Date of Hearing: April 23, 2013

ASSEMBLY COMMITTEE ON AGING AND LONG-TERM CARE
Mariko Yamada, Chair
AB 518 (Yamada and Blumenfield) – As Amended: April 11, 2013

SUBJECT: Community-Based Adult Services (CBAS)

SUMMARY: Codifies various terms of "Darling vs. Douglas" settlement agreement (Case No. C-09-03798 SBA, United States District Court, Northern District of California), establishing the CBAS, within statute. Specifically, this bill:

1) Makes legislative findings and declarations regarding California's support of the right to live in the most integrated and community-based setting appropriate, and to be free from unnecessary institutionalization.

2) Establishes legislative intent that provides for the development of Medi-Cal policies and programs that:

   a) Continue to assure that elderly, and younger people living with disabilities, are not institutionalized inappropriately or prematurely;

   b) Provide for viable alternatives to institutionalization by assuring the availability of appropriate services;

   c) Promotes adult day health options, such as CBAS, accessible to economically disadvantaged elders and younger adults living with disabilities;

   d) Ensures that programmatic standards offer certainty to providers, regulators and beneficiaries; and,

   e) Complies with California's Bridge to Reform Section 1115(a) Medicaid Demonstration Waiver.

3) Defines CBAS as an outpatient, facility-based program that offers nursing, therapeutic activities, social services, facilitated participation in group or individual activities, social services, personal care services and other, more complex care, when specified in the client's plan of care.

4) Establishes CBAS as a Medi-Cal benefit upon expiration of the Darling vs. Douglas settlement agreement.

5) Establishes eligibility criteria for CBAS services reflecting the criteria of the Darling vs. Douglas settlement agreement.

6) Limits access to CBAS to those enrolled in Medi-Cal managed care (MCMC) in counties where the Department of Health Care Services (DHCS) has implemented mandatory MCMC, with some exceptions; and to those who are Medi-Cal beneficiaries in counties where DHCS has not implemented mandatory MCMC and CBAS is available.

7) Requires that CBAS be provided at licensed Adult Day Health Centers (ADHC) certified by DHCS as CBAS providers.

8) Requires MCMC plans to authorize service, for the same number of days and the same duration, as provided in a Medi-Cal fee-for-service basis, and requires face-to-face evaluations, under certain conditions, as specified.

9) Requires managed care plans (MCPs) to publish an implementation plan that describes the process and criteria to determine member eligibility for services, reauthorization of services, and criteria for determining the number of days of service to be provided.

10) Requires eligibility standards to be no more restrictive, or administrative burdensome, than under the terms of the Darling vs. Douglas settlement agreement.

11) Requires CBAS providers to be "non-profit" entities exempt from taxation under Section 501 (c)(3) of the Internal Revenue Code, as of July 1, 2015.

12) Requires submission of a quality assurance proposal to relevant budget and policy committees of the Legislature after the DHCS has consulted with CBAS providers, MCPs, consumers and consumer representatives, which will address how DHCS will address quality assurance within the CBAS program under managed care.

13) Acknowledges that the terms of the CBAS settlement agreement, as ordered by the Superior Courts of California, shall prevail when programmatic conflicts arise through August of 2014 when the settlement agreement expires.

EXISTING LAW:

1) In partnership with the federal government, establishes the Medi-Cal program, to provide various health and long-term services to low-income women and children, seniors, and people with disabilities.

2) Authorizes DHCS to enter into contracts with MCPs to provide services to Medi-Cal enrollees.

3) Requires eligible families, children, seniors, and people with disabilities to enroll in a Medi-Cal MCP for health care services in specified counties.

4) Establishes the Coordinated Care Initiative (CCI) that required DHCS to seek federal approval to establish demonstration sites in up to eight counties to better serve the state's eligible seniors and persons with disabilities by integrating delivery of medical, behavioral, and long-term care services, and to identify strategies to integrate Medicare and Medi-Cal for people in both programs (dual eligible).

5) Authorizes DHCS to require SPDs who are eligible for Medi-Cal only to enroll in MCMC plans for Long-Term Services and Support.

FISCAL EFFECT: Unknown

PURPOSE OF THE BILL: Currently, no statute authorizes CBAS. The program operates under authority of a court directive scheduled to expire in August 2014, along with an administrative request granted by the federal government through an "1115" waiver. An 1115 waiver allows states to experiment, pilot or demonstrate projects which are likely to assist in promoting the objectives of the Medicaid program. The 1115 waivers are flexible, so states have room to develop Medicaid Plans that suit their state's health care goals.

According to the author, without legislative action, the future of the CBAS program is uncertain after the court directive issued in December of 2011, expires in August of 2014. At that time, program participants risk losing the vital health and social services provided by CBAS, and the state risks further costly court battles and more expensive institutional placements for CBAS participants. Placing the court-ordered CBAS program into statute assures medically fragile Californians and their families' certainty and access to a range of social and health supports delivered in a clinical setting that avoids costlier institutional placements. Like daycare for children in working families, this daytime care model for frail, elder or functionally impaired adults is essential in order to meet the moral, ethical, and legal duties of caregiving families.

BACKGROUND:

HISTORY: In 1978, California authorized the establishment of 5 Adult Day Health Care Programs in Sacramento, San Francisco and San Diego. For the next 20 years, the state extended start-up grants to non-profit entities wishing to provide such services, ultimately reaching a roughly $3.5 million investment amongst about 66 sites. A report at the time issued through the Offices of Senator Henry Mello, identified state cost savings of about $7 for every $1 spent on ADHC, and identified an unmet need of roughly 600 sites. In 1994, SB 1492 (Mello), (Chapter 1121, Statutes of 1994), removed that non-profit tax status restrictions and permitted for profit companies to develop ADHC programs. Upon the passage of SB 1492, the number of centers grew from 72 to over 350 in 2004.

Since the rapid expansion early in the century, a multiplicity of government initiated reforms occurred in what appears to be a partial attempt to acknowledge the growth of the population dependent upon adult day services, and find efficiencies. Significant attention and legislative activity has been focused on the dramatic growth of ADHC centers, and increased Medi-Cal costs for ADHC. Less acknowledged is why this rapid growth occurred, even though Senator Mello's report described significant unmet need.

As the number of centers grew, the former Department of Health services (DHS) expressed concerns that some centers were providing only very limited services, and potentially engaging in Medi-Cal fraud by not complying with state requirements, although wide-spread fraud was never detected. In addition, in 2004 the federal CMS ordered California to change the ADHC program from an optional Medicaid benefit to a home- and community-based program provided through a 1915 (c) Medicaid waiver. As part of the 2004-05 budget, the Legislature instituted a moratorium on new licenses for ADHC, with the intent of enacting program reforms, and the moratorium remained in effect. The California Association of Adult Day Services (CAADS), a professional organization representing ADHC providers throughout California, working

cooperatively with DHS, made several attempts to secure a change in federal law that would protect California's model of ADHC as an optional Medicaid benefit, but those efforts failed. In 2006, SB 1755 (Chesbro: Chapter 691, statutes of 2007) revised eligibility and moved the program to a cost-based reimbursement system. Reforms in 2003 to limit the numbers of days of services was held a violation of an individual's right to live in the most home-like, or "integrated" environment. In 2011, what the legislature intended to be a program reduction turned into a full-scale elimination. Consumers sued in what is now known as the Darling vs. Douglas case, and both the state and the plaintiffs settled on a program to address the immediate and ongoing needs of consumers, known as Community Based Adult Services, or CBAS.

After a decade of instability, the loss of ADHC as an optional Medi-Cal benefit in 2011 nearly devastated an entire industry of day services upon which California's aging population, health care providers and families have come to rely.

COMMUNITY BASED ADULT SERVICES: CBAS assures that, like children, elders and other adults with disabilities that require health monitoring and health supervision and whom are at great risk if left alone, in their homes to fend for themselves, have access to necessary health supervision, services and supports. Nursing homes and other institutional settings are rapidly changing due to shorter hospital stays, better management of chronic illnesses, and changing governmental policies that taken together conspire in an increasing reliance upon home and community-based options to meet the needs of long-term service and support seeking populations. Indeed, the Department of Finance's Demographic Research unit predicts a 10% growth in the general population between 2010 and 2020. During the same period, estimates are that the 65+ population will grow by 44% and the 85+ population will grow by just over 20%.

During the recent transition period that saw the entire case-load of the Adult Day Health Care program assessed, re-assessed, and services re-authorized to roughly 30,000 participants 48 sites with an accumulated case-load of over 3800 participants were shuttered. As former ADHC enrollees began to seek services under the terms of the CBAS settlement agreement, reports of a range of concerns began to emerge. By September 24, 2012 when this committee conducted an oversight hearing on the ADHC to CBAS transition, eligibility determination procedures, treatment authorizations, appeal hearing processes, quality assurance, and access were all at issue. Based on testimony from a range of experts, due to the nature of the fragility and vulnerability of the population seeking CBAS services, questions or uncertainty about eligibility, treatment authorizations, appeal hearings, quality assurance, or access could result in an unnecessary and unintended institutionalization, and anecdotal information collected by the committee verified this misfortune.

Providing permanent codification assures consumers, providers and regulators with a clear articulation of the program parameters to support the needs of dependent adults, define services so providers can focus upon quality and services, and establish a stable apparatus by which to regulate and monitor the service in an efficient and beneficial manner.

PREVIOUS LEGISLATION:

SB 1008 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2012 and SB 1036 (Committee on Budget and Fiscal Review), Chapter 45, Statutes of 2012 authorize the CCI as an eight-county pilot project to: i) integrate Medi-Cal and Medicare benefits under managed care for dual eligibles; and, ii) integrate LTSS under managed care for dual eligibles and Medi-Cal

only SPDs.

AB 96 (Committee on Budget, 2011), would have established the KAFI program, and required DHCS to submit an application to CMS to implement the program. AB 96 was vetoed by Governor Brown.

AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, among other provisions eliminates ADHC as a Medi-Cal benefit.

SB 208 (Steinberg), Chapter 714, Statutes of 2010, contains the provisions implementing Section 1115(b) Medicaid Demonstration Waiver from CMS entitled "A Bridge to Reform Waiver." Among the provisions, this waiver authorized mandatory enrollment into MCPs of over 600,000 low-income SPDs who are eligible for Medi-Cal only (not Medicare) in 16 counties.

SB 117 (Corbett), Chapter 165, Statutes of 2009, extends the deadline by which the DHCS was required to establish a new Medi-Cal rate reimbursement methodology for ADHCs, from August 1, 2010 to August 1, 2012.

AB 572 (Berg), Chapter 648, Statutes of 2008 clarifies requirements pertaining to ADHC hours of service, core staff, and staff absences, transportation services, and meal requirements.

SB 1755 (Chesbro), Chapter 691, Statutes of 2006, establishes new eligibility criteria for ADHC services for the purposes of Medi-Cal reimbursement, required the Department of Health Services, (now DHCS), to establish a cost-based Medi-Cal reimbursement methodology for AHDC services, and establishes daily core services to be provided by ADHC centers to each participant.

POLICY COMMENTS:

1) CHALLENGED BY A LACK OF INFORMATION: AB 518 is intended to codify the terms of the CBAS settlement agreement in state statute in order that this model of service delivery remains available to eligible populations. Compelling demographics, upward pressure of long-term health care costs, and consumer preferences support the need for a reliable, uniform program. Historical misinformation about fraud in the program has never been fully documented. Misinformation about the elimination of the ADHC program and creation of, and migration to, the CBAS program resulted in fear and anxiety among program participants. Even DHCS acknowledged these concerns and extended the timeline for enrollment into the new CBAS program in 2012. Additional information about recent reductions to the program "saving" the state money has not been fully documented.

Recommended amendments:

1) 14590.10 which establishes legislative intent that programmatic standards are codified to offer certainty to providers and regulators. Families, caregivers and beneficiaries need the same level of confidence. Therefore, the following amendment is recommended for 14590.10:

   (e) Ensure programmatic standards are codified to offer certainty to providers ~~and regulators~~**, regulators, beneficiaries, their families, caregivers and communities**.

2) 14590.12 establishes CBAS as a Medi-Cal benefit. The author may wish to consider including language that assures that managed care health plan contracts include provisions of CBAS services.

   14590.12. Notwithstanding the operational period of CBAS as specified in the Special Terms and Conditions of California's Bridge to Reform Sections 1115(a) Medicaid demonstration (11-w-00192/9), and notwithstanding the duration of the CBAS settlement agreement, case no. C-09-03798 SBA, CBAS shall be a Medi-Cal benefit, **and shall be included as a covered service in contracts with all managed health care plans, with standards, eligibility criteria, and provisions that are at least equal to those contained in the demonstration that is operative at the time of enactment of this section. Any modifications to the CBAS program that differ from the Terms and Conditions of the Demonstration shall be permitted only if they offer more protections or permit greater access to CBAS.**

3) 14590.19 calls for the DHCS to submit a plan for quality assurance within the CBAS program. 14590.19 should be amended as follows:

   14590.19 On or before July 1, 2014, and after consultation with CBAS providers, managed care plans, consumers, and consumer representatives, the department shall submit to appropriate legislative budget and policy committees for review and comment a quality assurance proposal, which shall specify how the DHCS will address quality assurance in the CBAS program ~~under managed care~~.

This bill passed out of Assembly Health on April 9th with a vote of 19-0.

REGISTERED SUPPORT / OPPOSITION:

Support

Community Clinic Association of Los Angeles (CCALAC)
County Welfare Directors Association (CWDA)
LeadingAge California (formerly Aging Services of California)
National Association of Social Workers, California Chapter (NASW-CA)

Opposition

None on file.

Analysis Prepared by: Robert MacLaughlin / AGING & L.T.C. / (916) 319-3990