

# **Background**

## **The 2010 Medi-Cal Waiver and the Future of Seniors & People with Disabilities in the Medi-Cal Program.**

**Joint Oversight Hearing of the  
Senate & Assembly Health Committees  
Wednesday, December 7, 2011  
1:30 pm ~ Room 4202**

### **Environment**

California is in the forefront of a transformation of the health care delivery system. In March of 2010, President Obama signed into law the new federal health reform law, the Patient Protection and Affordable Care Act (ACA), which among other provision, requires most U.S. citizens and legal residents to have health insurance beginning in 2014 and establishes a state-based system of health insurance exchanges. California established the first in the nation Exchange in 2010 through SB 900 (Alquist), Chapter 659, Statutes of 2010, and AB 1602 (J. Perez), Chapter 655, Statutes of 2010. Beginning January 2014, the ACA will expand coverage by using the Medicaid program to cover uninsured low-income adults under age 65 who are not disabled and by providing premium tax credits for those with incomes too high to qualify for Medicaid.

In November of 2010, California obtained federal approval for a Section 1115(b) Medicaid waiver from the Centers for Medicare and Medicaid Services (CMS) authorizing, among other provisions, expansion of mandatory enrollment into Medi-Cal managed care (MCMC) plans in 16 counties of over 600,000 low-income seniors and persons with disabilities (SPDs) who are eligible for Medi-Cal only (not Medicare). The California Department of Health Care Services (DHCS) decided to phase in enrollment over a one-year period in the affected counties. This new mandatory enrollment began on June 1, 2011 and approximately 20,000 people per month are being enrolled. Prior to this, enrollment was mandatory for children and families in 30 counties and for SPDs in 14 counties.

SB 208 (Steinberg), Chapter 714, Statutes of 2010, contained many of the provisions implementing the waiver requirements. It also required DHCS to establish a demonstration program to begin enrolling persons who are dually eligible for Medi-Cal and Medicare into coordinated health care delivery models.

A major focus of the ACA is to improve coordination between Medicare and Medicaid for the dually eligible population and to provide incentives to lower the costs of health care. To that end, the ACA established two new federal entities-The Federal Coordinated Health Care Office (or Medicare-Medicaid Coordination Office) and the Center for Medicare and Medicaid Innovation (CMI) to test innovative payment and delivery models to lower costs and improve quality for dual eligible beneficiaries. Both CMS and the federal Department of Health and Human Services have indicated it is a priority to significantly increase the number of Medicare-Medicaid enrollees in seamless coordinated care systems that will improve beneficiary experiences and quality outcomes, while also achieving savings for both States and the Federal government. During waiver negotiations, CMS requested that California pursue the dual eligible pilots through this new federal initiative rather than as part of the Medicaid Waiver. California was one of 15 states to receive a \$1 million design contract through the CMI and the Medicare-Medicaid Coordination Office in April 2011 in order to develop service delivery and payment models that integrate care for dual eligibles. DHCS is in the process of site-selection and aims to have multiple demonstration sites operational by the end of 2012.

### **Hearing Objectives**

The purpose of this hearing is to fulfill the legislative oversight role with regard to these two health care initiatives affecting SPDs; specifically, mandatory enrollment of SPDs into MCMC and the dually eligible demonstration projects. A primary goal is to inform the public and legislature as to the status of these initiatives. However the timing of this hearing also provides an opportunity to use lessons learned from the current activities to inform and shape current and future policy decisions and program implementation.

The mandatory enrollment of SPDs is at the mid-way mark. Data and anecdotal evidence is beginning to accumulate. It is hoped that this hearing will provide an opportunity to educate the affected stakeholders as well as to allow for corrections and modifications that will improve the process. Secondly, DHCS is about to apply the same enrollment process to disabled children who are in fee-for service (FFS) Medi-Cal. This is the ideal point in time to highlight successes and make corrections based on the experiences to date.

In the planning stages are demonstration projects in four counties to test new models of coordinated care for people dually eligible for Medi-Cal and Medicare. Reflecting federal direction articulated in the ACA, California is moving towards a more coordinated and cost-effective way to provide physical and behavioral health care, long-term care and social

services to this population. DHCS is in the process of soliciting input and feedback on the site selection process which is due to be announced in December 2011. It is estimated that the demonstration pilots will be operational November to December of 2012. Input is being sought by DHCS at this time regarding the development of the financial models. A secondary goal of this hearing is to provide a public, stakeholder and legislative forum to inform the DHCS planning process. The dual eligible demonstration pilot project oversight is specifically combined with oversight of the SPD enrollment as both initiatives are composed of SPDs with similar multiple, chronic and complex conditions.

A third goal of this hearing is to inform preparation for the future implementation of the ACA. In 2014, up to 1.4 million uninsured, low-income adults, under age 65 and who are not disabled will be eligible for Medi-Cal. An unknown additional number of the seven million uninsured Californians will be eligible for premium tax credits through the Exchange. The Exchange Board, in consultation with DHCS, the California Health and Human Services Agency (HHS) and the Managed Risk Medical Insurance Board are grappling with the myriad of policy, consumer assistance, Information Technology, operations and governance issues and decisions that must be in place to meet the deadlines established by the ACA and begin enrollment by January 2014. Although the Exchange and Medi-Cal expansion population is not elderly or disabled, they have many characteristics in common with the SPDs and duals. Many are low-income and ethnically and linguistically diverse. Many have chronic health conditions, behavioral health needs and are approaching senior or disabled status. A final goal of this hearing then is to identify strategies that can be replicated by the Exchange and DHCS as they move to enroll these populations and conversely learn some lessons about what to avoid or do differently.

### **Program Background**

Medi-Cal. Medi-Cal is California's version of the federal Medicaid program. Medicaid is a 46-year-old joint federal and state program offering a variety of health and long-term services to low-income women and children, elderly, and people with disabilities. Each state has discretion to structure benefits, eligibility, service delivery, and payment rates under requirements established by federal law. State Medicaid spending is "matched" by the federal government, at a rate averaging about 57% for California, based largely on average per capita income in the State. California uses a combination of state and county funds augmented by a small amount of private provider tax funds as the state match of the federal funds.

Medicaid is the single largest health care program in the United States. According to the Kaiser Family Foundation (KFF), in 2011 the average monthly enrollment is projected to exceed 55 million, and a projected 70 million people, roughly 20% of Americans will be covered by the Medicaid program for one or more months during the year. In California, the

estimated average monthly enrollment is eight million or roughly one seventh of the national total program enrollment. Approximately 29% of Californians are on Medi-Cal.

Beginning in 2014, the ACA will expand Medicaid coverage to nearly all non-elderly Americans and legal immigrants who have been in the United States at least five years and who have incomes below 133% of the Federal Poverty Level. This is estimated to expand Medicaid by 16 million additional people nationally and by 1.4 million in California, by 2019.

The Medi-Cal program utilizes a variety of service delivery and payment systems. Originally the primary payment mechanism was FFS Medi-Cal which means that a Medi-Cal enrollee obtains services from an approved Medi-Cal provider who is willing to take him/her as a patient for the service and accepts the Medi-Cal payment rate set by the state and governed by federal law. The provider then bills Medi-Cal directly when there is a claim. In 1982 California obtained federal approval to implement a selective provider contracting program for hospital inpatient services. This allowed the state to negotiate with hospitals in areas with multiple competitors for a per diem rate that was below the cost-based FFS rate. This negotiated rate process currently applies only to private hospitals and is in transition to a diagnosis-related group payment system similar to what is used in Medicare.

Medicare. Medicare is a federally-sponsored health insurance program for people age 65 and older; people younger than 65 who have been disabled for 24 months; people diagnosed with amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's disease; and those with end-stage renal disease. Eligibility for Medicare is based on working for at least forty quarters (ten years) in Medicare-qualifying employment. Once a person has met this requirement, both the individual and spouse are eligible for Medicare at age sixty-five. Younger workers and their dependents also qualify if they have been receiving federal disability insurance for two years or have end-stage renal disease. Individuals with work histories of less than forty quarters can buy into Medicare Part A (hospital insurance) by paying a monthly premium. Medicaid can buy Part A coverage for Medicaid beneficiaries who do not meet the forty-quarters test, as well as Part B coverage for physicians' services. Medicare's benefits include inpatient and outpatient hospital stays, physicians' fees, prescription drugs (through Part D discussed below), diagnostic laboratory fees, and other professional medical services. Medicare, however, covers only limited long-term care services, such as skilled nursing facility (SNF) care and skilled home health care for enrollees who meet various conditions.

The Balanced Budget Act of 1997 (BBA) established a new Part C of the Medicare program, known then as the Medicare+Choice program, effective January 1999. As part of the Medicare+Choice program, the BBA authorized CMS to contract with public or private organizations to offer a variety of health plan options for beneficiaries, including coordinated care plans (such as health maintenance organizations (HMOs), provider sponsored

associations (PSOs), and preferred provider organizations (PPOs)). These health plans provide all Medicare Parts A and B benefits, and most offer additional benefits beyond those covered under the Original Medicare program. The Medicare+Choice program in Part C of Medicare was renamed the Medicare Advantage (MA) Program under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which was enacted in December 2003. The MMA updated and improved the choice of plans for beneficiaries under Part C, and changed the way benefits are established and payments are made. Under the MMA, beneficiaries may choose from additional plan options, including special needs plans (SNPs). The MMA further established the Medicare prescription drug benefit (Part D) program, and amended the Part C program to allow (and, for organizations offering coordinated care plans, require) most MA plans to offer prescription drug coverage.

Medicaid Waivers. Federal law authorizes multiple waiver and demonstration authorities to allow states flexibility in operating Medicaid programs. Each authority has a distinct purpose and requirements. Section 1115, Research & Demonstration Projects, provides the HHS broad authority to approve projects that test policy innovations likely to further the objectives of the Medicaid program. Traditionally designed as research and demonstration programs to test innovative program improvements and to facilitate coverage expansions to populations not otherwise eligible, they are also used to modify benefits structures and financing mechanisms. CMS generally requires “budget neutrality” so that the federal spending would be no more than it would have been in the absence of the waiver. Section 1915(b), Managed Care/Freedom of Choice Waivers provides the Secretary authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals’ choice of provider under Medicaid. Section 1915(c) Home and Community-Based Services (HCBS) Waivers, provides the Secretary authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term services in institutional settings.

California’s Section 1115 Waiver. In 2005, the State of California sought a five year federal waiver as a Medicaid demonstration project under the authority of Section 1115(a) of the Social Security Act. Under this waiver, hospital financing was fundamentally restructured. The waiver created the Special Needs Care Pool (SNCP) to pay for services to the uninsured and for unreimbursed Medi-Cal expenditures delivered through public hospitals, other governmental entities and state-funded programs. Under the 2005 waiver, \$180 million in federal funds were allotted to the county-based Health Care Coverage Initiatives (HCCI) to provide coverage to more than 130,000 medically-indigent adults who are not eligible for other public programs. Using a competitive process, California selected 10 counties in waiver years three, four, and five (September 1, 2007-August 31, 2010) to provide coverage to this population through an organized system of care. The participating counties— Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo,

Santa Clara, and Ventura—used local expenditures, referred to as Certified Public Expenditures, to draw down the available federal funds.

CMS also set aside a portion of the SNCP funding contingent on the state expanding mandatory enrollment into managed care of SPDs. Except for in the County Organized Health System (COHS) counties this provision of that waiver was never enacted. However, DHCS continued to encourage voluntary enrollment and using funding from foundations, made a number of system improvements to prepare for enrollment. These efforts included pilot testing enrollment materials, developing enhanced performance standards for services provided to SPDs through MCMC plans, developing draft screening tools, policy standards for care coordination/case management, provider training, and ensuring that services and equipment are physically accessible.

On November 2, 2010, the federal Secretary of HHS approved a new five year “Bridge to Reform” Section 1115 Medicaid Demonstration Waiver for California which makes up to \$10 billion in federal matching funds available over a five-year period. The new waiver continued much of the hospital funding from the 2005 waiver and included three significant new initiatives that are considered to be a model for transition to health reform in 2014. Experience from this waiver is intended to inform implementation of the ACA, not just in California, but for other states, safety net providers, and the federal government.

One of the initiatives in the 2010 waiver is the mandatory enrollment of SPDs into managed care plans. The savings from managed care enrollment is intended to offset the cost of the other initiatives. The stated goals of the waiver with regard to SPDs are: (1) to improve access and coordination of the most appropriate, cost effective care in order to improve health outcomes and contain costs; (2) provide a choice of organized systems of care; (3) support and strengthen the local safety net and its integration into organized systems of care through payment reform and outpatient managed care models; and, (4) align financial incentives to support providers in delivering the most appropriate care and containing costs.

According to data from 2007, SPDs accounted for 25% of Med-Cal enrollees but 62% of the expenditures. This group accounted for 81% of the total FFS expenditures. Approximately 40% of the SPDs are Medi-Cal only. Approximately 74% are adults between the ages of 19 and 64, 12% are children under 18 and 14% are seniors. A relatively small percentage of the adult disabled population generates a large percentage of the total FFS expenditures. One percent was responsible for roughly 18% of the total. The most expensive 10% of the adult disabled population accounted for 58% of the total adult disabled FFS expenditures. These high cost enrollees have a wide array of conditions. The most common are cardiovascular, mental health, diabetes, neurological and pulmonary. Two-thirds of the high-cost enrollees have multiple conditions. The prevalence of these conditions is similar among high-cost dual eligibles and high-cost Medi-Cal only with the exception of mental health conditions which are almost twice as prevalent among the Medi-Cal only population.

The demonstration waiver also included a Low-Income Health Program (LIHP) to extend coverage to uninsured low-income childless adults. The LIHPs build on the coverage initiative that was in 10 counties under the 2005 waiver. The third key component is a new Delivery System Reform Incentive Pool which provides up to \$3.8 billion over five years for payments to safety-net providers, primarily public hospitals, which meet milestones to improve quality of care. In addition, the previous 1915(b) waivers authorizing mandatory managed care for families and children were incorporated into this waiver.

MCMC. In addition to inpatient contracting, California has adopted the national trend to use various models of managed care in place of FFS. In MCMC, the beneficiary must receive a defined package of the Medi-Cal benefits through a managed care plan. The plan is paid a per member capitated rate for each enrollee which is set by an actuarial methodology. The plan in turn pays contracted providers to provide care. In MCMC, as in commercial managed care, the enrollee's choice of providers may be limited to those in the plan's network, but the plan is required to ensure timely access to care. A recent report by the KFF, "A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey," discusses factors that contribute to the success or failure of these models. Specifically, it states that while managed care offers significant potential to improve access and care for enrollees, it can fail as a strategy if capitation payment rates are not adequate, transitions from FFS are not well-conceived, provider networks are not sufficient to meet the care needs of the enrolled population, or state oversight of managed care programs is lacking.

As of August 2011, MCMC in California served about 4.4 million enrollees in 30 counties, or about 60% of the total Medi-Cal population. California employs three models of managed care. The oldest model is the COHS. COHS serve about 885,000 beneficiaries through six health plans in 14 counties: Marin, Mendocino, Merced, Monterey, Napa, Orange, San Mateo, San Luis Obispo, Santa Barbara, Santa Cruz, Solano, Sonoma, Ventura, and Yolo. In the COHS model, DHCS contracts with a health plan created by the County Board of Supervisors. In a COHS county, everyone is in the same managed care plan.

Fourteen counties are part of the two-plan model. In most Two-Plan model counties, there is a "Local Initiative" (LI) and a "commercial plan" (CP). DHCS contracts with both plans. Local government, community groups and health care providers were able to give input when the LI was created. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. The Two-Plan model serves about three million beneficiaries in 14 counties: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare.

Two-counties employ the Geographic Manage Care (GMC) model: Sacramento and San Diego. GMC serves about 450,000 beneficiaries. In a GMC county, DHCS contracts with several commercial plans.

Enrollment in MCMC. Enrollment in a MCMC plan varies depending on the circumstances in each county. In a COHS county everyone is automatically enrolled in the one county plan regardless of age, disability or other eligibility category. In two-plan counties and in the Sacramento GMC, a Medi-Cal enrollee who is in a mandatory enrollment category is sent an enrollment packet that provides information about plan choices and includes lists of providers that are available in the network. The packet includes a plan choice form. Ideally, the enrollee chooses a plan based on personal choice of providers in the contracted network. If the person does not return the packet with a plan choice, they are enrolled in a plan by default. An auto-assignment algorithm is used that is based on quality measures and the plan's use of traditional safety-net providers in the network. With regard to SPDs, SB 208 made changes in the default process intended to minimize disruption in care and that were based on the assumption that in many cases the person has a Medi-Cal FFS provider.

Traditionally in California, about 30% of the enrollees actually choose a plan. Except for San Diego which runs its own enrollment activities, California utilizes a third party enrollment broker to provide the plan information to potential enrollees and to handle enrollment. This Health Care Options (HCO) program is currently operated by Maximus. Prior to implementation of mandatory SPD enrollment, DHCS and HCO undertook a number of preparatory efforts. Even before receiving authority for mandatory enrollment, DHCS began encouraging voluntary enrollment through outreach and awareness activities. This included pilot testing a special guide for SPDs. A measureable increase in voluntary enrollment resulted from these efforts. Nonetheless, under mandatory enrollment of the SPD population, the rate of choice, meaning the person proactively chooses a plan, is still running only about 30 to 40% based on initial data.

Under SB 208 and the Special Terms and Conditions imposed by CMS, there are a number of requirements relating to enrollment intended to ensure a seamless transition. For instance, DHCS was required to develop a SPD sensitivity training manual and all appropriate plan and state staff were required to receive training. There are requirements to conduct outreach activities including community presentations, involvement of stakeholder groups and to make available materials in multiple languages and formats and to provide in-person assistance.

In order to minimize disruption in care for those who don't choose, CMS also directed DHCS to make repeated efforts to contact individuals and encourage choice. Secondly, DHCS is required to utilize claims data to make a default selection into a plan based on the person's usual and known providers, including specialty providers. Finally, SB 208 also provided an opportunity for extended continuity of care that allows an enrollee to continue to receive services from a current Medi-Cal FFS provider, including specialists, who is not in one of the plan networks. Health plans are required allow the enrollee to have access to this provider for 12 months as long as there is an ongoing prior relationship and the provider agrees to accept the health plan's contracted rate or the FFS rate, whichever is higher. If the provider

does not agree the plan must work with the enrollee to find in-network alternatives. On September 21, 2011, the DHCS Medi-Cal Managed Care Division notified plans of the details of this continuity of care policy in an All Plan Letter.

Medical Exemption Request (MER). Existing regulations provide that a person who is receiving Medi-Cal FFS treatment or services for a complex medical condition from a physician, a certified nurse midwife, or a licensed midwife who is participating in the Medi-Cal program but does not contract with one of the plans available through mandatory enrollment may request a medical exemption to continue FFS Medi-Cal for the purposes of continuity of care up to 12 months or until the medical condition has stabilized to a level that would enable the individual to change physicians without deleterious medical effects. A form is included with the enrollment packet and must be filled out by the physician and submitted to HCO/Maximus.

A MER is an option for a limited number of conditions, such as cancer, HIV, or dialysis. The original mandatory population was a relatively healthy population of parents and children. This is partially due to the exemption of disabled children and the fact that treatment of children for certain chronic conditions was “carved-out” or delivered outside the plans through the California Children’s Services Program. When mandatory enrollment was extended to SPDs, including children, it was agreed that a more expansive continuity of care should also be available for this population which was more likely to have chronic conditions and an existing relationship with a Medi-Cal FFS provider. However, the number of MERs also increased and the interaction with the new continuity of care provisions led to some confusion. As a result, DHCS is in the process of clarifying the MERS policy and process and is circulating a draft Provider Bulletin.

According to this draft, a patient receiving maintenance care or being seen for routine follow-up of their complex medical conditions will not be granted an exemption from plan enrollment. In addition, as dictated by the current regulations, a MER will not be granted if the person had been in the plan more than 90 days, has a current provider who is in the plan network or has begun or was scheduled to begin treatment after the date of enrollment. Furthermore, even though substantial documentation has traditionally been required, DHCS is now asking for additional documentation to verify the MER.

Health Risk Assessment and Stratification. An additional strategy established for the SPD population in SB 208 is a requirement that the plans conduct risk stratification and risk assessment of all new SPD members. The purpose of this was to identify new members who were at an increased risk of having an adverse health outcome or worsening of their health status if they did not receive an initial contact by the plan within 45 days. Plans are required to develop two tools. The first, a risk stratification mechanism or algorithm is to be applied using member specific utilization data supplied by DHCS that will trigger the 45 day requirement if the member is identified as high risk with more complex health needs.

Developing this tool necessitated sample files to test the data exchange beginning six months prior to implementation of mandatory enrollment. Those identified as lower risk are also required to receive a comprehensive health assessment, but the plan has 105 days to conduct it. Secondly, the plan must develop a risk assessment survey tool that is to be used for the comprehensive assessment of the member's current health risk within these time frames, depending on the stratification. The purpose of the risk assessment is to develop individualized care management plans for the SPDs identified as high risk.

Dual Eligibles. In California, as in most states, low-income SPDs may qualify separately for both Medicare and the state Medicaid program (Medi-Cal in California) and are called "dual eligibles." Nationally, there were nearly nine million individuals eligible for both the Medicare and Medicaid programs in 2008. The majority of dual eligibles (6.9 million) receive full Medicaid benefits and assistance with Medicare premiums and cost-sharing. The remaining dual eligibles (2.0 million) receive assistance only with their Medicare premiums and cost-sharing. According to national data from CMS, dual eligibles are among the most chronically ill and costly individuals enrolled in both the Medicare and Medicaid programs, with many having multiple chronic conditions and/or long-term care needs. More than half of Medicare-Medicaid enrollees have incomes below the poverty line, compared with 8% of other Medicare beneficiaries. Forty-three percent of Medicare-Medicaid enrollees have at least one mental or cognitive impairment, while 60% have multiple chronic conditions. Nineteen percent live in institutional settings compared to only 3% of Medicare beneficiaries who are not also eligible for Medicaid. In California, 54% of duals have a cardiovascular disease, 52% have a psychiatric illness, 28% have a disease of the central nervous system, and 22% have diabetes. As of January 2011, there were 1.1 million dual eligibles in California. Of these individuals, 770,042 were age 65 or older (70 percent) and 326,822 individuals (30%) were between 22-64 years of age. Of the 1.1 million dual eligibles in California, an estimated 175,000 (16%) are in managed delivery systems, such as the Program for All-Inclusive Care for the Elderly (PACE), Two-Plan Model managed care plans or COHS.

For dual eligible beneficiaries, Medicare generally is the primary payer for benefits covered by both programs. Medicaid is then available for any remaining beneficiary cost sharing. Medicaid may also provide additional benefits that are not (or are no longer) covered by Medicare. For example, Medicare covers SNF services when a dual eligible beneficiary requires skilled nursing care following a qualifying hospital stay. During this time, Medicaid benefits may be available for amounts that are not paid by Medicare. Once the beneficiary no longer meets the conditions of a Medicare skilled level of care benefit, Medicaid may cover additional nursing facility services, including custodial nursing facility care. In California, most state General Fund dollars spent on dual eligibles are for long-term care services. In 2007, dual eligibles accounted for 75% of the \$4.2 billion spent by Medi-Cal on long-term care.

According to the KFF's "Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 state Design Contracts Funded by CMS" (KFF, August 2011), dual eligibles are attracting attention in part due to the medical needs and associated health care costs that typically exceed those of other Medicare and Medicaid enrollees. As an example, the KFF August 2011 Report states nationally they comprise 15% of Medicaid enrollees but 39% of total Medicaid spending. Similarly, dual eligibles represent 21% of Medicare enrollees but 36% of total Medicare expenditures. In California, DHCS indicates dual eligibles are less than 10% of Medi-Cal beneficiaries, but account for \$8.6 billion or nearly 25% of annual Medi-Cal costs.

Health Care Programs Providing Services to Dual Eligibles. California currently has several Medi-Cal programs that serve dual eligibles, including PACE, Adult Day Health Care (ADHC) and Medicare SNPs. However, prior to the enactment of SB 208, enrollment in a managed care plan was not required, except in COHS counties for Medi-Cal services.

PACE is a capitated benefit provided primarily to certain Medi-Cal and Medicare beneficiaries that offers a comprehensive service delivery system and integrates Medicare and Medicaid financing. The program was modeled after the acute and long-term care services of On Lok Senior Health Services in San Francisco. Participants must be at least 55 years old, live in the PACE service area, and be certified as eligible for nursing home care. Enrollment in PACE is voluntary. An interdisciplinary team, consisting of professional and paraprofessional staff, assesses participants' needs, develops care plans, and delivers all services (including acute care services and, when necessary, nursing facility services). The PACE service package must include all Medicare and Medicaid covered services, and other services determined necessary by the interdisciplinary team for the care of the PACE participant. PACE providers assume full financial risk for participants' care without limits on amount, duration, or scope of services. California has five PACE programs that operate PACE centers in Alameda, Contra Costa, San Francisco, Sacramento, Los Angeles, Santa Clara and San Diego counties and collectively serve over 2,800 individuals.

ADHC is an organized day program of therapeutic, social and health activities and services provided to elderly persons or other persons with physical or mental impairments for the purpose of restoring or maintaining optimal capacity for self-care. Under federal law, ADHC services are an "optional benefit" states may provide. DHCS indicates that, of the approximately 35,000 Medi-Cal beneficiaries receiving ADHC services, 82% are dual eligibles, and 34,350 of the 35,000 (98%) ADHC beneficiaries reside in a MCMC county. The Adult Day Health Medi-Cal Law established ADHC services as a Medi-Cal benefit for beneficiaries who meet certain criteria, but this benefit was proposed for elimination in this year's health budget trailer bill. Following litigation challenging the elimination of ADHC services, DHCS and several organizations reached a settlement in November 2011 that phases out and replaces ADHC on March 1, 2012, with a new program called Community-Based Adult Services (CBAS), which will provide necessary medical and social services to

those with the greatest need. DHCS estimates roughly half of current ADHC participants will qualify for the new program. Eligibility to participate in CBAS will be determined by state medical professionals on the basis of medical need, and the benefits provided will be coordinated with managed care plans. The ADHC benefit will continue until February 29, 2012, to allow those in need to transfer into the new program.

The MMA created a new subset of Medicare Advantage (MA) coordinated care plans that focus on Medicare beneficiaries with special needs called SNPs. SNPs serve beneficiaries who meet one of the following: (1) are institutionalized or meet the institutional level of care and live at home; (2) are dually eligible; or (3) have severe or disabling chronic conditions. The MMA authority, allowing MA organizations to offer SNPs expired in 2008 and was subsequently reauthorized through 2010, and the Affordable Care Act reauthorized the program through December 31, 2013. In 2013, federal law requires all MA organizations seeking to offer a SNP to dual eligibles to execute a contract with the State Medicaid Agency in the state it wants to offer the plan. California has approximately 147,000 dual eligibles enrolled in SNPs.

State Law Changes for Dual Eligible Integration Projects. In May 2010, DHCS proposed trailer bill language as part of the Governor's May Budget Revision to establish dual eligible integration service projects. DHCS indicated its proposal was intended to allow DHCS to seek federal approval to establish pilot projects that enable dual eligibles to receive a continuum of services, and to maximize the coordination of benefits between the Medi-Cal and Medicare programs and access to the continuum of services needed.

Instead of adopting the proposed trailer bill language, language was included in SB 208 to require DHCS to seek federal approval to establish pilot projects in up to four counties under a Medicare or Medicaid demonstration project or waiver (or a combination of the two). The purpose of the pilot projects is to develop effective health care models that integrate Medicare and Medicaid services. At least one of the four counties selected for the pilot project must be a county served by a COHS, and at least one county must be served by a county served through the two-plan model. After federal approval is obtained, DHCS is required to establish pilot projects that enable dual eligibles to receive a continuum of services, and that maximize the coordination of benefits between the Medi-Cal and Medicare programs and access to the continuum of services needed.

In determining the counties in which to establish a pilot project, the DHCS Director is required to consider local support for integrating medical care, long-term care, and home- and community-based services networks and a local stakeholder process that includes health plans, providers, community programs, consumers, and other interested stakeholders in the development, implementation, and continued operation of the pilot project. The pilot projects can also include additional services as approved through a demonstration project or waiver, or through a combination of the two.

Under SB 208, DHCS can require that dual eligibles be assigned as mandatory enrollees into managed care plans established or expanded under the pilot program for the beneficiary's Medi-Cal benefits only. Under SB 208, beneficiaries have the choice to enroll in a MA SNP offered by the managed care plan established or expanded by the pilot program, and individuals eligible for PACE can select a PACE plan if one is available in that county.

Under a Medicare demonstration project, DHCS is authorized by SB 208 to operate the Medicare component of a pilot project as a delegated Medicare benefit administrator, and is authorized to enter into financing arrangements with CMS to share in any Medicare program savings generated by the operation of any pilot project.

To implement SB 208, DHCS is authorized to enter into exclusive or nonexclusive contracts on a bid or negotiated basis to provide or arrange for services to dual eligible under the pilot project. In addition, DHCS is exempt from the rulemaking requirements of the Administrative Procedures Act and the Public Contract Code in implementing the dual eligible pilot programs, and DHCS is allowed to implement the dual eligible pilot program provisions through letters or similar instructions without taking regulatory action. Prior to issuing any letter or similar instrument, DHCS is required to notify and consult with stakeholders, including advocates, providers, and beneficiaries. Additionally, DHCS is required to notify the legislative fiscal and policy committees of its intent to issue instructions at least five days in advance of their issuance.

DHCS is required to conduct an evaluation to assess outcomes and the experience of dual eligibles in these pilot projects. DHCS is required to consult with stakeholders regarding the scope and structure of the evaluation, and is required to report to the Legislature after the first full year of pilot operation, and each year thereafter.

DHCS originally intended to include a program for dual eligibles as part of the Section 1115 Waiver. Because federal Medicaid law gives Medi-Cal beneficiaries freedom of choice to choose their health care providers and requires benefits to be the same statewide, a federal waiver was needed to implement this requirement so that DHCS could require that individuals receive benefits through managed care plans who could not otherwise be required to enroll in managed care, and to enable DHCS to provide managed care plans only in certain geographic areas. However, the dual eligible population was retracted from the waiver at CMS' request. Instead, DHCS elected to pursue the dual eligible program through CMS' Office of the Duals and the CMMI. CMS has outlined two financial alignment models for the integration demonstrations: a capitated and a managed FFS approach. Under the capitated approach, CMS, the State, and health plans would enter into a three-way contract. The participating entities would receive a prospective Medicare and Medi-Cal blended payment to provide comprehensive, seamless coverage. Demonstration sites would have to meet established quality thresholds. Under the managed FFS structure, CMS and the State would enter into an agreement where the State would be eligible to benefit from savings

resulting from initiatives that improve quality and reduce costs for both Medicaid and Medicare. DHCS expressed interest in both models in a letter to CMS in September 2011.

There are several significant policy issues as part of implementation of the dual eligible pilot programs, including site selection, consumer protections for dual eligibles, whether subsets of dually eligible beneficiaries are “carved out” of mandatory enrollment, the level and scope of benefits and services included in the pilot programs, how enrollment in the pilot program will be handled, and the outcomes measures that will be used to evaluate the programs.

In preparation for the dual eligible pilots, DHCS has convened a 29-member technical workgroup to provide technical support to DHCS regarding the development of the implementation plan for enrollment of dual eligibles in an organized system of care that more fully integrates Medicare and Medi-Cal benefits and financing, and to provide technical support regarding the Section 1115 Waiver for ways to provide more effective delivery of HCBS.

In April 2011, DHCS issued a Request for Information to solicit input concerning the ideal model/models for services for dual eligibles, including questions for entities that DHCS would potentially contract with and questions for interested parties generally (including potential contracting entities). DHCS received over 35 responses by June 1, 2011 (the response deadline), and in August 2011 helped convene a stakeholder meeting on dual eligibles. The Center for Health Care Strategies summarized the stakeholder responses by potential contractors and interested parties regarding:

- Model designs (suggested models include initial comprehensive assessment and screening for risk, possibly in the person’s home, with care management for those at higher risk for poor outcomes; a multidisciplinary team approach to care; individualized care planning; high-tech solutions such as remote monitoring of people in their homes; comprehensive care management with a single point of contact; management of care transitions across different care settings and home; and health home or medical home models);
- Target population (whether to serve all dual eligibles, including duals under age 65 and individuals who are developmentally disabled; whether to have populations “carved out” of the pilots);
- Benefits/recommended services (ensuring access to care is at least as good as the best offered by either Medi-Cal or Medicare; need for transportation, cultural and linguistically appropriate services; access to the full range of long-term services and supports; whether to provide the full spectrum of services versus only medical care and other services delivered through other means; whether current programs, such as Multipurpose Senior Services Program, ADHC and In-Home Supportive Services, are integrated into the pilot programs);

- Enrollment process (voluntary versus mandatory, and whether to have an opt out of mandatory enrollment); and,
- Beneficiary protections (choice, receiving care that is at least as good as if the individual were not enrolled in the pilot program, beneficiary-centered services, increasing access to HCBS, meaningful consumer protections [such as appeals and complaints processes and network adequacy], a phased approach to implementation, and reinvestment of savings to expand the quality and availability of health and long-term services and supports).

In October 2011, Harbarger Consulting released an overview paper entitled “California’s Duals Demonstration: Background and Process Overview.” That paper indicated DHCS would announce the site selection criteria for the duals integration demonstration in December 2011, with DHCS working toward the goal of announcing the sites in the spring of 2012 to ensure that they are operational by the end of 2012. DHCS has indicated it plans to enroll up to 150,000 dual eligibles in its pilots by May 2013. By 2015, DHCS indicates it hopes to expand integrated care statewide based on the successes and lessons learned in these pilots. Of the state’s 1.1 million dual eligibles as of July 2010, 370,785 or nearly 33% live in Los Angeles County, and 13% live in San Diego (75,019) and Orange (71,188) counties.

## **Policy Questions Related to Seniors and People with Disabilities**

The first year of mandatory enrollment of SPDs began in June 2011. The data is beginning to accumulate. Based on the first six months of experience, the panelists are being asked to focus on the following, as appropriate:

- 1) Please describe the role of DHCS with regard to enrollment.
- 2) What challenges have occurred in the enrollment process? What has gone well? What is Health Care Options (HCO)? What are the consumer experiences with the HCO contractor?
- 3) Do you have any suggestions to increase choice and decrease default?
- 4) What is provider linkage and how is it working?
- 5) Are there lessons from this enrollment that could be applied to future initiatives, such as the Exchange or the dual pilot projects?
- 6) What is the Medical Exemption Request (MER) process? What are the grounds for approving or denying a MER? How is the policy communicated? What population does it apply to?
- 7) How does an individual request a MER? What are the qualifications and training of the staff that review and approve or deny the MER? How is it processed? Is there an appeal?
- 8) What are the grounds for an emergency disenrollment? What is the process?
- 9) What is the role of the ombuds? What types of calls are they receiving? What are the primary complaints?
- 10) If the ombudsman in DHCS receives a complaint from a managed care enrollee, such as difficulty finding a provider, difficulty accessing care, or a denial of care, what steps does DHCS take?
- 11) DHCS will soon begin mandatory enrollment of disabled children who are also in the CCS program, are there any lessons learned from the current enrollment that could be used to change or improve the enrollment of children?

- 12) What is the Health Risk Assessment? Who has the responsibility of performing it? What happens to the data? What is the plan responsibility after it is conducted? What efforts are made to ensure that it is performed? How is it enforced?
- 13) What was the intent of the continuity of care provisions? How is it working in practice? Are providers agreeing? Are there any remedies for a consumer if the provider refuses? What are the consumer's options?
- 14) Many of the enrollees with HIV were receiving care from providers that were not in any of the plan networks and they and their providers were most affected by the continuity of care. Are there any similar unique populations or unexpected issues that should be considered in the future?
- 15) How can a consumer continue access to treatments, prescriptions or medical supplies if continuity does not apply?
- 16) How will the program requirements change for newly eligible seniors and persons with disabilities as compared to those who are converting from FFS to MCMC?

## Policy Questions Related to Dual Eligibles

- 1) What lessons have been learned from the mandatory enrollment of seniors and persons with disabilities that will guide the implementation of the mandatory enrollment of dual eligibles through the pilot programs? What should be done differently? What has worked well?
- 2) The federal government's Center for Medicare and Medicaid Innovation aims to explore innovations in health care delivery and payment that will enhance the quality of care for dual eligibles, improve the health of the population, and lower costs. In addition, the Legislature established goals for the pilot projects that include maximizing the ability of dual eligibles to remain in their homes and communities, and increasing the availability of and access to home and community-based alternatives. How will dual eligibles enrolled in the pilot programs, DHCS, the public, and the Legislature know if these goals have been achieved? What is CMS requesting of the states on dual eligibles?
- 3) An October 2011 Issue Brief from the Kaiser Family Foundation states that strong state oversight of managed care organizations is essential, and quality measures are needed. What consumer protection requirements and quality measures should be required for dual eligibles enrolling in managed care plans?
- 4) Will dual eligibles who are currently enrolled in a managed care plan, a PACE plan or a Medicare Special Needs Plan in a pilot program county be able to stay enrolled in their current plan?
- 5) Medicare and Medi-Cal (Medicaid) have different program rules, benefits, appeals systems, and coverage standards. What standards will control in the event of a conflict between Medi-Cal and Medicare standards?
- 6) The mandatory enrollment of seniors and persons with disabilities was phased in so enrollees were enrolled in their birth month. How should enrollment for dual eligibles be structured?
- 7) Should specific services and/or populations be "carved out" out of the mandatory enrollment of dual eligibles? What should be the extent of integration of long-term services and supports in the pilots?

- 8) How does the federal government intend to share savings achieved from the pilot program with the state? How much revenue does the state anticipate receiving? Does the state anticipate state General Fund savings as compared to current state General Fund spending on dual eligibles?
- 9) Does DHCS intend to provide a choice of plans in each county where the pilot programs are implemented?
- 10) What criteria is DHCS using to select program sites? What process does DHCS intend to use following completion of the four pilot programs?