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Senate Budget Committee #3
The Honorable Mark DeSaulnier, Chair
Discussion and Oversight of
Administration's Transition Plan for Adult Day Health Care
September 2, 2011

TESTIMONY OF LYDIA MISSAELIDES, MHA, EXECUTIVE DIRECTOR

Mr. Chair and Members of the Senate Budget Committee, thank you for holding this oversight hearing on the ADHC transition plan that eliminates the ADHC 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 community and who are upset, confused and angry about the elimination of the ADHC benefit and the turmoil 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 as an alternative not only to nursing facility placement but also high cost ERs and hospitals. As my hospital colleagues will say, the quickest way to a nursing home is through the emergency department.

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."

It is a tragedy that this model of care would be decimated just at the moment in time that innovative national health care reform efforts call for team-based community care in partnership with medical services – in other words, the ADHC model! Let's be clear. The elimination of ADHC has removed the only out-of-home option that serves to improve and stabilize health or mental status and the functioning of the patient in the community setting and also supports the caregiver by providing the outcome of respite. The social and medical literature is clear that caregiver stress is a high predictor of nursing facility placement.

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 testifies to this fact. In fact, reports I receive from around the state indicate increasing alarm as more details of the transition plan are revealed. ADHCs, alternative service providers and managed care organizations are realizing the complexity of the task, accelerated timeframe, lack of services and vulnerability of the population.

Here are the simple truths we have learned from months of testimony and outcomes of the 18 center closures to date:

1. The personal choice to have one's care needs met outside of the home in a group setting has been taken away for the vast majority of the neediest Medi-Cal and private pay Californians
2. California is the only state to abandon this model of care as a choice for poor and middle income seniors and families
3. A person can be institutionalized in their own home, deprived of regular human contact, leading to isolation and depression which leads to a downward spiral of functioning
4. Caregivers without out-of-home relief will institutionalize their family member when they can no longer cope with the stress or become disabled and die prematurely.
5. Feelings of abandonment will lead to acting out and suicidal behaviors.
6. Hospitalizations and nursing facility placements will occur even when other services may be available because of the waiting time to be admitted into community-based services and supports, while admission to the ER and nursing facility is immediate.
7. No one can say what the true societal or budgetary cost of eliminating ADHC will be, during the transition period or ongoing.

Have we just substituted one integrated model of care with even more fragmented care than exists today? I believe you will discover that the unfortunate answer is, yes.

That being said, we are very clear the ADHC benefit has been eliminated and there is no substitute, in spite of what appeared was an agreement in March to create a new version of ADHC through a waiver, as has been done in other states.

We are also very clear that the administration intends to move rapidly toward a heavy reliance on managed care or fee-for-service care coordination for all Medi-Cal beneficiaries. This may work as intended for the Medi-Cal only population, but does little for the dually eligible because dually eligible ADHC patients receive most of their health care through Medicare.

It is also clear that the implementers of this plan, led by the very capable Director Toby Douglas and Deputy Director Jane Ogle, have been given an incredibly difficult assignment with no additional resources and under extreme time pressure to move entire bureaucracies and layers of government and commercial plans and companies toward one goal.

They are doing the best they can, but even that best is not enough.

Managed Care for Duals

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 creating four pilot projects in four counties, to be launched 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.

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.

Also, bear in mind, the average age is 78; 25% of our beneficiaries have some form of dementia, 47% have diagnosed mental illness and 62% are non-English speakers, **according to the department’s own transition plan charts.** They do not understand the notices they are getting let alone their options.

Enrollment

Requiring ADHC patients to make a decision about enrolling in Medi-Cal managed care within only four weeks, based on confusing letters not always provided in the language of choice, and enrollment packets designed for Medi-Cal only beneficiaries, simply does not provide adequate explanation or time for beneficiaries to make an informed choice.

In contrast, please consider:

1. Medicare beneficiaries are given 90 days to select a plan. HICAP counselors are available to explain benefits. They are not equally equipped to explain Medi-Cal managed care or how the two insurances interact.
2. The Legislature authorized 12 months to move Seniors and Persons with Disabilities (Medi-Cal only insurance) into managed care. There were community education and outreach activities to prepare beneficiaries for this transition.

There have been no information and outreach meetings in the community about this mandatory enrollment process for ADHC patients.

I have received many communications in the past weeks indicating confusion about what the beneficiary letter mean.

Even a Health Insurance Counseling and Assistance Counselor read the first beneficiary letter as meaning that a person had to enroll in Medicare managed care. Now there are five different letters that have gone out. Some are getting the letter in English and the enrollment packets in their preferred language. All the initial letters went out in English only.

Some beneficiaries believe they are losing their Medicare benefit if they enroll in managed care, others have thrown out the packets, others are paralyzed with inaction not knowing what they mean and what to do. There is confusion about how Medi-Cal Managed care affects Medicare.

The promise to be able to “opt-out” prior to or after being auto-enrolled, rings false because **most will not comprehend how to opt-out prior to enrollment or navigate out of managed care. Again, the form is designed for Medi-Cal only mandatory enrollment and is confusing to understand.**

Why is there disparate treatment of ADHC beneficiaries, who by the state’s own definition, comprise the most vulnerable population? ADHC patients are being treated as experimental subjects in a process over which they have virtually no control. **Most ADHC patients will be enrolled in Medi-Cal managed care on October 1, without their understanding of what that means or with their consent, which, by ethical standards, resembles coercion more than real choice.**

Managed Care Issues

There has been an incredibly steep learning curve on the part of ADHCs, the department, and Plans. The managed care system in large part operates in isolation from home and community based services and supports. Numerous discussions have been held just to understand each others’ world and it is clear there are huge challenges figuring out how the Medi-Cal and Medicare systems are going to work in addition to the carved out benefits such as MSSP and IHSS, and home and community services that are not part of managed care.

The reality is that the dual eligible’s major health services and costs such as physician care, hospital services, and pharmacy are covered by *Medicare* insurance. This is acute and short term medical care.

So, what are patients getting for signing up for Medi-Cal managed care? Not much. Medi-Cal pays what Medicare does not cover for co-insurance, premiums and deductibles. **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.**

The few Medi-Cal benefits left are non-emergency transportation, some limited private duty nursing and limited physical and occupational therapy, if you can find a provider willing to take the meager Medi-Cal rate. The beneficiary will also be assigned a Medi-Cal primary physician even though they already have a Medicare physician. The likelihood they are one and the same physician appears to be low.

Also, not stated in the transition plan, with the exception of County Organized Health System Counties, is the reality is Medi-Cal Managed Care Plans are not required to coordinate with the Medicare benefits, carve-outs or community services, nor is there the systems capacity to do so. The director has stated that plans are free to contract back with centers for ADHC-like services. But, there is little incentive to do so when the bulk of needed care is outside of the purview of managed care, is paid for by Medicare, or carved-out services.

So, what is the point of enrolling everyone in Medi-Cal managed care? The care coordinator actually has control over very few services. And they are not those services critical to maintaining a person in the community without ADHC.

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. An oversight hearing to discuss the SPD enrollment process and how it is faring would be most instructive.**

Plans will not even get information about who is enrolled from ADHCs into their plans until October 6, and then have to do data sorts to figure it out. During October and November the patients will be the dual responsibility of the plan and the center.

- **Who is responsible for seeking and getting alternative services?**
- **How will the plans coordinate with the centers?**
- **When do centers begin discharging patients? Is there a warm hand-off?**
- **If centers close prior to December 1, 2011, what happens then?**
- **What can the plans purchase back from the center if no other workable exist?**
- **If a person is in fee-for-service and handled by APS Healthcare, how does that work?**
- **Since the plan does not control Medicare, how will they know about hospitalizations or medication mismanagement problems or transportation issues, when they do not see them on a regular basis.**

Every week some new information is revealed but not in any organized manner. Weekly meetings are being held with the Plans but the state stopped scheduling weekly meetings with our association leadership when the August plan was released and they have not resumed. Frankly, my volunteer leadership and I are doing our best but are having difficulty tracking and understanding how all the moving parts are going to fit together.

A state run webinar was held this week on the 1,000 slot In-Home Operations (IHO) waiver eligibility criteria and basis of Medicare. While helpful, it was not enough and actually left some people more confused about the IHO waiver, thinking it was for admitting people into a nursing facility. This is not at all a criticism of the efforts of well-meaning state staff, but merely an illustration of the incredible complexity of the many components of transition that are difficult to explain in a two hour webinar. **This is the only training that has been provided to ADHCs. Much more is needed.**

Simply put, this transition plan is moving too fast, with too few details for anyone to get on board and understand what is happening and what it means. 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.

Discharge Planning Issues

There is much confusion and potential for duplication of efforts in determining patients' needs and discharge plans. We keep being told that this transition plan is evolving. Well, that does little good to help providers and patients make plans and avoid wasting time and money figuring out what they are supposed to be doing.

CAADS developed a standardized discharge tool in mid-July because providers received a notice saying all centers are to prepare discharge plans.

Now, at the end of August, the department tells us and the plans that ADHCs should use the IHO waiver assessment tool to assess everyone and will add a one page discharge sheet yet to be provided. This assessment is supposed to be done by state nurse evaluators and is not designed to be a discharge tool.

Expecting providers to complete yet another assessment that contains no objective criteria and relies on a subjective finding to be made regarding NF B level of care, that was designed for state nurses to use, not designed for discharge and duplicates the patient chart, is an example of wasted time and taxpayer dollars (providers learned they are to be paid some unknown amount for doing discharge plans but no details have been provided). We have recommended that the centers use the IHO form for those being referred to the IHO waiver, which is being negotiated with CMS to add a center-based service option. And, centers should be given the choice to use the CAADS standardized form which has been provided electronically thanks to a volunteer donation of labor.

It was reported to me yesterday that the Plans were given the 16-page IHO form and told that centers are to use it and submit to the plans along with a 5-8 page discharge plan and a 10-15 page client plan of care. Then, the plans are still required to do their own Health Risk Assessments on top of all this? This is a labyrinth of assessment, paperwork and workload that is likely to lead to conflicting data and really does not get to the heart of the matter. What are the current needs of this patient and what services might be available to substitute for ADHC and how are they going to access those services? And what happens if no substitute services are available? No one has addressed that question yet.

The department, while well intentioned, has come up with a discharge plan process at the 11th hour with no discussion with the providers and after centers had already begun working on discharge, as they were directed in July by CDA.

This duplication of effort is an unnecessary workload on top of the burden of trying to figure out how to keep center doors open, provide actual daily hands-on care to patients, calm people's nerves, figure out what is expected, meet with Plans or APS, and comply with state rules for daily operations while planning for discharge is not realistic.

This could have been avoided with a more thoughtful stakeholder process. If I am confused about the process and details, I can't give guidance to my members. Since new information seems to emerge every day it has been extremely challenging to figure out what is going on.

Alternative Services

The alphabet soup of alternatives 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 plans or any of many of these alternative services.

There has been no guidance or technical assistance provided to teach providers or beneficiaries what these alternative options mean.

Everyone is familiar with IHSS, most know about MSSP and other community services. But, few know about other listed alternatives such as a Special Needs Plan and what it offers? Can SCAN health plan purchase ADHC services? How much capacity is there in PACE (Program of All Inclusive Care for the Elderly)? What exactly is the IHO waiver and how is it being changed? When will it be approved by CMS? What is APS healthcare going to do for patients? Are they responsible for making referrals or is the center? Information about process, timeframes, who is responsible for what and many details are lacking. Families and providers are being given virtually no guidance. How can families or patients make informed decisions about their health care options with no information?

Alternative services are not equal in scope or nature to ADHC services in preventing unnecessary use of institutional care, have long waiting lists, varying eligibility criteria, don't match up with needs, or simply don't exist in a particular area. With the exception of PACE, this means services will require even more coordination, transportation arrangements and close monitoring to assure services are actually being provided.

It is a challenge for the providers to do discharge planning not knowing whether services that may be referred to are actually available (due to limited slots or eligibility determinations that are out of the ADHC control); or what to do if the family or participant refuses alternative services.

There is no comprehensive listing of these various so-called alternative services and eligibility criteria, availability or how to access these services. Providers cannot prepare discharge plans if they do not understand what these resources are.

Care Coordination

The plan relies heavily on care coordination but care coordination itself is insufficient and will only be frustrated if adequate services are not available. The services that keep someone out of higher cost care are frequently those things that the health system does not pay for. The decimation of home and community services for elders over the past budget cycles leaves even fewer resources to coordinate. Telephonic coordination is not going to cut it for the majority of patients in ADHC. If that were possible, the Medi-Cal field office could have offered that as an option at any time. **But, instead, ADHC was approved because other alternatives were, by definition of the admission criteria, not sufficient or available.**

Nothing is known about APS Healthcare, or who the plans may contract with for care coordination, or their experience with managing care for medically and socially complex duals. This heavy reliance on care management in the absence of services will only frustrate the efforts of well-intentioned people to prevent use of higher cost settings. We worry that care will become even more fragmented because ADHC was able to be the nexus between medical and social services that together made the difference in people's health status and lives.

Summary

It is now clear that the decision to eliminate funding for ADHC was not a budget savings decision, because \$85 million in funding was retained by the Governor, and I predict that budget number will be significantly higher once all 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 unproven 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 the managed care plans have made clear that they **cannot deliver the same services that ADHC provides and expectations must 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:

- 1. Your continued Legislative oversight of this ADHC transition toward elimination is critical because too many vulnerable lives are literally at stake in your communities.**
- 2. The Department must be held accountable for tracking what happens to the 37,000 patients displaced from ADHC to report health, morbidity and mortality outcomes as well as financial impact of eliminating ADHC.**

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

The Legislature has the ability to direct the department to make course corrections before it is too late, find a way to keep the integrity of the congregate health setting for this target population to avoid higher costs, and keep some infrastructure in place for health care reform through the following options:

- Immediately urge the administration to use their authority to postpone 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;
- Phase in the transition over, at minimum, a period of one year so appropriate resources and services can be properly matched with patient's needs, managed care contracts as appropriate and needed can be put in place with centers, and feedback about implementation problems can be monitored and lead to course corrections. This could be done by county or geographic region.
- Require a budget for the \$85 million appropriation, including administrative costs associate with the transition;
- Submit a federal waiver to convert ADHC to a waiver program for a more targeted high risk/high cost population for whom other services are not feasible or available;
- Add ADHC as a "carved-in" managed care benefit with an adequate rate paid to the managed care plans for patients who qualify for the benefit;
- Direct the state to contract with the ADHCs that are in rural counties or serve a highly specialized population;