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California's In-Home Supportive Services Program: Who is Served?

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LIST OF ACRONYMS USED THROUGHOUT REPORT

CDDS	California Department of Developmental Services
CDHS	California Department of Health Services
CDSS	California Department of Social Services
CDSS MPP	California Department of Social Services Manual of Policies & Procedures
CMIPS	Case Management Information and Payrolling System
DD	Developmental Disability (Developmentally Disabled)
ICF-DD	Intermediate Care Facility for the Developmentally Disabled
IHSS	In-Home Supportive Services
PCSP	Personal Care Services Program
RCF	Residential Care Facilities

EXECUTIVE SUMMARY

Governor Schwarzenegger's preliminary 2004-05 Budget Bill proposed to eliminate a component of California's In-Home Supportive Services (IHSS) program serving approximately 68,000 individuals. This component, known as the Residual Program, included Protective Supervision and Domestic Care services, and services provided by parents and spouses. Under the then existing regulations and the state's approved state plan for Medicaid, these services did not qualify for shared financing with the Medicaid program and were thus funded solely by state and county sources. The objective of the administration's proposal was to obtain an estimated net savings from the IHSS program in Fiscal Year 2005 of $366 million.

These proposals were strongly opposed by service recipients, family members, providers, and advocates for home and community-based care. Additionally, analyses by the Legislative Analyst's Office, the University of California, San Francisco and others suggested that the cost savings may have been overestimated, and that other cost savings alternatives may be available and more viable. The administration eventually withdrew the proposal to eliminate the Residual Program and elected to pursue revisions in the state plan and waivers from existing Medicaid regulations. This new approach left in tact the services available in the Residual Program, but permitted the receipt of federal matching funds, effectively reducing state and county expenses for the residual services by 50 percent. The waiver request was approved on August, 2004. The study reported here examines several key assumptions underlying the state's original net savings estimate and other cost shifts that had not been included in this estimate of net savings. These results show that the original savings estimates were overly optimistic. The approach eventually adopted, that of seeking federal matching funds, likely yields more true cost savings to the state.

Population Affected: With the proposed Residual program elimination, approximately 70,000 recipients would lose services. Individuals would be affected very differently, depending on the services lost. The groups potentially affected by program elimination would have been: 1) recipients with a parent or spouse provider, 2) recipients receiving only domestic care services, 2) recipients receiving protective supervision services, 4) recipients utilizing the Advance Pay option, and 5) those receiving restaurant/meal allowance services. Of these groups, those receiving Protective Supervision appeared to have had the highest risk of institutionalization or out-of-home placement as a result of the policy proposal. Others, such as individuals utilizing Advance Pay and those with meal allowances, had a high likelihood of moving into the regular IHSS program.

State Costs from Eliminating the Residual Program: There is a large degree of uncertainty in determining where individuals would turn in the absence of Residual Program services. This report has considered state costs from Residual recipients utilizing four possible service options: the IHSS Personal Care Services Program (PCSP), nursing homes, Community Care Facilities, and Intermediate Care Facilities for the Developmentally Disabled. Alternative scenarios were developed showing the potential state costs under varying assumptions about the proportion of persons electing these options.

The originally proposed Residual Program cost savings likely underestimated the number of Advanced Pay and meals allowance recipients who would move into the standard IHSS program, and the number of those receiving Protective Supervision and/or parent spouse reimbursed care who might enter out-of-home placements. Also underestimated was that the state could have been funding the Domestic Care Only and Protective Supervision component of the Residual Program under shared federal expenses, and that these recipients could be transferred into the standard program. The uncertainty of the new costs associated with elimination contrasts with the certainty of state expenditures reductions obtained by retaining the Residual Program services under practices that qualify for federal matching funds.

In reviewing the IHSS Residual Program operations, we identified that the Domestic Only Services program and the Protective Supervision program both qualified for federal matching funds. These programs provide basic services to meet the instrumental activities of daily living needs (e.g., shopping, meals preparation) and cueing services. Such services have been allowed under federal state plan rules since 1997. The Centers for Medicare & Medicaid Services (CMS) have since approved (effective in August 2004) the state's request to include these services as part of its standard IHSS program, and to fund the other services under a Medicaid section 1115 waiver.

Litigation Expenses and Penalties: A further consideration relative to the possible elimination of the Residual Program was that such an action would likely be challenged in a legal battle with the disability community based on the United States Supreme Court's 1999 *Olmstead* decision. This ruling requires states to increase home and community-based alternatives to institutional care for the elderly and disabled. Litigating Olmstead-related lawsuits would bring extra costs for the state. They will also likely delay implementation of any proposed reductions, moving back any realized cost savings expected in the budget.

Other Alternatives: Even with the eventually adopted and approved options of modifying the Medicaid state plan to include Protective Supervision and Domestic Care Only in the IHSS program, and obtaining a Medicaid waiver to reimburse parent and spouse providers, and the Advance Pay recipients, the state continues to seek means of reducing overall expenses within the IHSS program. The Legislative Analyst's Office and others have suggested refinements in the administrative practices of the program as one possible source of such savings. Our analysis has documented the wide variability among counties in the number of hours of service authorized under the IHSS program. Reducing this variability through implementation of a more uniform assessment and care planning process, and perhaps the adoption of the administrative procedures of some of the more efficient counties, may be a viable source of additional cost reductions.

INTRODUCTION

On January 9, 2004, Governor Schwarzenegger submitted the 2004-05 Budget to the California State Legislature. This set out an "economic path to recovery" in its attempt to confront California's fiscal crisis which included $22 billion in debt. California's In-Home Supportive Services (IHSS) program was one of many programs proposed for budget cuts and a flattening in the rate of growth. The budget proposed a net overall decrease in IHSS support of 13 percent from state General Funds. One source of the proposed savings was the elimination of a program component known as the Residual program. This is a component of the program that had been funded exclusively with state and county dollars. Elimination of this program was proposed by the Administration as resulting in a net savings of approximately $366 million in fiscal year 2005.

The IHSS program provides personal assistance services for low-income people with physical, sensory, memory, or cognitive disabilities. Services available include assistance with activities of daily living (e.g., bathing, dressing, eating, bladder/bowel requirements) and instrumental activities of daily living (e.g., shopping, meal preparation, house cleaning). IHSS serves about 320,000 aged, blind, and disabled adults or children per month, or about 370,000 persons annually. Of these about 70,000 persons received all or a portion of their assistance through the Residual Program services in 2003. These are services provided by parent or spouse providers, or services such as protective supervision, domestic care, and advance payment that were not "eligible" for federal matching funds at that time.

The General Fund savings estimates under the Administration's proposal to eliminate the Residual program implicitly assumed few adverse consequences for the affected population or cost shifts to other programs or services. For example, it was assumed that the vast majority of recipients would be able to receive sufficient unreimbursed care from family members to remain in community settings, that transfers to out-of-home placements would have no additional cost to the state, that other state funded programs would not be affected by these reductions in home care services, and that counties and others would not attempt to move substantial proportions of the recipients into standard IHSS services, which are collectively known as the Personal Care Services Program (PCSP). PCSP is the component of IHSS eligible for federal matching funds.

The Residual program's elimination was strongly opposed by service recipients, family members, providers, and advocates for home and community-based care. The California Healthcare Foundation responded to these concerns by contracting with the University of California, San Francisco to conduct an analysis of the proposed program changes, to identify those likely to be effected, and to evaluate possible alternatives for state consideration. During March through May 2004, we provided a variety of preliminary findings to the Senate Budget Committee, and presented a briefing paper to administration staff and others as part of the April 15th California Program on Access to Care, Policy Briefing. Subsequently, we have made analyses and recommendations available to state and federal officials pertaining to information needed to develop and consider the Medicaid waiver proposal.

The administration eventually withdrew most of the proposed reductions and elected instead to pursue revisions in the Medicaid state plan and waivers from existing Medicaid regulations.

This new approach left in tact the services available in the Residual program, but permitted the receipt of federal matching funds, effectively reducing state and county expenses for the residual services by 50 percent. The waiver request was approved in August, 2004.

This report is summary of our analyses and findings. In it we examine several key assumptions underlying the state's original net savings estimate and consider other costs that had not been included in the administrations original estimate of net savings resulting from the elimination of the Residual Program. These results show that the original savings estimates were overly optimistic. The approach eventually adopted, that of seeking federal matching funds, likely yields more true cost savings to the state, and with far fewer untested assumptions about transfers into community care facilities and nursing homes that could have increased costs to the state.

Part I is an overview of the IHSS and Residual programs as of fiscal year 2003-04 and program recipients in calendar year 2003. Part II presents the assumptions used by the Administration in forecasting outcomes for residual recipients and a range of possible outcomes not considered in those assumptions. Part III is an analysis by the Residual program sub-groups and state cost estimates under alternative assumptions about out-of-home service use, should it be adopted. Part IV concludes with a summary of findings, areas for further consideration, and alternative options the state may wish to pursue.

Part I: IHSS and the Residual Program

Services that provide alternatives to institutionalization of the elderly and disabled have gained prominence in recent decades as part of California's response to long-term care needs. However, the state's long-term care system faces increasing challenges. These are both immediate and persistent. They are the result of both growing demand for services and wage increases. California's elderly population is projected to nearly double over the next twenty-five years as technological and medical advances allow individuals with chronic disabilities to live longer lives.

> "Institutional" long-term care is provided in settings such as nursing homes and intermediate care facilities, outside the recipient's home. "Home and community-based" services are provided in an individual's own residence or in other settings such that consumers with ongoing need for assistance are able to live in their own homes (Streett, 2001).

In 1999, a U.S. Supreme Court ruling in *Olmstead v. L.C.*, 119 S. Ct. 2176, required state governments to allow elderly and disabled persons to live in the "least restrictive" and most integrated environment appropriate to their needs. Under the Court's decision, states are required to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services. As California implements its plan for compliance with the *Olmstead* decision, additional home and community-based services are seen as necessary to allow individuals to move out of institutional facilities (California Health and Human Services Agency, 2003).

California's nursing homes experienced a diminishing per capita occupancy rate over the past decade in spite of a growing state population. The In-Home Supportive Services (IHSS) program, along with residential care and other programs, are seen as important resources in reducing nursing home utilization in California (CA Assembly Budget Subcommittee No.1, 2004).

What is IHSS?

Established in 1973 under Governor Ronald Regan, In-Home Supportive Services is a statewide public program providing in-home personal assistance services to individuals who are blind, disabled, and/or elderly. These include services such as bathing; dressing; transferring; domestic assistance such as meal preparation, shopping, heavy house cleaning; and protective supervision. IHSS is California's main program of in-home and community-based long-term care services. Currently it serves about 320,000 recipients monthly. This program is financed through a combination of federal funds through Medicaid, and state and county funds. Table 1 provides definitions for the IHSS services.

To qualify for IHSS, an individual must be over age 65 or disabled, eligible for or a current recipient of Supplemental Security Income/State Supplementary Payment (SSI/SSP);[1] or meet all

[1] The SSI is a federally funded income support program (Social Security Act, title XVI) for the aged, blind, and disabled. The SSP is a state program that supplements the SSI income level. SSI/SSP benefits in California (as in

the eligibility criteria for SSI/SSP except for income limits (CDSS, 2000).[2] Through fiscal year 2003-04, all components of IHSS operated as an entitlement program, meaning that IHSS is available to all persons who meet these eligibility criteria. In principle there is no waiting list for admittance into the program and no cap on the overall growth of the program. The types and amount of services provided are determined by county social workers who conduct eligibility assessments, according to state and federal policies. See Appendix C for needs assessment and authorization procedures and guidelines.

Table 1: IHSS Service Definitions

Service	Definition
Personal Care Services	Ambulation; bathing and grooming; dressing; bowel, bladder, and menstrual care; repositioning, transfer, skin care, and range of motion exercise; feeding and hydration assistance; assistance with self-administration of medications; and respiration.
Paramedical Services	Activities necessary to maintain health, when individuals are unable to perform them. Services include administration of medications, puncturing the skin, or inserting a medical device into a body orifice, activities requiring sterile procedures. Paramedical services must be authorized by a client's treating physician.
Domestic and Related Services	Preparation of meals and meal clean-up; routine laundry; shopping for food; other errands and shopping; heavy cleaning; accompaniment to medical appointment; accompaniment to alternative resource of care; removal of grass, weeds, and rubbish; removal of ice and snow; and domestic services.
Protective Supervision Services	Necessary observation to make sure that individuals who are confused, mentally impaired, or mentally ill, are safe against injury and accidents.

Source: CDSS MPP (1993), Sections 30-780 and 30-757

Total cost of IHSS more than doubled (going from $1.39 billion to $3.4 billion) between fiscal years 1998-99 and 2003-04 (CA Senate Committee on Budget and Fiscal Review, 2004). Contributing to this was a 64 percent growth in caseload from 1995 to 2003. This is believed to be partially a function of California's aging population and a clinical and programmatic shift to support elderly and disabled persons in community settings (CA Senate Committee on Budget and Fiscal Review, 2004). Most of the growth has been in the federal share portion of the program. Caseloads within the state/county-funded portion of IHSS have remained stable and even declined in some counties.

While program growth is indicative of increasing demand for long-term care services it is important to consider the cost of these services relative to other alternatives, such as out-of-home care services. Table 2 shows average daily costs per IHSS recipient compared to those of other service alternatives. These figures do not adjust for recipient case mix, but even the most expensive IHSS recipients receive services costing less than $100 per day.

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most states) are administered by the Social Security Administration (SSA). Eligibility for both programs is determined by SSA using Federal criteria for income and assets. Benefits are in the form of cash assistance (CDSS, 2003, *SSI Eligibility*).

[2] About 2.7% of IHSS recipients do not meet income limits, so pay a "share of cost" for services.

Table 2

Average Medi-Cal and SSI/SSP Payment Rates Per Day in California	
Hospital	$1,230
Intermediate-Care Facility	$142
Nursing Home	$118
Residential Care Facility	$32
IHSS	$24

Source: Cline & Hiehle, 2003; U.S. Social Security Administration, 2004

What is the IHSS Residual Program?

Through fiscal year 2003-04 the IHSS program has consisted of two components: the Personal Care Services Program (PCSP) and the Residual IHSS program. As shown in Table 3, these are funded by different sources. From 1973 to 1992, IHSS was supported entirely by state and county funds. To take advantage of federal funding available for personal care services under Medicaid, the California Legislature passed AB 1773 in 1992. This allowed the program to receive Medicaid[3] funds for services meeting federal reimbursement criteria (CDSS Fiscal Policy and Estimates Branch, 2003). The portion of the IHSS program eligible for funding under federal Medicaid regulations is known as PCSP. Services that did not qualify for Medicaid were retained within IHSS as the "Residual" Program and were paid for using state and county funds.

Table 3: PCSP and Residual Funding Sources

	PCSP	Residual IHSS
Eligibility	**Services and provider qualify for federal reimbursement**	**Services and/or provider do not qualify for federal reimbursement**
Funding Source:		
Federal Funds (Medicaid)	50%	0%
State Funds (General Fund)	33%	65%
County Funds	17%	35%

Through fiscal year 2003-04 the Residual program was defined by the following IHSS services. See Appendix D for detailed definitions and procedures for allocation of hours, limitations, stipulations, qualifications, and criteria regarding the Residual services outlined below:

- ***Any Services Delivered by a Responsible Relative:*** A "responsible relative" is defined as a parent of a minor child or a spouse. Residual program funds can cover the cost of IHSS services provided by a spouse or by a parent of a minor recipient, under certain conditions.
- ***Domestic and Related Services ONLY:*** Consumers who require only domestic and related services (as defined in Table 1) have been funded through the Residual program, unless these services are ancillary to other personal care services and/or paramedical services.
- ***Protective Supervision Services:*** Protective supervision services (as defined in Table 1) are provided to clients with cognitive impairments when they need 24-hour supervision and can remain safely in their home if it is provided.

[3] Medicaid is a federal program (Social Security Act, Title XIX) that provides health and long term care coverage for low-income families and aged, blind, or disabled individuals. Medi-Cal is the term California uses for Medicaid.

- ***Advance Pay Services:*** Under federal regulations for reimbursement, providers must submit timesheets and get paid retroactively directly by IHSS. The Residual program has been used to fund services for consumers classified as "severely-impaired," who receive payment directly by the state in order to pay the provider(s) in advance of service.
- ***Restaurant/Meal Allowance Services:*** The Residual program has paid for a restaurant/meal allowance as an optional alternative to meal preparation and cleanup services, which are available as ancillary services through PCSP.

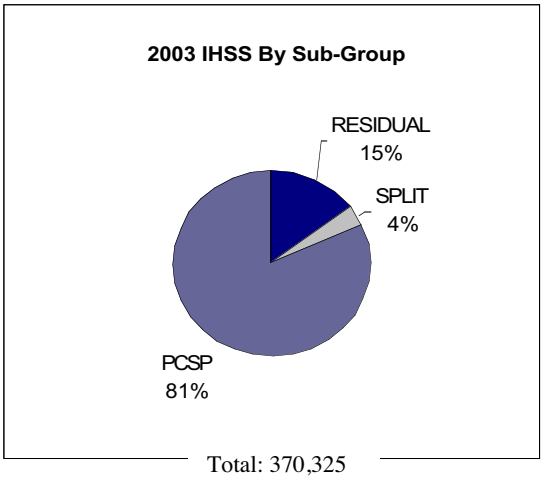
Consumers receiving Residual program-funded services meet the same income requirements as PCSP beneficiaries. Depending on needs and providers, clients may receive services through both PCSP and the Residual program. Such clients are known as "split" cases. Receipt of Residual funding, PCSP funding, or both depends entirely on the IHSS services required and the arrangement for receiving care. It is not uncommon for IHSS recipients to move in and out of Residual coverage over the course of a year. In 2003, about 14% changed status at least once.

We used the types of services authorized and the relationship of the provider and recipient to identify Residual, PCSP, or Split recipients in the CMIPS datasets. This logic is based on the rules and regulations that outline IHSS funding sources. For purposes of data tabulation, recipients were classified in this manner monthly, with service use and expenditures compiled by "exposure" months. See Appendix A for the details of our logic code.

The IHSS and Residual Program Populations

Since 1998 the PCSP component of the program has grown by 96% while the IHSS Residual caseload has remained stable (CA Assembly Budget Subcommittee No. 1, 2004). Figure 1 shows the distribution of IHSS consumers among the three sub programs in 2003.

Figure 1



Source: CMIPS data, calendar year 2003, based on total exposure months in the period

Descriptive Statistics

Figures 2 and 3 show the age composition of both the entire IHSS population and the Residual population in calendar year 2003. Recipients are broken into three groups: children (ages 0-17), adults (ages 18-64), and elderly (ages 65 and over). There is a higher concentration of children and adults in the Residual population, while the entire IHSS population as a whole has a higher concentration of elderly recipients. The data used to create these Figures are in Appendix E

Figure 2

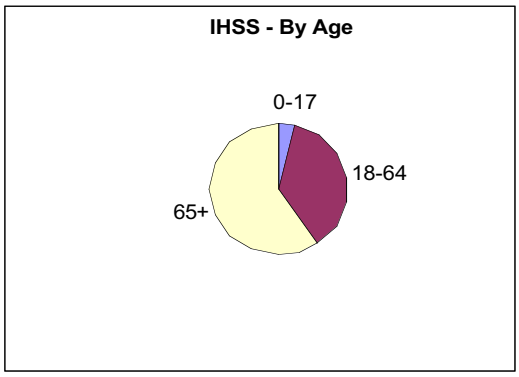
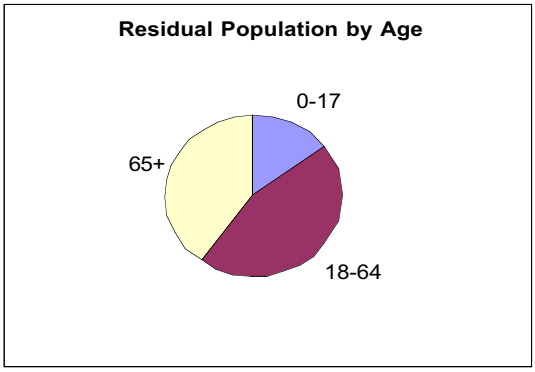


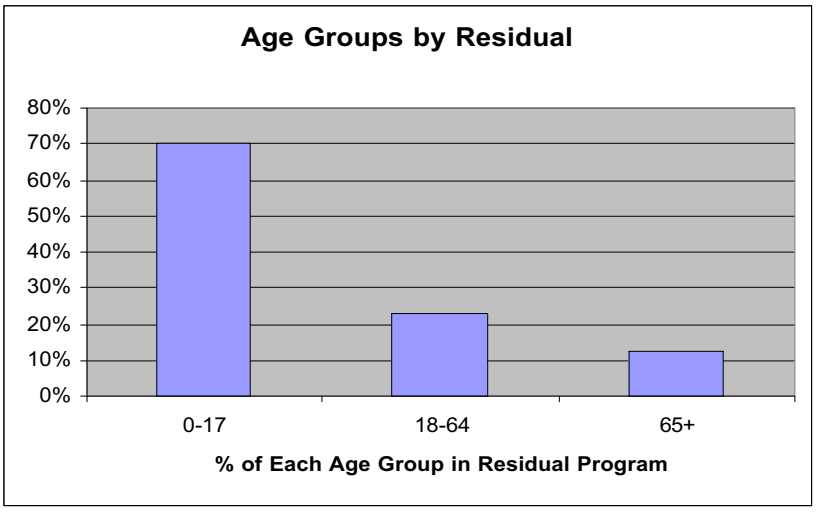
Figure 3



Source: CMIPS data, calendar year 2003, based on total exposure months in the period

Figure 4 shows another perspective on the age distribution, this time as the percentage of each age group served by IHSS in 2003 who received this service through the Residual program. The majority (70%) of children in the IHSS program received Residual services.

Figure 4



Source: CMIPS data, calendar year 2003, based on total exposure months in the period

Table 4 shows the number of individuals served by each of the Residual program sub-groups in 2003. Recipients in more than one category have been collapsed into one primary category to avoid double counting. See Appendix A for the details of this classification method.

Table 4

Residual & Split Recipients by Service Sub-Group, Calendar Year 2003		
All Recipients Receive Residual Services		
	#	%
(1) Parent Provider	9,507	13.9%
(2) Spouse Provider	11,264	16.5%
(3) Domestic Care Only	31,035	45.4%
(4) Protective Supervision	15,044	22.0%
(5) Advance Pay	685	1.0%
(6) Meal Allowance	826	1.2%
Total	68,361	100.0%

Source: CMIPS data, calendar year 2003, based on total exposure months in the period

The severity of impairment, or "frailty," of individuals varies among the sub-groups. This affects both authorized service hours and relative risk for institutional placement. The CMIPS assessment instrument contains 14 items that classify functional and cognitive impairment in different activities. See Appendix A for further details on frailty measures. These 14 activities have been collapsed into four major domains:

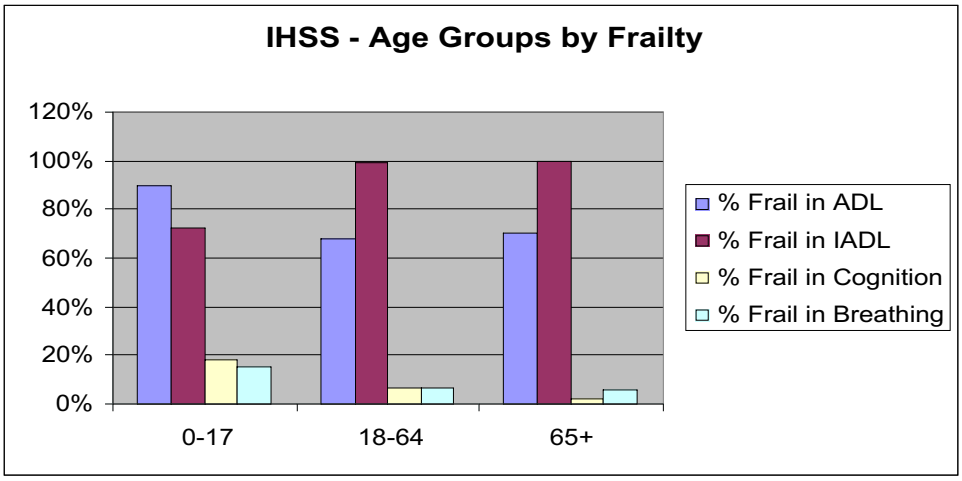
- **Activities of daily living (ADL's)**, i.e., bathing and grooming; dressing; bowel, bladder, and menstrual care; transfer; and eating
- **Instrumental activities of daily living (IADL's),** i.e., housework; laundry; shopping and errands; meal preparation and cleanup; and mobility inside;
- **Cognition**, i.e., memory; orientation; and judgment
- **Breathing difficulty**

Problems in functioning are measured on a 0-5 (or sometime 0-6) scale, with "being unable to function without assistance from another person" or "without substantial assistance" defining the higher scores (see Appendix A). For the present analyses individuals were defined as "frail" within a domain if they needed some help from another person (a score of 3) in two or more activities in that domain. An exception was for breathing, where individuals were defined as "frail" if they have a ranking of 3 or higher on one activity,"breathing," as this is the only activity in that category. When used in combination with one another, these frailty classifications explain about 65% of the variance in the number of hours authorized for IHSS assistance.

Figure 5 shows the percentages of each age group that are frail in each of the four main impairment categories, for the entire IHSS population in 2003. ADL and IADL frailty dominate among all age groups. Figure 6 shows the frailty distribution among those in the Residual program in 2003. Frailty levels in each age group were generally similar between the IHSS and Residual populations in 2003. The main difference involved cognitive frailty. Within the overall IHSS population, 18% of children had cognitive frailty, compared to 6% of adults and 2% of

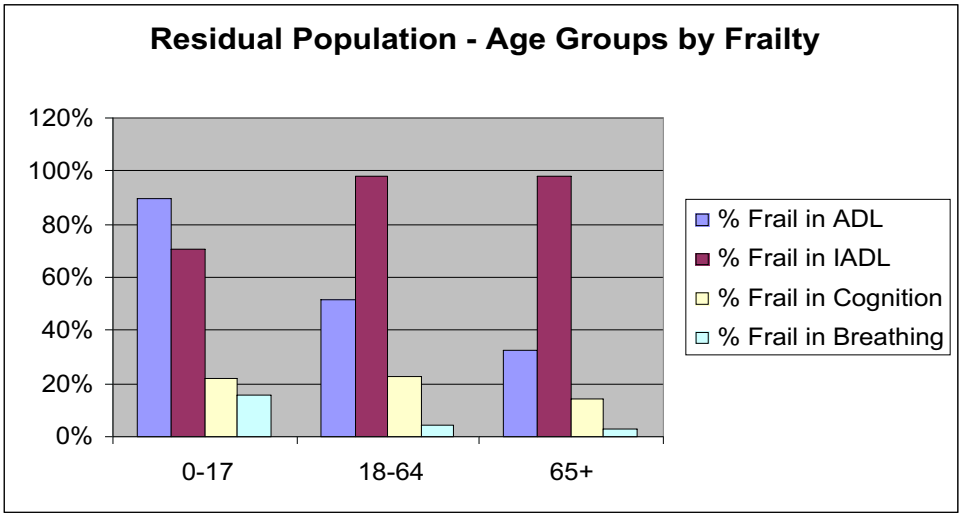
elderly. Within the Residual population, non-aged adults and children had similar proportions with cognitive frailty. See Appendix E for the data used to create Figures 5 and 6.

Figure 5



Source: CMIPS data, calendar year 2003, based on total exposure months in the period

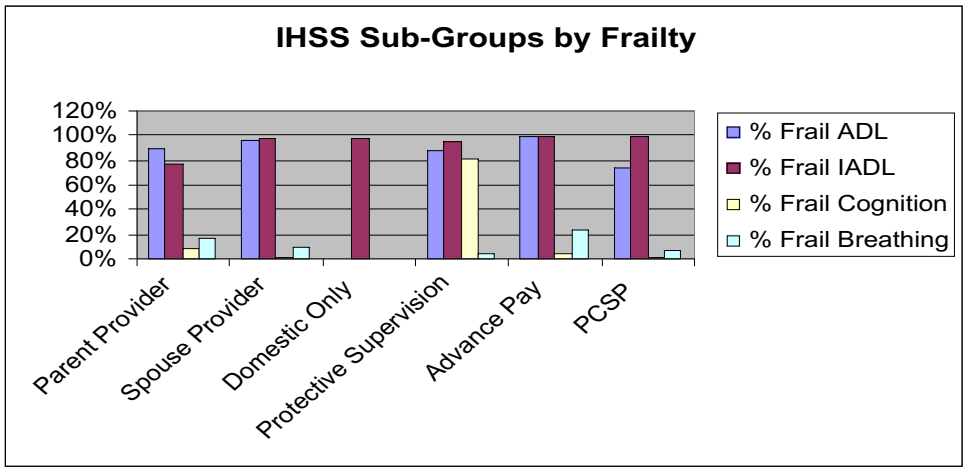
Figure 6



Source: CMIPS data, calendar year 2003, based on total exposure months in the period

Frailty within the specific Residual sub-groups are shown in Figure 7 below. The Protective Supervision sub-group has over 80% of recipients who are frail in three of the four frailty categories. IADL frailty levels are consistent across all sub-groups, with at least 76% of recipients in each group having IADL frailty. The Domestic-Only sub-group ranks lowest for ADL frailty, with only 1% of these recipients classified as frail in ADL's, compared to 75% of all PCSP recipients, and over 87% in all other Residual sub-groups. Those in Protective Supervision rank highest in cognitive frailty (81% of recipients), compared to 8% of the Parent Provider sub-group, 4% or less among the others.

Figure 7

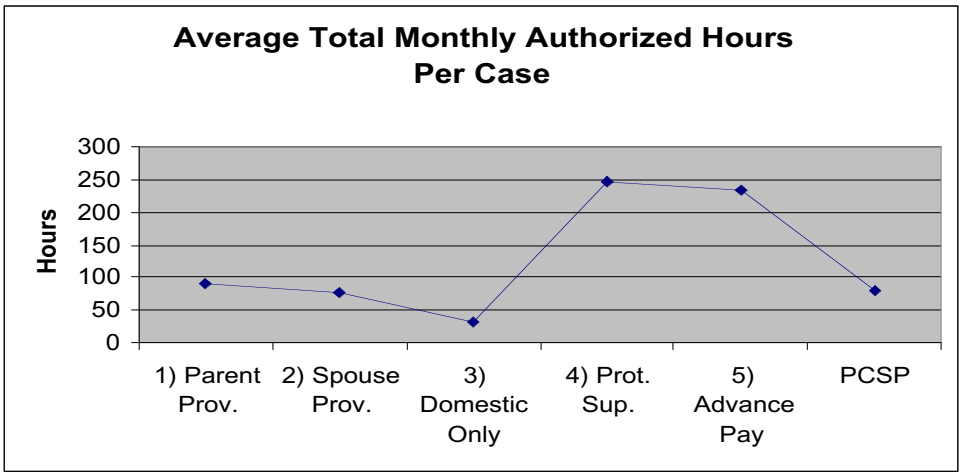


Source: CMIPS data, calendar year 2003, based on total exposure months in the period

Authorized IHSS Service Hours

As shown in Figure 8, the average authorized hours of IHSS assistance vary directly with the relative frailty levels in each of these program sub-groups. Within the IHSS program 283 is generally the maximum number of hours that can be authorized in a month. This authorization is based on the level of need, and adjusted for household size. Recipients within Protective Supervision and Advanced Payment groups average about 250 hours monthly of authorized services. This number is inclusive of all the IHSS services being received, not just the hours for these specific services. The average authorized services among the other IHSS recipient groups is generally well below 100 hours. The Domestic-Only group had the lowest average authorized hours, around 40 per month in 2003.

Figure 8



Source: CMIPS data, calendar year 2003, based on total exposure months in the period

PART II: SERVICE ALTERNATIVES FOR RESIDUAL RECIPIENTS

Several options were considered in the course of the 2004-05 budget negotiations between the Governor's office and the California Legislature. The most striking of these was the original proposal to eliminate the Residual program. Options subsequently considered included transferring portions of the Residual program into PCSP and obtaining waivers for those program components that would not otherwise meet Medicaid regulations. The Centers for Medicare & Medicaid Services (CMS) has since approved the conversion of most of the program into PCSP. The balance, namely the parent and spouse provider component, will be covered under a Medicaid 1115b waiver approved in August 2004. The state pays 33 percent of the services costs under PCSP compared to 66 percent under the Residual program.[4]

Reported in this section is a discussion of the potential costs that may have been incurred by the state had they adopted the option of Residual program elimination. These analyses report substantially less expenditure savings to the state than the $366 million that had been estimated when the program elimination option was initially introduced. The Administration estimated that General Fund (GF) savings from eliminating the Residual program would be $422 million, offset by $56 million in costs to the state of all former parent or spouse provider cases remaining in IHSS by shifting into PCSP (LAO, 2004) for FY 2005. These estimates did not make allowance for shifts into other service alternatives or the election of eligible providers. Transferring the Residual program fully into PCSP or waivers would be expected to produce state general fund savings of about $183 million in Fiscal Year 2005.

The under-estimation of potential cost shifting in the initial proposal was recognized, although not quantified, by the California Senate Budget and Fiscal Review Subcommittee (2004):

> "The Governor's Budget appears to over-estimate the level of savings resulting from the proposed elimination of the Residual Program. The Budget underestimates the number of consumers that may transition to PCSP…Lastly, the Budget assumes that the elimination will not increase demand for out-of-home care although IHSS is required by statute to serve consumers who can not safely remain at home without program services." (p. 7).

In its *Overview of the 2004-05 Budget Bill*, the California Senate Committee on Budget and Fiscal Review (2004) stated that:

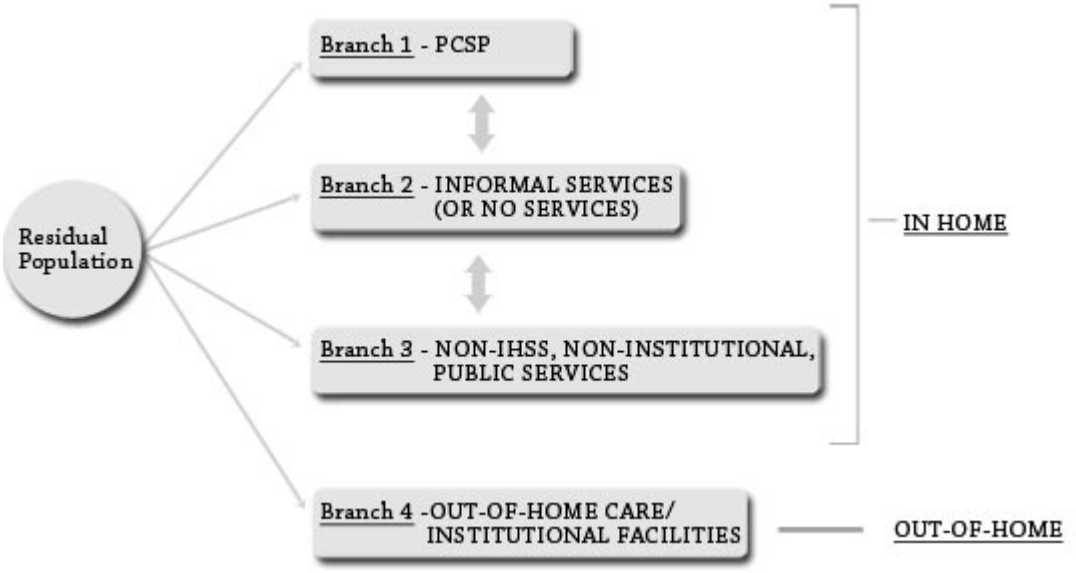
> "The Legislature may wish to consider how the proposed program elimination will affect the different categories of IHSS Residual consumers. The Legislature may also wish to examine the extent to which the proposed elimination will result in *cost shifting* to other state funded services…or contribute to *increased utilization of out of home care and IHSS PCSP services*." [Italics added], (p. 3-69).

Described here are service options used to quantifying some potential cost shifts and other expenditures that were not considered in the original proposal. Figure 9 presents an "Outcomes

[4] The state used monthly data from September, 2001 to calculate that 24% of all residual cases in that month had a parent or spouse provider. This percentage was then applied to the projected caseload for 2004-05 (LAO, 2004).

Tree" that outlines the theoretical range of major options that current IHSS recipients may utilize had the Residual program been terminated, rather than converted into PCSP and waivers. The top three branches are NOT mutually exclusive; rather, clients who lose some portion or all of their services may move into multiple and/or overlapping branches at one time.

Figure 9: Assumed Outcomes Tree for Residual Recipients



Interviews conducted during March through July, 2004 with IHSS county administrators, executive staff in the state departments that administer long-term care, and other experts were helpful in identifying these potential outcomes. A listing of the informants participating in these interviews is shown in Appendix B. Table 5 provides a summary of the major outcomes for which the state may incur costs not considered in the Governor's savings estimates.

Table 5

Major Potential Program Transfer or Alternative State Cost Options			
Branch 1	**Branch 2**	**Branch 3**	**Branch 4**
PCSP	Hospitalization Adult Protective Services	Adult Day Health Care Linkages Program EPSDT Nursing Facility Waiver Model Nursing Facility Waiver MSSP In-Home Medical Care Waiver	Nursing Homes Residential Care Facilities ICF-DD's

Branch 1 – Stay Within IHSS and Transfer Services into PCSP

Some recipients who lose benefits may be able to transfer some portion or all of their services into PCSP. Costs of switchover into PCSP would exceed the Administration's estimates if any recipients from the Advance Pay and Domestic-Only sub-groups enter this branch because the only switchover considered was from the Parent and Spouse Provider groups. This outcome has been realized by the negotiated budget agreement and with the concurrence of CMS in granting state plan changes and the Medicaid waiver for federal funds to cover these services.

Branch 2 – Informal Services and/or No Services

The Governor's proposal to eliminate the Residual IHSS program assumed that all recipients not falling into Branch 1 would either receive unpaid informal care or remain at home without care. State expenditures for these recipients under such a scenario were assumed to be zero. However, there are several possible consequences that may have costs for the state.

For example, caregivers formerly paid under the Residual program may need to find employment to replace their IHSS income. In such situations it may be necessary to leave recipients without care or supervision during their hours of employment. Recipients who go without adequate care may experience deterioration, injuries, or worsening of their conditions. The lack of adequate care result in a hospitalization, the state will assume one-half of Medi-Cal costs for this care for those not eligible for Medicare. One hospital day had an average cost of $1,155 in 2002 (Cline & Hiehle, 2003). In 2003, fewer than 1% of all IHSS recipients were discontinued from the program because of a hospital stay, but just over 4% were discontinued because of death. The actual number experiencing a hospital stay or emergency room visit is not reported in CMIPS.

Another possible adverse event may be increased vulnerability to neglect and hazardous living situations. These may result in increased utilization of Adult Protective Services (APS), a state program that helps maintain the health and safety of individuals with functional impairments who live in their homes (Phone Interview)**.** APS is funded through a combination of state and county general funds and federal Title XX funds. APS involvement could subsequently result in an out-of-home placement to protect the recipient or other actions affecting state and county program funding. The monthly rate for out-of-home placements in 2004 range from $853 to $3,963 depending on the level of care. About $425 of this amount would be federal SSI funds; the balance would be state funds. In 2003, 1.8% of IHSS recipients were discontinued due to a residential care or nursing home placement. Another 2.8% were discontinued because they 'moved' outside the county or to a location unidentified by the social worker.

Branch 3 – Non-IHSS Non-Institutional Public Services

Individuals who are not able to switch into PCSP and who require services beyond the informal care available to remain living at home, will likely search for supplementary services. The state-funded programs and services that may experience increased caseload include: CDDS Regional Centers, Adult Day Health Care, the Linkages Program, the Multipurpose Senior Services Program (MSSP), and Medi-Cal's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for children. The state's yearly share of costs in these programs in 2002 ranged from $2,000 per participant to over $10,000 per participant.

These programs may experience increased utilization by Residual clients, but they are generally not alternatives to completely replace IHSS services. Most programs have capped enrollment and are already at full caseload capacity (CA Health and Human Services Agency, 2003, *Strategic Plan* and *Olmstead Plan*; and Streett, 2002). In addition, most programs also faced proposed budget cuts in the Governor's 2004-05 Budget Bill. Further, these programs do not provide enough hours to replace the number of IHSS service hours that will be lost (CA Health and Human Services Agency, 2003, *Strategic Plan* and *Olmstead Plan*; and Streett, 2002). The

bottom line is that these services will likely experience increased demand and use (increasing state costs), but without adequately replacing the IHSS personal assistance. This may place more individuals at risk of out-of-home placement.

Branch 4 – Out-of-Home Care/Institutional Facilities

The major out-of-home options that may be impacted by elimination of the Residual Program or other cutbacks in the level of personal assistance services are discussed below:

Nursing Homes: 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. Based on the 2002 Medi-Cal average daily payment for Nursing Facilities, annual state costs would be at least $21,400 for every IHSS client that transfers into a nursing home (Cline & Hiehle, 2003). This is an average daily rate at least double that of those in IHSS.

Intermediate Care Facilities for the Developmentally Disabled (ICF-DD's): An ICF-DD is a type of nursing home that provides medical care, nursing, and developmental training to developmentally disabled (DD) individuals who require 24-hour supervision. Appendix F provides a synopsis of the various subcategories of these facilities. Based on the 2002 Medi-Cal average daily payment for ICF-DD's, annual state costs would be at least $26,400 for every IHSS client that transfers into an ICF-DD (Cline & Hiehle, 2003). There are 1,097 ICF-DD facilities in California (including ICF-DDH and ICF-DDN). These range in size from 4-15 beds. Almost half of these facilities are located in three Southern California counties. An alternative to ICF-DDs are the state-administered Developmental Centers. These have an even higher annual resident cost, estimated to range from $90,000 to $114,000. The high daily and annual costs for these out-of-home placements for the developmentally disabled have been a major factor in most states' attempts to move this population to home or community residential settings. Within the Residual program, those receiving Protective Supervision are likely the group at highest risk for ICF-DD placement. These individuals have average annual state-funded IHSS (inclusive of all authorized services) expenses of $13,500 (age 0-17) and $15,800 (for adults) in 2003. Fewer than 1% of children and non-aged adult IHSS recipients were discontinued from IHSS because they entered nursing homes in 2003. This rate was 2.2% among those age 65 or over.

Residential Care Facilities (RCF's): Residential Care Facilities (also termed Community Care Facilities) include a variety of licensed housing categories. Facilities are licensed by the Community Care Licensing Division of the State Department of Social Services. There are separate licensing titles for facilities serving children, non-aged adults, and the elderly. Appendix F provides a summary of these subgroups, including their price structure. These facilities have the common function of providing room, board, housekeeping, supervision, and personal care assistance with basic activities like personal hygiene, dressing, eating, and walking. This level of care and supervision is for people who are unable to live by themselves but who do not need 24-hour nursing or medical care. Individuals may use their SSI/SSP payments towards RCF care. California's supplemental payment varies depending on the recipient's living arrangement. The state payment is $174 higher per month (in 2004) for those in residential care facilities than for those in IHSS who have "independent living status" (U.S. Social Security Administration, 2004). Therefore, for every IHSS program recipient that enters a RCF, annual state SSP expenses increase by an average of about $2100 over those living in community

settings. Total state SSP costs for those in residential care are about $5100 annually. When the authorized level of care exceeds Service Level 1, SSI/SSP rates are supplemented with additional state payments. These rates are set by the Department of Developmental Services (2004). The level of service determination is made by the Regional Center. Parents pay a share of costs (up to $662 per month in 2004) for children under age 18. Monthly costs of Adult Residential Care (ARC) and Small Family Homes (SFH) range from $853 (level 1) to $5,009 (Level 4). Currently, there is only a Level 1 rate for Residential Care Facilities for the Elderly (RCFE).

The supply of these facilities varies widely among counties and communities across the state. Statewide there are 390 Small Family Homes (1760 beds), 5,018 ARC facilities (40,740 beds), and about 3430 RCFEs (63,130 beds). Further complicating access to these limited residential alternatives is that many will not accept developmentally disabled children with high service needs or behavioral problems. Families seeking this level of care may be on waiting lists or have to relocate outside their communities. The consequences of this on quality of life, quality of care, and recipient outcomes have not be estimated. If developmentally disabled individuals cannot be accommodated in community care facilities they may have to obtain housing in one of the state's Developmental Centers or an ICF-DD as discussed above.

PART III: IMPACT ANALYSIS

The analysis in this section estimates various state costs that may result from an elimination of the Residual program, should there not be a redistribution of recipients into PCSP or waiver funding. The analysis gives an extended focus on the Protective Supervision sub-group because of their high levels of frailty and the limited and expensive community service alternatives available to them; however, all the Residual programs are discussed at some length. There is a great deal of uncertainty about the range of possible population behaviors and outcomes. Because of this we have generally used conservative assumptions about likely cost shifts. This may bias the results to suggest higher program savings than may occur.

Methodology

To help identify qualitative issues of process and the variables most relevant to this analysis, interviews were conducted in March, 2004 with IHSS administrators in eight counties. These included a mix of urban and rural counties, as well as counties with a mix of high and low percentages of IHSS caseload in the Residual program. All eight counties had at least 1,000 individuals in the IHSS program per month in 2003.

Interviews were also conducted with executive staff in three state departments that administer a majority of the state's long-term care services: the Department of Health Services (CDHS), the Department of Developmental Services (CDDS), and the Department of Social Services (CDSS). These interviews were further supplemented in June-July 2004 to include the perspectives of Regional Centers, children's disability advocacy groups, and housing providers and ombudsmen. These interviews identified several factors that are not evident in the CMIPS datasets, each of which may be influential in how Residual program recipients might react to the proposed policy change. The interviews also suggested parameters and scenarios that served as a framework for the analysis. A listing of these informants is provided in Appendix B. For confidentiality, the discussion does not identify the specific source of comments.

The Administration's initial savings projections were used as a baseline; the analysis focused on sub-groups and outcomes with the greatest potential to add costs, thus altering baseline savings. The outcomes considered were limited to potential entry into out-of-home settings such as nursing homes, residential care facilities, and intermediate care facilities for the developmentally disabled. Cost shifts resulting from utilization of non-institutional public services and/or higher risks among those relying solely on informal care have not been forecasted because of the absence of reliable data on current use patterns of these services among IHSS recipients.

Data Limitations as a Source of Uncertainty

A number of household and other factors potentially affect the options pursued by the Residual program recipients. Not all of these factors are directly measured in the CMIPS dataset. The major areas of concern are discussed here.

Case-Level Variables. CMIPS does not identify whether a provider has income in addition to IHSS wages. Nor does it identify whether an IHSS provider is the sole income earner in the household. Therefore, the overall financial impact of losing IHSS services for a household or family is unknown. Isolating living arrangements is also limited. CMIPS does record whether a recipient "lives with others," but the relationship of "others" to the recipient (i.e., other than parent or spouse) is not defined. Therefore, it is not possible to identify conclusively whether a recipient lives with family and/or if a recipient has access to informal care (including Domestic care). "Number in household" is the measure used to represent possible access to this resource. While CMIPS records functional impairment levels, there is no record of a recipient's named condition (i.e. "developmentally disabled," "epileptic," "paraplegic," etc.). Where individuals turn for services may depend on the nuances and distinctions of their conditions that cannot be identified in the CMIPS data.

Preferences and Options. Where a disabled or elderly individual receives long-term care services is a function of several factors, such as family ties, financial concerns, cultural beliefs, and emotions, as well as personal preference for and awareness of different service alternatives. CMIPS data do not fully measure either set of items, adding unmeasured dimensions to attempts to develop statistical estimation models from this data set.

Cost Estimation Methods and Assumptions

Because the Governor's estimated IHSS program savings were projected for Fiscal Year 2005, our cost estimates are similarly for one year. Unless stated otherwise, all estimates for PCSP, nursing homes, RCF's, and ICF-DD's are based on costs for twelve months in that services.

Age Groups. The choice to enter the most appropriate type of facility may be influenced by one's age. For each option and within each Residual sub-group, all recipients were broken into three age groups: children (age 0-17), adults (age 18-64), and elderly (age 65+). Nursing homes, ARC and RCF's are generally geared to those over age 18, while ICF-DD's are geared towards adults and children with DD, as are SFHs. In our analyses, costs of transfer into nursing homes and residential care facilities are only considered for those over age 18, and exclude children. Costs of transfer into ICF-DD's are only considered for those under age 65, and exclude the elderly. Costs for transfer into PCSP and current IHSS costs considered all three age groups.

Estimated Gross Savings of Eliminating IHSS. Estimated gross savings of eliminating the IHSS Residual program were calculated by assuming that current Residual IHSS expenditures drop to zero. Therefore, current IHSS expenditures for each Residual sub-group served as the "estimated maximum gross savings" of eliminating the Residual program. Various "new" costs (as described below) that may result as a consequence of losing Residual services are estimated and subtracted from gross savings to calculate net estimated savings/costs.

The average authorized monthly gross expenditures in 2003 per person (by age- and Residual sub-group) were taken from CMIPS. The state share of Residual services were calculated as 65% of the average authorized monthly gross expenditures per person, reflecting the state share in the funding of these services. The state's annual average expenditures are calculated by multiplying the monthly state share by twelve months, and then by multiplying by the number of individuals

in the specified age- or Residual sub-group. These expenditures do not include current payments made to SSI/SSP and are based on authorized, not actual, gross expenditures.

Costs of Transfer into PCSP. The state is responsible for 33% of PCSP service costs. Therefore, the state's monthly share for clients moving from the Residual program into PCSP are calculated as 33% of the average authorized monthly gross expenditures per person in a particular age- or Residual sub-group. In other words, the cost to the state of individuals moving from a Residual program sub-group into PCSP is 33% of average 2003 IHSS gross authorized monthly expenditures on individuals in that sub-group. The monthly share is multiplied by 12 months, and then by the number of individuals in the specified age- or sub-group. Calculations are based on the assumption that individuals will be authorized the same number of hours after their switch into PCSP that they were authorized before the switch. This assumption may overestimate costs if clients are authorized fewer hours if they move into PCSP.

Costs of Transfer into Nursing Homes. All nursing home cost estimates are based on the 2002 Medi-Cal average daily reimbursement rate. Cost estimates assume that all individuals transferring into nursing homes will receive Medi-Cal reimbursement; this may overestimate costs if all clients do not actually receive Medi-Cal coverage. In 2002, the daily Medi-Cal reimbursement rate was $118 (Cline and Hiehle, 2003). Because the state is responsible for 50% of Medi-Cal payments for nursing homes, (Streett, 2001), the state share is calculated as one half of Medi-Cal costs, or $59 per day. Annual state costs were calculated by multiplying $59 by 365 days in a year, and then multiplying by the number of individuals in a particular age- or Residual sub-group.

To be conservative we have assumed that Medicare[5] may pay for the first 30 days of nursing home care for those age 65 or more. Accordingly, state costs for the first 30 days were adjusted to zero for all individuals over age 65 in all nursing home cost estimates. Annual costs for individuals in this age group were calculated by multiplying by 335 days instead of 365.

Costs of Transfer into ICF-DD's. Cost estimates assume that all individuals transferring into ICF-DD's will receive Medi-Cal reimbursement; this may overestimate costs if all clients do not actually receive Medi-Cal coverage. Similarly to nursing homes, all ICF-DD's cost estimates are based on the 2002 Medi-Cal average daily reimbursement rate for ICF-DD's, which was $144.51 (Cline and Hiehle, 2003). Because the state is responsible for 50% of Medi-Cal payments for ICF-DD's (Streett, 2001), the state share is calculated as one half of Medi-Cal costs, or $72.26 per day. Annual state costs were calculated by multiplying $72.26 by 365 days in a year, and then multiplying by the number of individuals in a particular age- or Residual sub-group.

Costs of Transfer into Community Care Facilities. All Community Care Facility cost estimates are based on two factors. The first is the additional amount that the state pays to SSI/SSP for non-medical room and board above the state's share of SSI/SSP for individuals "living independently." This additional state payment was $174 higher per month (in 2004) for those in community care facilities, than for those in IHSS who have an "independent living status" (U.S. Social Security Administration, 2004). Therefore, this additional state cost for a

[5] Medicare is a federally funded program (Title XVIII of the Social Security Act) that pays for health care services for U.S. residents over 65 years of age.

transfer into CCF's is calculated by multiplying $174 by twelve months, and then by the number of individuals in a particular age- or Residual sub-group. This assumes that all IHSS individuals are currently receiving the SSI/SSP payment for individuals "living independently," which would increase by $174 for the state if those individuals moved into a CCF. This is the lowest estimate for new costs, and assumes that all transitions will be at Level 1 frailty. Should the non-aged individuals making these transitions have higher frailty (a likely scenario), then state monthly costs could likely begin to exceed the reduced cost of IHSS services. This is the second factor in cost estimates. For example, a Protective Supervision client authorized for 250 hours of IHSS services would have monthly IHSS expenditures of about $2000-$2,500 depending on the county of residence. This compares to the monthly community care facility rates for Service Level 4(a) clients ($2,855) and range up to $5,009 for Service Level 4(i) clients. (See Appendix F for a definition of each level.)

Costs Not Considered. There are several costs of eliminating the Residual program that are not included in this analysis. One such cost is increased hospitalization due to program elimination. Emergency hospitalizations due to accident, injury, or illness that result from loss of services cost the state at least $577 per day in 2002. In 2003, 518 Residual recipients entered hospitals from IHSS (CMIPS Data, 2003); the potential for more recipients to enter if IHSS services are lost may be far greater. Increased utilization of non-institutional options such as Adult Day Health and Regional Center services are also not considered. These services would add annual costs of $2,424 and $7,678, respectively, per person (California Health and Human Services Agency, 2003, *Olmstead Plan)*. Other costs not considered in this analysis are increased demand for public assistance from caregivers who have given up employment in order to provide care for a child or spouse, who will lose their IHSS wages, and thus may be on other forms of public assistance, including SSI/SSP.

County Variation

Presented here are general findings and observations about the variations in the IHSS program across the state. These are followed by analyses of potential state costs assuming elimination of the Residual Program service.

IHSS Participation

Table 6 shows the variability between counties in IHSS participation per 1,000 adult population and in the percentage of the IHSS caseload receiving Residual services. There is also substantial variation in authorized hours and discontinuance among the counties. This variation remains after adjusting for the characteristics of the recipients. Much of these differences are likely explained by variations among the IHSS social workers and in administrative practices pertaining to the monitoring of practice variation among their staff. None of these factors are directly measured in the CMIPS. Because of this a number of measures have been used in various stages of analysis to serve as proxy indicators of county differences (other than simply using county indicators as adjusters). The measures include items derived from county-level aggregations of the IHSS recipients, and other attributes that adjust for service supply and other possible resources available within the counties.

Table 6

Annualized County Distribution of IHSS Recipients, 2003

County	Total IHSS	IHSS/1000 Population	% of IHSS in Residual & Split
ALAMEDA	13,851	9	16%
ALPINE	11	9	45%
AMADOR	203	6	21%
BUTTE	3,121	15	22%
CALAVERAS	385	9	10%
COLUSA	218	11	25%
CONTRA COSTA	7,007	7	12%
DEL NORTE	422	15	20%
EL DORADO	713	4	28%
FRESNO	13,183	16	20%
GLENN	516	19	9%
HUMBOLDT	2,269	18	28%
IMPERIAL	4,275	28	26%
INYO	97	5	38%
KERN	5,211	7	22%
KINGS	1,506	11	18%
LAKE	2,118	35	21%
LASSEN	284	8	33%
LOS ANGELES	152,121	15	15%
MADERA	1,602	12	12%
MARIN	1,339	5	24%
MARIPOSA	275	16	15%
MENDOCINO	1,667	19	26%
MERCED	3,000	13	25%
MODOC	132	14	17%
MONO	43	3	65%
MONTEREY	3,034	7	23%
NAPA	638	5	23%
NEVADA	791	8	18%
ORANGE	11,560	4	22%
PLACER	1,274	5	23%
PLUMAS	360	17	14%
RIVERSIDE	13,515	8	22%
SACRAMENTO	16,063	12	19%
SAN BENITO	317	6	13%
SAN BERNARDINO	17,729	10	17%
SAN DIEGO	22,501	8	26%
SAN FRANCISCO	16,360	21	14%
SAN JOAQUIN	6,221	10	23%
SAN LUIS OBISPO	1,592	6	32%
SAN MATEO	2,728	4	25%
SANTA BARBARA	2,649	6	19%
SANTA CLARA	9,463	6	28%
SANTA CRUZ	1,810	7	24%
SHASTA	2,834	17	17%
SIERRA	51	14	33%
SISKIYOU	570	13	17%
SOLANO	2,826	7	16%
SONOMA	3,817	8	21%
STANISLAUS	5,271	11	18%
SUTTER	572	7	20%
TEHAMA	1,354	24	37%
TRINITY	170	13	16%
TULARE	2,896	8	31%
TUOLUMNE	358	6	11%
VENTURA	3,157	4	23%
YOLO	1,404	8	10%
YUBA	871	14	14%

Source: California Department of Finance, County Population Data, CMIPS Data

The percentage of IHSS caseload receiving Residual services in counties ranges from 10% to 37% (including only counties with more than 1,000 IHSS recipients). After adjusting for frailty, this variation may be indicative of a county's ability to define conditions as eligible for federal

participation or an ability to somehow screen out applicants that do not meet federal qualifications; alternatively, it may be indicative of a county's willingness to offer a more generous range of benefits than those permitted under Medicaid regulations. The election of spouse/parent providers may also be a reflection of the labor supply available for personal assistance services. This supply is affected by county wage rates for IHSS providers and employment alternatives for family and other providers. Per capita income and the age mix of a county's population may be indicative of the potential demand for services and the possible extension of this demand beyond publicly subsidized IHSS recipients.

Variation in LTC Resources

Long-term care options vary widely across counties. Therefore, where Residual clients may turn for services depends upon what other resources are available within the county and the distance to available resources. Some counties (e.g., San Luis Obispo) seem to have higher numbers of IHSS recipients and are relatively low on alternative supply; some (e.g. Tehama, Ventura, and Santa Clara) have lower levels of both recipients and alternative supply; some (e.g., San Diego and Los Angeles) have high levels of both. Some (e.g., San Francisco) are located in regions that are high in resources although some resources may be limited in individual counties. The presence of available resources relative to the potential demand represented among IHSS recipients, in other words, is not constant among counties and needs to be considered in evaluating the impact of program changes on a county by county basis.

Temporal Uncertainty

As evidenced by 14,752 IHSS clients who switched between Residual, PCSP, and Split status over the course of 2003, conditions and service needs change over time (CMIPS Data, 2003). Some of these recipients moved into and out of Residual and PCSP several times over the course of a single year. The dynamic nature of service needs (or perhaps provider availability) adds to the uncertainty in projecting the impact of eliminating the Residual program. Several county administrators mentioned the potential for neglect and worsening of conditions for cases that are coming in and out of funding. This may contribute to the decisions to select higher versus lower cost service alternatives. The causes underlying the movement between funding sources is not explicitly documented within CMIPS.

PROTECTIVE SUPERVISION

Individuals receiving Protective Supervision are largely those found to have substantial levels of cognitive frailty. About 80% of Protective Supervision recipients need assistance on at least two of three measures of cognitive function. This compares to less than 8% with similar cognitive frailty in all other groups. Cognitive frailty is also associated with high rates of functional limitations. Ninety-five percent of Protective Supervision cases need assistance in at least 2 IADL's, and 87% have limitation in at least 2 ADL's. These levels of frailty qualify for out-of-home placement.

Under current policy, 283 is the maximum number of IHSS service hours that can be authorized in a month.[6] This is the equivalent of just over 9 hours per day. Protective Supervision recipients, as a group, have the highest average monthly hours of all the Residual program sub-groups, averaging about 250 hours monthly or about 8 hours per day. Protective Supervision hours account for about 64% of these hours or 158 hours per month. Thus an elimination of Protective Supervision coverage does not eliminate all IHSS expenses for most recipients. Further, authorized hours for some of the other service needs might be expanded. Should that not occur it is important to recognize that the average Protective Supervision client would be going from about 8 hours of service daily to about 3 hours. Whether families would be able to sustain the recipient at home with this substantial reduction in time is problematic from two perspectives. One involves the loss of income from outside employment that might result from having to provide more care and supervision during working hours. An alternative may be to seek community care facilities. Almost all of the IHSS administrators interviewed stated that Protective Supervision recipients, because of higher service needs, would be at high risk for community care placement if the Residual program were eliminated.

We have not estimated the effects on household employment rates or family income. Should these drop, this may have a cost implication for the SSI/SSP or state social welfare programs.

The state's share of IHSS average expenditures on the Protective Supervision recipients in 2003 was approximately $228.8 million. A transfer of all these recipients into PCSP or a waiver program keeping current service levels unchanged would result in savings in state dollars of something less $114.4 million dollars. While all new PCSP reimbursed services would have half the expenditures absorbed by the Medicaid program, as much as 10-15% of the total IHSS expenditures on this group are currently being reimbursed under PCSP and would not be affected by the transition to this source of payment. Thus savings of $114.4 million is the upper limit estimate. Should fewer than 100% of the recipients transition to federal funding, the state's savings would be reduced proportionately.

If Protective Supervision coverage was eliminated, then consideration shifts to the cost consequences of having some proportion of the recipients transfer to home placements. Given the levels of ADL, cognitive, and IADL frailty, all would meet the placement criteria for either community care facilities or nursing homes. The following tables show expenditure estimates under two scenarios. One is transitions into nursing homes/ICF-DDs, the second into licensed housing. Cost estimates are shown in Table 7 for two rates of placement using the methodology described in the previous section. Estimates are presented by age group. The daily rates and settings vary by age group. For example, while all three age groups may conceivably transfer into PCSP, only those age 65 or more were considered in cost estimates for transfer into nursing homes. Those age 0-17 and 17-64 were assumed to be entering ICF-DDs. The daily rate for a nursing home was set at $118 in these estimates and the rate for ICF-DD was set at $144.50. Residential care/community care facility costs are potentially more complex to model as the rates vary substantially as the Service Level rises. For those age 65 or more we assumed the basic

[6] For severely-impaired Residual clients, hours are capped at 283 per month; for non-severely impaired Residual clients, maximum hours are 195 per month (See Appendix D for details regarding the "severely-impaired" classification). For all individuals receiving only PCSP services, maximum hours are 283 per month, regardless of whether they are severely impaired or not.

SSI/SSP payment would increase by $174 monthly to help off-set the rent and personal assistance care in these facilities. Under current regulations IHSS reimbursed services cannot be provided to RCFE residents, so this small increase in SSI/SSP payments is off-set by an elimination of any IHSS payments. For children and developmentally disabled adults the same assumptions were made about an increase in SSI/SSP; additionall,y we assumed a mid-point Service Level (4b) and its corresponding residential payment of $3000 monthly. This rate was reduced by $642 per month for those age 0-17 assuming that all parents contributed this maximum level of cost sharing.

Table 7: Protective Supervision Cost Estimate Scenarios

Scenario 1: Transfer into Nursing Homes or ICF-DDs				
Age Group	2003 State IHSS Expenditures*		50%	25%
0-17	$26,712,174	Cost	$28,411,018	$14,205,509
		Net Savings	**-$1,698,844**	**$12,506,665**
18-65	$128,075,300	Cost	$111,077,137	$55,538,568
		Net Savings	**$16,998,163**	**$72,536,731**
65+	$74,015,888	Cost	$46,101,862	$23,050,931
		Net Savings	**$27,914,025.81**	**$50,964,957**
Scenario 2: Transfer into RCF/Community Care Facilities				
	2003 State IHSS Expenditures*		50%	25%
0-17	$26,712,174	Cost	$32,115,888	$16,057,944
		Net Savings	**-$5,403,714**	**$10,654,230**
18-65	$128,075,300	Cost	$157,398,660	$78,699,330
		Net Savings	**-$29,323,970**	**$69,145,628**
65+	$74,015,888	Cost	$4,870,260	$2,435,130
		Net Savings	**$69,145,628**	**$71,580,758**

*This includes all IHSS expenditures by Protective Supervision recipients in 2003.

Under these scenarios there is a substantial erosion of the state's IHSS cost savings under either assumption of placement rates. Should the out-of-home placement rate into CCF's approach 50%, the state's cost would actually increase over current Protective Supervision program costs for two age groups. Under the assumption of 25% moving to licensed residential settings, the state would potentially realize more savings than if the program were transitioned into PCSP. However, this estimate does not include the IHSS expenditures that might continue among those remaining in the community. Thus, unless the relocation rate remains substantially under 25% it is likely that the state will experience no greater cost savings from an elimination of this program than they might realize from transitioning it to shared payment with Medicaid.

Further uncertainty around cost savings estimates arises due to the many unmeasured variables that could potentially influence someone to enter an out-of-home facility that are not built into this model because of data limitations. For instance, outside sources of income, family networks, availability of informal care, and housing options may be particularly important in determining the likelihood of institutionalization, yet are unidentifiable in CMIPS. Within this group, there are older adults with dementia or Alzheimer's disease, clients with mental health problems,

adults and children with DD, and various other distinct conditions that may influence which option is most appropriate for a recipient. Such distinctions are not identified in CMIPS.

Aside from the potentially high variable new cost to the state should Protective Supervision be eliminated, there is a further consideration arguing for the option of transferring this service to the PCSP program. Since 1997 CMS Medicaid guidelines have permitted the funding of cueing services within state plan covered services. California had not previously taken advantage of this option. We proposed this alternative to state officials, and a legal opinion was also provided on this by Protection & Advocacy (see Appendix G). In August 2004, California received approval from CMS to include protective supervision as Medicaid covered within the IHSS program.

ADVANCE PAY

Of all groups, the Advance Pay sub-group has the highest percentage of individuals meeting the criteria defining "frail" in IADL's, ADL's, or breathing measures (100%, 100%, and 24%, respectively). 100 percent of Advance Pay cases are "severely-impaired," and thus entitled to the maximum allowable hours per month. Many individuals using the Advance Pay option are quadriplegic, and many use ventilators (California Health Care Foundation, 2003).

Up until now, these cases have had the choice of using a payment system that allows them to pay multiple providers directly. Due to their high levels of frailty, severe impairments, high needs, and high number of authorized service hours, it is likely that these recipients will change their payment process in order to maintain their services through PCSP (CA Senate Budget and Fiscal Review Subcommittee No.3, 2004). When faced with a choice between losing all services and switching to retroactive payment, these cases may likely choose to maintain services. Those not making such a transition would be at high risk for nursing home placement (at a minimum of $118/day). For every such case, the state would experience expenditures great than those incurred under the residual program even after allowing for SSI/SSP savings and an federal match of half the nursing home cost. In addition to this the state would be vulnerable to law suits relative to possible violations of the Olmstead Act.

Recognizing these likely scenarios, the state elected to seek (and subsequently obtained) a Medicaid section 1115 waiver to be able to continue the Advance Pay program with federal matching funds. The net savings to the state will be 50% of prior expenditures, without any increased risk for increased secondary expenditures that might occur with an elimination of the program.

DOMESTIC CARE ONLY

The Domestic-Only sub-group is the least impaired of the IHSS residual program recipient subgroups, with about 1% being defined as frail on ADL's, Breathing, or Cognition. However, 98% of these cases are frail in IADL's, and under Medicaid guidelines in place since 1997 (see Appendix G), they could qualify for the PCSP program. Once this option was made known to state officials, they sought CMS approval to switch the program to a state plan funded program. Approval was obtained in August 2004 and the state is now able to receive federal matching funds for the Domestic-Only recipients, reducing state expenditures by 50%.

Had the state not pursued this option the originally projected cost savings would likely have not been this high, even though the program was proposed for elimination. One reason for this was the expectation by many officials interviewed that a large number of the program recipients could become eligible for PCSP by a determination that personal care services were also necessary. Domestic care during this period (even without 1997 the CMS rule change) was available as an adjunct to personal care under Medicaid regulations. Interviews with IHSS administrators revealed a wide range of county plans to handle re-assessments of Domestic-Only cases and authorization of personal care services to facilitate switchover into PCSP. Some counties had already made efforts to educate clients about their risk of losing all services if they do not express a need for personal care services. Administrators in such counties acknowledge that several elderly individuals end up in this sub-group simply because they are too "stubborn" or "proud" to admit the need for help with personal care services. If someone cannot do shopping, laundry, cooking, and cleaning, then they may need assistance with at least some personal care services such as shampooing their hair and dressing. The commonly expressed sentiment was that once a client was informed that they may lose all IHSS services, they would likely to admit the need for further assistance. All this suggests that a potentially high proportion of the then current recipients would transition to PCSP funding.

An additional consideration was that while the Domestic care only subgroup was thought to be at low risk for nursing homes or ICF-DD's placements, but the high prevalence of IADL frailty suggests that those without live-in relatives would be candidates for Community Care/Residential Care Facilities. For most of those making such a transition this would be at best a budget neutral shift, namely the increase in SSP payments would likely off-set the monthly expenditures savings for IHSS. However, any of these individuals qualifying for Service Level 2 or higher in community care facilities would have increased state costs over those in the IHSS program.

The alternative with the lowest risk for increased state cost was to have the Domestic-Only cases switch into PCSP.

PARENT/SPOUSE PROVIDER

Clients with a parent or spouse provider accounted for 20,770 of all the Residual program recipients in 2003 and almost 3/4ths of the children receiving IHSS services. On number of authorized hours and frailty levels, these individuals fall in a middle range above Domestic Care-Only cases, and below Protective Supervision and Advance Pay recipients. Under Medicaid regulations it would be possible to move these recipients into PCSP by switching to a non-responsible relative provider. The administration's original budget estimates assumed that perhaps as many as 25% of recipients would be able to make such a change in providers. Financial incentives may also be large enough to encourage "paper divorces" so that spouses may continue to receive payment for providing care, or to falsify the identity of their primary caregiver. Monitoring these adaptations would be an added state cost.

The Administration's assumption about the number likely to switch into PCSP by changing providers may be problematic for several reasons. First, it does not acknowledge the difficulty

that some individuals may have had in finding alternative providers, especially in rural areas with low provider supply. According to the CDSS Manual of Policies and Procedures, a parent/spouse provider in IHSS must already be the provider of last resort. Parents providing services have already met the standard of being precluded from working full time because of the severity of their child's disability. Social services staff are required to establish that the only remaining adequate alternative to parent-provided care would be institutional care (California Health Care Foundation, 2003). If these requirements are being followed in the counties, then it unlikely that substantial proportions of those with parent or spouse providers would be able to find a different provider or choose to do so.

Secondly, in situations where the parent or spouse provider would lose income from IHSS and would need to leave the home to earn income as a result of the policy change, recipients could be left without in-home service options. Such recipients who likely be at risk of entering more expensive levels of care.

Further complicating matters is a factor unique to this sub-group. Recipients of IHSS, by eligibility criteria, are persons with low-incomes. For many families, the IHSS wages earned by a parent or spouse provider may be the only payment enabling the recipient to live at home. Average monthly net payments for recipients in the Parent Provider sub-group were $695, or $8,342 annually in 2003 (CMIPS Data, 2003). These wages would be lost as a result of the originally proposed policy change. Parents and spouses who continued to provide unpaid care and who could not increase their monthly income may then require assistance from cash aid programs like CalWORKS and the food stamp program. Financial consequences are difficult to predict because data on outside wages or additional family income are not available in CMIPS. However, it is likely that the responsible relative may need to replace the lost IHSS wages with other earnings. Under current federal regulations, in certain situations these earnings would be counted as "family income" available to the IHSS recipient. Such an interpretation could reduce or completely eliminate the IHSS recipient's SSI/SSP payment, or require a share of cost for IHSS participation. The California Department of Social Services is unable to provide data to determine how many households may face potential reduction in SSI/SSP benefits in this manner (LAO, 2004).

Another issue unique to this group is the importance of IHSS provider supply. It may be especially difficult to find individuals outside the family to provide care in counties with labor shortages and low IHSS wages. Legislative hearings in Los Angeles and Sacramento in 2003 have been attended by parents of minors who were especially reluctant to give up caring for their disabled children. Choices for parents are complicated by the fact that they are liable to either provide or locate adequate sources of care, or they can be prosecuted for abandonment.

The preceding factors make any estimate of rate or proportion of transfers into PCSP, absent a waiver, very uncertain. The variable supply of community care facilities further complicates county-level estimates in the use of this more costly to alternative. This high degree of uncertainty does not allow the construction of a likely range of costs that is non-arbitrary. A less uncertain strategy in the short term is to strengthen county practices to assure that parent/spouse providers are indeed the providers of last resort, and/or to pursue waivers that permit these

providers. Over the longer term data might be added to CMIPS to better document the living arrangements and income sources of relative providers.

The administration's decision (in May 2004) to place the parents and spouses under a Medicaid 1115 waiver appear to be the best option. The waiver approved by CMS in August 2004 allows the continuation of services for this group and assures the state of a 50% reduction in its prior expenditures with the concerns of whether clients could change providers in a short transition period, whether the authorized hours for non-family member providers would be higher than for family members, and whether substantial proportions of the recipients would have to relocate to out-of-home placements.

PART IV: CONCLUSION

Summary of Findings

California's initial fiscal year 2005 budget proposed a state General Fund savings of $366 million over prior year spending in the In-Home Supportive Services program. These savings were assumed to be obtained by the elimination of an IHSS component known as the Residual Program. These estimated savings are based on the assumption that most residual service recipients will remain in the community and substitute unpaid assistance for the services formerly reimbursed by IHSS. These changes would directly effect about 70,000 recipients and the assumptions did not fully consider the viability of family support, the ability and willingness of counties to transfer recipients into other IHSS services, and the additional state expenses that might occur due to inadequate assistance, loss of income, or transfers into out-of-home settings such as nursing homes, intermediate care facilities for the developmentally disabled, and community care facilities.

The elimination of the Residual Program was opposed by service recipients, family members, providers, and advocacy groups. The analyses reported here, and those by others, suggested that the proposed savings may have been over estimated and that there was high uncertainty regarding the effects on the recipient population. This uncertainty included possible increased costs associated with out-of-home placement and legal activity associated with possible violations of the Supreme Court's 1999 *Olmstead* decision. A further basis supporting a more balanced approach arose from the finding that changes in federal policy (dating to 1997) permitted major components of the Residual Program (i.e., Protective Supervision and Domestic Care Only) to be eligible for federal matching funds. The state ultimately withdrew the proposals to eliminate the Residual Program, and sought federal approval to fund Protective Supervision and Domestic Care Only under Medicaid as part of its state plan. Medicaid section 1115 waivers were also sought to fund the remaining residual services (e.g., parent and spouse providers, Advance Pay recipients). Medicaid approval for all these proposed changes was obtained in August 2004. This effectively reduced state spending on Residual Program services by 50%, but removed the uncertainty about possible adverse effects that may have occurred had the services been eliminated instead.

Of the many outcome scenarios considered, obtaining a 50% reduction in expenses without increased uncertainty seems to be the most reasonable alternative to have adopted. For example, should (in the absence of the Residual Program) as few as 25% of those in Protective Supervision and Domestic Care Only elect to move from their in-home setting to a community care facility or ICF-DD, state expenditures would be about the same level as those obtained by moving the program into the state plan. Should placement rates go higher, or should other IHSS services be substituted for any lost Residual Program services, state expenditures could be even higher—and budget savings lower.

Areas for Further Consideration

The immediate task of reducing state and county IHSS expenditures for Residual Program services is but an initial response to ongoing costs of the IHSS program itself. IHSS costs more than doubled between 1998-99 and 2003-04, going from $1.4 billion to $3.4 billion. There are multiple forces affecting this: population growth, the aging population, enrollment increases, deinstitutionalization, wage increases, and administrative practices. Of these, the most tractable may be program administration.

We conducted a preliminary analysis using recipient characteristics in the CMIPS data set (e.g., gender, race, household size, parent/spouse provider, and frailty indicators), and measures representing each individual county compared to the state average for authorized hours (i.e., Los Angeles county). This model was used to predict IHSS authorized hours. Separate models were estimated for each of the three main age groups, (0-17, 18-64, 65+). All models "explained" about 60% of the variation in authorized hours, and showed that many counties had significantly higher authorized hours than Los Angeles. A next stage in these preliminary analyses compared counties on other outcomes such as death rates, nursing home placement, community care placement, and other discontinuance from IHSS, using the same variables as earlier and authorized hours. These analyses showed Los Angeles to have outcomes similar to those of many counties, including those with higher authorized hours. These analyses were then incorporated into a simulation model to assess the effect on authorized hours if all counties performed at the same case mix adjusted level as Los Angeles County. These results suggested that the total number of case mix adjusted hours could be reduced in the state (with adverse consequences) if the practices of Los Angeles County (or other exemplar counties) could be replicated across the state.

Such a finding leads to at least four recommendations

- The Department of Social Services should re-examine the administrative practices among the counties (particularly those authorizing hours well above the state average) to determine the source of county authorized hours variation.
- Practices in those counties with lower average case mix adjusted authorized hours could be compared with each other, and with professional standards to derive "best practice" approaches.
- Training and other programs could be implemented to disseminate and adopt the best practice approaches across the state, or in a sample of counties.
- Implementation and the incentives leading to effective adoption should be monitored and evaluated.

There are many things that make these findings preliminary. For one, the selection of Los Angeles County was illustrative, and the models upon which the outcomes derived were based on the limited information available in the CMIPS data. Los Angeles County accounts for almost half the statewide population using IHSS. While for many services the county has mean case mix adjusted authorized hours that are at or below the statewide average, we do not have

detailed knowledge of how their administrative practices vary within the county or compared to other counties, or whether the practices of some other counties might be more efficacious. Further, information on the living arrangements of IHSS recipients and the housing and other service alternatives available to them are not fully measured in the analysis. Such things may contribute to the patterns of authorized hours.

- Further analysis of the IHSS program, and refinement of the CMIPS data set (such as adding information on household members, housing type, income sources of providers) and of county characteristics (such as labor supply, service and housing alternatives) would be useful in helping to refine the predictive and simulation modeling.
- Developing data sets that better document the total state program service use and cost of IHSS recipients (i.e., all state funded services, not just IHSS) and the outcomes (and expenditures) for those discontinuing IHSS are needed.

Presently, documentation of discontinuance is most reflective of the first month of terminated eligibility (e.g., death, hospital stay, moved). Any sequence of events such as a hospital stay leading to a nursing home stay, leading to death or to a community care facility stay are not systematically documented by the IHSS program. Because the sequence of events is not well known, the total costs of post discontinuation are unknown, as are the possible risk factors that might be associated with these events. Refining the IHSS data set, and systematic monitoring of the outcomes (and costs) such as those noted here will be useful to DSS in monitoring state and county practices within the IHSS program.

Finally, the IHSS program does not operate in isolation from changes in long term care delivery. Among others these include issues of provider supply, efforts to reduce nursing use, and the movement toward consumer choice and consumer directed care. CMIPS and the data system expansions suggested above provide a real time window into the long term care system, and how this system is affecting recipients applying for IHSS services, and the consequences of IHSS practices (e.g., eligibility, authorized hours, provider eligibility) on the population subgroups being served. CMIPS has not been used in this manner by the state, but it appears to offer real potential as a needed information resource for the state's on-going role in planning and refining the state's long term care resources.

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Appendix A: Data Sets and Coding Rules

Annualizing the Dataset: In order to conduct analysis for all of 2003, monthly files were annualized using "exposure months," whereby variables are averaged over the months that a recipient received services. 14,752 recipients changed their Residual, PCSP, or Split classification one or more times throughout the year. These recipients were classified according to their status during their most recent month in the program to get the most accurate sense of current caseload. 3.7 million monthly records for 2003 included duplicate cases (a single recipient having separate records for each month in the program); these records were collapsed to 370,325 unduplicated cases in the annualized dataset.

Logic Code for Residual/Split/PCSP Classification: There are no distinctions in the REL datasets that indicate whether a recipient is classified as Residual, PCSP, or Split. Funding sources are determined retroactively by CMIPS personnel after services are provided. In order to create this distinction, a logic code was built based upon the rules and regulations in the CDSS Manual of Policies and Procedures that outline IHSS funding sources. The logic code is based on a combination of the types of services authorized (found in the REL files) and the relationship of the provider and recipient (found in the PELG file). The following logic code was derived by using the IHSS Regulations outlined in the CDSS Manual of Policies and Procedures to construct the variable which classifies recipients as Residual, Split, or PCSP.

- "Pure Residual" Group – The entire caseload data was filtered to identify individuals who satisfy any of the following:

1. Individuals that have only one provider and their provider is a parent or spouse. If "number of providers" = 1 (PELG data), AND one of their providers is coded as a spouse or parent of a minor child (PELG data).
2. Individuals who receive domestic-care and/or protective supervision ONLY, with no other services If "domestic/protective" = 1 (RELC data), AND non-domestic/protective = 1, where domestic/protective = 1 if authorized hours in ANY field classified in CDSS Manual of Policies and Procedures (1993) Section 30-757.1.11(a-k) or Protective Supervision (field WW) is greater than 0, and non-domestic/protective = 1 if authorized hours in ANY other field = 0.
3. Individuals using the "advance pay" option If "advance pay" = F or P (Line M, RELB data), where F or P indicates a form of advance payment.
4. Individuals who receive only a meal allowance and no other services. If "meal allowance" = Y (Line M, RELB data) AND non-AA-YY = 1 (RELC data), where non-AA-YY = 1 if authorized hours in every category other than meal allowance = 0.

- "Split" Group – For recipients not satisfying the steps above, the remaining cases were filtered to identify individuals who satisfy any of the following:

1. Individuals who have a parent/spouse provider paid through Residual in addition to a non-parent/spouse provider paid through PCSP. If "number of providers" >= 2 (PELG data), AND one of their providers is coded as a spouse or parent of a minor child (PELG data).
2. Individuals who receive protective supervision in addition to other PCSP services. If "protective" = 1 (RELC data).
3. Individuals who receive a meal allowance in addition to other PCSP services. If "meal allowance" = Y (Line M, RELB data).

- "PCSP" Group – All remaining cases not satisfying the above steps are "pure PCSP" cases, receiving no Residual services.

Method Used to Classify Duplicate Cases into 6 Residual/Split Sub-Groups: All individuals receiving any Residual services are classified into 6 sub-groups according to which Residual services they receive. The primary 6 sub-categories are as follows:

Group 1. Parent of minor provider
Group 2. Spouse provider
Group 3. Domestic-care only
Group 4. Protective Supervision
Group 5. Advance Pay
Group 6. Meal allowance

Clients may fall into as many as three duplicate categories. For example, a recipient may have a spouse provider and also receive protective supervision. All duplicate cases were analyzed along the following variables: age, frailty, and total number of authorized monthly hours. Based on these variables, duplicate groups were collapsed back into the "primary" category that they were most similar to. Duplicate groups with very small numbers (<100) were grouped back into the larger primary group. Duplicates were re-grouped according to the following hierarchy:

- Any recipient in Group 4 (protective supervision) joins Group 4. The following duplicate cases are all included in Group 4:

	Residual	Split	Total:
(1) and (4) (Parent Provider & Prot. Sup.)	1866	69	1935
(2) and (4) (Spouse Provider & Prot. Sup.)	327	26	353
(4) and (5) (Advance Pay & Prot. Sup.)	90	0	90
(4) and (6) (Meal allowance & Prot. Sup.)	0	3	3
(1) and (4) and (5)	32	0	32
(2) and (4) and (5)	4	0	4
Total Duplicate Cases Included in Group 4	**2319**	**98**	**2417**

- Aside from those in Group 4, any recipient in Group 1 (parent provider) joins Group 1. The following duplicate cases are all included in Group 1:

	Residual	Split	Total:
(1) and (3) (Parent Provider and Domestic-Only)	35	0	35
(1) and (5) (Parent Provider and Advance Pay)	39	0	39
(1) and (6) (Parent Provider and Meal Allowance)	1	0	1
Total Duplicate Cases Included in Group 1	**75**	**0**	**75**

- Aside from those in Group 4, any recipient in Group 2 (spouse provider) joins Group 2. The following duplicate cases are all included in Group 2:

	Residual	Split	Total
(2) and (3) (Spouse Provider and Domestic-Only)	19	0	19
(2) and (5) (Spouse Provider and Advance Pay)	42	0	42
(2) and (6) (Spouse Provider and Meal Allowance)	1	0	1
Total Duplicate Cases Included in Group 2	**62**	**0**	**62**

- Aside from those in Groups 1 and 2, any recipient in Group 3 (domestic-only) joins Group 3. The following duplicate cases are all included in Group 3:

	Residual	Split	Total
(3) and (6) (Domestic Only and Meal Allowance)	310	0	310

Methodology used to determine Frailty*:* In the dataset, recipients receive a score from one to six on 14 different activities related to frailty.[1] The 14 activities were re-coded into four new variables: Activities of Daily Living (ADL's), Instrumental Activities of Daily Living (IADL's), Breathing, and Cognition.[2] The ADL, IADL, cognition, and breathing variables include the following:

ADL's	Bathing and grooming Dressing Bowel, bladder, and menstrual careTransfer Eating
IADL's	Housework Laundry Shopping and errands Meal preparation and cleanup Mobility inside
Cognition	Memory Orientation Judgment
Breathing	Breathing

For each activity, recipients are given a ranking based on the following scale (CDSS, 2002, CMIPS User's Manual):

[1] The Cronbach Coefficient Alpha was used to check the consistency of internal relationships between these 14 variables.

[2] ADL's and IADL's are the standard measures used by medical, social service, and nursing practitioners in the determination of care services for the elderly and disabled. ADL's = bathing, dressing, eating, bowel/bladder requirements, etc. IADL's = shopping, meal preparation, house cleaning, etc. The standard for "frailty" is defined as a need for assistance with more than one ADL or IADL.

1-1.9	Independent – Able to perform functions without human assistance though client may have difficulty. However, completion of the task with or without devices poses no risk to his/her safety.
2-2.9	Able to perform but needs verbal assistance such as reminding, guidance or encouragement.
3-3.9	Can perform with some human help, i.e. direct physical assistance from the provider.
4-4.9	Can perform with a lot of human assistance.
5-5.9	Cannot perform function at all without human assistance.
6	Paramedical services needed.

For comparison of frailty between sub-groups, a consistent definition was applied for frailty according to the standard definitions that identify an individual as frail if they need assistance in more than one ADL or IADL. The original 6-point scale is used to determine frailty in any of these four measures. A rank of 3 or higher on the 6-point scale indicates that at the minimum, a recipient can perform the activity "with some human help (i.e. direct physical assistance from the provider)." For ADL's, IADL's, and cognition, individuals are defined as frail if they have a ranking of 3 or higher in two or more activities that fall into that variable. For breathing, individuals are defined as frail if they have a ranking of 3 or higher for "breathing."

Appendix B: Key Informants

County Administrators:

Baran, Margaret. IHSS Specialist, IHSS Consortium of San Francisco. June 29, 2004

Boggio, Barbara. Program Manager for Adult Services and Employment Services, Tehama County. March 11, 2004.

Bonds, Melinda. Area Agency on Aging Information Specialist, Los Angeles County. March 15, 2004.

Buck, Bob. Executive Director of IHSS Public Authority and Manager of Adult Services Program Administration, Ventura County. March 8, 2004.

Burton, James. Director, Regional Center of the East Bay, Oakland, CA. July 19, 2004

Dymott, Barry. IHSS Supervisor, San Luis Obispo County. March 10, 2004.

Evers, Victoria. Manager of Intergovernmental Relations, Los Angeles County. March 15, 2004.

Irwin, Tippy. Executive Director, San Mateo County Ombudsman Services, Inc., San Mateo, CA. June 21 2004

Nicco, Anthony. Program Manager of IHSS, San Francisco County. March 3, 2004.

Ramoni, Jim. IHSS Director, Santa Clara County. March 4, 2004.

Rosine, Lisa. Chief of Social Services, Golden Gate Regional Center, San Francisco. July 22, 2004

Schmeding, Ellen. Operations Chief for Aging and Independent Services, San Diego County. March 12, 2004.

Sorbello, Dale. Deputy Director, Community Services Division, Department of Developmental Services, San Francisco. August 2, 2004

Travers, Ann. Adult Services Division Manager, San Luis Obispo County. March 12, 2004.

Warren, Jeannie. IHSS Program Manager, Tulare County. March 10, 2004.

Wilson, Jim. IHSS Director, Department of Social Services, Los Angeles County. March 15, 2004.

California State Departments:

Acosta, Paula. Office of Long-Term Care, California Department of Health Services. March 8, 2004.

Boucher, Sue. Manager of Information Services, California Department of Developmental Services.

Dent, Shelton. Residential Services Section, Department of Developmental Services, Sacramento, CA. August 3, 2004

Hughes, Greg. Nurse Consultant, Medi-Cal Operations Division Home and Community Based Services Branch, In-Home Operations Section.

McCuistion, Yvonne. Section Chief of Services and Support Section, California Department of Developmental Services.

Van Beckman, Marie. Manager, Adult and Aging Services, California Department of Social Services. March 8, 2004.

Experts in Long-Term Care and/or IHSS:

Brotken, Margaret. Coleman Advocates for Children and Youth, San Francisco, CA. June 30, 2004

Eaton, Janet. Planning and Program Specialist, California State Council on Developmental Disabilities, Sacramento, CA. July 5, 2004.

Kemerling, Patricia. Executive Director, ARC San Francisco. June 30, 2004

Scharlach, Andrew. Eugene and Rose Kleiner Chair for the study of aging processes, policies and practices, School of Social Work at UC Berkeley. March 11, 2004.

Wolfinger, Charlie. Attorney at Law specializing in IHSS litigation. March 2, 2004

Appendix C: IHSS Hours Authorization & Assessment Procedures

Needs Assessments: Needs assessment procedures are identical for Residual and PCSP services. Needs assessments are performed prior to the authorization of IHSS services when the applicant is determined eligible and prior to the end of the 12th calendar month from the last assessment. (CDSS, 1993, Manual of Policies and Procedures, Section 30-761.21). Assessments may also occur whenever the recipient experiences a change in eligibility or service hour needs due to events such as an injury or change in condition. Policy changes external to the recipient such as altered wage rates in a particular county may also instigate new assessments.

Time for Task Guidelines: Authorization of hours for certain services follow "Time For Task" and Frequency guidelines, as follows:

Service:	Guideline Time Shall Not Exceed:
Domestic Services	6 hours per month (per household)
Laundry (Facilities in Building)	1 hour per week
Laundry (Outside of Building)	1.5 hours per week
Grocery Shopping	1 hour per week
Other Errands	30 minutes per week

Source: CDSS, 1993, Manual of Policies and Procedures, Section 30-758

California Welfare and Institutions Code Section 12301.2 states that "Time for task guidelines can be used only if appropriate in meeting the individual's particular circumstances. Exceptions to time per task guidelines shall be made when necessary to enable the recipient to establish and maintain an independent living arrangement and/or remain safely in his/her home or abode of his/her own choosing" (CDSS, 1993, Manual of Policies and Procedures, Section 30-758.4). Time for task guidelines may not be used to determine personal care services or paramedical services.

Co-habitation: When assessing need for clients living with others, domestic services, related services, and heavy cleaning services are pro-rated for co-habitation. Services are pro-rated for protective supervision if two or more IHSS recipients are living together who both require protective supervision (CDSS, 1993, Manual of Policies and Procedures, Section 30-763.3 and .331).

Physician Authorization: The treating physician is sent a form asking for information about a client's capacity for self-care, functional abilities, etc. If the client needs paramedical services, a paramedical form is sent to the treating physician for authorization. Only doctors decide what paramedical services the county must provide and pay for; the county may not cut the service hours ordered by a doctor (Protection and Advocacy, Inc., 2002).

Appendix D: Authorization & Residual Service Guidelines

The Residual program funds the following IHSS services which are excluded from federal reimbursement according to Medicaid regulations:

- Services delivered to consumers whose IHSS provider of those services is a spouse
- Services delivered to minor children whose IHSS provider of those services is a parent
- Services delivered to consumers who require only assistance with "domestic and related" chores. "Domestic and related" chores are defined as: preparation of meals; meal clean-up; routine laundry; shopping for food; other errands and shopping; heavy cleaning; accompaniment to medical appointment; accompaniment to alternative resources of care; removal of grass, weeds, and rubbish; removal of ice and snow; and domestic services.
- Protective supervision services provided to clients with cognitive impairments who need around-the-clock care. Protective supervision services are defined as necessary to make sure that those individuals who are confused, mentally impaired, or mentally ill, are safe against injury and accidents.
- Cases where the recipient is severely disabled and receives payment in advance of service delivery
- Restaurant meal allowances to consumers who receive those services

Services Delivered by a Spouse. According to state regulations, when the recipient has an "able and available spouse," the spouse may be paid to provide personal care services and paramedical services only. Personal care services include assistance w/ eating, bathing, dressing, and bowel and bladder care. Paramedical services are defined as activities necessary to maintain health, when individuals are unable to perform them. If the spouse leaves full-time employment or is prevented from obtaining full-time employment because no other suitable provider is available, and as a result, there is a risk of inappropriate, out-of-home placement or inadequate care, the spouse also may be paid to provide transportation and protective supervision (CDSS, 1993, Manual of Policies and Procedures, Section 30-763.41).

Services Delivered by a Parent of a Minor. When the recipient is under 18 and living with parent(s), IHSS services may be purchased from a parent when the parent has left full-time employment or is prevented from obtaining full-time employment because of the need to provide care to the child, AND when there is no other suitable provider, AND there is risk for inappropriate out-of-home placement or inadequate care without IHSS services. Parents of minors may be paid for all services except domestic services and protective supervision needed strictly due to the age of the child. Paid services are limited to: related services; personal care services; assistance with travel; paramedical services; and protective supervision needed due to functional impairment (CDSS, 1993, Manual of Policies and Procedures, Section 30-763.45).

Domestic and Related Services ONLY. In order to qualify for Medicaid funds, domestic and related services (as defined above) must be ancillary to other personal care services. If a

consumer requires only domestic and related services, with no need for personal care and/or paramedical services, services will be funded through the Residual program.[3]

Protective Supervision Services. Consumers are eligible for protective supervision when they need 24-hour supervision and can remain safely in their home if it is provided. Medicaid regulations prohibit federal payment for any protective supervision services. Because federal funds were unavailable for these services, they were authorized to become part of the program by AB 5 in 1993. Unlike domestic care-only services, protective supervision services may NOT be reimbursed through PCSP, even if ancillary to other personal care services. Therefore, protective supervision services are available strictly through the Residual program. Unlike other services, allocation of protective supervision depends on whether a recipient is classified as "Severely Impaired" (SI) or "Non-Severely Impaired" (NSI). See below for SI and NSI classifications. Allocation of protective supervision is as follows:

Consumers who are:	Will receive:
NSI and also receiving PCSP services	Up to 195 hours of protective supervision per month, provided PCSP and protective supervision hours do not exceed 283. If they do, protective supervision hours will be reduced to keep hours under 283.
NSI and not eligible for PCSP services (because of advance pay or a parent/spouse provider)	A maximum or 195 total hours (including protective supervision).
SI	A maximum of 283 hours. Protective supervision hours will be the difference between other hours (regardless of PCSP/Residual) and 283 hours.

Source: Protection and Advocacy, Inc., 2002

Clients eligible for protective supervision are always given the maximum number of monthly hours (at least 195 hours for NSI and 283 hours for SI). They get the maximum hours even if a county cuts their hours for some other IHSS service.

Advance Pay Services. A very small portion of IHSS recipients utilize an advance payment arrangement whereby payment from the state goes directly to the consumer, who may pay their provider(s) in advance of service. In all other cases, providers submit timesheets and are then paid directly by IHSS. In order to receive advance pay, a consumer must meet SI criteria (see below). This service is often utilized when a client has multiple caregivers and needs the flexibility to pay a last-minute provider "on the spot" in the event that a regular provider does show up. Once a consumer uses the advance pay option, all services are paid through the Residual program and cannot be covered through PCSP. In order to receive any PCSP funds, a consumer would need to change their pay arrangement.

Restaurant/Meal Allowance Services. IHSS pays for a restaurant/meal allowance for individuals who are unable to use their own cooking facilities. This allowance is separate from a meal allowance provided by SSI to individuals who do not have cooking facilities. The meal allowance saves the state money because it costs less than meal preparation and cleanup services, which are available as ancillary services through PCSP to those needing such services. Restaurant/Meal allowances are only reimbursed through the Residual program.

[3] Minor children may not receive paid domestic care services.

Severely and Non-Severely Impaired in the Residual Program. The SI vs. NSI classification holds ramifications for the allocation of certain Residual services. SI individuals are defined as those who require 20 or more hours per week in one or more of the following services: bowel and bladder care; respiration; feeding; bed baths; bathing and oral hygiene; grooming; dressing; rubbing of skin to promote circulation; moving into and out of bed; assistance with prosthesis; assistance with self-administration of medicines; routine menstrual care; ambulating; or paramedical services (CDSS, 1993, Manual of Policies and Procedures, Section 30-701.s.1). Having an SI classification gives entitlement to advance payment services and a higher maximum hour cap for those individuals receiving protective supervision (as noted above).

PCSP Services in Contrast. According to IHSS Regulations, personal care services paid through PCSP include: ambulation; bathing and grooming; dressing; bowel, bladder, and menstrual care; repositioning, transfer, skin care, and range of motion exercise; feeding and hydration assistance; assistance with self-administration of medications; respiration; and paramedical services. To be funded through PCSP, the following "ancillary" services must be provided *in addition to* a personal care service listed above: domestic services; laundry; reasonable food shopping; meal preparation and cleanup; accompaniment to appointments or site of other IHSS services; heavy cleaning; and yard hazard abatement. If provided alone, these services will be paid through Residual funds. PCSP services must be prescribed by a physician and eligibility for PCSP is limited to those recipients who do not receive advance pay (CDSS, 1993, Manual of Policies and Procedures, Section 30-780).

Split Cases. Clients may receive services through both the Residual Program and PCSP. For instance, even if a client receives services from a spouse or parent, that client may also receive PCSP services from a separate provider. If a non-PCSP (i.e. spouse or parent) provider and a PCSP provider are both providing services to a PCSP-eligible recipient, then those services provided by PCSP provider will be eligible for PCSP funding and the client is a "split" case. Another split case example is a recipient receiving all PCSP services, with the exception of Protective Supervision. Once this client receives any protective supervision in addition to other PCSP services, he/she is a split case. The Case Management, Information and Payrolling System (CMIPS) within the California Department of Social Services determines the source of funding for each provider.

Appendix E: Descriptive Statistics

IHSS Population By Age		
Age Group	Number	%
0-17	14196	4%
18-64	137219	37%
65+	218910	59%
Total	370325	

"Residual" Population By Age		
Age Group	Number	%
0-17	9987	15%
18-64	31082	45%
65+	27292	40%
Total	68361	

IHSS Population Age Groups by Frailty				
Age Group	% Frail in ADL	% Frail in IADL	% Frail in Cognition	% Frail in Breathing
0-17	90%	72%	18%	15%
18-64	68%	99%	6%	6%
65+	70%	100%	2%	6%

"Residual" Population Age Groups by Frailty				
Age Group	% Frail in ADL	% Frail in IADL	% Frail in Cognition	% Frail in Breathing
0-17	90%	70%	22%	15%
18-64	52%	98%	23%	4%
65+	32%	98%	14%	3%

IHSS Sub-Groups by Frailty				
	% Frail ADL	% Frail IADL	% Frail Cognition	% Frail Breathing
Parent Provider	90%	76%	8%	16%
Spouse Provider	96%	98%	1%	10%
Domestic Only	1%	98%	0%	0%
Protective Supervision	87%	95%	81%	4%
Advance Pay	100%	100%	4%	24%
PCSP	75%	99%	1%	6%

Appendix F: Community Care and Intermediate Care Facilities

Community Care Facilities

Adult Residential Facilities (ARF) are facilities of any capacity that provide 24-hour non-medical care for adults ages 18 through 59, who are unable to provide for their own daily needs, Adults may be physically handicapped, developmentally disabled and/or mentally disabled (http://ccld.ca.gov/AdultResid_1750.htm).

Small Family Homes (SFH) provide 24-hour a day care in the licensee's family residence for 6 or fewer children who are mentally disabled, developmentally disabled, or physically handicapped and who require special care and supervision as a result of such disabilities (http://ccld.ca.gov/SmallFamil_1744.htm).

Both ARFs and SFHs are considered Community Care Facilities (CCF) and are licensed by the Community Care Licensing Division of the State Department of Social Services (http://ccld.ca.gov/FacilityTy_1727.htm). Based upon the types of services provided and the persons, served, each CCF vendored by a regional center is designated at one of the following service levels (http://www.dds.ca.gov/LivingArrang/ccf.cfm):

- Service Level 1 – Limited care and supervision for persons with self-care skills and no behavioral problems.
- Service Level 2 – Care, supervision, and incidental training for persons with some self-care skills and no major behavioral problems.
- Service Level 3 – Care, supervision, and ongoing training for persons with significant deficits in self-help skills, and/or some limitations in physical coordination and mobility and/or disruptive or self-injurious behavior.
- Service Level 4 – Care, supervision and professionally supervised training for persons with deficits in self-help skills and/or severe impairment in physical coordination and mobility, and/or severely disruptive or self-injurious behavior. Service Level 4 is subdivided into Levels A through I, in which staffing levels are increased to correspond to the escalating severity of disability levels.

There are 5018 ARFs in California, ranging in bed size from 1-204, with a total of 40739 beds (http://www.ccld.ca.gov/docs/ccld_search/ccld_search.aspx). There are 390 SFHs in California, all under 6 beds, with a total of 1763 beds.

The monthly costs of ARFs and SMFs range from $853-$5009, which consists of the SSI/SSP portion and the Alternative Residential Model (ARM rate), which is the regional center supplement portion (http://www.dds.ca.gov/Rates/rates.cfm). There is a requirement for parents to share the cost of 24 hour out of home placements for children under the age of 18. This share depends on the parents' ability to pay (does not exceed $662 per month). The Department of Developmental Services sets the community care facility rates. Rates effective January 1, 2004 are as follows (http://www.dds.ca.gov/Rates/rates.cfm):

Service Level 1	$853
Service Level 2 (owner)	$1694
Service Level 2 (staff)	$1904
Service Level 3 (owner)	$1948
Service Level 3 (staff)	$2220
Service Level 4A	$2855
Service Level 4B	$3043
Service Level 4C	$3229
Service Level 4D	$3463
Service Level 4E	$3714
Service Level 4F	$3963
Service Level 4G	$4258
Service Level 4H	$4570
Service Level 4I	$5009

Intermediate Care Facilities

Intermediate Care Facilities (ICF) are health facilities licensed by the Licensing and Certification Division of the California Department of Health Services to provide 24-hour per day services (http://www.dds.ca.gov/livingarrang/icf.cfm). The four types of ICFS providing services for Californians with developmental disabilities in the community are:

- ICF/DD (Developmentally Disabled) Intermediate care facility/developmentally disabled is a facility that provides 24 hour personal care, habilitation, developmental and supportive health services to developmentally disabled clients whose primary need if for developmental service and who have recurring but intermittent need for skilled nursing services
- ICF/DD-H (Developmentally Disabled - Habilitative) – Intermediate care facility/developmentally disabled - habilitative is a facility with a capacity of 4-15 beds that provides 24 hour personal care, habilitation, developmental and supportive health services to 15 or fewer developmentally disabled persons who have intermittent recurring needs for nursing services, but have certified by a physician as not requiring availability of continuous nursing care
- ICF/DD-N (Developmentally Disabled - Nursing) –Intermediate care facility/developmentally disabled-nursing is a facility with a capacity of 4-15 beds that provided 24 hour person care, developmental services and nursing supervision for developmentally disabled persons who have intermittent recurring needs for skilled nursing care, but have been certified by a physician or surgeon as not requiring continuous skilled nursing care, The facility shall serve medically fragile persons with developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated.(medically fragile)
- ICF/DD/CN – Continuous Nursing Pilot Program. These facilities proved services to ICF/DD-N with the addition of 24-hour skilled nursing services for those consumers whose medical conditions require continuous nursing care and supervision. This is a limited pilot program only

The daily rates for ICFs are set by the Department of Health Services / Medi-Cal Policy Division and the current daily rates range from $131.38-$181.74 depending on facility type and size (http://www.dds.ca.gov/Rates/PDF/LONGTERMCARE_RATE_TABLE.pdf).

There are 1097 ICFs for persons with developmentally disabilities in California. There are 14 ICF-DD facilities (variable number of beds), 779 DD-H facilities (4-15beds) and 304 ICF-DD-N facilities (4-15) (http://www.calcarenet.ca.gov/facilities_search.asp).

Resources/References Used

California Care Network: http://www.calcarenet.ca.gov

California Department of Social Services: http://www.dss.cahwnet.gov
http://ccld.ca.gov

California Department of Developmental Services: http://www.dds.ca.gov

California Department of Health Services: http://www.dhs.ca.gov

California State Council on Developmental Disabilities: http://www.scdd.ca.gov

Housing Supply and Regulation References

ICF http://www.calcarenet.ca.gov/facilities_search.asp

ARF http://www.ccld.ca.gov/docs/ccld_search/ccld_search.aspx

SFH http://www.ccld.ca.gov/docs/ccld_search/ccld_search.aspx

Appendix G: Protection & Advocacy Legal Opinion

MEMORANDUM

TO: Stan Rosenstein, Acting Deputy Director, Medical Care Services, DHS, via e-mail srosenst@dhs.ca.gov

Donna L. Mandelstam, Deputy Director, Disability and Adult Program Division, DSS, via e-mail donna.mandelstam@dss.ca.gov

cc: Charlene Harrington[4]

FROM: _____
Marilyn Holle, Senior Attorney, (213) 427-8757 x 3011, marilyn.holle@pai-ca.org

RE: Opinion Letter: California can save over a hundred million a year by amending the State Plan to cover domestic and related services under the Medi-Cal personal care services program

DATE: April 6, 2004

Currently slightly over 40% of the cost of the state funded (or original or residual) IHSS program are domestic services cases. Due to a change in federal law, IHSS cases where no nonmedical or paramedical services are authorized are actually eligible for federal financial participation and could be covered as Medi-Cal personal care service through a simple amendment to the state Medicaid plan. This will both address the state's budget shortfall this and remove any reason to eliminate these important services next year.

As explained below, California did not include cases with domestic services only as part of the Medi-Cal personal Care Services program based on an early policy interpretation of the federal Medicaid program. This policy was subsequently changed as reflected in the 1999 amendments to the personal care section of the State Medicaid Manual. The Centers for Medicare and Medicaid Services (CMS) now recognize that services California categorizes as domestic and related services are coverable under the Medi-Cal Personal Care Services program even if those are the only services authorized.

We urge the State to take immediate action to amend the State Plan in order to collect federal match retroactively for at least for this fiscal year on cases where only domestic and related services are currently authorized.

Background prior to OBRA 1993

[4] This opinion letter was triggered by Charlene Harrington's questioning of the continuing applicability of the old ancillary or incidental limitation on domestic and related services under the Medi-Cal personal care services program.

Prior to OBRA 1993, personal care services had to be prescribed by a physician, supervised by an R.N. and delivered only in the home. The Health Care Financing Agency or HCFA, the former name of CMS, interpreted the personal care services program in a very restrictive manner as reflected in an HHS administrative decision – Decision of the Administrator, No. 87-12, March 19, 1990, CCH MEDICARE AND MEDICAID GUIDE New Dev. ¶ 38,467.[5] The decision explained:

> Personal care services are medically oriented tasks which enable a patient to be treated on an outpatient, rather than an institutionalized basis. The level of care is of a supportive or maintenance type. The tasks, which require less skill than skilled nursing care, include assisting the patients with personal hygiene, dressing, feeding, and transfer and ambulatory needs. Basic homemaker and chore services are not included within the meaning of personal care services.[6]

Background – 1993 to 1997

Section 13601(a)(5) of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) expressly added personal care services to the Medicaid program by the addition of Section 1905(a)(24) to the Social Security Act, 42 U.S.C. § 1396d(a)(24). OBRA 1993 de-medicalized personal care services by eliminating the requirement that the services be prescribed by a physician, by making nurse supervision optional, and by providing that the services could be provided at locations other than the home at the state's election.

HCFA was slow to fully implement the OBRA 1993 changes. Until 1997, Section 4480 of the State Medicaid continued to focus on "hands-on" tasks "similar to those that would be performed by a nurse's aide" in a hospital. The State Medicaid Manual retained the concept that domestic and related services could be covered only to the extent they were ancillary or incidental to medical based "hands-on" care:

> C. *Scope of Services* – Personal care services are services related to a patient's physical requirements, such as hygiene, activities of daily living, bladder and bowel requirements, and taking medications. Services may include assistance with preparation of meals. . . . When specified in the plan of treatment, they may also include services which are essential to the health and welfare of the beneficiary, such as housekeeping chores like bed making, dusting and vacuuming. Personal care services primarily involve "hands on" assistance by a personal care attendant with a recipient's physical dependency needs (as opposed

[5] The decision invalidated those parts of Minnesota's State Plan that allowed the personal care services provider to accompany the person with a disability out into the community. Minnesota fixed the problem for its state alone through a subsequent COBRA provision.

[6] Prior to the issuance of the rewrite of State Medicaid Manual Section 4480 by Transmittal No 67 (April 1995), my recollection is that "homemaker chore" services were covered under Medicaid only to the extent they were ancillary or incidental to what is covered in our Medi-Cal personal care services program as nonmedical personal care services.

[6] The pre-1995 personal care services section of the State Medicaid Manual was less restrictive than apparently Section 5-140-00 of the old Medical Assistance Manual.

to purely housekeeping services). These tasks are similar to those that would normally be performed by a nurse's aide if the beneficiary were in a hospital or nursing facility. . . .

Section 4480, amended via Transmittal 67 (April 1995), CCH MEDICARE AND MEDICAID GUIDE New Dev. ¶ 43,183.

1999 Rewrite of Section 4480 of the State Medicaid Manual

In 1999, HCFA re-issued Section 4480 of the State Medicaid Manual on personal care services. Transmittal No. 73 (October 1, 1999), CCH MEDICARE AND MEDICAID GUIDE New Dev. ¶ 150,766. The rewritten section on Scope of Services was "revised to delete references to physical tasks while referring to assistance with both activities of daily living (ADLs) and instrumental activities of daily living (IADLs)."[7] This change finally implemented the policy underlying OBRA 1993 to de-medicalize personal care services. The new manual section eliminates the distinction found in the previous version of Section 4480 between "housekeeping chores" on the one hand and "hands-on" paramedical or nurse's aide services on the other:

C. *Scope of Services* – Personal care services (also known in States by other names such as personal attendant services, personal assistance services, or attendant care services, etc.) covered under a State's program may include a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/her self. Such assistance most often relates to performance of ADLs [activities of daily living] or IADLs [instrumental activities of daily living]. ADLs include eating, bathing, and dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. Personal care services can be provided on a continuing basis or on episodic occasions. . . .

Section 4480, CMS State Medicaid Manual (emphasis added).

Conclusion

California's State Medicaid Plan provision governing personal care services incorporates the now unnecessary limitation that domestic care services must be "incidental" to nonmedical or paramedical services. *See* Transmittal No. 02-21 at http://www.cms.hhs.gov/medicaid/stateplans/spa/ca.asp?.

[7] 62 Fed. Reg. 47896, 47898 (September 11, 1996) (Comment and Response)

The State Plan should be amended immediately and retroactively to delete that reference in line with current CMS policy. If this is done without delay, California could collect FMAP at least for this fiscal year on cases where only domestic and related services are currently authorized.

It is also important to advise counties of the change. Our experience is that county workers strain to find some sort of nonmedical personal care need in order to bring the case under the Medi-Cal personal care services program for the benefit of the reduced county match. They need to know that that is no longer necessary.