August 22, 2023 *(updated 10-16-23)*

Honorable Gavin Newsom
Governor of California
California Capitol
Sacramento, CA 95814

RE: FY 24-25 State Budget Proposals to address severe lack of equitable access to Community Based Adult Services (CBAS)

Dear Governor Newsom:

The California Association for Adult Day Services, on behalf of 283 Community Based Adult Services (CBAS) providers that serve more than 35,000 frail, low-income elders in our state, respectfully submits the following proposals for your consideration as part of in your FY 24-25 January budget:

1. Increase the base Medi-Cal published CBAS rate from the current $76.27 to $122.42. This reflects the increase in inflation for adult day care and nursing homes between July 2009 (when ADHC rates were frozen during the Great Recession) and July 2023.[1]

2. Adjust the base Medi-Cal published CBAS rate annually to account for cost of living increases using the same U.S. Bureau of Labor Statistics index.

3. Amend WIC Section 14184.201 (e) to establish the Medi-Cal published CBAS rate as the rate floor in Managed Care Plans contracts with CBAS providers.[2]

4. Impose a two-year moratorium on CDPH licensing fees required from CBAS providers, effective January 1, 2024.

5. Following the licensing fee moratorium, permanently reduce fees by 80% to minimize the state's regulatory burden on providers, the vast majority of which are

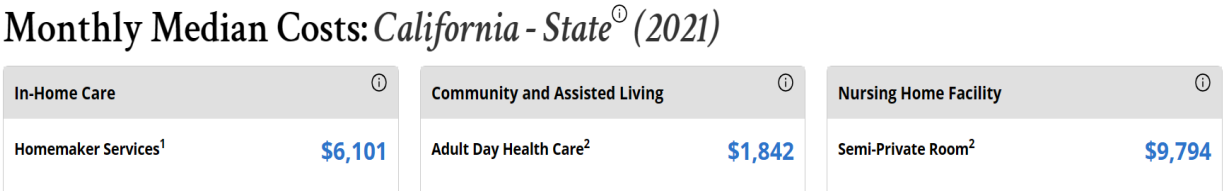
[1] Source: U.S. Bureau of Labor Statistics. BLS began tracking the Consumer Price Index for Nursing homes and adult day services in 1996.
[2] Proposed WIC Code Amendment

small businesses. This can be funded in part by removing CBAS licensing from CDPH and consolidating licensing and certification functions at CDA.

CBAS is an essential component of the state's system of long term services and supports

Community Based Adult Services (CBAS) provide life-affirming and life-saving services to one of California's most vulnerable populations: Medi-Cal eligible frail elders, including those living with dementia, people with chronic disabling conditions, and people with disabilities. CBAS centers predominantly serve culturally and ethnically diverse populations, providing services in a manner that is culturally congruent.[3]

CBAS supports people where they choose to live while addressing complex social determinants of health and prevents use of higher cost care as seen in the chart below published by Genworth.[4]



Demand for CBAS greatly exceeds supply

A recent UCLA Center for Health Policy Research analysis identified significant and growing unmet need for CBAS, finding "there are many more individuals who are potentially eligible for CBAS and MSSP than are currently receiving these services."[5] This is no surprise given that one in five Californians will be 65 or older by 2030; this population is expected to grow more than three times as fast as the total population.[6]

In contrast, access to CBAS has significantly declined over the past decade. Medi-Cal recipients residing in 32 counties have no access to CBAS.[7] Some of these are rural counties where a center once existed but has since closed its doors.

- **The number of ADHC/CBAS centers in the state peaked at 366 in the year 2004.**[8]

[3] https://aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/Participant_Characteristics/
[4] Cost of Long Term Care by State | Cost of Care Report | Genworth
[5] Search Publications | UCLA Center for Health Policy Research
[6] https://aging.ca.gov/Data_and_Reports/Facts_About_California's_Elderly/
[7] https://aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/Service_Area_Map/
[8] CBAS Closures Graph 2004 to 2013

- Only 283 licensed and certified centers remain open today, a net decline of 23%.[9]

- F**ive CBAS centers closed in the 12 months** between May 2022 and April 2023, resulting in two additional counties (Marin; San Joaquin) that have no CBAS center. [10]

- Remarkably, in the eight months between September 2022 and May 2023 there has been a **17% drop in the number of participants served** (from 40,000 to 35,000).[11] This is not because participants stopped needed services. Their needs are going unmet, resulting in negative social and health outcomes, or their needs are being addressed in higher cost institutional settings

- **A 2023 CAADS survey showed that 9% of centers are at high risk of closure**.

- **Centers have little to no ability to shift costs to Medicare**, private pay, or other payers as Medi-Cal beneficiaries make up 97% of all enrollees.[12]

CBAS closures result from decades of disinvestment and other policy changes

This dramatic reduction in access to care results from decades-long depressed CBAS provider rates and Medi-Cal policy changes. Centers are highly stressed because rates have lagged behind the actual cost of doing business. This includes significantly higher labor costs in response to severe workforce shortages; drastic increases in transportation and fuel costs; and new expenses resulting from mandated Medi-Cal and pandemic related policy changes.

Going back to the creation of Adult Day Health Care ("ADHC") as an optional Medi-Cal benefit in 1978, **rates for CBAS have never been based on reasonable cost as required** by state law (W&I Code 14571).

- The current published rate of $76.27 has existed since 2009, a total of 14 years.

- U.S. Bureau of Labor Statistics data show that between 2009 and 2022 inflation for the adult day center sector rose a significant 61%![13]

[9] https://aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/CBAS_Providers/
[10] Source: CDA CBAS Openings & Closures 2012-2023
[11] https://aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/Participant_Characteristics/
[12] Center Overview - Community-Based Adult Services - Providers & Partners | California Department of Aging - State of California
[13] Source: U.S. Bureau of Labor Statistics. https://www.bls.gov/cpi/factsheets/medical-care.htm
BLS began tracking the Consumer Price Index for Nursing homes and adult day services in 1996.

- California and local mandated minimum wage increases have not been acknowledged with commensurate increases in rates, compounding access to quality staff and exacerbating financial stress.

- CAADS created a sample budget applying state and federal law and other mandates for ADHC / CBAS using publicly available data. The result shows the **cost of meeting current regulatory requirements to successfully pass a state survey for an average size center in LA county (160 average daily attendance) exceeds the Medi-Cal reimbursement rate by 31.4%.**

- **Four MCPs that did not restore the 10% rate reduction to CBAS providers in July 2019** (HealthNet; Blue Shield, Molina, and Kaiser) further eroded the fiscal stability of the centers in their service areas.

- In addition to government mandates, MCPs also have imposed additional requirements on CBAS providers without commensurate increases in reimbursement rates. (Examples: authorizations delays that result in barriers to person-centered access; misaligned requirements from various managed care plans requiring unique data reporting systems for compliance; and eligibility variation among managed care plans and Fee-for-Service).

- In addition to not reflecting the reasonable cost of doing business, system problems beyond the centers' control such as unreliable or unavailable public transportation; post-pandemic workforce shortages; and inflation are <u>not</u> considered in the rates MCPs pay centers.

- The imbalance of negotiating power between CBAS centers and MCPs results in "take it or leave it" contracts, contrary to the presumption that reimbursement rates are derived based on analysis of reasonable cost or mutual agreement.

- CAADS cannot legally negotiate with MCPs on behalf of CBAS centers due to antitrust laws prohibiting collective action; these antitrust laws also prohibit centers from collaborating in rate negotiations with MCPs.

- In 2006 CDPH licensing fees were restructured. The cost of licenses required by the state increased overnight from $30 to $4,650 annually. Since then, the licensing fee has risen steadily to the current level of $10,800 - regardless of the size of the facility.[14] This is for no reason other than providing a source of funding for the department with no commensurate increase in the level of service provided by CDPH.

Additional background

- Prior to 1995, the Medi-Cal published rates for ADHC/CBAS were periodically adjusted through the state budget negotiation process.

- In response to a lawsuit settlement in 1995, ADHC rates were linked to 90% of the NF-A rate. This methodology ended in FY 2003-04.

- In 2006 CAADS and DHCS worked together to create a new ADHC rate methodology that would be based on audited cost reports.[15] DHCS ceased requiring cost reports in 2011. Yet again, a rate methodology was not implemented.

- In 2009, because of the historic state budget deficit, the state enacted a series of Medi-Cal cost reduction measures, including a 10% rate cut followed by elimination of ADHC as a State Plan Benefit.

- As a result, public interest advocates filed a federal lawsuit (Darling v. Douglas) under the Americans with Disabilities Act ("ADA") which temporarily halted ADHC elimination.

- In 2011, the parties settled and the resulting agreement created CBAS as a mandatory Medi-Cal managed care benefit under an 1115 Demonstration Waiver.

- The CBAS transition to managed care was completed in mid-2012, with the transition of rural counties.

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[14] https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/2022-23_Health_Care_Facility_License_Fees.pdf

[15] Chapter 691, Statutes of 1996

- As a result of this elimination, transition, and turmoil, fifty (50) centers closed their doors, and at least 3,296 participants lost services.[16]

- Effective July 1, 2019, the state restored funding for provider rates that had been cut in 2009, including CBAS rates. However, four MCOs have not fully restored CBAS rates, as noted earlier. Two of the four have made back payments and two refuse to acknowledge their obligation to do so.

Impact on MediCal eligible seniors and people with disabilities

At the very time when access to these person-centered, lifesaving, cost-saving services has declined, CBAS is needed more than ever before. California's low income and historically marginalized seniors are suffering in silence:

- **The U.S. Surgeon General's 2023 Advisory states that isolation and loneliness are an epidemic** as damaging to Americans' individual and public health as smoking and obesity. "The physical health consequences of poor or insufficient connection include a 29% increased risk of heart disease, a 32% increased risk of stroke, and a 50% increased risk of developing dementia for older adults. Additionally, lacking social connection increases risk of premature death by more than 60%."[17] Studies also show that loneliness and social isolation are associated with higher rates of depression.[18]

- **Depression** is a common problem among older adults, but clinical depression is not a normal part of aging. The services provided at CBAS centers address clinical depression and other mental health conditions. Centers provide socialization and community for participants who would otherwise remain alone in their homes.

- **Seniors are the fastest growing demographic among unhoused people**. One in five participants entered homelessness from an institution.[19]

- The services provided at CBAS centers keep recipients out of institutions. All CBAS participants must meet strict eligibility, including nursing home level of care.

CBAS is the antidote to social isolation, loneliness, and depression

[16] Technical-Brief-on-Access-to-the-CBAS-Program 2014

[17] New Surgeon General Advisory Raises Alarm about the Devastating Impact of the Epidemic of Loneliness and Isolation in the United States | HHS.gov

[18] Loneliness and Social Isolation Linked to Serious Health Conditions (cdc.gov)

[19] CASPEH_Executive_Summary_62023.pdf (ucsf.edu)

Investment in CBAS furthers the state's policy goals

The statewide decline in access to CBAS conflicts with the state's policy goals as envisioned in the **Master Plan for Aging** (MPA) Goal Two: Health Reimagined

> *"We will have access to the services we need to live at home in our communities and to optimize our health and quality of life."*

CBAS is also identified as a core service on Page 19 in the **MPA** LTSS Subcommittee Report.[20]

CBAS is an integral component of **California Advancing and Innovating Medi-Cal (CalAIM)** as the only mandated LTSS non-institutional Managed Care benefit. CBAS is also featured as a community program for Enhanced Care Management and also may offer Community Supports.

From the June 2023 DHCS ECM Policy Guide

> *"ECM is intended to be interdisciplinary, high touch, person centered and provided primarily through in-person interactions with Members where they live, seek care and prefer to access services. Members who will be eligible for ECM are expected to be among the most vulnerable and highest-need Medi-Cal Managed Care Members. It will be critical for ECM Providers to establish strong relationships with these Members (and their parent, caregiver, guardian if applicable), and this will occur most effectively through in-person interactions in locations most convenient for the Member."*

CBAS fits this description beautifully because of decades of accumulated expertise in addressing the complex needs of the dual eligible population, CalAIM Populations of Focus and people living with dementia.

Finally, investment in CBAS aligns with the laudable goals of the Department of Health Care Services as identified in its 2023-2027 Strategic Plan, specifically:

- Goal #1: Be Person Centered - Put people first and design programs and services for whole person care in the community.

[20] https://cdn-west-prod-chhs-01.dsh.ca.gov/chhs/uploads/2020/05/MPA-LTSS-Subcommittee-Report_FINAL-May-2020.pdf

- Goal #2: Increase meaningful access - Ensure individuals get care when, where, and how they need it by strengthening health care coverage, benefits, and provider and service capacity.

- Goal #3: Achieve excellence in health outcomes - Improve quality outcomes, reduce health disparities, and transform the delivery system.

Status at the federal level and in other states

- Centers are eligible to apply for contracts with Veterans Affairs. VA publicly posted rates for CBAS contractors are significantly higher than the current Medi-Cal rate of $76.27.[21]

- Massachusetts ADHCs are comparable to CBAS. MA increased Medi-Cal rates for ADHC on July 1, 2023 to $102.40 per diem for complex beneficiaries. Transportation is paid separately at $26.30 for wheelchair users and $21.47 for non-wheelchair (one-way trip).[22]

Estimated Costs

1. Increase the base Medi-Cal published CBAS rates from the current $76.27 to $122.42. This reflects the rate of inflation between 2009/2010, when ADHC rates were frozen, to calendar year 2023 as found in the U.S. Bureau of Labor Statistics Consumer Price Index subset for California Adult Day Care and Nursing Facilities.

    - **Estimated Cost:** We do not have access to the information required to calculate the estimated GF cost. We propose the state utilize revenue from 2022 MCO tax that are not already allocated to specific provider types.

2. Increase annually the base Medi-Cal published CBAS rate by the Bureau of Labor Statistics CPI.

    - **Estimated Cost:** We do not have access to the information required to calculate the estimated GF cost. We propose the state utilize revenue from 2022 MCO tax that are not already allocated to specific provider types.

[21] V.A. 2023 Fee Schedule - Community Care (Adult Day Care data set for CA)
[22] MASS ADHC ADH Rates101-CMR-310.00 7.2023

3. Amend WIC Section 14184.201 (e) to establish the Medi-Cal published CBAS rate as the rate floor for Managed Care Plan contracts with CBAS providers. [23]

    - **Estimated Cost**: **$1 million GF** administrative costs.

4. Impose a two year moratorium on CDPH licensing fees required from CBAS, effective January 1, 2024.

    - **Estimated Cost:** Per CDPH 2023 Fee schedule[24]: 310 facilities[25] X $10,800 = **$3.348 million GF** in Year 1 and **$3.348 million GF** in Year 2.

5. At the conclusion of the licensing fee moratorium, permanently reduce CBAS licensing fees by 80%. This can be funded in part by transferring certain licensing and certification functions from CDPH to CDA.

    - **Estimated Cost:** Per CDPH 2023 Fee schedule[26]: 310 facilities[27] X $10,800 = $3.348 million x 80% = **$2.678 million GF ongoing**

Projected Outcomes

1) With a sustainable and equitable rate structure policy in place for CBAS, the state is more likely to achieve its goal of achieving equitable access to high quality, person-centered care resulting in positive health and social outcomes for highly at-risk beneficiaries.

2) Access for Medi-Cal beneficiaries will improve, most acutely in rural areas, as fewer centers cease operations and new organizations are licensed and certified as CBAS with the opportunity to then become ECM providers.

3) Medi-Cal system cost savings generated from avoidance or delay of emergency department visits, preventable hospitalizations, and premature or avoidable institutional placement will be realized.

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[23] See Draft Trailer Bill Language - footnote [2]

[24] https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/2022-23_Health_Care_Facility_License_Fees.pdf

[25] https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LC-Health-Care-Facility-Licensing-Fees.aspx

[26] https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/2022-23_Health_Care_Facility_License_Fees.pdf

[27] https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LC-Health-Care-Facility-Licensing-Fees.aspx

For reasons cited above, we respectfully urge your support for these necessary budget proposals.

Thank you in advance for your consideration. We respectfully request the opportunity to meet with you and your team to discuss these proposals in greater detail.

Sincerely,

Lydia Missaelides
Interim Executive Director