April 2013

Summary of California's Dual Eligible Demonstration Memorandum of Understanding

The Nation's Largest, Most Aggressive Plan for Integration

On March 27, 2013, the Centers for Medicare and Medicaid Services (CMS) released a Memorandum of Understanding (MOU)[1] with the state of California that represents the nation's largest, most aggressive plan yet for integrating Medicare and Medicaid (Medi-Cal in California) services and financing for dual eligibles using a capitated managed care model.

California was one of 26 states to submit to the Medicare-Medicaid Coordination Office (MMCO) at CMS a proposal to participate in CMS' Dual Eligible Financial Alignment Demonstration. The state first produced a high-level summary of the demonstration in October 2011, and authorizing state legislation was signed into law on June 27, 2012.[2] California is the fifth state to enter into a demonstration MOU.[3] California's demonstration is called "Cal MediConnect." Passive enrollment in most counties is set to begin as soon as October 1, 2013. California's current schedule allows just six months between the signed MOU and the beginning of passive enrollment—less time than any other state.

While Cal MediConnect, the dual eligible integrated care demonstration, is itself a major undertaking, it is important to note that it is just one part of a larger state project, called the Coordinated Care Initiative (CCI). In addition to Cal MediConnect, the CCI provides for simultaneous, mandatory enrollment of dual eligibles into Medi-Cal managed care plans and inclusion of all long-term services and supports (LTSS) in those Medicaid managed care plans. Historically, California has generally excluded dual eligibles from mandatory Medi-Cal managed

[1] Memorandum of Understanding between the Centers for Medicare & Medicaid Services (CMS) and the State of California Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees; California Demonstration to Integrate Care for Dual Eligible Beneficiaries, available online at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf.

[2] SB 1008 and SB 1036, www.leginfo.ca.gov/pub/11-12/bill/sen/sb_1001-1050/sb_1008_bill_20120627_chaptered.html and www.leginfo.ca.gov/pub/11-12/bill/sen/sb_1001-1050/sb_1036_bill_20120627_chaptered.html.

[3] The others, in order of the date which each MOU was signed, Massachusetts, Washington, Ohio and Illinois. All MOUs can be found at http://dualsdemoadvocacy.org/state-profiles.

care requirements and LTSS from Medi-Cal managed care benefit packages. The CCI changes this.[4]

The terms of the MOU apply only to Cal MediConnect, the dual eligible demonstration, not the mandatory Medicaid managed care and LTSS changes the state is proposing. The state needs to seek separate authority from CMS to make those changes.

As with other MOUs, a number of questions and details remain to be determined in the three-way contracts between CMS, the state and managed care plans. The following summary provides a high level overview of the MOU and its impact beneficiaries.

Basics

Under the MOU, California and CMS will contract with managed care plans (called "Participating Plans") to provide Medicare and Medi-Cal services to dual eligibles in certain counties. Participating managed care plans will be paid on a capitated basis to provide all Medicare and Medi-Cal services,[5] including long-term supports and services, to enrollees. The demonstration will last for approximately three years, from October 1, 2013, to December 31, 2016.

Cal MediConnect will be implemented in eight of the state's most populous counties: Alameda, Los Angeles, San Bernardino, San Diego, San Mateo, Santa Clara, Orange and Riverside.[6]

Authority

Like other dual eligible demonstration projects, Cal MediConnect is a new, integrated delivery model for dual eligible individuals authorized by section 1115A of the Social Security Act, 42 U.S.C. § 1315a. Existing Medicare and Medicaid managed care rules and regulations will apply to Cal MediConnect, unless explicitly waived in the MOU.[7] While the MOU is an important step

[4] For more information about the CCI, see www.calduals.org. The National Senior Citizens Law Center will also produce an advocates' guide to the CCI, forthcoming in early May 2012, which will be available online at www.nsclc.org and http://dualsdemoadvocacy.org/california.

[5] There are limited carve-outs from the capitated rate for some county-run specialized behavioral health and drug treatment services.

[6] The state has indicated that its longer term plan is to expand Cal MediConnect to additional counties.

[7] MOU p. 4, pp. 39-40 (Appendix 4, Medicare Authorities and Waivers), pp. 41-42 (Appendix 5, Medicaid Authorities and Waivers). Medicare rules are waived to allow passive enrollment, to allow a joint Medicare-Medicaid process for setting plan payment rates, to require both CMS and state approval of marketing materials, to provide for alternative grievance and appeal processes (see infra _), and to permit plans to waive Part D cost-sharing for non-institutionalized individual duals. MOU pp. 39-40. Medicaid statewideness rules are waived to provide plans only in certain geographical areas, and contract requirement rules are waived to allow a joint Medicare-Medicaid process for setting plan payment rates. MOU p. 42.

toward implementation of Cal MediConnect, California must receive additional CMS authority for related, proposed Medi-Cal program changes before enrollment begins. Specifically, California still needs to obtain CMS approval to mandatorily enroll dual eligibles into Medi-Cal managed care plans and to integrate LTSS into managed care plan benefit packages. Both of these changes are intended to be implemented simultaneously with Cal MediConnect. The state plans to amend its current 1115a waiver in order to make these program changes.

As with other MOUs, the California MOU and its appendices "are not intended to create contractual or other legal rights between the parties."[8] These legal rights between the parties – and the rights and protections that apply to beneficiaries – will be detailed in the three-way contracts between CMS, California and the plans. The MOU explicitly defers to the contracting process for the development of further details in 40 different places involving beneficiary safeguards and plan reporting requirements. A list is attached to this summary outlining where in the MOU the three-way-contracts are referenced. In many other places, it is clear that more detail than is included in the MOU will be needed.

Eligible Population

The MOU indicates that California will enroll as many as 456,000 full dual eligible individuals into Cal MediConnect. Los Angeles County's enrollment is capped at 200,000 enrollees. There are no enrollment caps in the other seven Cal MediConnect counties.

The MOU specifies that the following groups of individuals will **not** be eligible to enroll in Cal MediConnect:[9]

- Individuals under age 21;
- Those with other private or public health insurance;
- Clients of regional centers, state developmental centers, or intermediate care facilities for individuals with developmental disabilities;
- Individuals living in Veterans' Homes in California;
- Dual eligibles with a share of cost who are not in a nursing facility, enrolled in MSSP, or certified as meeting their share of cost using IHSS;
- Those living in certain rural zip codes in Los Angeles, San Bernardino and Riverside counties; and
- Individuals with a diagnosis of end stage renal disease before enrollment.[10]

[8] MOU p. 4.
[9] MOU pp. 8-11.

Other groups of individuals may choose to enroll in Cal MediConnect, but will not be passively enrolled.[11]

- Those living in certain rural zip codes in San Bernardino county where there is only one plan option;
- Individuals enrolled in a 1915(c) home and community based waiver;[12]
- Program of All-Inclusive Care for the Elderly (PACE) enrollees;
- AIDS Healthcare Foundation enrollees; and
- Kaiser enrollees.[13]

Dual eligibles who are not listed above will be passively enrolled into Cal MediConnect, including:

- Medically needy dual eligibles with a share of cost who are nursing home residents or are enrolled in the Multipurpose Senior Services Program (MSSP).[14]
- Dual eligibles with a share of cost who receive In-Home Supportive Services (IHSS), California's personal care services program, if they meet their share of cost on the first day of the month in the fourth and fifth months prior to the date of their effective passive enrollment.[15]
- Current Medicare Advantage plan enrollees, though they will not be passively enrolled until January 1, 2014.

Spousal impoverishment eligibility rules will apply to individuals receiving LTSS, including to those living in the community.[16]

[10] There are some exceptions to this: those with an ESRD diagnosis are eligible for Cal MediConnect in Orange and San Mateo county, as are ESRD patients who are already enrolled in a separate line of business operated by the "Prime Contractor." MOU p. 8.
[11] MOU pp. 9-11.
[12] Specifically, these are the Nursing Facility/Acute Hospital Waiver, HIV/AIDS Waiver, Assisted Living Waiver, and In Home Operations Waiver.
[13] Kaiser is not referred to by name, but is the only California plan that meets the MOU definition on p. 9 ("a non-profit health care services plan with at least 3.5 million enrollees statewide…").
[14] MOU p. 7.
[15] MOU p. 7.
[16] MOU p. 7-8.

Enrollment Process

The MOU authorizes the use of a passive enrollment process and does not include a 'lock-in' for Medicare benefits. Dual eligibles subject to passive enrollment will receive a notice informing them that if they take no action they will be automatically enrolled into a Participating Plan. The state will use prior claims data and an algorithm to assign passively enrolled individuals into the plan that appears to be the best match.

As an alternative to the passive enrollment process, dual eligibles can either select their own Cal MediConnect plan or opt out of the demonstration altogether. Individuals will have the right to opt out of the demonstration prior to the passive enrollment taking effect. They will also retain the right to disenroll from Cal MediConnect or switch plans at anytime during the year. Assuming California receives all necessary additional authority from CMS, opting out of the demonstration, will not exempt dual eligibles from the requirement that they enroll in Medi-Cal managed care plans to receive Medi-Cal services like LTSS.

Prior to passive enrollment taking effect, dual eligibles will receive three notices. The first notice will be sent 90 days prior to enrollment. The second notice will be sent 60 days prior and the third notice will be sent 30 days in advance.

In all counties, passive enrollment will be phased, with considerable variation in the process from one county to the next. In San Mateo County, all passive enrollments will occur on one of two days, October 1, 2013 and January 1, 2014. In Los Angeles County, implementation will begin with only voluntary enrollments starting no sooner than October 1, 2013. Passive enrollment in Los Angeles County would not begin until January 1, 2014. While the MOU indicates that passive enrollment will be phased over 12 months in Los Angeles County, it indicates that the exact process to be used has not yet been developed. The MOU requires California to develop and share with stakeholders for a 30 day comment period a plan for phasing enrollment in the county.

The remaining six counties will all conduct a 12 month passive enrollment process starting as soon as October 1, 2013. Dual eligibles in these counties will generally be passively enrolled on the first day of their birth month. There are, however, at least six exceptions to this general rule and the exact rules vary among counties.

Exception	Enrollment Date
Duals already in Medicare Advantage	January 1, 2014
Duals enrolled in MSSP	October 1, 2013 (except LA)
Duals already enrolled in Medi-Cal Managed Care in Alameda and Santa Clara counties	October 1, 2013
In counties enrolling by birth month, duals born in January	February 1, 2014
Duals that were reassigned effective 1/1/2013 as part of the Part D reassignment process	January 1, 2014
Duals that would be reassigned in effective 1/1/2014 as part of the Part D reassignment process	January 1, 2014

California will use an independent contractor (Health Care Options) to process Cal MediConnect enrollments and disenrollment requests in all counties except Orange and San Mateo. In those counties, the Participating Plans will provide the enrollment processing functions, as they do today in those counties for Medi-Cal managed care enrollment.[17]

Covered Benefits and Medical Necessity

Participating plans must provide all Medicare and Medicaid services, including primary and acute care, prescription drugs, behavioral health and LTSS.[18] Participating plans must also cover supplemental benefits that are not otherwise available under California's Medicaid program, including dental care, vision care, and non-emergency medical transportation.[19] Plans have discretion to provide other home and community-based services,[20] but they are not required benefits. Medicare hospice benefits will be paid under Medicare fee-for-service.[21]

For overlapping Medicare and Medicaid benefits, the more generous of the Medicaid or Medicare medical necessity standards will apply.[22] The MOU also specifies that "Any services will be provided in a manner that is fully compliant with requirements of the ADA, as specified by the *Olmstead* decision."[23]

[17] MOU p. 68.
[18] MOU pp. 12-13, 92.
[19] MOU p. 93.
[20] MOU pp. 93-94. These additional HCBS include personal care hours beyond the limits of the state plan option; in home therapies; respite care; nutrition; licensed residential care facilities, home maintenance or home or environmental adaption, etc.
[21] MOU p. 94.
[22] MOU p. 92.
[23] MOU p. 92.

Personal Care Services (IHSS) and Self-Direction

The MOU follows applicable state law in preserving In-Home Supportive Services (IHSS), California's personal care benefit. Plans must enter into agreements with the counties, which will continue to administer IHSS, including conducting needs assessments, authorizing hours, providing background checks for home care providers and more.[24] Beneficiaries will continue to have the right to self-direct services, including hiring, firing and supervising personal care providers.[25] California's language on self direction is stronger and more specific than in other state MOUs.

Care Continuity

California's MOU provides a longer transition period during which enrollees can continue to see current providers who are out of the plan's network than any other state's MOU. The types of providers the care continuity protection applies to, however, is limited. Participating plans must allow enrollees to continue to see their current Medicare providers and maintain their current service authorizations for six months, and their current Medi-Cal providers for 12 months, if the beneficiary: (1) has seen the provider at least twice within the previous 12 months; (2) the provider is willing to accept payment from the plan at the applicable Medicare or Medi-Cal rates; and (3) the provider meets applicable state, federal and plan standards.[26] Continuity of care protections do not apply, however, to durable medical equipment, medical supplies, transportation, and other ancillary services.[27]

Care Coordination

Participating plans will be required to offer care coordination services to all enrollees. The MOU requires that care coordination follow the beneficiary's direction, and include both medical and long term supports and services.[28] Plans must offer "Interdisciplinary Care Teams" with expertise in "person-centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery and wellness principles."[29] Beyond describing the team as interdisciplinary, the MOU does not spell out qualifications for the care team or clearly designate a care coordinator. Plans must conduct a health risk assessment of all enrollees. Individuals identified by a risk stratification mechanism or

[24] MOU pp. 78-79.
[25] MOU p. 77.
[26] MOU p. 95-96.
[27] MOU p. 96.
[28] MOU p. 69.
[29] MOU p. 70.

algorithm as higher-risk must be assessed within 45 days of enrollment; all others must be assessed within 90 days. Reassessments must be conducted at least annually. [30]

Grievances and Appeals

In the MOU, California and CMS agree to develop an integrated grievance and appeals process that combines both Medicare and Medicaid.[31] In the first year of the demonstration, however, the existing Medicare and Medi-Cal appeals systems will remain available to enrollees.[32] Pursuant to state law, IHSS disputes will be appealed directly and only through the state fair hearing process and not through an internal plan process since county agencies, not the plans, assess the need for IHSS.

While all other state MOUs include a new beneficiary protection, aid paid pending for Medicare services during an internal plan appeal, the California MOU does not. Aid paid pending rights for Medi-Cal covered services remain.

Enrollment Counseling & Ombudsman

Under the MOU, CMS and the state will "work to support" the State Health Insurance Assistance Program (SHIP) (called HICAP in California), Aging and Disability Resource Centers (ADRCs), and other community-based organizations.[33] These organizations will provide one-on-one enrollment counseling to help dual eligibles decide whether to join Cal MediConnect and, if they do elect to join, select a plan.

The MOU also describes an ombuds program that will "conduct impartial investigations" and "support individual advocacy and oversight" on behalf of those dual eligibles that enroll in the demonstration.[34] The MOU does not clarify if the ombuds office will be independent, and it does not indicate where the ombuds office will be housed or how it will be funded.

Network Adequacy

The MOU requires that participating plans meet Medicaid network adequacy standards for long term services and supports, and Medicare standards for pharmacy and other Medicare services, unless the applicable Medicaid standards are more stringent.[35] For services like home health

[30] MOU pp. 70-71.
[31] MOU p. 18.
[32] MOU p. 99.
[33] MOU p. 14.
[34] MOU p. 14.
[35] MOU p. 83.

and durable medical equipment that are covered by both programs, the more stringent network standards apply.

For LTSS, the MOU contains no specific numbers for how many providers each plan must contract with. Instead terms like 'sufficient number' and 'adequate number' are used without specific reference to an existing standard defining these terms. The MOU does require that plans have an MOU with each county regarding the administration of IHSS; each MSSP program (with a commitment to maintain MSSP funding for 19 months); and all willing, licensed and certified Community Based Adult Services (CBAS) providers (also known as adult day health care).[36] Plans may contract with nursing facilities in covered and adjacent zip codes. The MOU notes that continuity of care provisions will likely keep nursing facility residents in place for the first 12 months, but is silent on the likelihood that beneficiaries will have to switch facilities after the 12 month continuity of care protection expires.[37] The MOU specifically mentions the need to ensure physical accessibility.

Readiness Review

The MOU indicates that CMS and the State will require each Participating Plan to pass a readiness review before that plan can accept any enrollment.[38] It is not clear whether notices regarding enrollment will be sent to passive enrollees prior to the successful completion of the readiness review process. The readiness review will involve a desk review and "may" involve a site visit as well.[39]

Quality

The MOU includes a long list of quality measures by which Participating Plans will be evaluated. The list builds off of current quality metrics used for Medicare Part D and Dual Eligible Special Needs Plans. Limited additional measures directed at evaluating the quality or amount of long term services and supports provided are included.[40]

[36] MOU pp. 84-85.
[37] MOU p. 85.
[38] The readiness review is described in detail in a separate document. Financial Alignment Capitated Readiness Review: California Readiness Review Tool, www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CARRTool.pdf.
[39] MOU p. 31.
[40] MOU pp. 108-115

Financing

The California MOU includes a spending reduction that is more aggressive than other states that have signed MOUs relying on capitated managed care models. The California MOU sets a statewide, minimum savings rate and then adds county-specific interim savings percentages that act as savings maximums. The minimum savings rates are 1% in the first year, 2 % in the second year, and 4% in the third year.[41] The maximum rates are county specific and when added to the minimum savings rates bring the total savings rates as high as 1.47%, 3.5% and 5.5% in each respective year. These percentages are higher than those found in other MOUs.

State	Demonstration Savings Yr 1, Yr 2, Yr 3
Massachusetts	1%, 2%, 4%
Ohio	1%, 2%, 4%
Illinois	1%, 3%, 5%
California	1%, 2%, 4% (min) 1.5%, 3.5%, 5.5% (max)

The California MOU also contains provisions for limited risk adjustment and risk corridors.[42]

In addition to these spending reductions, a quality withhold will be applied to plan payments each year. Plans will have amounts withheld from their rates equal to 1% in the first year, 2% in the second year and 3% in the third year.[43] Each plan must meet certain quality standards to have these withheld amounts released.

This memo is a summary of the MOU; however, a number of policy and operational questions are still outstanding. For more information, go to www.dualsdemoadvocacy.org, or subscribe to the National Senior Citizens Law Center's health policy alerts at www.nsclc.org/index.php/store/subscriptions/. Questions about the California MOU can be directed to Amber Cutler, Anna Rich or Kevin Prindiville.

[41] MOU p. 57
[42] MOU pp. 57-58.
[43] MOU pp. 52-54

California MOU References to the Three-Way Contract

The California MOU includes forty references to information and agreements that will be "further specified in a three-way contract to be executed among the Prime Contractor Plans, the State and CMS."

- p. 2: Specifications on program specific and evaluation requirements
- p. 3: Further detail on flexibilities and specific beneficiary safeguards
- p. 3 : Participating plans' responsibilities and operational and technical requirements
- p. 4: Information for plans re: waivers of sub-regulatory guidance (Medicare)
- p. 5 : Information for plans re: waivers of sub-regulatory guidance (Medicaid)
- p. 5 : Medicare Advantage and Part D requirements and Medicaid managed care requirements
- p. 7: Provisions re: evaluation of contracts with subcontracting plans
- p. 12: Details re: use of independent 3rd party for enrollment
- p. 13: Participating plan service capacity
- p. 13: Offering of additional benefits
- p. 16 : Beneficiary participation on governing advisory boards
- p. 17: Participating plans responsibility to keep beneficiary data private
- p. 18 : Specific information on appeals and grievances
- p. 20: Standards for removal of participating plan for poor performance
- p. 20: Reporting of data (diagnoses, etc.)
- p. 21: Additional information on quality management reporting and frequency
- p. 22: Additional information on quality standards for participating plans
- p. 22: Further detail on data collection for evaluation
- p. 23: Timeframe for reporting evaluation data
- p. 39 : Changes to Medicare manuals/exceptions to guidance
- p. 52: Additional information on quality withhold measures (year 1)
- p. 54: Additional information on quality withhold measures (years 2 and 3)
- p. 56: Details of behavioral health incentive payments
- p. 56: Details on how risk corridors will be operationalized
- p. 60: Each area of Appendix 7 will be further addressed in 3-way contracts
- p. 62: Subcontracts with Prime Contracts
- p. 76: How the State will monitor participating plans
- p. 86: Corrective action process when no tangible net equity
- p. 92: Standard for medically necessary determinations when Medicare and Medicaid overlap
- p. 92: Minimum requirements for each benefit in the benefit package
- p. 97: Coordinated care requirements
- p. 92: Prescription drug specifics
- p. 100: Overlapping Medicare/Medicaid services appeal process
- p. 102: Education procedures for individuals who opt out and in same parent plan
- p. 105: Monitoring compliance as part of day-to-day oversight
- p. 106: How the State will inform the Contract Management Team about health plan audits
- p. 108: Core quality metrics
- p. 108: How plans will be required to report data
- p. 117: State and plan reporting requirements