Highlights of California's Memorandum of Understanding (MOU) with CMS for the California Demonstration to Integrate Care for Dual Eligible Beneficiaries, Cal MediConnect

Geographic Scope and Eligible Populations

- The Demonstration will be limited to individuals living in the following eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.
- Two-plan model counties include Alameda, Los Angeles, Riverside, San Bernardino, and Santa Clara. County organized health system (COHS) counties include Orange and San Mateo while San Diego county has geographic managed care.
- Individuals must be 21 and older, entitled to received benefits under Medicare Parts A, B, and D, and must be receiving full Medicaid (Medi-Cal) benefits.
- Also eligible are individuals only in San Mateo County or Orange County with a diagnosis of end stage renal disease (ESRD) at the time of enrollment and individuals already enrolled in the demonstration in the eight demonstration counties who are subsequently diagnosed with ESRD.
- CMS and the State project that about 456,000 dual eligibles, roughly half of the State's total dual eligible population, will be moved into Medicare-Medicaid plans. The MOU sets a cap of no more than 200,000 enrolled beneficiaries in Los Angeles County.

Excluded Populations

- Individuals under age 21, persons residing in Veterans' Homes of California, developmentally disabled individuals receiving service through the State's regional centers or state developmental centers or intermediate care facilities, individuals in certain rural zip codes in the demonstration counties of San Bernardino, Los Angeles, and Riverside, and persons with other private or pubic health insurance are excluded.

Contracting and Rates

- CMS and the State, through a joint selection and procurement process, selected entities based upon previous performance in Medicare and Medi-Cal who met certain CMS requirements as detailed in the appendix of the MOU.
- CMS, the State, and each participating prime contractor plans will sign a single, three-way contract. Prime contracting plans are responsible for subcontracted plans adherence to the contract and to relevant regulations described in the MOU and applicable laws.
- The State is continuing to work with CMS to develop rates. The State currently expects to release more information in May 2013.
- Rates for each demonstration year will incorporate minimum projected savings as follows: Year 1, 1%; Year 2, 2%; Year 3, 4%.

Enrollment

- Eligible individuals will be notified of their right to select a participating plan no fewer than 60 days prior to the initial effective implementation date of October 1, 2013. For those individuals who do not select a plan or choose to opt out by that date, the State will passively enroll such individuals, who may still opt out of the demonstration at any time.
- The MOU lays out enrollment strategies for each county. For example, San Mateo County enrollment is scheduled to start October 2013 while Los Angeles County enrollment will occur over a 15-month period, which will begin first with a 3-month opt-in only period followed by a passive 12-month enrollment period.
- CMS and the State will utilize an independent third party entity to facilitate enrollment into the Participating Plans in Two-Plan and Geographic Managed Care Counties. In the two County Organized Health Systems (COHS) counties, the Prime Contractor Plans will facilitate enrollment, as done today.
- Individuals enrolled in PACE, the AIDS Healthcare Foundation, or the following 1915(c) waivers are exempted from passive enrollment but may enroll in the demonstration only after they have disenrolled from their current program: Nursing Facility/Acute Hospital; HIV/AIDS; Assisted Living, and; In Home Operations.
- Individuals enrolled in a Medicare Advantage plan may enroll in the demonstration but cannot be passively enrolled.

Care Model and Assessments

- Participating plans are required to implement an evidence-based model of care (MOC) having explicit components consistent with the Special Needs Plan (SNP) MOC and must meet a minimum standard score of 70%. A plan with an MOC score of 85% or higher will receive a three-year approval, a score between 75% and 84% will receive a two-year approval, and a plan with an MOC score of 70% to 74% will receive CMS approval for one year.
- Care Coordinators will provide care coordination services, appropriate referrals, transmit enrollee information, participate in the initial assessment of each enrollee, and will serve on an Interdisciplinary Care Team (ICT) that will assist enrollees to develop, implement, and maintain their individualized care plan.

Consumer Protections

- Beneficiaries who are eligible for passive enrollment into the Demonstration will receive an informational notice about the Demonstration and process of passive enrollment 90 days prior to the effective date of enrollment.
- Participating plans are required to obtain beneficiary and community input on issues of program management and enrollee care through several approaches, including beneficiary participation on participating plan governing and quality review boards.
- The State is developing an ombudsman structure that will assist beneficiaries in conducting impartial investigations of member complaints. The ombudsman will assist beneficiaries with urgent and disenrollment problems.
- CMS and the State agree to work together in the development of marketing materials and the State will consult with CMS on the development of these materials. Participating Plans must receive prior approval of all marketing and enrollee communications materials in categories of materials that CMS and the State require to be prospectively reviewed.

Continuity of Care

- CMS and the State will require participating plans to ensure individuals have access to care and plans will be required to authorize payment to providers at Medicare rates and Medi-Cal rates for each programs' services, respectively.
- Participating plans must inform beneficiaries when they have received care not covered at an in-network level and, as needed, must contact providers not already members of their network with information on becoming credentialed as in-network providers.
- Participating plans must follow the continuity of care requirements established in current law and must allow enrollees to maintain their current providers and service authorizations for a period of up to 6 months for Medicare and 12 months for Medi-Cal services. Descriptions of continuity of care rights will be developed in all threshold languages and distributed to enrollees in their enrollment choice packet, distributed 60 days before they are enrolled in a Participating Plan.

Evaluation/Monitoring and Grievances/Appeals

- CMS has contracted with an independent evaluator to measure, monitor, and evaluate Financial Alignment Demonstrations, including the California Demonstration. Key issues that will be targeted for evaluation include: 1) beneficiary health status and outcomes; 2) quality of care provided across care settings; 3) beneficiary access to and utilization of care across care settings; 4) beneficiary satisfaction and experience; 5) administrative and systems changes and efficiencies; and 6) overall costs or savings for Medicare and Medicaid
- The State is hoping to work with CMS to develop a unified appeals and grievance process. Until such a process is implemented, the same process in place today for the separate programs will continue in October.