



**CAADS**

California Association for Adult Day Services

921 11<sup>th</sup> Street  
Suite 1100  
Sacramento, California  
95814

Phone: 916.552.7400  
Fax: 916.552.7404  
E-mail: caads@caads.org  
Web: www.caads.org

Assembly Committee on Aging and Long Term Care  
Mariko Yamada, Chair  
Cost and Consequences:  
Elimination of the Adult Day Health Care Optional Benefit  
August 16, 2011

TESTIMONY OF LYDIA MISSAELIDES, MHA, EXECUTIVE DIRECTOR

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Madame Chair and Members of the Assembly Aging and Long Term Care Committee, thank you for holding this important hearing on the cost and consequences of eliminating adult day health care as a Medi-Cal benefit for 37,000 patients on December 1, 2011. My name is Lydia Missaelides, and I am here representing the tens of thousands of patients, families and staff who make up our extended Adult Day Health Care family and who are outraged about the elimination of the ADHC benefit and the turmoil and havoc it is already causing.

In my 35 year career I have witnessed the rise of ADHC in the early 1980's as an innovative and humane model of community care for frail elders in response to public outcry about terrible nursing home conditions, and now, its elimination.

The team-based person-centered care model has worked for over 30 years by providing an integrated combination of medical care and social services to keep high-risk older adults out of nursing facilities and hospitals, while preserving the circle of family support because care is provided outside the home, giving caregivers a needed break from 24/7 care responsibilities. And, over time ADHC has evolved to meet the changing needs and higher acuity of patients as medical innovations have pushed people out of hospitals "quicker and sicker."

Like you, Madame Chair, I never dreamed the ADHC model of care would be decimated just at the moment in time that new national health care reform efforts call for team-based community care in partnership with medical services – in other words, the ADHC model!

**California eliminated ADHC as a Medi-Cal benefit in the March health trailer bill (AB 97)** with the understanding, held by you and many other members of the Legislature, that ADHC would be moved to a federal waiver for the neediest patients, with half the funding and a federal match.

**But, all of us discovered too late, there was no compromise.** AB 96 -- the bill championed by Mr. Blumenfield to create a waiver program -- was vetoed. Now, California now has the unfortunate distinction of becoming **the one state in the nation to abandon ADHC as a choice for poor and ill seniors, relegating them to live out their lives in isolation behind closed doors.**

**The inaccurate information provided to the Legislature this year about the ADHC program has been disturbing** and should give you little comfort that the state's latest Transition Plan is any more accurate or well-reasoned. In fact, the state's own transition plan admits the data "is very difficult, if not impossible, to reconcile."

**There is palpable anger in the community as expressed through the extensive and sustained media attention covering the ADHC elimination story.** The universal opposition to elimination of ADHC by physician groups, hospitals, managed care, AARP, the Congress of California Seniors, constituents, the business community and Boards of Supervisors remains unchanged, and with release of the transition plan, is even stronger.

The updated Transition Plan released at 5:00 PM on Friday August 5, can scarcely be considered a plan because it lacks credible detail. But it does finally reveal the heavy reliance on managed care as the cornerstone of the transition to “alternative services.”

**The state’s failure to involve community stakeholders in any meaningful way as this plan was being developed,** reveals the extreme pressure the department is under to make their budget numbers, but also demonstrates serious misunderstanding of this vulnerable population’s needs, how community services work in the real world, and the benefits of ADHC in preventing health crises and decline.

**So, a human disaster is about to unfold in your communities.** Eighty-three percent (83%) of the people served in ADHCs today are called “dual eligibles” -- those with Medicare and Medi-Cal insurance coverage -- who are, by the state’s own reports, the most high cost/high risk individuals in the health care system. Their needs are many and complex and not well understood by those in the bureaucracy who are making life and death decisions for these people and their caregivers.

### **Managed Care Consequences and Costs**

My next remarks will focus on the transition plan’s reliance on managed care because others will discuss the challenges and myths related to transitioning ADHC patients to other services. My comments do not apply to PACE, SCAN Health Plan or County Organized Health System Counties, which operate under different rules.

**The Legislature made it clear last year in approving SB 208 (Steinberg) that the state should move with extreme caution before enrolling all dual eligibles into Medi-Cal managed care, by specifically excluding them from mandatory enrollment,** except through the creation of four pilot projects in four counties, to be launched early in 2012.

**This Legislative mandate is being ignored as the state rushes headlong to mandatorily enroll ADHC dual eligibles into Medi-Cal managed care within the 28 counties where ADHCs still exist.**

Also, consider that the Legislature authorized 12 months to move Seniors and Persons with Disabilities (Medi-Cal only insurance) into managed care.

**Mandating enrollment into Medi-Cal managed care for ADHC patients within the month of September is completely unrealistic.** Letters are being mailed this week with instructions about enrolling in managed care.

I have to ask, how many of you can explain the difference between Medi-Cal Managed Care and Medicare Advantage Plan? Try Medi-Cal Fee-for-Service and Medicare Fee-for-Service. Do you know what benefits a SNP (Special Needs Plan) covers? How about PACE (Program of All Inclusive Care for the Elderly) and SCAN?

**This alphabet soup is confusing and overwhelming** for the patients, families, providers and community-based partners, who, until now, have had little reason to interact with managed care. Keep in mind, many of our beneficiaries have some form of dementia, cognitive impairment or mental illness and getting these notices describing changes to their benefits are frightening, because they will not understand what is happening.

**Consider, the average age of those in ADHC is 78; dementia accounts for 25% of the population; mental health diagnoses 46.6%; and non-English speaking is 62%, according to the department's own transition plan charts.**

**Most ADHC patients will be enrolled in managed care on October 1, without their understanding or consent,** which, by ethical standards, resembles coercion more than real choice.

**Simply put, this managed care train is moving too fast for anyone to get on board and understand what is happening and what it means.**

Even the promise for "opting-out" after being auto-enrolled, rings false because most **will not comprehend how to navigate out of managed care.**

As for the Plans, they are being told to accept an actuarially complex population that represents, by insurance standards, adverse selection. Plans are getting an enhanced rate, on *average*, \$60 per person per month – barely enough to pay for a care coordinator's time for just one hour.

Plans are being directed to take on this additional burden just a few months after the Seniors and Persons with Disabilities (SPD) mandatory enrollment began in June, and **prior to any analysis of how *that* transition is working. A hearing to discuss the SPD enrollment process and how it is faring would be instructive.**

**Most important to understand is the reality that the dual eligible's major health costs such as physician care, hospital services, and pharmacy are covered by *Medicare* insurance. Medi-Cal benefits have shrunk considerably in the past few years due to budget cuts and those that remain are not crucial to keeping someone out of institutional care.**

**Medi-Cal Managed Care Plans are not required to coordinate with the Medicare benefits, nor is there the capacity to do so. So, what is the point?**

**California would do well to take a time out from this disaster-in-the-making, and look at what other states are doing.** New Jersey is proposing a more logical way to move vulnerable adults into managed care that includes adding (carving-in) ADHC to the package of managed care benefits.

## **The Myth of Alternative Services**

One of many challenges in the Transition Plan is the list of so-called “alternative services” which centers are expected to consider for discharge planning. Others here today will discuss the problems with alternative services more fully, but **these services are not equal in scope or nature to ADHC** in preventing unnecessary use of institutional care or simply don’t exist.

### **Summary**

**California can and should do better for its seniors and disabled adults.** It is now clear that the decision to eliminate funding for ADHC was not a rational budget or policy decision, because \$85 million in funding was retained by the Governor, and I predict that budget number will be significantly higher once all the damage is assessed and the dollars are added up.

**The state’s Transition Plan released on August 5, 2011 should give the Legislature serious cause for concern because it is short on details, long on false promises about people being able to access “alternative services” in a seamless manner to avoid institutionalization, and builds a bridge to nowhere for our state’s most vulnerable citizens.**

The Transition Plan assumes managed care and fee-for-service care coordination will deliver the same services patients receive in ADHC at a lower cost, which a public managed care plan association representative cautioned at the August 5, 2011 stakeholder meeting that the **plans cannot deliver the same services that ADHC provides and expectations have to be lowered.**

The state’s Transition Plan assumes that other services are going to substitute for ADHC, when **it is a fact that many Medi-Cal and community services have been cut or completely eliminated in recent years.**

**The Transition Plan actually *increases* fragmentation of care** because low-income elderly and disabled patients will be forced to find and get their care from multiple settings. With access barriers to transportation a well documented problem, medical appointments will be missed and health conditions will deteriorate.

**Even more tragically, there will be patients who simply disappear between the cracks, become institutionalized or die.** This will cost the taxpayer more than the pennies saved by elimination of the ADHC benefit, because the patients will have lost the regular eyes-on, hands-on monitoring, care management and skilled health care that ADHC uniquely provides.

### **Recommendations:**

**Your continued Legislative oversight of this ADHC transition toward elimination is critical because too many vulnerable lives are at stake in your communities.**

**The Department must be held accountable for tracking what happens to the 37,000 patients displaced from ADHC to report health and morbidity outcomes as well as financial impact.**

**The cost and consequences of this decision to eliminate access to ADHC for the Medi-Cal population must be made public and transparent to inform your future decisions as health care reform descends upon California.**

The Legislature has an opportunity in the next month to convince the Governor to correct this mistake before it is too late, and retain ADHC as a site-of-care choice and benefit, through the following options:

- Immediately acting to delay the October 1 date for automatic enrollment into managed care so all patients and stakeholders can be well informed about managed care and their choices;
- Insisting on the development of more details, a budget for the \$85 million appropriation, and all costs of the transition;
- Submission of a federal waiver to convert ADHC to a waiver program for a more targeted high risk/high cost population;
- Adding ADHC as a “carved-in” managed care benefit with an adequate rate paid to the managed care plans;
- Directing the state to contract with ADHCs that are in rural counties or serve a highly specialized population;
- Phasing in the transition over, at minimum, a period of one year so managed care contracts can be put in place with centers, and feedback about implementation problems can be monitored and lead to course corrections.

The Legislature set this elimination in motion along with the Governor and has a duty to satisfy itself that no dual eligible seniors or adults with disabling conditions will be left behind to suffer the consequences of a failed transition plan.