



A Brief Analysis of the Inadequacies of the ADHC “Transition Plan”

INTRODUCTION

Frail elders and their families across the state will soon feel the loss of Adult Day Health Care (ADHC) services in their communities. As part of the recent state budget deal, ADHC was eliminated as an optional Medi-Cal benefit to save the state \$88 million out of a total of \$177 M (the transition plan has an \$85 M appropriation). On December 1, 2011 more than 35,000 people who are aged, chronically ill with complex conditions, and living at the poverty level, will be “involuntarily discharged” from 300 local ADHC centers.

ANALYSIS OF PROGRAMS HIGHLIGHTED IN THE “TRANSITION PLAN”

The following sections provide a snapshot of the various alternatives referenced in the “Transition Plan” as well as the facts related to appropriateness, access and availability of these alternatives for current ADHC patients and their families.

1. In-Home Supportive Services (IHSS) has been characterized by the state as a viable transition option available in every county for current ADHC patients that will provide the necessary supportive services for this vulnerable population. **REALITY:** The services provided by IHSS address only non-skilled support with tasks related to activities of daily living, not skilled medical, nursing or therapy care. DHCS states that 63% of IHSS workers for ADHC beneficiaries are family members. Adding more IHSS hours only increases the burden on family caregivers.

2. Medi-Cal Managed Care Plans are noted by DHCS to be “available to ADHC participants and will provide care coordination and case management services as part of their benefit package.” DHCS has stated they will automatically enroll dually eligible ADHC patients into Medi-Cal managed care plans, if available in their community. **REALITY:** According to the state’s own data, the vast majority of ADHC patients (83%) are dually eligible (covered by Medicare and Medi-Cal insurance). For the first time, and contrary to SB 208 provisions governing the 1115 waiver’s treatment of dual eligibles, ADHC duals will soon be automatically enrolled in Medi-Cal managed care plans, even though Medicare pays for their medical care.

Outpatient care, hospital, physician, hospice, short-term restorative therapies and pharmacy benefits for duals are covered by *Medicare* benefits. There are few Medi-Cal-only services remaining for the plans to coordinate. If a patient does not want to enroll in a plan, he/she will have to take the necessary steps to “opt-out” from the plan. National experts have strongly advised against the “opt-out” model for dual eligibles because of the unique characteristics of this population. Navigating managed care plan disenrollment processes, let alone “member services” telephone menu systems, is a significant challenge.

Medicare Special Needs Plans (SNPs) can enroll dually eligible beneficiaries and some offer case management services for “special needs individuals.” **REALITY:** There are a limited number of SNP service areas in California (33 plans for duals, 18 plans for those with specific limited chronic disabling conditions).

3. In-Home Operations Waiver is suggested as an alternative for ADHC patients involuntarily discharged as a result of the elimination of the ADHC program. **REALITY:** This waiver is designed for people transitioning out of nursing facilities so it is not clear how it will be utilized for the ADHC population. DHCS recently stated that it is changing the waiver criteria in cooperation with CMS, and adding another 500-1,000 waiver “slots” but no description of the changes to the plan have been made public.

4. APS Healthcare, Inc. (APS) contracts with states and private businesses to conduct health assessments, care coordination and case management services. The DHCS will “expand its contract with APS,” which is a New York-based publicly-traded company. **REALITY:** APS is a company that is unfamiliar to local, community-based service providers. It is not clear how APS has performed in California. Is this option less costly than using the three (3) local community-based non-profit ADHCs that are within the rural counties without managed care? Recent interviews with APS have revealed they plan to offer telephonic care coordination to 95% of ADHC patients in the rural communities, which indicates a serious misunderstanding of the complex population currently in ADHC.

5. Program for All-Inclusive Care for the Elderly (PACE) is noted by the DHCS as another service available to provide care coordination for patients displaced from ADHC. **REALITY:** While an appropriate care option, PACE programs only serve adults who are at least 55 years old and certified by the state to need Nursing Home level of care. There are five PACE organizations operating 20 “PACE Centers or sites.” To receive PACE services, a patient needs to reside within a designated zip code area, and turn over all medical and social support care to PACE.

6. Area Agencies on Aging (AAA) provide Information and Assistance (I&A) services based on the availability of resources and agencies in their communities. **REALITY:** Community-based supportive service options for even the healthiest of older Californians are few. Most of the resources and services administered by the AAAs have experienced funding reductions, further diminishing their efficacy as realistic options for “alternative services.” The transition plan fails to recognize that affordable and accessible transportation services in local communities are limited for this complex population. In contrast, ADHC offers medical and social services at one location, eliminating the need to piece together transportation services to access a variety of health providers.

7. Multi-Purpose Senior Services Program (MSSP) is a Home and Community-Based case management program that is administered by either an Area Agency on Aging or non-profit entity. **REALITY:** MSSP may meet some of the care needs of ADHC patients, but the program is not statewide, has a limited number of openings and operates with long waiting lists. The program serves Medi-Cal-only beneficiaries (with no share of cost) who are at least 65 years of age residing in a particular region and certified for nursing home placement. Over the past two years, MSSP funding has been reduced by \$2.5 million (or 24%), forcing providers to dramatically reduce services and lay off staff. Recently, DHCS announced that up to 1,500 additional slots were being added to the MSSP waiver. Coming on the heels of recent budget reductions, this action took the MSSP providers by surprise and it remains unclear how this expansion will take place and whether MSSP can gear up quickly enough to enroll and have a service plan in place to meet a December 1 deadline.

IN SUMMARY

Individuals and their family caregivers now served by ADHC are faced with the formidable task of finding other types of long-term care and health services in order to remain in their homes. Instead of providing clarity and guidance, the transition document provided by the DHCS, like California’s long-term care services system, is piecemeal and further fragments care for this vulnerable population.

As a result of the passage of the Affordable Care Act of 2009, California has the opportunity to build upon what has worked and is working. Instead, the state appears to be moving backward by removing a health care choice that integrates medical and social services in a safe out-of-home environment for “at risk” individuals who would otherwise be admitted to emergency rooms, hospitalized or placed in nursing facilities.