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An 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. These centers are staffed with teams of care professionals who have helped ADHC patients maintain their health, connections in their communities and avoid costly nursing home placement. ADHC costs represent a tiny fraction (two-tenths of one percent) of the state's total budget.

Individuals approved by the state for enrollment in ADHC are by the state's own definition among the most high-cost and high-care individuals served in the health care system. Their multiple medical conditions must result in significant deficits in their ability to function and must warrant skilled nursing care and social service supports and services each day of attendance. They must have multiple chronic disabling conditions, require complex medication management from a skilled nurse, suffer from isolation with little or no social support and have suffered from years of poor access to health care. This combination puts them at significant risk of nursing facility placement; ER admissions; and hospitalization.

This transition of ADHC dual eligible beneficiaries is taking place in advance of the SB 208 1115 waiver framework for moving dual eligibles into managed care in four pilot project counties, expected to commence in 2012. Counties participating in this pilot project have not been selected.

Transition Plan Toward Elimination

The Department of Health Care Services (DHCS) published a document entitled, "Adult Day Health Care (ADHC) Transition" (also described as a "Transition Plan") that was distributed to all ADHC providers via email on July 1, 2011. An additional document referenced as a "Resource Guide" was sent with the Plan to all ADHC providers. The "Resource Guide" (specific to the City of Los Angeles) is a DRAFT two-page chart listing several community-based programs and services with corresponding telephone numbers and web sites.

On August 5, 2011 at 5:00 PM, an updated Strategy and Plan was released by the Department of Health Care Services via email. Much of the updated strategy and plan was repetitive of the earlier document but some additional details were revealed.

The "Transition Plan" implies that the DHCS is diligently addressing alternative care options for current ADHC patients who will be transitioned out of ADHC centers and into comparable long term care services and programs.

However, the August 5, 2011 updated "Transition Plan" remains inadequate because:

1) Most programs or services cited in the transition plan are not available statewide and have rigid eligibility requirements or capacity.
2) Eligibility restrictions associated with options prevent access for many thousands of ADHC patients.
3) Many programs and services listed as options do not have the necessary expertise or capacity to meet all the complex medical and social service and support needs of ADHC patients that today are provided under one roof.
4) The heavy reliance on Medi-Cal managed care organizations in advance of implementing the 1115 waiver pilot projects for dual eligibles is highly questionable because the Medicare and Medi-Cal systems are not designed to work in tandem; the transactional and service costs are greater than the Plans **capitated** rate to serve the more medically and socially complex ADHC population; the Plans are not required to coordinate care across Medicare and community-based systems; and the few Medi-Cal services that are under the control of the Plans are insufficient to meet the ongoing needs of the ADHC population.

Programs Highlighted in the "Transition Plan"

The following section provides 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)

IHSS has been characterized by the state as a viable transition option for current ADHC patients that is available in every county and can provide the necessary supportive services for this vulnerable population. IHSS provides in-home care services for individuals with limited incomes who are disabled, blind or at least 65 years of age.

REALITY: IHSS is designed as a non-medical service provided by an hourly worker hired by the client or by a family member designated to be the IHSS worker to assist with tasks related to activities of daily living, or instrumental activities of daily living. It does not provide skilled professional services. DHCS states that 63% of IHSS workers

for ADHC beneficiaries are family members. Adding more IHSS hours only increases the burden on family caregivers.

- Monthly services hours are capped at 195 hours per month for non-severely impaired applicants and at 283 hours per month for the severely impaired, out of 720 possible hours in a month. Often these hours fall short of what families need to keep current ADHC patients safely at home. Those who require 24-hour supervision or care frequently are those with Alzheimer's disease or other neurological disorders, or who are severely disabled and cannot be left alone.

- Hours are calculated based on discrete tasks such as shopping, meal preparation, bathing, assistance with dressing. Substituting IHSS for ADHC does not replace the ADHC care hours lost because there is little overlap of services.

- Increasing the IHSS hours will not have any net benefit to the patient because family members are already providing around-the-clock care in addition to their IHSS hours.

- Needs assessments, which are conducted by the County Social Services Agency, are required for each client at the time of application. As part of the "involuntary discharge" planning process, local ADHC providers have reached out to IHSS programs to help their patients and their families prepare for a transition. In these discussions, some IHSS programs have indicated that they cannot process new clients until after local ADHC centers close, and some have noted that the assessment process for eligibility will take up to eight (8) weeks. Following approval of additional hours, there are challenges in finding and screening additional workers as many IHSS providers are unable to take on additional hours.

- The majority of IHSS benefits (hours for caregiving in the home) are paid to family members of the IHSS recipients (approximately 60%). Most IHSS family members or friends that serve as caregivers typically are not skilled health care providers. IHSS workers are not skilled in monitoring medical symptoms and the de-stabilization or exacerbation of medical, cognitive and psychological conditions; however, ADHC skilled professionals can and do identify these critical changes while the cost of intervention is still low.

- Consequently, families frequently contact ADHC staff with questions and concerns. Increasing the IHSS hours will not have any net benefit to the patient because family members are already providing around-the-clock care in addition to their IHSS hours. In contrast, ADHC centers provide skilled nursing care, physical, occupational, and speech therapy as needed, and skilled psychological services with licensed and credentialed personnel who not only provide direct care but serve as "eyes and ears" for the physician and family.

- The FY 2011-12 state budget contains a special trigger mechanism that could reduce IHSS hours by 20% across-the-board should revenue projections fall short of the budgeted amount at the end of 2011. This would leave patients

discharged from ADHC effective December 1, 2011 vulnerable and without other options to replace lost hours.

2. Medi-Cal Managed Care (Section 1115 Waiver, aka "Bridge to Reform")

DHCS asserts that "plans are available to ADHC participants and will provide care coordination and case management services as part of their benefit package."

REALITY: According to the state's own data, the vast majority of ADHC patients (83%) are dually eligible (covered by both Medicare and Medi-Cal). For the first time, and contrary to SB 208 provisions governing the 1115 waiver's cautionary approach to enrollment of dual eligibles, ADHC duals will be enrolled in Medi-Cal managed care plans by October 1, 2011.

In the Transition Plan, the DHCS references the "the movement of these clients into managed care," as a "prelude" to the "dual integration project" scheduled to "occur after 2012." Currently, Medi-Cal managed care plans are available in 29 counties.

Currently, Medicare managed care and Medi-Cal managed care plans are not designed to work in tandem. In fact, these different plans operate as two distinct and independent organized delivery systems with no coordination of care between them. The Medi-Cal Managed Care contracts do not address coordination with *Medicare* benefits because the contracts were written to address the needs of Medi-Cal-only (SPD) patients, not dual eligibles.

- **It is not clear how care coordination will occur between the Medicare Advantage Plan's primary care physician and the Medi-Cal Managed Care Plan's assigned primary care physician,** for those dually eligible patients that are already enrolled in a Medicare Advantage Plan and then automatically enrolled by the state into a Medi-Cal Managed Care Plan. Will the patient have two physicians assigned – one under Medicare and one under Medi-Cal Managed Care?

- **Medicare** benefits cover outpatient medically necessary care, hospital, physician, hospice, short-term restorative therapies and pharmacy benefits for dually eligible.

- **Few Medi-Cal-only** services remain for the plans to coordinate and even those few are not designed to be provided over the long term to meet chronic health needs. The following Medi-Cal services were eliminated as benefits over the past few years:
  - Acupuncture (not covered by Medicare)
  - Adult dental services (not covered by Medicare)
  - Audiology services (not covered by Medicare)
  - Chiropractic services (not covered by Medicare)
  - Incontinence washes and creams (not covered by Medicare)

- Dispensing Optician services, including services provided by a fabricating optical laboratory (not covered by Medicare)
- Podiatry services (Medicare covers only if medically necessary)
- Psychology services (Medicare does not cover)
- Speech therapy services (Medicare covers only if medically necessary with the expectation of restoring function, not for maintenance of function)

- Remaining Medi-Cal services not covered by Medicare include private duty nursing; non-emergency medical transportation; limited hospital days not covered by Medicare; and durable medical equipment not covered by Medicare.

- **Behavioral health services, MSSP, IHSS and ADHC are "carved out"** of Medi-Cal managed care, along with long-term nursing facility stays (enrollees must be disenrolled from Medi-Cal managed care within 60 days on a nursing facility placement), unless part of a County Operated Health System (COHS) managed care plan.

Beginning in June 2011, DHCS began mandatory enrollment of Medi-Cal-only "Seniors and Persons with Disabilities" (SPDs) into Medi-Cal managed care plans. The SPD enrollment was planned to take 12 months to roll out, with enrollment based on a beneficiary's month of birth. The ADHC benefit ends only 5 months into the time period for mandatory enrollment of SPDs into managed care. It is not clear what happens to those SPDs who lose ADHC and are not yet enrolled in a Medi-Cal plan.

- There is documented concern among numerous stakeholders who participated in the 1115 waiver process that plans will not have the resources and expertise to adequately address the unique needs of SPDs, let alone dual eligibles, who, by definition, are the most needy and costly group of publicly insured persons.

- There has not been an evaluation of how the SPD transition into Medi-Cal Managed Care has fared and what problems have arisen. The Plans did not ask for the new responsibility of taking on ADHC dual eligibles but have been thrust into the ADHC Transition Plan with little notice and planning. Taking responsibility for the ADHC dual eligibles at the same time Plans are adding the SPD population is a significant burden and is adding to the beneficiary confusion about enrollment into managed care.

In contrast to the 12-month roll out of SPD enrollment, DHCS will automatically enroll dually eligible ADHC patients into a Medi-Cal Managed Care plan on October 1, 2011, unless a plan is selected by the beneficiary by September 16, 2011. The involuntary enrollment of ADHC "duals" leapfrogs the I implementation of the duals pilot projects in spite of expert opinion and Legislative direction to carefully manage mandatory enrollment of dual eligibles, under the 1115 waiver. As a result, ADHC patients have become" Involuntary subjects" in an experiment that is poorly designed because of the extraordinary time pressure to transition ADHC patients by December 1, 2011, without the necessary systems changes that were to be tested by the 1115 dual eligibles pilot project.

- **The announcement by the state at the August 16 Assembly Committee on Aging and Long Term that they will increase the capitated rate an average of $60 per person per month for each ADHC beneficiary is insufficient to cover the services provided by ADHC.** The Plans are on record questioning how they can be expected to provide alternative services for this high cost population with virtually no additional resources.

- In spite of the DHCS assertion in the "Transition Plan" that "intensive outreach" would be accomplished, beneficiary notices were mailed out on August 16, 2011 with no outreach or engagement of community-based agencies that might have served as a resource for bewildered ADHC patients and their families, as well as providers. As a result, there is tremendous confusion about the instructions in the enrollment packet (that were not customized to address the fact that dual eligibles receive their primary health care through Medicare). This rush to enroll has created undue anxiety among the beneficiaries and families who do not understand what they are being asked to do.

- In the extremely short time frame given to transition to a managed care plan, there is **serious concern that ADHC patients and their families do not have adequate time, information and assistance they need to make an informed choice.**

- Navigating managed care plan enrollment processes, let alone "member services" telephone menu systems, is a significant challenge for most ADHC patients and caregivers and most will be unable to make an informed choice in time to avoid automatic enrollment.

- A telephone call from a Medi-Cal managed care plan representative, a stranger to the patient, will not provide the type of information a patient needs in order to make an informed decision regarding how to access their health benefits as a dually eligible beneficiary in Medi-Cal managed care.

- As a result, if a patient does not want to enroll in a plan, but ends up being ***involuntarily enrolled*** into Medi-Cal managed care, that person will have to take the necessary steps to disenroll or "opt-out" from the plan. **A recent *Issue Brief* published in July 2011 by the National Senior Citizens' Law Center (NSCLC), notes serious concerns with an "opt out" model,** especially "if applied to new, untested integration models." Advocates urge policymakers to implement an "opt in" model emphasizing a "more effective and beneficiary-centered program."

- A letter published by the Western Center on Law & Poverty (WCLP), as part of the DHCS *Technical Workgroup on Dual Eligibles*, highlighted the importance of consumer protections for vulnerable populations in managed care and specifically asserted that, **"Beneficiaries must be given adequate time, assistance and information to make an informed choice."**

- Managed care case managers will face the same challenges associated with the lack of long-term care supportive services in the community. If there are

insufficient services to coordinate, who is responsible for seeing that ADHC patients ultimately receive appropriate “alternative services”?

- Because DHCS shares regulatory oversight for care plan compliance and performance in California with the Department of Managed Health Care, which entity is ultimately responsible for assuring compliance and accountability for the provision of a health risk assessment, care coordination, case management, service provision, and tracking and reporting of ADHC patients, as described in the current “transition plan?” Who do consumers turn to with complaints and which entity is responsible for hearing patient appeals?

- Which entity bears the legal responsibility for compliance with the state’s Olmstead Plan and mandate? Is the state shifting the burden of responsibility to the Plans and counties?

Special Needs Plans (SNPs)

The Transition Plan identifies managed care plans known as Medicare Advantage, Special Needs Plans (SNPs) which can enroll dually eligible beneficiaries who meet certain criteria and reside within defined service areas. SCAN is one of these plans described as a solution in the Transition Plan.

SCAN Health Plan is a Medicare Advantage Special Needs Plan that contracts with the Department of Health Care Services to provide services for the dual eligible Medicare/Medi-Cal population subset residing in Los Angeles, San Bernardino, and Riverside counties. SCAN provides all services in the Medi-Cal State Plan; including home and community based services to SCAN members who are assessed at the Nursing Facility Level of Care and nursing home custodial care, following the member in the nursing facility. The SCAN eligibility criteria requires that a member be at least 65 years of age, have Medicare Part A and B, have full scope Medi-Cal with no share of cost and live in SCAN’s approved service areas of Los Angeles, Riverside, and San Bernardino counties. **It is not clear if SCAN can purchase ADHC services for its members, even if they require this level of care, since ADHC is no longer a benefit.**

REALITY: Besides SCAN, there are a limited number of SNPs (33 plans for duals, 18 plans for those with specific chronic disabling conditions).

- Potential enrollees need to actively enroll – that is, attend a scheduled marketing session, call the 1-800 Medicare national hotline, contact a plan, go on the medicare.gov website, or seek local assistance from a consumer assistance program such the Health Insurance Counseling and Advocacy Program (HICAP).

- Many duals choose to be in the Medicare fee-for-service system (not Medicare managed care), so a change in their primary care physician and other medical care providers would most likely be necessary if enrolling in a SNP. For chronically ill patients, a change in the primary care physician could affect continuity and quality of care.

- It is very difficult to determine which SNP plans are offered in a community unless a consumer goes to medicare.gov, 1-800 Medicare, directly to a plan or seeks assistance from a consumer assistance agency such as HICAP. For many ADHC patients, especially those coping with cognitive impairments, mental illness, or limited or no English language skills, successfully navigating the enrollment process using a toll free telephone number or web site is an impossible task.

3. In-Home Operations Waiver

The state's updated transition plan displays the In-Home Operations (IHO) Waiver as an alternative for ADHC patients involuntarily discharged as a result of the elimination of the ADHC program. The IHO Waiver is a Home and Community-Based Services (HCBS) waiver which is approved for only 500 Medi-Cal beneficiaries. The purpose of this waiver is to identify the highest risk, most medically complex individuals who need medical care delivered at the Nursing Facility-B level of care to avoid hospitalization or nursing facility placement. These individuals have fragile medical conditions requiring licensed, skilled nursing and specialized therapeutic services, such as tracheostomy care, respiratory and inhalation therapy, tube feeding, and intravenous therapy.

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.

- The state combined the In-Home Operations (IHO) Waiver with the Nursing Facility (NH)/Acute Hospital (AH) Waiver and will phase out the IHO Waiver option after the current recipients are no longer eligible.

- The 200 current IHO recipients were "grandfathered" into this waiver as they did not otherwise qualify under the federal waiver guidelines for cost neutrality.

- Services currently available under the IHO waiver include:
  - Environmental Accessibility Adaptations
  - Case Management
  - Respite Care (Home & Facility)
  - Personal Emergency Response System (PERS)
  - PERS Installation and Testing
  - Community Transition Services
  - Home Health Aide Services
  - Habilitation Services
  - Family Training
  - Waiver Personal Care Services
  - Transitional Case Management
  - Medical Equipment Operating Expenses
  - Private Duty Nursing, including Shared Services

- *Following the release of the August 5, 2011 "Transition Plan," the DHCS stated at the August 9, 2011 ADHC Stakeholder Meeting 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. Targeted Case Management (TCM) and APS Healthcare, Inc. (APS)

TCM is listed as an alternative with respect to the transition of ADHC patients. Local government entities determine the target population served, and use local funds to apply for federal TCM (Medi-Cal) matching funds as a reimbursement mechanism for serving that "target" population, primarily pregnant women and children.

REALITY: Clients receiving services through contractors funded by TCM funds must be Medi-Cal eligible but not receiving HCBS waiver services, or dually eligible. **In other words, the vast majority of ADHC participants would not be eligible.**

- Matching funds must be provided by the county in order to access TCM funds. With diminishing county budgets this option is not likely to be expanded, even for the SPD population.

- Local government agencies. Los Angeles County, with the largest ADHC population, does not use TCM funds for the provision of case management for older adults, so it is not a relevant option for the vast majority of ADHC beneficiaries.

APS Healthcare, Inc. (APS)

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 Healthcare, Inc.," which is a New York-based publicly traded company. APS is currently providing care management services, through a contract with the DHCS, in 16 counties in California, primarily for behavioral health patients who are considered to be among the top 5% of the most complex patients.

Following the release of the August 5, 2011 "Transition Plan," the DHCS announced at the August 9, 2011 Stakeholder Meeting that APS will be the care coordinator for ADHC patients who reside in a county without a managed care option, or where an ADHC patient successfully "opts out" after being voluntarily or involuntarily enrolled by the state in a managed care plan.

REALITY: APS is a care coordination company that is unfamiliar to local, community-based service providers. According to DHCS, APS will manage care for those who elect to remain in fee-for-service Medi-Cal as well as those residing in counties with no Medi-Cal managed care. This means that the APS contract will have to be expanded to cover all counties in California where ADHC patients "opt-out" to remain in fee-for-service. Consequently, there are concerns about APS' capacity to quickly ramp up personnel and assess the needs of the ADHC population, and realistically meet the needs of

ADHC patients and their families, most of whom are considered to be medically complex and whose care needs cannot be managed with care coordination alone.

- More information is needed about how APS will work with local providers and ADHC patients and their families. Are local care managers located in all 28 counties where ADHC patients may choose fee-for-service? Will APS services, such as health risk assessment and care coordination, be provided telephonically or in person?

- The APS Healthcare, Inc. web site lists program results for Missouri, Georgia, Wyoming and Ohio. It is not clear, at this time, how APS, Inc. has performed in California and how quickly they can ramp up to take of ADHC patients.

- What are the terms of the contract with APS? How are rates determined? Is this option less costly than using the existing non-profit community-based ADHCs that have been serving their communities for decades and know their patients and the local services best?

- Rural counties in California do not have managed care available as an option. There are six rural counties served by eight ADHCs (the Chico-based ADHC serves three counties): Humboldt, Butte, Tehama, Glenn, Shasta and Imperial. It is illogical to break the continuity of care these patients receive from their ADHCs' integrated care home in favor of APS Healthcare, Inc., which is not a place for delivering health care but rather a care coordination service. The state's decision to substitute care coordination for actual delivery of hands-on care should be questioned, especially in rural counties where few services exist.

5. Program for All-Inclusive Care for the Elderly (PACE)

There are five (5) PACE organizations operating 20 "PACE Centers or sites" located in Los Angeles, Alameda, Contra Costa, San Francisco, Santa Clara, San Diego and Sacramento counties. PACE relies on ADHC as a platform for delivering integrated medical and social services to avoid higher cost services for which they are at risk to provide. PACE is a capitated model of managed care that focuses on a specific high need senior population.

REALITY: PACE programs only serve adults who are at least 55 years old and live within a PACE service area. All care from physicians to hospital and nursing home care is provided directly or under contract with community sub-contractors.

- In order to receive PACE services, individuals must live within designated zip code areas associated with the programs.

- PACE services are only provided to those who are certified by the state to meet Nursing Facility "B" level of care. At the time of enrollment, individuals must be able to live in a community setting without jeopardizing their own health or safety.

- ADHCs will be asked to make referrals for the frailest patients who meet the PACE eligibility criteria. The decision to choose to enroll in PACE lies with the patient, there is not mandatory enrollment.

- It is unknown how DHCS plans to handle the possibility that more beneficiaries apply for PACE than there are “slots” within a particular PACE service area. The notion of PACE contracting with free-standing ADHCs in the event there is greater patient demand than capacity is notably absent from the transition plan.

6. Area Agencies on Aging (AAA)

AAAs provide Information and Assistance (I&A) services based on the availability of resources and agencies in their communities. DHCS asserts that coordination efforts to address a smooth transition for ADHC patients are underway between state and local entities. The DHCS has provided a contact list of the 33 Area Agencies on Aging (AAAs) and a map of each planning and service area to various state departments and provider organizations. A sample directory of services for the City of Los Angeles was included with the original transition plan but has subsequently been removed from the ADHC transition website.

REALITY: As noted above, very few appropriate AAA replacement services and programs are readily available to meet the complex health care needs of the ADHC population due to geographic limitations, restrictive eligibility requirements, and the AAA mission to provide or coordinate social services in contrast to medical services.

- Most of the state-funded resources and services administered by the AAAs have been drastically reduced or eliminated, further diminishing their efficacy for provision of “alternative services.”

  I&A offices operated by the AAAs can only make referrals based on the availability of services within their communities. Community-based supportive service options for even the healthiest of older Californians are limited. For ADHC patients needing an array of medical, therapeutic and social services in order to safely remain in their home and avoid an emergency room visit, hospital stay or nursing home placement, the options are slim.

- While included in the original transition plan’s directory of services, affordable and accessible transportation services in local communities are limited for this complex population, many of whom suffer from dementia or mental illness. It is a challenge for anyone to piece together transportation services for accessing a variety of health providers, in contrast to the out-of-home integrated medical and social services offered within the ADHC.

7. Multi-Purpose Senior Services Program (MSSP)

MSSP is a 1915(c) Home and Community-Based waiver case management program administered by either an Area Agency on Aging or non-profit entity. The program is

available in all counties except the following: Colusa, Del Norte, Monterey, Nevada, Plumas, San Benito, San Luis Obispo, Sierra and Sutter.

REALITY: MSSP is a referral source for ADHC. Although the program might be able to meet some of the care needs of ADHC patients, in the absence of their ADHC services, it has a limited number of openings and operates with waiting lists.

- The program serves only Medi-Cal beneficiaries, with no share-of- cost, who are at least 65 years of age, residing within a particular MSSP service region and certified for nursing home level of care.
- It typically takes several weeks to determine eligibility for MSSP. This admission process is not unique to MSSP (ADHC admission also takes many weeks), but will result in gaps in care. In contrast, nursing home admission takes about three days to complete and is the typical discharge location after a hospital admission..
- 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.
- *At the August 9, 2011 ADHC Stakeholder Meeting, DHCS announced that up to 1,500 additional slots were being added to the MSSP waiver. Coming on the heels of the recent budget reductions approved by the Legislature, this action took the MSSP providers and others by surprise.*
- It is unclear if MSSP can gear up quickly enough to accept new clients discharged from ADHC, and how the slots will be distributed. Will they all be reserved for ADHC clients even if others have been waiting a longer period of time?

In Summary

ADHC centers serve frail elders with chronic conditions, persons with Alzheimer's disease and related dementias, mental health patients and younger adults (18 years and older) with functional impairments. These 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 DHCS, like California's long-term care services system, is piecemeal and further fragments care for this vulnerable population.

Contrary to assertions that "stakeholder participation" is "critical to the success of the refinement of the process," ADHC providers have not been invited to attend information gathering meetings among state departments and local service providers convened by DHCS.

The "Transition Plan" as presented by the DHCS is inadequate. It lacks necessary protections for this vulnerable population and it lacks standard core elements typically reflected in planning documents:

1) Specific timeline with anticipated milestones
2) Assessment of existing services
3) Thoughtful analysis of options
4) Clear process for engaging community stakeholders (including ADHC patients and their families)
5) Intended outcomes and ultimate goals
6) A detailed budget of projected costs

Instead, the transition document provided by the DHCS, on which 55,000 uniquely identified ADHC patients and their families must rely, is long on promises and short on meaningful information.

As a result of the passage of the Affordable Care Act of 2009, California has the opportunity to build on what has worked and is working. Instead, the state appears to 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.

The state’s own voluminous documents and citations of literature that underpin its decision to take incremental steps to test the mandatory enrollment of dual eligibles into managed care through pilot projects, underscores the disparate treatment that ADHC beneficiaries are receiving with this rush to enroll them into managed care with little preparation or consideration of their own experts’ cautions about this population.

Although home and community-based waivers currently available in California may provide an alternative for individuals to live in the community who would otherwise be institutionalized, access is limited and they actually create more silos of care because they each differ in eligibility criteria, number of slots, and service availability.

Disability Rights California recently published recommendations addressing critical access issues such as the need to increase the number of waiver slots in proportion to the “number of Medi-Cal recipients in nursing facilities or at risk of placement.” <u>Currently, the numbers of available nursing facility beds far outnumber MSSP or IHO waiver slots.</u> Placement into a facility or hospital is far easier and quicker than being on a waiting list for admission to a waiver, or a lengthy waiver admission processes.

The Little Hoover Commission, an independent state oversight agency, published a report in April 2011, which clearly described the dismal condition of California’s long-term care system, “There is virtually no coordination or communication between programs and staff responsible for long-term care services. There is no integrated management or coordination of financing, service delivery or assessment of long-term care client needs or of providers.” The “Transition Plan” developed and published by the DHCS hinges on the availability of services and support systems that are insufficient or do not exist.

ADHC centers are the only home and community-based service in California's fragile long-term care network that combines a safe out-of-home medical and social environment with built-in care coordination for "at risk" individuals who would otherwise be admitted into emergency rooms, hospitalized or placed in nursing facilities. Like California's long-term care services system, the ADHC Transition Plan is fragmented and incomplete in its presentation and practical implementation.

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