

Dual Eligibles and Integration Efforts

The LTC Fundamentals series is produced by The SCAN Foundation to highlight and describe the organization and financing of long-term care (LTC) in California. This LTC Fundamentals brief describes individuals eligible for both Medicare and Medicaid, as well as past and current efforts in the state to integrate services for this population.

Introduction

Low-income older adults and people with disabilities who are eligible for both the Medicare and Medicaid programs are often called “dual eligibles.” Medicare is the federal health insurance program for persons age 65 and over, certain persons with disability under age 65, and those who have end-stage renal disease, among others. Medicaid, funded by the federal and state governments, covers health services and long-term services and supports (LTSS) for millions of low-income Americans. In general, dual eligibles receive health care services through Medicare, while Medicaid pays for Medicare premiums and cost-sharing as well as other services not covered by Medicare, including institutional and community-based LTSS.¹

The medical and LTSS systems are highly fragmented because the Medicare and Medicaid programs frequently work at cross-purposes, impeding coordination of care for dual-eligible beneficiaries.² Historic misalignments between the two programs have often prevented individuals from accessing the full range of services needed

across the service continuum in an integrated, person-centered way. In addition, misalignments have led to program inefficiencies and higher system costs, as providers and states have found ways to shift financial responsibility between Medicare and Medicaid in ways that generally have not benefitted individuals needing services. Over the years, California and other states have sought to better integrate programs and services to move toward a more cost-effective and person-centered delivery system. The *Patient Protection and Affordable Care Act* (ACA) bolstered these efforts with initiatives aimed at spurring innovations across states, including improvements to supports and services for dual eligibles. This LTC Fundamentals brief describes dual eligibles nationally and in California, as well as the state’s past and current efforts to better integrate services for this population.

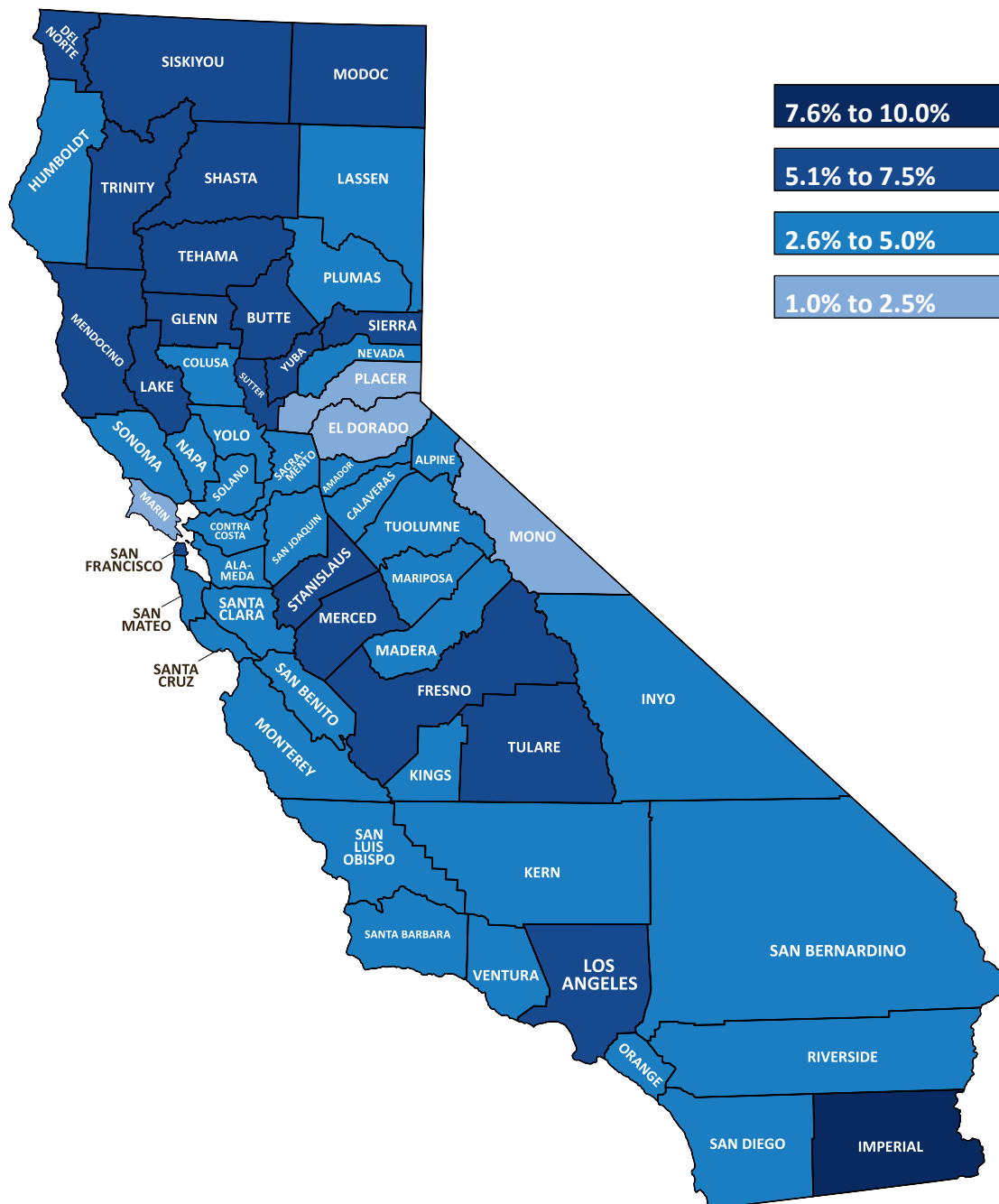
Characteristics of Dual Eligibles

There are over nine million dual eligibles nationally.³ Approximately 1.2 million of these

individuals reside in California, representing 13 percent of the national dual eligible population and three percent of the state's population.^{4,5} The distribution of dual eligibles varies across California's 58 counties. Imperial County has

the largest proportion of this population per adults age 21 and older (See Figure 1), and Los Angeles County has the greatest number: 370,785 residents, accounting for over 32% of the state's dual eligible population.⁶

FIGURE 1 Percentage of Dual Eligibles Per Population of Adults Age 21 and Older by County, California, 2012



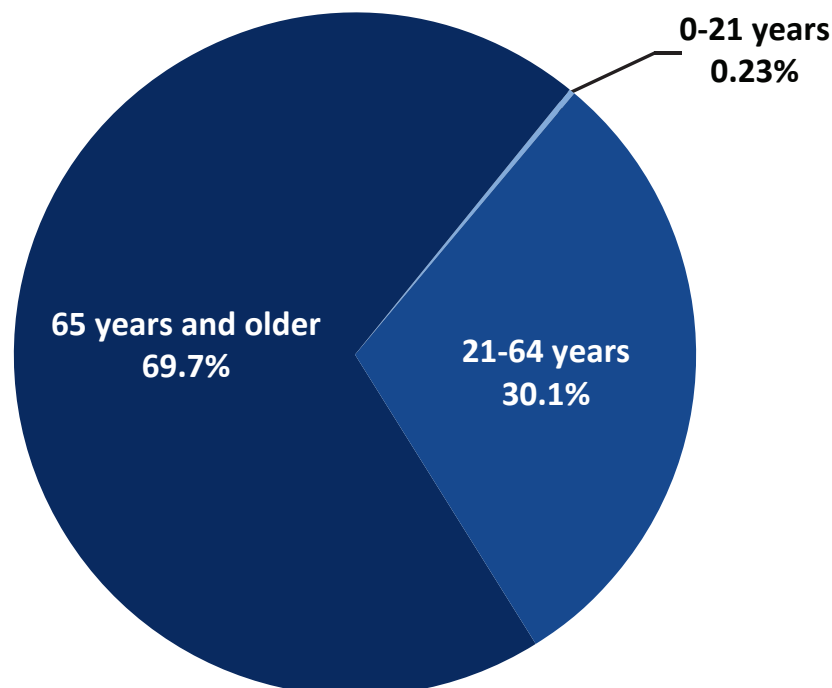
Source: The SCAN Foundation's analysis of data on *Medi-Cal/Medicare Dual Eligibility By Age, By County, July 2012* from the State of California, Department of Health Care Services and *General Population and Housing Characteristics: 2010* from the U.S. Census Bureau's 2010 Census Summary File 2.

In general, dual eligibles are poorer and sicker than most Medicare or Medicaid-only enrollees.⁷ The majority of this population (86 percent) have annual incomes below 150 percent of the federal poverty level (FPL).⁸ They also have high rates of chronic illness and functional impairment. Thirty-three percent of dual eligibles have one or more of the following chronic health conditions: diabetes, stroke, dementia, or chronic obstructive pulmonary disease. These conditions often result in functional limitations and may require the use of personal care and supportive services.¹ They are also more likely to use more health services, and have higher per capita health spending than beneficiaries who rely on Medicare or Medicaid only.^{1,5,9} While dual eligibles account for a smaller percentage of enrollees in both the Medicare and Medicaid programs, their services account for a disproportionate share of the costs. In California, dual eligibles comprise 26 percent of the enrollees and 36 percent of spending within Medicare, as well as 11 percent of enrollees

and 35 percent of spending within Medi-Cal.⁵ In 2007, combined Medicare and Medi-Cal expenditures for dual eligibles in California totaled \$27 billion.^{5,10} Less than 20 percent of dual eligibles within California are enrolled in organized health care delivery systems, most of which do not offer a full continuum of medical, behavioral health, and long-term care services. The remainder receive services through the uncoordinated fee-for-service system.¹¹

In California, adults age 65 and older comprise about 70 percent of the state's dual eligible population (See Figure 2), compared to 60 percent nationally. Approximately 17 percent of dual eligibles live in institutional settings, and those who live in the community may or may not use LTSS.⁹ Approximately one-third of dual eligibles have a mental illness, and 24 percent require help with three or more activities of daily living (ADLs), such as eating, walking, bathing, and dressing.⁹

FIGURE 2 California's Dual Eligible Population by Age, 2011



Source: State of California, Department of Health Care Services, *Medi-Cal/Medicare Dual Eligibility by Age, by County, July 2011*.

Eligibility

An individual can become a dual eligible through one of several eligibility pathways:¹²

- Medicare beneficiaries can qualify for full Medicaid benefits when they are eligible to receive Supplemental Security Income (SSI), covering individuals at or below 75 percent of FPL and couples at 83 percent of FPL.
- Medicare beneficiaries can also qualify for Medicaid through the “medically needy” coverage option. California is one of 33 states that provides Medicaid to aged, blind and disabled individuals with higher incomes who have met state Medi-Cal “spend-down” requirements after deducting medical expenses from their monthly income.¹³
- The California Working Disabled Program offers full scope Medi-Cal to people with disabilities who work and have income that is too high to qualify for other Medi-Cal categories. For this program, you can have up to 250% of the Federal Poverty Level in countable income and still receive Medi-Cal benefits. Enrollees pay a monthly, sliding-scale premium for this health coverage.¹⁴
- Medi-Cal beneficiaries may become dual eligibles when they age into Medicare or become eligible for Medicare due to a disability.

Individuals meeting the categorical and financial criteria for Medicare and Medicaid are referred to as “full duals” and are entitled to receive full benefits from both programs. Individuals with slightly higher incomes (100 percent to 200 percent of FPL) who do not qualify for full Medicaid but still need financial assistance with Medicare premiums and cost-sharing are often referred to as “partial” or “supplemental” dual

eligibles. They can participate in one of the four Medicare Savings Programs (MSPs) under which Medicaid supplements Medicare on behalf of the beneficiary.¹⁵ Almost 88 percent of dual eligibles in California are “full duals,” compared to 76 percent nationally.^{5,16}

Fragmentation Across the Medicare and Medicaid Programs

Individuals with both Medicare and Medicaid coverage theoretically have one of the most comprehensive coverage packages available. However, in practice, operationalizing this coverage in a seamless and person-centered way is nearly impossible. In general, Medicare covers medical services, while Medicaid provides assistance with Medicare premiums and cost-sharing, and covers services that Medicare does not, such as LTSS (See Table 1).¹¹ But while Medicare and Medicaid complement each other on some basic financial elements, misalignments between the two programs impede access and create disincentives for providers to serve the population. Neither program is fully responsible for the totality of a beneficiary’s needs and there is no systematic care coordination to assist in navigating programs and services across the continuum of care. Individuals and their families become the default care coordinators between two complex government-administered programs. This lack of coordination often results in poor health outcomes, inappropriate utilization of services, unnecessary costs and most importantly, high levels of frustration among beneficiaries and their loved ones.

In some instances, Medicare and Medicaid’s differing benefit authorization and payment procedures lead to denial of coverage and delays in accessing services. For example, Medicare

TABLE 1 Division of Services Covered by Medicare and Medi-Cal

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

Source: Harbage Consulting, California Duals Demonstration Overview: Working Paper, 2011 adapted from Medicare Payment Advisory Committee, Aligning Incentives in Medicare: Report to Congress, 2010.

authorizes services based on medical necessity, meaning that Medicare will pay for a service if it is deemed “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”¹⁷ In contrast, Medicaid will pay for any service that helps individuals to “attain or retain capability for independence or self-care.”¹⁷

Additionally, when a service is covered by both programs, Medicaid is the payer of last resort and will only reimburse a provider after Medicare has rejected the claim or paid its share. Typically, rates paid by Medicaid are less than what are paid by Medicare, which can create a disincentive among providers to treat those dually eligible for both programs.¹⁸

Consumer protection rights also differ between Medicare and Medicaid, including differing grievance and appeals processes. These differences include distinct protections regarding notices, review entities, levels of appeal, timelines for filing appeals and for making decisions and related issues.¹⁹ Noting that in most cases Medicaid has stronger protections, consumer advocates have pressed for an integrated appeals process that includes whichever program rule is strongest on each appeals issue.¹⁹

The fragmentation and misalignment between Medicare and Medicaid is also evident in other programs and services intended to assist people to access appropriate and timely care. In California,

for example, there are fourteen departments and programs within the California Health and Human Services Agency that affect older adults and people with disabilities. A person with chronic conditions or functional limitations might connect directly with programs and services provided or funded by the state's Departments of Health Care Services (including Medi-Cal—California's Medicaid program), Managed Health Care (overseeing Medicare Advantage plans in the state), Social Services (for In-Home Supportive Services—the state's personal care services program for adults with functional limitations), Aging (for Older Americans Act services, such as home-delivered meals or caregiver support), Rehabilitation, Developmental Services (for those with intellectual or developmental disabilities), and so forth.²⁰ For beneficiaries, this fragmentation can seriously complicate getting access to the right care at the right time by the most appropriate provider.

In 2001, the Institute of Medicine presented six aims for improving the nation's health care for the twenty-first century,²¹ including a system that is organized around person-centered care, which respects and addresses the person's preferences and needs — with his or her core values guiding care decisions. This concept is the primary aim of any integrated system. In a well-designed, integrated system of care, individuals with chronic health conditions and functional impairment would have access to a readily-available network of affordable options that provides high-quality care and supports, allowing them to live well and safely in their homes and communities. The needs, values, and preferences of these individuals and their family caregivers would be regularly honored by the providers, organizations and delivery systems that serve them. Health care providers would be knowledgeable about LTSS that assist people with daily support services they

need, including help with bathing, dressing, and managing medications at home, and would provide assistance connecting people with these services. An array of community service providers would assist individuals to navigate options for care and provide the tangible services. Community service providers would link accurate and timely information back to health care providers to enable individuals to use all services in the most appropriate and cost-effective manner. All providers would focus on making and maintaining key integrated connections between the main service platforms – primary, acute, behavioral, and rehabilitative care with LTSS – and place the individual in the center of the care experience. Overall, the right providers would engage with individuals at the right time and right place, involving family as appropriate and creating a rational plan of care that puts the person's preferences, values, and desires first.²²

The History of Integration and Care Coordination Efforts in California

California's current effort to achieve an integrated system of care for dual eligibles is one in a long line of previous attempts to better serve this population. A review of some of the state's previous efforts provides background, context and key lessons about the challenges of building a person-centered system of care that is cost-effective and assists people with chronic conditions and functional limitations to live independently in their home or community.

National efforts to develop integration for dual eligibles have included delivery system innovations such as Programs of All-Inclusive Care for the Elderly (PACE) and Medicare Dual Eligible Special Needs Plans (D-SNPs). At the state level, a number of policy proposals sought

to move toward a more integrated system of care, but were not implemented for a variety of reasons.

Delivery System Innovations

The PACE program was developed at On Lok Senior Health Services in the early 1970s in the Chinatown-North Beach community of San Francisco in order to address the long-term care needs of immigrant community elders. The PACE model is centered around the well-being of seniors with chronic conditions and their families, with comprehensive LTSS provided in the community whenever possible. PACE serves seniors who need a nursing home level of care with intense care coordination in a team-based care model. With the support of these services, frail seniors who would otherwise require nursing home care can remain safely living at home and in their communities. If a PACE enrollee does need nursing home care, the PACE program pays for it and continues to coordinate the person's care. In 1987, with the support of the Robert Wood Johnson Foundation, the John A. Hartford Foundation and the Retirement Research Foundation, On Lok successfully replicated their model, and by 2012 there were 88 PACE programs operating in 29 states across the country.²³

In 2003, the Medicare Modernization Act established Special Needs Plans, Medicare Advantage plans that provide coordinated care to certain vulnerable groups of Medicare beneficiaries, including dual eligibles (D-SNPs). D-SNPs enroll beneficiaries who are entitled to both Medicare and Medicaid, and offer the opportunity of enhanced benefits. They have interdisciplinary care teams that coordinate Medicare services for their members. There are currently 32 D-SNPs operating in California, enrolling nearly 160,000 dual eligibles. They are

administered by both local health initiatives and private health systems.

State Efforts

The Long-Term Care Integration Pilot Program represents one of California's earliest integration efforts. Assembly Bill (AB) 1040 (Chapter 875, Statutes of 1995) required the Department of Health Services (DHS; now referred to as the Department of Health Care Services) to establish up to five pilot projects across the state to integrate the delivery and financing of LTSS.²⁴ In 1997, DHS developed an implementation strategy to allow counties to phase in integration activities on an incremental basis. In 1999, the Legislature provided the initial funding for planning and implementation, with over \$2.6 million awarded to 16 counties between 1999 and 2004.²⁵ Additional funding established the Center for Long Term Care Integration at the University of Southern California to provide technical assistance with data analysis and other development activities. Many early grantees generated significant local interest for integrated systems. However, due to a number of implementation, administrative, and political issues, the pilots were not implemented.

The Cal Care Options (CCO) program was proposed in Senate Bill (SB) 1671 (Vasconcellos, 2004), and would have integrated Medicare and Medi-Cal funding and services for dual eligibles with services arranged through an entity providing access to a network of medical, health care, and social services.²⁶ The components of the proposed program included:

- The integration of medical and LTSS benefits for dual eligibles.
- A contractual arrangement between the state and no more than five entities, such as a licensed health care plan, Medi-Cal managed

care plan, or disability insurer, providing coverage for these integrated services.

- A program evaluation that focused on the extent to which each contracting entity reduced fragmentation and improved the coordination of the LTSS delivery system; the system was more efficient; and each contracting entity could demonstrate progress towards measurable performance outcomes.

However, SB 1671 failed passage in 2004.

The Acute and Long-Term Care Integration (ALTCI) projects were proposed in Governor Schwarzenegger's 2005-06 budget. These projects would have been established in Contra Costa, Orange, and San Diego Counties to restructure reimbursement for long-term care in order to create incentives to promote HCBS, achieve savings through more appropriate use of services, and increase care management.²⁷ The program targeted dual eligibles as well as Medi-Cal-only seniors and people with disabilities, who would have enrolled in a managed care plan to receive a range of services across the continuum, including interdisciplinary care management, primary care, acute care, drugs, emergency care, dental services, institutional care and HCBS.²⁸ The proposal did not gain the necessary legislative approval, and therefore was not included in the final budget.

In the next iteration, Governor Schwarzenegger's 2006-07 budget proposed \$1.2 million (\$525,000 General Fund) to establish "Access Plus and Access Plus Community Choices." This proposal sought to improve the continuity of care for dual eligibles and Medi-Cal-only seniors and people with disabilities by developing ways to better coordinate care and reduce costs within the Medi-Cal and Medicare programs by addressing fragmentation and creating incentives for HCBS over institutional care. The proposal

was eventually removed from the budget into legislation (AB 2979, Richman), but did not receive the necessary votes to become law.

California Section 1115 "Bridge to Reform" Waiver

In 2010, CMS renewed California's Section 1115 Medicaid Demonstration Waiver for another five years. Entitled *California's Bridge to Reform*, the waiver implemented a number of provisions, expanding coverage to uninsured individuals and permitting the mandatory enrollment of Medi-Cal-only seniors and persons with disabilities into Medi-Cal managed care plans in all 30 counties with Medi-Cal managed care.²⁹ In its original form, the waiver also called for the integration of Medicare and Medi-Cal for dual eligibles. The state sought to develop a model of care that would create one point of accountability for the delivery, coordination, and management of medical care and LTSS; blending and aligning Medicare and Medicaid services and financing to streamline care and eliminate cost shifting between the two programs. Ultimately, proposals to integrate Medicare and Medi-Cal services were removed from the 1115 waiver proposal in order to pursue the emerging opportunities in the ACA.

Dual Eligible Integration Initiatives Included in Federal Health Care Reform

The passage of the ACA laid the foundation for several significant opportunities to improve service delivery for dual eligibles. Among these was the creation of the Medicare-Medicaid Coordination Office (MMCO) within the federal Centers for Medicare and Medicaid Services (CMS), a new entity aimed at ensuring dual eligibles have full access to high-quality

health care that is provided in an efficient manner.³⁰ In 2011, the MMCO implemented the *Alignment Initiative* to support integration of the Medicare and Medicaid programs, publishing the *Opportunities for Alignment List* that laid out the areas of Medicare and Medicaid that have conflicting requirements or create incentives that prevent dual eligibles from receiving seamless, high quality care. These alignment issues included coordinated care, fee-for-service benefits, prescription drugs, cost sharing, enrollment and appeals. The list was published in the Federal Register in May 2011 and made available for public comment through July 2011.³¹

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.”³³

In April 2011, the MMCO collaborated with the CMS Center for Medicare and Medicaid Innovation (CMMI, another entity created by the ACA), awarding \$1 million contracts to 15 states, including California, to design strategies for implementing person-centered models of care that fully coordinate care for dual eligibles, including primary, acute, behavioral health services and LTSS.³² The goal of this effort was to identify and validate delivery system and payment coordination models that can be tested and replicated in other states. Elements of state design proposals included establishing accountable care organizations

(ACOs) to target high-cost duals, contracting with managed care organizations to deliver integrated services or allowing the state to assume administrative responsibility for both Medicare and Medicaid benefits.³³

In July 2011, the MMCO and CMMI announced the Financial Alignment Initiative, a component of the larger *Alignment Initiative*, for states to test two models that would better align the financing and delivery of care for dual eligibles, with the aim to integrate and improve quality of Medicare and Medicaid-financed services. The two models are: a capitated managed care arrangement or a managed fee-for-service arrangement. States could choose one or both models to test. Under the capitated model, a state, CMS, and a managed care plan would enter into a three-way contract, and the managed care plan would receive a prospective blended payment to provide the full array of services to each beneficiary. In the managed fee-for-service model, a state and CMS would enter into an agreement where the state would be eligible to benefit from savings that resulted from improving quality and reducing costs for both Medicare and Medicaid in an existing fee-for-service system.³⁴ Thirty-eight states expressed interest in participating, including the 15 states that were awarded design

* In addition to California (MOU finalized March 2013), Massachusetts (August 2012), Washington (October 2012), Ohio (December 2012), and Illinois (February 2013) have finalized MOUs under the Financial Alignment Demonstration.

contracts from CMS in April 2011. At this time, five states (including California) have finalized Memorandums of Understanding (MOUs) with CMS to proceed with their Demonstrations.* The following section provides more details regarding California's Demonstration.

California's Dual Eligible Integration Demonstration

State legislative authority for Medicare/Medi-Cal integration was established by SB 208,³⁵ which called for a pilot project (now referred to as the "Dual Eligibles Integration Demonstration" or "Cal MediConnect") to be implemented in up to four counties, including at least one county with a County-Organized Health System and one county with a Two-Plan model of Medi-Cal managed care.[†] The broad goals of the demonstration as defined in state law are to:

- Coordinate state and federal benefits and access to care across care settings, improve continuity of care, and use a person-centered approach;
- Maximize the ability of dual eligible beneficiaries to remain in their homes and communities with appropriate services and supports in lieu of institutional care;
- Increase the availability of and access to home- and community-based alternatives;
- Preserve and enhance the ability for consumers to self-direct their care and receive high quality care; and

- Optimize the use of Medicare, Medi-Cal and other state and county resources.³⁵

In 2011, California was one of 15 states awarded a \$1 million planning contract from the Centers for Medicare and Medicaid Services (CMS) to develop the Demonstration to "alleviate fragmentation and improve coordination of services for dual eligibles, enhance quality of care for this population, and reduce costs for the State and the Federal government."³⁶ On May 31, 2012, California submitted its Demonstration proposal to CMS entitled, "California Demonstration to Integrate Care for Dual Eligible Beneficiaries" for public comment.^{37,38}

On June 27, 2012, 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."³⁹ The CCI formalizes in statute elements of the Demonstration, while also outlining changes to the medical care and LTSS systems.⁴⁰⁻⁴² 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 LTSS into Medi-Cal managed care; and 4) coordination of behavioral health services.

The CCI expanded the number of counties participating in the Demonstration from four to eight. The eight counties are: Alameda, Los Angeles, Orange, Riverside, San Bernardino,

[†]COHS currently serve about 885,000 beneficiaries through six health plans in 14 counties. In the COHS counties, DHCS contracts with a health plan created by the County Board of Supervisors. The County administers the health plan, and all Medi-Cal beneficiaries residing in that county are enrolled in the COHS health plan. Two-Plan Models serve about three million beneficiaries in 14 counties. In most Two-Plan model counties, there is a "Local Initiative" (LI) and a "commercial plan" (CP). DHCS contracts with both plans. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. Geographic Managed Care (GMC) models serve approximately 450,000 beneficiaries in two counties: Sacramento and San Diego. In GMC counties, DHCS contracts with several commercial plans.

San Diego, San Mateo, and Santa Clara. Further details about the CCI may be found in The SCAN Foundation fact sheet entitled *California's Coordinated Care Initiative: Background and Overview*.⁴²

Approved Memorandum of Understanding with CMS

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.”⁴³ The signed MOU 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” Cal MediConnect (page 3).⁴³ 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 participating health plans in each county. Table 2 summarizes the key features of the original proposal to CMS for the Demonstration and the changes reflected in the MOU. For more detail on the MOU, please refer to The SCAN Foundation’s fact sheet entitled *Cal MediConnect: A Summary of the Memorandum of Understanding Between California and the Centers for Medicare and Medicaid Services*.⁴⁴

Conclusion

While California continues on its path toward system integration, much work remains to be done at the federal, state, and local levels. In the near term, CMS and state officials will conduct readiness reviews for all health plans

selected to participate in Cal MediConnect. The readiness review will evaluate each health plan’s enrollment systems, continuity of care protections, and network access to Medicare, Medicaid, and pharmacy providers. In addition, California and CMS will develop a three-way contract for each participating health plan, including a contracting process that outlines a structure for coordinated program operation, enforcement, monitoring, and oversight. Finally, stakeholder engagement will play a critical role during the implementation and operational phases of Cal MediConnect.

While Cal MediConnect begins to tackle the larger issue of system fragmentation for dual eligibles, wholesale system change will require additional effort at the state and federal levels. In order to achieve a more person-centered and integrated medical and LTSS system, policy makers need to ensure the financing and administrative structures provide and promote access to services in the home and community, in accordance with individual needs and preferences. Successful implementation of Cal MediConnect means that dual eligibles in the state get the right care from the right provider in an organized, efficient manner. If done well, this and other demonstrations can provide further evidence for bridging health care and supportive services for all individuals with chronic conditions and functional limitations.

TABLE 2 Summary of California's Dual Eligibles Integration Demonstration: Cal MediConnect

	State's Proposal to CMS ³⁷	Memorandum of Understanding (MOU) ⁴³
Target Population	All full benefit dual eligibles in specified counties, with specified exceptions (estimated to be 685,000).	All full benefit dual eligibles in specified counties, with specified exceptions. Estimates have been reduced to 456,000 with a capped enrollment in Los Angeles County of 200,000.
Geographic Service Area	Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara Counties, with expansion to other counties in 2014 and 2015.	Counties remain the same; the MOU limits the Demonstration for all three years to those eight counties. Certain rural zip codes in Los Angeles, Riverside, and San Bernardino are excluded.
Summary of Covered Benefits	<ul style="list-style-type: none"> • Medicare (Parts A, B, and D) • Medi-Cal services, including institutional long-term care and home- and community-based services such as In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), and Multipurpose Senior Services Program (MSSP), and additional benefits in lieu of institutionalization. • County-administered mental health and substance use services (not included in the capitation rate, but closely coordinated with "shared accountability" strategies). 	<ul style="list-style-type: none"> • Medicare (Parts A, B, and D) • All Medicaid state plan services • Dental, vision, transportation • Long-term services and supports, including institutional long-term care and home- and community-based services defined as In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), and Multipurpose Senior Services Program (MSSP), and "other HCBS" at the plan's discretion. • County-administered mental health and substance use services (not included in the capitation rate, but closely coordinated with "shared accountability" strategies).
Financing Model	Capitated payment model	Capitated payment model
Proposed Implementation Dates	Phased-in enrollment process starting between March and June 2013 in up to eight counties.	Phased-in enrollment process starting no sooner than October 2013 in the eight designated counties. Enrollment varies by county.

Note: Please see The SCAN Foundation's [fact sheet](#) on the MOU for more detail regarding the elements of the Demonstration (Cal MediConnect).⁴⁴

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