California State Auditor

BUREAU OF STATE AUDITS

Oversight of Long-Term Care Programs:

Opportunities Exist to Streamline State Oversight Activities

April 2004
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April 13, 2004 2003-111

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning the State's oversight structure of six long-term care programs that the departments of Health Services, Aging, and Social Services oversee.

This report concludes that government oversight is critical to protect vulnerable clients in long-term care facilities; however, a balance should exist between appropriate oversight and allowing providers to operate independently. Significant opportunity exists to streamline oversight activities for three programs. For the adult day health care program, consolidating the licensing and certification reviews that Health Services and Aging separately perform could make oversight more efficient and less burdensome on providers. Further, creating a separate license unique to the program of all-inclusive care for the elderly could streamline oversight. In addition, Health Services needs to finish a pilot project for oversight of the multipurpose senior services program and either develop a reasonable rationale for the number of oversight visits that it attends with Aging or assume responsibility for the program itself.

For two other programs—the adult day program and the Alzheimer's day care resource centers—better communication between Social Services and Aging, respectively, with other entities that oversee these programs is needed to ensure that all parties are aware of each others' oversight concerns. Finally, because of federal funding requirements, there is limited flexibility for Health Services to change how it oversees skilled nursing facilities.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE
State Auditor

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SUMMARY

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Our review of the oversight for six long-term care programs noted the following concerns:

- ☑ *The departments of Health Services and Aging duplicate their oversight for the adult day health care program.*
- ☑ *Creating a separate license unique to the program of all-inclusive care for the elderly could streamline oversight.*
- ☑ *Health Services' expanded oversight of the multipurpose senior services program mirrors Aging's efforts.*
- ☑ *Better communication between the departments of Social Services and Aging, respectively, with other entities overseeing the adult day program and the Alzheimer's day care resource centers needs to occur.*
- ☑ *Federal funding requirements limit the flexibility to streamline oversight of skilled nursing facilities.*

RESULTS IN BRIEF

Long-term care covers an array of services for older or disabled people who need extended assistance or care for their social and medical needs. The State's need for long-term care will increase over the next two decades, when the number of Californians age 65 or older is projected to increase from 3.4 million in 2000 to 6.4 million in 2025, according to the U.S. Census Bureau. Further, in 2000, the U.S. Census Bureau reports that there were 3.8 million disabled Californians between the ages of 21 and 64. To monitor the quality of long-term care, various state departments oversee California's long-term care programs. These long-term care programs had costs of approximately $10.5 billion for fiscal year 2000–01, funded from a variety of sources. Oversight by government entities is critical to protect this industry's vulnerable clients, as shown by documented problems with the quality of long-term care services. At the same time, the State must limit overlap and fragmentation of these oversight activities, which can burden providers. We reviewed six of the State's long-term care programs (see textbox on the following page) and found opportunities to streamline the oversight activities of three programs: the adult day health care program, the program of all-inclusive care for the elderly (PACE), and the multipurpose senior services program (multipurpose program).

For example, the Department of Health Services (Health Services) and the Department of Aging (Aging) duplicate each other's efforts when they conduct separate licensing and certification onsite reviews to oversee adult day health care centers (health care centers). This duplication occurs because the separate sets of regulations the departments follow when conducting their respective reviews overlap. Moreover, the departments do not conduct a joint review, which could mitigate the regulatory overlap. In addition, certain Health Services' Medi-Cal field offices conduct separate visits to some health care centers and may find noncompliance with many of the same regulations reviewed during the health care centers' licensing and certification reviews. Consolidating and coordinating these reviews could make oversight more efficient and may lessen any burden created for health care centers.

Another area in need of streamlining is the oversight of PACE, which offers health care centers and primary care clinics, among other services. PACE providers are governed by separate state licensing regulations for various services their facilities offer and are subject to numerous onsite visits by Health Services. In addition, PACE providers must comply with federal program regulations and a state contract, which are monitored on an ongoing basis by a distinct entity within Health Services. Creating a separate license unique to PACE could lessen the burden on the providers and make Health Services' oversight more efficient.

Long-Term Care Programs Reviewed

- Adult day health care
- Program of all-inclusive care for the elderly
- Multipurpose senior services program
- Skilled nursing facilities
- Alzheimer's day care resource centers
- Adult day programs

Health Services' expanded oversight of the multipurpose senior services program (multipurpose program)—which Aging oversees under Health Services' supervision—now overlaps with Aging's role. After a federal review conducted in 1999, Health Services expanded its oversight role by accompanying Aging's staff on many of their utilization reviews to the local multipurpose program sites. Health Services believes this expanded oversight is needed to respond to federal concerns about inadequate oversight and to ensure that multipurpose program sites use federal funds appropriately. Although Health Services is conducting a pilot process to devise a permanent model for multipurpose program oversight, we believe it should develop a reasonable rationale for the number of utilization reviews it ultimately decides to attend or, alternatively, assume responsibility for the program itself.

We found fewer opportunities to streamline oversight of the remaining three programs we reviewed: skilled nursing facilities, adult day programs, and Alzheimer's day care resource centers (Alzheimer's centers). For skilled nursing facilities, there is little flexibility for Health Services to reduce the scope, number, or frequency of its reviews because the federal government, as a condition of receiving federal funding, mandates how these reviews are conducted. Oversight by the Department of Justice's Operation Guardians program, which conducts surprise inspections of skilled nursing facilities, adds a level of protection for residents of these facilities rather than duplicating Health Services' oversight. Also, the State's Long-Term Care Ombudsman adds another oversight dimension by resolving complaints about skilled nursing facility residents' quality of life.

Further, because the Department of Social Services (Social Services) limits its oversight of adult day programs, we found no significant overlap in oversight for this program. Regional centers, county mental health departments, and local area agencies on aging (local area agencies) also oversee adult day programs, but they focus primarily on the delivery of services to their clients. Communication about adult day programs takes place between Social Services and the regional centers, but better communication between Social Services and two other departments, Health Services and Aging, would create more efficient oversight for a small number of facilities shared by adult day programs and other long-term care programs we reviewed.

Finally, because most Alzheimer's centers reside in facilities offering other long-term care programs—mostly health care centers and adult day programs—the oversight of Alzheimer's centers could benefit from better coordination among state and local agencies. Alzheimer's centers are under Aging's oversight but are directly overseen by local area agencies, which are government or nonprofit entities under contract with Aging to provide services to seniors. However, there is no formal process to share oversight information between the local area agencies and Health Services, which licenses health care centers, and between the local area agencies and Social Services, which licenses adult day program facilities. In the governor's proposed budget for fiscal year 2004–05, separate funding for the Alzheimer's centers is merged into a block grant that will be provided to the local area agencies. Thus, Alzheimer's centers may continue to exist only to the extent that the local area agencies choose to fund them.

RECOMMENDATIONS

To minimize duplication of effort in adult day health care oversight and potentially lessen the resulting burden on health care centers, Health Services should incorporate Aging's certification review into its licensing review, combine the licensing and certification regulations, and coordinate to the extent possible any Medi-Cal field office oversight activities to occur during the licensing and certification reviews. If Health Services determines a statutory change is necessary to implement our recommendation, it should ask the Legislature to consider changing the statutes governing the adult day health care program.

To streamline PACE oversight, the Legislature should consider allowing a single license that authorizes all the long-term care services a PACE provider offers, regardless of the facility that provides the services.

To reduce overlapping efforts between itself and Aging in overseeing the multipurpose program, Health Services should complete its pilot process and develop a reasonable rationale for the percentage of utilization reviews it attends. Alternatively, after evaluating the results of its pilot process, Health Services could assume responsibility for the multipurpose program.

Aging should work with Health Services to implement our recommendations to streamline the oversight for the adult day health care and multipurpose programs.

Social Services should better coordinate its oversight efforts with Health Services and Aging for the small number of adult day programs that share facilities with other programs.

If the Alzheimer's centers remain a separately funded program in fiscal year 2004–05, Aging should work with Health Services and Social Services to share and act on findings from oversight visits. If funding for the Alzheimer's centers is merged into a block grant, the departments and area agencies on aging should share information to the extent that area agencies on aging choose to continue funding Alzheimer's centers.

Health Services should work with Social Services and Aging to implement our recommendations regarding adult day program and Alzheimer's centers oversight.

AGENCY COMMENTS

The departments of Aging, Health Services, and Social Services generally agree with our recommendations and indicate that they have begun taking steps to address the issues raised in our report. The Health and Human Services Agency (agency) indicates that the governor is currently conducting a complete performance review of state government, during which the function of each department within the agency will be examined to ensure efficient and effective operations. The agency states that our report will help inform these review efforts. ■

INTRODUCTION

BACKGROUND

Long-term care covers an array of services provided to people who need extended assistance or care, as opposed to a short hospital stay for an acute illness. People needing long-term care often have chronic illnesses, physical or mental disabilities, or difficulties with activities of daily living. Long-term care ranges from minimal personal assistance with basic activities of daily living—bathing, dressing, eating, toileting, transferring, walking—to total care. The care settings that meet these needs include skilled nursing facilities, residential care facilities, day care centers, and individuals' homes. Rather than focusing on diagnosing, curing, or treating illnesses, long-term care services help individuals with limited abilities to take care of themselves and maintain their highest level of functioning.

The Need for Long-Term Care Is Significant

Recent studies show a significant need for long-term care in California. The population needing long-term care is expected to grow over the coming decades as more of the baby boom generation—people born between 1946 and 1964—enter retirement. According to the U.S. Census Bureau, in 2000 there were about 3.4 million people 65 or older residing in California. This figure is projected to increase by 90 percent, growing to a projected 6.4 million people, by 2025. Other studies note that California's senior population has been growing at a faster pace than the general population. Also, according to the U.S. Census Bureau, in 2000 the number of disabled Californians between 21 and 64 years of age numbered approximately 3.8 million.[1] Although not all elderly or disabled persons need long-term care services, the expected growth in these populations will increase the need for long-term care services.

[1] The U.S. Census Bureau asked individuals about the existence of sensory, physical, mental, self-care, going outside the home, or employment disabilities. Individuals were classified as having a disability if they had a response of "yes" to any of these categories. The U.S. Census Bureau had no projection figures available as of March 2004.

How Long-Term Care Is Funded

Long-term care is funded primarily through public programs. The Medicaid program—known in California as the Medical Assistance Program, or Medi-Cal—is the largest funding source for long-term care. A General Accounting Office (GAO) analysis estimated in 2000 that Medicaid paid 46 percent of the nation's long-term care expenditures. Individuals' out-of-pocket payments accounted for 23 percent of long-term care expenditures, with Medicare, private insurance, and other public and private sources financing the remainder of these expenditures. Nationally, spending from all public and private sources totaled about $137 billion in 2000, according to the GAO analysis.

California's Department of Health Services (Health Services) administers Medi-Cal, a federal program funded and administered through a state and federal partnership, to benefit certain low-income individuals who lack health insurance, including families with children and persons on Supplemental Security Income who are aged, blind, or disabled. Health Services directly administers Medi-Cal by formulating policy that conforms to federal and state requirements. A federally financed health program—Medicare—provides health insurance to most people who are 65 or older, some people under age 65 with disabilities, and people with permanent kidney failure requiring dialysis or a transplant. Medicare also pays for limited post-acute stays in skilled nursing facilities.

WE REVIEWED SIX OF THE STATE'S LONG-TERM CARE PROGRAMS

According to a May 2003 report from the California Health and Human Services Agency (agency) Long-Term Care Council, the State administers funding and oversight for 52 long-term care programs. The report indicates that other programs exist that provide long-term care services in addition to their primary purpose. This audit focuses on six long-term care programs, representing almost 26 percent of the fiscal year 2000–01 expenditures for all 52 programs, with one program—skilled nursing facilities—representing almost 24 percent of the $10.5 billion in expenditures for all 52 long-term care programs. Table 1 summarizes key characteristics of these programs, including which state departments oversee them and their fiscal year 2002–03 oversight costs.

TABLE 1

Overview of the Long-Term Care Programs We Were Asked to Review

Program	Population Served	Number of Clients	Fiscal Year 2002–03 Funding	Services Provided	Facilities or Providers	Administering Departments and Fiscal Year 2002–03 Oversight Costs and Staffing*
Adult day health care	Adults who are at risk of placement in a nursing facility.	33,700	$242.7 million	Medical, rehabilitative, and social services on a less than 24-hour basis.	329 facilities	Departments of Aging ($1.7 million and 22.7 staff) and Health Services ($997,000 and 13.5 staff)
Program of all-inclusive care for the elderly (PACE)	Persons 55 years or older who are eligible for placement in a nursing facility.	1,700	$59.7 million	Medical, social, and long-term care services.	4 providers	Department of Health Services ($131,000 and 1.2 staff)
Multipurpose senior services program (multipurpose program)	Frail persons who are 65 years or older, eligible for Medi-Cal, and eligible for placement in a nursing facility, but who wish to remain in the community.	Capped at 11,789	$44.5 million	Social and health care case management to prevent or delay premature institutional placement.	41 providers	Departments of Aging ($1.1 million and 12 staff) and Health Services ($310,000 and 3.2 staff)
Skilled nursing facilities	Persons needing 24-hour inpatient care.	98,000	$2.8 billion	Continuous skilled nursing and supportive care, including at a minimum, physician, skilled nursing, dietary, and pharmaceutical services, and an activity program.	1,395 facilities	Department of Health Services ($33 million and 433 staff)
Adult day programs	Adults in need of personal care, supervision, assistance with daily activities, or protection.	35,900	Mostly private payment.	Non-medical care on a less than 24-hour basis. Services include protective supervision, assistance with daily activities, development of social and recreational skills, and employment through a contract between the provider and an employer.	734 facilities	Department of Social Services ($488,000 and 8.2 staff)
Alzheimer's day care resource centers (Alzheimer's centers)	Persons in the moderate to severe stages of Alzheimer's disease or related dementia.	3,149	$4.2 million	Day care, as well as support and educational services for family caregivers and the community.	50 providers	Department of Aging†

Sources: Program descriptions were obtained from state departments and provider organizations; client numbers and fiscal year 2002–03 expenditures were obtained from state departments; facility and provider numbers are from Appendix A; we compiled oversight costs from the departments' accounting records; and personnel years were provided by departments. Note that client numbers are as of June or August 2003, except for skilled nursing facilities. For skilled nursing facilities, the client figure represents an estimate of the average number of residents per day for the 2002 calendar year using data from the Office of Statewide Health Planning and Development.

* In personnel years. A personnel year is equal to 12 months of full-time employment for one person.

† The Department of Aging indicates that it does not separately track the costs or personnel years directly related to its oversight of Alzheimer's centers.

The fiscal year 2002–03 oversight costs shown in Table 1 include the salaries of oversight staff and operating expenses—such as travel and minor equipment costs—for oversight activities. In addition, the Office of the State Long-Term Care Ombudsman, which oversees the 35 local long-term care ombudsman programs, incurred costs of $662,000 in fiscal year 2002–03. We did not calculate the oversight costs incurred by local governments because their oversight was limited compared to state departments; thus their oversight costs would have been minor in comparison to those of state departments.

THE STATE'S OVERSIGHT OF LONG-TERM CARE PROVIDERS

To ensure that providers give quality care to people residing in or using long-term care facilities and to ensure that these providers are eligible to charge costs to Medi-Cal, various levels of government—local, state, and federal—oversee the delivery of long-term care services. For the six programs shown in Table 1, the State performs most of this oversight, which generally consists of screening providers before they can operate the programs and performing ongoing oversight of providers' program administration. The textbox at left defines the primary types of oversight, which are dictated largely by state and federal laws and regulations. For example, to conduct business in California, most health facilities must be licensed as meeting certain standards. Further, the federal government generally requires that providers wishing to be eligible for payments under the Medicare and Medi-Cal programs be certified. Under contract with the federal government, the State certifies that the medical practices of providers of skilled nursing facilities meet federal standards through annual inspections—onsite reviews—and complaint investigations. The federal government prescribes how the State will conduct these inspections, including the frequency and timing of the reviews and the documents used to conduct them. Also, when these programs have federal funding, federal agencies may conduct oversight of participating providers. Some programs may receive visits from local governments—such as fire, building, or health departments—but for the programs reviewed, we found that these local government visits are relatively minor in comparison to the State's oversight activities.

Types of Long-Term Care Oversight

Licensing—an onsite review to determine whether a provider meets state regulations to operate a facility legally.

Certification—an onsite review to certify that a facility may receive funding from the Medi-Cal and/or Medicare programs.

Monitoring—evaluating a provider's ongoing compliance with program requirements.

Complaint investigation—generally an onsite visit to investigate allegations of misconduct or noncompliance at a long-term care facility.

Reporting—requiring providers to submit program information periodically.

Oversight is critical to ensuring that people receive quality long-term care. In July 2003, the GAO reported that the magnitude of documented serious deficiencies that harmed nursing home residents remained unacceptably high. Nationwide, the GAO found that one in five nursing homes had serious deficiencies with the delivery of long-term care for the 18-month period ending in January 2002. In California, this ratio was only about one in 10 nursing homes for the same period, but problems were more widespread in the past: the ratio was more than one in four nursing homes for an 18-month period ending in July 2000. The GAO identified several contributing factors, including problems with federal and state oversight.

Further, providers participating in the programs we reviewed interact with state departments for reasons less directly related to oversight. Examples of this interaction include: health facilities providing financial data to the Office of Statewide Health Planning and Development, audits that Health Services performs of skilled nursing facilities to set reimbursement rates, and submission of treatment authorization requests to Health Services' Medi-Cal operations division for approval.

PAST EFFORTS TO STUDY LONG-TERM CARE OVERSIGHT

Previous studies have noted concerns with the State's oversight structure. In December 1996, the Little Hoover Commission (commission) issued a report that concluded the State's oversight structure was too fragmented to allow effective coordination and integration of long-term care services. The commission made several recommendations, including consolidating long-term care programs into a single state agency and focusing the State's efforts on consumer-oriented, outcome-based assistance in the least restrictive setting appropriate for each person. In January 1999, state law charged the agency to report to the governor on options for integrating long-term care programs. One approach the agency considered was to consolidate the licensing of long-term care facilities into a single department or to shift licensing authority to departments with responsibility for the programs. However, the agency recognized that the options considered would require statutory changes and could involve administrative, fiscal, and program changes. Finally, a 1999 state law created the Long-Term Care Council (council) under the agency as an interdepartmental, interagency council charged to develop a strategic plan for long-term care policy and to coordinate long-term care policy

development and program operations, among other things. In performing its duties, the council was to consider and act on the agency's January 1999 report, as appropriate. The council published several annual reports and created a state plan in response to a U.S. Supreme Court decision. In addition, as discussed in Chapter 1, the council created workgroups to study long-term care topics, including consumer information, coordinating community services, automated data sharing, development of a program inventory, licensing issues, and implementing two recent changes to state law.

SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee (committee) asked the Bureau of State Audits (bureau) to examine the State's oversight structure for the six long-term care programs listed in Table 1 on page 7. For each program, the committee asked us to identify the agencies that provide oversight and the number of hours each department spends conducting on-site compliance reviews, inspections, and complaint investigations. Also, the committee asked us to identify oversight activities that overlap between different departments and determine whether the overlapping activities could be streamlined into a central process.

To identify the number of departments providing oversight to these programs, we first interviewed staff from the departments that administer these programs at the state level—Aging, Health Services, and Social Services—to learn about the oversight activities they implement for these programs. We also asked these same staff to identify other departments and units they interact with related to these six programs. We then contacted the identified departments and units to determine the extent of their oversight of these programs.

We attempted to identify the number of hours each department spent on oversight activities; however, we found that most departments did not record staff time spent performing specific oversight activities. Instead, we found that most departments could identify specific staff or units that perform oversight, so we used accounting records or departments' estimates to identify the costs associated with the oversight that departments performed on these six programs for fiscal year 2002–03. We did not identify costs from local governments performing oversight because their involvement is not as extensive as the State's.

For providers that operate multiple programs subject to state oversight, we reviewed whether departments took steps to coordinate their oversight activities to minimize overlap and make their oversight more efficient. In addition, to discover if departments coordinated their monitoring with other departments' oversight activities, we determined if there were practices in place to coordinate the timing of site inspections. We also asked if departments shared information about their findings with other departments performing oversight.

Further, for the six programs we reviewed, we established the extent to which providers administered more than one program. We believed this was an important step to identify any potential duplication of oversight activities between programs. Because the departments do not prepare provider lists in a similar manner, we had to manually compare providers between programs. Although we believe this manual comparison located most of the providers operating multiple programs, our method could not detect all providers that operate facilities with different names and locations or providers associated with each other through contractual arrangements. However, we believe our results provide a conservative compilation of the providers that operate multiple programs. We found that other than PACE and Alzheimer's center providers, most providers do not operate more than one of the six programs we were asked to review and thus are not subject to oversight for multiple programs. However, these providers may operate other federal or state long-term care programs that were outside the scope of our review and may be subject to redundant oversight for those programs. Our detailed results are shown in Appendix A. We discuss our concerns with the overlapping oversight for PACE providers and the Alzheimer's centers in Chapters 1 and 2, respectively.

We also interviewed several providers and associations representing providers to obtain their perspectives on the State's oversight activities. We inquired about their views on the coordination of oversight activities by state departments and other entities, whether they considered any oversight was duplicated, and whether they saw opportunities for streamlining oversight. All providers and provider associations we interviewed said that oversight was a necessary element of ensuring quality long-term care and most believed that some changes were needed to streamline oversight activities.

Finally, this audit did not evaluate the quality of the State's oversight efforts or whether the State is performing all oversight activities required under federal and state laws and regulations. Although we recognize the importance of performing the appropriate quality and level of oversight, the committee's request focused specifically on whether overlap exists among the current oversight activities of state departments. Moreover, we realize that our recommendations to streamline oversight activities may result in cost savings to the State and to long-term care providers, but we did not calculate the potential cost savings because the governor and the departments must decide how to implement our recommendations. Also, it is not possible to accurately estimate the cost savings to long-term care providers that may result from our recommendations because providers' level of effort to accommodate oversight visits varies based on numerous factors, such as the size of a provider's operation and the extent of the issues raised during an oversight visit. Although we noted that the State has numerous long-term care programs in addition to the six we reviewed, we did not attempt to assess any overlap, duplication, or fragmentation of oversight in any of these programs. ■

CHAPTER 1

The State Can Streamline Its Oversight of Three Long-Term Care Programs

CHAPTER SUMMARY

The State can streamline its oversight of three long-term care programs we reviewed to make its efforts more efficient and lessen the burden on providers while continuing to play a vital role in overseeing long-term care programs. Duplication of oversight is most notable in the adult day health care program. The Department of Aging (Aging) monitors adult day health care centers' (health care centers) compliance with state certification regulations to qualify for federal reimbursement through Medi-Cal, and the Department of Health Services (Health Services) oversees health care centers for compliance with state licensing regulations. The departments' separate sets of regulations overlap in numerous places, creating duplication of the departments' review efforts. Further, two of Health Services' Medi-Cal field offices conduct onsite visits to certain health care centers to assess whether clients need adult day health care services and may find noncompliance with many of the same regulations that Health Services and Aging review, which the field offices refer to other Health Services units or to Aging for follow-up. To reduce duplication of oversight efforts, Health Services could combine Aging's certification reviews with its licensing reviews as well as coordinate with its Medi-Cal field offices, thus eliminating redundancy and reducing the providers' need to respond to separate onsite visits.

The State's fragmented oversight of the program of all-inclusive care for the elderly (PACE) could benefit from a more unified approach. In addition to having to comply with federal regulations and a state contract, PACE providers are subject to multiple state licensing regulations that apply to the various services a provider may offer, so they face multiple oversight visits from Health Services. Developing a single license specific to PACE could reduce the oversight burden on the State and on providers.

Aging oversees the multipurpose senior services program (multipurpose program) under Health Services' supervision, but Health Services' expanded oversight has caused the two departments' efforts to overlap. After a review by the federal Centers for Medicare and Medicaid Services (CMS)

found deficiencies in oversight of the multipurpose program, Health Services expanded its oversight of Aging's onsite utilization reviews of the multipurpose program. Health Services is implementing a new pilot process designed to establish a more permanent approach to multipurpose program oversight, but it still expects to accompany Aging on a significant portion of its utilization reviews even after it completes the pilot process. Thus, Health Services needs to develop a reasonable rationale for the percentage of utilization reviews it ultimately chooses to attend or assume responsibility for the program itself.

OVERSIGHT SHOULD ENSURE THE QUALITY OF LONG-TERM CARE, BUT NOT UNDULY BURDEN PROVIDERS

Without adequate oversight of long-term care, the State cannot protect some of its most vulnerable residents from possible neglect and abuse.

Without adequate oversight of long-term care, the State cannot protect some of its most vulnerable residents from possible neglect and abuse. On the other hand, the State's oversight activities should not result in unnecessary demands on long-term care providers. Our findings indicate that Health Services and Aging have some redundant oversight practices that may burden providers unnecessarily.

As noted in the Introduction, documented problems with the quality of long-term care services establish the need for oversight of long-term care providers. Also, Health Services and Aging continue to observe that some providers do not comply with program requirements. Besides protecting clients, oversight provides other benefits to long-term care programs because regulatory agencies also offer training and technical assistance to providers for improving the delivery of long-term care services. This technical assistance can be very beneficial in identifying methods to better assist people needing long-term care and to make a provider's program more effective.

It is important to ensure both appropriate oversight and a healthy degree of provider independence in operating long-term care programs. Oversight can be burdensome because accommodating an oversight visit disrupts the daily activities of a provider's staff and requires additional work to respond to regulatory agencies' needs. To accommodate the oversight visit, a provider's staff must be available for interviews and facility walk-throughs, as well as reviews of client records and other documents. Adding to the stress of such visits is that they may be unannounced, so a provider cannot modify normal operations to ensure that it passes the review. Moreover, a

provider's staff must be responsive to any concerns raised during the oversight visit because there are serious consequences for noncompliance with federal or state laws and regulations. Depending on the severity of the noncompliance, these consequences range from a written report on the deficiencies—requiring a response to correct the noted problems—to monetary fines, suspension of a provider's license to operate, and in some instances, criminal prosecution.

Finally, oversight from multiple agencies can be frustrating, particularly if a provider is unaware of each agency's roles and responsibilities. With more than one agency involved in oversight, a provider may not know which to contact for guidance and may mistakenly seek guidance from one agency when, in fact, the other agency is solely authorized to provide that guidance. Thus, particularly for programs in which more than one agency is involved, agencies must ensure that providers clearly understand the oversight agencies' authority.

CONSOLIDATION AND COORDINATION ARE NEEDED TO STREAMLINE ADULT DAY HEALTH CARE OVERSIGHT

The State's oversight of adult day health care involves overlapping efforts between Health Services and Aging. To monitor licensing requirements for health care centers, Health Services' licensing and certification division (licensing division) conducts onsite reviews of health care centers, and to monitor certification requirements, Aging conducts separate onsite reviews of health care centers. As explained in the Introduction, licensing reviews determine if providers meet state regulations for legally operating a facility, while certification reviews approve a facility for Medi-Cal and/or Medicare funding. Health Services and Aging use two different sets of regulations for guidance in their separate reviews, but many regulations in the two sets overlap, creating duplication of efforts during the onsite reviews, and may unnecessarily burden providers of this program. Increasing the potential for additional duplication, certain Health Services' Medi-Cal field offices (field offices) conduct separate onsite visits to some health care centers and may find noncompliance with many of the regulations already reviewed during the licensing and certification visits.

The health care centers provide community-based programs where frail elderly and disabled adults can receive health and social services based on individual plans of care. The program seeks to restore or maintain the client's capacity for self-care and prevent inappropriate institutionalization in a long-term care facility. Long-term care

services provided at a health care center include nursing, personal care, therapy, social services and activities, psychiatric and psychological services, nutrition services, and transportation.

The Two Departments That Oversee the Adult Day Health Care Program Conduct Separate Onsite Visits

Health Services' licensing division licenses health care centers, while Aging certifies them for Medi-Cal participation.

By statute, Health Services and Aging share oversight responsibility for the adult day health care program, but must define each department's authority, functions, and responsibility for the program's administration in an interagency agreement that specifies how the departments will work together and what their responsibilities are for licensure and certification. Under the interagency agreement, Health Services' licensing division licenses health care centers, while Aging certifies them for Medi-Cal participation, with each department relying on a separate set of state regulations.

Although the interagency agreement calls on Health Services and Aging to conduct joint onsite licensing and certification reviews and issue joint reports of findings whenever possible, the departments, in fact, conduct separate reviews at different times. As a result, health care centers are subject to two onsite visits—an annual licensing review conducted by Health Services' licensing division staff and a certification review by Aging staff that may occur annually, but no less frequently than every two years. The departments' reviews are conducted by one to four staff members with the duration ranging from one to three days. Each department documents any violations in a statement of deficiencies, which it sends the health care center, along with a request for corrective action to address the deficiencies. The departments also share their statements of deficiencies with each other.

The approach toward licensing and certification reviews of health care centers differs from the State's approach to licensing and certifying skilled nursing facilities. State law exempts skilled nursing facilities and certain other health facilities that are certified to participate in Medicare or Medicaid from licensing inspections. Thus, Health Services' certification review of these facilities, which the federal government requires, serves to cover licensing requirements as well. Moreover, CMS does not have a position on how the State is to certify health care centers for Medi-Cal eligibility, so the State is free to develop its own policy. We would expect that, as the single state agency responsible to the federal government for Medicaid (state Medicaid agency), Health Services, rather than Aging, would conduct a combined certification and licensing review of health care centers, the majority of which rely on Medi-Cal funding.

For Oversight, Health Services and Aging Use Separate Sets of Regulations That Overlap in Many Areas

To conduct their respective reviews, each department relies on a separate set of state regulations; however, the two sets of regulations overlap in numerous places, leading to duplication of effort by Health Services and Aging during the separate licensing and certification reviews. When regulations overlap, Health Services and Aging risk duplicating efforts and burdening the health care centers with additional work to analyze the two sets of regulations.

Table 2 categorizes the subject areas of the licensing and certification regulations each department follows and the number of certification regulations that overlap at least partly with licensing regulations. Appendix B provides the specific regulations that we identified as overlapping.

TABLE 2

Many Separate Certification and Licensing Regulations Overlap

Area of Regulation	Aging's Certification Regulations	Health Services' Licensing Regulations	Number of Certification Regulations That Overlap With Licensing*
Eligibility, participation, discharge	11	4	4
Services and standards	20	24	14
Administration	23	19	13
Payment of services	5	0	0
License	0	17	0
Physical plant	0	7	0
Violations	0	4	0
Totals	**59**	**75**	**31**

Source: Bureau of State Audits' analysis based on the California Code of Regulations, Title 22, Adult Day Health Care Medi-Cal Certification (Division 3, Chapter 5) and Licensing (Division 5, Chapter 10).

* Our table counts the number of instances in which the language of a certification regulation overlaps with the language in the licensing regulations. Therefore, if a certification regulation overlaps with two licensing regulations, we count this as one instance, but if two certification regulations overlap with the same licensing regulation, we count this as two instances.

In some instances, the language of a licensing regulation almost replicates its counterpart on the certification side—offering the benefit of consistency, but increasing the likelihood of duplication of effort in reviewing these areas. For example, the language describing the duties of a health care center's program director is very similar in the two sets of regulations, so Health Services' and Aging's reviews likely will duplicate each other in determining whether a program director fulfills his or her regulatory duty. In other instances, one set of regulations places more requirements on a health care center than the corresponding set of regulations. Licensing regulations require a health care center only to develop written policies and procedures for providing transportation services, but certification regulations are more detailed, requiring, for example, that one-way transit time to and from participants' homes not exceed one hour. Even in these instances, however, the two department's efforts likely will overlap because each department will need to review similar records and interview health care center staff to assess compliance with the respective regulations. Thus, to comply with regulatory requirements, health care centers must analyze both sets of regulations.

The Departments' Reviews Overlap in Many Areas

Using overlapping regulations, Health Services and Aging overlap in their respective reviews, requiring health care centers to provide access to the same types of records twice and respond to similar questions about the health care center's operations. For example, both departments review participant health records, transportation services, basic program services, policies and procedures, and staff qualifications. Without consolidating both their regulations and reviews, Health Services and Aging will continue duplicating each other's efforts and burdening health care centers with two separate reviews. Moreover, even though Aging and Health Services have a process to share their oversight concerns, we saw no indication that either department scaled back its respective oversight activities when finding that the other department recently had reviewed a health care center.

Without consolidating both their regulations and reviews, Health Services and Aging will continue duplicating each other's efforts and burdening health care centers with two separate reviews.

For example, reviewing one health care center's compliance with transportation regulations, Aging's certification team determined that one of the center's three drivers who operates a large passenger van lacked the appropriate vehicle operator's license to transport adult day health care clients. Seven weeks later,

when Health Services reviewed the same health care center, its licensing team found similar violations. At another health care center, Health Services reviewed four participant health records and found the health care center failed to ensure that skilled nursing care staff included required quarterly notes indicating any of the four participants' progress toward identified health goals. One month later, Aging reviewed the same health care center and reached a similar conclusion, determining that the health care center's nursing staff failed to include quarterly progress notes in one of the two participant health records it reviewed. In both instances, the teams from Aging and Health Services likely reviewed similar records and asked similar questions of the health care center's staff to reach their conclusions.

Before September 2000, Aging and Health Services combined the licensing and certification functions at Aging. According to Health Services and Aging, from approximately 1992 until September 2000, Health Services funded a health facilities evaluator nurse to work onsite with Aging. The nurse and the Aging staff worked together to avoid duplication of reviews and to issue joint reports. According to both Health Services and Aging, the locating of licensing and certification review staff together encouraged a more efficient and consistent method of reviewing health care centers. Further, Health Services and Aging indicated that, because of their ability to work together, findings and interpretations were more consistent and there was a backup for each other's work. The Health Services nurse retired in September 2000. Because of an increase in the number of health care centers and the inability to recruit nurses willing to accept extensive travel out of Aging's Sacramento office, the licensing function returned to Health Services.

According to Health Services' licensing division, recognizing that approximately 50 percent of review requirements overlap, either Aging or Health Services could do a single review that consolidates the standards from both licensing and certification regulations to perform a more efficient but no less effective review.

Health Services agrees that only one agency could review health care centers. According to the deputy director of Health Services' licensing division, recognizing that approximately 50 percent of review requirements overlap, either Aging or Health Services could do a single review that consolidates the standards from both licensing and certification regulations to perform a more efficient but no less effective review. We did not evaluate which of the two departments performs the more effective review. However, as the state Medicaid agency, Health Services is positioned more appropriately to undertake this responsibility, potentially including an Aging staff member on the review to take advantage of Aging's expertise with the senior population.

Better Coordination With Adult Day Health Care Licensing and Certification Reviews Is Needed During Health Services' Onsite Reviews of Treatment Authorization Requests

Providing further oversight of health care centers, certain Health Services' Medi-Cal field offices (field offices) have identified an important problem—inappropriate use of adult day health care services. However, more coordination with the licensing and certification reviews is needed to avoid performing an additional review of many of the same regulations that Health Services and Aging already review. Because two of the three field offices that conduct onsite reviews of treatment authorization requests (TARs) also may observe instances of noncompliance with 24 regulatory areas that Health Services' licensing division and Aging already review, affected health care centers may spend time accommodating three separate teams looking at the same types of information.

To be reimbursed by Medi-Cal for adult day health care services, a health care center must submit TARs and receive approval from a field office. A TAR indicates the client's eligibility for Medi-Cal and the extent of services the provider deems necessary to meet the client's needs. According to Health Services' chief of the southern field operations branch, after a six-month pilot project in fiscal year 2000–01 found that health care centers were submitting inaccurate or inappropriate TARs, two field offices initiated unannounced onsite visits of health care centers to assess whether clients needed the services requested in TARs. A third field office joined this practice in fiscal year 2002–03. An internal report summarized the Los Angeles field office's onsite monitoring of 153 health care centers between 2001 and 2003. This report identified not only overuse of the adult day health care services, but also some cases of potentially fraudulent activities leading to Medi-Cal overcharges. The Los Angeles office's monitoring has led to discharging or reducing services for 631 of the 2,377 participants reviewed—because the participants did not need the services or did not need to attend the health care center for the requested number of days. Moreover, as a result of the onsite reviews the Los Angeles field office has referred approximately 60 health care centers to Health Services' audits and investigations division for investigation of potential misuse of Medi-Cal funds.

After a six-month pilot project in fiscal year 2000–01, which found that health care centers were submitting inaccurate or inappropriate treatment authorization requests, two field offices initiated unannounced onsite visits of health care centers to assess whether clients needed the services requested.

Despite having a beneficial effect and reviewing for a different purpose, the field offices' visits may duplicate the efforts of the licensing and certification reviews. In addition to assessing

whether clients are eligible and in need of the services, staff from two of the three field offices that conduct these onsite visits also may observe noncompliance with 24 of the regulatory areas that Health Services' licensing division and Aging already review during their visits. The third field office expects to implement a similar process on future onsite reviews. Appendix B identifies these 24 licensing and certification regulations. Although the field offices have a process to forward information about any regulatory violations they identify to other units in Health Services or to Aging for follow-up, and their review of the regulations is secondary to their review of concerns with TARs, the potential for duplicating the efforts of others could be avoided by coordinating the timing of the field office reviews with the licensing and certification reviews to the extent possible.

The potential for duplicating the efforts of others could be avoided by coordinating the timing of the field office reviews with the licensing and certification reviews to the extent possible.

Health Services' chief of the southern field operations branch, who proposed the pilot project, indicated that it is possible for field office staff to schedule their visits to occur at the same time as others if requested. However, he is concerned that health care centers could not handle a large group of staff from different oversight entities at the same time. Currently, the field offices send two or three of their staff members for a one-day visit. One additional staff member from the field office joining the licensing and certification team for the time needed to focus on the TAR review should not pose a significant burden.

In response to CMS concerns about federal financial participation in the adult day health care program, Health Services recently prepared a proposal that would transition the adult day health care program into a home and community-based waiver program beginning in federal fiscal year 2005–06. States use home and community-based waivers to obtain federal Medicaid matching funds to provide long-term care to patients in settings other than institutions. The proposal would tighten the licensing and certification criteria for health care centers, tighten the criteria for authorizing adult day health care services, place a limit on the number of health care centers certified to participate in Medi-Cal, update the methodology Health Services uses to set a reimbursement rate for adult day health care services, and possibly limit the capacity of health care centers. However, Health Services indicates that it does not plan to change the oversight structure. Nevertheless, our observations offer Health Services an opportunity to streamline health care centers' oversight structure while preparing for this potential transition.

A SINGLE LICENSE APPROACH COULD STREAMLINE THE OVERSIGHT OF PACE

The State's fragmented oversight of PACE also could benefit from a more unified approach. In addition to having to comply with federal regulations and a state contract, PACE providers are subject to multiple state licensing regulations that apply to the various services a provider may offer, so they face multiple oversight visits from Health Services. Developing a single license specific to PACE could reduce the oversight burden on the State and on the provider.

PACE Offers Seniors a Comprehensive Program

PACE provides an array of services to persons aged 55 years or older whom the State has certified as eligible for placement in an intermediate or skilled nursing facility. Through a comprehensive set of services, PACE seeks to maintain the seniors' independence at home and their ability to live safely in the community for as long as possible. Each PACE provider must operate at least one facility where program participants receive services. Each of California's PACE providers may furnish, or contract for, the services specified in a contract between the provider and the State. California's PACE services must include, but are not limited to, those listed in the textbox.[2] Any facility, whether operated by or under contract with the PACE provider, must comply with applicable state licensing standards. Thus, if it operates a facility with both a health care center and primary care clinic, the PACE provider must hold the appropriate license for each. Besides the program requirements in its state contract, each PACE provider must abide by all other applicable federal and state laws and regulations.

PACE Services Include

- Adult day health care center
- Primary care clinic
- Home health agency
- Necessary prescription drugs
- Social services
- Medical specialists
- Diagnostic procedures
- Acute inpatient and skilled nursing facility care

In 1971 On Lok Senior Health Services (On Lok), a provider in San Francisco, responded to what it believed was a pressing need for seniors' long-term care services by beginning to

[2] As an "at-risk" managed care health plan operating under a state contract as well as a three-way program agreement with Health Services and CMS, a PACE organization receives a set monthly payment from Medi-Cal and Medicare for each person enrolled and must provide the full range of services, regardless of their cost. For the purpose of this report, we focus on the oversight a PACE provider receives rather than its managed care health plan aspects.

develop a system for providing long-term care that by 1986 would serve as a model for PACE. Finding existing long-term care services somewhat fragmented and providers disparately located, On Lok designed a system for offering an array of services to maintain elderly clients' health and well-being. After years of considering PACE a demonstration program, the federal government permanently established it as a provider type under Medicare and Medicaid in 1997. In June 2001, Health Services estimated that PACE provided a savings of 5 percent to Medicare and up to 15 percent to the State. Currently, four PACE providers, including On Lok, operate in California.

PACE Providers Face Extensive and Fragmented Oversight

Several different entities monitor a PACE provider and its facilities for compliance with state and federal regulations. Table 3 shows the number and variety of oversight visits conducted by three Health Services units and Aging to the facilities of one PACE provider—On Lok—between January 2001 and November 2003. On Lok is the largest PACE provider in California in the number of facilities and clients, so its experience with state oversight may not be typical.

TABLE 3

Because of Licensing and Other Oversight Requirements, the State Frequently Visited On Lok's Seven Facilities January 2001 Through November 2003

Year Visited	Health Services' Licensing Division	Health Services' Office of Long-Term Care	Health Services' Audits and Investigations Division	Aging	Totals
2001	5	4	1	0	**10**
2002	7	3	0	3	**13**
2003	4	1	1	0	**6**
Totals	**16**	**8**	**2**	**3**	**29**

Sources: Oversight files from the departments of Health Services and Aging. Appendix C provides a detailed list of oversight visits conducted at On Lok.

Note: The table does not include investigations by Health Services' licensing division that resulted from a complaint or a provider's report of an unusual occurrence at a facility because these investigations are not routine although they are authorized by statute and regulation. Moreover, these visits afford a necessary means by which providers, clients, and interested parties may alert Health Services of potential health and safety concerns in long-term care facilities.

As Table 3 shows, four entities performed oversight of On Lok's facilities. The following sections describe these four entities' oversight.

Health Services' Licensing Division Issues Licenses to PACE Facilities

Health Services issues licenses to various health facilities. Before issuing or renewing a license to a PACE provider, Health Services is authorized to conduct an onsite review of the provider's compliance with applicable state licensing regulations at each facility for which a PACE provider requests a license. As Table 3 shows, Health Services' licensing division visited On Lok facilities 16 times in three years.

Even if it offers both health care center and primary care clinic services at the same facility, the PACE provider must hold two different licenses for that facility because of separate state licensing regulations that govern each type of service.

As we discuss earlier, each PACE provider must operate at least one facility where program participants receive services. The PACE facility must provide health care center and primary care clinic services, among other services. However, even if a PACE provider offers both health care center and primary care clinic services at the same facility, the PACE provider must hold two different licenses for that facility because separate state licensing regulations govern each type of service. Although On Lok operates seven facilities, each facility holds a health care center and a primary care clinic license—and one also holds a home health agency license—all of which must be issued separately by Health Services. Thus, On Lok's seven facilities hold a total of 15 licenses, as indicated in Table 4.

TABLE 4

On Lok's Seven Facilities Hold 15 Licenses

	Type of License		
Facility	Adult Day Health Care Center	Primary Care Clinic	Home Health Agency
1	✓	✓	✓
2	✓	✓	
3	✓	✓	
4	✓	✓	
5	✓	✓	
6	✓	✓	
7	✓	✓	

Source: On Lok Senior Health Services, February 2004.

Health Services does not have a policy to coordinate its licensing visits to review all of a PACE provider's facilities, or even all of the licenses held by a single facility, during one visit.

For each license it holds, a PACE provider is subject to a Health Services' licensing review at the facility that holds the license. Health Services does not have a policy to coordinate its licensing visits to review all of a PACE provider's facilities, or even all the licenses held by a single facility, during one visit. Consequently, for each licensing review, the licensing division team generally focuses on only one of the licenses each PACE facility may hold. The deputy director of Health Services' licensing division explains that coordinating visits face a variety of impediments, such as each facility having a unique timetable for when a visit is due, Health Services' desire to ensure compliance by having different individuals reviewing at different points in time, and Health Services' desire to limit the number of staff in a facility at one time. Moreover, according to the deputy director, multiple Health Services' district offices have jurisdiction over the large variety of services that Health Services reviews. Thus, depending on the number of licenses its facilities hold, each PACE provider may be subject to multiple annual licensing reviews at each facility. During each of the 16 visits to On Lok facilities shown in Table 3 on page 23, the licensing division reviewed only one license at one facility. In fact, 15 of the 16 licensing division visits in Table 3 focused only on the health care center license. Because primary care clinic and home health agency reviews generally follow a less frequent review cycle than health care centers, Health Services has not reviewed On Lok's primary care clinic or home health agency licenses as frequently—we noted only one licensing division visit to one facility over the time period to review On Lok's primary care clinic services and no visits to review On Lok's one home health agency. Nevertheless, because the laws and regulations governing these three licenses authorize licensing visits at Health Services' discretion, Health Services could choose a more frequent review cycle for these licensing visits.

Health Services' Office of Long-Term Care Has Broad Oversight of PACE

The office of long-term care, as the entity specifically charged with overseeing California's PACE, monitors PACE providers for compliance with their contracts with Health Services. This oversight entails desk reviews of information submitted by a PACE provider and onsite visits to follow up on any concerns. However, because of the office of long-term care's broad authority with regard to PACE oversight, not all PACE providers have faced the same kind of oversight from the office of long-term care.

The office of long-term care is authorized to monitor providers' compliance with contract provisions, as well as all applicable federal and state laws and regulations. As such, it ensures that PACE clients need the level of nursing home care required for PACE participation and reviews various reports each PACE provider submits in addition to the corrective action plans that result from a licensing division review or a medical review, discussed later, or a complaint investigation. At its discretion, the office of long-term care determines the need for onsite monitoring visits to the provider's facilities. As Table 3 on page 23 shows, the office of long-term care made eight visits to On Lok facilities over the three-year period. For example, in the summer of 2002, it visited three On Lok facilities over two days to determine whether the facilities implemented corrective action stemming from Health Services' licensing review findings.

Not all PACE providers have faced the same type or frequency of oversight from the office of long-term care.

Not all PACE providers have faced the same type or frequency of oversight from the office of long-term care. For example, the office of long-term care visited a PACE provider in Los Angeles almost monthly between October 2000 and January 2003. The office of long-term care indicates that during the visits it conducted medical record reviews to validate that the clients met the federal and state requirements for nursing home level of care as well as provided technical assistance and training to this provider, which had experienced a large volume of staff turnover that resulted in audit findings. However, this Los Angeles PACE provider requested relief from the continual cycle of preparing for and reacting to what it considered unique and unprecedented monthly site visits, which the provider claimed took valuable time away from its ability to effectively plan, implement improvements, and evaluate whether the improvements achieved the desired result. Although the office of long-term care, citing the State's budgetary situation, subsequently transferred the "level of care" review of this PACE provider to a Medi-Cal field office and discontinued its own monthly visits, it nevertheless retains the authority to visit PACE providers at its discretion. To clarify its oversight roles and responsibilities and develop a formal monitoring process, the office of long-term care recently began drafting monitoring protocols, which it expects to finalize by June 2004.

Health Services' Audits and Investigations Division Reviews PACE Providers Every Three Years

To further monitor the contract between a PACE provider and the State, every three years the medical review branch in Health Services' audits and investigations division reviews

each PACE provider, focusing on the following categories of performance: utilization management, continuity of care, availability and accessibility of medical care, members' rights, quality management, and administrative and organizational capacity. This onsite review used to occur annually, but around January 2002, Health Services changed its review cycle to every three years. The chief of the northern medical review branch says this change was in response to providers' concerns about the number of reviews they faced annually from government agencies and how the providers considered many of them to be duplicative. We found that during a recent review of On Lok, the medical review branch collaborated with the Department of Managed Health Care to conduct a joint review. The Department of Managed Health Care reviewed On Lok because it holds a Knox-Keene license, an optional license for health care service plans, such as PACE, that meet certain minimum standards. To their credit, these entities partnered to avoid what otherwise could have amounted to separate but similar oversight of On Lok.

During a recent review of On Lok, Health Services' audits and investigations division collaborated with the Department of Managed Health Care to conduct a joint review and avoided what could otherwise have amounted to separate but similar oversight of On Lok.

Aging No Longer Conducts Onsite Reviews of PACE Providers

As we discuss in the section on the adult day health care program, Aging conducts onsite reviews of health care centers to certify them for Medi-Cal reimbursement. Each of On Lok's facilities includes a health care center, and Aging conducted three certification reviews of three health care centers in 2002, as shown in Table 3 on page 23. Since then, Aging has determined that because the licensing division conducts onsite reviews of PACE facilities, and both the office of long-term care and CMS review the facilities and make the determinations that the provider meets the PACE program requirements agreed to in its contract, it is redundant for Aging to continue onsite certification reviews of health care centers operated by PACE providers. For this reason, and for reasons related to the capitation methodology by which the State pays for the package of PACE services (see footnote on page 22), Aging determined that it no longer would conduct onsite certification reviews of health care centers operated by PACE providers. CMS neither agrees nor disagrees with Aging's determination. However, there are minimum standards that a PACE provider must meet upon opening a new facility, and the State assures CMS through a review of the new facility that the PACE provider has met these standards. Thus, Aging's decision seems appropriate and has resulted in a streamlining of oversight.

A Single License for PACE Providers Could Streamline Oversight

With a single license, the State could more easily unite its oversight activities based on the requirements established in the license agreement rather than having many reviews scattered over time.

Many oversight visits to PACE providers result from state regulations applied to each license a provider may hold. The State could streamline this oversight by allowing a single license that covers all the state and federal regulations pertaining to the various PACE services, regardless of the facility providing the services. With a single license, the State could unite its oversight activities more easily based on the requirements established in the license agreement. Such oversight could use a cooperative approach—combining staff who specialize in different areas of the single license—for a comprehensive review of all a PACE provider's facilities during the same time period rather than having many reviews scattered over time. This would relieve the extended burden on PACE providers from a succession of licensing visits to each of their facilities.

According to the deputy director of Health Services' licensing division, Health Services suggested a similar idea in the past. In 1997, Health Services sponsored legislation for an innovative health facilities license for facilities outside the legally defined health facility types. This legislation, which did not pass, would have allowed a provider to propose such a facility, and with Health Services' approval, be licensed to provide an innovative mix of services. Under the innovative health facility license, Health Services would enter into a contractual agreement to provide oversight and evaluation of the provider, which would be subject to specific provisions for safety, quality, efficiency, and effectiveness. At the time, Health Services stated that it was spending a significant amount of staff time advising providers on state licensing requirements and assisting providers with innovations in meeting statutory requirements for the specified licensing categories.

In 2002, the State's Long-Term Care Council (council) established a workgroup that revisited the single license idea. The workgroup's draft recommendations identified PACE as an ideal candidate for piloting reforms in licensure, noting that the missing piece is a system of licensure that has the capacity to customize a license for new models of care. However, the deputy director—who co-chaired the workgroup—says the council shifted its focus to another long-term care issue and it is unclear when or if the workgroup recommendations will be considered or acted upon.

In addition to a PACE license to offer multiple services at one facility, which the failed legislation proposed, we believe the Legislature may want to consider establishing a PACE license that authorizes multiple services at multiple facilities. Thus, all

of a PACE provider's facilities would fall under a single license and all the facilities would be monitored during one time period according to the provisions that authorize the license. In the event a PACE provider operates other long-term care programs, the oversight could be consolidated under this type of license.

HEALTH SERVICES' EXPANDED OVERSIGHT OF THE MULTIPURPOSE PROGRAM OVERLAPS WITH AGING'S ROLE

Since Health Services expanded its oversight of the multipurpose program, its role has come to overlap with Aging's oversight responsibilities. Although the federal waiver authorizing the multipurpose program directs Aging to administer it under Health Services' supervision, Health Services, after a federal review that found deficiencies in the oversight of the multipurpose program, increased its presence and participation during Aging's utilization reviews of local sites, which now face direct oversight from two state agencies. Health Services is conducting a pilot process to design how it will supervise Aging and the local providers. Health Services needs a reasonable basis for the percentage of reviews that it will attend with Aging or should assume responsibility of the program itself to avoid overlap of oversight of the multipurpose program by the two agencies.

Aging Administers the Multipurpose Program Under the Supervision of Health Services

Under a federal Medicaid Home and Community-Based Long-Term Care Services Waiver (federal waiver), Aging administers the multipurpose program and oversees the 41 multipurpose program sites in California. Home and community-based waivers are tools that states use to obtain federal Medicaid matching funds to provide long-term care to patients in settings other than institutions. Established in 1977, the multipurpose program was authorized, as of August 2003, to serve up to 11,789 clients per month. The program provides social and health care case management for frail elderly clients who are eligible for Medi-Cal and certified or certifiable for placement in an intermediate or skilled nursing facility, but who wish to remain in their own homes and communities. Multipurpose program clients may receive services at home rather than at one type of facility, in contrast to most of the other long-term care programs we reviewed. Local site staff work with the client, physician, family, and others to develop an individualized

care plan to prevent the client's institutionalization. Services, which must be provided at a lower cost than the cost of placing the participant in a skilled nursing facility, include social care, housing assistance, in-home chore and personal care, respite care, transportation, meals, protective services, and special communication assistance.

To ensure compliance with the federal waiver requirements, Aging performs biennial visits called utilization reviews at each multipurpose program site.

To ensure compliance with the federal waiver requirements, Aging performs biennial visits called utilization reviews at each multipurpose program site. During these site visits, which last about one week, generally two Aging staff members review a sample of client records, conduct at least one visit to one client's home, and interview site staff as needed to verify that clients receive allowable, appropriate, and actual services. After the review, Aging presents its findings in a report and requests corrective action from the site, if needed. Although the federal waiver indicates Aging is to conduct the primary oversight of the multipurpose program sites, the federal waiver charges Health Services with supervising Aging's efforts because Health Services is the state Medicaid agency. Under this federal waiver, which CMS approved, Health Services supervises Aging's administration of the multipurpose program through reviewing records and visiting local multipurpose program sites. However, the required number of record reviews or visits is not specified.

After a Federal Review, Health Services Expanded Its Monitoring of the Multipurpose Program

In fiscal year 1999–2000, Health Services did not have staff assigned to oversee Aging's administration of the multipurpose program. Aging administered the program and conducted utilization reviews with little Health Services involvement. However, when CMS concluded in a 1999 review that Health Services did not always provide monitoring and oversight of Aging, nor did Aging always provide monitoring and oversight of local multipurpose program sites, Health Services sought and received funding to increase its oversight role. Its request for funding offered only two options to address CMS' concerns: either do nothing and risk CMS sanctions, such as loss of federal funding, or allocate additional staff to Health Services to conduct monitoring and oversight of the federal waiver.

In the summer of 2001, two or three Health Services staff members began to accompany Aging's staff during some of the onsite utilization reviews. As Table 5 shows, since that time Health Services' presence on utilization reviews has increased. Health Services' presence initially entailed observing how Aging's staff

conducted the utilization review both to train Health Services' employees in the multipurpose program as well as to assist Aging or the local site in any areas where Health Services could provide guidance. Although Health Services did not give Aging formal written feedback about its administration of the program, managers from both departments met periodically to discuss any issues or concerns. As described in the next section, Health Services is modifying its role from observing Aging's reviews to conducting its own concurrent review.

TABLE 5

Between 2001 and 2003 Health Services Accompanied Aging on Increased Numbers of Utilization Reviews of the Multipurpose Program Sites

Year	Utilization Reviews by Aging	Reviews for Which Health Services Accompanied Aging	Percentage of Aging Reviews Health Services Accompanied
2001	19	4	21%
2002	22	9	41
2003	20	14	70

Sources: Listings of site visits provided by the departments of Health Services and Aging.

The extent of Health Services' presence on Aging's utilization reviews appears to have exceeded what a reasonable person might construe as a supervisory role.

The extent of Health Services' presence on Aging's utilization reviews during this time appears to have exceeded what a reasonable person might construe as a supervisory role. In addition, a site or a client visited by several staff from two state departments may consider the effort excessive if not duplicative. In at least one instance, a staff member from Aging expressed concern that Health Services' increased presence on the utilization reviews might lead to duplication of effort. The staff member correctly pointed out that CMS is required to monitor as few as 5 percent of Health Services' oversight of facilities within the much larger skilled nursing industry. In contrast, Health Services accompanied Aging on 21 percent of the utilization reviews in 2001. Health Services responded to this concern by saying it planned to go on approximately seven utilization reviews, or 33 percent, each year. Although Health Services has clearly exceeded this plan for 2002 and 2003—as Table 5 indicates—the chief of Aging's multipurpose senior services program section said that Aging deferred to Health Services because, as the state Medicaid agency, Health Services determines the type of oversight that it believes is necessary to comply with federal requirements.

Health Services' Parallel Reviews Mirror Aging's Utilization Reviews

Seeking to improve upon its observational oversight of Aging, in January 2004 Health Services began a new pilot process for oversight, developed in collaboration with a CMS-contracted quality assurance consultant. The chief of Health Services' community options monitoring and assessment unit has indicated that the ultimate goal of the pilot process is to develop a more permanent plan for overseeing Aging's administration of the multipurpose program. Although the pilot process appears reasonable, we question Health Services' expectation that it ultimately still will accompany Aging's staff on around 35 percent of utilization reviews.

Under a new pilot process, Health Services is conducting a "parallel review," in which its staff independently review separate client files, conduct separate visits to clients in their homes, and separately interview clients and site staff.

Under this pilot process, Health Services initially is accompanying Aging's staff on six to eight of the 11 utilization reviews Aging has scheduled between January 1 and June 30, 2004. However, Health Services has changed the scope of its oversight. Health Services is now conducting what it calls a "parallel review," in which its staff independently review separate client files, conduct separate visits to clients in their homes, and separately interview clients and site staff. Although subject to reviews from both Aging and Health Services staff, the multipurpose site would receive a single report reflecting the observations of both departments.

According to its home and community-based services branch chief (branch chief), Health Services is conducting its parallel reviews to identify systemic problems and provide assistance—including the appropriate use of Medi-Cal services and waiver funds—and formal feedback to Aging. By doing so, Health Services' reviews generally mirror Aging's, as Table 6 illustrates. During its utilization reviews, Aging's staff review 15 client records and conduct at least one home visit. Under the pilot process, Health Services staff concurrently review a separate set of 14 client records as well as conduct six separate home visits. Moreover, both departments' monitoring tools indicate that each will review similar areas. For instance, when reviewing client records, both departments indicate they determine whether the local site appropriately assessed a client's level of care, which must be at the nursing home level.

The pilot process Health Services has begun is similar to the oversight methodology the General Accounting Office recommended in a report it issued on long-term care program oversight in 2003. The branch chief further explains that Health Services' activities also

seek to supplement Aging's activities in keeping with assurances that Health Services, as the state Medicaid agency, must provide to CMS. She describes Health Services' role as medically oriented, whereas Aging's expertise lies with understanding the elderly population and the services available.

TABLE 6

Health Services' Parallel Reviews Mirror Aging's Utilization Reviews (Shading Indicates Overlap)

Aging's Utilization Review	Health Services' Parallel Review
Review 15 client records (five of which are terminated)	**Review 14 client records (two of which are terminated)**
Level of care	Level of care
Case record documentation (includes review of individual plan of care development)	Individual plan of care development
Necessity/appropriateness of services	Necessity/appropriateness of services
Client rights	Client rights
Eligibility	Appropriate use of waiver versus Medi-Cal
Vendor agreement review	
Quality assurance activities (including home visit)	
Conduct a home visit to at least one of the 15 clients	**Conduct home visits to six of the 14 clients**
Client interview	Client interview
Family member/caregiver interview	Family member/caregiver interview
	Assigned care manager interview
Site staff interview	**Site staff interview**
As needed	Site management activity
	Technical assistance needs
	Nurse case management

Sources: Monitoring documents used by the departments of Health Services and Aging.

Health Services' pilot process appears to be a reasonable approach for identifying and reducing systemic problems at multipurpose program sites and with Aging's utilization reviews. However, the branch chief also notes that this monitoring process is a work-in-progress and is subject to change. She anticipates that Health Services will reevaluate and revise its

monitoring process as a result of findings from Health Services' reviews through June 30, 2004, findings from a recent CMS review of the federal waiver, and feedback from the CMS-contracted quality assurance consultant. According to the branch chief, Health Services' ultimate goal is to assume a similar role toward Aging as CMS has toward Health Services. For example, Health Services envisions a long-term goal of working with Aging and the local sites to select representative samples on which Health Services conducts reviews based on Aging's utilization review findings. The branch chief says Health Services is working toward decreasing the number of parallel reviews, and she expects that the target percentage of the utilization reviews on which it will accompany Aging will be around 35 percent.

Accompanying Aging on even 35 percent of utilization reviews seems excessive, particularly considering the federal minimum target of 5 percent for skilled nursing facilities.

Accompanying Aging on even 35 percent of utilization reviews seems excessive, particularly considering the federal minimum target of 5 percent for skilled nursing facilities. However, if Health Services anticipates that significant problems will exist with the multipurpose program even after the pilot process ends, a greater Health Services presence might be reasonable temporarily. According to CMS reviewers of California's federal waiver, although CMS prefers some collaboration and joint activity between Health Services and Aging, CMS accepts Health Services' judgment and would be comfortable with Health Services accompanying Aging on anywhere from zero to 100 percent of the utilization reviews. The reviewers indicated that CMS does expect Health Services to perform at least a desk review of Aging's utilization reviews before Aging reports its findings to the sites. CMS has no specific expectations, so Health Services should develop a reasonable rationale for the number of reviews it decides to conduct. For example, depending on the results of its oversight of Aging's utilization reviews, it might set a target of 5 percent parallel reviews if it has minimal concern with the quality of the utilization reviews or site operations, but a higher percentage if it has significant concerns. Alternatively, if Health Services has significant concerns, it could assume responsibility for the program itself.

RECOMMENDATIONS

To minimize duplication of effort in adult day health care oversight and potentially lessen the resulting burden on health care centers, Health Services should:

- Incorporate a review of certification requirements into its onsite licensing review, which may include Aging's participation at Health Services' request. Until Health Services develops the

necessary protocols for a single review, Health Services and Aging should conduct joint onsite licensing and certification reviews. If Health Services determines a statutory change is necessary to implement our recommendation, it should ask the Legislature to consider changing the statutes governing the adult day health care program.

- Combine the licensing and certification regulations.

- Coordinate to the extent possible any Medi-Cal field office oversight activities to occur during the licensing and certification reviews. Specifically, the licensing division should inform the appropriate field office of an upcoming onsite visit to a health care center to allow the field office an opportunity to send a representative along with the review team for the time needed to focus specifically on reviewing the TARs.

To streamline PACE oversight, the Legislature should consider allowing for a single license that authorizes all the long-term care services a PACE provider offers, regardless of the facility that provides the services.

To reduce overlapping efforts between itself and Aging in overseeing the multipurpose program, Health Services should complete its pilot process and develop a reasonable rationale for the percentage of utilization reviews it decides to attend. Alternatively, after evaluating the results of its pilot process, Health Services could assume responsibility for the multipurpose program.

Aging should work with Health Services to implement our recommendations to streamline the oversight for the adult day health care and multipurpose programs. ■

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CHAPTER 2

Other Programs Present Few Opportunities to Streamline Oversight, but Can Benefit From Improved Communication Among Oversight Entities

CHAPTER SUMMARY

Limited opportunities exist to streamline oversight of skilled nursing facilities, adult day programs, and Alzheimer's day care resource centers (Alzheimer's centers), but better communication could take place between state and local agencies overseeing adult day programs and Alzheimer's centers. For skilled nursing facilities, federal funding guidelines limit the opportunity to streamline oversight activities because these guidelines require the Department of Health Services (Health Services) to follow specific oversight practices. Also, there appears to be little duplication of oversight of adult day programs, as the Department of Social Services (Social Services) limits its oversight and local entities that visit adult day programs focus primarily on the delivery of services to their clients. However, Social Services can improve its communication about oversight activities with other entities for the limited number of adult day programs that share space with other programs. Most providers operating Alzheimer's centers also operate adult day programs, adult day health care centers (health care centers), or both. The Department of Aging (Aging)—which oversees the Alzheimer's centers—could improve its oversight efficiency by sharing information with the other entities that oversee these programs that share facilities with Alzheimer's centers.

FEDERAL MANDATES LIMIT STREAMLINING OF SKILLED NURSING FACILITY OVERSIGHT

Federal mandates tightly control Health Services' review of skilled nursing facilities, limiting opportunities to streamline oversight. To receive Medicare and Medi-Cal funds, Health Services must adhere strictly to rules that fix the schedules and establish the procedures of skilled nursing facility reviews, which are onsite reviews of a provider's compliance with program laws and regulations. Besides Health Services' reviews, the

Department of Justice (Justice), through its Operation Guardians program, conducts surprise inspections of skilled nursing facilities, and the State's Long-Term Care Ombudsman Program (ombudsman) reviews quality of care complaints about long-term care facilities.

Skilled nursing facilities provide continuous skilled nursing care and related services for injured, disabled, or sick persons requiring extended medical or nursing care and rehabilitation services. This care is provided on a 24-hour basis and includes, at a minimum, physician, skilled nursing, dietary, and pharmaceutical services, along with an activity program.

As a Condition of Federal Funding, the Federal Government Has Established Strict Requirements for the Oversight of Skilled Nursing Facilities

Covering frequency, timing, and scope of the skilled nursing facility reviews, CMS requirements leave California little flexibility to alter its current approach without risking the loss of federal funding.

Most skilled nursing facilities in California are certified for Medicare and Medi-Cal funding, and they must pass initial and annual certification reviews by Health Services' licensing and certification division (licensing division) to receive Medicare and Medi-Cal reimbursement for services to residents. To receive funding for performing these certification reviews, states must comply with certain requirements set by the Centers for Medicare and Medicaid Services (CMS). Covering frequency, timing, and scope of the skilled nursing facility reviews, these CMS requirements leave California little flexibility to alter its current approach without risking the loss of federal funding.

For the annual certification reviews, CMS requires states to review all skilled nursing facilities no later than 15 months after the previous review, while maintaining a statewide average of 12 months between reviews. CMS annually reviews California's compliance with these time frames. For federal fiscal year 2001–02, CMS found that Health Services' licensing division reviewed skilled nursing facilities every 12.7 months on average, but did not review nine of the approximately 1,400 skilled nursing facilities before the 15-month limit expired. Also, to control how states conduct their reviews, CMS requires states to use CMS' review documents to perform the skilled nursing facilities reviews. These documents list specific procedures to assess whether a skilled nursing facility complies with federal laws and regulations.

As a condition of receiving a federal grant, Health Services must investigate within certain time frames complaints alleging violations of nursing home regulations. Health Services must

respond with an onsite visit to the skilled nursing facility within 48 hours of a complaint involving immediate jeopardy to residents and within 10 days of a complaint of actual harm.

Until 1992 legislation, Health Services was required to inspect skilled nursing facilities for compliance with state licensing requirements. However, the 1992 legislation exempted skilled nursing facilities that are certified to participate in the Medicare or Medicaid programs from periodic state licensing inspections.

Justice and the Ombudsman Also Provide Oversight of Skilled Nursing Facilities

Justice leads Operation Guardians, a multiagency task force the State's attorney general established, which conducts surprise inspections of skilled nursing facilities.

Justice leads Operation Guardians, a multiagency task force the State's attorney general established, which conducts surprise inspections of skilled nursing facilities. Although they are not federally required, the one-day surprise inspections aim to protect and improve the quality of care for elderly and dependent adult residents of skilled nursing facilities by identifying violations of federal, state, and local laws and regulations. Established in March 2000, Operation Guardians has focused primarily on 16 selected counties, completing 150 inspections between April 2001 and March 2003 that resulted in Health Services issuing 34 statements of deficiencies. The task force inspecting a facility typically consists of two special agents from Justice, an investigative auditor, a nurse evaluator, the local fire inspector, and a medical doctor specializing in geriatric medicine. According to Justice's director of the Bureau of Medi-Cal Fraud and Elder Abuse, Justice and any local prosecutors on the team will prosecute any criminal violations found and refer any violations observed of skilled nursing facility regulations to Health Services for follow-up.

Further, the ombudsman is responsible for resolving complaints about issues affecting the quality of life of skilled nursing facility residents. Ombudsman staff operate throughout California through the local area agencies on aging (local area agencies) and visit skilled nursing facilities as needed to work with patients and long-term care providers to resolve concerns. The federal government mandates that states operate an ombudsman program and provides part of the program's funding. As of January 2004, the ombudsman indicates there were 1,145 program volunteers and 129 paid staff. The ombudsman refers known or suspected criminal activity or violations of skilled nursing facility regulations to Justice and Health Services, respectively.

ALTHOUGH OVERSIGHT OF ADULT DAY PROGRAMS DOES NOT APPEAR REDUNDANT, BETTER COMMUNICATION OF OVERSIGHT CONCERNS COULD OCCUR

Social Services, regional centers, county mental health departments, and local area agencies oversee adult day programs. Social Services visits only a sample of adult day program facilities and, according to representatives of some of these entities, the focus of regional centers, county mental health departments, and local area agencies is on the delivery of services to specific clients rather than the facilities. Therefore, we see no significant redundancy in oversight, although in some instances communication between oversight entities can be improved to make the oversight process more efficient by increasing awareness of the duties and responsibilities of each agency. The adult day program provides a variety of social, psychological, and related support services to clients, who spend part or most of the day at the facility. These services are not eligible for payment by Medi-Cal; they are funded mainly from private sources.

Social Services has primary responsibility for overseeing adult day programs by screening providers and licensing their facilities. Social Services recently implemented a new sample visit protocol for the licensing of community care facilities, including adult day program facilities, resulting from legislation passed in 2003. The new sample visit protocol requires annual visits to all facilities with a history of noncompliance, but to only a random sample of 10 percent of the remaining facilities. Social Services continues to give priority to investigating complaints received about providers, case management visits, follow-ups on incident reports, plan of correction visits, and applications processing. The 2003 legislation requires Social Services to visit each adult day program facility at least once every five years.

In addition to Social Services, regional centers, county mental health departments, and local area agencies monitor the services adult day programs provide to their clients. Regional centers—which the Department of Developmental Services (Developmental Services) oversees—are nonprofit private corporations that help the public find services available to individuals with developmental disabilities. These three entities may visit an adult day program facility to see their clients, but according to representatives of some of these entities, these visits focus primarily on the delivery of services to clients. However, given that these are local entities, we would expect that the oversight procedures and focus might vary among the entities.

For adult day programs that share space with other long-term care programs, the oversight process would be more efficient with better communication between Social Services and the departments that oversee those other programs.

For adult day programs that share space with other long-term care programs, the oversight process would be more efficient with better communication between Social Services and the departments that oversee those other programs. We identified 35 adult day programs that share facilities with other programs we reviewed. After our inquiry, Social Services determined that there was the need for it to follow up on the potential for redundant oversight for 29 of these 35 facilities—five that share space with a health care center, 17 that share space with an Alzheimer's center, and seven that share space with both programs. Although these 29 facilities represent a small fraction of the more than 700 adult day program facilities operating in California, Social Services should make its oversight as efficient as possible.

For the five adult day programs whose facilities also have health care centers and seven that share space with both programs, Social Services and Health Services license these facilities. However, under state law, if a health care center licensee also provides an adult day program, the health care center license is the only license required. The Social Services' statewide adult care program administrator (administrator) said this audit has brought to Social Services' attention that there are some facilities licensed by both Social Services and Health Services. She indicates that Social Services has confirmed that four facilities are dual-licensed by the departments, but that Social Services needs to follow-up with Health Services to determine if the remaining eight facilities are dual-licensed. For all dual-licensed facilities identified, the administrator indicates that Social Services will confer with Health Services regarding these facilities and determine whether the adult day program license is no longer necessary.

In addition to the seven adult day programs that share space with both programs, another 17 adult day programs share space only with an Alzheimer's center, which Aging oversees. The Social Services' administrator said the two departments do not routinely share reports, but Social Services will share public information in the reports if asked to do so. The administrator noted that the director of the Alzheimer's program is also the director of the adult day program at a few shared locations, and for these locations the director would have copies of Social Services' reports.

Formal communication about adult day programs exists between Social Services and the regional centers. According to a memorandum of understanding between Social Services and Developmental Services, Social Services and the regional centers

are to discuss visits to adult day program facilities and related concerns at quarterly meetings that give each entity a chance to share and resolve issues. Also, the Social Services administrator indicates that Social Services is updating the memorandum of understanding with Developmental Services to make the agreement more current. However, the administrator says there are no agreements in place for regular communication with county mental health departments except for Los Angeles County, but Social Services is developing these agreements.

MORE COMMUNICATION AMONG OVERSIGHT ENTITIES COULD IMPROVE OVERSIGHT OF ALZHEIMER'S CENTERS

Because Alzheimer's centers often share facilities with other long-term care programs, more communication of monitoring concerns among the various entities overseeing these programs would increase oversight efficiency. Alzheimer's disease is a progressive, degenerative disease that attacks the brain and results in short-term memory loss, inability to reason, deterioration of language, and decline in an ability to care for oneself. Alzheimer's centers target people having moderate to severe levels of care needs and behavioral problems. They provide services to support the physical and psychosocial needs of persons with Alzheimer's disease and related dementia. Persons needing these services usually spend part or most of the day at an Alzheimer's center, where individual care plans are developed based on each person's needs. The program's goals are to keep participants as healthy and active as possible and to provide respite to caregivers.

Local area agencies conduct annual, and sometimes more frequent, site visits to Alzheimer's centers to check for compliance with the program's requirements.

Aging oversees the local area agencies, which are governmental and nonprofit entities that directly oversee Alzheimer's centers. Local area agencies conduct annual, and sometimes more frequent, site visits to Alzheimer's centers to check for compliance with the program's requirements. Local area agencies are responsible by contract for the Alzheimer's centers' compliance with all requirements of the program standards, applicable laws, and regulations. Aging oversees the local area agencies through staff (area agency team) who provide policy guidance, technical support, monitoring tools and guidance, and training about the Alzheimer's centers to the local area agencies.

As Table 7 shows, 46 of the 50 Alzheimer's centers share a facility with a health care center or an adult day program. Because Health Services and Social Services oversee these other programs,

Aging potentially can increase the efficiency of its oversight by sharing monitoring information with these departments as well as with the local area agencies.

TABLE 7

Most Alzheimer's Centers Reside With Either a Health Care Center or Adult Day Program

Alzheimer's center only or an Alzheimer's center that resides with another program besides a health care center or adult day program	4
Alzheimer's center and health care center, including seven that also reside with other programs	20
Alzheimer's center and adult day program, including three that also reside with other programs	19
Alzheimer's center, health care center, and adult day program, including one that also resides with other programs	7
Totals	**50**

Source: Bureau of State Audits' analysis of provider listings from the departments of Aging, Health Services, and Social Services.

Note: See Appendix A for additional detail.

According to the policy manager for an area agency team at Aging, oversight information sharing occurs within Aging, which jointly oversees the adult day health care program with Health Services. The area agency team alerts Aging's adult day health care section when the team will be monitoring local area agencies that have an Alzheimer's center located with a health care center. Also, the area agency team has an informal process to share with Aging's adult day health care section any findings related to Alzheimer's centers that share facilities with health care centers. Similarly, the adult day health care section shares its statement of deficiencies reports with the area agency team when there is a serious issue involving a health care center located in the same facility as an Alzheimer's center.

However, the policy manager indicates the area agency team does not regularly notify other state departments of its and the local area agencies' oversight activities. Specifically, the area agency team does not alert Health Services or Social Services before making a monitoring visit to a local area agency. The policy manager notes that the local area agencies are directly responsible for monitoring the Alzheimer's centers; thus they

There is no formal process to share the monitoring reports from the local area agencies with Social Services or Health Services.

would be responsible for coordinating with Health Services or Social Services. However, Aging could require the local area agencies to coordinate activities when feasible. Further, there is no formal process to share the monitoring reports from the local area agencies with Social Services or Health Services.

Nevertheless, the policy manager indicated that during Aging's reviews of the local area agencies' oversight of Alzheimer's centers, Aging determines if the relevant licensing agency was contacted regarding complaints within its jurisdiction. Also, Aging's adult day health care section sends copies of its statements of deficiencies for any health care centers that share facilities with Alzheimer's centers to the responsible local area agency. The policy manager indicated that Aging has taken no action, but has considered coordinating monitoring visits with Social Services to Alzheimer's centers that are located with an adult day program. On the other hand, to improve coordination and streamline monitoring, Aging has been studying the possibility of incorporating its monitoring of Alzheimer's centers into the health care center monitoring process and moving the oversight of Alzheimer's centers from the area agency teams to Aging's adult day health care branch.

The policy manager also states that Aging may no longer oversee the Alzheimer's centers as a distinct program because of changes in the governor's proposed budget for fiscal year 2004–05, which eliminates specific funding for Alzheimer's centers. Instead, the budget proposes merging funding for the Alzheimer's centers into one block grant with funding of other Aging local assistance programs. The local area agencies would receive the block grants, with the authority to determine which programs to fund. It is impossible now to determine the effect on Alzheimer's centers of eliminating specific funding for the program.

RECOMMENDATIONS

To provide better communication of oversight concerns of the adult day program facilities, Social Services should:

- Coordinate its efforts with Aging and the local area agencies at those adult day program facilities that share space with an Alzheimer's center.

- Identify adult day program facilities that share space with a health care center and rely upon the health care center license, as the law requires.

- Continue its efforts to develop formal agreements with the county mental health departments, as well as its efforts to update the agreement with Developmental Services.

If the Alzheimer's centers remain a separately funded program in fiscal year 2004–05, Aging, as the overseer of the local area agencies, should work with Health Services and Social Services to implement a process to share and act on findings from the local area agencies' oversight visits to Alzheimer's centers. If funding for the Alzheimer's centers is merged into a block grant, the departments and local area agencies should share information to the extent that local area agencies choose to continue funding Alzheimer's centers.

Health Services should work with Social Services and Aging to implement our recommendations regarding adult day program and Alzheimer's centers oversight.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

ELAINE M. HOWLE
State Auditor

Date: April 13, 2004

Staff: Lois Benson, CPA, Audit Principal
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APPENDIX A

Among the Six Programs We Reviewed, Few Providers Operate Multiple Programs

To determine how many long-term care providers operate multiple programs, we identified providers or facilities that operated more than one of the six programs that we reviewed. The process we followed to perform this comparison is discussed in the scope and methodology. Our results show that few providers or facilities operate more than one of the programs we reviewed. The four providers in the program of all-inclusive care for the elderly, by their nature of providing all-inclusive care, offer multiple programs. Further, many providers of Alzheimer's day care resource centers operate multiple programs. Other programs listed did not have a high percentage of providers or facilities operating multiple programs. However, there are approximately 52 long-term care programs that the State oversees, so these providers may operate one or more programs we did not review. Table A.1 is on the following page.

TABLE A.1

Few Providers Operate Multiple Programs

	Programs						
	Alzheimer's Day Care Resource Centers (ADCRC)	Adult Day Health Care (ADHC)	Adult Day Programs (ADP)	Multipurpose Senior Services Program (MSSP)	Skilled Nursing Facilities (SNF)	Program of All-Inclusive Care for the Elderly (PACE)	Totals
Total facilities (F) or providers (P) in the program	50 (P)	329 (F)	734 (F)	41 (P)	1,395 (F)	4 (P)	**2,553**
ADCRC only	3						
ADHC only		286					
ADP only			693				
MSSP only				31			
SNF only					1,381		
ADCRC/ADHC	13	13					
ADCRC/ADP	16		16				
ADCRC/MSSP	1			1			
ADHC/ADP		8	8				
ADHC/SNF		4			4		
ADHC/PACE		2				2	
ADP/SNF			6		6		
ADCRC/ADHC/ADP	6	6	6				
ADCRC/ADHC/MSSP	3	3		3			
ADCRC/ADHC/SNF	3	3			3		
ADCRC/ADP/MSSP	3		3	3			
ADHC/ADP/SNF		1	1		1		
ADHC/MSSP/PACE		1		1		1	
ADCRC/ADHC/ MSSP/PACE	1	1		1		1	
ADCRC/ADHC/ ADP/MSSP	1	1	1	1			
Providers operating multiple programs	**47**	**43**	**41**	**10**	**14**	**4**	**69***
Percentage	**94%**	**13%**	**6%**	**24%**	**1%**	**100%**	**3%**

Source: Bureau of State Audits' analysis of provider listings from the departments of Aging, Health Services, and Social Services.

* The total of "Providers operating multiple programs" does not equal the sum of the column totals for each program because the total reflects the actual number of providers that operate multiple programs for all of the program combinations we identified, rather than the sum of the combinations listed on each line. In other words, for the ADCRC/ADHC line, the total includes 13 providers that operate both programs, not 26 providers, which would be the sum of the combinations on the line.

APPENDIX B

Specific Adult Day Health Care Regulations That Overlap

The following table compares the two sets of state regulations that the departments of Aging and Health Services rely on to conduct their separate reviews of the adult day health care program's centers (health care centers). As we note in Chapter 1, Aging relies on the certification regulations while Health Services' licensing division relies on the licensing regulations. We arranged Table B.1 so that the overlapping certification regulation appears on the same row as its counterpart from the licensing regulations. For example, regulatory language in Section 54203 of the certification regulations overlaps with Section 78407 of the licensing regulations.

The table also shows the 24 regulatory areas with which two of the three Health Services' Medi-Cal field offices that conduct on-site visits to health care centers may find noncompliance. As discussed previously, three Medi-Cal field offices conduct site visits to health care centers to assess whether clients should receive the services included in clients' treatment authorization requests. While on these visits, two of these three field offices also may observe noncompliance with many of the same regulations that Health Services and Aging review during their respective licensing and certification visits.

TABLE B.1

Regulatory Oversight Overlap in the Adult Day Health Care Program

Aging (Certification)		Health Services (Licensing)		Medi-Cal Field Office
Eligibility, Participation, Discharge				
54201	Eligibility			
54203	Participation	78407	Requirements for Participant Admission	X
54205	Physician Request			X
54207	Multidisciplinary Team Assessment	78303	Basic Program Services: Assessment	X
54209	Prior Authorization			X
54211	Multidisciplinary Team	78303	Basic Program Services: Assessment	X

continued on next page

Aging (Certification)		Health Services (Licensing)		Medi-Cal Field Office
54213	Discharge	78345	Basic Program Services-Plan for Discharge	X
54215	Reassessment*			X
54217	Beneficiary Agreement of Participation			X
54221	Hours of Operation			
54223	Attendance			X
		78411	Admission and Discharge Procedures	
Services and Standards				
54301	Certification			
54303	Denial of Initial Certification			
54305	Termination or Suspension of Certification			
54307	Denial of Renewal of Certification			
54309	Required Services	78301	Basic Program Services; General	
54311	Optional Services	78347	Optional Services	
54313	Physical Therapy Services	78307	Basic Program Services: Physical Therapy Services	X
54315	Occupational Therapy Services	78305	Basic Program Services: Occupational Therapy Services	X
54317	Speech Therapy Services	78309	Basic Program Services: Speech Therapy Services	X
54319	Staff Physician Services	78311	Basic Program Services: Medical Services	
54321	Personal Physician			X
54323	Nursing Service	78313	Basic Program Services: Nursing Services	X
54325	Psychiatric and Psychological Services	78337	Basic Program Services: Psychiatric or Psychological Services	X
54327	Personal Psychiatrist and Psychologist Services			
54329	Medical Social Services	78339	Basic Program Services: Social Services	
54331	Nutrition Service	78319	Basic Services: Nutrition Services	X
54331	Nutrition Service	78321	Nutrition Services: Menus	
54331	Nutrition Service	78333	Nutrition Services: Staff	
54333	Transportation	78343	Transportation Services	
54335	Emergency Service	78311	Basic Program Services: Medical Services	
54335	Emergency Service	78413	Employee Requirements	
54337	Program Aides	78419	Staffing Requirements	
54339	Activity Program	78341	Basic Services: Recreation or Planned Social Activities	X
		78315	Nursing Services-Restraints	
		78317	Nursing Services-Medications	
		78323	Nutrition Services: Quality of Food	
		78325	Nutrition Services: Food Sanitation	
		78327	Nutrition Services: Food Service	

Aging (Certification)		Health Services (Licensing)		Medi-Cal Field Office
		78329	Nutrition Services: Cleaning of Utensils	
		78331	Nutrition Services: Supplies and Equipment	
		78335	Nutrition Services: Food Storage	
Administration				
54401	Organization and Administration	78403	Plan of Operation	
54403	Administrator	78415	Administrator	
54405	Program Director	78417	Program Director	
54406	Activity Coordinator	78341	Basic Services: Recreation or Planned Social Activities	
54407	Grievance Procedure	78437	Participant Rights	
54409	Participant Fair Hearing	78437	Participant Rights	
54411	Reports	78427	Reports	
54413	Financial Reporting	78435	Retention of Records	
54415	Medical Review			
54417	On-Site Visits	78601	Inspection	
54419	Utilization Review Committee			
54421	Advisory Committee			
54423	Staffing Requirements	78419	Staffing Requirements	X
54425	Participant Records	78431	Participant Health Records	X
54429	Solicitation			
54431	Service Area	78407	Requirements for Participant Admission	X
54433	Subcontracts			
54435	Civil Rights of Participants			
54437	Civil Rights of Employees			
54439	Confidentiality of Data	78433	Confidentiality of Information	
54443	Informational Material			
54445	Conflict of Interest			
54447	Provider Sanctions			
		78401	Licensee Responsibility	
		78405	Composition of Governing Board†	
		78421	Finances	
		78423	Disaster Plan	
		78425	Transportation Safety	
		78429	Employee Records	
		78439	Equipment and Supplies	
Payment of Services				
54501	Adult Day Health Care Services			
54503	Fee Schedule			

continued on next page

Aging (Certification)		Health Services (Licensing)		Medi-Cal Field Office
54504	Transition Visits			
54505	Initial Assessment Rate			
54507	Billing Requirements			
License				
		78201	Right to Apply	
		78203	License Required	
		78205	Content of Application	
		78207	Fees	
		78209	Public Hearing	
		78213	Denial of Initial Application	
		78215	Inspections	
		78217	Program Flexibility	
		78219	Issuance of License	
		78221	Limitations on Participants Admitted	X
		78223	Posting of License	
		78225	License Not Transferrable	
		78227	New Application Required	
		78229	License Expiration and Renewal	
		78231	Revocation or Suspension of License	
		78233	Voluntary Suspension and Reinstatement	
		78409	Fire Clearance	
Physical Plant				
		78501	Physical Accommodations	
		78503	General Building Requirements	
		78505	Space Requirements	X
		78507	Maintenance and Housekeeping	
		78509	Safety	X
		78511	Supplies	X
		78513	Solid Waste	
Violations				
		78603	Deficiencies in Compliance	
		78605	Complaints	
		78607	Deficiencies	
		78609	Inspection Authority	

Sources: Bureau of State Audits' analysis based on the California Code of Regulations, Title 22, Adult Day Health Care Medi-Cal Certification (Division 3, Chapter 5) and Licensing (Division 5, Chapter 10), and Medi-Cal field office Southern Operations Branch adult day health care program onsite review list of potential recommendations.

* According to the Department of Aging (Aging), the timing requirements in Section 54215 are superseded by the Welfare and Institutions Code, Section 14529.

† According to Aging, Section 78405 has been eliminated by repeal of the statutory requirement in May 2003.

APPENDIX C

Details of the State's Visits to On Lok Senior Health Services

The following table gives details on the State's oversight visits to On Lok Senior Health Services (On Lok) between January 2001 and November 2003 that we list in Table 3 on page 23. As the table demonstrates, the state oversight visits are spaced irregularly, so that the State spent as many as seven days monitoring On Lok's facilities in one month, while the State may not have visited On Lok at all in other months. On Lok is the largest program of all-inclusive care for the elderly provider in California, so its experience with state oversight may not be typical. We did not include investigations by the Department of Health Services' (Health Services) licensing division that result from a complaint or a provider's report of an unusual occurrence at a facility because these investigations are not routine, although they are authorized by statute and regulation. Moreover, these visits afford a necessary means by which providers, clients, and interested parties may alert Health Services of potential health and safety concerns in long-term care facilities.

TABLE C.1

State of California Visits to On Lok
January 2001 through November 2003

Date(s)	Facility Visited	Purpose of Visit	Oversight Entity
1/30/01, 2/1/01	Bush Street administration	Medical review	Health Services' audits and investigations division
3/15/01	30th Street health care center and primary care clinic	Site visit	Health Services' office of long-term care (office of long-term care)
3/16/01	Mission Street health care center	Site visit	Office of long-term care
5/16/01, 5/17/01	Geary Street health care center	Licensing review	Health Services licensing and certification division (licensing division)
8/10/01	Bush Street administration	Site visit	Office of long-term care
10/22/01, 10/23/01	Montgomery Street health care center	Licensing review	Licensing division

continued on next page

Date(s)	Facility Visited	Purpose of Visit	Oversight Entity
10/30/01, 11/02/01	Mission Street health care center	Licensing review	Licensing division
11/9/01	Geary Street health care center	Follow-up review of corrective action plan	Office of long-term care
11/14/01, 11/16/01	30th Street health care center	Licensing review	Licensing division
11/27/01, 11/28/01	Powell Street health care center	Licensing review	Licensing division
1/15/02 through 1/17/02	Bush Street health care center	Licensing review	Licensing division
3/12/02, 3/13/02	Fillmore Street health care center	Licensing review	Licensing division
4/23/02	Fremont health care center	Initial licensing review	Licensing division
4/24/02, 4/25/02	Fremont primary care clinic	Initial licensing review	Licensing division
5/13/02	Fillmore Street health care center	Certification review	Department of Aging (Aging)
5/14/02	Geary Street health care center	Certification review	Aging
5/22/02, 5/23/02	Fremont health care center and primary care clinic	Pre-operations review	Office of long-term care
6/20/02	Geary Street health care center	Licensing review	Licensing division
6/20/02	30th Street health care center	Certification review	Aging
7/1/02, 7/2/02	30th Street and Fillmore Street health care centers, Montgomery Street health care center and primary care clinic	Follow-up review of corrective action plan	Office of long-term care
9/20/02	Fremont health care center and primary care clinic	Follow-up review of corrective action plan	Office of long-term care
9/24/02, 9/25/02	30th Street health care center	Licensing review	Licensing division
10/15/02, 10/16/02	Montgomery Street health care center	Licensing review	Licensing division
1/2/03, 1/3/03, 1/6/03	Powell Street health care center	Licensing review	Licensing division
1/9/03, 1/10/03, 1/13/03, 1/14/03	Bush Street health care center	Licensing review	Licensing division
4/7/03 through 4/11/03	All facilities	PACE provider review	Centers for Medicare and Medicaid Services—central and regional offices, office of long-term care
6/17/03, 6/18/03	Fremont health care center	Licensing review	Licensing division
8/5/03, 8/6/03	Montgomery Street health care center	Licensing review	Licensing division
10/20/03 through 10/22/03	Bush Street administration	Joint medical and follow-up review	Department of Managed Health Care, Health Services' audits and investigations division

Source: Oversight files from the Departments of Health Services and Aging.

Note: No reviews took place in November 2003. During this three-year period, On Lok operated a total of eight facilities but only seven were licensed at any time. On Lok voluntarily suspended the license for the Mission Street facility in late 2001 and the Fremont facility became licensed during 2002.

Agency's comments provided as text only.

Health and Human Services Agency
1600 Ninth Street, Room 460
Sacramento, CA 95814

March 26, 2004

Elaine M. Howle, State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

Thank you for forwarding a draft copy of the Bureau of State Audits' (Bureau) report titled "Oversight of Long-Term Care Programs: Opportunities Exist to Streamline State Oversight Activities". Per your request, responses to the audit from the Department of Health Services, the Department of Aging and the Department of Social Services are enclosed. In addition, each department has begun taking steps to address the issues raised in the Bureau's report.

As you know, the Governor is currently conducting a complete review of State government. This California Performance Review (CPR) provides a unique opportunity for the State to re-examine all facets of government to ensure efficient and effective operations. During the review, the function of each department within HHSA will be examined, and the Bureau's audit report will help inform these review efforts.

Once again, thank you for the opportunity to review this draft report. If you have any questions, please call Lauren Gomez, HHSA Chief of Administration and Financial Management, at (916) 654-0662.

Sincerely,

(Signed by: Terri Delgadillo)

Terri Delgadillo
Deputy Secretary

RESPONSE FROM CA DEPARTMENT OF AGING

CHAPTER 1

RECOMMENDATION: Aging should work with Health Services to implement recommendations to streamline the oversight for the adult day health care and multipurpose senior services programs.

The Department of Aging welcomes the opportunity to work with Health Services on streamlining the oversight of these programs.

Adult Day Health Care (ADHC)

CDA appreciates the work that BSA has done. Historically, CDA and DHS have identified some of the same issues and instituted changes to address them. For some areas, such as regulatory changes, final adoption of requirements that would eliminate the duplication are pending.[1]

The proposal to convert the ADHC program into a Home and Community Based Waiver will significantly change the program and will provide an opportunity to address the BSA's findings.

The State of California has recently received a federal mandate to move the ADHC program from a Medicaid (Medi-Cal) State plan program to a Medi-Cal waiver program. At present, the Administration is putting its efforts into converting the ADHC program into a Home and Community Based Waiver, under provisions of Section 1915 (c) of the Social Security Act. DHS and CDA are cooperating on the development of this waiver. DHS and CDA will provide updates to the BSA on progress in addressing the issues raised in this report as the ADHC waiver design progresses.

As stated by the BSA, the purpose of their audit was very focused based on the original audit request. CDA believes that more comprehensive, qualitative factors should be included in any major ADHC redesign plan. It is our understanding that the California Performance Review is addressing the organizational structure of the departments' administering the state's health and human services. We will also look to their recommendations for guidance in addressing these issues.

CDA's primary objective, consistent with many of the BSA's recommendations, is to eliminate overlapping reviews of providers when such reviews are not necessary, to promote compliance and positive outcomes for the beneficiaries, and to mitigate the confusion and anxiety providers may experience as the ADHC program transitions from a State plan to a waiver service. CDA believes that improved coordination and streamlining of survey processes will address these concerns. These goals can be achieved in the development of a waiver program, and should be applied in the development of recommendations for redesign of the AHDC program.

[1] CDA acknowledges that the current ADHC program regulations, promulgated in 1979, are outdated. With the exception of reimbursement rate adjustments and the addition of transition days as a category of reimbursable days, no changes have been made to these regulations since their inception. Although significant efforts have been made in the past to modify these regulations, these efforts have not been finalized, and are currently being reassessed due to the Executive Order (S-2-03).

Multipurpose Senior Services Program (MSSP)

We agree in principle with the BSA in their recommendations for the MSSP, especially in the area of DHS' parallel monitoring activities. It is imperative to avoid duplication and to ensure that respective roles and responsibilities between CDA and DHS are very clear and distinct. We look forward to continuing to work with DHS to achieve this balance and clarity.

CHAPTER 2

RECOMMENDATION: Social Services should coordinate its efforts with Aging and the local area agencies at those adult day program facilities that share space with an Alzheimer's center.

The Department of Aging welcomes the opportunity to work with the Department of Health Services, Department of Social Services, and the area agencies on aging to establish protocols to share information about these concerns and to act on findings. As noted by the BSA, the final outcome of the Governor's Block Grant proposal will have an impact on these protocols.

This is the California Department of Health Services' (Department) response to the Bureau of State Audits draft report entitled, "Oversight of Long-Term Care Programs: Opportunities Exist to Streamline State Oversight Activities"

Recommendation
Incorporate a review of certification requirements into on-site licensing, which may include Aging's participation at Health Services' request. Until Health Services develops the necessary protocols for a single review, Health Services and Aging should conduct joint onsite licensing and certification reviews.

Response
There are significant differences in requirements for timing and frequency of the licensing and certification surveys. Scheduling licensing and certification surveys together would require a considerable amount of additional planning and coordination. Creating a complex collaborative tracking and scheduling protocol may be premature as DHS is currently preparing a federally mandated Medi-Cal waiver converting and redesigning the Program in a Community Based Waiver.

Recommendation
Combine licensing and certification regulations.

Response
This is the type of activity that is currently under consideration through the California Performance Review (CPR) project that will assure consistency across numerous overlapping functions within the state processes. Such a lengthy process and investment of state resources necessary to rewrite and promulgate these two sets of regulations should be consistent with the overall recommendations from the CPR.

Recommendation
Coordinate to the extent possible any Medi-Cal Field Office oversight activities to occur during the Licensing and Certification reviews. Specifically, the Licensing Division should inform the appropriate field office of an upcoming onsite visit to a heath care center to allow the field office an opportunity to send a representative along with the review team to focus specifically on reviewing the treatment authorization requests (TARs).

Response
The Department agrees with the recommendation to coordinate on-site visits to ADHCs with Licensing and Certification staff to the extent possible. Medi-Cal Field Office Administrators, when notified of an upcoming on-site, will accompany Licensing and Certification staff to ADHCs for which the field offices have TARs for review/approval and the ADHC would have been selected for an on-site visit.

Recommendation
To streamline PACE oversight, the Legislature should consider allowing a single license that authorizes all of the long term care services a PACE provider offers, regardless of the facility that provides the services.

Response
The Department agrees in concept that a single license for the Program for the All Inclusive Care of the Elderly (PACE) programs would reduce the required licensing surveys for each PACE site. A new PACE licensure category would require statutory authority and sufficient resources necessary to develop the license provisions and companion regulations. This activity needs to be considered in light of priorities and the current fiscal situation.

Recommendation
To reduce overlapping efforts between itself and Aging in overseeing the multipurpose program, Health Services should complete its pilot process and develop a reasonable rationale for the percentage of utilization reviews it decides to attend. Alternatively, after evaluating the results of its pilot process, Health Services could assume responsibility for the multipurpose program.

Response
The Department concurs with the BSA recommendation that the Department "should complete its pilot process and develop a reasonable rationale for the percentage of utilization reviews it decides to attend."

The information resulting from the pilot review process will be utilized by the Department to finalize its internal review protocols and the results generated from these reviews will further assist the Department in providing ongoing guidance and technical assistance to Aging in their administration of the Multi-Services Senior Program Waiver.

Recommendation
Work with Social Services and Aging on adult day program and Alzheimer's center oversight.

Response
The Department will partner with sister agencies to help ensure the reasonable and consistent application of standards to all provider types in the continuum of home and community-based services for the elderly.

DEPARTMENT OF SOCIAL SERVICES

1) BSA Recommendation:
Department of Social Services should coordinate its efforts with Aging and the local area agencies at those adult day program facilities that share space with an Alzheimer's center.

CDSS Response: CDSS concurs with the recommendation of the BSA. The Department intends to expand communications with the Department of Aging and the local area agencies on aging to discuss issues of concern with respect to all licensed Alzheimer's Day Care Resource Centers. This communication process would model the one already in place with Regional Centers and the Long Term Care Ombudsman

2) BSA Recommendation:
Department of Social Services should identify adult day program facilities that share space with a health care center and rely upon the health care center license, as the law requires.

CDSS Response: CDSS concurs and is currently compiling a list of adult day program facilities that share space with a health care center and have the same licensee. CDSS will then rescind the Adult Day Care License and rely upon the Department of Health Services to monitor both care arrangements.

3) BSA Recommendation:
Department of Social Services should continue its efforts to develop formal agreements with the county mental health departments, as well as its efforts to update the agreement with Developmental Services.

CDSS Response: CDSS concurs and will continue activities already underway to develop formal agreements with the county mental health departments and the Department of Developmental Services.

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press