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# Recent History of Adult Day Health Care and Transition of Seniors and Persons With Disabilities Into Managed Care

LEGISLATIVE ANALYST'S OFFICE

Presented to:

Joint Oversight Hearing on Long-Term Care Integration and  
Medi-Cal Managed Care

Assembly Budget Subcommittee No. 1 on Health and Human Services  
Hon. Holly J. Mitchell, Chair

Assembly Committee on Aging and Long-Term Care  
Hon. Mariko Yamada, Chair





## Organization of Handout

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***Organization of Handout.*** This handout provides the following:

- Overview of Medi-Cal.
- Background information on Seniors and Persons with Disabilities (SPDs) and Adult Day Health Care (ADHC).
- Overview of the elimination of the ADHC benefit and the transition of certain ADHC beneficiaries to the new Community-Based Adult Services (CBAS) benefit.
- Overview of implementation of mandatory enrollment of Medi-Cal-only SPDs into managed care in certain counties.



## Overview of Medi-Cal

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- Medi-Cal.** Medi-Cal is California’s Medicaid program, the state-federal program to provide health care services to low-income persons.

  - Most Medi-Cal benefits are administered by the California Department of Health Care Services (DHCS), with oversight by the federal Centers for Medicare and Medicaid Services (CMS).
  - The federal government pays one-half of most Medi-Cal costs.
  
- Medi-Cal Delivers Care Through Two Systems.** There are two main Medi-Cal systems for the delivery of health care: managed care and fee-for-service (FFS).

  - Under Medi-Cal managed care, DHCS contracts with managed care plans to provide health care coverage for Medi-Cal beneficiaries residing in certain counties. The plans receive per person, per month “capitated” payments to deliver all necessary care for enrollees.
  - Under Medi-Cal FFS, a provider receives payment for each service delivered. Beneficiaries may obtain services from any provider who has agreed to accept Medi-Cal payments.
  
- Managed Care Is Provided Through Three Models**

  - **County Organized Health Systems (COHS).** Under this model, there is one health plan run by a public agency and governed by an independent board that includes local representatives. There are 14 COHS counties.
  - **Geographic Managed Care (GMC).** The GMC system allows Medi-Cal beneficiaries to choose to enroll in one of many commercial health plans operating in a county. There are two GMC counties.



## Overview of Medi-Cal

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- ***Two-Plan Model.*** The Two-Plan Model consists of counties where the DHCS contracts with only two managed care plans. One plan generally must be locally developed and operated. The second plan is a commercial health plan selected through a competitive bidding process. There are 14 Two-Plan Model counties.
  
  - ☑ ***Managed Care Available in 30 Counties.*** Currently 30 of the 58 counties in California operate both Medi-Cal managed care and FFS. The other 28 counties offer only Medi-Cal FFS.



## Background on SPDs and ADHCs

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- SPDs.** The SPDs are two categories of individuals who are eligible for Medi-Cal. There are about 1.9 million SPDs in California.

  - Seniors are 65 years or older. Persons with disabilities have physical or mental impairments that meet the requirements for Social Security or Supplemental Security Income benefits.
  - About 1.2 million SPDs—the “dual eligibles”—are also enrolled in Medicare. Medicare is the federal program that provides health care services for qualifying SPDs who have met minimum work requirements and/or disability waiting periods.
  - The SPDs without Medicare coverage are known as Medi-Cal-only SPDs.
  
- ADHC Is an Optional Medicaid Benefit.** All state Medicaid programs have the option to provide—and claim federal financial participation for—services *in addition* to those mandated by federal law. The ADHC is an optional Medi-Cal FFS benefit that consists of an outpatient day care program—up to five days per week per participant—for adult SPDs.
  
- ADHC Services Are Provided at Licensed Centers to Eligible Medi-Cal Beneficiaries.** The ADHC services are provided at licensed ADHC centers, and include medical services, nursing care, meals, social and therapeutic activities, and transportation. Eligibility is based on an individual’s functional limitations, severity of chronic or post-acute health conditions, and risk for nursing home placement. The ADHC centers can be both for-profit and not-for-profit. In 2010-11, most centers in California were for-profit.



## Legislation Authorized Elimination of ADHC Benefit

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- Governor's January 2011 Budget Plan Proposed Elimination of ADHC Benefit.*** The Governor's January budget plan proposed the elimination of ADHC as an optional Medi-Cal benefit in order to achieve General Fund savings. In March 2011, Chapter 3, Statutes of 2011 (AB 97, Committee on Budget), was enacted to eliminate ADHC as an optional Medi-Cal benefit subject to approval by the federal CMS. (The CMS recently approved an amendment to the state's Medicaid plan to delay elimination of the ADHC benefit until April 1, 2012.)
- Vetoed Legislation Would Have Created Alternative to ADHCs.*** In June 2011, the Legislature passed AB 96 (Committee on Budget)—legislation that would authorize creation of the Keeping Adults Free from Institutions (KAFI) program. Generally, KAFI would utilize licensed ADHC centers to provide services to Medi-Cal beneficiaries at high risk of institutionalization. In July of 2011, the Governor vetoed AB 96, and instead proposed that the administration would develop an alternate plan to transition ADHC participants to other services.
- Administration Presents Plan to Transition ADHC Beneficiaries.*** In August 2011, the DHCS presented its plan for transitioning ADHC participants to other services. The plan included the enrollment of ADHC participants in Medi-Cal managed care to coordinate medical and social support needs (possibly In-Home Supportive Services and ADHC-like services). From mid-August through October of 2011, DHCS began implementing the managed care portion of its transition plan.



## Legislation Authorized Elimination of ADHC Benefit (Continued)

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- ☑ ***Lawsuit Challenged Elimination of ADHC Benefit.*** In June 2011, seven plaintiffs filed a class action suit with the U.S. District Court on behalf of all 35,000 ADHC participants. The suit, *Darling et al. v. Douglas*, was brought against DHCS to block the elimination of ADHC as an optional Medi-Cal benefit. In November 2011, DHCS announced that it had reached a settlement with plaintiffs to resolve *Darling et al. v. Douglas*. In January 2012, the Court granted final approval of the settlement. Under the terms of the settlement, ADHC will be eliminated and replaced by a new program called CBAS. The settlement resulted in DHCS having to modify the transition plan that it had begun to implement in August.



## CBAS Replaces ADHC Benefit Under Court Settlement

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- Settlement Outlines Creation of CBAS.** The CBAS services are essentially the same services currently provided to ADHC participants. Most ADHC centers will become CBAS providers, but with few exceptions, only nonprofit entities may qualify as CBAS providers after July 1, 2012.
- CBAS Has Stricter Eligibility Requirements Than ADHC.** In addition to current ADHC eligibility requirements, participants in CBAS must meet (1) nursing home levels of care or (2) certain levels of cognitive impairment, brain injury, mental illness and/or developmental disability.

  - The DHCS is responsible for initial determination of CBAS eligibility for current ADHC participants.
  - The settlement includes due process options for ADHC participants who are initially found to be ineligible for CBAS.
- DHCS Has Begun Transition of ADHC Beneficiaries to CBAS.** About 200 DHCS nurses are conducting face-to-face assessments of ADHC participants who are not categorically or presumptively eligible for CBAS to determine whether these ADHC participants are eligible for CBAS.
- DHCS Still Seeking Federal Approval for CBAS Benefit.** At the time this handout was prepared, the federal CMS was reviewing the proposed "Section 1115 waiver" amendment for the state to implement CBAS as a Medi-Cal benefit.





## Mandatory Enrollment of SPDs Into Managed Care Allowable Under 1115 Waiver

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- ☑ **California's 1115 Waiver.** The 1115 waiver gives the state authority to waive certain provisions of the federal Medicaid statute in order to operate demonstration projects.
  
- ☑ **Federal Government Approves Waiver to Mandatorily Enroll Medi-Cal-Only SPDs in Managed Care**
  - In June 2010, the DHCS submitted a 1115 waiver proposal to CMS titled "California's Bridge to Reform."
  - In November 2010, the federal government approved the Bridge to Reform waiver for the five-year period ending October 31, 2015.
  - The approved waiver includes the state's intent to mandatorily enroll 380,000 Medi-Cal-only SPDs residing in Two-Plan and GMC counties (16 counties total) in managed care, using a phased-in 12-month transition.
  - The waiver's *Special Terms and Conditions* include a "continuity of care" requirement for plans to (1) allow "seamless care with existing providers" for a period of 12 months after enrollment and (2) attempt to bring these providers into their networks.



## Legislature Authorized Transition of Medi-Cal-Only SPDs Into Managed Care

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### **Budget-Related Legislation Allows DHCS to Mandatorily Enroll Medi-Cal-Only SPDs in Managed Care**

- In October 2010, Chapter 714, Statutes of 2010 (SB 208, Steinberg), was enacted to permit DHCS to mandatorily enroll Medi-Cal-only SPDs into Medi-Cal managed care plans as proposed under the Bridge to Reform waiver.
- Chapter 714 requires DHCS to provide semiannual reports to the Legislature on managed care enrollment activities for Medi-Cal-only SPDs.



## Transition of Medi-Cal-Only SPDs Into Managed Care Is Ongoing

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- ☑ ***DHCS Postpones Start of Enrollment.*** Under DHCS' implementation plan, the original date for initiating mandatory enrollment of Medi-Cal-only SPDs into managed care was February 1, 2011. In September 2010, DHCS revised the start date to June 1, 2011, shifting the 12-month enrollment period to June 2011 through May 2012.
- ☑ ***DHCS Provides Second Semiannual Report to Legislature.*** In July 2011, DHCS presented its second semiannual report to the Legislature. The report covered the period of January through June 2011 and described the following activities:

  - ***Plan Review Completed—January 2011.*** The DHCS completed reviews of each plan's readiness to serve SPD beneficiaries.
  - ***Notification Strategy Developed—February Through March 2011.*** The DHCS developed a notification strategy for affected SPDs, consisting of three separate mailings and two telephone calls. The DHCS also held one community presentation in each Two-Plan and GMC county regarding the transition.
  - ***Key Data Provided to Health Plans—April 2011.*** The DHCS provided FFS utilization data for health plans to perform risk assessments of prospective SPD members and better understand their health care needs.
  - ***CMS Gives Approval—May 2011.*** The CMS approved final contracts between DHCS and managed care plans for Medi-Cal-only SPDs.
- ☑ ***Some SPDs and Providers Requested Exemptions.*** The second report to the Legislature stated that during the first month of enrollment, DHCS received medical exemption requests from SPDs and their providers.



## Transition of Medi-Cal-Only SPDs Into Managed Care Is Ongoing *(Continued)*

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***Legislature Has Performed Oversight of the SPD Transition.***

On December 7, 2011, the Assembly and Senate health committees conducted a joint oversight hearing on the Medi-Cal-only SPD transition, with DHCS and stakeholders testifying on the enrollment process up to that point.