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MEDICAID COMMISSION
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On behalf of the California Association for Adult Day Services (CAADS), I am pleased to provide comments to the Medicaid Commission about the importance of Adult Day Health Care (ADHC) to the nation's seniors and individuals with disabilities and how it can improve the long-term sustainability of the Medicaid program.

CAADS is a not-for-profit statewide membership association that supports ADHC programs as an alternative to nursing home care. It is the oldest and largest ADHC association in the country, representing California's 336 licensed and certified ADHC centers. While each center is unique, CAADS provides industry unity and leadership through quality improvement and training activities, as well as promotes the common values that its members share: respect for the uniqueness and strengths of each individual, and support for choice and independence.

What is Adult Day Health Care?

Adult Day Health Care (or Adult Day Services) is a cost-effective alternative to nursing home care and a preventive health care service for frail elders or adults with chronic, disabling conditions who are at risk of institutional placement. Almost every state authorizes and regulates the provision of some type of ADHC, usually through a Home and Community-Based Services 1915(c) Medicaid waiver. However, the following eight innovator states offer it as an optional Medicaid benefit to reduce utilization of nursing homes, emergency rooms, and hospital days: California; Maryland; Massachusetts; New Hampshire; New Jersey; New York; Texas; and Washington. Together, these states currently serve approximately 100,000 Medicaid beneficiaries in ADHC programs.

The eight states that have ADHC model programs offer daytime programs that provide multiple health and preventive services under one roof. This "one-stop" program increases compliance with medical treatments, therapy orders, complex medication regimens, and therapeutic dietary orders.

These model, innovative ADHC programs provide eligible individuals with individualized programs that manage chronic conditions. They also comport with Secretary Leavitt's goal of providing expanded choices and enhanced access to health care services in home- and community-based settings. Thus, the programs offered in the eight states reduce the risk factors for more expensive nursing home placement and institutional care by providing the following services:

→ **Skilled nursing care** to monitor, intervene, and treat health conditions before they become acute;

→ **Therapeutic activities and socialization** with peers to improve and maintain mental status, decrease isolation, and depression;

→ **Individualized dietary and nutrition services**, which are critical to health;

→ **Physical therapy,** which restores and maintains large muscle functioning to maintain independence in activities of daily living and prevent falls;

→ **Occupational therapy,** which restores and maintains the independent living skills needed to manage household activities;

→ **Speech therapy**, which restores the ability to communicate through speech or alternative means, addresses swallowing problems associated with Alzheimer's disease or other neurological conditions, and reduces the risk of pneumonia or choking; and

→ **Social work services** to coordinate with physicians, home care, transportation, community services, and address family and care-giving needs.

How is the Ability of the Eight Model States to Provide ADHC Being Compromised?

Since the mid-1970s, the eight model states have provided ADHC as a benefit under the Rehabilitation Services or Nursing Facility Option in their respective Medicaid state plans. However, over the past two years, the Centers for Medicare and Medicaid Services (CMS) has developed the position that ADHC may no longer be provided under a Medicaid state plan and only can be provided under a 1915(c) waiver.

To comply with CMS's recent demand, the eight states would need to convert the ADHC program to one operating under a 1915(c) waiver. Unfortunately, this retreat from the flexibility previously permitted will put a significant number of frail elders and chronically ill adults at risk of institutionalization because they will be displaced from ADHC services. That is because the 1915(c) waiver contains the following significant limitations and problems for ADHC as an integrated multi-service program:

- Federal law defines discrete populations that may not be combined within one waiver. For example, aged or disabled people may not be served in the same waiver as a waiver for mentally ill individuals. This would unnecessarily segregate and restrict individuals from accessing ADHC services, based merely on diagnosis.
- Waiver rules limit beneficiaries to enrollment in only one waiver at any time. This means that beneficiaries would be placed in the position of choosing either an ADHC waiver or another waiver service, potentially preventing thousands of individuals from accessing ADHC services.
- Federal regulations define eligibility criteria in a manner that is less flexible than what is permitted under a state's Medicaid plan. Under the waiver, beneficiaries must be assessed as being within 30 days of eligibility for nursing home admission, while eligibility for state plan services are defined by each state.

- Waiver programs create significant additional workload and administrative costs for the states, CMS, and providers.
- There is currently no state that defines ADHC as a single service 1915(c) waiver, nor has any state ever converted ADHC from a Medicaid benefit to a program operating under a waiver.

What Would Be the Impact on the Medicaid Program if Beneficiaries Lost ADHC Services?

If Medicaid beneficiaries in the eight model states lose their ADHC services, it would cost the Medicaid program more money in the long run and make it less sustainable.

First, a beneficiary's alternative to ADHC is a nursing home, which is a far more costly set of services for the Medicaid program to provide. In California, the average monthly public expenditure for ADHC is 23 percent of the cost of a nursing home, or $714 versus $3,589. This monthly difference of $2,875 translates into an annual savings of $34,500 per beneficiary over nursing home care. Even taking into account other public costs such as In-Home Support Services and Supplemental Security Income, the annual average cost of maintaining an ADHC beneficiary in the community is 67 percent of the cost of 24-hour nursing home care.

Second, ADHC is economically efficient by providing multiple services for one rate under one roof. If purchased separately, ADHC medical services would cost California an estimated $147.26 per day, exclusive of administrative and facility costs. The current reimbursement rate for ADHC is an all-inclusive $68.57 per day, which includes skilled nursing, therapies, transportation, food services, modified exercise programs, and social work services. Simply put, the economies of scale achieved by bringing frail elders to one location, where they receive multiple services, make cost-effective use of Medicaid's limited resources.

Not only does it produce savings for the Medicaid program, but ADHC also improves health care outcomes for chronically ill or elderly beneficiaries. A 2001 outcomes study underwritten by the California Health Foundation showed that, over a six-month period, ADHC beneficiaries in Alameda County reduced their use of hospital emergency rooms by 7.5 percent, reduced hospital days by 5.4 percent, and reduced the percent of persons using nursing facility days from 7.6 percent to 0.7 percent.

Commission Request

In light of the above, CAADS respectfully requests that, in its final report, the Medicaid Commission make the following recommendations:

1) Permit the eight model states to continue providing ADHC services to their Medicaid beneficiaries as an optional benefit under their Medicaid state plans; or alternatively

2) Reform 1915(c) waivers to give states greater flexibility in designing and maintaining model programs that are cost-effective and improve health care outcomes.

On behalf of CAADS, I appreciate the opportunity to provide this testimony to the Commission. Please do not hesitate to contact us if we can be of any assistance on ADHC or any other Medicaid-related issues.

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