HMA

HEALTH MANAGEMENT ASSOCIATES

# Keeping Adults Free from Institutions (KAFI): Medicaid Options to Guide Program Design

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*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring*

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# Contents

Introduction ..... 1
Background: The Medi-Cal ADHC Benefit ..... 2
Eligibility for Medi-Cal-Funded ADHC Services ..... 2
Scope of Medi-Cal Covered ADHC Services ..... 3
Other Medi-Cal-Funded Adult Day Services and Supports ..... 4
Summary of AB 97 KAFI Requirements ..... 5
Transition Services ..... 6
The Keeping Adults Free from Institutions (KAFI) Program ..... 6
Medicaid Coverage of Adult Day Health Care (ADHC) In Other States ..... 7
Analysis of Available Medicaid Options ..... 8
The 1915(i) Medicaid State Plan Option ..... 8
Amend an Existing 1915(c) Waiver ..... 9
Create a new 1915(c) Waiver for ADHC Services ..... 10
Amend California's Medicaid State Plan to include ADHC as a Managed Care Service ..... 10
Using the PACE Option ..... 11
Amend California's existing 1115 Waiver ..... 11
Implement Multiple Options ..... 12
Discussion ..... 13
Conclusion ..... 15
Appendix I: Excerpt from AB 97 (Chapter 3, Statutes of 2011) ..... 16
Appendix II: High-Level Comparison of 1915(i) and Waiver Options ..... 18
Appendix III: Comparison of 1915(i) Option Pre and Post ACA ..... 19

# Introduction

The 2010-2011 California Legislature enacted AB 97 eliminating Adult Day Health Care as a Medi-Cal covered service.

The legislature is instead proposing to transition individuals no longer eligible for ADHC services to other service options including California's In-Home Supportive Services program, (which provides personal care and related services) or to existing home and community-based services (HCBS) waivers.

The legislation also proposes creation of a new Keeping Adults Free from Institutions (KAFI) program, but additional legislation is required to authorize this program. AB 97 also authorizes the provision of short-term transition services.

The proposed KAFI program is targeted to persons with "higher acuity needs", which is not further defined.

The budget passed by the legislature (but not yet sent to the Governor) reduces appropriations previously used to fund ADHC services by 50 percent. The 50 percent of remaining funding is to be used for short-term expenditures to support transition of previously eligible ADHC services recipients to alternative services and for the KAFI program.[1]

The California Department of Health care Services (DHCS) is now working on various activities related to the legislation. These include:

- Issuing notice to tribal organizations of the elimination of ADHC as a Medi-Cal service (a notice that is required by federal law);
- Removing ADHC services from the Medi-Cal state plan and preparing to submit this change to the federal Centers for Medicare and Medicaid Services (CMS) for review and approval; and
- Designing the short term transition plan.

DHCS has not yet been authorized to work on the KAFI program.

AARP has asked Health Management Associates (HMA) to provide an Issue Brief that describes the options available to California in crafting the new KAFI program, including:

- An analytic framework for deciding how to approach the design of the new KAFI program, which will help to inform decisions to address the abovementioned objectives;
- Information on options available under the federal Medicaid program, with the advantages and disadvantages of each option, in consideration of the objectives; and
- Examples of how other states have addressed Medicaid options for providing the services proposed to be provided under the new KAFI program.

[1] ADHC could not be limited to a set dollar amount because it was a Medi-Cal covered service The appropriation serves as an estimate of future spending for Medi-Cal services.

## Background: The Medi-Cal ADHC Benefit

California's Medicaid State Plan has included Adult Day Health Care (ADHC) services as a covered benefit for over 25 years and in 2009, nearly 39,000 elders or persons with disabilities received Medi-Cal funded ADHC services.[2]

During the State Fiscal Year 2011-12 state budget deliberations, however, the California Legislature enacted AB 97 eliminating ADHC as a Medicaid State Plan benefit. While this change is subject to CMS approval, with the passage of AB 97, the state has no program or budget expenditure authority to continue the program. A description of the Medi-Cal ADHC eligibility criteria and service package immediately prior to the passage of AB 97 follows.

### Eligibility for Medi-Cal-Funded ADHC Services

Most beneficiaries receiving Medi-Cal-funded ADHC services are frail older adults, often with multiple chronic medical, cognitive and mental health needs such as Alzheimer's disease and dementia. However, ADHC recipients also include individuals with developmental disabilities and severe and persistent mental illness.[3] To be eligible for ADHC services, beneficiaries must meet all of the following criteria.[4]

- ***Age:*** Be 18 years of age or older.
- ***Medical Necessity:*** Have one or more chronic or post-acute medical, cognitive, or mental health conditions, and have the ADHC services requested by a physician, nurse practitioner, or other health care provider.
- ***Functional Impairments:*** Require assistance or supervision with two or more functional impairments involving six specified activities of daily living (ADLs) or nine specified instrumental activities of daily living (IADLs). Examples include ambulation, bathing, dressing, self-feeding, toileting, transferring, medication management, hygiene, laundry and meal preparation.
- ***Need for Ongoing or Intermittent Interventions:*** Require ongoing or intermittent protective supervisions, assessment, or intervention by a skilled health or mental health professional to improve, stabilize, maintain, or minimize deterioration of the medical, cognitive, or mental health condition.
- ***Need for Individualized Services:*** Require services that are individualized and planned, including when necessary, the coordination of formal and informal services to support the individual in the living arrangement of choice and to avoid or delay the use of emergency department services, inpatient acute care hospital services, inpatient mental health

[2] The Lewin Group, *Projected Economic Impact of Eliminating California's Medi-Cal Adult Day Health Care Program*, Prepared for the Congress of California Seniors, May 18, 2010. Estimates based on the California Department of Aging's ADHC Program Fact Sheet.
[3] Ibid.
[4] See Welfare and Institutions Code 14525.1 for complete text.

services or placement in a nursing facility or Intermediate Care Facility for the Developmentally Disabled-Habilitative (ICF/DD-H).

The DHCS proposed to implement more restrictive eligibility requirements effective March 1, 2010 but on February 24, 2010, the US District Court (Northern California) enjoined the state from implementing these more restrictive eligibility criteria.[5,6]

## Scope of Medi-Cal Covered ADHC Services

ADHC centers that provide Medi-Cal-funded ADHC services are required to provide both daily core services and services that are separately-billable.[7] Daily core services include:

- Professional nursing services;
- Personal care services;
- Therapeutic services provided by the ADHC center activity coordinator or other trained personnel, and
- At least one meal per day of attendance.

Additional services that may be provided include:

- Podiatric services;
- Optometric screening and advice for low-vision cases;
- Dental Screening Services, and
- Other services within the concept and objectives of the adult day health care, as approved by the DHCS.

Services that are separately billable to Medi-Cal (not included in the daily ADHC rate) include:

- Physical therapy services;
- Occupational therapy services;
- Speech and language pathology services;
- Mental health services;
- Registered dietician services, and
- Transportation services.

[5] In 2009, the requirement that an individual meet institutional level of care was added to the existing eligibility requirements.

[6] California attempted to revise the eligibility criteria for ADHC to reduce the number of qualifying ADLs and IADLs, to include a requirement that participants meet hospital, skilled nursing facility or intermediate care facility level of care, and to impose additional requirements on individuals with mental illness, Alzheimer's Disease, or other cognitive impairments.

[7] See Welfare and Institutions Code §14550.5 for daily core service requirements, and Welfare and Institutions Code §14571.2 (b) for a list of separately-billable services.

## Other Medi-Cal-Funded Adult Day Services and Supports

Unlike many other states, California does not include adult day health services in its existing 1915(c) home and community-based services (HCBS) waivers. While "Adult Day Services" and "Adult Day Supports" are included in one of California's HCBS waivers (the Multipurpose Senior Services Program (MSSP)), neither of these services includes a health component.

- Adult Day Services is a service that provides opportunities for socialization in a day program setting.
- Adult Day Support centers provide a structured (but non-medical) program to individuals who have functional deficits and who need oversight and supervision.

Further, MSSP enrollment is limited to individuals who meet nursing home admission requirements but who reside at home, and is not available in all California counties.

## Summary of AB 97 KAFI Requirements

The 2010-2011 California Legislature enacted AB 97 eliminating Adult Day Health Care as a Medi-Cal covered service.

The legislature is instead proposing to transition individuals no longer eligible for ADHC services to other service options including California's In-Home Supportive Services program, (which provides personal care and related services) or to existing home and community-based services (HCBS) waivers. AB 97 also authorizes the provision of short-term transition services.

The legislation proposes creation of a new Keeping Adults Free from Institutions (KAFI) program, but additional legislation is required to authorize this program. The proposed KAFI program is targeted to persons with "higher acuity needs", which is not further defined.

The budget passed by the legislature (but not yet sent to the Governor) reduces appropriations previously used to fund ADHC services by 50 percent. The 50 percent of remaining funding is to be used for short-term expenditures to support transition of previously eligible ADHC services recipients to alternative services and for the KAFI program.[8]

The California Department of Health care Services (DHCS) is now working on various activities related to the legislation. These include:

- Issuing notice to tribal organizations of the elimination of ADHC as a Medi-Cal service (a notice that is required by federal law);
- Removing ADHC services from the Medi-Cal state plan and preparing to submit this change to the federal Centers for Medicare and Medicaid Services (CMS) for review and approval; and
- Designing the short term transition plan.

DHCS has not yet been authorized to work on the KAFI program. At least two bills have been introduced that provide additional program authority for KAFI: SB 73 (DeSaulnier), as amended on March 25, 2011, permits the DHCS to implement KAFI through a Medicaid state plan amendment (SPA), federal waiver, or a combination of the two. [9] SB 1415 (Blumenfield) introduced on March 16, 2011 requires the DHCS to establish the KAFI program for purposes of transitioning individuals from the ADHC program to a program under a Section 1915(c) waiver or to any other supportive services.[10]

[8] ADHC could not be limited to a set dollar amount because it was a Medi-Cal covered service The appropriation serves as an estimate of future spending for Medi-Cal services.
[9] Text of AB 73 is found at the following link: http://info.sen.ca.gov/cgi-bin/postquery?bill_number=sb_73&sess=CUR&house=B&site=sen
[10] Text of AB 1415 is found at the following link: http://info.sen.ca.gov/pub/11-12/bill/asm/ab_1401-1450/ab_1415_bill_20110316_introduced.html

As of the date of this Issue Brief, however, neither SB 73 nor SB 1415 have been enacted leaving AB 97 as the only statutory reference for the new KAFI program. A description of the applicable AB 97 requirements follows.

## Transition Services

AB 97 directs DHCS to implement a short-term program to fund organizations to assist individuals receiving ADHC services to transition to other Medi-Cal services, social services, and respite programs, or to provide social activities and respite assistance for individuals who were receiving ADHC services at the time the services were eliminated. The goal is to minimize the risk of institutionalization for these individuals. Authority is also provided to DHCS to contract for transition services, including exemptions from certain state procurement requirements and authority for advance payments. Implementation of the short-term transition program, however, is subject to an appropriation in the annual Budget Act.

## The Keeping Adults Free from Institutions (KAFI) Program

AB 97 does not actually contain language establishing or creating the KAFI program. Instead, it generally refers to other legislation to be adopted during the 2011-12 Regular Session of the Legislature that will do so.

AB 97 goes on to state, however, that the new KAFI program will provide a "well-defined" scope of services to persons who meet a "high medical acuity standard" and are at "significant risk of institutionalization" without community-based services. Specific benefit and eligibility criteria, however, are not provided.

AB 97 also states that it is "the intent of the Legislature" that the KAFI program allow current ADHC recipients who meet "certain high-acuity measures" to "immediately transition" to KAFI services, but no detailed parameters are included to define the high acuity measures or describe the transition process or timelines.

Finally, AB 97 directs DHCS "as prescribed by subsequent statute" to develop a federal waiver to maximize federal reimbursement for the KAFI program to the extent permitted under federal law, but does not specify a particular type of waiver (i.e., a Section 1915(c) HCBS waiver, a 1915(b) freedom of choice waiver or a Section 1115 demonstration waiver).

Therefore, AB 97 expresses legislative intent that a KAFI program be authorized by additional legislation, but does not authorize the development or implementation of the KAFI program.

An excerpt from AB 97 addressing the elimination of the Medi-Cal ADHC benefit, authority for a transition program and the new KAFI program has been included as Appendix I to this Issue Brief.

## Medicaid Coverage of Adult Day Health Care (ADHC) In Other States

Forty-nine states plus the District of Columbia offer Adult Day Health Care (ADHC) Services as a Medicaid-covered service either as a part of their Medicaid State Plan or through a Medicaid waiver, primarily a home and community-based services (HCBS) waiver.[11] Only West Virginia does not offer any Medicaid coverage for ADHC.[12]

There are ten states that cover adult day services or adult day health services under their Medicaid State Plan.[13]

- California (prior to the effective date of elimination), Massachusetts, Maryland, New Jersey, New York, and Texas all provide ADHC services under the Medicaid rehabilitative services option (MRO).
- Washington converted its ADHC services to the 1915(i) HCBS state plan option effective January 1, 2010 after direction from CMS to do so.[14] (CMS has indicated that ADHC services are not "rehabilitative in nature" and so these services should be authorized under either a HCBS waiver or through the 1915(i) HCBS state plan option.) Maryland made this conversion effective July 1, 2008.[15] Nevada also provides ADHC through the 1915(i) option.
- Texas is in the process of converting ADHC services from the MRO to a 1915(i) state plan service.[16]

The remaining states use Medicaid waivers:

- Florida uses a combination 1915(b) Freedom of Choice waiver and 1915(c) HCBS waiver to provide a special ADHC program implemented by a limited number of providers. Florida also includes ADHC services in several of its 1915(c) HCBS waivers.
- Thirty-nine states, plus the District of Columbia, include ADHC services in one or more 1915(c) HCBS waivers.
- Arizona and Tennessee include ADHC services in their 1115 waivers that cover most or all of the state's Medicaid services.[17]

[11] HCBS waivers provide personal care and other services to individuals residing at home or in a homelike setting who would otherwise require care in a nursing home, Intermediate Care Facility for persons with Developmental Disabilities (ICF/DD), or a hospital.
[12] Leading Age, *Adult Day Services/Adult Day Health: Financial Viability and Scope of Services Provide Under Medicaid Waivers,* February 16, 2011.
[13] Some states cover ADHC services under more than one authority. For example, Florida operates a special ADHC program and includes ADHC services as part of some HCBS waivers. Therefore, the total count of states based on the program authority used to implement ADHC services is greater than fifty.
[14] Washington Department of Social and Health Services. HCS Management Bulletin. H09 – 07- Procedure December 16, 2009.
[15] Maryland Medical Assistance Program Transmittal. Medical Day Care Services in HCBS waivers. June 30, 2008.
[16] Other states may be in the process of changing the authority under which they provide ADHC services.
[17] Information summarized from Leading Age, *Adult Day Services/Adult Day Health.*

## Analysis of Available Medicaid Options

The design of a KAFI program that will consume only half of the funds previously spent for ADHC services will obviously require a number of difficult eligibility and benefit policy trade-offs. To leverage federal Medicaid matching funds, the state must also design the program to comply with a Medicaid benefit option. Depending upon the option selected, the state's latitude to define eligibility and benefits will be somewhat constrained. A summary chart of the key features and requirements for each Medicaid option (including the waiver options, as well as the 1915(i) state plan option) are provided in Appendices II and III and a discussion of each option follows.

### The 1915(i) Medicaid State Plan Option

The state option to offer HCBS as a Medicaid State Plan service became available in 2005 and was amended by the Patient Protection and Affordable Care Act (PPACA) effective April 1, 2010.

This option permits states to make an array of HCBS (such as personal care and respite and which may include ADHC services) available to two groups of individuals:

- Individuals who have functional deficits (who need help with such things as bathing, walking, cooking or eating, for example) but who do not meet the criterion for institutional care; and
- Individuals who meet the criterion for institutional care (would otherwise be eligible for nursing facility, ICF/DD, or hospital services).

As noted earlier, several states are using the 1915(i) option to implement ADHC services. However, there are two requirements under 1915(i) that will prevent the State from implementing the KAFI program in the way AB 97 prescribes. These are:

- Section 1915(i) does not permit the state to limit the number of individuals who receive services or to limit 1915(i) expenditures to a specified amount.
- It also requires that a state include the needs-based group (persons who do not meet the criteria for institutional care). The institutional group may also be included but only in conjunction with the needs-based group. It is not clear if AB 97 is targeting persons who meet institutional level of care, but if it is 1915(i) will not meet these target group objectives.

This option does permit a state to phase-in enrollment of individuals in a target group or to phase-in services. However, by the end of five years a state must be serving all individuals eligible for the benefit. To date, CMS has not provided guidance on how a state may utilize the phase-in options.

The DHCS would need to complete a 1915(i) Medicaid state plan template to implement this option and submit it to CMS for review and approval. It is unlikely the 1915(i) submission could be approved by CMS in 90 days although it is not impossible.

### Amend an Existing 1915(c) Waiver

The vast majority of states that provide adult day care and/or adult day health care as a covered Medicaid benefit include them in 1915(c) waivers. California has several 1915(c) waivers, which could be amended to include adult day health services. The existing HCBS waivers including the DD Waiver, NF/AH Waiver, AIDS Waiver, AL Waiver and MSSP Waiver, serve individuals who meet the criterion for institutional care (the DD waiver, for ICF/DD services, the MMSP Waiver and AL Waiver, for nursing home services, and the NF/AH Waiver and AIDS Waiver, for skilled nursing facility and hospital services).

**Table 1: California HCBS Waivers**

| HCBS Waiver Name | Enrollment Cap in 2011 |
|---|---|
| **Developmental Disabilities Waiver** | 95,000[18] |
| **Multipurpose Senior Service Program (MSSP) Waiver** | 16,335 |
| **Assisted Living Waiver (ALW)** | 1,300 (year one) to 3,700 (year five) |
| **AIDS Waiver** | 4,250 |
| **Nursing Facility/Acute Hospital** | 3,032 |

ADHC services could be included in these waivers and medical necessity criteria could further limit who within each waiver could receive ADHC services. 1915(c) waivers can be capped by setting a specific limit on the number of waiver slots available each year for total waiver participation. However, the waiver cannot impose a limit on the number of waiver enrollees who access a service or set a limit on total dollars available for a specific service.

Once an individual is enrolled into a HCBS waiver, they may access all covered waiver services subject only to medical necessity limitations (need for the specific service). It is likely that individuals who previously used only ADHC services and other Medicaid State Plan services, but who were not enrolled into a HCBS waiver, would use some or all waiver services, potentially driving overall expenditures upward. Just over five percent of ADHC services recipients were enrolled in an HCBS waiver in February 2011.[19]

[18] The DD Waiver is an entitlement. Enrollment is not capped. This number represents the projected enrollment for 2011.
[19] DHCS – February 2011 paid claims data.

The existing 1915(c) waivers each have enrollment caps. The MSSP Waiver has a low cap on per person spending at $4,285 annually. Waivers with low cost caps would require an increase in the cap to support the cost of ADHC services. This increase, however, cannot be used solely for ADHC services.

The DHCS would need to complete a 1915(c) waiver amendment to add ADHC services to an existing waiver (for each waiver selected) and submit this to CMS for review and approval. It is unlikely the 1915(c) amendment could be approved by CMS in 90 days.

### Create a new 1915(c) Waiver for ADHC Services

The state could create a new 1915(c) waiver for ADHC services. The waiver could be capped based on the number of individuals the state expects they could serve with the appropriated funds. The waiver could provide a single service, although waiver participants must have access to case management. Case management can be provided as a waiver service, as targeted case management (TCM) or as an administrative activity. The state's existing TCM benefit would be an appropriate and available option. The waiver would be limited to individuals who need institutional care: in this case, probably nursing home care. 1915(c) waiver participants may only be enrolled in one 1915(c) waiver at a time. Therefore, enrollment into an ADHC Waiver would result in loss of access to additional services available in other 1915(c) waivers. However, as noted previously, only a fraction (slightly more than five percent) of ADHC recipients received both HCBS waivers and ADHC services previously.

The DHCS would need to complete a 1915(c) waiver application to implement this option and submit it to CMS for review and approval. It is unlikely a new 1915(c) waiver could be approved by CMS in less than 180 days.

### Amend California's Medicaid State Plan to include ADHC as a Managed Care Service

The state has implemented managed care using various managed care models (for example the Two Plan and Geographic Managed care models), which are authorized in the Medicaid State Plan. ADHC services are currently excluded from managed care but could be "carved-in" to the managed care contracts. This would require:

- A Medicaid State Plan amendment;
- Managed care contract amendments; and
- A revised actuarial study/certification.

Services included in a managed care arrangement must first be authorized under the Medicaid State Plan, under a waiver, or provided as supplemental services, which are services funded from savings achieved from the managed care arrangement.

Once California removes ADHC services from the Medicaid State Plan, the state will need to use one of the three previously mentioned options to include ADHC services as a Medi-Cal service

**and** will also need to amend the managed care portion of the Medicaid State Plan in order to include the services in the managed care contracts.

Inclusion of the services as supplemental services requires identification of managed care savings sufficient to cover the cost of ADHC services.

### Using the PACE Option

The program of All-Inclusive Care for the Elderly (PACE) permits states to provide comprehensive Medicare and Medicaid medical and social services using an interdisciplinary team approach in a PACE Center.

The PACE Center operates as an Adult Day Health Care Center and provides and coordinates all needed preventive, primary, medications, medical and assistive devices, emergency, mental and behavioral health, acute and long-term care services.

An individual is eligible for PACE enrollment if they are 55 years of age or older and meet the criterion for skilled nursing home care. PACE is not available statewide and California has set a cap on the number of PACE slots.

There are five PACE organizations in California serving approximately 2,400 frail elders, with at least three additional organizations pursuing the application process.

While PACE provides access to ADHC services, the narrow age and eligibility requirements, lack of statewideness, and limit on slots, does not make this a viable option for significant access to ADHC services.

### Amend California's existing 1115 Waiver

In late 2010, California received approval from CMS for a new Section 1115 Demonstration waiver that made sweeping reforms in how Medi-Cal services are provided and which sets the stage for implementing provisions of the PPACA.

One key feature of this new waiver is the required mandatory enrollment of seniors and persons with disabilities (SPDs) into at Medi-Cal managed care plan in the 27 counties that have Medi-Cal managed care plans. This requirement applies to SPDs who are eligible for Medi-Cal only. However, dual-eligibles can voluntarily enroll in Medi-Cal managed care plans. Individuals who pay a share-of-cost for Medi-Cal benefits are also mandatory enrollees.[20]

Managed care enrollment is expected to result in a cost savings of 10 percent of the fee-for-service equivalent costs. More than 380,000 individuals[21] are expected to be newly-enrolled in Medi-Cal managed care plans.

[20] Department of Health Care Services, *Medi-Cal Members Questions and Answers,* *http://www.dhcs.ca.gov/individuals/Pages/MMCDSPDMbrFAQ.aspx#process*

[21] California Healthline, *Aged, Blind and Disabled Moving into Managed Care Medi-Cal,* April 25, 2011, http://www.californiahealthline.org/features/2011/aged-blind-disabled-moving-into-managed-medi-cal.aspx

DHCS has established, and CMS has approved, the benefits to be provided to SPDs under the waiver. Adult Day Health Care benefits are excluded.[22] The waiver Special Terms and Conditions imposed by CMS requires that "…any addition or subtraction in Medicaid program benefits, such as home and community based services (HCBS), for any specific population added to the established benefit package will require an amendment to the Demonstration. Attachment M [sic] must also be updated and submitted when such a change is proposed."[23]

**Table 2: SPD Distribution FFS vs. Managed Care Enrollment (Two-Plan, Geographic Managed Care and County Organized Health Plans) As of October, 2009**[24]

| Managed Care Plan Type | SPD Count in Managed Care | Percent of SPD in Managed Care as Total of SPD | SPD Count in Fee for Service | Percent of SPD in FFS at Total of SPD | Total SPD County |
|---|---|---|---|---|---|
| Two-Plan[25] | 159,984 | 14 | 983,319 | 86 | 1,143,303 |
| Geographic Managed Care (GMC) | 32,702 | 17.2 | 157,183 | 82.8 | 189,885 |
| County Organized Health System (COHS) | 217,403 | 98.5 | 3,208 | 1.5 | 220,611 |
| Two-Plan, GMC, & COHS | 410,089 | 26.4 | 1,143,710 | 73.6 | 1,553,799 |

Since ADHC services are no longer a covered benefit, the DHCS could amend the 1115 waiver to include ADHC services as a covered benefit for only SPDs enrolled in mandatory Medi-Cal managed care programs. This would provide an incentive for dual-eligibles to voluntarily enroll in Medi-Cal managed care programs, which may help to offset some of the costs of the ADHC benefit.

DHCS could also permit managed care organizations to provide ADHC services as a substitute for more costly services without the need to amend the 1115 waiver.

## Implement Multiple Options

The state could undertake several options simultaneously. DHCS could apply for a 1915 (c) waiver, amend one or more existing 1915(c) waivers, apply for a 1915(i) State Plan Amendment (or seek to add ADHC to any pending 1915(i) State Plan Amendment) and also submit an amendment to the 1115 waiver to carve in ADHCs for the SPD population. However, if a limit on ADHC expenditures is a primary objective, a new 1915(c) waiver and 1115 waiver amendment are more likely to achieve this objective than other combination of options.

[22] CMS Special Terms and Conditions, California Bridge to Reform Demonstration Waiver. Appendix N. Also, Department of Health Care Services, *SPD Managed Care Exclusion Logic V-5,* prepared by Mercer for basing actuarial estimates.
[23] CMS Special Terms and Conditions, California Bridge to Reform Demonstration Waiver. Condition 78b, page 34.
[24] Summarized from chart prepared by Department of Health Care Services, http://www.dhcs.ca.gov/provgovpart/Documents/Chart%20SPD%20Distribution%20FFS%20v%20Managed%20Care_%202-Plan_%20GMC_%20COHS_%20Oct%202009.pdf
[25] This data does not include Madera and Kings counties as those counties' two-plan model was approved after this data was collected.

## Discussion

Restricting access to ADHC services is likely to leave some individuals without a feasible community-based option for care during the day when family members work or are otherwise unavailable. These individuals may enter nursing homes. Some individuals no longer eligible for ADHC services may be able to remain in the community with access to other services including the HCBS waivers (and so will incur different but continued Medi-Cal costs). However, not all individuals will qualify for the HCBS waivers. The Lewin Group has previously determined that "… the savings associated with eliminating this program would be more than offset by cost-shifting to other services and reductions to State revenue resulting from the program elimination".[26]

**State Objectives**

- ✓ Achieve specified cost savings
- ✓ Prevent unnecessary institutionalization
- ✓ Guard against potential for fraud
- ✓ Complement and coordinate with other community-based services and support
- ✓ Minimize the risk to current ADHC participants during and after transition to KAFI

**Stakeholder Objectives**

- ✓ Minimize the risk to current ADHC participants during and after transition to KAFI
- ✓ Prevent unnecessary institutionalization
- ✓ Consider the impact of ADHC services elimination on family caregivers
- ✓ Consider the economic impact of ADHC center closures on current health and social services, and ADHC centers and their staff
- ✓ Promote cost-effectiveness, preventing fraud and being accountable for use of public funds

Representatives from the Legislature, Brown Administration, providers, consumers, advocates and other stakeholders have all grappled with the excruciating realities of declining revenues and the resulting need to reduce Medi-Cal expenditures.

With these objectives in mind, Table 3 identifies the pros and cons, from both perspectives, of four potential design options that appear to be feasible alternatives for the new KAFI program.

[26] The Lewin Group, *Projected Economic Impact of Eliminating California's Medi-Cal Adult Day Health Care Program*, Prepared for the Congress of California Seniors, May 18, 2010, Estimates based on the California Department of Aging's ADHC Program Fact Sheet. Page 1.

**Table 3: Analysis of KAFI Design Options**

| | AB 97 Objectives | | ADHC Consumer Objectives | |
|---|---|---|---|---|
| **Option** | **Pros** | **Cons** | **Pros** | **Cons** |
| **New 1915(c) waiver for ADHC Services** | Can limit expenditures for ADHC services by capping enrollment and covering a single waiver service – budget certainty | Might result in increased spending in other service categories, such as nursing home services for consumers who can no longer access ADHC services. | Better than no ADHC services at all? | Removes entitlement to services |
| | Narrows the eligibility to higher acuity – must meet institutional level of care | | Permits use of the higher income limit for HCBS waiver group. | Excludes persons below institutional level of care |
| **Amend existing 1915(c) waivers** | Can limit expenditures by capping enrollment but not specifically for ADHC services (can be limited by reasonable medical necessity requirements) | Could drive up costs as persons who did not previously get HCBS waiver services now access these services | Better than no ADHC services at all? | Removes entitlement to services |
| | Narrows the eligibility to higher acuity – must meet institutional level of care | Might result in increased spending in other service categories, such as nursing home services for consumers who can no longer access ADHC services. | Permits use of the higher income limit for HCBS waiver group. | Excludes persons below institutional level of care |
| **Develop a 1915(i) Medicaid State Plan Amendment for ADHC services** | | Might result in increased spending in other service categories, such as nursing home services for consumers who can no longer access ADHC services. | | |
| | | Cannot limit expenditures or cap enrollment | Is an entitlement | |
| | Must include a needs-based group who has needs below institutional level of care. (This might include a broader target group than envisioned by AB 97) | | Must include a needs-based group, who has needs below that of institutional level of care. (Therefore, this option may preserve broad eligibility. | |
| | Might meet objectives depending on how high acuity is defined | May be larger group than envisioned under AB 97. | Permits use of the higher income limit for persons who meet criteria for an existing HCBS waiver in the state (without needing to be enrolled in waiver). | |
| **Add ADHC Services to Managed Care as a covered service** | | Cannot limit expenditures by capping enrollment – if service is offered as a Medicaid State Plan covered service may only be limited by reasonable medical necessity requirements | Better than no ADHC services at all? | Managed care network might offer fewer ADHC providers than now available |

## Conclusion

At the present time, it appears that the option most likely to provide the greatest access to ADHC services and that is feasible based on legislative intent is to **develop a new ADHC HCBS waiver and to permit managed care organizations for SPD to offer ADHC services** as an alternative to more costly care. This approach has some major advantages and disadvantages:

↑ The HCBS waiver will make ADHC services available to a portion of former ADHC services recipients.

↓ The HCBS waiver will exclude individuals who do not meet institutional level of care requirements.

↓ The HCBS waiver must be approved by CMS, which could take six months or longer.

↑ ADHC services included in managed care contracts could be provided to individuals who do not meet institutional level of care.

⇔ The managed care organizations may vary in how they target individuals for this option.

↑ Amendment of the managed care contracts is relatively easy (compared to developing a waiver) and could be accomplished more quickly.

↑ The inclusion of ADHC services in the managed care plans for SPD could attract enrollment of dual eligibles, and increased enrollment is attractive to the state and, potentially, to the managed care plans.

↑ The managed care option as described above does not require an amendment to the recently approved 1115 waiver.

The option that could provide the broadest access to ADHC services but that is less viable in the current budget environment is **use of the 1915(i) HCBS State Plan option**.

This approach also has some major advantages and disadvantages:

↑ This option must include individuals whose needs are below that of institutional care (the needs-based group), and may include persons at institutional level of care as long as the needs-based group is also included.

↓ This option does not permit a cap on enrollment and must be implemented statewide. Therefore, it may be difficult to garner state support to move forward with a 1915(i) program.

↓ The 1915(i) State Plan amendment must be approved by CMS, which could take six months or longer.

## Appendix I: Excerpt from AB 97 (Chapter 3, Statutes of 2011)

**SEC. 104.** Article 6 (commencing with Section 14589) is added to Chapter 8.7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

### Article 6. Cessation of Adult Day Health Care and Assistance with Transition from Adult Day Health Care Services to Other Services

**14589.** (a) The Legislature finds and declares the following:

(1) During times of economic crisis, it is crucial to find areas within the program where efficiencies can be achieved while continuing to provide community-based services that support independence.

(2) Adult Day Health Care (ADHC) has been vulnerable to fraud and, despite attempts to curtail and prevent fraud, including, but not limited to, a moratorium on new facilities and onsite treatment authorization request review, fraud continues in this area.

(3) The state has added services and programs to enable vulnerable populations to remain in the community, including, but not limited to, the Money follows the Person project, California's 1115 Comprehensive Medi-Cal Demonstration Project Waiver: a Bridge to Reform, and services and supports, including day programs, provided under the Lanterman Act. It also continues to explore opportunities to add additional services and programs to help individuals remain in the community, including, but not limited to, pilot projects to better meet the health care needs of individuals dually eligible for both Medicare and Medicaid, and exploring the Community First Choice Option as a Medi-Cal benefit.

(4) There are alternative services to meet the needs of Medi-Cal beneficiaries utilizing ADHC, including in-home supportive services, physical, occupational, and speech therapies, nonemergency medical transportation, and home health services.

(b) Therefore, it is the intent of the Legislature for the department to obtain federal approval to eliminate ADHC as an optional Medi-Cal benefit.

**14589.5.** (a) Notwithstanding any other provision of law related to the Medi-Cal program or to adult day health care, adult day health care is excluded from coverage under the Medi-Cal program.

(b) This section shall only be implemented to the extent permitted by federal law.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the provisions of this section by means of all-county letters, provider bulletins, or similar instructions, without taking further regulatory action.

(d) This section shall be implemented on the first day of the first calendar month following 90 days after the effective date of the act that adds this section or on the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later.

**14590.** (a) As a result of the enactment of this article to eliminate adult day health care as an optional benefit under the Medi-Cal program, the department shall implement a short-term program to fund organizations to assist individuals receiving ADHC services to transition to

other Medi-Cal services, social services, and respite programs, or to provide social activities and respite assistance for individuals who were receiving ADHC services at the time the services were eliminated. The goal of this funding is to minimize the risk of institutionalization by identifying needed services available in the community and providing beneficiaries assistance in accessing those services.

(b) To ensure a smooth transition, adult day health care centers shall provide relevant participant information, including the most recent copy of a participant's individual plan of care, to the department. Final Medi-Cal payment to adult day health care centers is contingent upon the provision of participants' individual plan of care and all documentation supporting that individual plan of care, including medical records, to the grantee. Failure to provide documents under this section is grounds for a temporary withhold of payment to the adult day health care center under the process established pursuant to Section 14107.11.

(c) To implement this section, the department may contract with public or private entities and utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary. Contracts entered into for the purposes of implementing this article, including any contract amendments, system changes pursuant to a change order, and any project or system development notices, may be developed using a competitive process established by the department and shall be exempt from Chapter 5.6 (commencing with Section 11545) of Part 1 of Division 3 of Title 2 of the Government Code, Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, and the Public Contract Code, and any associated policies, procedures, or regulations under those provisions, and shall be exempt from review or approval by any division of the Department of General Services and the California Technology Agency. A contract may provide for periodic advance payments for services to be performed.

(d) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department may implement this article through provider bulletins or similar instructions without taking regulatory action.

(e) Implementation of the short-term program to assist individuals receiving ADHC services to transition to other Medi-Cal services, social services, and respite programs, or to provide social activities and respite assistance for individuals who were receiving ADHC services at the time the services were eliminated, is subject to an appropriation in the annual Budget Act.

**SEC. 105.** During 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. This program will 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 the intent of the Legislature that the program allow current recipients of Adult Day Health Care (ADHC) services that meet certain high acuity measures to immediately transition to KAFI services. As 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. The Budget Act of 2011 includes funding for the KAFI program.

## Appendix II: High-Level Comparison of 1915(i) and Waiver Options

| Federal Authority | Application Requirements | Initial Approval Process | Timeframe for Review and Determination | Features | Budget/Cost Neutrality | Considerations |
|---|---|---|---|---|---|---|
| **1915(b)** | Complete a web-based CMS-issued pre-print waiver application | CMS Regional and Central Office review process | Up to two 90-day periods (not counting time taken to answer CMS questions) | Generally used to restrict freedom of choice of provider (for managed care)<br>May provide enhanced benefits to the extent that managed care savings can be used with CMS approval<br>Does not expand eligibility | "Cost effectiveness" test requires state to show that projected PMPM cost will be no greater than would have been incurred under fee-for-service including a projected inflation factor | CMS more flexible in how States target enhanced benefits |
| **1915(c)** | Complete a web-based CMS-issued pre-print waiver application | CMS Regional and Central Office review process | Up to two 90-day periods (not counting time taken to answer CMS questions) | Provides a wide array of home and community-based services<br>May be operated on less than a statewide basis<br>Can extend Medicaid eligibility to individuals who would be eligible if they resided in an institution | "Cost neutrality" test compares waiver cost to the cost of institutional care at average per person and aggregate cost level (for a specific level of care or separate/ combined levels of care) | Can cap enrollment and establish waiting lists |
| **1115** | No set application | CMS Regional and Central office review; other HHS divisions and Office of Management and Budget more involved | No set timeframe; can be lengthy | Can be used to implement major redesign of the Medicaid program in a state<br>Can also be used to test new programs (Research and Demonstration) Can offer additional services<br>Can be used as a vehicle to expand Medicaid eligibility | "Budget neutrality" test compares waiver costs to a negotiated without-waiver baseline and sets a 5-year cap on federal matching funds | Greatest flexibility for redesigning Medicaid including long-term care<br>CMS policy on 1115 waivers after 2014 remains an unknown |
| **1915(i) HCBS State plan Option** | Complete a CMS-issued pre-print State Plan Amendment | CMS Regional and Central Office review process | Up to two 90-day periods (not counting time taken to answer CMS questions) | Provides a wide array of home and community-based services<br>Can extend Medicaid eligibility to individuals who would be eligible if they were enrolled in a HCBS waiver operating in the state | Not required | Caps and waiting lists are not permitted and services must be offered statewide. |

## Appendix III: Comparison of 1915(i) Option Pre and Post ACA

| Feature | State Plan HCBS option – 1915(i) as amended by ACA (Effective October 1, 2010) | 1915(c) Waiver |
|---|---|---|
| **Vehicle** | State Plan option: Rules for state plans are contained in 42 Code of Federal Regulations (CFR) 430<br>**State Medicaid Director letter SMDL# 10-013, ACA# 4, released August 6, 2010 provides specific guidance on HCBS State Plan option**<br>(Draft rule for SPA HCBS option released 2008 - no further action) | Waiver option: Rules contained in 42 CFR 441<br>Interpretation provided in the CMS 1915(c) Waiver Application Guide |
| **Waiver of Comparability** | Provides authority to offer HCBS (services not otherwise available under the state plan) | States receive this waiver automatically when applying for a Section 1915(c) waiver |
| **Waiver of Statewideness** | Pre-ACA: Could waive statewideness<br>**ACA: Cannot waive statewideness** | Can waive statewideness |
| **Array of services offered** | Pre-ACA: States could use the services listed in 1915(c)(4)(B) **except for** the "other services requested by the state"[27]<br>**ACA: Same service array as available under a 1915(c) waiver. In addition, services for institutional group may differ from services for needs-based group. Services may also be phased-in over a 5-year period.** | States can use all the services listed in 1915(c)(4)(B) including other services the state selects and that are approved by CMS |
| **Number of Persons Served** | Pre-ACA: States can specify a maximum number of persons served (set a cap) and modify this limit as needed<br>**ACA: States may not limit the number served, but states have 5 years to phase-in enrollment of eligible individuals (must be complete within 5 years).**<br>States must submit a projected number of individuals who will receive HCBS and subsequently the actual number.<br>If enrollment exceeds projection, states may modify the non-financial needs-based criteria by notice to CMS and the public 60 days before changes are to be effective.<br>**If needs-based criteria is changed, must continue to offer service to participants under old criteria for as long as option is in** | States can limit the numbers of persons served |

[27] 1915(c)(4)(B): Case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.

| Feature | State Plan HCBS option – 1915(i) as amended by ACA (Effective October 1, 2010) | 1915(c) Waiver |
|---|---|---|
| | **effect.** | |
| **Waiting lists** | Pre-ACA: States may maintain waiting lists for HCB services<br>**ACA: No waiting lists are permitted** | States may maintain waiting lists for HCBS waiver services. There is no federal policy concerning how states administer waiting lists. |
| **Presumptive eligibility** | Permitted for up to 60 days but only for SPA HCBS – not for all Medicaid services that may be available. | No provision to provide presumptive eligibility and receive FFP if consumer is later determined ineligible. |
| **Functional Eligibility/Level of Care** | Pre-ACA: Eligibility criteria is need-based (not tied to institutional level of care) and the criteria for institutional services must be **more stringent** than for SPA HCBS. | Eligibility based on institutional level of care (NF, ICF/MR or hospital)<br>Additional targeting criteria may be used such as diagnosis, age, ADL deficits, etc. |
| **Financial eligibility** | Pre-ACA: Limited to persons with incomes up to 150% FPL. May use institutional deeming rules for medically needy only.<br>**ACA: May utilize the special income eligibility category (incomes up to 300% SSI) for persons eligible for home and community-based services under a waiver approved for the State under subsection (c), (d), or (e) or under section 1115. Such persons do not have to be receiving services under one of these options.** | States may elect to cover persons with incomes up to 300% SSI (aprox 221% FPL) who would, absent the waiver, require services in an institutional setting (as specified in waiver).<br>May also include the medically needy. |
| **Assessment of need** | States are required to provide each individual a face-to-face, independent assessment of need to determine the person's level of necessary services and supports, to establish a service plan, and to prevent unnecessary or inappropriate care. | Individual assessments are required. |
| **Redetermination of eligibility** | Required annually. | Required no less than annually. |
| **Targeted benefits** | Pre-ACA: Not permitted. (One 1915(i) option per state permitted.)<br>**Post-ACA: May offer specific HCBS to specific, targeted populations. May offer multiple 1915(i) service packages or target services within a single benefit package to each group.** | Not permitted. |
| **Care Plan** | States are required to have a written individualized care plan based on the person's assessment. Care plans should be developed using a person-centered planning process. | |
| **Self-direction** | May include self-directed option. | May include self-directed option - now part of standard 1915(c) application. |

| Feature | State Plan HCBS option – 1915(i) as amended by ACA (Effective October 1, 2010) | 1915(c) Waiver |
|---|---|---|
| **Quality Standards** | States need to meet performance standards to illustrate how effectively services meet individuals' needs and maintain persons' health and welfare. AHRQ will be responsible for developing program performance indicators, participant function indicators, and measures of client satisfaction. | States are required to submit a Quality Management Strategy with their waiver application and periodically report progress to CMS through the CMS-373Q process. |
| **Cost-neutrality** | Does not apply – state plan must describe method for calculating the budget for HCBS and include a method for making adjustments. | Must be cost-effective/budget neutral relative to institutional cost. |
| **State match available** | Standard FMAP | |
| **Cost-sharing and post-eligibility treatment of income** | Cost-sharing may apply<br>Pre-ACA: Post-eligibility treatment of income did not apply.<br>**Post-ACA: For the institutional group, may use community post-eligibility rules as for 1915(c) waivers.** | Cost-sharing may apply.<br>Post-eligibility treatment of income may apply. |
| **Annual reporting requirements** | None. | Annual reporting using the CMS-372 report – number of individuals served, service utilization (units and dollars), cost-effectiveness demonstration and quality report. |
| **Submission and Timeframes** | SPA HCBS template for state use<br>Approved by regional administrator CMS – consults with central office of CMS. Disapproval requires central office review<br>CMS has 90-days to act. If CMS requests additional information (RAI), state has 90 days to respond. If CMS takes no action, considered approved. When CMS receives response, new 90-day clock starts.<br>• Effective first day of quarter in which state plan is submitted.<br>• Expenditures may not be earlier than first day of statewide operation, unless otherwise authorized by CMS.<br>Pre-ACA: No time limit on approval period: changes may require amendment.<br>**Post-ACA: If a state elects to target benefit packages or services, SPA is approved for a 5-year period.** | CMS now requests use of the electronic HCBS application, which has been revised and expanded relative to the older paper version.<br>Reviewed by CMS regional office.<br>Time frames: 90 days following submission to CMS to approve or request additional information followed by an additional 90 days to make a decision.<br>Effective on a date specified by CMS. May be retroactive.<br>Initial approval 2 years - renewed subsequently for 2-year periods.<br>**Post-ACA: Pending confirmation from CMS, it appears HCBS waivers will be approved for 5 years if they include dual eligibles.** |