

Costs and Consequences:
Elimination of the Adult Day Health Care Medi-Cal Optional Benefit

BACKGROUND

Decades before California began grappling with chronic budget crises, the state led the nation in innovative home and community-based services to individuals who require assistance with health conditions and activities of daily living. During the mid-1970s, Adult Day Health Care (ADHC) emerged from the successful On-Lok integrated services model in San Francisco for persons receiving Medicare and Medi-Cal benefits. ADHC quickly gained popularity as an alternative to institutional care facilities during highly publicized and disturbing media accounts of nursing home abuse and neglect. By the early 1980s, California policymakers seized upon ADHCs as a cost-effective and more humane alternative for those who needed intermittent medical supervision.

Adult Day Health Care (ADHC) is a Medi-Cal "optional" benefit that treats the health and supportive needs of older adults with multiple, chronic conditions in a medically supervised day setting. According to the California Association of Adult Day Services (CAADS), the average profile of an ADHC client is an impoverished female, 78 years old, with three or more chronic diagnoses, who is dependent upon others for a range of supports. ADHCs also provide specialized care to individuals who have Alzheimer's Disease or other dementia, stroke-related conditions, chronic disorders such as cardiovascular disease, diabetes, neurological disorders, head or spinal cord injuries, developmental disabilities, and mental illnesses. The goal of ADHC is to manage the conditions in order to prevent or delay placement into nursing homes or other, costlier settings while improving and preserving each individual's physical and mental health, and improving their quality of life. A typical day in an ADHC program costs approximately \$76.

Each ADHC center has a multidisciplinary team of health professionals who conduct assessments of each potential participant to determine and plan the ADHC services needed to meet the individual's specific health and social needs. Services provided at the center include: medical services; nursing and personal care services; physical,

occupational and speech therapy; psychiatric and psychological services; social services; therapeutic activities; hot meals and nutritional counseling; and transportation to and from the center.

The program stresses partnerships with the participant, the family, the physician, caregivers, and the community to promote and achieve individual independence. In some situations, individuals already institutionalized may be placed back in the community with ADHC assistance and support services.

ISSUES

Aging: The aging population in California is expanding, as is the number of people with disabilities. The California Department of Finance's Demographic Research Unit estimates that California's 65+ population will grow by 43 percent from 4.4 million in 2010, to 6.35 million by 2020. Then, another 39 percent increase to 8.83 million by; and another 21percent growth to an astounding 10.5 million Californians over the age of 65 by 2040. The ratio of older Californians in the population will climb accordingly. In 2010, the Department of Finance estimated that 11.25 percent, or about 1:10, of California's population was aged 65+. By 2040, 19.4 percent of the population, or approximately 1:5, will be 65+. Disabilities will increase, as will the dependent relations that stem from them. Besides the predictable disabilities that will come with age, is adequate attention given to the impact of special populations, such as persons living with Autism, or AIDS, or Alzheimer's? These three "special" populations alone are projected to grow, notwithstanding "normal" demographic aging issues, and will undoubtedly impact the state's capacity to offer support and service options. How can policy makers respond to the measurable demographic changes California is currently experiencing? What strategies can be deployed to change attitudes toward dependent adult care? How do we staff, fund and protect the exploding "special needs" groups (Autism, AIDS and Alzheimers)? Returning veterans are another significant population with special needs, including high numbers with Traumatic Brain Injury and Post Traumatic Stress Disorder and Military Sexual Assault.

Budget: In response to the state's deteriorating financial condition, Governor Brown proposed the elimination of ADHC in his 2011-12 budget proposal. Previous efforts to reduce the state's exposure to Medicaid (Medi-Cal) obligations through the use of utilization caps and the elimination of Medi-Cal "optional" benefits had resulted in mixed outcomes. When third parties sued the state in response to proposed cuts, the courts consistently upheld California's right to eliminate "optional" benefits, and further prohibited the state from capping or reducing general Medi-Cal benefits.

The Legislature rejected the Governor's wholesale elimination proposal, instead proposing a scaled-back alternative known as "Keeping Adults Free from Institutions," or KAFI. Through trailer bills, the Legislature adopted the elimination of ADHC, advancing AB 96 with the conceptual KAFI framework, allocating \$85 million to fund the program along with 100 percent federal matching funds, boosting the total to \$170 million.

On Monday, July 25, AB 96 was vetoed by Governor Brown citing, "(i)t does not address the immediate need to transition ADHC beneficiaries to other home and community-based services that can meet their needs, and would cause confusion for both consumers and providers about when an ill-defined KAFI program would be available."

The message continued, "In order to ensure that ADHC beneficiaries do not face the risk of unnecessary institutionalization when the benefit expires, my Administration is currently working with adult day health centers, managed care plans and local community-based organizations to ensure that needed medical services and home and community-based services are available. Additionally, in order to ensure that there is enough time for transition to such services, the Department of Health Care Services (DHCS) recently extended the ADHC benefit through administrative action until December 1, 2011, with federal funding approval."

Alternatives: The DHCS states that other similar Medi-Cal services would still be available if ADHC services were eliminated, including:

- Home Health Services;
- In-Home Supportive Services;
- Physical and occupational therapy;
- Clinic services that would include dietitian, physician, social worker, and nursing services; and,
- Physician Services through the individual's medical health care provider.

A spokesperson for DHCS has indicated that, "We've been planning for months on a comprehensive transition plan. This veto simply moves forward our plans and moves us further toward a good outcome." The \$85 million remains allocated to DHCS, who submitted a request to eliminate ADHC to the federal Centers for Medicare and Medicaid Services (CMS), and was granted permission to close the program on

September 1, 2011, but has administratively extended that deadline until December 1, 2011.

Legal: In the meantime, consumers sued the state to prevent the closure of ADHC sites until alternative services that would not harm or institutionalize existing clients are identified. A hearing to vet arguments for and against the suit was initially set for July 26, 2011, and then postponed until November 1, 2011.

Given the compressed timelines available to transition approximately 35,000 ADHC enrollees from the ADHC program into other community-based supports and services, Assemblymember Mariko Yamada, Chair of the Assembly Committee on Aging and Long-Term Care, has scheduled an oversight hearing to collect information about DHCS activities. Some of the Chair's and Committee's concerns are:

- The number of clients involved in each stage of the transition process;
- Tracking clients and documenting placements in the 17 ADHC's that have already closed;
- The progress DHCS is making assessing each clients' needs;
- The DHCS strategy to address service gaps;
- A description of coordination efforts;
- Strategies to reduce exposure of clients to the effects of transfer trauma;
- Implementation of discharge plans;
- A description of considerations given to rural areas lacking the infrastructure available in urban areas, such as managed care, and strategies the department has identified or undertaken to meet those needs; and,
- Challenges DHCS is facing in meeting the elimination mandate.

Jobs: In addition to the 35,000 clients whose care needs will be transferred and transitioned, some 300 centers employing approximately 7,000 Californians may face certain closure and job loss. Some strategies to reduce the impact of closure have been suggested, and include:

- Incorporating the services and benefits of some sites into managed care service contracts;
- Deeming ADHC as eligible to serve clients with lesser, non-medical needs; and,
- Incorporating ADHC, when appropriate, into Program for All-inclusive Care for the Elderly (PACE) programs.

OTHER

Previous cost-containment efforts regarding ADHC services have included the following:

- In 2004, a statutory moratorium was placed on the expansion of ADHC providers. This remains in place and only the Director of DHCS has the discretion to add more providers.
- In 2009, on-site treatment authorization reviews (TARS) were implemented to reduce expenditures by \$1.6 million (\$824,000 General Fund) in 2011-12.
- In 2009, trailer bill legislation enacted medical acuity criteria. The intent was to focus ADHC services on the most medically acute individuals. The DHCS has estimated this would reduce expenditures by about 20 percent. This action was enjoined by the court. The State has filed an appeal.
- In 2009, trailer bill legislation limited the number of days an individual could receive ADHC services to three days per week, except for individuals with developmental disabilities receiving services through Regional Centers (these individuals were not limited). This action was enjoined by the court and the state is not intending to file an appeal.