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**Enhanced Medical Home for Adults With Disabilities in Medi-Cal Fee for Services
Comments and Recommendations on Department of Health Care Services 1115 Waiver Concepts**

The concepts outlined in the “Concept Paper for a Comprehensive Section 1115 Waiver” and the “Enhanced Medical Home” concept paper are broad in scope, lofty in ideals, and vague in how this new enhanced financing model and service structure for California’s Medicaid eligible Seniors and Persons with Disabilities (SPD) population would work within the budget neutrality requirement of the 1115 waiver. The timeframe for finalizing and submitting a proposal to the Centers for Medicare and Medicaid Services (CMS) is ambitious given the magnitude of the changes being considered. Implementation details of how and when implementation would begin are not provided nor are many details about preferred service structures or timeframe.

The controversy among stakeholders representing SPD populations about mandatory enrollment into managed care and the capacity of the current health care system to absorb and appropriately address the needs of this group of beneficiaries makes turning concept into reality complex and ambitious.

That being said, if mandatory enrollment of the SPD population into managed care or enhanced medical home proceed in this waiver application, then the most cost-effective approach is to maximize use of existing providers who are experienced in serving the target population through better coordination of medical and community based services centered on the beneficiaries’ assessed needs.

Improved coordination at the county level of services and integration of Medicare and Medicaid funding streams to bring together the traditional health delivery systems and home-and-community based services will be fundamental to success for the new target population. This effort will require modernization of current eligibility, treatment authorization, reimbursement processes and information technology to prevent harm and maintain continuity of care as beneficiaries are transitioned into new and different systems of care.

ADHC as an Outpatient Integrated Health Setting

Adult Day Health Care (ADHC), which is a model of care built on the concept of a multidisciplinary team, should be included, along with In Home Supportive Services, Multipurpose Senior Services Programs, and PACE as core service providers for this population in a managed care or alternative coordinated system of care.

For almost 30 years, ADHC has played a key role in providing skilled rehabilitative and preventive services to the aged, blind, disabled population, furthering the state’s policy goal of preventing unnecessary or premature institutionalization. ADHC is built on a philosophy of multidisciplinary team care and patient-centered services.

The preventive and health maintenance goals of the ADHC model align with the concept paper’s stated goals of improving coordination of care for beneficiaries with complex medical and psychosocial needs.

ADHC, a key component of the Program of All Inclusive Care for the Elderly (PACE) model, is aligned with the fourth core waiver concept which states that redesign thru the 1115 waiver proposal will “...address the psychosocial, preventative care, and social support needs of high-risk beneficiaries through effective care coordination and management interventions, and linkages to appropriate community-based services.”

This is precisely what the ADHC model does for this high need, high cost population of dually eligible adults with multiple disabling conditions and complex psychosocial needs. The ADHC multi-disciplinary team conducts a thorough assessment of needs and current services and caregiving supports, then develops a plan for delivery of these integrated services and days of attendance. The goal is to minimize beneficiary risk for higher cost medical services, stabilize existing conditions, and maximize independent functioning. Each Medi-Cal beneficiary is approved by Medi-Cal for ADHC service.

Services include:

- Daily nursing
- Skilled social work
- Physical, occupational and speech therapies
- Personal care
- Transportation
- Dietary services and meals
- Social services including coordination with caregivers, physicians and specialists, transportation providers, caregiver education and training, and coordination with other home and community based services the beneficiary may be receiving.

According to a 2006 Health Management Associates report “This cluster of (ADHC) services can be vital to helping people with chronic illnesses and disabilities improve and stabilize their medical, cognitive or mental conditions to maintain their independence and avert a downward slide that results in institutionalization.”¹

Recommendation: It is important to note that over the years several existing county organized health system plans, notably CalOptima and San Mateo County, have attempted to add ADHC as a benefit as part of their benefit package and capitated rate; but negotiations with the state have not led to a successful resolution of these requests to modify the benefit package to include ADHC. We suggest that now is the time.

Promote Organized Delivery Systems of Care / Enhanced Medical Home

The Population Served in ADHC Matches Target Population in Concept Papers

ADHC eligibility criteria target the very high care/high cost dual eligible beneficiaries at risk for institutional use, defined as emergency room, hospital, or nursing facility (See W&I Code 14525) that the concept papers identify as the population for which the greatest savings may be achieved. ADHC serves

¹ *Issue Brief: July 23, 2007, Adult Day Health Care Services: Serving the Chronic Health Needs of Frail Elderly Through Cost-Effective, Non-Institutional Care. Health Management Associates, Washington DC.*

any eligible adult regardless of primary diagnosis. The primary populations served are medically frail elders, mentally disabled, developmentally disabled, cognitively impaired, Alzheimer's disease and related dementia, and physically disabled. The 325 ADHCs throughout the state serve an ethnically and culturally diverse population, many of whom are mono-lingual.

Average Age:	78 (63 percent are over the age of 75)
Gender:	64 percent female; 35 percent male (50 percent are widowed)
Top Five Diagnoses:	Cardiovascular disease; Dementia; Diabetes; Musculoskeletal and Connective Tissue Diseases; Stroke
Number of Diagnoses	64 percent have 3 or more chronic conditions
Medications:	63 percent are dependent on others for medication management.
Number of Medications:	39 percent take six or more medications.

New ADHC medical necessity criteria enacted with the 2009-2010 budget act target exceptionally high need physically, mentally or cognitively disabled individuals who will require more intensive skilled services, "substantial human assistance," with activities of daily living, and care coordination to remain living safely at home. It is expected that the ADHC participant profile will change accordingly to reflect a higher acuity participant who will have a shorter "length of stay" and require more post-ADHC coordination of care and community support. **If these individuals are not part of a medical home, or coordinated system of care, many will cycle back through emergency departments, hospitals and nursing homes after they are discharged from ADHC.**

Enhanced Medical Home

Medi-Cal's current fee-for-service system creates barriers to coordination of care. ADHC beneficiaries represent those the population identified in numerous studies as having high difficulty accessing primary care and specialist physicians. Health disparities are well documented among persons of color. Old age, poverty, ethnicity, and disability also combine to create barriers to timely and appropriate primary and tertiary care. The top five medical, mental and cognitive conditions found among ADHC beneficiaries match those high cost conditions that are most responsive to preventive care.

The benefit of creating an enhanced medical home as an alternative to a fully integrated system is clear. ADHCs are required by law to obtain medical/health information from a beneficiary's personal physician and communicate regularly with the physician or specialist. It is our experience that many ADHC beneficiaries do not have a personal care physician at the time of enrollment in the ADHC for a variety of reasons. If the beneficiary does not have a personal physician the ADHC is required to assist beneficiaries in establishing a relationship with a personal physician. The center physician may temporarily provide the necessary medical information in this instance. We have first-hand knowledge of the difficulties our beneficiaries have in accessing primary health care providers and the consequences of not having a medical home.

Even for ADHC beneficiaries with personal physicians, some physicians are resistant to referring to ADHC or receiving ongoing communication from the ADHC because of the additional burden of time and paperwork for which they are not reimbursed.

Other physicians rely extensively on the ADHC clinical staff for their monitoring and reports of their patient's health status. However, **the existing fee for service system does not reward physicians who do spend extra time with ADHC beneficiaries and do their best to coordinate care planning with the ADHC and oversee medical conditions. But, there are many dedicated medical professionals who see the benefit to their patients and do their utmost to coordinate care. Without addressing the low rates paid to physicians for serving this high need population, the medical home will be an empty promise.**

ADHCs are required to address the diverse ethnic and cultural needs of beneficiaries, many of whom are elderly, frail and mono-lingual. These are individuals who require the services of health professionals who speak their language and understand their culture. **ADHCs are well equipped both linguistically and professionally to partner with the physician, whether primary care or specialist, to optimize care for the beneficiary.**

Recommendation: Therefore, the enhanced medical home concept should include structures and incentives to create a more formal collaboration between physicians, directing medical care, and the ADHC delivering nursing and therapy services to beneficiaries identified by the physician as requiring this level of care. In theory, the current challenges with ADHCs obtaining physician history and physical forms, exchange of patient information and communication between the physician and the ADHC and lack of understanding about the model of care should be reduced or eliminated if the patient has a medical home.

The responsibilities of the medical home are as yet unclear, but as standards are developed, timely communication and clarity about the role of care management will be important to avoid unnecessary overlap or duplication with ADHC responsibilities for coordinating care.

Specialist Care

ADHC participants have challenges accessing specialist care due to the low reimbursement rates and paperwork associated with Medi-Cal. The enhanced medical home is purported to address this issue by including specialists in physician medical home networks, but **we are unclear how the medical home would incentivize specialty physicians to participate.**

Limited examples of how an enhanced medical home collaboration between primary physicians, clinics, hospitals discharge planners and ADHCs might look are occurring today in a small way, resulting from community need and mission to serve this population.

Some ADHC centers have reported success coordinating with mobile physicians and mobile labs to provide care on-site to their patients served by the ADHC center. This coordination and on-site visit allows the physician to see their patient, review the medical chart maintained by the ADHC clinical staff and discuss medical care needs directly with the patient and the ADHC nurse and other staff. The physician's ability to examine, treat and interact with their patient in the ADHC setting has the advantage of providing immediate access to the patient record. ADHC nursing and other care provider

daily charting would provide the opportunity to better monitor health status, coordinate care, make adjustments in medication or care plan treatments and create a “team” approach with the patient and caregivers all on the same page.

Recommendation: Using the medical home concept to permit physicians to visit their patients attending their ADHC promotes effective coordination and creates efficiency of time since the physician can see more than one patient in a group setting, and observe their interactions and behaviors with staff and others, while reviewing the medical record. Group patient visits have been introduced in the Kaiser system for patients with certain conditions. The state should learn from this model and apply it within the enhanced medical home concept with the ADHC serving as a setting for this coordinated medical, nursing and therapy care.

There is a movement among some primary care physicians to return to the practice of making home visits for their elderly and disabled patients. Under a new medical home framework, physicians or clinics could partner with ADHCs to extend the medical home’s ability to coordinate care in the community and provide direct care for patients who need the nursing, therapy, medication monitoring and administration, nutritional monitoring and social services that the ADHC provides under one roof.

Providing a payment and practice mechanism to include the physician as part of the care planning from the outset at the ADHC center for their patient would also enhance the medical home principles of coordinated care management.

Care Management and Coordination

Care coordination is the assurance that the required services are in place to allow the beneficiary to remain in their home safely while accessing needed medical care and other support services. Disease management is self directed care management. For the population served by ADHCs, self directed disease management may be a goal but often is not possible due to mental or cognitive conditions, lack of transportation or inability to communicate needs, or language barriers.

During the ADHC enrollment process ADHCs obtain clinical information from physicians, including specific medical parameters for notification of a change in condition. The regular monitoring of chronic conditions allows the ADHC nurse to intervene on a beneficiary’s behalf, maximizing their relationship with the physician.

ADHC staff know beneficiaries well because they see them on a regular basis. Nurses and clinical staff are able to observe subtle changes in conditions that represent an underlying issue, which, if left untreated by their physician, would result in a full blown health crisis and potential hospitalization.

When a specialty referral does occur, it is often the ADHC care coordinator who will schedule the appointment for the beneficiary who is unable to do so. ADHC staff advocate for beneficiaries in the absence of family members and for families when language barriers prevent them for accessing health or social service resources directly.

But, medical issues are only one part of the story when it comes to the population targeted by the expanded waiver concept paper. Avoidable utilization of high cost medical resources requires more than a good medical home. Lack of social supports, family caregiver dynamics, living arrangements, mental

status, lack of transportation, inadequate nutrition, unsafe living conditions fall outside of traditional medical care, but are often the drivers behind avoidable use and re-use of institutional settings. These are the issues that ADHC staff address every day.

Recommendation: Physicians could contract with ADHCs to provide this level of care coordination for their patients, furthering the goals of this medical home concept.

Managed Care

Although ADHC is currently carved out as a benefit in Medi-Cal managed care systems, there has been interest expressed by county organized health systems (COHS) in including ADHC as a benefit for their dual eligible population.

Recommendation: We support the inclusion of ADHC as a managed care benefit and encourage the state to negotiate appropriate capitated rates to test this approach under the waiver. **If ADHC continues to be accessed under fee for service arrangements as a carve out, it is even more critical to include standards for managed care organizations to coordinate care with fee for service providers such as ADHC and community based waiver services.**

County Medical Services Program

County Medical Services Program added ADHC as a benefit more than a decade ago, recognizing the limited care options available in rural communities and the role that ADHC plays in providing integrated care in one setting. It is not clear how this program would interact with the new envisioned managed care structures.

The unique needs of rural counties and beneficiaries must be addressed through local design and support for alternative non-traditional methods of delivery flexibility and limited options.

Improved Care Delivery – Hospital to Home

We support the concept of improving hospital to home transitions through the use of post acute discharge responsibilities for hospitals, who can utilize community partners to help manage care for those individuals who are at risk for re-admission or nursing home placement due to lack of appropriate support at home. For the SPD population, this could be tested in areas where there is sufficient infrastructure in the community, including ADHC services, to show results of this approach. National health care reform may include incentives to create now hospital to home models. ADHC is positioned to partner with hospital discharge planners to contract for post acute care similar to that offered by home health should this new concept be put into law.

Preparation for National Reforms

Health Care Reform Legislation

The anticipated increase in Medicaid beneficiaries contained in national health care reform will add new SPD beneficiaries to an already stressed and frayed system in California. The potential need for all medical services is significant for this uninsured population. It should be assumed that this new Medicaid population has not had access to regular and preventative medical services. Their conditions

and needs are not known, but the potential increased demand for care management for dual eligibles with chronic conditions means that California must have systems in place outside of the emergency room and hospital to meet their needs.

Besides the obvious concern about the number and availability of primary care and specialist physicians to provide medical services to this expanded population, the capacity of clinics, ADHC, IHSS and other home and community based services should be examined and included in the waiver planning.

The concept paper anticipates incorporating health care reform measures passed by Congress into the waiver. We wish to point out several significant developments affecting ADHC Federal healthcare reform legislation and in Congress.

- Protection for California and other states' adult day health care program to continue as an State Plan benefit is included in the House health care reform legislation as a "no cost" provision.
- Congresswoman Sanchez has introduced HR 3043, which allows adult day health care to be provided as a substitute for Medicare home health services. *Neurology Now September/October 2009* states "Fifty-two percent of the people using adult day care center services {ADHC} nationwide have some cognitive impairment...With so many neurology patients who would potentially benefit from HR.3043 it should come as no surprise that the American Academy of Neurology back the legislation..." The article goes further to state "The American Academy of Neurology (AAN) realizes that this bill [HR 3043] has the potential to provide great benefits to our patients and their caregivers at a time when the aging of the population looms as a huge challenge."

Other Trends

- The epidemic of Alzheimer's disease must be addressed in the waiver. The State Plan for Alzheimer's disease, currently underway at the Health and Human Services Agency should be linked to the waiver in some manner. Earlier detection of Alzheimer's disease and other neurological conditions will require new strategies for integrating health and social services. This disease continues to be "carved out" of the mental health system which creates problems with appropriate access to care.
- As persons with HIV/AIDS are living longer with potent medication regimens, an alarming incidence of cognitive impairment is becoming evident. While the cause is speculative, the fact remains that the health delivery system must prepare for this emerging trend.
- The number and needs of war veterans with traumatic brain injury and disabling physical or mental conditions who are excluded from Veteran's care for various reasons should be considered as a special population with a high need for coordination of services.
- Persons with developmental disabilities are also living longer and as a result experiencing diseases of old age that require specialized training, access and coordination with the regional center care managers.
- Persons with mental illness are considered to be a target population in the waiver concept paper. Existing trained personnel and local mental health resources have been eroding over time, the system has reached a crisis point.