Master Plan for Aging
Integrated Delivery System

Issue Statement: California must commit to designing and implementing an integrated healthcare and long-term services and supports (LTSS) delivery system to serve the 1.4 million dual eligibles in the state to ensure access to services and care that that optimize health and quality of life.

California's Dual Eligibles

There are approximately 1.4 million dual eligibles – those with both Medicare and Medi-Cal coverage – in California. The majority of duals in California are 65 and over and female,[1] and populations of color are more likely to be duals than those individuals with only Medicare coverage.[2] Duals' health status is also poorer than the Medicare-only population. For example, duals are more likely to have end stage renal disease compared to individuals with Medicare-only coverage (3 percent versus .8 percent)[3], and are nearly twice as likely to have three or more chronic conditions (48 percent versus 27 percent).[4]

Duals account for a disproportionate share of Medicare and Medi-Cal expenditures. While duals represent just 25 percent of all Medicare enrollees in the state, they account for 39 percent of total Medicare expenditures. Similarly, duals make up just 11 percent of Medi-Cal enrollees, but account for 32 percent of total Medi-Cal expenditures.[5] For Medicare, the bulk of those costs are for hospital and outpatient services, whereas for Medi-Cal the costs are for long-term services and supports, most notably for nursing facility care.[6] Nationally, recent research demonstrates that a large portion of both Medicare and Medicaid spending occurs at the end of life, as duals 65 and over are nearing death and are repeatedly hospitalized and incur high costs in nursing facilities.[7]

Fragmented System of Care

Duals receive their benefits in **eleven** different fee-for-service (FFS) and managed care delivery systems or combinations of delivery systems depending on where they live, what services they are receiving, and their enrollment choices. Delivery systems include more integrated models in certain counties and zip codes including Cal MediConnect, the Program for All Inclusive Care for the Elderly (PACE) and Fully Integrated Dual Special Needs Plans (FIDE-SNPs) to the least integrated models in which duals are enrolled in two different managed care plans – one for Medicare and one for Medi-Cal – in which neither have any responsibility for coordinating services for enrolled members.

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[1] State and County Level Profiles, available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html. (2012 data released in 2017).
[2] Id.
[3] Id.
[4] Centers for Medicare & Medicaid Services, "Medicare-Medicaid Enrollee Information California, 2011," available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2011StateProfilesCA.pdf.
[5] Id.
[6] Id.
[7] Bynum, J. et al, "High-Cost Dual-Eligibles' Service Use Demonstrates Need for Supportive and Palliative Models of Care," (Jul. 2017), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5633373/.

Delivery Systems for Dual Eligibles in California

Medicare FFS + Medi-Cal FFS
Medicare FFS + Medi-Cal Plan
Medicare FFS + Medi-Cal Plan LTSS (MLTSS)
Medicare Plan + Medi-Cal FFS
Medicare Plan + Medi-Cal Plan Alligned
Medicare Plan + Medi-Cal Plan Alligned (MLTSS
Medicare Plan + Medi-Cal Plan Not Alligned
Medicare Plan + Medi-Cal Plan Not Alligned (MLTSS)
Cal MediConnect
PACE
FIDE-SNP

Lack of integration leads to significant access issues. For duals, Medicare is the primary payer for services, including coverage for most medical services. Medi-Cal is the payer of last resort and acts to fill in the gaps for services not covered by Medicare, including non-emergency transportation to medical services, certain durable medical equipment and supplies, dental and vision, and most notably, long-term services and supports. While duals theoretically have coverage for services that is fairly comprehensive, they often face barriers to receiving services because their benefits are delivered through two different programs. Medicare is a federal program while Medi-Cal is a state and federally-funded program. The two programs have different rules and regulations and standards of medical necessity. Additionally, most of the providers who duals see for their medical needs are contracted with Medicare and may not necessarily be contracted with Medi-Cal. Meanwhile, the providers duals use for long-term services and supports and other services are contracted only with Medi-Cal. Having providers contracted through two different insurance programs often means lack of coordination between these services, leading to barriers to accessing care and improper billing for services.

<u>Medi-Cal Healthier California for All Proposal (Formerly, CalAIM)</u>
In October 2019, the Department of Health Care Services released a proposal to transorm the Medi-Cal program. The section of the proposal regarding how care will delivered to dual eligibles was further supplemented by a paper released in December 2019. Together these proposals represent a step backwards from California's current efforts to integrate and coordinate care for duals. The proposal fails to provide a rational explanation for this decision, lacks a commitment to move forward with a system that would result in more integration rather than less, and does not incorporate the many lessons learned and best practices and policies gained through integration efforts to date. Additionally, there is very limited formal stakeholder process regarding a proposal of such signficance.

Lastly, while the Medi-Cal Healhier California for All Proposal aims to set the future path for the state's Medi-Cal program, it includes very little mention of older adults despite identifying them as a vulnerable

population. Elements of the proposal such as integration, behavioral health, oral health, and in lieu of services make only limited, if any, reference to older adults and how changes in these areas could be leveraged to improve access and outcomes for older people as well as other populations.

MPA Framework Goal:

- **Goal 1:** Services and Supports: We will be able to live where we choose as we age and have the help we and our families need to do so.
- **Goal 2:** Livable Communities and Purpose: We will live in and be engaged in communities that are age-friendly, dementia- friendly, and disability-friendly.
- **Goal 3:** Health and Well-Being: We will maintain our health and well-being as we age.

MPA Framework Objective: Objective 3.2 - Californians will have access to quality, affordable, and person-centered health care through delivery systems that are age-friendly, dementia-friendly and disability-friendly.

Recommendation: Design and implement an integrated delivery system that adequately serves the 1.4 million dual eligibles in California.

Target Population and Numbers: 1.4 million low-income older adults and people with disabilities who rely on Medicare and Medi-Cal.

Detailed Recommendation:

- **Develop an Integration Plan**. Develop a 5-10 year plan for building an integrated Medi-Cal/Medicare delivery system for dual eligibles in California that builds on lessons learned from integration efforts to date.
- **Establish Robust Integration Stakeholder Process**. The State should develop a specific and robust stakeholder process for informing the development of the integration plan. That process must include multiple and ongoing meetings of the workgroup to review any integration proposal(s) and ongoing meetings to effectively implement any transitions proposed.
- **Commit to Essential Elements of Integration**. The State should commit to an integrated delivery system with essential elements including:
    - **Commitment to the Highest Level of Integration**. The state must commit to developing an integrated system that accomplishes the highest level of Medicare/Medicaid integration through Fully Integrated Duals Special Needs Plans (FIDE-SNPs); Highly Integrated Duals Special Needs Plans (HIDE-SNPs); and the Program for All Inclusive Care for the Elderly (PACE).
        - **Regulate D-SNP Look Alikes**. With a commitment to the highest integrated delivery systems, the state must regulate the availability of lesser or non-integrated products including D-SNP look alikes.
        - **Incorporate Learnings**. Many promising and best practices have been identified in Cal MediConnect. These practices should be incorporated into any new integrated system. For example, Cal MediConnect plans were required to train care coordinators on Alzheimer's and dementia; health plans formalized partnerships with long-term care ombuds partnerships with plans to improve

quality of care in nursing facilities; county and health plan partnerships led to increased hours for IHSS consumers; deeming and robust continuity of care protections minimized disruption and unnecessary disenrollment from plans; and many more.

- **Choice**. Dually eligible beneficiaries, their family caregivers and representatives, as appropriate, should be informed of all health care and long-term services and supports (LTSS) options, independent of plans or models, from which they can choose. This information must be easy to understand and culturally and linguistically appropriate.
- **Voluntary enrollment**. Choice of care must be voluntary, "opt in" enrollment vs. mandatory enrollment or assignment. Dually eligible beneficiaries must not be forced or locked into any plans or delivery models or be deprived the right to choose afforded to other Medicare beneficiaries.
- **Person-Centered**. All care and services provided to dually eligible beneficiaries should be individualized to each beneficiary's health care needs and preferences. Each individual should receive a personalized health care assessment and care plan, and have the option to self-direct their care.
- **Home and Community Based Services**. The integrated model should be designed to improve access to and utilization of home and community-based services (HCBS). Clear goals for increased use and spending on HCBS should be set, Financial incentives, monitoring mechanisms and quality measures should be designed to ensure plans are meeting the goals.
- **Care Coordination**. Care coordination for dually eligible beneficiaries should include face-to face, comprehensive care coordination. Participants in the care team should be appropriate to the dual eligible's needs and consistent with the individual's choice. Coordination must be across services including carved out services (e.g. oral health, behavioral health, hospice, etc.) and connect duals to services provided by community based organizations – particularly when addressing social determinants of health.
- **Strong Consumer Protections**.
    - **Appeals & Grievances**. Dually eligible beneficiaries should be able to appeal decisions and file complaints about problems with a health plan. Appeals must be integrated and provide the most favorable appeal path for the beneficiary.
    - **Continuity of Care**. Dually eligible beneficiaries should receive continuous care with access to current providers, services, treatments, and prescription formularies during care transitions. The most expansive protections should be adopted.
    - **Deeming and Aid-Paid Pending**. Deeming and aid-paid pending must be maintained in an integrated system. These protections both minimize disruption and prevent loss of services.
    - **Consumer Participation**. Service delivery, policy development, and implementation should include meaningful mechanisms for participation by dually eligible beneficiaries, their family caregivers or representatives, consumers, and consumer advocates.
- **Maintain and Expand Ombuds Program for Integrated System.** As responsibility for deciding what care will be provided in which setting shifts from DHCS to managed care

plans, dual eligibles will need assistance navigating plan procedures and advocates to work on their behalf if errors or mistakes are made. Since many managed care plans have limited experience serving this population and, in particular, providing behavioral health and LTSS, there will be systemic challenges to confront and address as new systems mature. The CCI Ombuds has proven to be essential in protecting plan enrollees and in helping to better understand and monitor plan performance and resolve systemic issues. The current ombuds program should be continued and expanded statewide.

- **Implement Ongoing and Robust Evaluation.** Integration models should be rigorously evaluated for meaningful comparison. Sufficient data should be collected to conduct useful evaluation. Oversight should be comprehensive and coordinated between federal and state governments and other independent quality assurance entities to ensure that integrated models are performing contracted duties and delivering high-quality services. Evaluation results should be publicly available.

Evidence that supports the recommendation:

- **Cal MediConnect Evaluations**: https://www.thescanfoundation.org/initiatives/advancing-integrated-care/evaluating-cal-mediconnect/

Examples of local, state or national initiatives that can be used as an example of a best practice:

- **Local:** Cal MediConnect; Health Homes; Whole Person Care Pilots; PACE.
- **State:**
  - **California**
    - **Deeming** – http://www.dualsdemoadvocacy.org/wp-content/uploads/2017/04/Updated-Cal-MediConnect-Deeming-042017.pdf
    - **Regulating D-SNP Look Alikes** - https://www.justiceinaging.org/wp-content/uploads/2019/07/D-SNP-Look-Alikes-A-Primer.pdf
  - **Massachussets**
    - **One Care Implementation Council**, https://www.mass.gov/service-details/one-care-implementation-council
  - **Minnesota**
    - **Minnesota Managed Care Longitudinal Data Analysis,** compares fully-integrated managed care to service delivery when Medicare and Medicaid-funded services are delivered independently**,** https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis
- **National:**
  - Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans: https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_SMACSampleLanguage_FINAL.pdf
  - On Advisory Councils: https://www.healthinnovation.org/resources/publications/body/Consumer-Advisory-Council-Report_Final.pdf

- Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Integrating Medicaid Managed Long-Term Services and Supports into D-SNP Models of Care, https://www.integratedcareresourcecenter.com/sites/default/files/ICRC-MOC-Tip-Sheet-June-2019.pdf
- RTI Evaluations of duals demonstrations, https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations
- Building Relationships between Managed Care Organizations and Beneficiary Ombudsman Programs, https://www.integratedcareresourcecenter.com/sites/default/files/SHC_Ombuds%20FINAL%20FOR%20508.pdf

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