Informational Hearing
of the
Assembly Committee on Aging and Long-Term Care

"The Community Based Adult Services Transition:
Impacts to Participants, Families and Communities"
Assemblymember Yamada, Chairperson

Monday, September 24, 2012
State Capitol, Room 126
1:00 – 3:00 p.m.

ISSUE PAPER

BACKGROUND

Since December of 2011 when a settlement agreement mitigating the elimination of the Adult Day Health Care (ADHC) Program by establishing the Community-Based Adult Services (CBAS) Program was initially published, the Department of Health Care Services has performed extensive preparations in the form of trainings, webinars, written notifications, counseling, and coordination, to achieve the settlement agreement's goals. Correspondingly, legislative offices have received notices of concern from consumers and providers describing loss of benefits, confusion, financial uncertainty and barriers to care. Today's hearing is an opportunity to publicly discuss the impact of the ADHC to CBAS transition upon participants, their families, and the communities that support adult day programs and services.

The Community Based Adult Services (CBAS) was created by a settlement between the State of California and Adult Day Health Care (ADHC) consumers who sued to block implementation of AB 97 (Chapter 3, Statutes of 2011), a budget trailer bill which repealed the ADHC program. AB 97 was signed by Governor Brown on March 24, 2011. A state-plan amendment was subsequently filed with the Centers for Medicare and Medicaid Services to activate the elimination of ADHC in California. On June 27th of that year, ADHC clients concerned about the loss of benefits for which there were no identifiable replacement services, filed for an injunction against the elimination of ADHC. Approval to eliminate ADHC was granted by CMS on July 1, 2011, and elimination was scheduled for September 1, 2011. By July 12th, the US Department of Justice weighed-in with their observation that elimination of ADHC may deprive recipients of important rights related to receiving care in the least restrictive setting. Subsequently, DHCS requested permission to delay elimination of the ADHC optional benefit until December 1, 2011. On November 17, 2011, both the

state and the ADHC clients facing the loss of benefits agreed to a settlement creating CBAS as an alternative to ADHC.

During this period, the Legislature introduced and passed legislation creating a smaller, though similar program to ADHC called, Keeping Adults Free of Institutions, "KAFI." Eighty five million was appropriated to support the program, though Governor Brown vetoed the legislation.

Adult Day Health Care (ADHC): Previously, consumers of ADHC received a Medi-Cal "optional" benefit that treated 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 was an impoverished female, 78 years old, with three or more chronic diagnoses, who is dependent upon others for a range of supports. ADHC also provided 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 was 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.

Community-Based Adult Services (CBAS): CBAS, the temporary replacement program mandated by the settlement agreement is nearly identical to ADHC. Effective April 1, 2012, the CBAS program was established under California's "Bridge to Reform" 1115 Medicaid waiver. Like ADHC, CBAS is an outpatient, facility-based program that delivers skilled nursing care, skilled social services, skilled therapies, personal care, meals, transportation and caregiver training and support. The majority of CBAS beneficiaries are dually eligible for Medi-Cal and Medicare. Under the terms of the settlement, most beneficiaries must enroll into a Medi-Cal managed care plan to get the CBAS benefit. CBAS will provide services roughly equivalent to those offered at ADHC centers, and funded at the same rate, for patients who qualify. Eligibility is based on medical need for those who are at risk for institutionalization. The difference between CBAS and ADHC is that CBAS will provide enhanced case management at home for those who are not in *imminent danger of institutionalization*. All patients who want to receive these benefits -- whether it's CBAS-eligible patients or the ones who receive more intensive case management service at home -- will need to enroll in a managed care plan. CBAS currently functions as a managed care benefit in all 13 of California's "County Organized Health System," or COHS counties. "COHS" counties and their favorable integrated administrative environments are already functioning as mandatory managed-care systems for Medi-Cal enrollees, and therefore,

transition in COHS counties may not necessarily be comparable to transition in other counties where a fragmented administrative environment creates numerous challenges for providers.

DHCS has worked to educate beneficiaries about how to enroll in a Medi-Cal managed care plan to keep their CBAS benefit. Despite these efforts, a large number of beneficiaries have opted to remain in Medi-Cal fee-for-service, which means they will no longer be eligible for CBAS benefits. Throughout the course of the settlement process concerns have been raised about eligibility assessments, appeals to determinations of ineligibility and various barriers to access.

During the corresponding periods of patient eligibility determination, many CBAS centers have extended care to previous ADHC clients awaiting appeal of ineligibility determination outcomes. Appeals to determinations of ineligibility have proceeded in a deliberate manner. According to DHCS, some 2000 appeals of ineligibility determinations have been filed, though fewer than 100 cases have been adjudicated. Many appeals were initially filed in the spring and early summer.

Services extended to those clients are not officially authorized by DHCS and are therefore not reimbursable. In many of those situations, facilities are faced with the choice to send clients who demonstrate significant self-care deficits home, exposing them to avoidable risk, or to provide unauthorized and unreimbursed care which places the CBAS provider business model at financial risk, and potential for permanent closure and community-wide loss of service.

Today's Hearing: Today's hearing of the Assembly Committee on Aging and Long-Term Care is intended to provide oversight while responding to a growing number of constituent concerns regarding the ongoing transition of ADHC to CBAS. Director Toby Douglas of the California Department of Health Care Services has been asked to provide detailed testimony on the following:

- **Costs/Savings:** Total costs of the transition process to date including appeal hearing costs and penalties to-date, with projections through July 1, 2013.

- **Appeal Hearings:** Number of filed, conducted, and adjudicated appeals in response to negative eligibility determinations for CBAS. Average waiting period from date of request for a hearing to the date of a hearing, and information about hearing results.

- **Treatment Authorization Requests:** Department protocol for handling CBAS treatment authorization requests (TARs) submitted to the Department, TAR

reauthorization protocol, and Department capacity to comply with the 30-day limit provided in the Welfare Institutions Code.

- **Eligibility Denials:** Number of clients deemed ineligible for CBAS. Comparisons of December 2011 through March, 2012 data with April, 2012 through present data. Descriptions and explanations of variations amongst Medi-Cal field offices. Also an explanation of protocols that ensure uniform application of statewide criteria in determining eligibility.

- **Quality Assurance and Monitoring Tool:** A description of how the "quality assurance" review process is allowed under the settlement agreement, and the monitoring tool used to measure CBAS access, and the impact of institutional admissions resulting from decreased access to adult day services.

Litigation: It should be noted that as of September 15, 2012, attorneys representing consumers filed a motion for among other things, appointment of a "special master" citing violations of the terms of the CBAS settlement agreement relating to eligibility assessments, and impeding access to services. DHCS responded on August 18 with a response refuting the plaintiff's assertions. Nonetheless, DHCS and Disability Rights California, the parties to the pending motions filed in the US District Court have agreed to participate in today's hearing. Consumers are represented by Disability Rights California, the National Senior Citizens Law Center, the National Health Law Forum, AARP Litigation Foundation, and Morrison & Forrester. The California Department of Justice is representing the Department of Health Care Services.