

Adult Day Health Care (ADHC) Reform
Department of Health Care Services Report to the Legislature
March 2010

Background:

Senate Bill (SB) 1755 (Chesbro, Chapter 691, Statutes of 2006) required the Department of Health Care Services (DHCS) to implement changes to Medi-Cal's ADHC program, i.e., establish new eligibility criteria for ADHC services as well as specific requirements for Medi-Cal treatment authorization requests (TARs) for ADHC centers, including requiring authorization to be granted only if beneficiaries meet specified medical necessity criteria. SB 1755 also required DHCS to submit an annual report regarding the status of ADHC reform to the relevant policy and fiscal committees of the Legislature (Welfare and Institutions Code, Section 14521.1). This is DHCS' third status report.

The ADHC benefit is a program of health and social services provided to eligible Medi-Cal beneficiaries in a four-hour day format with the goal of preventing or delaying the need for institutionalization and/or the need for more costly Medi-Cal services. The ADHC program is an optional benefit under the Federal Medicaid program and is reimbursed by the federal government at approximately 50 percent federal financial participation (FFP) (61.59 percent FFP under the American Recovery and Reinvestment Act of 2009).

SB 1755 established new eligibility criteria for ADHC services as well as specific requirements for Medi-Cal treatment authorization requests (TARs) for ADHC centers. Overall, SB 1755 resulted in significant reforms to the ADHC benefit under Medi-Cal, as did the following legislation:

- Assembly Bill (AB)x4 5 (Evans, Chapter 5, Statutes of 2009, Fourth Extraordinary Session, Budget Health Trailer Bill) significantly updates the eligibility and medical necessity criteria originally specified in SB 1755. Specifically, ABx4 5 limited the maximum participation for enrollees from five to three days per week until the higher threshold for medical necessity/medical acuity could be implemented by DHCS. This bill also established definitions of medical acuity for enrollment into ADHCs and provided for an enhanced TAR review process. DHCS had targeted implementation of these criteria on March 1, 2010, but, with the exception of an enhanced TAR review, these actions were enjoined by the federal court on February 24, 2010.
- SB 117 (Corbett, Chapter 165, Statutes of 2009) changed SB 1755's original implementation date for the unbundling of the all-inclusive procedure code into its component services and the development of a new reimbursement methodology from August 1, 2010, to August 1, 2012.

SB 1755 required DHCS to implement the following changes to Medi-Cal's ADHC program:

1. Development of new beneficiary eligibility criteria for entry into the program.
2. Development of new medical necessity criteria for adjudication of ADHC TARs.
3. Specification of the role of the participant's personal health care provider and the ADHC center staff physician.
4. Specification of conflict of interest in ADHC center ownership.
5. New requirements for minimum (core) ADHC services.
6. Unbundling of the all-inclusive procedure code into its component services.
7. Development of a new reimbursement methodology based upon prospective costs of the ADHC center.
8. Annual report to the Legislature, starting January 1, 2007, on the implementation of SB 1755-related changes made to the ADHC program and the impact of those changes on the number of centers and participants.

Changes since 2007 report:

DHCS implemented the following on February 1, 2008:

- New definitions to standardize the use of commonly used terms.
- New eligibility criteria that are used to determine when a Medi-Cal beneficiary is eligible for ADHC services.
- New medical necessity criteria for authorization of TARs to standardize the authorization of ADHC services.
- New requirements for participant's personal health care provider that make the provider the person at the center of the participant's health care.
- New conflict of interest language regarding ownership of an ADHC center that will decrease the practice of self-referral (e.g., a physician referring all of his patients to the ADHC center owned by him or his family).
- New minimum service requirements (core services) that mandate the minimum services that an ADHC center must provide to all participants on each day of attendance at the ADHC center.

Changes since 2008 report:

DHCS is on schedule to implement the following by August 1, 2012:

- Unbundling of the current ADHC procedure code into its component services.
- New rate methodology from an all-inclusive per diem rate based on 90 percent Nursing Facility Level A (NF-A) rate to a prospective cost-based rate for "core" services, separately billable services and a reimbursement limit that will cap the maximum amount of dollars the ADHC center can receive per beneficiary per day of attendance.

Overall implementation of SB 1755 is on schedule, including:

1. Development and publication of the Individual Plan of Care (IPC) form:
 - In December 2007, the IPC was published in the Medi-Cal provider manual as required by SB 1755, with copies sent via email and disk to providers upon request.
 - Completion of field office training on use of the new IPC in late 2007 by the DHCS Utilization Management Division.

- Training of all providers (representing approximately 320 ADHC centers) over an approximate 60-day period in late 2007 along with a PowerPoint presentation available upon request.
 - Completion of full implementation of the IPC as specified in SB 1755 by July 2008.
2. Development of a History and Physical form is in process and expected to be completed in 2010. This form will be developed in collaboration with the California Association for Adult Day Services (CAADS) and the California Department of Aging (CDA).
 3. Implementation of all provisions of SB 1755, except unbundling of the all-inclusive billing code and the new rate methodology, began in 2007 with implementation of the IPC. Rate unbundling and the new rate methodology are scheduled for implementation on August 1, 2012.
 4. Development of the new cost reporting form:
 - Created in collaboration with CDA and CAADS.
 - Provider training completed in late 2007 by DHCS Financial Audits Branch for a pilot of the cost reporting form conducted during mid-2008.
 - Pilot completed with scheduled DHCS audits of the returned cost reporting forms from a select number of ADHC providers; audits completed by the end of 2008.
 - Training of ADHC centers statewide for general use of the cost report form completed in spring 2008 by DHCS Financial Audits Branch staff. The cost reporting forms are currently in use.
 5. Internal DHCS discussions regarding the rate methodology for core services, reimbursement limit and rates for the individual bill-direct ADHC services began in March 2008 and continue to date.

It is too soon to determine the impact of these changes to the State and to the ADHC industry. The industry reported favorable impressions of the SB 1755 changes but as noted, DHCS actions associated with ABx4 5 were enjoined by the federal court on February 24, 2010. DHCS is on schedule to implement the following by August 1, 2012:

- Unbundling of the current ADHC procedure code into its component services.
- New rate methodology from an all-inclusive per diem rate based on 90 percent Nursing Facility Level A (NF-A) rate to a prospective cost-based rate for “core” services, separately billable services and a reimbursement limit that will cap the maximum amount of dollars the ADHC center can receive per beneficiary per day of attendance.

Additional impact will come later when the unbundling and new rate methodology are implemented.