



# CAADS

California Association for Adult Day Services

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Via email and U.S. Postal Service

Cynthia Mann  
Deputy Administrator and Director  
Center for Medicaid, CHIP and Survey and Certification  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1805

RE: Elimination of Adult Day Health Care (ADHC) as a Medi-Cal State Plan Optional Benefit

Dear Ms. Mann:

On behalf of the California Association for Adult Day Services (CAADS), and the 37,000 patients served in adult day health care, I am writing to urge CMS to exercise due caution in using its authority to approve or disapprove of California's forthcoming State Plan amendment to eliminate ADHC as a Medi-Cal benefit as authorized in AB 97, the health budget trailer bill.

While there is no question that the Legislature may determine which optional benefits the state will provide, adult day health care deserves special consideration under the Americans with Disabilities Act as a medical setting that almost exclusively serves a medically compromised Medi-Cal population.

The decision to eliminate the ADHC benefit was made under extraordinarily challenging budget conditions and without due deliberation of the policy impact on California's vision to better manage high care, high cost chronic conditions in the community setting. As a result, there is great uncertainty and risk associated with the state's plan to transition the patients currently served in the Adult Day Health Care (ADHC) program to either 1) alternative services to the extent they are available in the community, or 2) a new waiver program.

Recently, the state publicly announced it has no plans to submit a waiver application to CMS in the absence of statutory authority to enact the intent of the Legislature as expressed in AB 97. While we are aware that the Legislature intends to advance such statutory authority, it is our duty to California's ADHC Medi-Cal patients and families to advocate for an orderly transition from elimination of the ADHC state plan benefit to a new program operating under a waiver. This should occur in a manner that assures sufficient time is allowed to access adequate and appropriate services in the community that will accept the discharge of tens of thousands of ADHC patients. There must be assurance of a clear path and plan to transition eligible patients to alternative services or to a new program in an orderly manner to avoid the consequences of harm, institutionalization or death.

An orderly care transition for patients who *will not* qualify under a waiver and seamless conversion of ADHC from a state plan benefit to a waiver benefit is our utmost goal and priority so patients are protected from unnecessary trauma, illness, injury or death. Ideally, to assure such an orderly transition process, CMS will approve elimination of the state plan benefit to coincide with approval of the new waiver program. This approach is the most likely to prevent institutionalization and harm to this medically complex, high care population.

**The entire population of 37,000 ADHC patients whose services are Medi-Cal funded will be affected by AB 97.** Included in this population are individuals with Alzheimer's disease or dementia, serious psychiatric conditions or cognitive disabilities, most of whom have significant co-morbid health issues: notably diabetes, heart disease, chronic obstructive pulmonary disease, and other high care, high cost chronic conditions. All patients have individualized plans of care and have been determined by the State to be at risk of hospitalization and/or institutionalization but for ADHC services.

The only way to assure continuity of care for these at risk patients is for CMS to insist that the state provide a detailed plan with a timeline describing how existing beneficiaries will gain access to new *comparable* services when the current state plan benefit ends, and how and when remaining patients will transition into a new 1915 or other waiver or state plan benefit that the Legislature intends to be submitted to and approved by CMS.

We have direct information that the closure of ADHC centers in the past month has led to nursing facility placements, with more on the way. It is ironic that **as the state continues to expend federal and state resources to transition individuals out of nursing facilities through the Community Transitions Program, the elimination of the ADHC benefit is leading to new avoidable nursing home placements.**

Our concern is that many more programs will follow suit because of the confusion and tremendous uncertainty resulting from the approval of AB 97 and the absence of a clear path to the transition of patients and conversion of the ADHC program to a waiver.

**CMS' stated policy goals for advancing home and community-based care will be eviscerated in California if CMS chooses to approve elimination of the ADHC benefit without concurrently approving a new single service waiver** for eligible patients currently served in ADHC, who must be afforded the opportunity to continue to be served in the setting of their choice.

We note that this process of eliminating the ADHC benefit while converting ADHC to a waiver program operating under Section 1915 authority has occurred in relatively smooth fashion in three other states (Maryland, Nevada and Washington), and is underway in Texas. Forty-nine (49) states and the District of Columbia have CMS approved adult day health care programs operating under a waiver or as a state plan benefit (West Virginia has an ADHC program but has not funded it at a level sufficient to attract providers).

**Complicating the situation in our state, based on assessment from experts in the field, are the following access problems:**

1. Insufficient local resources to fully replace the skilled nursing and therapy services currently received within the ADHC setting. A number of home and community-based services and optional Medicaid services were dramatically reduced or eliminated in the past three California budget cycles, including the budget bills passed in March 2011.
2. Insufficient Medicaid nursing home beds; virtually no community-based mental health services, except for crisis care in emergency situations; extremely limited Medicaid funded home health; little access to non-emergency medical transportation; and waiting lists for the limited waiver services offered by California.

3. Dually eligible patients in ADHC will be unable to access ongoing long term services through the Medicare program for non-acute chronic care management, long term care in a nursing facility or ongoing nursing care. The Medicare program is not designed to provide long term supports and services.
4. Significant cost shift from Medi-Cal funded care to Medicare funded services as current dually eligible ADHC patients who are left without proper ongoing medical care will end up in higher cost hospital-based setting through emergency departments and unnecessary hospital admissions and readmissions.
5. Medicare reimbursable post-acute services are time limited and will be insufficient for many of the ADHC patients. The result will be conversion from a short term Medicare nursing home admission to a long term Medi-Cal nursing home stay, defeating the Olmstead decision and CMS policy goals.
6. The state has identified the In-Home Supportive Services(IHSS) program as the major alternative services. But, IHSS is not designed nor legally authorized to provide skilled medical care. IHSS is not the appropriate alternative solution for many of the current ADHC patients either because they will not qualify for additional hours under IHSS rules, their family caregiver is unable to increase their hours, or there are not sufficient non-family caregivers available.

Additionally, IHSS is not available to individuals living in "Board and Care" facilities, where a significant number of persons with developmental disabilities and behavioral health problems reside, most of whom have co-morbid conditions that ADHC addresses. With recent budgetary restrictions imposed on IHSS and heightened scrutiny of the IHSS program for fraud and abuse, this service option does not have the capacity to appropriately address the needs of the ADHC population, many of whom are unable to self-direct their care and are easily taken advantage of.

7. AB 97 references alternative services to which ADHC patients can be transitioned; however, there are numerous barriers to these individuals' receipt of any such services, should they exist within their community, including eligibility restrictions, enrollment caps, waiting lists, geographic limitations, and limitations on coverage and scope of services for those who do qualify. The budget cuts of the past several years have devastated or completely eliminated community-based services such as Alzheimer's specialty care, caregiver support, and care coordination.

### **Current Status of Budget**

The 2010-2011 state budget for ADHC was \$369.8 million, of which \$176.6 million came from state general funds, matched by federal funds. In the budget bill passed by the Legislature, SB 69 (Budget Act of 2011), this appropriation was reduced by nearly 50%. To date, SB 69 has not been signed by the Governor and thus, there is currently no appropriation to provide either short-term transition and/or new ADHC waiver services.

As set forth in the health trailer bill, AB 97, California is required to submit to CMS an amendment to its state plan to eliminate ADHC as an optional Medi-Cal Benefit. But, AB 97 merely expresses *Legislative intent* that:

“[d]uring the 2011–12 Regular Session of the Legislature, legislation will be adopted to create a new program called the Keeping Adults Free from Institutions (KAFI) program... [a]s prescribed by subsequent statute, the Department of Health Care Services shall develop a federal waiver to maximize federal reimbursement for the KAFI program to the extent permitted by federal law.”

Thus, in the absence of further enabling legislation during the current legislative session that expires on September 30, 2011, to convert the program to a waiver approximately 37,000 patients who depend on ADHC for skilled nursing services, therapies, psychological and support services will be left without care due to the insufficient alternatives and the state’s lack of Medi-Cal infrastructure to absorb the care needs of this number of chronically ill elderly and disabled.

**We wish to bring to your attention the following concerns about the transition and new waiver program as expressed in AB 97.**

1. **Timing of a new or amended federal waiver.** AB 97 states that the legislature will adopt new legislation to create a new “KAFI” program – Keeping Adults Free from Institutions. The apparent intent of the KAFI program is to provide a “well-defined scope of services to eligible beneficiaries who meet a high medical acuity standard and are at significant risk of institutionalization in the absence of such community-based services.” It is intended that this new program will (1) be passed by the legislature; (2) funded in the short term; and (3) continue to be viable through the application for and approval of a federal waiver. **We strongly urge that authority for the existing ADHC program should not be terminated until a new or amended waiver program has been approved by CMS.**
2. **Lack of access to long-term alternatives for non-KAFI waiver participants:** It is unclear whether and how AB 97 accounts for the long-term service needs of those individuals who will not receive KAFI and/or other waiver services. For those individuals who will not qualify for the waiver program, or who exceed expected enrollment caps, AB 97 contains no provisions for long-term community-based alternatives to ensure they are not unnecessarily institutionalized. For such individuals, the “short-term program” would need to be extended or alternative services made available to meet their needs in order to avoid unnecessary institutionalization.
3. **Feasibility of “short term program” to fund transition.** AB 97 requires the creation of a “short term program” to fund organizations to assist discharged ADHC patients to transition to other Medi-Cal services and/or to provide social or respite services. However, there is no requirement that such programs be fully in place before the elimination of ADHC and no details as to how this will be accomplished. Moreover, it is unclear whether these organizations will actually provide services or merely attempt to link individuals to any available alternative services, which, as described above, cannot at present accommodate the needs of everyone who will be affected.

4. **Feasibility of assessment and transition process.** In order to accomplish an orderly transition, existing care plans will need to be considered as new care plans are developed. AB 97 requires the 309 existing ADHC programs to provide care plans and relevant participant information to DHCS for the 37,000 currently enrolled ADHC patients. We believe the State should be required to build in adequate time and resources for contractors to assess and transition this volume of fragile people in the coming months, even assuming ADHC providers are able to provide their support in transitioning their patients. No changes should be made to existing ADHC programs until there is evidence that a transition to new services or KAFI is safely and effectively underway. Already, programs have closed their doors in the cities of Ukiah, Lodi, Sonora, San Francisco and Los Angeles resulting in immediate institutional placements, with other placements expected in a matter of months. Three out of these five are in rural counties with no other ADHC and few other services for patients to access.
5. **April 15, 2011 proposed rulemaking for the Medicaid program.** Home and Community Based Services Waivers would permit the combining of target populations and more clearly defines person-centered care planning. We support these changes and urge CMS to expedite adoption of the regulations so that these provisions may be applied to our existing population should the state choose to apply for a 1915 (c) waiver. We currently serve all the target populations in the existing ADHC program as there are few alternative services that combine necessary medical and psycho-social supports in the community.
6. **Mandatory enrollment into managed care for Seniors and Persons with Disabilities.** ADHC providers are assisting in the transition of this population, comprising approximately 19% of the ADHC population, into managed care. Managed care organizations are increasingly expressing their support for the ADHC program model as a key component of their strategies to manage care and cost. The loss of ADHC would be a severe setback at the very moment in time when the benefit can be of the most value to those individuals identified to be medically complex, high care, high cost beneficiaries.
7. **Impact on California's 1115 Waiver Dual Eligibles Project.** California recently won approval and a \$1 million grant from the Office of Innovation to begin planning for four county-wide pilot projects to integrate funding and services for dually eligible beneficiaries, to begin in 2012. Should the ADHC infrastructure disappear because elimination of the ADHC benefit causes most centers to cease operation, the pilot project will not be able to rely on this integrated psycho-social medical setting as planned in the application and it will be difficult to re-start programs in the selected communities due to the current economic conditions, high cost of start-up and insufficient state personnel capacity to re-license and certify ADHC.

### **ADHC Benefit Today**

There are 309 approved ADHC centers located in 32 of California's 58 counties serving approximately 37,000 frail seniors or adults with **medically complex** disabling conditions.

California's ADHC program is designed to prevent the unnecessary institutionalization of the frail elderly, chronically ill, and persons with disabilities. Eligibility for the program is determined

by a multidisciplinary team of skilled clinicians who must certify that the patient has a high potential for the deterioration of their medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency room visits, hospitalizations, or other institutionalization if ADHC is not provided.

- All have been identified to be at risk for repeat hospitalizations or nursing facility placement due to their multiple chronic medical, cognitive or mental health conditions and functional deficits.
- **92 percent of ADHC patients rely on Medi-Cal for their health care. According to the state, 83% of these are dually eligible for Medicare and Medi-Cal.**
- By providing medical oversight on a continual basis, the ADHC program allows seniors and disabled adults, **deemed by the state to be at the level of nursing facility placement/ care or hospital admission** without the provision of specific ADHC services to remain living in their community as independently as possible.
- There is no comparable medically supervised daytime care program under Medi-Cal for this population. While some ADHC patients receive IHSS, this option is not authorized to provide ongoing medical care or therapy services.

### **Summary**

Continuity of care is critical for the medically complex, high care ADHC patients and their families. There are only three home and community based programs of any capacity in California: IHSS, serving 442,638 beneficiaries; ADHC, serving 37,000 patients; and the Multi-Purpose Senior Services Program, operating under a 1915 (c) waiver for 10,000 beneficiaries.

There is great risk for harm to and institutionalization of these vulnerable seniors and persons with disabilities unless the state facilitates an orderly conversion of ADHC from a state plan benefit to a waiver benefit with **no gap in services for the patients, and predictability of reimbursement for qualified centers, to avoid precipitous and unwanted closures.**

The extreme level of uncertainty about the future care of ADHC patients created by the enactment of AB 97 will lead to serious unintended consequences. Closures and nursing home placements have already occurred. With so many vulnerable lives at stake, we urge CMS to use its authority and power to insist that the state engage in a full public process resulting in a plan and timeline that assures patients, families and providers that there is a reasonable expectation for development of an appropriate ADHC waiver program and transition of those patients who will not qualify to other comparable services. This will do much to avoid disruptions in accessing appropriate services, ensure continuity of care, and avoid a gap in reimbursement so ADHC providers do not unnecessarily and abruptly close their doors.

Therefore, we respectfully urge CMS to withhold approving the elimination of the ADHC Medi-Cal Optional Benefit until a satisfactory transition plan is in place, and the application for a new waiver program has been reviewed and approved. This will identify the number of centers eligible for certification under a waiver and their capacity to serve existing patients whose needs cannot be met in any other setting within the community.

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We look forward to working with you and the State of California to accomplish the goals of a seamless conversion to a waiver program and protection of the health and safety of our most vulnerable patients. Please contact me at 916.552.7400 should you have any questions or if additional information is required.

Respectfully yours,



Lydia Missaelides, MHA  
Executive Director

cc: Herb K. Schultz, Regional Director, U.S. Department of Health and Human Services, Region IX  
Gloria Nagle, Associate Regional Administrator, Division of Medicaid & Children's Health Operations, Region IX  
John Wodatch, Chief, U.S. Department of Justice  
Renee Wohlenhaus, Deputy Chief, Civil Rights Division, Disability Rights Section U.S. Department of Justice  
Toby Douglas, Director, California Department of Health Care Services  
Darrell Steinberg, President pro tem, California State Senate  
John Pérez, Speaker, California State Assembly  
Senator Mark Leno, Chair, California State Senate Budget Committee  
Senator Bob Dutton, Vice-Chair, California State Senate Budget Committee  
Assembly Member Bob Blumenfield, Chair, California State Assembly Budget Committee  
Assembly Member Jim Nielsen, Vice Chair, California State Assembly Budget Committee