



California's protection and advocacy system

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**THE NURSING FACILITY/ACUTE HOSPITAL WAIVER:
PROBLEMS AND SOLUTIONS (June 18, 2014)**

Background

Medicaid Waivers allow states to deliver and pay for health care services with the federal government waiving some of the usual Medicaid requirements, such as “statewideness.” Home and Community Based (HCBS or 1915(c)) Waivers are intended to provide an alternative to institutional care for people who qualify for placement in a Medicaid-funded facility. Even with the movement of Medi-Cal long term services and supports into managed care through the Coordinated Care Initiative, California’s Nursing Facility/Acute Hospital (NF/AH) Waiver provides virtually the only home and community-based alternative to nursing facility placement for people who require skilled home care or services beyond In Home Supportive Services (IHSS). While this Waiver has great potential, California has made choices which create unnecessary and costly barriers to community living for eligible individuals.¹

Specifically:

- The number of Waiver slots available statewide is inadequate to meet the need;

¹ California’s NF/AH Waiver “provides case management/coordination, habilitation, home respite, Waiver personal care services, community transition, continuous nursing and supportive services, environmental accessibility adaptations, facility respite, family/caregiver training, medical equipment operating expense, PERS-installation and testing, PERS, private duty nursing including home health and shared services, transitional case management for medically fragile and technology dependent individuals age 0 - no max age.” The NF/AH Waiver is an umbrella for three distinct Waivers (Nursing Facility-A/B (NF-A/B), Sub acute, and Acute), each with distinct eligibility criteria.

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- The cost-cap for community care is unnecessarily low when compared to the cost of institutionalization and is based on individual rather than aggregate costs;
- When costs of certain Medi-Cal services, such as IHSS, increase, some consumers on the Waiver lose services because their individual Waiver budgets do not increase;
- Waiver coverage for people who need extensive unskilled care (“between” nursing facility Level B and sub-acute level-of-care) is lacking; and
- Children turning 21 experience a service “cliff” and lose critically needed home nursing when they age out of EPSDT.

Discussion

1. Number of Slots is Inadequate

The Developmental Disabilities Waiver, by which people served by the regional center system can receive services in the community, has around over 100,000 slots.

The NF/AH Waiver has a maximum of about 3,500 slots statewide, including 300 slots for people at the Acute Hospital level of care. There are approximately 70,000 people who receive Medi-Cal in nursing homes on any one day, 25% of whom express an interest in leaving the facility and living in the community.

While the Acute Hospital and Subacute levels of care do not apparently have waitlists, the NF-A/B Waiver (one part of the NF/AH Waiver that serves people who would otherwise require care in a nursing facility) has a waitlist for people currently living in the community. That means that people who meet the criteria for admission to a nursing facility, but remain at home with insufficient services, must wait several months or even years before getting more attendant care or home nursing care.

Fix: Increase the number of slots on the NF-A/B Waiver to be commensurate with the number of Medi-Cal recipients in nursing facilities or at risk for placement who could benefit from or who desire this alternative. As an immediate fix, the Administration should expand the NF-A/B Waiver to permit all people on the waiting list to immediately get Waiver services.

1. Cost Cap Inadequate

Federal requirements for home and community-based Waivers include a cost-neutrality provision. Federal cost-neutrality means that providing home and community-based Waiver services to an individual, or a group of individuals, cannot cost the Medi-Cal program more than serving that individual, or that group of individuals in an institutional setting. California applies a more rigorous standard that favors institution placements, which poses an unnecessary and unwarranted barrier to community living for many individuals with higher care needs. Moreover, despite a federal option to utilize an “aggregate” cost-cap, California has opted instead to utilize an “individual” cost-cap, which does not permit the State to offset the Waiver costs of higher need individuals with the lower cost of lower-need individuals. The DD home and community-based services Waiver utilizes such an aggregate cost-cap with great success. This chart shows how much Medi-Cal pays for an institutional level of care and how much it pays for the equivalent Waiver service. Note: the current institutional rates are now higher, increasing the disparity.

Institutional Level of Care	Annual Institutional Rate (based on 2005 NF/AH Waiver)	Annual Waiver Cost-Cap (Current in 2012 NF/AH Waiver)
Nursing Facility (NF)-A	\$34,388	\$29,548
Nursing Facility (NF)-B	\$56,074	\$48,180
NF-B Pediatric	\$110,280	\$101,882
NF-Distinct Part	\$124,342	\$77,600
NF-Subacute, Adult	\$271,697	\$180,219
NF-Subacute, Pediatric	\$282,574	\$240,211
Acute Hospital	\$437,757	\$305,283

Fix: Increase the Waiver cost caps to be equivalent to their institutional equivalent; and the Waiver amended to create an aggregate, instead of an individual cost-cap, similar to the developmental disability (DD) Waiver.

3. Waiver cost cap remains fixed while Waiver service costs increase

The NF/AH Waiver uses an individual cost-cap. Medi-Cal State Plan services such as IHSS are deducted from each individual’s Waiver budget, which reduces the amount of Waiver services that can be purchased. For example, the monthly

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Waiver budget for someone on the NF A/B Waiver at the NF-B (skilled nursing facility) level of care equals approximately \$4,000 per month. If the person receives the maximum of 283 hours of IHSS services per month, and lives in a county which pays \$12/hr for IHSS, \$3,396 out of \$4,000 goes to pay IHSS. This leaves very little for any other of the services which are theoretically available.

As an added problem, if IHSS wages increase, that in turn will reduce the individual's budget for purchasing Waiver services and the individual will receive fewer hours of service.

Fix: Change to an aggregate cost-cap or, failing that, increase the Waiver cost-caps commensurate with institutional rates and adjust upward as Medi-Cal service rates (IHSS, nursing facilities, etc.) increase.

4. Gap in Eligibility for Services

The NF/AH Waiver is an umbrella for three distinct Waivers (NF-A/B, Sub acute, and Acute), each with distinct eligibility criteria. These Waivers do not form a continuum. Some individuals who exceed nursing facility skilled level-of-care (Level B) (and whose needs cannot be met on the NF-A/B Waiver), do not meet the specific requirements for sub-acute level-of-care (and therefore do not qualify for the Sub acute Waiver). Disability Rights California has represented individuals who remain needlessly in acute care hospitals for extended periods of time, remain inadequately served at home and at risk, or whose service needs are gap-filled by other service agencies.

Fix: NF/AH Waiver eligibility criteria should be expanded to include individuals whose needs for attendant care or skilled monitoring exceeds the nursing facility skilled level-of-care, but whose needs do not fit Subacute level-of-care criteria.

This deficiency can be resolved by offering an "*Olmstead* exception" which would permit DHCS to use its discretion in assigning a level of care that is appropriate to provide an adequate amount of home attendant or nursing care.

5. Remove the EPSDT "Cliff"

Children with the most significant medical needs can live at home with the support of home nursing. For Medi-Cal eligible children under age 21, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) funds this nursing. Home nursing hours are calculated based on the appropriate institutional level of

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care equivalent. For example, a child eligible for nursing facility level B will be eligible to receive in-home nursing hours up to the cost of the pediatric nursing facility level B.

At 21, Medi-Cal recipients should be able to transition from EPSDT home nursing to home nursing funded by the Nursing Facility Acute Hospital (NF/AH) Waiver, the Developmental Disabilities Waiver, or regional center services, as appropriate. Unless their need has changed, this transition should be seamless and services should not decrease. However, some individuals experience a devastating reduction in home nursing because:

1. The rates for adult facilities are considerably lower than the pediatric facilities. Example: the pediatric nursing facility level B rate is approximately \$110,000 per year; the adult nursing facility level B rate is \$56,000 annually.
2. The NF/AH Waiver cost caps are even lower. Example: The adult nursing facility level B Waiver rate is just \$48,180. Thus, a child who ages out of EPSDT and into the adult nursing facility level B Waiver would lose 57% of her budget (\$110,000 reduced to \$48,180) and their nursing hours. And, since IHSS costs are not deducted from EPSDT nursing services, the actual loss is even more significant.
3. Children who meet the pediatric Subacute level of care may not meet the more rigid adult Subacute level of care. These individuals are designated at the Nursing Facility-B level of care, although no nursing facility could meet their medical needs. The result can be unnecessary placement in developmental centers or other institutions.

For regional center consumers, the issue is further complicated because the Lanterman Act includes an entitlement to services which is uncapped. Because the 2009 Amendments to the Lanterman Act required the use of generic resources including Medi-Cal, regional centers require consumers to seek in-home nursing through the NF/AH Waiver, including filing questionable appeals, before regional centers will fund in-home nursing to supplement the often meager allotment provided by the NF/AH Waiver. If consumers are placed on the NF/AH Waiver, additional nursing services must be purchased by the regional center with state-only dollars because individuals can only be on one HCBS Waiver (e.g., NF/AH Waiver or DD Waiver but not both).

DHCS and the Department of Developmental Services do not always ensure that the “aging-out” individuals receive: a) adequate and timely notice of the change

in hours; b) an opportunity to challenge the reduction, including aid paid pending; and c) seamless transition to another source of funding for the lost hours, e.g. an adult Waiver, the DD Waiver, or regional center supplement of the hours lost.

Fix for Regional Center Consumers:

1. Ensure that the aging-out individual experience no reduction or interruption in nursing services, absent an improvement in assessed needs.
2. Require that DDS and DHCS jointly develop a care plan, at least 180 days before an affected individual reaches his/her 21st birthday, to deliver the services. The plan must include:
 - a. Reevaluating the individual's level of care and nursing need;
 - b. Determining which funding source will pay. If the nursing care (apart from regional center nursing respite) cannot be met entirely by the NF/AH Waiver, DDS and DHCS must determine which other sources of funding will be made available to meet the individual's need.
 - c. Informing the family and processing necessary paperwork in a timely way avoiding service interruption.
3. If DHCS and DDS are unable to ensure that the individual will experience neither reduction nor interruption in nursing services, they must issue a timely and adequate notice, informing the individual of his/her right to file for a Medi-Cal or regional center administrative hearing, and the availability of aid paid pending the hearing decision.
4. DHCS and DDS must issue written directives and provide training on this protocol for IHO staff and regional centers.

Fix (for Non-Regional Center Consumers):

The fixes proposed above (1-4) would go far to ensure that individuals turning 21 do not experience a catastrophic loss in in-home nursing and other services. Specifically, using an aggregate instead of an individual cost-cap would allow the small number of higher cost individuals to receive the services they need, and their costs would be balanced out by the cost of serving lower need individuals. Alternatively, increasing the Waiver cost-caps commensurate with institutional rates and offering an "Olmstead exception" would enable these

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individuals to receive at least the services that Medi-Cal would fund if they were forced into an institution. Finally, providing the due process protections described above (Item 5, Fix 3) would ensure that such individuals would not experience a precipitous loss in services without a hearing.