GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Long-Term Care Series

California, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2023

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

California, USA

In-Kind Benefits

Plan details 1992-2023 * †

Public long-term care (LTC) benefits in California are primarily provided by Medi-Cal, California's Medicaid public health insurance program for low-income individuals. Medi-Cal enrollment is voluntary.

In California, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, semi-residential care, and residential care. Programs may vary in eligibility criteria.

Since 1992, California's Medicaid LTC system has been subject to two major policy reforms: the replacement of the Adult Day Health Care (ADHC) program with the Community-Based Adult Services (CBAS) program in 2012, and eligibility expansions (immigration status and asset limit) in 2022.

Key Dates

First law: 1965

Major changes since 1992: 2012, 2022

Contents

* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-2011

Overview

Long-term care (LTC) benefits in California are primarily provided by Medi-Cal (California's Medicaid program), a public health insurance program for low-income individuals (CHCF, 2020). Medi-Cal is administered at the state level by the Department of Health Care Services (DHCS), and enrollment is voluntary (KFF, 2016). Health plans are organized and administered at the county level by county-based government health insurance plans and/or private plans licensed by the state and county.

Eligibility for Medi-Cal is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in California are mostly provided through state plan benefit programs (In-Home Supportive Services - IHSS, Adult Day Health Care - ADHC, Nursing Facility Care).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. IHHS provides home care for beneficiaries that have established medical necessity, ADHC provides care in an outpatient facility, and Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care.

Benefit programs vary in dependence requirements. IHSS recipients receive a set number of provider service hours depending on their assessed need, which is based on an assessment for a set of daily functions, such as housework, laundry, dressing, and eating. ADHC requires that recipients have certain medical conditions, mental or physical impairments, an expectation that the service will maintain or improve their present level of functioning, and high risk for deterioration and institutionalization if the program were not available. Nursing Facility Care requires recipients to receive prior authorization from a Medi-Cal consultant before admission.

In 1993, the Personal Care Services Program (PCSP) began as a subprogram under IHHS, providing personal care services to eligible beneficiaries. In 1998 and 1999, California state plan amendments to the PCSP were approved by the Centers for Medicare and Medicaid Services (CMS) to expand PCSP eligibility to medically needy aged, blind, and disabled individuals (previously, only categorically-eligible persons were eligible) and income-ineligible recipients (i.e., recipients with a share of cost), respectively (CDSS, 2015). The IHSS Plus Option (IPO) began in September 2009 and replaced the IHSS Plus Waiver (IPW) demonstration program, establishing IPO as a Medi-Cal state plan benefit (WIC 14132.952).

During this policy period, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 restricted most legal immigrants entering the United States after August 22, 1996 from receiving federally funded Medicaid (and some other public assistance) for at least five years after immigration.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2022c)

California Law for Medi-Cal

- Welfare and Institutions Code - WIC, Division 9. Public Social Services, Part 3. Aid and Medical Assistance
  - Chapter 7. Basic Health Care (WIC 1400-14199.67)
  - Chapter 3. State Supplementary Program for Aged, Blind and Disabled, Article 7. In-Home Supportive Services (WIC 12300-12318)
- California Code of Regulations, Title 22. Social Security, Division 3. Health Care Services, Subdivision 1. California Medical Assistance Program (22 CCR T. 22, Div. 3)

Financing

Source of financing

Funding for Medi-Cal is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Medi-Cal spending on beneficiaries in fiscal year 1992 was 50%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (50% in 1992), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medi-Cal, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medi-Cal. Here we detail eligibility for Medi-Cal, followed by additional requirements for specific benefits and programs under Medi-Cal.

Medi-Cal

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in California.

Eligibility for Medicaid in California for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 1992, the monthly federal benefit amount was $422 for an individual and $633 for a couple (SSA, 2023). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[2]
  - Citizenship/immigration requirements: The applicant must be a California resident and a U.S. Citizen or non-citizen who meets additional eligibility requirements.[3] After 1996, the applicant must be a California resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled (SSA, 2022).[4]

Eligibility Track 2: Optional Categorically Needy

- 2b. Federal Poverty Level (FPL) aged and disabled
  - Income requirements: Monthly income may not exceed 100% of the FPL. In 1992, this was $568 for an individual and $766 for a household of two. See Table 3 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[5]
  - Asset requirements: Same asset requirements as eligibility track 1a. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[6]
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled (42 USC 1382c(a)(1-3); WIC 14005.50).[4]

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: There is no income limit so long as the person meets their share of cost requirements, which are further detailed in 22 CCR 50653 and the *User Charges* section of this policy period. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[5]
  - Asset requirements: Same asset requirements as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[6]
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled as defined in 22 CCR 50219, 50221, 50223.

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Medi-Cal Dialysis Only Program, or other Medi-Cal Special Treatment Program: Programs providing Medicaid coverage to individuals meeting certain medical conditions or diagnoses (22 CCR 50264).

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

In-Home Supportive Services (IHSS), Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Adult Day Health Care (ADHC)

Beyond meeting minimum level of dependence requirements, applicants must reside outside of a licensed health facility, or reside in a licensed health facility but are provided transition visits in accordance with (22 CCR 54504). Transition visits are for individuals transitioning from a nursing facility to the community.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Multipurpose Senior Services Program
- Home and Community-Based Alternatives Program
- Program of All-Inclusive Care for the Elderly (PACE)

Benefit

Home care benefit

IHSS

IHSS provides (CDSS, 2020b):

- Personal care services
  - Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Home health services
  - Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
  - Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Each of the IHSS subprograms (i.e., IHSS-R, PCSP, IPO, CFCO) differ in the level of care necessary to qualify or the provider provisioning the services, not the benefits provided. The maximum number of IHSS service hours non-severely impaired recipients can be allocated is at most 195 hours per month, or for severely impaired recipients, 293 hours per month (IHSS MPP 30-757).

ADHC, Nursing Facility Care

These programs do not provide home care during this policy period.

Semi-residential care

IHSS, Nursing Facility Care

These programs do not provide semi-residential care during this policy period.

ADHC

ADHC is an outpatient, facility-based program that includes the following services:

- Professional nursing services
- Physical, occupational and speech therapies
- Mental health services
- Therapeutic activities
- Social services
- Personal care
- Meals
- Nutritional counseling
- Transportation to and from semi-residential services

Residential care

IHSS, ADHC

These programs do not provide residential care during this policy period.

Nursing Facility Care

Medi-Cal covers residential care in a nursing facility. Services must include the following (SSA 1919(b)(4)):[7]

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Medi-Cal provides additional benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Provision of care

Medi-Cal benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the California Department of Public Health. Providers that accept Medi-Cal payment rates and meet licensing requirements may participate in Medi-Cal. Managed care plans will have limited provider networks.

IHSS

IHSS care providers are certified by the California Department of Social Services and county IHSS authorities and can include family members, friends, or neighbors that can become registered IHSS providers (CDSS, 2022b).

ADHC

The California Department of Aging licenses and monitors each ADHC center as Medi-Cal providers for the ADHC program.

Nursing Facility Care

Nursing facilities are licensed by the California Department of Public Health (HSC 1250-1264).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the three largest programs are summarized below.

IHSS

Beneficiaries meet at least a Rank 2 level of care for each requested service. Rank 2 is defined as "able to perform a function, but needs verbal assistance, such as reminding, guidance, or encouragement." Individuals that score in Rank 1 for any service do not qualify for that particular service. See *Definition of Dependence* for more information.

ADHC

Applicants must have all of the following (22 CCR 54209, WIC 14525):

- A medical condition that requires treatment or rehabilitative services prescribed by a physician
- Mental or physical impairments which handicap daily living activities but which are not of such a serious nature as to require 24-hour institutional care
- A reasonable expectation that preventative service will maintain or improve the present level of functioning
- A high potential for further deterioration and probable institutionalization if ADHC were not provided

These eligibility conditions are further detailed in Box 1.

Nursing Facility Care

A patient must have a medical condition which requires visits by a physician at least every 60 days and constantly available skilled nursing services (22 CCR 51335).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months.

IHSS

Continued eligibility for receipt of IHSS is reassessed every 12 months with a face-to-face assessment (IHSS MPP 30-761).

ADHC

Reauthorizations are required every 3 months (22 CCR 54209).

Nursing Facility Care

Reauthorizations for nursing facility care are required every 12 months (22 CCR 51334 and 51335). The attending physician must recertify the patient's need for continued care at least every 60 days.

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

IHSS

There are 6 levels of dependence that quantify the beneficiary's level of functioning (IHSS MPP 30-756):

- Rank 1: Independent —able to perform function without human assistance, although the recipient may have difficulty in performing the function, but the completion of the function, with or without a device or mobility aid, poses no substantial risk to his or her safety
- Rank 2: Able to perform a function, but needs verbal assistance, such as reminding, guidance, or encouragement
- Rank 3: Can perform the function with some human assistance, including, but not limited to, direct physical assistance from a provider
- Rank 4: Can perform a function but only with substantial human assistance
- Rank 5: Cannot perform the function, with or without human assistance
- Rank 6: Paramedical Services —all needed services in the task are met by paramedical services in lieu of the correlated task

For mental functioning, the functions of memory, orientation, and judgement are evaluated on a 3-level scale (Rank 1, Rank 2, and Rank 5).

Ranks 2-6 correspond to a number of service category hours. As of 2019, assessors use the Hourly Task Guideline to determine number of service hours, detailed in Table 4 (Part 1), Table 5 (Part 2), and Table 6 (Part 3). Individuals that score in Rank 1 for any service do not qualify for that particular service.

ADHC

General criteria that are used to consider the need for ADHC services include medical necessity, which is detailed in Box 1.

Nursing Facility Care

Medi-Cal consultants use criteria outlined in 22 CCR 51335(j) as a guide to determine appropriate placement. General criteria that can be used in evaluating admission for nursing facility services are further detailed in Box 5.

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

IHSS

Designated county staff determine the applicant's level of ability, dependence, need for physical assistance, limitations with ADLs and IADLs, and cognition (e.g., memory, orientation, and judgement). For an exhaustive list, see (IHSS MPP 30-756). The Annotated Assessment Criteria (AAC) assists the evaluator in evaluating the recipient's capacity to perform certain IHSS tasks with examples of observations and possible indicators with each function and rank. To view the AAC as of 2020, see (CDSS, 2020).

Once a social worker has evaluated the level of dependence for each function/service category, they use the Hourly Task Guidelines to determine the appropriate time needed on a weekly basis in each service category. See Table 4 (Part 1), Table 5 (Part 2), and Table 6 (Part 3) for additional detail on Hourly Task Guidelines.

ADHC

Prior authorization from a designated Medi-Cal consultant determines if ADHC services are medically necessary (22 CCR 54209). In determining the need for ADHC, the Medi-Cal Consultant must consider the following:

- Medical factors including the necessity for nursing care, supervision or observation on an ongoing intermittent basis to abate health deterioration, to see a physician or psychiatrist no less than every 60 days, to monitor medications for response and effect on an intermittent basis, for medications which cannot safely be self-administered due to physical or mental disabilities, and for individualized therapeutic treatment designed to restore optimal functional potential or to prevent deterioration.
- Functional status including, limitation in movement, inability to perform ADLs, incontinency, vision, hearing or sensory loss to some degree, and dependency and the need for part-time or full-time basic supervision by persons other than day health center staff.
- Psychosocial limitations including the inability of person or family to cope adequately with problems associated with the person's disability, need for a psychosocial environment involving peer group membership and social rehabilitation, mild or moderate confusion or depression, or tendency to wander, and inappropriate affect, appearance or behavior.

Nursing Facility Care

Prior authorization from the designated Medi-Cal consultant determines if nursing facility services are authorized. Per federal guidelines, individuals applying for institutional care must have a comprehensive assessment conducted prior to admission. See Box 2 for a list of items evaluated in the comprehensive assessment.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 3 for more information on the PASRR, and Box 4 for the MDS.

Evaluators

Evaluators vary by LTC health benefit program. The details of the three largest programs are summarized below.

IHSS

Functional needs assessments are conducted by a county social worker (IHSS MPP 30-756).

ADHC

Assessments and reassessments are conducted by a Medi-Cal consultant (22 CCR 54209).

Nursing Facility Care

Eligibility is determined by a designated Medi-Cal consultant from the district where the facility is located, and the attending physician signs the authorization request (22 CCR 51334(b)).

Benefit limitations

Can you mix LTC benefits?

All Medi-Cal beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medi-Cal

As required by federal law, California enforces Estate Recovery. The acceptance of Medi-Cal creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medi-Cal recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (DHCS, 2021b).

Most individuals qualifying for Medi-Cal under eligibility track 3a are required to pay a share of cost. The share of cost is a monthly amount an individual pays before Medi-Cal covers necessary services, allowing individuals to qualify for Medi-Cal if they meet the residency and categorical requirements but have income higher than the income limits of other eligibility tracks.

If a beneficiary is not in a nursing facility, their share of cost is equal to their countable income minus their monthly maintenance need level (MNL), which is $600 for an individual and $934 for a couple (22 CCR 50603, 50653). If a beneficiary is in a nursing facility, their share of cost is equal to their countable income minus their maintenance need, which is equal to $35, an income allowance for a non-applicant spouse (MMNA), home upkeep, and support of a disabled relative (22 CCR 50605, 50653).

IHSS, ADHC

Unknown

Author's note: Authors have not yet identified this information.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. In 1992, the PNA was $35 per month (22 CCR 50605).

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 2012-2021

Policy change in 2012

Between 2012-2014, policy reforms and legal settlements resulted in the replacement of the Adult Day Health Care (ADHC) benefit with the Community-Based Adult Services program in 2012, a reduction in In-Home Supportive Services (IHSS) service hours in 2013, the creation of a new IHSS subprogram, the Community First Choice Option in 2014, the expansion of Medi-Cal in 2014 to most adults at or below 138% of the Federal Poverty Level (FPL) through the Affordable Care Act (ACA), and an increase in income limits for eligibility track 2b (FPL aged, blind, or disabled).

As a result of a 2011 class action lawsuit filed by ADHC beneficiaries against the California Department of Health Care Services (Esther Darling, et al. v. Toby Douglas, et al., 2011), ADHC was eliminated and a new program, CBAS was created in March 2012. CBAS provided similar benefits and services as ADHC but included stricter eligibility requirements and a new dependency assessment process. Former ADHC beneficiaries were required to do face-to-face assessments to qualify for the new CBAS program. The lawsuit was filed in response to a legislative bill (California Assembly Bill 97) that would have eliminated ADHC as a Medi-Cal benefit (DRC, 2011).

Between 2009 and 2012, the California state legislature attempted to reform the IHSS program by implementing a stricter threshold of need for IHSS, reducing IHSS service hours for all recipients by 20 percent, and reducing wages and benefits to IHSS providers. These reforms were challenged by two separate court cases, Oster v. Lightbourne, et al., and Dominguez v. Schwarzenegger, et al (later Dominguez v. Brown), with both cases reaching settlement on March 27, 2013, resulting in an 8% reduction to IHSS hours for 2013-2014 and a 7% reduction to IHSS hours in future years (SACHS, 2018; Oster v. Lightbourne & Dominguez v. Brown, 2013).

The ACA established CFCO as a new state plan option for providing home-and community-based services (HCBS). Implementation of the California CFCO program began in 2014 as a new IHSS program (CDSS, 2014). Additionally, as a result of the ACA, California opted to expand Medi-Cal eligibility to eligibility track 2c, adults aged 19 to 64 with income at or below 138% of the FPL beginning January 1, 2014. Individuals qualifying for Medi-Cal through this track are required to enroll in a Medi-Cal managed care plan (MCP) (WIC 14005.60, Assembly Bill 1, 2013).

The ACA also required states to extend spousal impoverishment rules to individuals receiving LTC through HCBS programs, including CFCO and CBAS. From 2014, additional income and asset disregards applied to the community spouse of an individual receiving HCBS through Medi-Cal. It is possible that California extended spousal impoverishment rules to spouses of individuals receiving HCBS prior to 2014; however, authors were unable to verify the year that California implemented this extension.

In 2020, California received approval to increase the income limit for eligibility track 2c. The limit increased from 100% of the FPL to 138% of the FPL, allowing more individuals at least age 65, blind, or disabled to become eligible for Medicaid (CMS, 2020).

Other reforms during this period:

- (2014) Case management was added as a state plan benefit for Medi-Cal beneficiaries. However, coverage varies by county (DHCS, 2021).

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Benefit programs vary in dependence requirements. IHSS recipients receive a set number of provider service hours depending on their assessed need, which is based on an assessment for a set of daily functions, such as housework, laundry, dressing, and eating. CBAS recipients must meet or exceed a nursing facility level of care (NFLOC), and Nursing Facility Care requires recipients to receive prior authorization from a Medi-Cal consultant before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2022c)

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Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medi-Cal, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medi-Cal. Here we detail eligibility for Medi-Cal, followed by additional requirements for specific benefits and programs under Medi-Cal.

Medi-Cal

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in California.

Eligibility for Medicaid in California for people needing LTC services is primarily attained by satisfying at least one of 4 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients

  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2012, the monthly federal benefit amount was $698 for an individual and $1,048 for a couple. See Table 2 for historical income limits.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    * Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[10]
  - Citizenship/immigration requirements: The applicant must be a California resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996 are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023) for additional information.
  - Other requirements
    * The applicant must be at least age 65, blind, or disabled (SSA, 2022).[4]

Eligibility Track 2: Optional Categorically Needy

- 2b. Federal Poverty Level (FPL) aged and disabled
  - Income requirements: Monthly income may not exceed 100% of the FPL. In 2012, this was $931 for an individual and $1,261 for a household of two. See Table 3 for historical income limits. Additional income disregards exist if a person is institutionalized or receiving HCBS and has a spouse residing in the community.[11] From 2020, income may not exceed 138% of the FPL. In 2020, this was $1,468 for an individual and $1,983 for a household of two.
  - Asset requirements: Same asset requirements as eligibility track 1a. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[12]
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    * The applicant must be at least age 65, blind, or disabled (42 USC 1382c(a)(1-3); WIC 14005.50).[4]
- 2c. Affordable Care Act (ACA) expansion adults
  - Income requirements: Monthly income may not exceed 138% of the FPL. In 2014, this was $1,343 for an individual and $1,809 for a household of two. See Table 3 for historical income limits.
  - Asset requirements: There is no asset test for this population.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    * Applicants must be ages 19-64, ineligible for Medicare, ineligible for other Medicaid eligibility tracks, and not pregnant at the time of application.

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: There is no income limit so long as the person meets their share of cost requirements, which are further detailed in 22 CCR 50653 and the *User Charges* section of this policy period. Additional income disregards exist if a person is institutionalized or receiving HCBS and has a spouse residing in the community.[11]
  - Asset requirements: Same asset requirements as eligibility track 1a. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[12]
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    * The applicant must be at least age 65, blind, or disabled as defined in 22 CCR 50219, 50221, 50223.

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Medi-Cal Dialysis Only Program, or other Medi-Cal Special Treatment Program: Programs providing Medicaid coverage to individuals meeting certain medical conditions or diagnoses (22 CCR 50264).

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

In-Home Supportive Services (IHSS), Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Community-Based Adult Services (CBAS)
Beyond meeting minimum level of dependence requirements, applicants must be at least age 18, enrolled in a Medi-Cal Managed Care Plan (MCP) or MCP exempt, and reside in a geographic service area where CBAS benefits are available (22 CCR 54201).

Other community-based programs
There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Multipurpose Senior Services Program
- Home and Community-Based Alternatives Program
- Program of All-Inclusive Care for the Elderly (PACE)

Benefit

Home care benefit

IHSS
IHSS provides (CDSS, 2020c):

- Personal care services
  - Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Home health services
  - Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
  - Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Each of the IHSS subprograms (i.e., IHSS-R, PCSP, IPO, CFCO) differ in the level of care necessary to qualify or the provider provisioning the services, not the benefits provided. The maximum number of IHSS service hours non-severely impaired recipients can be allocated is at most 195 hours per month, or for severely impaired recipients, 293 hours per month (IHSS MPP 30-757).

CBAS, Nursing Facility Care
These programs do not provide home care during this policy period.

Semi-residential care

IHSS, Nursing Facility Care
These programs do not provide semi-residential care during this policy period.

CBAS
CBAS is an outpatient, facility-based program that includes the following services:

- Professional nursing services
- Physical, occupational and speech therapies
- Mental health services
- Therapeutic activities
- Social services
- Personal care
- Meals
- Nutritional counseling
- Transportation to and from semi-residential services

Residential care

IHSS, CBAS
These programs do not provide residential care during this policy period.

Nursing Facility Care
Medi-Cal covers residential care in a nursing facility. Services must include the following (SSA 1919(b)(4)):[7]

- Physician services
- Room and board
- All general nursing services, including restorative nursing

- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Medi-Cal provides additional benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy
- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care —this service was added in 2014, and coverage varies by county (DHCS, 2021)

Provision of care

Medi-Cal benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the California Department of Public Health. Providers that accept Medi-Cal payment rates and meet licensing requirements may participate in Medi-Cal. Managed care plans will have limited provider networks.

IHSS

IHSS care providers are certified by the California Department of Social Services and county IHSS authorities and can include family members, friends, or neighbors that can become registered IHSS providers (CDSS, 2022b).

CBAS

The California Department of Aging licenses and monitors each CBAS center as Medi-Cal providers for the CBAS program (CDA, 2022).

Nursing Facility Care

Nursing facilities are licensed by the California Department of Public Health (HSC 1250-1264).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the three largest programs are summarized below.

IHSS

IHSS CFCO applicants must meet a nursing facility level of care (NFLOC). The NFLOC criteria is further detailed in Box 8. The other IHSS subprograms (i.e., PCSP, IPO, IHSS-R) require beneficiaries meet at least a Rank 2 level of care for each requested service. Rank 2 is defined as "able to perform a function, but needs verbal assistance, such as reminding, guidance, or encouragement." Individuals that score in Rank 1 for any service do not qualify for that particular service. See *Definition of Dependence* for more information.

CBAS

As of 2012, individuals that previously received ADHC could be determined as categorically or presumptively eligible for CBAS if they met the requirements detailed below (Esther Darling, et al. v. Toby Douglas, et al., 2011; DHCS, 2015):

- Categorically eligible: The applicant must be either a Regional Center consumer, Multipurpose Senior Services Program (MSSP) recipient, Specialty mental health services (eligible or receiving), or individual eligible for 195 or more hours/month for IHSS
- Presumptively eligible: The applicant must be likely to meet NF-B level of care (detailed in Box 9) as determined by DHCS or have an Individual Plan of Care that indicates a need for assistance or supervision with the following:

  - Three of the following ADLs/IADLs: Bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene
  - One nursing intervention provided at ADHC
- For those previously receiving ADHC, there is no developmental disability qualification option (option 5 above) and no requirement to meet the ADHC eligibility and medical necessity criteria

Alternatively, new applicants (as of 2012) must meet all eligibility criteria detailed in Box 1, and meet at least one of the following medical criteria (CMS, 2012; CMS, 2021, p.18-19):

1. Meet or exceed the "Nursing Facility Level of Care A" (NF-A) criteria as set forth in 22 CCR 51120(a), 51334(l) (detailed in Box 10)
2. Have a diagnosed organic, acquired or traumatic brain injury, and/or chronic mental disorder and need assistance or supervision with either two ADLs (e.g., bathing, dressing, self-feeding) or one ADL and one IADL (e.g., money management, meal preparation, transportation)
3. Have moderate to severe Alzheimer's disease or other dementia characterized by the descriptors of, or comparable to, Stages 5, 6, or 7 Alzheimer's disease
4. Satisfy both requirements below:
   - Have a mild cognitive impairment including Alzheimer's disease or other dementias characterized by the descriptors of, or comparable to, Stage 4 Alzheimer's disease
   - Have a demonstrated need for assistance or supervision with at least 2 ADLs or IADLs
5. Have a developmental disability meeting the definitions and requirements set forth in 17 CCR 54001(a) as determined by a regional center under contract with the Department of Developmental Services

Nursing Facility Care

A patient must have a medical condition which requires visits by a physician at least every 60 days and constantly available skilled nursing services (22 CCR 51335).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months.

IHSS

Continued eligibility for receipt of IHSS is reassessed every 12 months with a face-to-face assessment (IHSS MPP 30-761).

CBAS

Continued eligibility for receipt of CBAS is reassessed at least every 6 months through the reauthorization process, or up to every 12 months for individuals determined by the MCP to be clinically appropriate (CMS, 2021).

Nursing Facility Care

Reauthorizations for nursing facility care are required every 12 months (22 CCR 51334 and 51335). The attending physician must recertify the patient's need for continued care at least every 60 days.

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

IHSS

There are 6 levels of dependence that quantify the beneficiary's level of functioning (IHSS MPP 30-756):

- Rank 1: Independent —able to perform function without human assistance, although the recipient may have difficulty in performing the function, but the completion of the function, with or without a device or mobility aid, poses no substantial risk to his or her safety
- Rank 2: Able to perform a function, but needs verbal assistance, such as reminding, guidance, or encouragement
- Rank 3: Can perform the function with some human assistance, including, but not limited to, direct physical assistance from a provider
- Rank 4: Can perform a function but only with substantial human assistance
- Rank 5: Cannot perform the function, with or without human assistance
- Rank 6: Paramedical Services —all needed services in the task are met by paramedical services in lieu of the correlated task

For mental functioning, the functions of memory, orientation, and judgement are evaluated on a 3-level scale (Rank 1, Rank 2, and Rank 5).

Ranks 2-6 correspond to a number of service category hours. As of 2019, assessors use the Hourly Task Guideline to determine number of service hours, detailed in Table 4, Table 5, and Table 6. Individuals that score in Rank 1 for any service do not qualify for that particular service.

CBAS

Previous recipients of ADHC transitioning to CBAS in 2012 can be determined as presumptively eligible for CBAS if DHCS determines that the applicant could likely meet a NF-B level of care. The NF-B level is defined in Box 9 (Esther Darling, et al. v. Toby Douglas, et al., 2011, pg. 9).

New applicants must meet all criteria detailed in Box 1, and one of the medical criteria detailed in *Minimum Level of Dependence* for this policy period. For the medical criteria, the following definitions apply:

- NF-A level of care according to 22 CCR 51120(a), 51334(j) and detailed in Box 11 —a guide for determining the need for intermediate care services is further detailed in Box 10
- Stages of dementia according to the CBAS Record of Dementia Stages for CBAS Screening Tool (DHCS, 2015):
  - Stage 1: No cognitive impairment
  - Stage 2: Very mild decline
  - Stage 3: Mild cognitive decline
  - Stage 4: Moderate cognitive decline
  - Stage 5: Moderately severe cognitive decline
  - Stage 6: Severe cognitive decline
  - Stage 7: Very severe cognitive decline

  These stages are further detailed in Box 12. Based on the stages, the individual will be placed in 1 of 4 groups, detailed in Box 13.

Nursing Facility Care

Medi-Cal consultants use criteria outlined in 22 CCR 51335(j) as a guide to determine appropriate placement. General criteria that can be used in evaluating admission for nursing facility services are further detailed in Box 5.

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

IHSS

Designated county staff determine the applicant's level of ability, dependence, need for physical assistance, limitations with ADLs and IADLs, and cognition (e.g., memory, orientation, and judgement). For an exhaustive list, see (IHSS MPP 30-756). The Annotated Assessment Criteria (AAC) assists the evaluator in evaluating the recipient's capacity to perform certain IHSS tasks with examples of observations and possible indicators with each function and rank. To view the AAC as of 2020, see (CDSS, 2020).

Once a social worker has evaluated the level of dependence for each function/service category, they use the Hourly Task Guidelines

to determine the appropriate time needed on a weekly basis in each service category. See Table 4, Table 5, and Table 6 for additional detail on Hourly Task Guidelines.

CBAS

A designated nurse with level of care determination experience uses a standardized tool and protocol approved by the DHCS, unless DHCS or its contractor(s) to determine if an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information that the plan possesses (CMS, 2021). However, the term "clinically appropriate" is not defined in the CBAS program application.

DHCS uses the CBAS Record of Dementia Stages for CBAS Screening Tool to determine which stage of dementia (stages 1 to 7) an applicant is in (DHCS, 2015). DHCS also uses the appropriate statutes articulated in the *Definition of Dependence* section of this policy period to guide medical necessity and level of care determinations.

Nursing Facility Care

Prior authorization from the designated Medi-Cal consultant determines if nursing facility services are authorized. Per federal guidelines, individuals applying for institutional care must have a comprehensive assessment conducted prior to admission. See Box 2 for a list of items evaluated in the comprehensive assessment.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 3 for more information on the PASRR, and Box 4 for the MDS.

Evaluators

Evaluators vary by LTC health benefit program. The details of the three largest programs are summarized below.

IHSS

Functional needs assessments are conducted by a county social worker (IHSS MPP 30-756).

CBAS

The face-to-face review is conducted by a registered nurse with level of care determination experience. However, if the MCP has determined that CBAS is clinically appropriate for the individual based, the review conducted by the registered nurse is not needed.

Nursing Facility Care

Eligibility is determined by a designated Medi-Cal consultant from the district where the facility is located, and the attending physician signs the authorization request (22 CCR 51334(b)).

Benefit limitations

Can you mix LTC benefits?

All Medi-Cal beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medi-Cal

As required by federal law, California enforces Estate Recovery. The acceptance of Medi-Cal creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medi-Cal recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (DHCS, 2021b).

Most individuals qualifying for Medi-Cal under eligibility track 3a are required to pay a share of cost. The share of cost is a monthly amount an individual pays before Medi-Cal covers necessary services, allowing individuals to qualify for Medi-Cal if they meet the residency and categorical requirements but have income higher than the income limits of other eligibility tracks.

If a beneficiary is not in a nursing facility, their share of cost is equal to their countable income minus their monthly maintenance need level (MNL), which is $600 for an individual and $934 for a couple (22 CCR 50603, 50653). If a beneficiary is in a nursing facility, their share of cost is equal to their countable income minus their maintenance need, which is equal to $35, an income allowance for a non-applicant spouse (MMNA), home upkeep, and support of a disabled relative (22 CCR 50605, 50653).

IHSS, CBAS

Unknown

Author's note: Authors have not yet identified this information.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. In 2012, the PNA was $35 per month (22 CCR 50605).

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 3: Policy enacted 2022-2023

Policy change in 2022
In 2022, policy reforms expanded the eligible population for Medi-Cal to older individuals regardless of immigration status (as long as financially eligible) and increased the asset limit for eligibility track 2b (Federal Poverty Level for aged, blind, or disabled).

As a result of the state legislature passing Assembly Bill 133 in 2021, full-scope Medi-Cal became available to individuals age 50 and older, regardless of immigration status, provided they meet all eligibility rules for full-scope Medi-Cal under any eligibility track, effective May 2022 (DHCS, 2022k; WIC 14007.8, 14011.2). Previously, only U.S. citizens or those with "satisfactory immigration status" could qualify for full-scope Medi-Cal.

Starting in July 2022, the asset limit for eligibility track 2b was raised to $130,000 in countable assets for an individual, $195,000 for a couple, and an additional $65,000 for each added person, up to 10 additional people (Assembly Bill 133, 2021; WIC 14005.62). Previously, the assets limits were $2,000 for an individual and $3,000 for a couple, which had not changed since 1989 (DHCS, 2022g). The asset limit will not be increased again until it is phased out in January 2024 (DHCS, 2022c). From 2024, there will be no asset test for this population.

Overview

Long-term care (LTC) benefits in California are primarily provided by Medi-Cal (California's Medicaid program), a public health insurance program for low-income individuals (CHCF, 2020). Medi-Cal is administered at the state level by the Department of Health Care Services (DHCS), and enrollment is voluntary (KFF, 2016). Health plans are organized and administered at the county level by county-based government health insurance plans and/or private plans licensed by the state and county.

Eligibility for Medi-Cal is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in California are mostly provided through state plan benefit programs (In-Home Supportive Services - IHSS, Community-Based Adult Services - CBAS, Nursing Facility Care).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. IHHS provides home care for beneficiaries that have established medical necessity, CBAS provides care in an outpatient facility, and Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care.

Benefit programs vary in dependence requirements. IHSS recipients receive a set number of provider service hours depending on their assessed need, which is based on an assessment for a set of daily functions, such as housework, laundry, dressing, and eating. CBAS recipients must meet or exceed a nursing facility level of care (NFLOC), and Nursing Facility Care requires recipients to receive prior authorization from a Medi-Cal consultant before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2022c)

California Law for Medi-Cal

- Welfare and Institutions Code - WIC, Division 9. Public Social Services, Part 3. Aid and Medical Assistance
  - Chapter 7. Basic Health Care (WIC 1400-14199.67)
  - Chapter 3. State Supplementary Program for Aged, Blind and Disabled, Article 7. In-Home Supportive Services (WIC 12300-12318)
- California Code of Regulations, Title 22. Social Security, Division 3. Health Care Services, Subdivision 1. California Medical Assistance Program (22 CCR T. 22, Div. 3)

Financing

Source of financing

Funding for Medi-Cal is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Medi-Cal spending on beneficiaries in fiscal year 2022 was 56.2%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (56.2% in 2022), though there are exceptions for certain administrative functions and populations that may receive a higher federal matching rate.[8,][9]

In-Home Supportive Services (IHSS)

There are separate FMAPs for each IHSS program (CDSS, 2022b). The state share of Medicaid costs for IHSS are split between state and county funding.

- Community First Choice Option (CFCO): 56% federal funding, 44% state and county funding
- Personal Care Services Program (PCSP): 50% federal, 32.5% state, and 17.5% county funding
- IHSS Plus Option (IPO): 50% federal, 32.5% state, and 17.5% county funding
- IHSS Residual (IHSS-R): 65% state and 35% county funding —there is no FMAP for this IHSS program, as it is entirely state and county funded

Community-Based Adult Services (CBAS)

50% federal funding, 50% state funding (CDA, 2022)

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medi-Cal, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medi-Cal. Here we detail eligibility for Medi-Cal, followed by additional requirements for specific benefits and programs under Medi-Cal.

Medi-Cal

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in California.

Eligibility for Medicaid in California for people needing LTC services is primarily attained by satisfying at least one of 4 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2022, the monthly federal benefit amount was $841 for an individual and $1,261 for a couple. See Table 2 for historical income limits.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[10]

  - Citizenship/immigration requirements: The applicant must be a California resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996 are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023) for additional information.
  - Other requirements
    * The applicant must be at least age 65, blind, or disabled (SSA, 2022).[4]

Eligibility Track 2: Optional Categorically Needy

- 2b. Federal Poverty Level (FPL) aged and disabled
  - Income requirements: Monthly income may not exceed 138% of the FPL. In 2022, this was $1,564 for an individual and $2,106 for a household of two. See Table 3 for historical income limits. Additional income disregards exist if a person is institutionalized or receiving HCBS and has a spouse residing in the community.[13]
  - Asset requirements: Resources may not exceed $130,000 for an individual and $195,000 for a couple. Additional asset disregards exist if a person is institutionalized or receiving HCBS and has a spouse residing in the community.[14] From 2024, there will be no asset test for this population.
    * Asset transfer: Same asset requirements as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    * The applicant must be at least age 65, blind, or disabled (42 USC 1382c(a)(1-3); WIC 14005.50).[4]
- 2c. Affordable Care Act (ACA) expansion adults
  - Income requirements: Monthly income may not exceed 138% of the FPL. In 2022, this was $1,564 for an individual and $2,106 for a household of two. See Table 3 for historical income limits.
  - Asset requirements: There is no asset test for this population.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    * Applicants must be ages 19-64, ineligible for Medicare, ineligible for other Medicaid eligibility tracks, and not pregnant at the time of application.

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: There is no income limit so long as the person meets their share of cost requirements, which are further detailed in 22 CCR 50653 and the *User Charges* section of this policy period. Additional income disregards exist if a person is institutionalized or receiving HCBS and has a spouse residing in the community.[13]
  - Asset requirements: Same asset requirements as eligibility track 2b. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[14]
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    * The applicant must be at least age 65, blind, or disabled as defined in 22 CCR 50219, 50221, 50223.

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Medi-Cal Dialysis Only Program, or other Medi-Cal Special Treatment Program: Programs providing Medicaid coverage to individuals meeting certain medical conditions or diagnoses (22 CCR 50264).

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

In-Home Supportive Services (IHSS), Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Community-Based Adult Services (CBAS)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 18, enrolled in a Medi-Cal Managed Care Plan (MCP) or MCP exempt, and reside in a geographic service area where CBAS benefits are available (22 CCR 54201).

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Multipurpose Senior Services Program
- Home and Community-Based Alternatives Program
- Program of All-Inclusive Care for the Elderly (PACE)

Benefit

Home care benefit

IHSS

IHSS provides (CDSS, 2020c):

- Personal care services
  - Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Home health services
  - Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
  - Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Each of the IHSS subprograms (i.e., IHSS-R, PCSP, IPO, CFCO) differ in the level of care necessary to qualify or the provider provisioning the services, not the benefits provided. The maximum number of IHSS service hours non-severely impaired recipients can be allocated is at most 195 hours per month, or for severely impaired recipients, 293 hours per month (IHSS MPP 30-757).

CBAS

CBAS does not provide home care benefits except in special circumstances under CBAS Emergency Remote Services. Services such as professional nursing care, personal care services may be provided in alternative service locations (e.g., community setting, participant's home, via telehealth) in cases of qualified emergencies, such as state or local disasters (e.g., wildfires, power outages), and personal emergencies for time-limited illness/injury, crises, or care transitions (CMS, 2021).

Nursing Facility Care

Nursing Facility Care does not provide home care during this policy period.

Semi-residential care

IHSS, Nursing Facility Care

These programs do not provide semi-residential care during this policy period.

CBAS

CBAS is an outpatient, facility-based program that includes the following services:

- Professional nursing services
- Physical, occupational and speech therapies
- Mental health services
- Therapeutic activities
- Social services
- Personal care
- Meals
- Nutritional counseling
- Transportation to and from semi-residential services

Residential care

IHSS, CBAS

These programs do not provide residential care during this policy period.

Nursing Facility Care

Medi-Cal covers residential care in a nursing facility. Services must include the following (SSA 1919(b)(4)):[7]

- Physician services
- Room and board

- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Medi-Cal provides additional benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy
- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care —this service was added in 2014, and coverage varies by county (DHCS, 2021)

Provision of care

Medi-Cal benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the California Department of Public Health. Providers that accept Medi-Cal payment rates and meet licensing requirements may participate in Medi-Cal. Managed care plans will have limited provider networks.

IHSS

IHSS care providers are certified by the California Department of Social Services and county IHSS authorities and can include family members, friends, or neighbors that can become registered IHSS providers (CDSS, 2022b).

CBAS

The California Department of Aging licenses and monitors each CBAS center as Medi-Cal providers for the CBAS program (CDA, 2022).

Nursing Facility Care

Nursing facilities are licensed by the California Department of Public Health (HSC 1250-1264).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the three largest programs are summarized below.

IHSS

IHSS CFCO applicants must meet a nursing facility level of care (NFLOC). The NFLOC criteria is further detailed in Box 8. The other IHSS subprograms (i.e., PCSP, IPO, IHSS-R) require beneficiaries meet at least a Rank 2 level of care for each requested service. Rank 2 is defined as "able to perform a function, but needs verbal assistance, such as reminding, guidance, or encouragement." Individuals that score in Rank 1 for any service do not qualify for that particular service. See *Definition of Dependence* for more information.

CBAS

Individuals that previously received ADHC could be determined as categorically or presumptively eligible for CBAS if they met the requirements detailed below (Esther Darling, et al. v. Toby Douglas, et al., 2011; DHCS, 2015):

- Categorically eligible: The applicant must be either a Regional Center consumer, Multipurpose Senior Services Program (MSSP) recipient, Specialty mental health services (eligible or receiving), or individual eligible for 195 or more hours/month for IHSS
- Presumptively eligible: The applicant must be likely to meet NF-B level of care (detailed in Box 9) as determined by DHCS or have an Individual Plan of Care that indicates a need for assistance or supervision with the following:

  - Three of the following ADLs/IADLs: Bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene
  - One nursing intervention provided at ADHC
- For those previously receiving ADHC, there is no developmental disability qualification option (option 5 above) and no requirement to meet the ADHC eligibility and medical necessity criteria

Alternatively, new applicants must meet all eligibility criteria detailed in Box 1, and meet at least one of the following medical criteria (CMS, 2012; CMS, 2021, p.18-19):

1. Meet or exceed the "Nursing Facility Level of Care A" (NF-A) criteria as set forth in 22 CCR 51120(a), 51334(l) (detailed in Box 10)
2. Have a diagnosed organic, acquired or traumatic brain injury, and/or chronic mental disorder and need assistance or supervision with either two ADLs (e.g., bathing, dressing, self-feeding) or one ADL and one IADL (e.g., money management, meal preparation, transportation)
3. Have moderate to severe Alzheimer's disease or other dementia characterized by the descriptors of, or comparable to, Stages 5, 6, or 7 Alzheimer's disease
4. Satisfy both requirements below:
   - Have a mild cognitive impairment including Alzheimer's disease or other dementias characterized by the descriptors of, or comparable to, Stage 4 Alzheimer's disease
   - Have a demonstrated need for assistance or supervision with at least 2 ADLs or IADLs
5. Have a developmental disability meeting the definitions and requirements set forth in 17 CCR 54001(a) as determined by a regional center under contract with the Department of Developmental Services

Nursing Facility Care

A patient must have a medical condition which requires visits by a physician at least every 60 days and constantly available skilled nursing services (22 CCR 51335).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months.

IHSS

Continued eligibility for receipt of IHSS is reassessed every 12 months with a face-to-face assessment (IHSS MPP 30-761).

CBAS

Continued eligibility for receipt of CBAS is reassessed at least every 6 months through the reauthorization process, or up to every 12 months for individuals determined by the MCP to be clinically appropriate (CMS, 2021).

Nursing Facility Care

Reauthorizations for nursing facility care are required every 12 months (22 CCR 51334 and 51335). The attending physician must recertify the patient's need for continued care at least every 60 days.

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

IHSS

There are 6 levels of dependence that quantify the beneficiary's level of functioning (IHSS MPP 30-756):

- Rank 1: Independent —able to perform function without human assistance, although the recipient may have difficulty in performing the function, but the completion of the function, with or without a device or mobility aid, poses no substantial risk to his or her safety
- Rank 2: Able to perform a function, but needs verbal assistance, such as reminding, guidance, or encouragement
- Rank 3: Can perform the function with some human assistance, including, but not limited to, direct physical assistance from a provider
- Rank 4: Can perform a function but only with substantial human assistance
- Rank 5: Cannot perform the function, with or without human assistance
- Rank 6: Paramedical Services —all needed services in the task are met by paramedical services in lieu of the correlated task

For mental functioning, the functions of memory, orientation, and judgement are evaluated on a 3-level scale (Rank 1, Rank 2, and Rank 5).

Ranks 2-6 correspond to a number of service category hours. As of 2019, assessors use the Hourly Task Guideline to determine number of service hours, detailed in Table 4, Table 5, and Table 6. Individuals that score in Rank 1 for any service do not qualify for that particular service.

CBAS

Previous recipients of ADHC transitioning to CBAS in 2012 can be determined as presumptively eligible for CBAS if DHCS determines that the applicant could likely meet a NF-B level of care. The NF-B level is defined in Box 9 (Esther Darling, et al. v. Toby Douglas, et al., 2011, pg. 9).

New applicants must meet all criteria detailed in Box 1, and one of the medical criteria detailed in *Minimum Level of Dependence* for this policy period. For the medical criteria, the following definitions apply:

- NF-A level of care according to 22 CCR 51120(a), 51334(j) and detailed in Box 11 —a guide for determining the need for intermediate care services is further detailed in Box 10
- Stages of dementia according to the CBAS Record of Dementia Stages for CBAS Screening Tool (DHCS, 2015):
  - Stage 1: No cognitive impairment
  - Stage 2: Very mild decline
  - Stage 3: Mild cognitive decline
  - Stage 4: Moderate cognitive decline
  - Stage 5: Moderately severe cognitive decline
  - Stage 6: Severe cognitive decline
  - Stage 7: Very severe cognitive decline

  These stages are further detailed in Box 12. Based on the stages, the individual will be placed in 1 of 4 groups, detailed in Box 13.

Nursing Facility Care

Medi-Cal consultants use criteria outlined in 22 CCR 51335(j) as a guide to determine appropriate placement. General criteria that can be used in evaluating admission for nursing facility services are further detailed in Box 5.

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

IHSS

Designated county staff determine the applicant's level of ability, dependence, need for physical assistance, limitations with ADLs and IADLs, and cognition (e.g., memory, orientation, and judgement). For an exhaustive list, see (IHSS MPP 30-756). The Annotated Assessment Criteria (AAC) assists the evaluator in evaluating the recipient's capacity to perform certain IHSS tasks with examples of observations and possible indicators with each function and rank. To view the AAC, see (CDSS, 2020).

Once a social worker has evaluated the level of dependence for each function/service category, they use the Hourly Task Guidelines

to determine the appropriate time needed on a weekly basis in each service category. See Table 4, Table 5, and Table 6 for additional detail on Hourly Task Guidelines.

CBAS

A designated nurse with level of care determination experience uses a standardized tool and protocol approved by the DHCS, unless DHCS or its contractor(s) to determine if an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information that the plan possesses (CMS, 2021). However, the term "clinically appropriate" is not defined in the CBAS program application.

DHCS uses the CBAS Record of Dementia Stages for CBAS Screening Tool to determine which stage of dementia (stages 1 to 7) an applicant is in (DHCS, 2015). DHCS also uses the appropriate statutes articulated in the *Definition of Dependence* section of this policy period to guide medical necessity and level of care determinations.

Nursing Facility Care

Prior authorization from the designated Medi-Cal consultant determines if nursing facility services are authorized. Per federal guidelines, individuals applying for institutional care must have a comprehensive assessment conducted prior to admission. See Box 2 for a list of items evaluated in the comprehensive assessment.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 3 for more information on the PASRR, and Box 4 for the MDS.

Evaluators

Evaluators vary by LTC health benefit program. The details of the three largest programs are summarized below.

IHSS

Functional needs assessments are conducted by a county social worker (IHSS MPP 30-756).

CBAS

The face-to-face review is conducted by a registered nurse with level of care determination experience. However, if the MCP has determined that CBAS is clinically appropriate for the individual based, the review conducted by the registered nurse is not needed.

Nursing Facility Care

Eligibility is determined by a designated Medi-Cal consultant from the district where the facility is located, and the attending physician signs the authorization request (22 CCR 51334(b)).

Benefit limitations

Can you mix LTC benefits?

All Medi-Cal beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medi-Cal

As required by federal law, California enforces Estate Recovery. The acceptance of Medi-Cal creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medi-Cal recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (DHCS, 2021b).

Most individuals qualifying for Medi-Cal under eligibility track 3a are required to pay a share of cost. The share of cost is a monthly amount an individual pays before Medi-Cal covers necessary services, allowing individuals to qualify for Medi-Cal if they meet the residency and categorical requirements but have income higher than the income limits of other eligibility tracks.

If a beneficiary is not in a nursing facility, their share of cost is equal to their countable income minus their monthly maintenance need level (MNL), which is $600 for an individual and $934 for a couple (22 CCR 50603, 50653). If a beneficiary is in a nursing facility, their share of cost is equal to their countable income minus their maintenance need, which is equal to $35, an income allowance for a non-applicant spouse (MMNA), home upkeep, and support of a disabled relative (22 CCR 50605, 50653).

IHSS, CBAS

Unknown

Author's note: Authors have not yet identified this information.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. In 2023, the PNA was $35 per month (22 CCR 50605).

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: California Federal Medical Assistance Percentage (FMAP) for Medicaid

Fiscal Year	FMAP
1992	50.00%
1993	50.00
1994	50.00
1995	50.00
1996	50.00
1997	50.23
1998	51.23
1999	51.55
2000	51.67
2001	51.25
2002	51.40
2003	52.18
2004	52.21
2005	50.00
2006	50.00
2007	50.00
2008	50.00
2009	61.59
2010	61.59
2011	56.81
2012	50.00
2013	50.00
2014	50.00
2015	50.00
2016	50.00
2017	50.00
2018	50.00
2019	50.00
2020	54.65
2021	56.20
2022	56.20
2023[1]	56.20

Source: U.S. DHHS (2022)

Notes: FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period H.R. 6201. [1] The enhanced FMAP decreased from 6.2 to 5 percentage points from April to June 2023, 2.5 percentage points from June to September 2023, and 1.5 percentage points from October to December 2023.

Table 2: Medi-Cal SSI and SSP Monthly Amounts

Year	SSI (Individual)	SSI (Couple)	SSP (Individual)	SSP (Couple)	Total SSI & SSP (Individual)	Total SSI & SSP (Couple)
1992	$422.00	$633.00	$223.00	$557.00	$645.00	$1,190.00
1993	434.00	652.00	186.00	488.00	620.00	1,140.00
1994	446.00	669.00	157.40	440.22	603.40	1,109.22
1995	458.00	687.00	156.40	414.71	614.40	1,101.71
1996	470.00	705.00	156.40	396.20	626.40	1,101.20
1997[1]	484.00	726.00	156.40	399.29	640.40	1,125.29
1998	494.00	741.00	156.40	414.71	650.40	1,155.71
1999	500.00	751.00	176.00	450.00	676.00	1,201.00
2000	513.00	769.00	180.00	460.00	692.00	1,229.00
2001	531.00	796.00	181.00	469.00	712.00	1,265.00
2002	545.00	817.00	205.00	515.00	750.00	1,332.00
2003[1]	552.00	829.00	217.25	537.17	769.25	1,366.17
2004	564.00	846.00	226.00	553.00	790.00	1,399.00
2005[1]	579.00	869.00	231.25	564.25	810.25	1,433.25
2006[1]	603.00	904.00	229.25	562.50	832.25	1,466.50
2007[1]	623.00	934.00	229.75	563.25	852.75	1,497.25
2008[1]	637.00	956.00	244.67	589.58	881.67	1,545.58
2009[1]	674.00	1,011.00	197.08	493.38	871.08	1,504.38
2010	674.00	1,011.00	171.00	396.20	845.00	1,407.20
2011[1]	674.00	1,011.00	163.32	396.20	837.32	1,407.20
2012	698.00	1,048.00	156.40	396.20	854.40	1,444.20
2013	710.00	1,066.00	156.40	396.20	866.40	1,462.20
2014	721.00	1,082.00	156.40	396.20	877.40	1,478.20
2015	733.00	1,100.00	156.40	396.20	889.40	1,496.20
2016	733.00	1,100.00	156.40	396.20	889.40	1,496.20
2017	735.00	1,103.00	160.72	407.14	895.72	1,510.14
2018	750.00	1,125.00	160.72	407.14	910.72	1,532.14
2019	771.00	1,157.00	160.72	407.14	931.72	1,564.14
2020	783.00	1,175.00	160.72	407.14	943.72	1,582.14
2021	794.00	1,191.00	160.72	407.14	954.72	1,598.14
2022	841.00	1,261.00	199.21	504.64	1,040.21	1,765.64
2023	814.00	1,371.00	219.73	556.62	1,133.73	1,927.62

Source: SSA (2022b); DHCS (2022); DHCS (2022b)

Notes: SSI and SSP amounts for individuals and couples are monthly. State Supplementary Payments (SSP) in California are provided to all SSI recipients, including children. This table provides the SSP amounts for eligible individuals and couples living independently, but there are additional payment amounts for other groups that vary by living arrangement. [1] Figures for these years are averages that reflect adjustments made to SSP amounts throughout the course of the year.

Table 3: Historical California Medi-Cal Income and Asset Limits

Year	MNL (Individual)	MNL (Couple)	100% FPL (Individual)	100% FPL (Couple)	138% FPL (Individual)	138% FPL (Couple)	MMMNA	CSRA
1992	$600.00	$934.00	$568.00	$766.00			$1,718.00	$68,700.00
1993	600.00	934.00	581.00	786.00			1,769.00	70,740.00
1994	600.00	934.00	614.00	820.00			1,817.00	72,660.00
1995	600.00	934.00	623.00	836.00			1,871.00	74,820.00
1996	600.00	934.00	645.00	864.00			1,919.00	76,740.00
1997	600.00	934.00	658.00	885.00			1,976.00	79,020.00
1998	600.00	934.00	671.00	905.00			2,019.00	80,760.00
1999	600.00	934.00	687.00	922.00			2,049.00	81,960.00
2000	600.00	934.00	696.00	938.00			2,103.00	84,120.00
2001	600.00	934.00	716.00	968.00			2,175.00	87,000.00
2002	600.00	934.00	739.00	995.00			2,232.00	89,280.00
2003	600.00	934.00	749.00	1,010.00			2,267.00	90,660.00
2004	600.00	934.00	776.00	1,041.00			2,319.00	92,760.00
2005	600.00	934.00	798.00	1,070.00			2,378.00	95,100.00
2006	600.00	934.00	817.00	1,100.00			2,489.00	99,540.00
2007	600.00	934.00	851.00	1,141.00			2,541.00	101,640.00
2008	600.00	934.00	867.00	1,167.00			2,610.00	104,400.00
2009	600.00	934.00	903.00	1,215.00			2,739.00	109,560.00
2010	600.00	934.00	903.00	1,215.00			2,739.00	109,560.00
2011	600.00	934.00	908.00	1,226.00			2,739.00	109,560.00
2012	600.00	934.00	931.00	1,261.00			2,841.00	113,640.00
2013	600.00	934.00	958.00	1,293.00			2,898.00	115,920.00
2014	600.00	934.00	973.00	1,311.00	1,343.00	1,809.00	2,931.00	117,240.00
2015	600.00	934.00	981.00	1,328.00	1,354.00	1,832.00	2,981.00	119,220.00
2016	600.00	934.00	990.00	1,335.00	1,367.00	1,843.00	2,981.00	119,220.00
2017	600.00	934.00	1,005.00	1,354.00	1,387.00	1,868.00	3,023.00	120,900.00
2018	600.00	934.00	1,012.00	1,372.00	1,397.00	1,893.00	3,090.00	123,600.00
2019	600.00	934.00	1,041.00	1,410.00	1,437.00	1,945.00	3,161.00	126,420.00
2020	600.00	934.00	1,064.00	1,437.00	1,468.00	1,983.00	3,216.00	128,640.00
2021	600.00	934.00	1,074.00	1,452.00	1,482.00	2,004.00	3,260.00	130,380.00
2022	600.00	934.00	1,133.00	1,526.00	1,564.00	2,106.00	3,435.00	137,400.00
2023	600.00	934.00	1,215.00	1,643.00	1,677.00	2,268.00	3,715.00	148,620.00

Source: SSA (2022b); DHCS (2022); DHCS (2022b)

Notes: MNL, 100% FPL, 138% FPL, MMMNA, and CSRA limits for individuals and couples are monthly. Income limits at 138% of the FPL begin in 2014, corresponding to the implementation of the new eligibility track under the Affordable Care Act.

Box 1: Adult Day Health Care (ADHC) Eligibility and Medically Necessity Criteria

Any adult, 18 years of age or older, meets the medical necessity criteria for ADHC if the applicant meets all the following criteria:

- Have one or more chronic or postacute medical, cognitive, or mental health conditions, and a physician, nurse practitioner, or other health care provider has requested ADHC services
- Have functional impairments in two or more ADLs, IADLs, or one or more of each, and requires assistance or supervision in performing these activities
- Require ongoing or intermittent protective supervision, skilled observation, assessment, or intervention by a skilled health or mental health professional to improve, stabilize, maintain, or minimize deterioration of the medical, cognitive, or mental health condition
- Require ADHC services, as defined in WIC 14550, that are individualized and planned, including, when necessary, the coordination of formal and informal services outside of the ADHC program to support the individual and their family or caregiver in the living arrangement of their choice and to avoid or delay the use of institutional services

However, any person who is a resident of an intermediate care facility for the developmentally disabled-habilitative are eligible for ADHC services if that resident has disabilities and a level of functioning that without supplemental intervention through ADHC, placement to a more costly institutional level of care would be likely to occur.

Source: WIC 14525

Table 4: In-Home Supportive Services Hourly Task Guidelines (HTGs) - Part 1

Service Category[1]	Rank	Low	Medium	High
Preparation of Meals	2	3:01	5:00	7:00
	3	3:30	5:15	7:00
	4	5:15	6:08	7:00
	5	7:00	7:00	7:00
Meal Clean up	2	1:10	2:20	3:30
	3	1:45	2:38	3:30
	4	1:45	2:38	3:30
	5	2:20	2:55	3:30
Bowel and Bladder Care	2	0:35	1:17	2:00
	3	1:10	2:15	3:20
	4	2:55	4:23	5:50
	5	4:05	6:02	8:00
Feeding	2	0:42	1:30	2:18
	3	1:10	2:20	3:30
	4	3:30	5:15	7:00
	5	5:15	7:17	9:20
Routine Bed Baths	2	0:30	1:08	1:45
	3	1:00	1:40	2:20
	4	1:10	2:20	3:30
	5	1:45	2:38	3:30
Dressing	2	0:34	0:53	1:12
	3	1:00	1:26	1:52
	4	1:30	1:55	2:20
	5	1:54	2:42	3:30
Ambulation	2	0:35	1:10	1:45
	3	1:00	1:33	2:06
	4	1:45	2:38	3:30
	5	1:45	2:38	3:30
Transfer	2	0:30	0:50	1:10
	3	0:35	0:59	1:24
	4	1:06	1:43	2:20
	5	1:10	2:20	3:30
Bathing, Oral Hygiene, and Grooming	2	0:30	1:13	1:55
	3	1:16	2:13	3:09
	4	2:21	3:13	4:05
	5	3:00	4:03	5:06

Source: CDSS (2019)

Notes: Current MPP regulations define the HTGs in decimal format, e.g., 1.50 hours. To align service assessment/authorization with the Case Management, Information, and Payrolling System (CMIPS) data entry, time allocations are re-formatted to hours:minutes.

[1] Adjustments refer to a need met in common with housemates.

Table 5: In-Home Supportive Services Hourly Task Guidelines (HTGs) - Part 2

Service Category	Low (Time Guidelines)	Mid (Time Guidelines)	High (Time Guidelines)
Menstrual Care	0:17	0:32	0:48
Repositioning and Rubbing Skin	0:45	1:47	2:48
Care of and Assistance with Prosthetic Devices	0:28	0:47	1:07

Source: CDSS (2019)
Notes: Current MPP regulations define the HTGs in decimal format, e.g., 1.50 hours. To align service assessment/authorization with the Case Management, Information, and Payrolling System (CMIPS) data entry, time allocations are re-formatted to hours:minutes.

Table 6: In-Home Supportive Services Hourly Task Guidelines (HTGs) - Part 3

Service Category	Time Guidelines[1]
Domestic and Related Services	6:00 total maximum per month per household unless adjustments apply; Prorations may apply
Shopping for Food	1:00 per week per household unless adjustments apply; Prorations may apply
Other Shopping/Errands	0:30 per week unless adjustments apply; Prorations may apply
Laundry	1:00 per week (facilities within home); 1:30 per week (facilities out of home); per household; Prorations may apply

Source: CDSS (2019)
Notes: Current MPP regulations define the HTGs in decimal format, e.g., 1.50 hours. To align service assessment/authorization with the Case Management, Information, and Payrolling System (CMIPS) data entry, time allocations are re-formatted to hours:minutes.
[1] Adjustments refer to a need met in common with housemates.

Box 2: Nursing Facility Care Comprehensive Assessment Items

The comprehensive assessment contains the following:

- Medically defined conditions and prior medical history
- Physical and mental functional status
- Sensory and physical impairments
- Nutritional status and requirements
- Special treatments or procedures
- Mental and psychosocial status
- Discharge potential
- Dental condition
- Activities potential
- Rehabilitation potential
- Cognitive status
- Drug therapy

Source: 42 CFR 483 (1996)

Box 3: Preadmission Screening and Resident Review (PASRR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR). The purpose of PASRR is to prevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level 1 screening), and a final determination. All applicants of Medicaid certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASRR evaluation.

PASRRs were required on an annual basis until 1996, when the annual requirement was removed. Some states continue to conduct PASRRs on an annual basis.

Source: 42 CFR 483.100-138

Box 4: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: UCSF (2023)

Box 5: Medi-Cal Long-Term Care Nursing Facility Admission Considerations

General criteria that may be used to inform nursing facility admission include:

- Need for patient observation, evaluation of treatment plans, and updating of medical orders by the responsible physician
- Need for constantly available skilled nursing services with one more of the following conditions:
  - A condition which needs therapeutic procedures (e.g., dressing of postsurgical wounds, tracheostomy care, nasal catheter maintenance, or tube feeding)
  - A condition which needs skilled nursing observation at frequent intervals throughout a 24-hour period to warrant care (e.g., regular observation of blood pressure, pulse, and respiration is indicated by the diagnosis or medication and ordered by the attending physician)
  - The patient needs medications which cannot be self-administered and requires skilled nursing services for administration of the medications (e.g., injections administered during more than one nursing shift)
  - A physical or mental functional limitation —a physical functional limitation is when physical functional incapacity of certain patients exceeds the patient care capability of intermediate care facilities, requiring nursing facility care (e.g., bedfast patients, severe paralysis case, patients unable to feed themselves), and a mental function limitation is when patients are severely incapacitated by their mental illness or developmental disability

Source: 22 CCR 51335

Box 6: Community Spouse Resource Amount (CSRA) Counted Property

Real property includes land, buildings, mobile homes that are taxed as real property, life estates in real property, mortgages, promissory notes, and deeds of trust. Personal property is any liquid or non-liquid asset such as cars, jewelry, stocks, bonds, financial institution accounts, boats, trucks, trailers, etc. Medi-Cal does not count the following in countable assets/property: 1 car; Personal items and household furnishings; The home you live in; Money in your checking account that was counted as income in the month that it is received; Balances in an Individual Retirement Account (IRA), KEOGH or work-related pension fund do not count if you receive regular payments from these types of accounts. Only the income received will count.

Source: DHCS (2022h)

Box 7: Medi-Cal Managed Care - Institutional Care Coverage

Prior to 2023, institutional care was covered by Medi-Cal managed care plans (MCPs) in around 27 counties (CHCF, 2022). The remaining counties provide institutional care through the fee-for-service system.

For the counties where institutional care was not an MCP covered benefit, MCPs are only responsible for institutional care for the first 60 days of a stay. After 60 days, individuals are disenrolled from their MCP and enrolled in Medi-Cal fee-for-service.

Starting Jan 1, 2023, institutional care became a mandatory statewide Medi-Cal managed care benefit, requiring MCPs to be responsible for institutional care in all counties.

Source: CHCF (2022); DHCS (2022e)

Box 8: IHSS Community First Choice Option - Nursing Facility Level of Care Criteria

The Nursing Facility Level of Care (NFLOC) for the IHSS CFCO program is determined based on the following criteria:

- Have a total assessed need (excluding heavy cleaning and yard hazard abatement) of 195 or more IHSS hours per month
- Have a total assessed need (excluding heavy cleaning and yard hazard abatement) under 195 IHSS hours per month and have 3 or more of the following services with the designated Functional Index (FI) Ranks:
  - Eating, FI Rank of 3-6; Bowel and bladder/menstrual care, FI Rank of 3-6; Bathing/grooming, FI Rank of 4-5; Dressing, FI Rank of 4-5; Mobility inside, FI Rank of 4-5; Transfer, FI Rank of 4-5; Respiration, FI Rank of 5-6; Paramedical (FI Rank not applicable)
  - OR Have a combined FI Rank of 6 or higher in mental functioning (memory, orientation, and judgment). FI Ranks for mental functioning can be either 1, 2, or 5.
- Have a combined "Individual Assessed Need" —a total of 20 hours or more per week in one or more of the following services: preparation of meals, meal clean-up (if preparation of meals and feeding are assessed needs), respiration, bowel and bladder care, feeding, routine bed baths, dressing, menstrual care, ambulation, transfer, bathing, oral hygiene, grooming, repositioning and rubbing skin, care and assistance with prosthesis, paramedical services

Source: CDSS (2014)

Box 9: NF-B Level of Care - Definition of Dependence

The NF-B level of care is defined as:

- A medical condition which needs an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration. Intermediate care services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encouragement of individual patient independence to the extent of their ability. Factors used to determine the need for intermediate care services are further detailed in 22 CCR 51334(j).
- There must be a need for a level of service which includes the continuous availability of procedures such as, but not necessarily limited to, the following:
  - Administration of intravenous, intramuscular, or subcutaneous injections, and intravenous or subcutaneous infusions
  - Gastric tube or gastrostomy feedings
  - Nasopharyngeal aspiration
  - Insertion or replacement of catheters
  - Application of dressings involving prescribed medications and aseptic techniques; treatment of extensive decubiti and other widespread skin disorders
  - Heat treatments which require observation by licensed personnel to evaluate the patient's progress
  - Administration of medical gases under prescribed therapeutic regimen
  - Restorative nursing procedures which require the presence of a licensed nurse

Source: Esther Darling, et al. v. Toby Douglas, et al. (2011)

Box 10: Nursing Facility-A Level of Care Criteria

Factors used to help determine the need for intermediate care services include:

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

Source: 22 CCR 51334(l)

Box 11: NF-A Level of Care - Definition of Dependence

The NF-A level of care is defined as:

- Requiring protective and supportive care, because of mental and/or physical conditions above the level of board and care
- Not requiring continuous supervision of care by a nurse, except in brief spells of illness
- Not having an illness, injury or disability for which hospital or skilled nursing facility services are required
- Having a medical condition which needs an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration.
- Requiring intermediate care services emphasizing care aimed at preventing or delaying acute episodes of physical or mental illness and encouragement or individual patient independence to the extent of their ability

Source: Esther Darling, et al. v. Toby Douglas, et al. (2011)

Box 12: CBAS Stages of Dementia Screening Tool

The DHCS CBAS Screening Tool for record of dementia stages uses the following stage definitions:

- Stage 1: No cognitive impairment
  - Unimpaired individuals experience no memory problems and none are evident to a health care professional during a medical interview.
- Stage 2: Very mild decline
  - Individuals at this stage feel as if they have memory lapses, forgetting familiar words or names or the location of keys, eyeglasses or other everyday objects. But these problems are not evident during a medical examination or apparent to friends, family or co-workers.
- Stage 3: Mild cognitive decline (Check all that apply):
  - Word- or name-finding problems noticeable to family or close associate
  - Decreased ability to remember names when introduced to new people
  - Performance issues in social and work settings noticeable to others
  - Reading a passage and retaining little material
  - Losing or misplacing a valuable object
  - Decline in ability to plan or organize
- Stage 4: Moderate cognitive decline (Check all that apply):
  - Decreased knowledge of recent events.
  - Impaired ability to perform challenging mental arithmetic. For example, to count backward from 100 by 7s.
  - Decreased capacity to perform complex tasks, such as marketing, planning dinner for guests, or paying bills and managing finances.
  - Reduced memory of personal history.
  - The affected individual may seem subdued and withdrawn, especially in socially or mentally challenging situations
- Stage 5: Moderately severe cognitive decline (Check all that apply):
  - Be unable during a medical interview to recall such important details as their current address, their telephone number, or the name of the college or high school from which they graduated.
  - Become confused about where they are or about the date, day of the week or season.
  - Have trouble with less challenging mental arithmetic; for example, counting backward from 40 by 4s or from 20 by 2s.
  - Need help choosing proper clothing for the season or the occasion.
  - Usually retain substantial knowledge about themselves and know their own name and the names of their spouse or children.
  - Usually require no assistance with eating or using the toilet.
- Stage 6: Severe cognitive decline (Check all that apply):
  - Lose most awareness of recent experiences and events as well as of their surroundings.
  - Recollect their personal history imperfectly, although they generally recall their own name.
  - Occasionally forget the name of their spouse or primary caregiver but generally can distinguish familiar from unfamiliar faces.
  - Need help getting dressed properly; without supervision, may make such errors as putting pajamas over daytime clothes or shoes on wrong feet.
  - Experience disruption of their normal sleep/waking cycle.
  - Need help with handling details of toileting (flushing toilet, wiping and disposing of tissue properly).
  - Have increasing episodes of urinary or fecal incontinence.
  - Experience significant personality changes and behavioral symptoms, including suspiciousness and delusions (for example, believing that their caregiver is an impostor); hallucinations (seeing or hearing things that are not really there); or compulsive, repetitive behaviors such as hand-wringing or tissue shredding.
  - Tend to wander and become lost.
- Stage 7: Very severe cognitive decline (Check all that apply):
  - Frequently individuals lose their capacity for recognizable speech, although words or phrases may occasionally be uttered Individuals need help with eating and toileting and there is general incontinence.
  - Individuals lose the ability to walk without assistance, then the ability to sit without support, the ability to smile, and the ability to hold their head up. Reflexes become abnormal and muscles grow rigid.
  - Swallowing is impaired.

Source: DHCS (2015); DHCS (2022f)

Box 13: CBAS Record of Dementia Stages - Placement Groups

Based on the stages, the individual will be placed into 1 of 4 groups:

- Client has no signs or is in the early stages of dementia (exhibiting signs from stages 1 and 2)
- Client is in the early to mid-stages of dementia (exhibiting signs from stages 2 through 3)
- Client is in the moderate stages of dementia (exhibiting signs through stage 4)
- Client is in the moderate to late stages of dementia (exhibiting signs from 5 to 7)

Source: DHCS (2015)

Sources

This section records key sources consulted when we collected the institutional details reported in this document. Archived versions of these sources are available at the Gateway Policy Explorer website (http://g2aging.org/policy-explorer).

California Department of Aging (2022). Community-Based Adult Services Program Narrative & Fact Sheets. As of April 4, 2023. [Link]

California Department of Health Care Services (2012). Community Based Adult Services Eligibility Criteria. Updated May 23, 2012. [Link]

California Department of Health Care Services (2014). Medi-Cal General Property Limitations for persons who don't qualify using their Modified Adjusted Gross Income. April 2014. As of April 4, 2023. [Link]

California Department of Health Care Services (2015). Community Based Adult Services Eligibility Determination Tool. As of October 25, 2015. [Link]

California Department of Health Care Services (2021). CCI Information for Beneficiaries. As of June 1, 2023. [Link]

California Department of Health Care Services (2021). Essential Health Benefits. Updated March 23, 2021. As of April 4, 2023. [Link]

California Department of Health Care Services (2021b). Estate Recovery Program. Updated March 23, 2021. As of April 4, 2023. [Link]

California Department of Health Care Services (2021c). 2021 Federal Poverty Levels, Program Descriptions by FPL, Enclosure 3. January 27, 2021. [Link]

California Department of Health Care Services (2021d). My Medi-Cal: How to Get the Health Care You Need, English Version page 5. Updated March 22, 2021. As of April 4, 2023. [Link]

California Department of Health Care Services (2022). Federal Poverty Levels 1992-2022. As of March 28, 2023. [Link]

California Department of Health Care Services (2022b). Medicare Catastrophic Coverage Act Spousal Impoverishment CAPS 1992-2022. As of March 28, 2023. [Link]

California Department of Health Care Services (2022c). Asset Limit Changes for Non-MAGI Medi-Cal. Updated July 12, 2022. As of April 4, 2023. [Link]

California Department of Health Care Services (2022d). Community-Based Adult Services. Updated April 27, 2022. As of April 4, 2023. [Link]

California Department of Health Care Services (2022e). Coordinated Care Initiative Overview. Updated August 19, 2022. As of April 4, 2023. [Link]

California Department of Health Care Services (2022f). Community Based Adult Services Eligibility Determination Tool. As of April 4, 2023. [Link]

California Department of Health Care Services (2022g) Asset Limit Changes FAQ. Updated August 8, 2022. As of April 4, 2023. [Link]

California Department of Health Care Services (2022h). Medi-Cal General Property Limitations for persons who don't qualify using their Modified Adjusted Gross Income. Updated July 2022. As of April 4, 2023. [Link]

California Department of Health Care Services (2022i). State Medicaid Plan - Full. As of March 28, 2023. [Link]

California Department of Health Care Services (2022j). State Medicaid Plan - Attachment 2.2A. As of March 28, 2023. [Link]

California Department of Health Care Services (2022k). Older Adult Expansion. Updated July 14, 2022. As of April 4, 2023. [Link]

California Department of Health Care Services (2022l). Do You Qualify for Medi-Cal Benefits? Updated February 28, 2022. As of April 4, 2023. [Link]

California Department of Social Services (2014). Implementation of Community First Choice Option (CFCO) Program. August 29, 2014. [Link]

California Department of Social Services (2015). In-Home Supportive Services (IHSS) History of Major Program Changes. Updated May 2015. As of April 4, 2023. [Link]

California Department of Social Services (2019). Hourly Task Guidelines. Updated May 29, 2019. Accessed August 24, 2022. [Link]

California Department of Social Services (2019b). Social Services Standards, Service Program No. 7 IHSS. Manual of Policies and Procedures 30-700 to 30-785. July 1, 2019. [Link]

California Department of Social Services (2020). Annotated Assessment Criteria. Updated November 2020. As of April 4, 2023. [Link]

California Department of Social Services (2020b). Share-Of-Cost. November 2020. [Link]

California Department of Social Services (2020c). Overview of the IHSS Program. November 2020. [Link]

California Department of Social Services (2022). SSI Eligibility Information. As of August 23, 2022. [Link]

California Department of Social Services (2022b). In Home Supportive Services (IHSS) Program. As of April 4, 2023. [Link]

California Health and Wellness (2022). Provider Update - Environmental Accessibility Adaptations. As of June 1, 2023. [Link]

California Health Care Foundation (2020). California Health Care Almanac, Long-Term and End-of-Life Care in California: Is California Meeting the Need? June 2020. [Link]

California Health Care Foundation (2020b). Medi-Cal Explained Fact Sheet: Long-Term Services and Supports in Medi-Cal. October 2020. [Link]

California Health Care Foundation (2022). CalAIM and Institutional Long-Term Care: Lessons for Medi-Cal Managed Care. March 2022. [Link]

California Legislature (1992). California Assembly Bill No. 1773. September 28, 1992. [Link]

California Legislature (2013). California Assembly Bill No. 1. July 27, 2013. [Link]

California Legislature (2021). California Assembly Bill No. 133. July 27, 2021. [Link]

California Legislature (2022). Health and Safety Code. As of April 4, 2023. [Link]

California Legislature (2022). Welfare and Institutions Code. As of April 4, 2023. [Link]

California Office of Administrative Law (2022). California Code of Regulations 22 CCR T. 22, Div. 3. As of April 4, 2023. [Link]

Center for Medicare and Medicaid Services (2021). CalAIM Section 1115 Approval Letter. December 29, 2021. [Link]

Center for Medicare and Medicaid Services (2022). CMS History. As of April 4, 2023. [Link]

Center for Medicare and Medicaid Services (2022b). Institutional Long Term Care, Nursing Facilities. As of April 4, 2023. [Link]

Center for Medicare and Medicaid Services (2022c). Spousal Impoverishment. As of April 4, 2023. [Link]

Centers for Medicare and Medicaid Services (2020). State Plan Amendment (SPA) 20-0045. As of August 10, 2023. [Link]

Code of Federal Regulations (1996). 42 CFR, § 483 Requirements for States and Long-Term Care Facilities as of April 3, 2023. [Link]

Code of Federal Regulations (2012). 42 CFR § 483.100-138. As of August 16, 2023. [Link]

Department of Health Care Services (2014). MEDI-CAL GENERAL PROPERTY LIMITATIONS. As of August 10, 2023. [Link]

Department of Health Care Services (2022). California State Supplementary Payments 1992-2023. As of August 31, 2023. [Link]

Disability Rights California (2011) Summary of Settlement Agreement in Adult Day Health Care Case. November 17, 2011. [Link]

Kaiser Family Foundation (1999). Medicaid Eligibility for the Elderly as of February 8, 2023. [Link]

Kaiser Family Foundation (2016). Medi-Cal Managed Care: An Overview and Key Issues. March 2, 2016. As of April 4, 2023. [Link]

Kaiser Family Foundation (2022). Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier. As of April 4, 2023. [Link]

Kaiser Family Foundation (2022b). Medicaid Financing Basics. As of April 4, 2023. [Link]

Kaiser Family Foundation (2022c). Medicaid Benefits: Intermediate Care Facility Services for Individuals with Intellectual Disabilities (2003, 2004, 2006, 2008, 2010, 2012, 2018). As of April 4, 2023. [Link]

Social Security Administration (1998). Noncitizens and the Supplemental Security Income Program as of March 28, 2023. [Link]

Social Security Administration (2022). Understanding Supplemental Security Income If You Have A Disability or Are Blind. As of April 4, 2023. [Link]

Social Security Administration (2022b). Understanding Supplemental Security Income SSI Eligibility Requirements – 2023 Edition. As of April 4, 2023. [Link]

Social Security Administration (2022c). SSI Federal Payment Amounts For 2022. As of April 4, 2023. [Link]

Social Security Administration (2022d). Title XIX: Grants to States for Medical Assistance Programs. As of April 4, 2023. [Link]

Social Security Administration (2023). SSI Federal Payment Amounts as of February 22, 2023. [Link]

Social Security Administration (2023). Supplemental Security Income (SSI) for Noncitizens as of May 9, 2023. [Link]

Social Security Administration (2023). Understanding Supplemental Security Income SSI Eligibility Requirements. As of August 8, 2023. [Link]

Southern Area Consortium of Human Services (2018). In-Home Supportive Services, the Olmstead Decision, and Possible Future Directions. March 2018. [Link]

U.S. Congress (2010). House Resolution 3590 - Patient Protection and Affordable Care Act. Updated March 23, 2010. As of April 4, 2023. [Link]

U.S. Congress (2020). House Resolution 6201 - Families First Coronavirus Response Act. Updated March 18, 2020. As of April 4, 2023. [Link]

U.S. Court of Appeals for the Ninth Circuit (2013). Oster v. Lightbourne & Dominguez v. Brown Settlement Agreement, Case No. CV 09-04668 CW & CV 09-02306 CW. March 28, 2013. [Link]

U.S. Department of Health and Human Services (2022). Federal Medical Assistance Percentages or Federal Financial Participation in State Assistance Expenditures (FMAP). As of April 4, 2023. [Link]

U.S. Department of Health and Human Services (2022). State Federal Medical Assistance Percentages. As of August 29, 2023. [Link]

U.S. District Court, Northern District of California San Francisco Division (2011). Esther Darling, et al. v. Toby Douglas, et al., Settlement Agreement, Class Action, Case No. C-09-03798 SBA. November 17, 2011. [Link]

U.S. Government (2022). Code of Federal Regulations. As of April 4, 2023. [Link]

University of California San Francisco (2023). Minimum Data Set (MDS) Data. As of March 30, 2023. [Link]

Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Activities of daily living (ADL): A common set of activities related to personal care used to assessed independence. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.

Adult Day Health Care (ADHC): Medi-Cal semi-residential health care benefit program at outpatient facilities that provides recipients with services such as professional nursing, social services, transportation, mental health care, and transportation. The ADHC benefit was replaced by the Community-Based Adult Services (CBAS) program on March 1, 2012.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act (ACA) made a number of changes to Medicaid, most notably the expansion of eligibility to adults with incomes up to 133 percent of the federal poverty level (FPL). Originally a requirement, the June 2012 Supreme Court ruling in National Federation of Independent Business v. Sebelius effectively made the Medicaid expansion an option. To date, over three-quarters of states have opted to expand.

Blind: The Social Security Administration defines blindness as having central visual acuity for distance of 20/200 or less in your better eye with use of a correcting lens, or having visual field limitation in your better eye, such that the widest diameter of the visual field subtends an angle no greater than 20 degrees.

Centers for Medicare and Medicaid Services (CMS): A federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid.

Community First Choice option (CFCO): An optional set of services under Medicaid that was authorized in the Affordable Care Act allowing for long-term services and supports that were previously only available through a waiver to be Medicaid State Plan Services. CFCO provides additional federal money to expand home and community-based services and supports to individuals in need of long-term care for help with everyday activities and health-related tasks that can be performed by an aide or direct care worker and would otherwise be at risk of institutionalization if these services weren't available.

Community Spouse Resource Allowance (CSRA): Amount of disregarded assets for a spouse residing in the community if their spouse is institutionalized or requires home and community-based long-term care.

Community-Based Adult Services (CBAS): Medi-Cal semi-residential health care benefit program at outpatient facilities that provides recipients with services such as professional nursing, social services, transportation, mental health care, and transportation. The CBAS benefit replaced the Adult Day Health Care (ADHC) program on March 1, 2012.

Department of Health Care Services (DHCS): California's state-level agency that administers and oversees Medi-Cal (California's Medicaid program).

Eligibility Track 1a. Supplemental Security Income (SSI) Recipients: Mandatory coverage group under Medicaid that generally automatically results in Medicaid coverage for individuals that receive SSI, a federal cash assistance benefit for aged, blind, and disabled individuals with low income and assets.

Eligibility Track 2b. Federal Poverty Level (FPL) Aged and Disabled: Optional coverage group under Medicaid that allows for expanded income limits, up to 100 percent of the federal poverty level, for individuals that are at least age 65 or disabled.

Eligibility Track 2c. Affordable Care Act (ACA) Expansion Adults: Optional coverage group under Medicaid that allows for expanded income and asset limits for individuals ages 19-64 who are ineligible for Medicaid through any other group. States that choose to cover this group may cover adults up to 138 percent of the federal poverty level. There is no asset test for this population.

Eligibility Track 3a. Medically Needy Aged, Blind, or Disabled: Optional coverage group under Medicaid for aged, blind, or disabled individuals who would qualify for Medicaid under a different track if not for excess income. This track allows these applicants to "spend down" their excess income on medical bills and other related expenses in order to become eligible for coverage.

Eligibility Track: Requirements for an individual to start receiving long-term care benefits. An individual must satisfy only one eligibility track to qualify for Medi-Cal.

Estate Recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age.

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP is computed from a formula that takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50 percent.

Federal Poverty Level: Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs (e.g., Medi-Cal). The Federal Poverty Levels (FPL) is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the FPL, meaning households with annual/monthly income at or below 100 percent of the FPL would qualify based on financial eligibility).

Fee-for-Service (FFS): A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

Full-scope Medi-Cal: California Medicaid coverage that includes more than just emergency health care. It includes medical, dental, mental health care, family planning care, vision care, treatment for alcohol and drug use, prescription medication, primary care, and specialist referrals. Full-scope coverage is available to individuals that meet all Medi-Cal eligibility criteria including immigrant/citizenship criteria.

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

Home Health Services: Medicaid mandatory health benefit program that provides services in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary.

Home-and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

In-Home Supportive Services (IHSS): Medi-Cal residential health care benefit program providing in-home assistance to recipients with personal care and paramedical care service needs.

In-Home Supportive Services Plus Option (IPO): IHSS sub program for people who get services from a spouse or parent (for people under age 18), or who get restaurant meal allowance or advance pay. The program provides a maximum of 195 to 283 hours of services per month, depending on the severity of the impairment.

In-Home Supportive Services-Residual (IHHS-R): IHSS sub program for people who are not eligible for full-scope Medi-Cal. It provides a maximum of 283 hours of services per month for people with severe disabilities and a maximum of 195 hours for people with disabilities that are not severe.

Instrumental activities of daily living (IADL): A common set of activities used to evaluate a person's ability to live independently in their community. They include being able to prepare hot meals, shop for groceries, take medication, manage money, use a phone, or use a map.

Maintenance Need Level (MNL): The budget allocation for a person to pay for basic needs, such as living expenses for food, housing, and clothing each month. Medi-Cal uses this maintenance need level to calculate an individual's share of cost.

Mandatory Categorically Needy: Groups that states are required to cover through Medicaid, which include low-income families, pregnant women, low-income children, and individuals receiving Supplemental Security Income (SSI).

Maximum Monthly Maintenance Need Allowance (MMMNA): Amount of disregarded income for a spouse residing in the community if their spouse is institutionalized or requires home and community-based long-term care. The MMMNA in 2022 was 3,435 dollars per month and it is adjusted yearly for inflation.

Medi-Cal Long-Term Care: Medi-Cal residential health care benefit program for institutional long-term care which includes services and supports at nursing facilities and intermediate care facilities.

Medi-Cal Managed Care Plan (Medi-Cal MCP): Medi-Cal health care delivery system providing Medicaid health benefits and additional services through contracted arrangements between the state Medicaid agency (California Department of Health Care Services) and managed care organizations that receive per member per month (capitated) payments for these services.

Medicaid State Plan: The standard health plan for Medicaid beneficiaries that are not eligible for a home and community-based program, such as the CBA program. Long-term care services offered through the MSP are limited to home help, home health services, and

nursing home care, if eligible. Services are applied for individually rather than through a full benefit package provided upon enrollment.

Medicaid State Plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available.

Medically necessary: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Medically Needy: A group states can elect to insure through Medicaid that would otherwise qualify for Medicaid through a categorically needy pathway if not for their income or assets (i.e., above SSI limits but below state determined limits for income or assets). This pathway for qualifying for Medicaid is an optional pathway.

Minimum Data Set (MDS): A federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes.

Modified Adjusted Gross Income (MAGI): The total income for the tax year reported by an individual to the IRS minus certain adjustments and adding on untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest (if applicable).

Nursing Facility Care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community and needed regularly due to a mental or physical condition.

Nursing facility level of care (NFLOC): Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programs.

Optional Categorically Needy: Groups that states may choose to cover through Medicaid, which may include aged and disabled individuals not receiving SSI and some individuals receiving long-term care.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

Personal Care Services Program (PCSP): IHSS sub program for people with full-scope Medi-Cal who are adults who get care services from a parent, or adults who don't have a spouse to provide services, or children under 18 who don't have a parent to provide services. Severely and non-severely disabled people can get up to 283 hours of services per month, including protective supervision.

Personal Care Services: Medicaid optional state plan benefit that provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility.

Personal Needs Allowance: A personal needs allowance (PNA) is an amount of a recipient's income that a recipient in an institutional setting may retain for personal use. It will not be applied against the costs of medical assistance furnished in the facility. In California is it 35 dollars.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Preadmission Screening and Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

Program of All-Inclusive Care for the Elderly (PACE): PACE provides comprehensive medical and social services to some older adults still living in the community. Most of the participants who are in PACE are dually eligible for both Medicare and Medicaid. However, enrollment in PACE programs is typically capped at a relatively low number of participants.

PRUCOL: An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

Restricted-scope Medi-Cal: California Medicaid coverage for emergency health care and pregnancy-related services and does not cover medicine or primary care. This type of coverage applies to individuals who meet all other Medi-Cal eligibility criteria except for immigration/citizenship criteria. California over the years has eliminated immigration status criteria for certain groups (children under 19 in May 2016, young adults under 26 in Jan 2020, older adults 50 and older in May 2022, and adults 26-49 in Jan 2024).

Share of Cost: A medical expense requirement for Medi-Cal beneficiaries with an income limit higher than a predetermined level (e.g. higher than SSI), requiring that a beneficiary spend a monthly amount before Medi-Cal covers health care costs.

Skilled Nursing Services: Skilled nursing care consists of those services that must, under State law, be performed by or under the supervision of a licensed or certified nurse. These services include injections, tube feedings, catheter changes, observation and assessment of a patient's conditions, and more.

Social Security Administration (SSA): United States government agency that administers public assistance programs covering disability, retirement, and survivors' benefits. The SSA administers Supplemental Security Income (SSI) payments.

State Supplemental Payment (SSP): Monthly cash payments offered by states to low-income individuals in addition to Supplemental Security Income (SSI). States offering optional SSPs may do so to account for higher costs of living or as an additional income disregard for individuals in certain living arrangements (e.g., nursing facility). In California, optional state supplements are provided to every aged, blind, and disabled SSI recipient, including children. The state supplementation is added to the federal payment. Countable income is deducted first from the federal payment, and any income that remains to be counted after the federal payment has been reduced to zero is then deducted from the state supplementary payment.

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI): The U.S. old-age cash assistance program for aged, blind, and disabled persons with limited income and assets.

Notes

This section reports notes from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1. Some SSI recipients and non-SSI recipients who meet state eligibility criteria may receive a State Supplementary Payment (SSP). SSP amounts vary by living arrangement. Receipt of this payment will marginally increase the income limit under this track. See Table 2 for historical SSP amounts and WIC 12150-12156 (2023) for more information.

2. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child (KFF, 1999).

3. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of and permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees) (SSA, 1998).

4. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2023) for more information on these requirements.

5. Spousal considerations for income: If a beneficiary is institutionalized (e.g., staying in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a Maximum Monthly Maintenance Need Allowance (MMMNA) and can allocate from the institutionalized spouse's income up to the MMMNA as the community spouse's income. In 1992, the MMMNA was $1,718 (DHCS, 2022b). See Table 3 for historical MMMNA amounts.

6. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the Community Spouse Resource Allowance (CSRA), which was $68,700 in 1992 (CMS, 2022c). Countable assets/property are real and personal property that are counted to determine eligibility. See Box 6 for additional details on what property is counted, and Table 3 for historical CRSA amounts.

7. Institutional care is covered by Managed Care Plans (MCPs) depending on geographic location. For more information, see Box 7.

8. The Affordable Care Act (ACA) provided 100% matching for newly eligible individuals with incomes up to 138% of the FPL between 2014-2016 and phased down to 90% matching until 2020 where it remains (US Congress, 2010).

9. The ACA also authorized the Community First Choice Option (CFCO), providing states with an additional 6% of FMAP, referred to as "enhanced FMAP," for eligible HCBS provided to individuals that would otherwise require an institutional level of care.

10. The look back period is 30 months prior to the date of institutionalization for non-exempt assets (DHCS, 2014).

11. Spousal considerations for income: If a beneficiary is institutionalized (e.g. staying in a nursing home/LTC facility) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a Maximum Monthly Maintenance Need Allowance (MMMNA) and can allocate from the institutionalized spouse's income up to the MMMNA as the community spouse's income. In 2012, the MMMNA was $2,841 (DHCS, 2022b). See Table 3 for historical MMMNA amounts. From 2014, the ACA required states to extend spousal impoverishment rules to spouses of individuals receiving HCBS. Authors were unable to verify whether California extended spousal impoverishment rules to HCBS recipients prior to 2014.

12. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the Community Spouse Resource Allowance (CSRA), which was $113,640 in 2012 (CMS, 2022c). Countable assets/property is real and personal property that is counted to determine eligibility. See Box 1 for additional details on what property is counted, and Table 3 for historical CRSA amounts. From 2014, the ACA required states to extend spousal impoverishment rules to spouses of individuals receiving HCBS. Authors were unable to verify whether California extended spousal impoverishment rules to HCBS recipients prior to 2014.

13. Spousal considerations for income: If a beneficiary is institutionalized (e.g. staying in a nursing home/LTC facility) or receiving HCBS (e.g., CFCO/CBAS) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a Maximum Monthly Maintenance Need Allowance (MMMNA) and can allocate from the institutionalized spouse's income up to the MMMNA as the community spouse's income. In 2022, the MMMNA was $3,435 (DHCS, 2022b). See Table 3 for historical MMMNA amounts.

14. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the Community Spouse Resource Allowance (CSRA), which was $137,400 in 2022 (CMS, 2022c). Countable assets/property is real and personal property that is counted to determine eligibility. See Box 1 for additional details on what property is counted, and Table 3 for historical CRSA amounts.

Version information

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Version History

- 1.0 (September 2023): First version.