Home and Community-Based Long-Term Care: Recommendations to Improve Access for Californians

EXECUTIVE SUMMARY

Prepared for:

California Community Choices
California Health and Human Services Agency

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Executive Summary

California faces enormous challenges maximizing opportunities for seniors and persons with disabilities of all ages to live independently in the setting of their choice. The challenges are fiscal, geographic and structural. Even when the state does not face unprecedented budget deficits, investments are needed in the services and delivery system to promote informed choice, access to preferred services and adequate financial support. The sheer size of the state makes statewide implementation of a major initiative far more complex, yet "pilot" programs that operate in limited areas of the state add to the fragmentation that hampers consumer access.

The California Community Choices (Choices) project is a five-year grant funded by the Centers for Medicare & Medicaid Services to increase consumer access to home and community-based long-term care services by establishing one-stop resource centers, Aging and Disability Resource Connection (ADRC) programs, in cooperation with the California Department of Aging. ADRCs provide information, referral, and assistance for persons with disabilities, caregivers, family and friends who seek information about long-term care services. The Choices project also developed the California Care Network (CalCareNet), a website guide to long-term care services in California. CalCareNet is being piloted with ADRCs in Orange and Riverside counties to provide complementary information and assistance in person or by phone to persons seeking services.

The Choices project also includes a financing study to examine the laws, regulations, policies and payment methodologies related to long-term care financing in California. The study was initiated to improve the state's understanding of the financial and structural barriers to increasing consumer access to home and community-based services, and to provide recommendations that enable the state to more effectively manage funding for long-term care in ways that promote community living options.

California spends more than $10 billion annually on long-term care, and the majority of the funds pay for services in the community. The programs that cover the services for adults with physical disabilities and older adults appear to function independently with separate delivery systems and management structures. Consumers must contact different organizations for each program. Only persons with developmental disabilities are able to contact a single entity, receive information about their options, assess their service needs and access the appropriate service.

The Choices project and the Department of Aging are developing Aging and Disability Resource Connection (ADRC) programs to provide additional centralized sources of information and referral. ADRCs provide information about programs, services and eligibility requirements to help consumers make informed decisions. Where an ADRC also administers long-term care programs, access to community services can be expedited.

The report recommends that California develop a strategic plan that describes which populations, services and programs will be addressed by the strategic plan, and describes the mission, values and goals for its long-term living services and supports programs. The plan should include a mission and vision statement and short, medium and long-term goals that include objectives, tasks that will be undertaken to achieve the objectives and the entity and staff that will be responsible for implementing each one.

This report includes findings from interviews with state officials, state staff and stakeholders, data obtained from the state and other sources as well as reviews of statutes, regulations and previous reports. Appendix A contains a nine-page bibliography that includes these previous reports.

General Findings

- Approximately 2.4 million persons in California report having two or more disabilities and an estimated 400,000 plus have intellectual or developmental disabilities.

- California has more persons age 65 and older than other states and the population is growing. In 2007, California was home to 4.0 million persons age 65 and older or 11.0% of the total population. By 2010, the number of Californians age 65 and older will increase to 4.4 million or 14.7%, and will increase to 8.3 million or 17.8% of all Californians in 2030.

- The system is organized by program rather than by person. California's services for older adults and individuals with disabilities are covered through programs managed by multiple state agencies and organizations. However, the programs provide a core of similar services that include support with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health and social needs. Tens of thousands of persons receive services from multiple programs, while others shift between programs in complex passages resulting in costs and consumer outcomes that are rarely studied since no one department is responsible for the entirety of a person's care and services.

- In 2009, California's DD programs ranked seventh in the nation for the best performing state Medicaid programs in a national study by United Cerebral Palsy which measured 20 factors.

- California ranks 1st in the nation on the number of personal care participants per 1,000 population, 19th on home health participants per 1,000 population, and 42nd on Home and Community-Based Services (HCBS) Waiver participants per 1,000 population. California ranks 6th in total HCBS participants per 1,000 population and 17th on total HCBS expenditures per capita in 2005.

- For older adults and adults with physical disabilities, California was ranked 5th nationally in the percentage of HCBS spending with 48% on institutional care and 52% on HCBS in 2007.

Note: The annual table of the percentage of spending on HCBS prepared by Thomson Reuters reports all Medicaid State Plan personal care expenditures (IHSS) in the data for aged and disabled beneficiaries. Medicaid service expenditures reported on CMS Form 64 are frequently used to rank states on long-term care spending. However, the Form 64 data under-report spending for community services in California and other states.

- In 2007, California was 48th in the nation on per capita spending for waiver expenditures, 4th on personal care and 18th overall on total HCBS.

  Note: Comparing California's rank for per capita HCBS spending to other states may be misleading since state expenditures on related Medi-Cal state plan services and services under the Lanterman Developmental Disabilities Services Act (Lanterman Act) funded by state general revenues are not captured in HCBS data reported on the CMS Form 64.

- In 2007, HCBS accounted for 62% of developmentally disabled (DD) spending and 38% for institutional care, which placed California 32nd among states. When spending for targeted case management and clinical services is included, the ratio is 66% HCBS and 34% institutional.

  Note: Comparing California's rank for waiver spending for persons with developmental disabilities to other states may be misleading since the state spends such a large amount on IHSS, other Medi-Cal state plan services and services under the Lanterman Act funded by state general revenues. Data on these expenditures are not captured in the CMS Form 64, which is frequently used to rank states on long-term care spending.

- Annual per capita spending presents a different perspective on spending. In FY 2007, California exceeded the national average for spending on state plan personal care services (referred to as IHSS in California)—$101.51 versus $34.47. California's spending for HCBS Waivers for aged and disabled beneficiaries is $3.00 per capita per year compared to $21.02 nationally, and for individuals with Mental Retardation/Developmental Disabilities (MR/DD), per capita spending was $35.12 in California compared to $68.04 nationally. The inclusion of targeted case management spending would increase per capita spending.

- California spent less annually per capita than the national FY 2007 average on nursing facility care—$100.04 per day compared to $155.76 per day nationally, and spending for Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) was $21.27 per day in California compared to $39.83 per day nationally.

- Nursing facility spending increased 40.7% between 2001 and 2007 while waiver spending for older adults and individuals with disabilities increased 20.6% during the same period. Nationally, nursing facility spending increased 10% and waiver spending

for older adults and individuals with physical disabilities rose 85% during the same period.

- Medi-Cal spending for all nursing facility and ICF/MR institutional services rose 46.9% between 2001 and 2007 while spending for community services—In-Home Supportive Services (IHSS), MR/DD and other waiver services—rose 88.4%.

- The state does not take full advantage of Medicaid provider fees.

System Design

- California lacks a strategic plan that would set priorities for services for the future to maximize the use of finite resources. The Olmstead Plan offers a framework for developing a strategic plan.

- New programs often require a new delivery system because there is no logical infrastructure or single entry point to administer new programs. Consumers admitted to a nursing facility do not have access to a central source of information, preadmission screening, or assistance and support to access community service options. Consumers living in the community who need assistance do not have access to options counseling to understand what services might be available to them as better alternatives to admission to an institution.

- While there is no statewide entry point for older adults and individuals with disabilities, ADRCs are being designed to provide information about the multiple services and access points.

- The state's budget deficit makes consideration of changes that require investment in services or the delivery system more difficult in the short term. However, investments in HCBS programs would likely improve the effectiveness of the overall delivery system and reduce the rate of growth by shifting more resources to community services.

- Collaboration between community service organizations and hospital discharge planners to divert admissions to nursing facilities is not well developed.

- Previous reports recommended consolidation of agencies and programs serving individuals with disabilities and older adults. However, each program and agency has a long and rich tradition with a strong network of providers, advocates and consumers that seem more comfortable with the system they know, than a new, untested structure that is not clearly defined.

In-Home Supportive Services (IHSS)

- Opinions about the reasons for IHSS caseload growth differed. Persons interviewed attributed the growth to the:
    - Low functional eligibility requirements
    - Widespread awareness of the program
    - Use of family and friends as caregivers
    - Statewide availability of services
    - Difficulty accessing HCBS Waivers
    - The program's well-established history and its administrative support structure
    - Aging of the population

- Persons interviewed stated that the low IHSS functional eligibility requirements help prevent further functional decline and that allowing family and friends to be reimbursed (which is becoming more common in state programs) addresses tight labor pools and supports family caregiving.

- New IHSS participants have higher assessed levels of impairment than persons who entered the program eight years ago.

- The IHSS limit on the maximum number of hours of service that may be authorized, 283 hours per month, is higher than almost all other states. However, persons interviewed said exceptions to the cap are warranted for participants with more intensive needs, to reduce the need for supplemental services through HCBS Waivers.

- Studies about the impact of wage and benefit increases to personal care workers report that increases have predictable positive impacts on their willingness to work and job turnover.

Home and Community-Based Services (HCBS) Waiver Programs

- Recent research found that states with well-established HCBS programs had less overall long-term care (LTC) spending growth. In contrast, states with low levels of HCBS expenditures had an increase in overall costs, as their institutional costs increased. California was rated an expanding HCBS state for non-MR/DD services and a low HCBS state for DD Waiver services.

- The Medi-Cal level of care criteria used to determine eligibility for each HCBS program seems appropriate given the intended populations served and the program services provided.

- Multipurpose Senior Services Program (MSSP) enrollment is limited by funding but experienced periods of growth. The program primarily provides case management to

persons age 65 and older who also receive IHSS services. Stakeholders noted that expanding MSSP services to provide more transition assistance to persons wishing to leave institutions would be a useful program development.

- The Assisted Living Waiver (ALW) expands long-term care settings by providing residential service choices but serves persons in a limited number of counties and is not available statewide.

- California does not use the special income level eligibility option, which would streamline access for individuals with income below 300% of the federal Supplemental Security Income (SSI) benefit.

- The cost differences between waiver expenses and institutional costs totaled $3 billion in FY 2006, which suggests that HCBS programs are cost-effective, and delay or substitute for hospital, nursing facility and ICF/MR care even if only a modest percentage of persons would have been served in institutions in the absence of the programs.

- The state has not studied the cost effectiveness of its waiver programs.

- Stakeholders commented that the number of waiver slots is low relative to most other states, and expanding the waiver capacity would be important to address in a strategic plan for long-term care.

Department of Developmental Services

- The Regional Center delivery system for individuals with developmental disabilities is well developed. It is California's only long-term care system that operates as a single entry point that provides access to comprehensive services.

- The growth in the number of persons served in Department of Developmental Services (DDS) programs has been steady throughout the last decade. The caseload has grown from just over 180,000 in 2001 to over 247,001 in July 2009.

- The state has made significant progress in helping persons with intellectual and developmental disabilities leave state-operated institutions. DDS stated that the effort to transition individuals out of private facilities focused on relocating persons with developmental disabilities from large facilities to small home-like settings. While the number of persons in private facilities has increased, the number of persons in large ICF-MRs has declined and the number of persons in smaller facilities has increased.

- Prior to July 1, 2008, regional centers negotiated rates for nonresidential services. The extent and depth of negotiated rates, and the degree to which negotiations are used in the cost-based approaches, is not reported by DDS. The uniformity of rate payments across regional centers is not known.

- When implemented, the April 2009 settlement of the class action lawsuit (Capitol People First v. DDS) will provide more information and choices to live in small community settings to individuals with developmental disabilities who currently live in government or privately operated facilities.

- The two main drivers of DD Waiver costs are sustained increases in enrollment and utilization. Once a person enrolls in the waiver, they tend to remain, although DDS staff indicated that between 5,000-6,000 persons disenroll from the waiver each year.

Adult Day Health Care (ADHC)

- A study of programs in six states (California, Maryland, New Jersey, New York, Texas and Washington) found that ADHC can save the Medicaid program significant resources by delaying or avoiding inappropriate entry into more costly institutional care.

- A review of Treatment Authorization Requests (TARs) estimated that between 30–40% of all participants would need nursing facility care in the absence of ADHC services. The specific level of nursing facility care—Level A, Level B or Subacute—was not indicated.

- Over 80% of ADHC participants are age 65 and older and fewer than half are age 80 and older, which is comparable to recipients who receive services in a nursing facility.

- ADHC often serves beneficiaries who receive other services. A review of paid Medi-Cal claims found that 60% also received IHSS services. A state official suggested that ADHC may supplement IHSS for participants who need more hours than can be authorized under IHSS. ADHC also provides skilled services that are not available through IHSS, and the combined services meet a broader range of health and functional needs.

- Legislation passed in 2006 made significant changes in the ADHC program and reduced expenditures.

- ADHCs serve two distinct populations—one receives temporary rehabilitative services and the other receives longer-term support and medical services.

Mental Health

- California does not operate an HCBS program that is designed specifically for persons with mental illness. A package of services for nursing facility residents with a mental illness could be designed under a §1915(c) Waiver or a §1915(i) state plan HCBS amendment.

Nursing Facilities

- California ranks 43rd among states in the supply of nursing facility beds per capita, and 31st with an occupancy rate of 86%. The Medi-Cal nursing facility resident census has declined slightly, 1.4%, over the past eight years. However, between December 2001 and December 2008, the number of Medicaid residents in nursing facilities dropped 8% nationally and 22 states experienced a reduction of 10% or greater, which suggests that further reductions are possible through diversion and transition/relocation initiatives. Although other factors may contribute to California's modest decline, effective diversion and transition programs along with fiscal incentives for counties would continue the trend.

- From December 2002 to December 2008, the number of nursing facilities in California declined approximately 6%, slightly above the national average. The numbers of nursing facility residents and nursing facility beds have also declined modestly, although less than the national decline, while the occupancy rate has increased slightly.

- While there is a perception among persons interviewed that California has a history of low nursing facility reimbursement rates, a review of national rates from 1998 to 2005 shows that California ranks in the midrange compared to other states in nominal dollar terms.

- California has a higher proportion of residential care and a lower supply of nursing facility beds per 1,000 persons age 65 and older than the other large states.

- Medicare nursing facility use increased 26% in California and 34% nationally between 2001 and 2008. Nursing facilities have a financial incentive to expand their Medicare and managed care subacute business by its profitable ancillary revenue.

- Increases in nursing facility Medi-Cal per diems in California have been greater than general inflation over the period 2001–2008 and have kept up with medical inflation.

- Operating margins of nursing facilities have increased substantially in California since 2000.

- Only about 55–60 nursing facilities report any caregiver training expenses although it is a 100% pass-through cost.

- California's nursing facility cost reimbursement methodology does not control for low occupancy. In per diem reimbursement systems, costs are divided by days of service. As the number of days becomes smaller, the cost per day goes up. Unless low occupancy rates are controlled for, the entities receiving the per diem reimbursement will get more money per person as they serve fewer persons.

- California also uses prospective cost-based rates that are not adjusted for the acuity of the residents.

- If California had the same nursing facility usage as the national average, about 42,600 more persons would have their nursing facility stay paid for by Medi-Cal. At 2007 costs, if these 42,600 persons had been receiving nursing facility Level B services for 219 days each at a cost of $139.70 (the average number of days and costs in 2007 in California paid by Medi-Cal), the state would have spent an additional $1.4 billion per year.

Transition Programs

- The state currently operates nursing facility transition initiatives through the Department of Rehabilitation, Centers for Independent Living, 1915(c) Waivers, a program in San Francisco, and the new Money Follows the Person (MFP) Rebalancing Demonstration.

- MFP offers an opportunity to develop and refine strategies that provide transition coordination to nursing facility residents who are interested in moving to the community. The fragmented delivery system poses additional challenges to transition coordination. The program's success will depend on the ability of the service network to provide access to the level of service needed by individuals who are interested in moving to the community.

- Access to affordable housing is a barrier to transitioning for persons who want to return to the community but lack a source of housing.

This report's recommendations support five primary goals:

- Define goals for balancing the long-term care system

- Reduce the rate of growth in spending on institutional care

- Expand HCBS programs over time as the economy recovers and state revenues increase

- Invest savings from a lower rate of institutional growth in home and community-based services for individuals who are at risk of entering an institution

- Improve the management of home and community services programs

The recommendations are grouped by the length of time it might take to implement them and then by category: Financing, Access and Service Delivery and State-level Organization.

Summary of the Recommendations

Recommendation	Brief Description	Action
General Recommendations		
1. Establish the Philosophy and Legislative Intent	The statutes describe the role and purpose of California's different long-term care programs but, taken together, they do not establish a framework for making decisions about new programs or services nor do they address the "system" as a whole.	Statute
2. Develop a Strategic Plan	California should prepare a strategic plan that describes which populations, services and programs will be addressed by the plan and describes the mission, values and goals for its long-term services and supports system. The goals should include measurable targets to improve balance between HCBS and institutional services for all populations.	Administrative/ Statute
Short-Term Recommendations—One Year to Implement		
3. Add a Special Income Level Eligibility Group	This option enables individuals with income below 300% of SSI in the community to become Medi-Cal eligible who would otherwise have to incur expenses equal to the share of cost under the Medically Needy Option. Meeting the spend-down creates a barrier for persons who readily meet the share of cost in a nursing facility but cannot afford the share of cost in the community and retain enough income to meet their expenses.	Administrative
4. Increase the Home Maintenance Income Exemption	Maintaining or establishing a home in the community is a major obstacle for Medicaid beneficiaries who want to return home after admission to an institution. Medicaid eligibility rules give states the flexibility to support this goal and allow states to exempt income to maintain a home. The existing exemption is $209 per month, which is too low to maintain a home in California.	Statute
5. Maintain the SSI/SSP Medi-Cal Eligibility Status	This option allows beneficiaries to retain their full SSI/SSP during the first 90 days of an institutional stay for beneficiaries who are able to return home.	Administrative
6. Adopt a Case-Mix Reimbursement System for Nursing Facilities	This option creates incentives to serve high acuity residents and facilitates community transition for lower acuity residents. The case-mix system would be "zero sum" and not result in additional payments to nursing facilities.	Statute
7. Establish a Nursing Facility Occupancy Provision	This option creates an incentive for facilities to reduce their licensed capacity, which ensures that beds will not be back-filled as residents relocate or as new admissions are diverted through preadmission screening/options counseling.	Statute

Recommendation	Brief Description	
8. Convert the Labor-Driven Operating Allocation to an Incentive to Promote Discharge Planning or Increased Quality of Care	Given the magnitude of the per diem and the fact that the offset does not reimburse an actual cost, we suggest that the state rethink this incentive and exercise policy-related control over it.	Statute
9. Review Department of Developmental Services (DDS) Regional Centers Rates for Nonresidential Services	Should budget conditions improve and the rate freeze be lifted, before restoring previous rate methodologies DDS should review the use of negotiated rates to avoid concerns about compliance with CMS policy.	Administrative
10. Conduct a Study of Need for Waiver Expansion	Waivers are cost effective and their use should be expanded.	Administrative
Medium Range Recommendations—One to Two Years to Implement		
11. Establish a Statewide Institutional Transition Program	Ideally, the transition program would be part of the single entry point entities and reflect the experience from the California Community Transitions program. Until single entry point entities are established, the State should establish a statewide institutional transition program and current MFP programs should continue and be expanded.	Administrative
12. Reinvest Savings from Institutional Care in HCBS	Savings from beneficiaries who transition can be transferred to home and community-based services program accounts. A reserve fund can be created for savings that may be used for investments in a subsequent fiscal year. The nursing facility appropriation can be used to pay for services in the community for individuals who relocate from an institution when waiver programs have reached their maximum capacity and wait lists are established.	Administrative
13. Provide Diversion through Preadmission Screening (PAS)/Options Counseling about Community Alternatives through Single Entry Points and Aging and Disability Resource Connections (ADRCs) and by Working with Hospitals	PAS/options counseling is a strategy to inform individuals and family members who apply for admission to an institution about the community services that are available to help them remain at home. Options counseling is often mandatory for Medicaid beneficiaries seeking admission to a nursing facility. It may be advisory for individuals who are not eligible for Medicaid but are likely to spend down within six months of admission.	Administrative
14. Expand Coverage of Residential Options Statewide to Offer More Service Alternatives for Older Adults	California currently offers limited coverage of services in Residential Care Facilities for the Elderly (RCFE) through the Assisted Living Waiver Program. Offering a full array of services gives consumers additional residential options besides a nursing facility bed. Residential settings are particularly useful for consumers who do not have	Administrative

Recommendation	Brief Description	
	a caregiver at night and on weekends, need 24-hour supervision or need access to assistance that cannot be scheduled.	
15. Increase the Use of Provider Fees for HCBS Providers	Federal regulations require that the fees: be broad based; be uniformly imposed throughout a jurisdiction; and not violate the hold harmless provisions of the regulations. The state should benefit from the financial advantages that are permitted under federal regulations.	Statute
16. Explore Converting a Portion of State Supplement Program (SSP) Payments to Provide Services in Residential Settings	Federal law allows states that increased the SSI State Supplement Program payment since 1983 to reduce the supplement to 1983 levels. General revenues saved by lowering the payment could be used to expand Medi-Cal supportive services in RCFEs without reducing the personal needs payment to residents. *Update: The 2009 budget agreement reduced the SSP payment to 1983 levels. This recommendation is retained as a reference.*	Statute
17. Create a Temporary Rental Assistance Housing Subsidy	This option converts a portion of the state share of the savings from Medi-Cal payments for individuals who transition from an institution to a housing subsidy while they wait for a housing voucher or other federal housing subsidy.	Administrative
18. Allow Presumptive Medi-Cal Eligibility for HCBS Waiver Applicants	This option allows case managers in a comprehensive entry point system to fast track or presume Medi-Cal eligibility to enroll applicants in a waiver program and avoid admission to a nursing facility. This recommendation should be considered in relation to the recommendation for co-locating eligibility workers	Administrative
19. Develop HCBS That Address Individuals with Mental Illness	A package of services for nursing facility residents with a mental illness could be designed under a §1915(c) Waiver or a §1915(i) state plan HCBS amendment. MFP includes demonstration services that address the needs of persons with mental illness living in nursing facilities. The services should be defined and implemented to improve the project's ability to meet the benchmarks for this population.	Administrative
20. Create Rate and Other Incentives to Reduce Nursing Facility Capacity	This recommendation would create rate incentives, perhaps using funds from the labor-driven operating allocation for nursing facility providers, to downsize nursing facilities, and the resulting savings can be used for pay-for-performance or to expand affordable housing, adult day health care, and in-home services.	Statute
Long-Term Recommendations—Two Years or Longer to Implement		
21. Create a Department of Long-Term Services and Supports	Individuals with developmental disabilities for the most part access services managed by one state agency and a strong comprehensive entry point system operated by 21 regional centers. While some consumers receive IHSS services, the majority of home and community-based services are accessed through regional centers. No similar	Statute

Recommendation	Brief Description	
	structure is available to serve older adults and individuals with physical disabilities. As a result, new initiatives are often built through new structures and administrative arrangements.	
22. Create Single Entry Points (SEPs) to Access Services for Aged/Disabled Beneficiaries	Without a visible entity that offers seamless entry to the system, consumers contact multiple agencies and organizations, complete multiple application forms and apply for programs that have different financial and functional eligibility criteria.	Administrative
23. Co-Locate Medi-Cal Financial Eligibility Workers in Single Entry Points/ADRCs	Determining financial eligibility quickly can mean the difference between entering a nursing facility and returning home.	Administrative
24. Create a Unified Long-Term Care Budget	This option creates a unified long-term care budget at the county/regional level that includes nursing facility spending, IHSS and selected HCBS Waiver programs.	Statute
25. Create a Standardized Rate Structure for HCBS Based on the Acuity of Persons Receiving Services	Long-term care services should be managed as if they are a single program. Persons with physical impairments and disabilities use multiple programs both over time and at the same time. Eligibility and service delivery changes in one program impact the utilization of other programs.	Administrative
26. Create Incentives for HCBS through Managed Long-Term Care and Capitation	Expand capitated managed long-term care options. A review of managed long-term care programs prepared in 2006 found that managed long-term care programs reduce the use of institutional services and increase the use of home and community-based services relative to fee-for-service programs, and that consumer satisfaction is high.	Administrative
27. Create Financing Strategies That Improve the Balance Between Community and Institutional Services	Examples of possible strategies from Washington and Vermont are described.	Statute
28. Develop a Long-Term Care Data Base	Develop a long-term care data base that contains information on the physical and mental characteristics and service utilization history of persons using long-term care services. The purpose of the database is to enable the state to manage long-term care services as though it were one program. The data base will permit the comparison of persons across programs so the state can understand who uses programs, what services they receive, and what the total costs are. Currently, data are organized by program; what is needed is data organization at the individual level.	Administrative

Recommendation by Category

Recommendation	Financing	Access and Delivery System	State-level Organization
1. Establish the Philosophy and Legislative Intent	●	●	●
2. Develop a Strategic Plan	●	●	●
3. Add a Special Income Level Eligibility Group		●	
4. Increase the Home Maintenance Income Exemption		●	
5. Maintain the SSI/SSP Medi-Cal Eligibility Status		●	
6. Adopt a Case-Mix Reimbursement System for Nursing Facilities	●		
7. Establish a Nursing Facility Occupancy Provision	●		
8. Convert the Labor-Driven Operating Allocation to an Incentive to Promote Discharge Planning or Increased Quality of Care	●		
9. Review Department of Developmental Services (DDS) Regional Centers Rates for Nonresidential Services	●		
10. Conduct a Study of Need for Waiver Expansion		●	
11. Establish a Statewide Institutional Transition Program		●	●
12. Reinvest Savings from Institutional Care in HCBS	●		
13. Provide Diversion through Preadmission Screening (PAS)/Options Counseling about Community Alternatives through Single Entry Points and Aging and Disability Resource Connections (ADRCs) and by Working with Hospitals		●	
14. Expand Coverage of Residential Options Statewide to Offer More Service Alternatives for Older Adults		●	
15. Increase the Use of Provider Fees for HCBS Providers	●		
16. Explore Converting a Portion of State Supplement Program (SSP) Payments to Provide Services in Residential Settings	●		
17. Create a Temporary Rental Assistance Housing Subsidy	●		
18. Allow Presumptive Medi-Cal Eligibility for HCBS Waiver Applicants		●	
19. Develop HCBS That Address Individuals with Mental Illness		●	
20. Create Rate and Other Incentives to Reduce Nursing Facility Capacity	●		
21. Create a Department of Long-Term Services and Supports			●
22. Create Single Entry Points (SEPs) to Access Services for Aged/Disabled Beneficiaries		●	

Recommendation	Financing	Access and Delivery System	State-level Organization
23. Co-Locate Medi-Cal Financial Eligibility Workers in Single Entry Points/ADRCs		●	
24. Create a Unified Long-Term Care Budget	●		
25. Create a Standardized Rate Structure for HCBS Based on the Acuity of Persons Receiving Services	●		
26. Create Incentives for HCBS through Managed Long-Term Care and Capitation	●	●	
27. Create Financing Strategies That Improve the Balance Between Community and Institutional Services	●		
28. Develop a Long-Term Care Data Base			●