services		
Multipurpose Senior Services Program (MSSP) Waiver	7,890 [#]	\$20,725,898
Adult Day Health Care	4,009 [§]	\$41,431,002 ^{††}
Department of Developmental Services		
Institutional Services		
Developmental Centers	3,857 ^{†§}	\$448,867,296 [†]
ICF/DDs	5,931 ^{†§}	\$263,343,879 [†]
Non-Institutional Services		
Regional Centers—Waiver	34,212 [#]	\$424,285,000
Regional Centers—TCM	46,176 [#]	\$83,518,000
Regional Centers—Other	NA	\$44,351,000
Total Medi-Cal	§§	\$5,007,120,180
Institutional Services	§§	\$2,995,368,731
Non-Institutional Services	§§	\$2,011,751,449

* Point-in-time estimate.

† CY 1998 data.

‡ An average patient receives about 21 days of care or fewer.

§ Average monthly estimate.

Annual unduplicated count.

** Expenditures are an estimate based on 50 percent of the total budget.

†† Expenditures are an estimate based on 16 percent of the total budget.

††† Although Adult Day Health Care is administered by the Department of Aging, its funding comes from the DHS budget.

§§ Beneficiary data cannot be summed because of overlap between programs; i.e., many beneficiaries use more than one type of service during the year.

What Policy Issues Lie Ahead?

As the major public funder of long-term care services in California, Medi-Cal must confront the challenges that are facing the long-term care system as a whole. Many of the following issues are already the topic of public debate, while others are likely to arise in upcoming months.



- **California's aging population.** With the aging of the baby boomers, California's elderly population is expected to nearly double in the next 25 years.³⁵ The Medi-Cal program will increasingly shift from a health insurance program for low-income families to a long-term care provider for the elderly. This changing demographic, coupled with spiraling health care inflation costs, will place an increasing burden on California's long-term care system and on the Medi-Cal budget in particular.
- **Long-term care workforce.** There is a concern that the supply of long-term care workers will not be able to meet the growing demand for long-term care services. Low wages and sparse benefits packages have already resulted in high turnover rates among workers, particularly in nursing homes, home health, and the IHSS program. Initiatives are underway to address this problem, such as the development of IHSS Public Authorities that bargain over wages and benefits and recruit, screen, and provide training for workers. It remains to be seen whether these efforts will be sufficient to attract adequate numbers of skilled workers into the long-term care field.
- **Integration and coordination.** There is little evidence of coordination among long-term care programs across the different state and county departments. Given the different administrative structures, funding sources, program mandates, and regulatory requirements, it is not surprising that the programs operate independently. However, this fragmented approach increases the difficulty for individuals who need a continuum of long-term care services. California has taken steps to address this issue, including the recent formation of an interagency long-term care council whose purpose is "to coordinate long-term care policy development and program operations and develop a strategic plan for long-term care policy."³⁶ A recent initiative (AB 1040) allows counties to integrate their long-term care finance and service delivery systems, but provides limited funding for implementation.
- **Quality of care.** Reports of poor quality of care in California's nursing homes have been a persistent problem. Further, there is an absence of standardized quality measurement occurring in home and community-based settings, and a lack of accepted quality measures for long-term care services in general. To this end, the California HealthCare Foundation, the University of California, and California Advocates for Nursing Home Reform have partnered to develop a

consumer information system on the Internet that will include quality performance information on every nursing home in the state. However, much more needs to be done in the area of quality measurement and improvement in other long-term care settings.

- ***Olmstead v. L.C.*** This 1999 U.S. Supreme Court ruling found that states must provide community-based services for people with disabilities who are otherwise entitled to institutional services if the community placement (1) is appropriate; (2) is desired by the individual in question; and (3) can reasonably be accommodated, taking into account the resources available to the state. It is not entirely clear what impact this ruling will have, but Medi-Cal may need to strengthen its network of home and community-based providers to ensure that individuals needing long-term care will have a range of services and settings from which to choose. These changes could increase the demand for publicly funded community-based services.
- **Role of private insurance.** Private insurance currently represents a very small percentage (5 percent nationally in 2000) of total spending on long-term care services.³⁷ As the need for long-term care services grows, will Medi-Cal continue to be the primary source of long-term care insurance for low-income individuals, or will public policies emerge that encourage public/private partnerships and the increased use of private long-term care insurance? Perhaps more important, will the private insurance market take an interest in this population?

As the major public funder of long-term care services in California, Medi-Cal must confront the challenges that are facing the long-term care system as a whole.



Online Resources

California State Sites

- **California Health and Human Services Agency (CHHS)**—www.chhs.ca.gov
CHHS oversees the California state departments that administer Medi-Cal long-term care services:
 - California Department of Aging—www.aging.state.ca.us
 - California Department of Developmental Services—www.dds.ca.gov
 - California Department of Health Services—www.dhs.ca.gov
 - California Department of Social Services—www.dss.cahwnet.gov
 - Long-Term Care Council—www.chhs.ca.gov/longtermcare.html
- **Legislative Analyst’s Office**—www.lao.ca.gov
A nonpartisan office that conducts fiscal and policy analysis for the California Legislature.

Other Sites

- **AARP (formerly the American Association of Retired Persons)**—<http://research.aarp.org/health>
The AARP’s Health and Long-Term Care site provides research on Medicaid and access to long-term care services for the elderly.
- **Agency for Healthcare Research and Quality (AHRQ)**—www.ahrq.gov
A division of the Department of Health and Human Services that supports research on access, quality, and financing of long-term care.
- **California Advocates for Nursing Home Reform**—www.canhr.org
This consumer advocacy organization provides data on the quality of California’s nursing homes.
- **California Association of Health Facilities**—www.cahf.org
An association of 1,600 skilled nursing, intermediate care, mental health, rehabilitation, and residential care facilities in California.
- **Center for Health Care Strategies**—www.chcs.org
A nonprofit, nonpartisan policy and resource center that manages the Robert Wood Johnson Foundation’s “Building Health Systems for People with Chronic Illnesses” program.
- **Centers for Medicare and Medicaid Services (CMS)**—www.hcfa.gov
Medicaid’s federal oversight agency, formerly known as the Health Care Financing Administration (HCFA), provides information on Medicaid’s long-term care services.
- **Home and Community Based Services Resource Network**—www.hcbs.org
A national partnership between federal and state agencies that is committed to high-quality consumer-directed services in integrated settings through cost-effective delivery models.
- **Kaiser Family Foundation**—www.kff.org
The Kaiser Commission on the Future of Medicaid and the Uninsured conducts research on Medicaid and long-term care.
- **Urban Institute**—www.urban.org
A policy research organization that investigates social and economic problems confronting the nation, including Medicaid and long-term care.

Glossary

Activities of Daily Living (ADLs)—Basic everyday personal functions such as eating, bathing, dressing, getting to and using the bathroom, and getting in and out of bed or a chair. Individuals who have difficulty with ADLs may require long-term care services.

Adult Day Health Care (ADHC)—A program funded by Medi-Cal and administered by the California Department of Aging that provides a variety of health, therapeutic, and social services to frail elderly and functionally impaired adults in a community-based setting. ADHC is designed to delay or prevent inappropriate nursing home placements.

Categorically Needy—Specified groups of individuals who, based on defined income criteria, are automatically eligible for Medi-Cal coverage. Categorically needy groups include families with children who are receiving CalWORKs, and elderly, blind, and disabled individuals who are receiving SSI.

Centers for Medicare and Medicaid Services (CMS)—A federal agency within the U.S. Department of Health and Human Services that administers Medicare and oversees the Medicaid program. Formerly known as the Health Care Financing Administration (HCFA).

Community-Based Services—Long-term care services that are either provided in an individual's own home or at a community agency (like an adult day health care center) for people who have an ongoing need for assistance, but who are able to remain in their own homes with some help.

Dual Eligible—Elderly and/or disabled individuals who qualify for benefits under both Medicaid and Medicare. In such cases, payments for any services covered by Medicare are made before any payments by the Medicaid program. Dual eligibles are sometimes referred to as “Medi-Medi’s.”

Home and Community-Based Service (HCBS) Waiver—A Medicaid state option established by the federal government in 1981 to allow states to provide community-based care alternatives to institutional care by waiving certain Medicaid statutes and regulations (specifically, section 1915[c] of the federal Social Security Act). HCBS waiver programs are targeted to individuals who would otherwise need to be in an institution. California has six HCBS waiver programs.

Home Health Care—A long-term care program that provides health-related services in the patient's own home, including skilled nursing, assistance with medications, physical and speech therapy, dietary counseling, and personal care services. Home health care is covered by Medi-Cal, but is primarily funded by Medicare in California.

Hospice—A long-term care program designed to enable patients with a terminal illness to live comfortably until their death. Hospice emphasizes pain relief and symptom control rather than aggressive curative treatments. Core services include physician and nursing services, physical and speech therapy, home health services, counseling, and pharmaceuticals. These services may be provided in the home, a hospice facility, or a hospital. Hospice is covered by Medi-Cal, but is primarily funded by Medicare in California.

In-Home Supportive Services (IHSS)—A long-term care program that is funded largely by Medi-Cal and administered by the Department of Social Services. IHSS helps to pay for personal care and chore services for the frail elderly and people with disabilities so that they can remain safely in their own homes. Services range from housekeeping to assistance with eating, bathing, and mobility.

Institutional Services—Long-term care services that are provided in residential facilities like nursing homes, hospitals, and intermediate care facilities.

Instrumental Activities of Daily Living (IADLs)—A set of tasks required to run a household and live independently, including shopping, taking medication, preparing meals, doing light housework, and managing finances.

Long-Term Care—A service or set of services provided to the frail elderly and to people with disabilities who need ongoing care due to chronic conditions. Services may include medical care, therapy, rehabilitation, case management, protective supervision, and assistance with “activities of daily living” (such as eating and bathing) and “instrumental activities of daily living” (such as housework and shopping).

Medicaid—A federal program, established in 1965, that provides health care coverage for low-income families and aged, blind, and disabled individuals who lack other health insurance. Medi-Cal is California’s Medicaid program, which, like other state Medicaid programs, is funded by both the federal and state governments.

Medically Needy—California’s medically needy program extends Medi-Cal eligibility to low-income individuals with incomes too high to otherwise qualify. The medically needy program allows a family or individual to deduct medical expenses from their income, thereby reducing it to a level that makes them eligible for Medi-Cal coverage.

Medicare—A federal program, established in 1965, that pays for the health care services of U.S. residents who are 65 years of age or older or who have permanent disabilities. There are no income eligibility criteria for the program. Medicare covers a limited set of long-term care services, including home health, hospice, and nursing home stays of up to 100 days.

Olmstead—*Olmstead v. L.C.* is a 1999 U.S. Supreme Court case that found that states must provide community-based services for people with disabilities who are otherwise entitled to institutional services if the community placement (1) is appropriate; (2) is desired by the individual in question; and (3) can reasonably be accommodated, taking into account the resources available to the state.

Personal Care Services—A set of non-medical long-term care services that assist an individual with activities of daily living, such as eating, bathing, dressing, toileting, and moving about the home.

Share of Cost—The amount of health care expenses some Medi-Cal beneficiaries must incur each month before Medi-Cal begins to cover costs. Whether or not a recipient has a share of cost, and how much it is, is determined by monthly family income. Share of cost allows a medically needy individual to deduct medical expenses from (or “spend down”) their income, thereby reducing it to a level that makes them eligible for Medi-Cal.

Supplemental Security Income (SSI)—A federal- and state-funded program that provides cash assistance to aged, blind, and disabled individuals. Many SSI beneficiaries need long-term care services, and individuals who qualify for SSI are automatically eligible to receive Medi-Cal.

Waiver—A term generally used to refer to a release from requirements in certain sections of federal law, particularly the Social Security Act. If a state wants to make changes to its Medicaid program that are in conflict with federal Medicaid requirements, CMS (formerly HCFA) must approve a waiver of the relevant requirements of the Social Security Act.

Endnotes

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Acknowledgments

The Medi-Cal Policy Institute would like to thank Lora Connolly from the California Health and Human Services Agency for her assistance in reviewing this report. In addition, the Institute gratefully acknowledges the expertise of the staff from the State of California who supplied data and provided feedback, including: Bob Bonkowski, Della Cabrera, Denise Crandall, Cris DeMorais, Lisa Kale, Renee Mollow, Stan Rosenstein, Marie Vann, and Jan Vick from the California Department of Health Services; Patricia Johnston, Peter Lucyga, and Alan Stelmack from the California Department of Social Services; Linda Croslin, Rick Ingraham, Julie Jackson, Walt Kealy, and Mary-Rose Repine from the California Department of Developmental Services; Alan O'Connor from the California Department of Aging; and John Kriege from the Office of Statewide Health Planning and Development. The Institute would also like to thank the following individuals for reviewing this report: Tom Bleeker, World Institute on Disability; Brian Burwell, MEDSTAT; and Laura Reif, UCSF Department of Nursing. Finally, we would like to thank Charlene Harrington, Valerie Wellin, and their colleagues at the UCSF Department of Social and Behavioral Sciences for the research they conducted on Medi-Cal long-term care services on behalf of the Medi-Cal Policy Institute.

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Medi-Cal *Policy Institute*

476 Ninth Street
Oakland, California 94607
Tel: 510/286-8976
Fax: 510/238-1382
www.medi-cal.org

A project of the California HealthCare Foundation