

Cal MediConnect: A Summary of the Memorandum of Understanding Between California and the Centers for Medicare and Medicaid Services

On March 27, 2013, the State of California and the Centers for Medicare and Medicaid Services (CMS) formalized a Memorandum of Understanding (MOU) to establish a Federal-State partnership to implement the Dual Eligibles Integration Demonstration, now referred to as “Cal MediConnect.” This Fact Sheet provides background information about Cal MediConnect and summarizes the key points of the MOU.

Background: The Dual Eligible Integration Demonstration and the Coordinated Care Initiative

The enacted 2012-2013 state budget established the Coordinated Care Initiative (CCI) with the goal of “transforming California’s Medi-Cal care delivery system to better serve the state’s low-income older adults and persons with disabilities.”¹ The main components of the CCI include the following: 1) provisions of the Dual Eligible Integration Demonstration; 2) mandatory enrollment of dual eligibles into Medi-Cal managed care; 3) integration of Medi-Cal long-term services and supports (LTSS) into Medi-Cal managed care; and 4) coordination of behavioral health services. Eight counties were selected as the implementation sites: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. For a detailed description of the CCI, please refer to The SCAN Foundation’s previously published fact sheet.²

Memorandum of Understanding: Establishing the Framework for the Cal MediConnect Program

In May 2012, California submitted its [proposal](#) to CMS to establish the Dual Eligibles Integration Demonstration.³ The signed [Memorandum of Understanding](#) (MOU), finalized on March 27, 2013, signifies federal approval for the Demonstration. The MOU includes the operational plan as well as “the principles under which CMS and California plan to implement” the Demonstration, now referred to as Cal MediConnect (page 3).⁴ The MOU establishes the general parameters and framework for Cal MediConnect. However, many of the specifics will be outlined in the three-way contracts between the state, CMS, and the participating health plans in each county. The key features of the MOU are described below.

Changes from California’s Original Proposal

The MOU reflects changes from what was submitted in California’s original Demonstration proposal in May 2012. The major changes include the following:

- **Timeline:** The original proposal outlined a start date of March 2013. The MOU calls for implementation to start no sooner than October 2013, continuing through December 31, 2016. The first year of the Demonstration spans from October 1, 2013 to December 31, 2014. Years 2 and 3 of the Demonstration will encompass the entire calendar years of 2015 and 2016, respectively.
- **Geographic Regions:** The original proposal intended to phase-in all California counties into the Demonstration over a three-year period, beginning with eight counties in 2013, expanding to other Medi-Cal managed care counties in 2014, and all remaining counties in 2015 (see Appendix 1 of the original proposal).³ In contrast, the MOU limits the Demonstration to the following eight counties for the three-year period: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.
- **Six-Month Lock-In Period:** In the original proposal, California outlined an initial enrollment lock-in of six months, referred to as the “stable enrollment” period, during which time beneficiaries would have been required to remain in the health plan for both their Medicare and Medi-Cal covered benefits. The MOU does not include a stable enrollment period, providing beneficiaries the ability to change plans and/or opt out of the Medicare portion of the Demonstration at any time.
- **Home- and Community-Based Services Benefits:** The original proposal defined home- and community-based service (HCBS) benefits as In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP) as well as additional “in-lieu of institutionalization” benefits (page 3) such as respite, nutritional assessment, minor home adaptations, habilitation, among others.³ The proposal did not specify whether the “in-lieu of institutionalization” benefits would be required for participating health plans to provide. In addition, it was the state’s intent to close enrollment in HCBS waivers, as the services were expected to be provided as part of the Demonstration. In contrast, the MOU indicates that “participating plans will have discretion to use the capitated payment to offer HCBS, as specified in the Individual Care Plan, as appropriate to address the member’s needs” (page 93).⁴ Enrollment in the HCBS waivers will remain open, but beneficiaries cannot be enrolled in both Cal MediConnect and an HCBS waiver, other than MSSP.⁵
- **Size:** The Governor’s proposed 2012-13 budget from January 2012 estimated approximately 800,000 enrollees, whereas the submitted proposal estimated about 685,000 enrollees in the first phase-in counties.³ The MOU estimates the total number of enrollees to be about 456,000.
- **Number of Participants in Los Angeles County:** The original proposal did not include an enrollment cap for any county. The MOU set a cap of no more than 200,000 enrolled beneficiaries in Los Angeles County.
- **Vision, Dental, Transportation Benefits:** The original proposal did not include dental, vision and non-emergency medical transportation benefits. The MOU specifies that, in addition to the other required Medicare and Medi-Cal services, health plans are required to provide these services.⁴

Demonstration Authority

Section 1115A of the Social Security Act authorizes the CMS Center for Medicare and Medicaid Innovation to test different models of service delivery and evaluate those models within the Medicare and Medicaid programs. Using the federal Medicare waiver authority, CMS has “waived” certain Medicare program

requirements, including but not limited to, provisions that limit enrollment to Medicare beneficiaries age 21 and over, as well as provisions that permit passive enrollment into the Cal MediConnect program.

Separate federal Medicaid waiver authority is required to implement changes to Medi-Cal and the Medi-Cal managed care program, including adding LTSS as a managed care benefit and mandating the enrollment of dual eligibles into Medi-Cal managed care in the eight Demonstration counties.* The state anticipates that this authority will be secured in the next few months through amendments to the 1115 Bridge to Reform Waiver, originally authorized by CMS in 2010.⁶

Eligibility

Eligible individuals include adults enrolled in Medicare, receiving full Medi-Cal benefits, and residing in one of the eight counties. Individuals receiving full Medi-Cal benefits also include those enrolled in the Multipurpose Senior Services Program (MSSP), those who meet the share of cost (including nursing facility residents with a share of cost, MSSP enrollees with a share of cost, and In-Home Supportive Services recipients who met their share of cost in the fifth and fourth months prior to their enrollment into the Demonstration), and individuals eligible for full Medi-Cal per spousal impoverishment provisions. Figure 1 provides a summary of Cal MediConnect's eligibility criteria.

FIGURE 1 Cal MediConnect Eligibility Criteria

Inclusion Criteria:	Excluded from Enrollment:
<ul style="list-style-type: none"> • Age 21 and older at time of enrollment 	<ul style="list-style-type: none"> • Under age 21
<ul style="list-style-type: none"> • Entitled to Medicare Part A and enrolled in Parts B and D 	<ul style="list-style-type: none"> • Enrolled in other private or public health insurance
<ul style="list-style-type: none"> • Receiving full Medicaid benefits 	<ul style="list-style-type: none"> • Receiving services through California's regional centers, state developmental centers, or intermediate care facilities for the developmentally disabled (ICF-DD)
<ul style="list-style-type: none"> • Residing in one of the eight Demonstration counties 	<ul style="list-style-type: none"> • Individuals with a share of cost not meeting requirements as defined in the MOU
<ul style="list-style-type: none"> • Individuals residing in San Mateo County or Orange County with a diagnosis of end-stage renal disease (ESRD) 	<ul style="list-style-type: none"> • Individuals residing in one of the Veterans' Homes of California
	<ul style="list-style-type: none"> • Individuals living in selected (rural) zip codes in Los Angeles, Riverside, and San Bernardino counties[†]
	<ul style="list-style-type: none"> • Individuals with ESRD in Demonstration counties other than San Mateo or Orange

Source: Memorandum of Understanding (MOU) Between the Centers for Medicare and Medicaid Services (CMS) and the State of California (2013).

*For more information, please see The SCAN Foundation's Long-Term Care Fundamental entitled "What is a Medicaid Waiver?": <http://www.thescanfoundation.org/what-medicare-waiver>.

[†] Residents of the following rural zip codes are not eligible for enrollment in the Demonstration: Los Angeles County – 90704; Riverside County – 92225, 92226, 92239; San Bernardino County – 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 92562, 92280, 93592, 92558.

Enrollment Timeline

Cal MediConnect will commence no sooner than October 1, 2013. Participating health plans may begin to accept enrollments two months prior to this start date (August 1, 2013). The first notices to beneficiaries will be mailed 90 days prior to the effective date of passive enrollment with subsequent notices mailed 60 and 30 days prior. With the exception of San Mateo and Orange Counties, which are both County Organized Health Systems with only one participating plan, the state will work through its enrollment broker to support the enrollment process. All notices will be reviewed and approved jointly by CMS and the state prior to initial mailings. The enrollment process differs for certain counties, as detailed in Figure 2 below. The MOU indicates that enrollment will be closed within six months prior to the end of the Demonstration.

Enrollment Process[†]

- **Passive Enrollment into Cal MediConnect:** Most eligible individuals will be passively enrolled into Cal MediConnect, meaning that unless they notify the state that they do not wish to enroll in a Cal MediConnect plan, the state will automatically enroll them into one. Medicare passive enrollment will begin on or after October 1, 2013. The enrollment process will vary from county to county, but generally will be based on beneficiary birthdate for most eligible individuals (see Figure 2 for a county-specific enrollment process).

Certain populations are excluded from passive enrollment. These include:

- Beneficiaries who reside in selected rural zip codes in San Bernardino County will need to voluntarily enroll in a participating health plan because there is only one plan operating in those areas (see page 9 of the MOU for the full list of zip codes).
- Beneficiaries enrolled in the Nursing Facility/Acute Hospital Waiver, the HIV/AIDS Waiver, the Assisted Living Waiver, or the In-Home Operations Waiver may choose to enroll in Cal MediConnect only after disenrolling from these waiver programs.
- Beneficiaries enrolled in the Program of All-Inclusive Care for the Elderly (PACE) or the AIDS Healthcare Foundation may choose to enroll in Cal MediConnect only after disenrolling from these programs.
- **Medicare Advantage Enrollees:** Beneficiaries currently enrolled in a Medicare Advantage plan, including Dual Eligible Special Needs Plans (D-SNPs) (except for Kaiser Medicare Advantage enrollees) will be passively enrolled into the demonstration no sooner than January 1, 2014.
- **Program For All Inclusive Care for the Elderly (PACE):** Individuals already enrolled in a PACE plan will not be passively enrolled into a Cal MediConnect plan. They can only join a Cal MediConnect plan if they first disenroll from PACE. PACE will be presented as an enrollment option for individuals who meet PACE program eligibility criteria (age 55 and older and need a higher level of care to live at home).

[†]Mandatory enrollment into Medi-Cal Managed Care: Nearly all dual eligibles in the eight counties will be required to enroll in Medi-Cal managed care for their LTSS and any other Medi-Cal benefits. The mandatory enrollment into a Medi-Cal plan will coincide with their scheduled date for passive enrollment. This means that if a beneficiary chooses not to enroll in a Cal MediConnect plan or “opts out” at that time, he or she will still have to enroll in a Medi-Cal health plan for their Medi-Cal benefits only. If a beneficiary opts out after enrolling in a Cal MediConnect plan, he or she will be required to stay enrolled in a Medi-Cal managed care plan. These provisions related to mandatory enrollment into Medi-Cal managed care for dual eligibles are not included in the MOU, but will be specified in the amendments to the state’s 1115 waiver.

For all Demonstration counties with multiple plans (this includes Alameda, Los Angeles, Riverside, San Bernardino, San Diego and Santa Clara), the state will employ an “intelligent assignment” process for selecting plans in the passive enrollment process. This process will prioritize continuity of care using claims history data to identify the most frequently used providers and the extent to which providers match the plan network.⁴ Beneficiaries have the option to disenroll from the Medicare portion of Cal MediConnect at any time. Plan transfers (in those counties where two or more options exist) or disenrollment will be allowed on a month-to-month basis.

FIGURE 2 County-Specific Enrollment Approach for Cal MediConnect

Bay Area:

Alameda and Santa Clara Counties: Beneficiaries currently enrolled in Medi-Cal managed care will be passively enrolled in Cal MediConnect all at once, no sooner than October 1, 2013. Beneficiaries in fee-for-service Medi-Cal will begin enrollment effective the first day of their birth month, beginning no sooner than October 1, 2013 and ending after 12 months.

San Mateo County: Beneficiaries will be passively enrolled into Cal MediConnect at the same time, no sooner than October 1, 2013 (except for those in a Medicare Advantage plans and low-income subsidy plan reassignees; they will be passively enrolled in January 2014).

Southern California:

Los Angeles County: As specified in the MOU, DHCS is required to release for comment a proposal regarding the enrollment approach for Los Angeles that will occur over 15 months and start with an initial three-month voluntary, opt-in only period. There is an enrollment cap for Los Angeles County of 200,000 individuals.

Orange County: Beneficiaries will be passively enrolled in Cal MediConnect beginning on or after October 1, 2013, based on birth month over a 12-month period. Beneficiaries with a birthday in January 2014 will be enrolled on February 1, 2014.

San Diego County: Beneficiaries will be passively enrolled in Cal MediConnect beginning on or after October 1, 2013, based on birth month over a 12-month period. Beneficiaries with a birthday in January 2014 will be enrolled on February 1, 2014.

Inland Empire:

Riverside and San Bernardino Counties: Beneficiaries will be passively enrolled in Cal MediConnect beginning on or after October 1, 2013, based on birth month over a 12-month period. Beneficiaries with a birthday in January 2014 will be enrolled on February 1, 2014.

Exceptions:

Multi-Purpose Senior Service Program (MSSP) Enrollees: All beneficiaries enrolled in MSSP across the seven counties with passive enrollment beginning on October 1, 2013 will be enrolled at the start of the Demonstration. MSSP enrollees residing in Los Angeles County will all be passively enrolled into the Demonstration beginning on January 1, 2014. These rules for MSSP enrollees supersede the county-specific enrollment plans described above.

Source: *Memorandum of Understanding (MOU) Between the Centers for Medicare and Medicaid Services (CMS) and the State of California (2013).*

Note: Exceptions to all these county-specific enrollment scenarios include beneficiaries enrolled in a Medicare Advantage plan, including D-SNPs, and beneficiaries who are reassigned to a new low-income subsidy plan for 2013. These beneficiaries all would be passively enrolled in January 2014.

Covered Benefits

Cal MediConnect will integrate the financing and service delivery of Medicare and Medi-Cal covered benefits, as well as other benefits, as follows:

- Medicare: Parts A, B, and D (prescription drug)
- Medi-Cal: All Medicaid state plan services (except for specialty mental health and Drug Medi-Cal treatment services, see below)
- Dental Benefits: Plans will be required to provide preventative, restorative, and emergency oral health benefits
- Vision: Plans will be required to provide preventative, restorative, and emergency vision benefits
- Transportation: Plans will be required to provide non-emergency, accessible medical transportation available in sufficient supply so that individuals can access medical appointments.⁴

IHSS: The MOU details requirements for participating health plans to coordinate IHSS benefits for eligible enrollees through county IHSS agencies. Plans will be required to pay for the IHSS hours for which an enrollee has been deemed eligible by the county IHSS agency. Plans have the option to authorize additional hours above those determined by the county IHSS agency for which an enrollee is eligible.

Other HCBS: The MOU indicates that “plans will have the discretion to use the capitated payment to offer HCBS, as specified in the member’s Individual Care Plan, as appropriate to address the member’s needs” (page 93).⁴ Discretionary HCBS include, but are not limited to, the following items:

- Supplemental personal care services
- Supplemental chore
- Supplemental protective supervision
- In home skilled nursing care and therapy services for chronic conditions
- Respite Care (in home or out-of-home)
- Nutritional supplements for home-delivered meals
- Care in licensed residential care facilities
- Home maintenance and minor home or environmental adaptationMedical equipment operating expenses and Personal Emergency Response System (PERS)
- Non-medical transportation
- Non-emergency medical transportation.⁴

Behavioral Health: Participating health plans will be required to provide or coordinate behavioral health services for all enrollees with these needs. Medi-Cal specialty mental health services currently administered by county Mental Health Plans under a 1915(b) waiver and Drug Medi-Cal services will not be included as Cal MediConnect health plan benefits (see MOU Table X, page 74 for a list of the excluded county-administered Medi-Cal mental health and substance use benefits). Participating health plans will be required to coordinate with county agencies to ensure enrollees have seamless access to these services. Additionally, plans will have the discretion to use their capitated payment to offer behavioral health services beyond those traditionally reimbursed by Medicare.

Hospice Benefit: If a Cal MediConnect enrollee elects to receive the Medicare hospice benefit, the enrollee will remain with the participating plan but will receive the hospice benefit through fee-for-service Medicare. The plan will no longer receive payment for the Medicare Part C benefit, as Medicare hospice services and all other Medicare services would be paid for under Medicare fee-for-service. Plans and providers of hospice services would be required to coordinate these services with the rest of the enrollee's care, including with Medi-Cal and Part D benefits.

Individual Care Plan, Care Coordination and Interdisciplinary Care Teams

An individual care plan will be developed for each enrollee. This care plan will specify the individual's preferences, goals, objectives, and timetables to meet medical, behavioral health, and LTSS needs. The MOU specifies that plans must engage enrollees and/or their representatives to play an active role in designing these care plans.⁴

All participating plans will be required to provide care coordination services to all enrollees reflecting a "member-centered, outcome-based approach" (page 69).⁴ The state has updated its draft Care Coordination Standards, which include guidance on enrollment and assessment of beneficiary health and functional status, delivery of basic and complex case management services, and requirements for referring to behavioral health, IHSS, and other HCBS.⁷ The revised Care Coordination Standards as released by DHCS will be incorporated into the three-way contracts between the health plans, DHCS and CMS.

Plans will be required to offer an Interdisciplinary Care Team (ICT), as necessary and as desired by the member. The purpose of the ICT is to ensure the integration of medical, behavioral health, and supportive services. The MOU details those individuals who may be members of the ICT: the enrollee, family members and other caregivers, designated primary physician, nurse, case manager, social worker, patient navigator, county IHSS social worker, IHSS provider, MSSP coordinator, pharmacist, behavioral health service providers, and other professional staff within the provider network.⁴ The enrollee has the option to choose to limit or disallow the role of IHSS providers, family members, and other caregivers on the team.⁴

Assessment Process

Every enrollee will be assessed using a health risk assessment (HRA), which will be the starting point for care planning. The HRA must be reviewed and approved by the state and CMS. All participating health plans will be required to develop and implement a risk stratification approach, approved by the state and CMS, which uses available data to identify beneficiaries at highest risk of poor health and functional outcomes. For those enrollees identified as at "high-risk" per the plan's risk stratification approach, the HRA will be completed within 45 days of enrollment. For enrollees in a nursing facility and those

identified at “lower risk” per the plan’s risk stratification approach, the plan will be required to complete the HRA within 90 days of enrollment. Reassessments will be conducted at least annually, within 12 months of the last assessment, or as often as the health of the enrollee requires. The MOU cites the state’s plan to develop a universal HCBS assessment, codified in the CCI statute, with plans to pilot test this assessment in 2015.^{4,8}

Network Adequacy

Participating health plans will be required to meet Medicare and Medi-Cal standards for network adequacy. California and CMS will monitor access to care and the prevalence of needs indicated through enrollee assessments. The MOU lists the following requirements for participating plans:⁴

- Contract with providers and health facilities that comply with physical accessibility requirements;
- Maintain an updated listing of provider’s ability to accept new patients; and
- Maintain an appropriate provider network with an adequate number of specialists, primary care physicians, hospitals, long-term care providers and accessible facilities within each service area.

Other LTSS network adequacy specifications include the following:

- **MSSP:** Participating health plans will be required to contract with MSSP providers, providing the same level of funding those providers would have received under MSSP contracts until March 31, 2015 or 19 months after beneficiary enrollment.
- **CBAS:** Participating health plans will be required to contract with all willing, licensed, and certified CBAS centers located in the covered zip code areas and in adjacent zip codes, not more than 60 minutes driving time from the enrollee’s residence. If a CBAS center does not exist within the targeted zip codes or does not have capacity to serve enrollees, then plans must coordinate IHSS and other HCBS for eligible enrollees.
- **IHSS:** Plans are required to establish a MOU or contract with the county IHSS agency regarding the provision of IHSS for enrollees, including county eligibility assessment and authorization of hours, coordination of service delivery, provider enrollment, background checks and data sharing. Plans must also contract with the California Department of Social Services regarding IHSS provider pay wages and payroll obligations, data sharing provisions, and other processes to “promote the integration of the IHSS program into managed care” (page 84).⁴
- **Nursing Facility:** Plans will have the discretion to contract with licensed and certified nursing facilities in covered zip codes and adjacent zip codes. Nursing home residents will not be required to change facilities within the first 12 months of the Demonstration, as long as specified continuity of care provisions are met (see next section and Appendix 7, pages 94-96).

Beneficiary Protections

The MOU outlines the following beneficiary protection provisions, with further details to be specified in the three-way contract:

- **Continuity of Care:** Participating health plans will be required to provide access to necessary services and providers for a transition period of up to six months for Medicare services if certain criteria are met[§] and a period of up to twelve months for Medi-Cal services if certain criteria are met.** Plans are required to perform an assessment within 45 or 90 days of beneficiary enrollment, depending on assessed risk level, to identify existing providers and establish a plan regarding continuity of care, if applicable.
- **Enrollment Assistance and Options Counseling:** The MOU states that individuals eligible for Cal MediConnect will be provided with independent enrollment assistance and options counseling to support their enrollment decisions. CMS and the Administration for Community Living (ACL) have set aside funds to support outreach, education, and options counseling efforts at State Health Insurance Assistance Programs (SHIPs, referred to as Health Insurance Counseling and Assistance Programs, or HICAPs in California) and Aging and Disability Resource Centers (ADRCs), and other community-based organizations.⁹
- **Ombudsman:** The MOU states that California will establish an Ombudsman office to help resolve issues between Medi-Cal managed care members and participating health plans. As of the date of publication, no additional details are available about the development of this office.
- **Person-Centered, Appropriate Care:** All medically-necessary services must be provided to enrollees in an appropriate manner that recognizes cognitive and physical functional status, language and culture, and caregiver involvement (to the extent desired by the beneficiary). Services are to be received in an appropriate setting with emphasis on the home- and community-based environment.
- **Americans with Disabilities Act (ADA) and Civil Rights Act of 1964:** Participating health plans will be required to be in compliance with the ADA and the Civil Rights Act of 1964. Plans will be required to accommodate the communication needs of beneficiaries, including making interpreters available as needed. The MOU cites the *Olmstead* decision, indicating that the state and CMS will provide ongoing monitoring to ensure that those beneficiaries needing LTSS receive such services in the “care settings appropriate to their needs” (p. 16).⁴
- **Enrollee Communications:** All communications with enrollees and prospective enrollees, such as notification regarding enrollment in Cal MediConnect, will need prior approval from CMS and the state before distribution. These communications will be available in alternate formats.
- **Beneficiary Participation on Governing and Advisory Boards:** CMS and the state will require participating health plans, as part of the three-way contract, to include beneficiary and community input on plan activities related to program management and enrollee care. This may include beneficiary participation on plan governing boards or quality review committees. Each plan must also establish at

[§]The beneficiary must demonstrate an existing relationship with the provider prior to enrollment, the provider must be willing to accept payment from the participating health plan on the current Medicare fee schedule, and the plan would not have otherwise excluded that provider from its network due to quality or other concerns.

^{**}The beneficiary must demonstrate an existing relationship with the provider prior to enrollment, the provider must be willing to accept payment from participating health plan based on the plan’s rate of service or the applicable Medi-Cal rate (whichever is higher), and the plan would not have otherwise excluded that provider from its network due to quality or other concerns. This policy does not apply to IHSS providers, durable medical equipment, medical supplies, transportation, or other ancillary services.

least one consumer advisory committee, with monthly meetings, to provide input to the governing board. The advisory committee must reflect the diversity of the enrollee population in the plan, including people with disabilities.

- **Additional Beneficiary Protections:** Other beneficiary protections detailed in the MOU include the requirement that participating health plans hire sufficient numbers of customer service representatives to respond to enrollee inquiries and complaints within a period of time as defined by CMS and the state. CMS and the state will staff call centers in sufficient numbers to respond to beneficiary inquiries and complaints. All plans must ensure the privacy and security of enrollee health records. The MOU details some cost-sharing provisions; plans are not permitted to charge Medicare Part C or D premiums or any cost-sharing for Medi-Cal services, and copays charged for pharmacy must not exceed that established by CMS under the Part D low-income subsidy or Medi-Cal cost-sharing rules. Lastly, no enrollee may be balance billed (charged the difference between the provider's billed rate and the rate reimbursed by the plan) by any provider for covered services.

Integrated Appeals and Grievances

The MOU indicates that through Cal MediConnect, CMS and the state will work to develop an integrated appeals process to support beneficiaries. Plan grievances and internal appeals procedures will be reviewed and approved by CMS and the state. CMS will continue to manage Part D appeals and grievances. The IHSS fair hearing process will continue as it exists today.

In Year 1 of Cal MediConnect, no changes will be made to the appeals process. Medicare and Medi-Cal appeals processes will remain intact until a new system of integrated appeals is developed and approved (see page 99 in Appendix 7 for more detail on the appeals process). The state will work with stakeholders and CMS to produce a more integrated appeals process.

Payments, Rate Setting Methodology, and Savings Calculations

CMS and the state have been engaged in a process to establish rates for the participating health plans. Plans will be paid a “blended” capitated monthly amount for each enrolled beneficiary that combines the Medicare and Medi-Cal capitated rates. Appendix 6 of the MOU describes the various steps that CMS and the state will engage in to establish the final rates. While the methodology to establish the rates has been made public, the rates themselves have not been released as of the date of publication of this fact sheet.

The rates will be established based on baseline Medicare and Medi-Cal spending and estimates of what would have been spent each year if Cal MediConnect did not exist. The rates consist of Medicare Parts A, B, and D costs, as well as Medi-Cal costs. The state and CMS will share in savings for Medicare Parts A and B and Medi-Cal costs equivalent to a minimum of one percent in Year 1, two percent in Year 2, and four percent in Year 3. Savings will not come from Medicare Part D. The total estimated spending will be projected for each year and the savings will be calculated based on this aggregated dollar amount. As noted in Appendix 6 of the MOU, changes to the minimum savings percentages “would only occur if and when CMS and the State jointly determine the change is necessary to calculate reasonable, appropriate, and attainable payment rates for the Demonstration” (page 48).⁴

The risk adjustment approach for the Medi-Cal portion of the rate consists of four population categories:

- Institutionalized individuals (those residing in a long-term care facility for 90 or more days);
- HCBS High: individuals who are high-utilizers of home- and community-based services including those enrolled in CBAS, MSSP, or IHSS with the classification of “severely impaired”;
- HCBS Low: individuals who are considered low-utilizers of home- and community-based services, including those enrolled in IHSS classified as “not severely impaired”; and
- “Community Well”: all other individuals with no Medi-Cal covered HCBS services.⁴

The Medi-Cal risk-adjusted rate will not include behavioral health services paid for and provided by county behavioral health agencies. It will also not include the administrative costs borne by the county-based IHSS programs, including eligibility determination, assessment of authorized hours, and maintaining the provider registry.

The Medicare risk adjustment approach will be based on standard methodologies used by CMS currently (Medicare Parts A and B will use hierarchical condition categories or HCCs; Medicare Part D will use RxHCCs).⁴

Quality Monitoring and Quality Withholds

Participating health plans will be subject to monitoring and evaluation as part of their participation in Cal MediConnect. CMS and the state will jointly monitor the plans’ performance on a broad set of metrics. Each plan will be required to report data for quality metrics selected by CMS and the state for ongoing monitoring during the demonstration period. There are 85 metrics in total listed in the MOU that will form the quality monitoring efforts of Cal MediConnect. These metrics are similar to those for other states that have approved MOUs for dual eligible integration efforts.¹⁰ The quality metrics selected are derived largely from standard measurement sets including the Healthcare Effectiveness Data and Information Set (HEDIS), the Health Outcomes Survey (HOS), and Consumer Assessment of Healthcare Providers and Systems (CAHPS) as well as measure sets used to evaluate quality in Special Needs Plans (SNPs). In addition, the state identified a selected set of metrics to evaluate LTSS quality. However, these have not been finalized and the state will continue to develop these measures with stakeholder input for eventual inclusion. Figure 7-1 beginning on page 108 of the MOU lists the core quality metrics for Cal MediConnect.

The Medicare and Medi-Cal programs will withhold a certain percentage of estimated capitation rates for each Demonstration plan (1, 2, and 3 percent in years 1, 2 and 3, respectively). If the plan meets specified performance targets, they will receive quality payments equal to the percentage deducted from the rates for enrolled beneficiaries. Most of the metrics selected for the quality withhold are part of the larger set of metrics to be used for ongoing health plan monitoring.

In Year 1, the quality withhold will be equal to one percentage point based on ten performance measures. These measures focus on key structure and process measures including submission of complete encounter data for enrolled beneficiaries, the proportion of initial health assessments completed within the specified timeframe, evidence of the establishment of a beneficiary governance board, evidence of appropriate access to services, among others (see Figure 6-3 on page 52 of the MOU for more detail).⁴

In Year 2, the quality withhold will increase to two percentage points and in Year 3, to three percentage points, and are based on an additional ten quality measures. These measures are focused more on process and outcomes with a clinical focus (see Figure 6-4 on page 54 of the MOU for more detail).⁴ The three-way contract will include more detail about the quality withhold measures, including performance standards. Part D payments will not be subject to a quality withhold.

The MOU states that plans meeting quality withhold requirements will be reported for each year and the quality scores for each plan will be publicly reported in Years 2 and 3 of the Demonstration. CMS has also implemented a contract with RTI International as the independent evaluator for the national Financial Alignment Demonstration, of which California is a part, as well as the state-specific activities under this Demonstration.

Next Steps and Timeline

Readiness Review: As a condition of participation in Cal MediConnect, health plans must undergo a readiness review process. CMS and state officials are conducting this review jointly, which applies to both the participating health plans and their subcontracted plans. The purpose of the readiness review is to evaluate each plan's capacity to meet all program requirements, such as having an adequate provider network for the full range of services (e.g., primary, acute, rehabilitative, LTSS) and capacity to ensure consumer protections.⁴ CMS has posted the California specific readiness tool^{††} that will guide the readiness review process.¹¹ The tool includes criteria related to continuity of care, assessment, care coordination, individualized care plan, coordination of services, transitions between care settings, confidentiality, beneficiary protections, communications with enrollees, and others.

Three-Way Contracts: California and CMS will develop a three-way contract for each participating health plan, including a contracting process that ensures a coordinated program operation, enforcement, monitoring, and oversight. The three-way contract will include provisions for CMS and California to evaluate the performance of the primary-contracted plans and sub-contracted plans. Plans will be held accountable for ensuring that sub-contracted plans meet all applicable laws and requirements.

Stakeholder Process: The state will continue to engage with stakeholders during the implementation and operational phases of Cal MediConnect. This will include ongoing public meetings, and monitoring individual and provider experiences. Participating health plans will be required to develop processes for beneficiary input as well as systems for measuring and monitoring the quality of services.

Conclusion

The MOU establishes the general framework and parameters of the Cal MediConnect program, with additional policy and program requirements to be further specified in the three-way contracts. Over the next several months, stakeholders at the state and local levels will have a critical role to play in highlighting key policy and program issues, educating providers and beneficiaries, and working with the state and Legislature to ensure that Cal MediConnect meets its intention of providing a more coordinated, higher quality service delivery system.

^{††}The readiness review tool can be found at the following link: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CARRTool.pdf>.

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