Disability Rights California

California's protection and advocacy system

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MEMORANDUM

TO: Interested Parties

FROM: Disability Rights California

RE: Eligibility for Community Based Adult Services (CBAS) under the *Darling v. Douglas* (Case No. C-09-03798 SBA) Settlement Agreement

DATE: December 2, 2011

On November 17, 2011, the parties reached a settlement in the lawsuit *Esther Darling, et al. v. Toby Douglas, et al.*, which challenged the State's elimination of Adult Day Health Care (ADHC) as an optional Medi-Cal benefit. Under the settlement, ADHC will become a new program, called Community Based Adult Services (CBAS) on March 1, 2012. CBAS will be funded through an 1115 Medi-Cal Waiver and will have some different rules for participant and provider eligibility. Eventually, CBAS will be offered primarily through managed care organizations in geographic areas where Medi-Cal managed care is available. This summary is to help explain the new requirements for eligibility for CBAS.

See http://www.disabilityrightsca.org/advocacy/Darling-v-Douglas/index.html for a copy of the Settlement Agreement and for more information about the case.

I. ELIGIBILITY FOR CBAS SERVICES

The following individuals shall meet the criteria for eligibility for Community Based Adult Services (CBAS) under the Settlement Agreement. First, they must meet the current ADHC eligibility and

medical necessity criteria contained in the ADHC statute [1] and then, the criteria in any one or more in the following categories:

A. Individuals who meet NF-A Level of Care or Above

1. Meet or exceed NF-A level of care as set forth in title 22, sections 51120(a) and 51334(l) of the California Code of Regulations. *These sections shall not be construed to preclude individuals who live in non-medical residential care facilities (board and care facilities), or who live at home, from meeting this level of care.*

2. These individuals do not have to meet any requirements for ADLs or IADLs contained in Welfare and Institutions Code sections 14525(b) and 14526.1(d)(2).

B. Individuals who have an Organic, Acquired or Traumatic Brain Injury and/or Chronic Mental Illness

1. Have been diagnosed by a physician as having an Organic, Acquired or Traumatic Brain Injury, and/or have a Chronic Mental Illness; AND

2. Demonstrate a need for assistance or supervision with at least:

    a. Two (2) of the following ADLs/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene; OR

    b. One (1) ADL/IADL listed in (a) above, and money management, accessing resources, meal preparation, or transportation.

[1] Specifically, California Welfare and Institutions Code §§ 14525 and 14526.1(d) and (e), attached.

C. Individuals with Moderate to Severe Alzheimer's Disease or other Dementia

1. Individuals have moderate to severe Alzheimer's Disease or other dementia, characterized by the descriptors of, or equivalent to, Stages 5, 6, or 7 Alzheimer's Disease;

2. These individuals do not have to meet any requirements for ADLs or IADLs contained in Welfare and Institutions Code sections 14525(b) and 14526.1(d)(2).

D. Individuals with Mild Cognitive Impairment including Moderate Alzheimer's Disease or other Dementia

1. Individuals have mild cognitive impairment or moderate Alzheimer's Disease or other dementia, characterized by the descriptors of, or equivalent to, Stage 4 Alzheimer's Disease; AND

2. the individual must demonstrate a need for assistance or supervision with two of the following ADLS/IADLS: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene.

E. Individuals who have Developmental Disabilities Meet the Criteria for Regional Center Eligibility.

These individuals do not have to meet any requirements for ADLs or IADLs contained in Welfare and Institutions Code sections 14525(b) and 14526.1(d)(2).

For eligibility purposes, applicants/recipients do not need to show a need for a service to be provided at the CBAS center to be included in the qualifying ADL/IADLs above.

II. ASSESSMENT FOR CBAS ELIGIBILITY

Most ADHC participants will be assessed by DHCS nurses between

December 19, 2011 to the end of January, 2012. These assessments will occur at the ADHC center, and in collaboration with ADHC center staff. In order to assess all or most ADHC participants before the ADHC Medi-Cal benefit ends on February 29, 2012, Some current ADHC participants are going to be considered **"categorically"** or **"presumptively"** eligible for CBAS.

A. Categorically Eligible

Class Members who are categorically eligible for CBAS are current ADHC recipients who are: Regional Center clients; Multi-Purpose Senior Services Program (MSSP) clients; eligible for Specialty Mental Health services; and/or eligible to receive 195 or more hours of In-Home Supportive Services (IHSS) per month. These individuals will be ascertained through a data run by DHCS or other departments. They will be eligible to receive CBAS services at the level that they currently receive ADHC services at least until their reassessment after transition to managed care.

B. Presumptively Eligible

Class Members who are presumptively eligible for CBAS are current ADHC recipients who are: likely to meet NF-B level of care (as set forth in 22 Cal. Code Regs. §§ 51334(j) and 51124), as determined by DHCS, or whose ADHC Individual Plans of Care indicate a need for assistance or supervision with three (3) of the following ADLs/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene, and one nursing intervention at ADHC, as determined by DHCS' review of all ADHC participants' current IPCs. Presumptively eligible Class Members will transition to fee-for-service CBAS and will receive a face-to-face assessment by DHCS within three (3) months.

III. OTHER DEFINITIONS OF INTEREST

A. Chronic Mental Illness

A person with "chronic mental illness," as set forth in Section I.B. above, shall have one or more of the following diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders*, DSM IV TR, Fourth Edition, Text Revision (2000), published by the American Psychiatric Association: (a) Pervasive Developmental Disorders (except as covered through Regional Centers); (b) Attention Deficit and Disruptive Behavior Disorders; (c) Feeding & Eating Disorder of Infancy or Early Childhood; (d) Elimination Disorders; (e) Other Disorders of Infancy, Childhood, or Adolescence; (f) Schizophrenia & Other Psychotic Disorders; (g) Mood Disorders; (h) Anxiety Disorders; (i) Somatoform Disorders; (j) Factitious Disorders; (k) Dissociative Disorders; (l) Paraphilias; (m) Gender Identity Disorders; (n) Eating Disorders; (o) Impulse-Control Disorders Not Elsewhere Classified; (p) Adjustment Disorders; (q) Personality Disorders; or (r) Medication-Induced Movement Disorders.

If the DSM IV is updated during the term of this Agreement, similar and related disorders defined in any subsequent versions of the DSM should be used in lieu of any disorders no longer used.

B. Developmental Disability

A person with a "developmental disability" shall have a disability meeting the definitions and requirements set forth in title 17, section 54001(a) of the California Code of Regulations, as determined by a Regional Center under contract with the Department of Developmental Services.

C. Nursing Facility-A (NF-A) Level of Care:

"Nursing Facility-A (NF-A) Level of Care" is set forth in title 22, sections 51120(a) and 51334(l) of the California Code of Regulations. For purposes of this settlement, sections 51120(a)(1), 51334(l), and 51334(l)(1) shall not be construed to preclude individuals who live in non-medical residential care facilities (board and care facilities), or who live at home, from meeting this level of care.

Title 22 section 51120(a) of the California Code of Regulations provides:

Intermediate care services means services provided in hospitals, skilled nursing facilities or intermediate care facilities to patients who:

(1) Require protective and supportive care, because of mental or physical conditions or both, above the level of board and care.
(2) Do not require continuous supervision of care by a licensed registered or vocational nurse except for brief spells of illness.
(3) Do not have an illness, injury, or disability for which hospital or skilled nursing facility services are required.

Title 22 section 51334(l) of the California Code of Regulations provides:

In order to qualify for intermediate care services, a patient shall have a medical condition which needs an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration. Intermediate care services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encouragement of individual patient independence to the extent of his ability. As a

guide in determining the need for intermediate care services, the following factors may assist in determining appropriate placement:

(1) The complexity of the patient's medical problems is such that he requires skilled nursing care or observation on an ongoing intermittent basis and 24-hour supervision to meet his health needs.

(2) Medications may be mainly supportive or stabilizing but still require professional nurse observation for response and effect on an intermittent basis. Patients on daily injectable medications or regular doses of PRN narcotics may not qualify.

(3) Diet may be of a special type, but patient needs little or no assistance in feeding himself.

(4) The patient may require minor assistance or supervision in personal care, such as in bathing or dressing.

(5) The patient may need encouragement in restorative measures for increasing and strengthening his functional capacity to work toward greater independence.

(6) The patient may have some degree of vision, hearing or sensory loss.

(7) The patient may have some limitation in movement, but must be ambulatory with or without an assistive device such as a cane, walker, crutches, prosthesis, wheelchair, etc.

(8) The patient may need some supervision or assistance in transferring to a wheelchair, but must be able to ambulate the chair independently.

(9) The patient may be occasionally incontinent of urine; however, patient who is incontinent of bowels or totally incontinent of urine may qualify for intermediate care service when the patient has been taught and can care for himself.

(10) The patient may exhibit some mild confusion or depression; however, his behavior must be stabilized to such an extent that it poses no threat to himself or others.

D. ADHC Eligibility Criteria:

Welfare and Institutions Code Section 14525 provides as follows:

Any adult eligible for benefits under Chapter 7 (commencing with Section 14000) shall be eligible for adult day health care services if that person meets all of the following criteria:

(a) The person is 18 years of age or older and has one or more chronic or post-acute medical, cognitive, or mental health conditions, and a physician, nurse practitioner, or other health care provider has, within his or her scope of practice, requested adult day health care services for the person.

(b) The person has functional impairments in two or more activities of daily living, instrumental activities of daily living, or one or more of each, and requires assistance or supervision in performing these activities.

(c) The person requires ongoing or intermittent protective supervision, skilled observation, 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.

(d) The person requires adult day health care services, as defined in section 14550, that are individualized and planned, including, when necessary, the coordination of formal and informal services outside of the adult day health care program to support the individual and his or her family or caregiver in the living arrangement of his or her choice and to avoid or delay the use of institutional services, including, but not limited to, hospital emergency department services, inpatient acute care hospital services, inpatient mental health services, or placement in a nursing facility or a nursing or intermediate care facility for the developmentally disabled providing continuous nursing care.

(e) Notwithstanding the criteria established in subdivisions (a) to (d), inclusive, of this section, any person who is a resident of an intermediate care facility for the developmentally disabled-habilitative shall be eligible for adult day health care services if that resident has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through adult day health care, placement to a more costly institutional level of care would be likely to occur.

E. ADHC Medical Necessity Criteria

Welfare and Institutions Code sections 14526.1(d) and (e) provide:

(d) Except for participants residing in an intermediate care facility/developmentally disabled-habilitative, authorization or reauthorization of an adult day health care treatment authorization request shall be granted only if the participant meets all of the following medical necessity criteria:

(1) The participant has one or more chronic or post acute medical, cognitive, or mental health conditions that are

identified by the participant's personal health care provider as requiring one or more of the following, without which the participant's condition will likely deteriorate and require emergency department visits, hospitalization, or other institutionalization:

(A) Monitoring.

(B) Treatment.

(C) Intervention.

(2) The participant has a condition or conditions resulting in both of the following:

(A) Limitations in the performance of two or more activities of daily living or instrumental activities of daily living, as those terms are defined in Section 14522.3, or one or more from each category.

(B) A need for assistance or supervision in performing the activities identified in subparagraph (A) as related to the condition or conditions specified in paragraph (1) of subdivision (d). That assistance or supervision shall be in addition to any other non-adult day health care support the participant is currently receiving in his or her place of residence.

(3) The participant's network of non-adult day health care center supports is insufficient to maintain the individual in the community, demonstrated by at least one of the following:

(A) The participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision.

(B) The participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the participant.

(C) The participant has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the participant.

(4) A high potential exists for the deterioration of the participant's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if adult day health care services are not provided.

(5) The participant's condition or conditions require adult day health care services specified in subdivisions (a) to (d), inclusive, of Section 14550.5, on each day of attendance, that are individualized and designed to maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization.

(e) When determining whether a provider has demonstrated that a participant meets the medical necessity criteria, the department may enter an adult day health care center and review participants' medical records and observe participants receiving care identified in the individual plan of care in addition to reviewing the information provided on or with the TAR.

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