Medicare/Medi-Cal Dual Eligibles

Summary of the Memorandum of Understanding (MOU) between the State of California and the Centers for Medicare and Medicaid Services

April 12, 2013

Background

On March 27th, the California Department of Health Care Services (DHCS) announced that the federal Centers for Medicare and Medicaid Services (CMS) has given approval to the project to require Medicare/Medi-Cal dual eligibles to enroll in a managed care plan[1]. The project, which was previously known as the "Coordinated Care Initiative," will now be called **CalMediConnect**.

This document is intended to help physicians understand the CalMediConnect project, so that you can advise your patients regarding their options in the program.

Scope and Timeline

The state plans to enroll approximately 450,000 dual eligibles into managed care in eight counties – Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

Enrollment in the program will begin on October 1, 2013. The length of the enrollment period depends on the county of residence:

County	Participating Plan(s)	Enrollment Timeline
Alameda	Alameda Alliance for Health and Anthem Blue Cross	12 months
Los Angeles*	LA Care and Health Net	15 months
Orange	CalOptima	12 months
Riverside	Inland Empire Health Plan and Molina	12 months
San Bernardino	Inland Empire Health Plan and Molina	12 months
San Diego	Care 1st, Community Health Group, Health Net, and Molina	12 months
San Mateo	Health Plan of San Mateo	3 months
Santa Clara	Anthem Blue Cross and Santa Clara Family Health Plan	12 months

****Enrollment in Los Angeles County will be capped at 200,000*.**

In all six counties where the transition is occurring over 12 months, patients will be transitioned into managed care in their birth month. The MOU does not describe the enrollment methodology for San Mateo or Los Angeles Counties. Further guidance is expected on those two.

[1] See http://www.calduals.org/cci-documents/ca-demo-documents/ for the complete text of the MOU.

Enrollment Process and Opt Out

Dual eligibles should begin receiving notices regarding the CalMediConnect program in July 2013, 90 days before enrollment is set to begin. There will be subsequent notices in August and September (60 days and 30 days before enrollment begins, respectively). Patients who do not select a health plan after all three notices will be "passively enrolled" into a plan selected by DHCS.

The State of California had proposed that, once a patient had selected or been assigned to a plan, they would be "locked-in" for six months. CMS, however, rejected that proposal completely. Patients will have the ability to opt out of the demonstration into fee-for-service Medicare at any time. They will continue to receive their Medi-Cal benefits, which are predominantly non-medical services such as in-home care, through a managed care plan.

The MOU does not specify what forms or methods or at what point in the process a patient can opt of the demonstration. However, CMA has been informed that the draft opt-out form and process will be made available for stakeholder input in late April 2013 or early May 2013.

Excluded Populations

Certain dual eligible populations will be excluded from CalMediConnect, including:

- Individuals under age 21;
- Individuals with other private or public health insurance;
- Individuals receiving services through a regional center, state developmental center, or intermediate care facility for the developmentally disabled;
- Most individuals with a share of cost;
- Individuals residing in a Veterans Home;
- Individuals in some rural zip codes:
  - San Bernardino: 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93592, and 93558.
  - Los Angeles: 90704
  - Riverside: 92225, 92226, 92239;
- Individuals with a diagnosis of end stage renal disease (ESRD) at the time of enrollment, except in San Mateo and Orange counties.

Physician Rates and Payment Rules

The MOU is generally silent on physician payment rates. The DHCS and CMS have not completed their contracts with the managed care plans, which will specify the capitation rates that the plans receive. It will then be left to the plan to negotiate with their provider networks.

There are, however, a couple of very important protections for physicians and their patients included in the MOU.

Once patients are enrolled in a plan, they can continue to see a physician with whom they have an existing relationship, even if the physician is not contracted with the plan, for up to 6 months for Medicare and up to 12 months for Medi-Cal services. The patient must demonstrate that they have seen the out-of-network physician at least twice in the previous twelve months, and the physician will be paid at the Medicare fee

schedule rate for those services. It is not clear how the patient would demonstrate this pre-existing relationship.

In addition, in an urgent or emergent situation, the plans will be required to pay out-of-network physicians at the Medicare fee-for-service rate for Medicare services, and the Medi-Cal fee schedule for Medi-Cal services. This is an important protection for physicians covered by federal EMTALA law, including emergency physicians.

Covered Benefits and Services

CalMediConnect plans will be required to cover all services currently covered by Medicare Parts A, B, or D (physicians, hospitals, and prescription drugs, respectively), and any services currently covered by Medi-Cal, including services in state waivers. In addition, plans will be required to cover some services that are currently not covered by either Medicare or Medi-Cal, including vision, dental, and medical transportation.

Delivery System

The intent of CalMediConnect is to allow managed care plans to coordinate all of a patient's services, including medical treatment and non-medical services, such as in-home care and behavioral health. The hope is that, by building better coordination between these services, patients will receive a more comprehensive treatment plan to meet their needs.

As part of meeting this intent, the MOU requires plans to offer enrollees an Interdisciplinary Care Team (ICT). This team of providers and caregivers could include a physician, nurse, case manager, family members, social workers, and others. The members of the ICT will be asked to coordinate on a health risk assessment and comprehensive treatment plan for the patient.

The exact structure and role of the ICT will be determined on a patient-by-patient basis.

Network Adequacy

For Medicare services, health plans will be required to meet Medicare Advantage standards for network adequacy[2], unless the Medi-Cal standards are more stringent. Networks will be subject to an initial assessment, and ongoing monitoring by the Department of Managed Health Care.

Physicians also need to be aware that plans will be required to ensure that their providers comply with all requirements of the Americans with Disabilities Act. Although it is not specified in the MOU, this could entail plans performing a facility site review (FSR) similar to what was done for the enrollment of seniors and persons with disabilities into managed care. If plans do perform FSRs, a representative of the plan will visit your practice to assess your physical accessibility.

[2]See: http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/downloads/CY2013_HSD_Provider_Facility_Specialties_Criteria_Guidance_111011.pdf for the complete MA network adequacy guidance.

Next Steps

Now that the State of California has completed their MOU with CMS, both government entities will now begin negotiating contracts with the health plans. These contracts should be finished in late Spring/early Summer 2013, to allow patient notices to begin in July.

The MOU provided a lot of important information, but left many questions unanswered, including important details about the opt-out form and process. CMA will be working with DHCS to answer these questions and will be highly engaged in the stakeholder process related to the opt-out form and requirements.

In addition, CMA and the county societies will continue to keep member physicians informed and provide physicians with the tools you need to help your patients understand the myriad of changes to their health care insurance.

If you have any questions, please contact the Member Help Center at 800-786-4262.