Executive Summary

California has approximately 1.1 million people enrolled in both Medicare and Medi-Cal, who are among the state's highest-need and highest-cost users of health care services. The State is planning a demonstration for launch at the end of 2012 that will examine the benefits of coordinated care by enrolling a portion of dual eligibles into coordinated health care delivery models. Through this three-year demonstration, the State, in partnership with the Federal Government and California's counties, aims to test how various models of patient-centered care delivery can improve beneficiary health and quality of life by reducing the fragmentation and inefficiencies in the existing fee-for-service system. By aligning financial incentives around the beneficiary, the demonstration hopes to drive coordinated and streamlined delivery of the full continuum of services that dual eligibles need, while better managing costs. The Department of Health Care Services will be seeking ongoing feedback on the demonstration to ensure adequate consumer protections are in place and that California remains a national vanguard in health care delivery innovation.

California's Duals Demonstration: Background and Process Overview

California has approximately 1.1 million people dually eligible for Medicare and Medi-Cal services. This heterogeneous group, commonly called dual eligibles,[*] consists of the state's most chronically ill individuals. The high concentration of illness and co-morbidities among this population means they require a complex range of services from a multitude of providers, making them ideal candidates for care coordination. Yet, less than 15 percent of the state's dual eligibles currently are enrolled in any kind of organized care. The vast majority must access services through the fragmented "fee-for-service" delivery system, where services can be scattered, medical records are not easily shared, and resources are unevenly distributed. The lack of coordinated care may lead to lower quality care and sometimes no care at all. Moreover, it often results in more expensive care.

The California Legislature directed the California Department of Health Care Services (DHCS) in 2010 to create new models of coordinated care delivery for dual eligibles. The legislation, SB 208 (Steinberg 2010), calls for demonstrations in four counties. To help with this process, California earned a $1 million planning contract from the US Centers for Medicare and Medicaid Services (CMS). DHCS aims to have multiple demonstrations sites operational by the

[*] Dual eligibles are entitled to Medicare benefits by meeting the eligibility requirements of being either chronically disabled people under age 65 or individuals aged 65 and older who qualify under Social Security. Medi-Cal is California's Medicaid program, which provides health coverage for people with low incomes and major disabilities.

end of 2012. The Department is seeking feedback from a broad range of stakeholders interested in development of the demonstration. After a brief background on dual eligibles and current delivery system challenges, this document provides an overview of the demonstration process as envisioned through the beginning of 2013.

California's Dual Eligibles

About one in seven Med-Cal enrollees are dual eligibles who account for nearly one in four dollars the state spends on Medi-Cal.[1] Dual eligibles tend to be older, poorer, and sicker than most Medicare and Medi-Cal enrollees. In California, 71 percent of dual eligibles are 65 and older and 59 percent are women.[1] They have multiple chronic conditions and high levels of inability to perform activities of daily living, such as bathing, getting in or out of a chair, and walking.[2] In 2007, California's spending on dual eligibles was about $7.6 billion, representing 23 percent of total Medi-Cal expenditures. Federal and State combined spending on dual elgibles in 2007 was about $20.9 billion.[1] Dual eligibles account for nearly half (46 percent) of Medi-Cal's highest cost patients[3] and for nearly 75 percent of the $4.2 billion Medi-Cal spent on long-term care in 2007.[1]

Table 1: Medicare and Medi-Cal Expenditures for Dual Eligibles, 2007

	Expenditures	Enrollment	Per Capita Cost
Disabled	$5.45 billion	395,808	$13,770
Aged	$11.4 billion	511,030	$22,306
Blind	$247 million	12,754	$19,333
LTC	$3.75 billion	67,803	$55,321
Other	$148 million	25,364	$5,831
Total	**$21 billion**	**985,383**	**$21,396**

Source: DHCS RASS using Medicare and Medi-Cal aid claims data from Jan. 1 2007-Dec. 31, 2007

Challenges with Fee-for-Service

While Medicare is the primary payer for dual eligibles, the Medi-Cal program plays a significant role in covering their out-of-pocket expenditures and pays for most long-term care services.[2] Medicare and Medi-Cal often work at cross-purposes, however, because they have different payment rules and cover different services. For beneficiaries, this means no single entity is responsible for ensuring they receive necessary care and services – both medical and social. Furthermore, beneficiaries must navigate two separate, complex systems on their own, which often results in fragmented and inefficient care, and sometimes no care at all[4] (see **Table 2** below for coverage division between Medicare and Medi-Cal).

For providers, the administrative burden of delivering care for dual eligibles has been described as a "nightmare" because they often must deal with separate health plans for Medi-Cal, Medicare and prescription drugs.[5] This confusion needlessly drives up administrative costs.

Table 2: Division of Services Covered by Medicare and Medi-Cal

Medicare	Medi-Cal
• Acute (hospital) services • Outpatient services (physicians and other qualified providers) • Temporary skilled nursing facility services • Rehabilitation services • Home health services • Dialysis • Durable medical equipment • Prescription drugs • Hospice	• Services not covered by Medicare, including transportation, vision, some mental health services • Cost-sharing for Medicare (Part A & B deductibles, Part B premiums and coinsurance) • Skilled nursing facilities after Part A benefits are exhausted • Home health, personal care services, and other home-based services not covered by Medicare • Portion of the cost for prescription drugs • Durable medical equipment not covered by Medicare

Source: Medicare Payment Advisory Commission, 2011

Bifurcated coverage between Medicare and Medi-Cal leads to limited coordination of the various services covered under each program. If a beneficiary is hospitalized, for example, no person or entity is assigned to ensure that the individual receives the services needed to avoid needless re-hospitalization or entry into a skilled nursing facility. This lack of coordination may decrease the person's chances of returning home after an acute care episode. It also leads to duplication of tests and services, dangerous medication interactions, and inadequate investment in less expensive home- and community-based services.[6] Many long-term supportive services operators reported working largely in isolation and feeling disconnected from medical providers and health plans.[5] In addition to fragmentation, access to care can be problematic, particularly for mental health, substance use and specialty services.[4]

California's Duals Demonstration

In partnership with the Federal Medicare-Medicaid Coordination Office at CMS, California has a new opportunity to establish care coordination programs for Medicare-Medicaid enrollees that will coordinate services across the two programs to better align benefits, delivery, financing and administration. As envisioned by CMS, the "initiative is intended to alleviate fragmentation and improve coordination of services for Medicare-Medicaid enrollees, enhance quality of care and reduce costs for the State and the Federal government."[7] The demonstration's focus is on creating a coordinated care delivery system that is tailored and responsive to beneficiaries' needs and overcomes the fragmentation and inefficiencies created by current categorical funding, service structures and regulatory requirements. Characteristics of this envisioned system include:

- At the beneficiary level, a person-centered care plan that addresses medical needs, behavioral health needs, social service needs and long-term supportive service needs.
- At the delivery system level, a coordinating mechanism that links the full continuum of services required by the person-centered care plan.
- At the funding level, a blended Medicare and Medi-Cal rate channeled through a single, full-risk-bearing entity that aligns incentives to ensure good health outcomes, patient satisfaction and an emphasis on community-based care.
- Across all levels, comprehensive consumer protections and oversight mechanisms to help ensure beneficiary choice, health and safety.

Several key questions require significant public input regarding the design and process for the demonstrations.

Key Question: Goals

The demonstration will involve models through which one entity is coordinating care for the total needs of a person – medical and social. That includes behavioral health, social supports, medical care, and long-term care. This design could take a number of different forms. It does not necessarily imply that demonstration sites control home- and community-based services; however there is an expectation that all services are coordinated and the care experience is seamless for the beneficiary. Significant input and collaboration from and between the State, counties, beneficiaries, providers, health plans and advocates will be needed to develop models that can achieve the following aims:

- Improve beneficiaries' quality of life, health care and satisfaction with the health care system;
- Identify and eliminate existing sources of fragmentation and inefficiencies that result from the incongruities between both programs;
- Develop financial models that drive streamlined and coordinated care through shared savings and the elimination of cost shifting;
- Create one point of accountability for the delivery, coordination and management of the full continuum of needed services;
- Promote and measure improvements in health outcomes; and,
- Slow the cost growth in Medi-Cal and Medicare, as possible.

DHCS is seeking input regarding these goals and how this draft list could be modified, if at all. Additionally, DHCS intends to work with stakeholders to define the "metrics for success" for the demonstration (see the **Appendix** for a more on demonstration evaluation). Through university partnerships, a rigorous evaluation will be planned to assess the demonstrations' impacts on care delivery and health outcomes. CMS is also contracting with an independent evaluator to measure quality and cost impacts to both Medicare and Medicaid, the results of which will help inform the potential for future program changes. Thus, CMS also will require

States to collect and provide individual-level quality, cost, enrollment and utilization data for the purposes of comparing the effects of these models across sub-groups of dual eligibles.

Key Question: Financing

CMS has outlined two financial alignment models for the integration demonstrations: a capitated and a managed fee-for-service approach.[7] 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 fee-for-service structure, CMS and the State would enter into an agreement whereby the State would be eligible to benefit from savings resulting from initiatives that improve quality and reduce costs for both Medicaid and Medicare.[7] Considering the size and diversity of California, DHCS expressed interest in both models in a letter to CMS dated September 19, 2011.[8]

DHCS will seek input over the next several months regarding the development of these financial models within the state's existing web of financing structures. At this stage, it is likely too early in the process to have a detailed discussion on financing.

Key Question: Site-Selection Process

California began the process of planning for the Duals Demonstration during the Medi-Cal 1115 waiver discussion that concluded in 2010. During Spring 2011, DHCS asked interested parties to respond to a Request for Information (RFI). DHCS received responses from 39 organizations. Many respondents summarized their proposals and positions at a meeting held on August 30, 2011 in Sacramento with about 300 people in attendance. DHCS will continue seeking input and feedback regarding the site-selection criteria through Fall 2011 with the goal of having three public meetings in November and releasing the site-selection criteria in December. DHCS will work toward the goal of announcing the sites in Spring 2012 and spend the remainder of that year working with the sites and stakeholders to ensure that they are operational by the end of 2012.

Table 3: Key Dates for Duals Integration Demonstrations*

September-October 2011	Develop criteria for site selection process
November 2011	Open public meetings to inform site-selection criteria
December 2011	DHCS announcement of site selection criteria
Winter 2012	DHCS receives and evaluates applications DHCS Director announces demonstration sites Open public meeting CMS-required public notice of proposal for public comment
Spring and Summer 2012	Work with selected demonstration sites, CMS, Mercer and others to finalize demonstration development
November –December 2012	Operationalize demonstration sites

*As of October 7, 2011, Subject to change

[†] The CMS later stated "other qualified entities" could also be considered.

SB 208 sets for the requirements for selecting demonstration sites. The law calls for demonstrations in up to four counties, including one county where Medi-Cal services are provided via a Two-Plan Model and one county with a County Organized Health System (COHS). When selecting the counties, the law says, the director shall consider: (1) local support for integrating medical care, long-term care, and home and community-based services networks, and (2) input from health plans, providers, community programs, consumers, and other interested stakeholders.

In contrast to a competitive Request for Proposals (RFP) process through which entities compete for a set number of slots, California could choose (and is seeking comments on) an alternative site-selection process referred to here as a Request for Solutions (RFS). Under this approach, the State would set criteria for a number of issue areas and applicants would have to demonstrate their ability to satisfy all criteria. The State would assess all entities through a pass-fail lens; all entities meeting or exceeding the high bar of criteria that would likely be developed would then be permitted to enter the operations planning phase when each entity will have to engage in rate discussions and detailed readiness assessments. Being selected through this process will be the first of several steps. In the event that entities are spread across more than four counties, DHCS is still considering how to narrow the number of counties to four, per SB 208, and is eager to take comments on that.

The over-arching rationale for a solutions-oriented approach is to balance the goal of both developing creative and innovative models with the need for rigorous consumer protections. Additional factors favoring this approach include:

- Setting explicit, uniformly high standards informed by consumers and advocates will ensure all participating entities adopt adequate consumer protections.
- The highly competitive nature of an RFP process may foster secrecy and not the environment of collaboration required to ensure beneficiaries receive appropriate care.
- The demonstration raises highly complex service integration questions and solving them in a manner satisfactory to all parties will require strong collaboration and information sharing up front.
- This approach encourages a variety of models that are tailored to local scenarios but still meet the high standards set by the State.

DHCS' capacity to administer and monitor the demonstrations will be a consideration in the site-selection process. To build on the lessons learned from the mandatory managed care enrollment of the Medi-Cal seniors and persons with disabilities (SPD) population, it is possible that one criteria for participation will be for the entity to have had a Medi-Cal service contract as of 2009.

The site-selection process will be crucial in deciding which beneficiaries are covered by the demonstration. Comments are being sought on whether or not stakeholders believe the RFS process outlined above is preferable to a traditional RFP process.

Key Question: Potential Demonstration Participants

The demonstration would apply to beneficiaries eligible for Medicare and full Medi-Cal benefits. DHCS will continue seeking input from stakeholders around whether subsets of dually eligible beneficiaries should be phased in over time or carved-out entirely. For example, DHCS may choose to carve-out beneficiaries with developmental disabilities from the demonstration.

CMS indicated in its July letter that it would allow a State to request passive enrollment, with an opt-out, for both Medicaid and Medicare.[7] CMS expects States to provide beneficiaries with meaningful, understandable notice of their opt-out rights. For the demonstration to move forward and be successful, adequate enrollment will be essential for ensuring the necessary care delivery investments are made and for establishing sound rates.

State law does not direct DHCS on how many dual eligibles should be enrolled in the demonstration. In 2010, DHCS had stated that the demonstrations would include at least 150,000 dual eligibles. After looking closely at the distribution of beneficiaries and considering the high level of interest among entities in urban counties, that number is likely to be higher. Los Angeles County alone has approximately 370,000 dual eligibles, one-third of the state's total (see **Table 4** below for dual eligibles by county). Excluding LA County, the next four counties with the most dual eligibles have nearly 250,000. To minimize adverse risk selection and ensure sufficient enrollment for adequate risk sharing, the actuarial analysis will likely prohibit the ability to cap county enrollment or to have sub-county divisions.

Decisions regarding the potential population that will be covered are critical. Comments are being sought as to whether: certain populations should be carved out, and if so, which ones; the appropriateness and necessity (if any) of passive enrollment; and the appropriate size of the demonstration in terms of the population included.

Table 4: Dual Eligibles By County, July 2010

County	Dual Eligibles	% of State's Duals
Los Angeles	370,785	32.9%
San Diego	75,019	6.7%
Orange	71,188	6.3%
San Bernardino	52,621	4.7%
Santa Clara	49,420	4.4%
Riverside	49,088	4.4%
Alameda	46,630	4.1%
Sacramento	44,806	4.0%
San Francisco	44,669	4.0%
Fresno	31,153	2.8%
Kern	24,616	2.2%
Remaining 47 Counties*	266,708	23.7%
Total	1,126,703	100.0%

Source: Research and Analytic Studies Section; California Department of Health Care Services

Next steps

In terms of next steps, there will be a process for continued public feedback regarding the demonstration criteria in an interactive and iterative manner. The three key areas for stakeholder input from a diversity of folks, including consumers, advocates, providers, health plans, and researchers, include:

- Coordinating long-term care services, including home and community-based services;
- Coordinating behavioral health (mental health and substance use services); and
- Developing satisfactory consumer protections.

For each of these issue areas, Harbage Consulting has been, and will continue, to conduct several rounds of meetings, having started with small listening sessions. In November, there will be increased focus on developing lines of communications between potential demonstration sites and other stakeholders. With each round of meetings, stakeholders will inform key principles and policy option documents related to each issue area. These principles and policy options will be presented at public meetings targeted for early December. DHCS will use all this input to inform its site-selection criteria.

Conclusion

While dual eligibles are among California's most vulnerable citizens, for too long they have endured the fragmentation and access barriers resulting from the misalignment between the Medicare and Medi-Cal programs. Efforts to shift delivery systems to better meet beneficiaries' needs have had success, though typically limited in scale. Yet now, the constellation of factors needed to develop an effective system of organized care seems to have come together so that the state and Federal government can test whether it is possible to improve health and quality of life while reducing care fragmentation and inefficiency.

Appendix: Evaluating Success

Tracking and evaluating the demonstration will be a complex undertaking, requiring input from numerous stakeholders. The Medicare Payment Advisory Commission (MedPAC) recommends using one set of outcome measures to gauge the overall performance for programs, which would allow for comparison of different models along similar dimensions of care.[4] MedPAC suggested a variety of sample outcome measurements, including risk-adjusted per capita costs, potentially avoidable hospitalization rates, rates of institutionalization, emergency room use, beneficiary satisfaction and risk-adjusted mortality rates. MedPAC also advised tracking condition-specific quality measures and indicators that reflect the level and success of care coordination for different subgroups of dual eligibles.

Additionally, an evaluation may examine administrative improvements and efficiencies, and specific care coordination activities.[9] This might include examining activities associated with care transitions, medication reconciliation, patient education, utilization management, and coordination of benefits. Administrative measures could evaluate the efficiency of program administration (medical loss ratio), call-waiting times for enrollees, and disenrollment rates.[9] CMS has contracted with an external evaluator to measure quality and cost impacts to both Medicare and Medicaid in all states participating in this demonstration. Any evaluation must consider the goal of minimizing the burden of data collection for all entities.

While the following questions are based heavily on work done for the Technical Advisory Panel earlier this year, some health systems researchers have cautioned that, given limitations with existing data systems and projected funding, all the questions may not all be able to be answered. Thus, the following questions are intended to represent a broad range of questions that stakeholders and policymakers are likely to be interested in. While we understand that answering the entire list is likely not feasible, stakeholders and policymakers should have the ability to discuss priorities for research and funding. While this list reflects the goals of the demonstration, the limitations of available time, data and funding are real. DHCS is eager to receive feedback regarding evaluation priorities and feasibility issues.

Sources of Data

Evaluating California's duals demonstration will rely on numerous data sources, such as the following list. The DHCS would appreciate feedback on the availability and accessibility data sources.

1. Surveys of enrollees to determine satisfaction, self-reported health status, access to care, and experience with care coordination and care management.
2. Medicare and Medi-Cal claims data and encounter data, to measure utilization changes.
3. Enrollment data, to determine characteristics of enrollees and those who disenroll, and to determine periods of enrollment.

Sample Evaluation Questions

Several of the following questions will be tracked through monitoring and oversight structures but also could be explored in an evaluation framework.

I. Enrollment and Retention of Beneficiaries in Pilots

1. What methods did pilots employ to retain beneficiaries?
2. What reasons did beneficiaries give for disenrolling?
3. Did enrollees differ in their demographic characteristics or health status compared to eligible beneficiaries who did not enroll, or those who disenrolled?

II. Care Coordination, Access to and Continuity

1. What benefits did beneficiaries identify with the "single point of entry" into the health care system?
2. Were individual care plans created for beneficiaries?
3. Were beneficiaries assigned to a health home and primary care provider? Was the beneficiaries experience with a health home and primary care provider positive?

4. What where the levels of service use by enrollees in each of the following categories, before and 6 months after enrollment in the pilots? One year? Did utilization increase or decrease?

    a. Primary Care
    b. Preventive services (HEDIS measures)
    c. Home- and community-based long-term supportive services
    d. Behavioral health services
    e. Emergency department
    f. Hospitalizations
    g. Rehospitalizations
    h. Admittance to a skilled nursing facility

5. Based on utilization rates above, were services rebalanced to emphasize home- and community-based long-term care services over institutionalization?

6. Did pilots improve appropriate access to care, including, for example, timely referrals, reducing barriers to care, reinforcing importance of the medical home, off-hours care, and coordination of Medicare and Medi-Cal covered services?

7. Did the blended Medicare and Medi-Cal rate increase provider flexibility and broaden the array of services provided?

8. Did monitoring/management of care transitions result in:
    a. Prescription drug coordination and adherence
    b. Improved beneficiary knowledge and confidence in self-management
    c. Timely return to home after hospitalization

d. Avoidance of preventable hospitalizations/rehospitalization

9. If IHSS workers received any additional training under the demonstration, what was the level of satisfaction with this training?

III. *Integrating behavioral services*

1. Did rates of client engagement, retention and utilization of services change?
2. Did rates of client follow-through with behavioral health treatment referrals change?
3. What was the level of integration within the medical home, e.g., communication; physical proximity of services; temporal proximity in the delivery of services; and availability of behavioral health expertise?
4. Did rates of referrals between primary care and behavioral health change?
5. What were the total and per-client costs of integrated behavioral care and cost-savings, if any, realized as a result of the behavioral care program?
6. Did the functional health status of the beneficiaries improve?

IV. Beneficiary Health Outcomes/Health Status

1. Did pilots achieve reductions in condition-specific adverse health outcomes?
2. Did pilots improve medication adherence?
3. Did pilots change beneficiary functional status?
4. Did pilots change self-reported health status?

V. Beneficiary Satisfaction

1. Did pilots improve beneficiary access, satisfaction and experience of care, based on CAPHS scores?
2. Were beneficiaries satisfied with the breadth of the provider network?
3. Did beneficiary satisfaction increase/decrease with longer length of enrollment in pilots?
4. Qualitatively, what methods, if any, did pilots employ to improve beneficiary satisfaction?
5. What mechanisms did pilots employ to ensure beneficiary quality of care?
6. Were beneficiary questions and grievances responded to in a timely manner, such as length of time between call/complaint and resolution?

VI. Administrative Efficiency

1. Does establishing one set of rules for appeals, marketing, quality measures, and reporting reduce the administrative burden on pilots?
2. Did pilots use care management effectively?
3. Did the blended rate allow for increased flexibility in covered services?

4. Did pilots have adequate IT capacity to provide timely and useful data for evaluating their performance? What barriers existed, if any, to timely reporting of data needed for pilot evaluation?
5. Did the administrative burden, such as claim submission and billing, increase or decrease?

VII. Provider Satisfaction

1. How was provider recruitment and retention?
2. What was provider satisfaction with participation in the pilots?
3. Measures of provider networks – geographical, physical access for those with disabilities, range of specialists in networks, etc?

VIII. Slowing Growth in Medi-Cal and Medicare Expenditures

1. Did pilots slow the growth of expenditures for Medi-Cal and Medicare covered services?
2. What service areas saw increased/decreased utilization?
3. Did the rate-setting methodology provide adequate support for covered services utilized under the pilots relative to the payments that would have been made using FFS payments?
4. Was risk-adjustment adequate to account for variation in beneficiary expenditures based on health status and health conditions?

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