

Features

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Will Ending Adult Day Health Care Services Save State Money?

by David Gorn, California Healthline Sacramento Bureau

The California Department of Health Care Services recently sent a letter to most Medi-Cal beneficiaries participating in the adult day health care program, informing them that their coverage for ADHC will end Dec. 1. Medi-Cal is California's Medicaid program.

In Sacramento, legislators are holding hearings on how to help 36,000 elderly and disabled residents continue to receive ADHC-type services in other programs. A lawsuit pending in federal court challenges whether the state can adequately supply replacement services for this population. ADHC providers have accused the department of bad planning for rushing elimination of the services.

All of this turmoil is predicated on one basic outcome: saving money for the state.

In previous budget cutbacks, adult dental services were eliminated as an optional Medi-Cal benefit along with speech therapy, vision services, chiropractic and podiatric care. Now it's ADHC's turn.

The ADHC transition is a kind of pilot project for California, which aims to transition many more individuals who are eligible for both Medicare and Medi-Cal into managed care. But advocates say that the ADHC population should be treated more carefully and more slowly, arguing that a rapid transition threatens the well-being of at-risk elderly and disabled residents.

"This is a human experiment on a scale we haven't seen in California, that's what we're embarking on," Lydia Missaelides of the California Association of Adult Day Services said. "There is no road map, because this has never been done before."

According to DHCS Director Toby Douglas, the ADHC transition is required by law and is a challenge the department can accomplish.

"The majority of these people will be served by our managed care plans," Douglas said. "We have deliberately slowed down the process, so we make sure we do it right. We want these people to be able to remain in the community."

Covering Multiple Needs

Jane Ogle, deputy director for DHCS, said relying on managed care plans for ADHC services could help save the state money.

"I see the savings in the transition and use of capitation payment to provide benefits to these members," Ogle said. "That's the bulk of the savings."

The idea, in shifting to managed care, is that the health plans get a chunk of money, a per-head or capitated rate, for each enrollee up front. Under capitation in a general population, the thought is that healthier people will use fewer services and balance out the costs of sicker enrollees.

That notion doesn't really apply to the ADHC population, according to Debbie Toth, who runs two ADHC centers in Contra Costa County.

"This is the most expensive, most fragile population in the state," Toth said. "This is an adverse selection population."

One-fourth of ADHC beneficiaries -- about 9,600 of them -- have dementia. Another 2,000 have mental disabilities, 17,000 have a psychiatric diagnosis, 14,000 are incontinent and almost 19,000 need restorative physical therapy. Almost 29,000 beneficiaries require skilled nursing services.

To account for ADHC beneficiaries with multiple conditions and high use of services, the state will chip in an additional \$60 per person monthly enhanced capitation benefit for the health plans, Ogle said.

But most ADHC beneficiaries could burn through that money without even blinking, Toth said. "Are they going to get all of these services for \$60 a month?" she asked. "That's one hour of staff time a month, if you're talking about intensive case management, done by a nurse. One hour a month."

Douglas has said that once assessments of new managed care enrollees are completed, DHCS might increase the enhancement.

Ogle said the state also can step in to help enrollees who need extra services beyond what managed care plans will cover.

For instance, some beneficiaries could be enrolled in the Los Angeles-based Senior Care Action Network, and the state also expects to expand the number of slots in the Program of All-Inclusive Care for the Elderly. Some rural residents will be served by a care management contractor. DHCS also might contract with some existing ADHC centers.

Ogle said that the state intends to add spots for 1,000 more people in both the Multipurpose Senior Services Program and In-Home Operations federal waiver program. In-Home Supportive Services program hours also could expand, she said.

Following the Money

It is still unclear how much all of those programs will cost the state and exactly how many beneficiaries they will cover, Ogle said. It is also not definite how much money will be spent during this transition, and how much will be spent in the future.

The state has allocated \$85 million to end ADHC as a Medi-Cal benefit. About \$42 million funded a three-month extension of the ADHC program.

That leaves the state with \$43 million for the transition, including outreach, the administrative cost of tracking and enrolling ADHC beneficiaries in a managed care plan, expanding the two waiver plans, the \$60 per person monthly enhancement, the rural contractor, additional money for PACE and extending IHSS hours.

"We're not planning for it to exceed the \$85 million," Ogle said.

However, the state likely will incur yearly costs after the transition to maintain ADHC services.

Providing the \$60 enhanced managed care payments will cost \$24.5 million annually. The additional waiver slots, the additional IHSS hours, the PACE commitments, the contracted services also will be annual costs.

Whatever those annual costs are, they likely will be lower than last year's \$170 million ADHC budget. At the moment, no one knows where, exactly, that money will come from.

"I imagine it would be a general fund expense," Ogle said, "but we haven't even started the budget for next year."

Savings Evaporate in Nursing Homes

ADHC advocates think the state will spend a considerable amount of money in the next year or two and ultimately provide fewer services. The biggest expense will come if former ADHC beneficiaries receive nursing home care.

"The rule of thumb is, it's five times more costly to be in a nursing home than in ADHC," Missaelides said. "You're looking at care 24/7 for 365 days a year, when you're talking about three days a week for ADHC."

According to a survey Missaelides' organization conducted with its ADHC center directors, without ADHC services, about 25% of patients would be placed in nursing facilities within 30 days. About 87% of them -- about 33,000 people -- would show up in emergency departments within 90 days, according to the survey.

Those kinds of numbers are what the state hopes to avoid. By making an especially strong effort to find appropriate services for an estimated 7,000 "frail and at-risk" patients, DHCS expects to keep the ADHC population living at home and out of the ED.

Many in the ADHC community have Nov. 1 circled on their calendars. That's the day a federal court will consider a lawsuit filed by Disability Rights California claiming the state must provide a program to replace ADHC because there are simply not enough services similar to ADHC to go around.

'No Place for These People To Go'

In a recent legislative hearing, Assembly member Holly Mitchell (D-Los Angeles) tried to put the situation into perspective.

"This morning, I had one of those 'Aha!' moments," Mitchell said, "and it was recognizing that we need to be putting more money into ADHC [for this transition], and recognizing that's not the case. The transition, I'm assuming, is finite. It's not open-ended. My concern is: transition to what?"

Mitchell pointed out that people use ADHC services for a reason and that even if some of them receive similar services after the transition is complete, there will be many more who won't get those services.

"The transition to managed care, that's just how we follow the money," she said. "But the actual services, that infrastructure will be gone."

Mitchell paused and spoke directly to DHCS' Douglas.

"So my 'Aha!' moment was, 'It's a new day.' And that the reality is, there will be no place for these people to go," Mitchell said. "The reality is, X number of people will simply not be served. Is that not a true statement?"

Douglas responded that there was some truth in that. "It's both a 'yes' and a 'no,'" he said. "No question it's a new day. But given the resources, we're trying to provide the continuum of care."