Cal MediConnect: Strategic and Operational Considerations for Hospitals

A White Paper

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ACA	Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152
ACO	Accountable Care Organization
APR-DRG	All Patient Refined Diagnosis Related Group
CBAS	Community-Based Adult Services
CCI	Coordinated Care Initiative
CDA	California Department of Aging
CDSS	California Department of Social Services
CMS	Centers for Medicare & Medicaid Services
DHCS	California Department of Health Care Services
DMHC	California Department of Managed Health Care
DP/NF	Distinct Part Nursing Facility
DSH	Disproportionate Share Hospital
ESRD	End-Stage Renal Disease
FFS	Fee-For-Service
IHSS	In-Home Supportive Services
IPA	Independent Practice Association
IRF	Inpatient Rehabilitation Facility
LTCH	Long Term Care Hospital
LTSS	Long-Term Services and Supports
MA	Medicare Advantage
MMCO	Medicare-Medicaid Coordinated Care Office
MOU	Memorandum of Understanding
MS-DRG	Medicare Severity Diagnosis Related Group
MSSP	Multipurpose Senior Services Program
PACE	Program of All-Inclusive Care for the Elderly
SNP	Special Needs Plans

I. Introduction

This paper examines Cal MediConnect, California's demonstration project to enroll patients with both Medicare and Medi-Cal coverage ("dual eligibles") into managed care plans ("Demonstration Plans"). This paper is intended to be an important resource for hospital personnel involved in meeting the strategic, financial and operational challenges presented by Cal MediConnect. In view of the scope and complexity of the demonstration project, the intended audience for this paper includes hospital chief executive officers, chief financial officers, compliance officers, in-house counsel, managed care contracting personnel, quality assurance and utilization review staff, directors of affected departments and personnel involved in admissions and patient financial services.

This analysis also includes a description of Cal MediConnect, its current status and the state's implementation plans. Beyond that, the paper addresses the critical and widespread implications of Cal MediConnect on hospitals and provides both strategic and practical considerations for hospitals as the demonstration project moves forward.

II. Executive Summary

On March 27, 2013, California entered in to a Memorandum of Understanding (MOU) with the Centers for Medicare & Medicaid Services (CMS) to undertake what will be, by far, the largest dual eligible demonstration project in the U.S. Pursuant to the MOU, the state will enroll 456,000 dual eligibles in Demonstration Plans beginning October 1, 2013, in eight California counties. The counties involved and the estimated number of affected beneficiaries in each county are:

County	Eligible Population
Alameda	31,076
Los Angeles	200,000
Orange	57,060
Riverside	34,477
San Bernardino	36,368
San Diego	50,952
San Mateo	10,652
Santa Clara	35,245

The Governor's office has estimated that Cal MediConnect will reduce state expenditures by $170.7 million in fiscal year 2013-14 and $523.3 million annually in subsequent years.[1] Assuming that the federal and state governments share equally, the payment reductions would be approximately double that amount: $341 million for fiscal year 2013-14 and more than $1 billion annually in subsequent years. Earlier data published by the Governor's office indicates that much of this savings is to come from reductions in payments for inpatient hospital services. According to the MOU and state law, these savings are intended to be driven by reductions in utilization rather than by reductions to payment rates. The state anticipates that hospital utilization by the dual eligibles enrolled in a Demonstration Plan will be reduced by 15 percent in the first year and by 20 percent in subsequent years.[2] These numbers may be revised as part of the Governor's May budget revision later this spring.

Although California law contains language reflecting legislative intent that hospital payment rates under Cal MediConnect will not be less than the Medicare fee-for-service rates where Medicare is primary, and the Medi-Cal fee-for-service rates where Medi-Cal is primary, the MOU contains no such rate protection. The Department of Health Care Services has indicated that rates for skilled nursing services, which presumably include hospital distinct-part nursing facility (DP/NF) services, will not be less than Medi-Cal rates where Medi-Cal is primary, but that there are no mandated minimum rates for other hospital services.

Dual eligibles will be "passively enrolled" in the Demonstration Plans, meaning that they will be assigned to a plan if they do not affirmatively opt out or choose a specific plan. The beneficiaries will be permitted to opt

out and remain in traditional fee-for-service Medicare for their Medicare benefits. Regardless of a beneficiary's choice of Medicare benefit enrollment, individuals who opt out of the demonstration will nevertheless be enrolled in a Medi-Cal managed care plan for their Medi-Cal benefits. Individuals who are enrolled in a Demonstration Plan will not be locked in and will be permitted to disenroll at any time and return to fee-for-service Medicare for Medicare benefits. However, they will continue to be enrolled for their Medi-Cal benefits.

Cal MediConnect will encompass all Medicare covered services under Parts A, B, and D, as well as all Medi-Cal covered services. The Demonstration Plans will be required to provide most services directly and to coordinate the provision of other services, such as certain county-administered mental health services. A separate MOU will be entered between each Demonstration Plan and the applicable county mental health plan(s), addressing the coordination between the Demonstration Plans and the county mental health plans. In addition, the state must receive permission from CMS under an amendment to the state's 1115 Waiver to transition long term care services and supports (LTSS) into managed Medi-Cal. The Cal MediConnect MOU does not address this transition, which is still under CMS review. Approval is expected by no later than October 2013.

The Demonstration Plans will receive pre-paid capitated payments in return for the services they are required to provide, but there will be risk corridors to moderate the risk that the plans assume. Providers will look to the Demonstration Plans for payment for most of the services furnished to the enrollees and will not be permitted to balance bill, although it appears that specialty mental health services administered by the counties, including acute inpatient psychiatric services, will continue to be paid for directly by the county mental health plans.

Now that the MOU has been approved, Cal MediConnect will move forward rapidly over a compressed time period. Dual eligibles in the affected counties will begin to receive notices of their enrollment options in the next few months. The Demonstration Plans are now developing their provider networks; many of the Demonstration Plans have already entered into discussions with hospitals and other providers for participation in their networks. Enrollment will begin October 1, 2013, less than six months from now.

Key considerations for hospitals as Cal MediConnect rolls out include:

- Financial impact: How much of the hospital's current utilization and revenue is derived from treating dual eligibles? What would the impact be of a 15 to 20 percent reduction in dual eligible utilization of inpatient hospital services? What would the impact be if a hospital does not contract with the Demonstration Plans? What is the impact on Medicare and Medi-Cal DSH payments? How are DSH and other add-on payments addressed in payments from the Demonstration Plans?

- Contracting: Should the hospital contract? What are the important terms that should be included in a contract with the Demonstration Plans? Are there unique concerns for the dual eligible population concerning verification of eligibility and authorization? How should post-acute services be integrated into the contract? What rate structure should the hospital pursue? What protections are there if the plan's post-acute network is inadequate and the hospital finds it difficult to discharge patients to a lower level of care? What is the appeals/grievance process?

- Operational challenges: What changes in operations will be necessary? For example, authorizations may now be required for particular service lines where authorizations have not been required in the past (e.g. for DP/NF and acute rehabilitation services). Is the hospital prepared to handle the authorization process and any related appeals?

- Patient communications: How might a hospital best share information with its dual eligible patients? Should the hospital inform the patients about the different Demonstration Plan options, including which plans contract with the hospital and the process for opting out for Medicare benefits?

- Physician relationships: Are there particular physician organizations with whom the hospital should partner in developing an approach to contracting with the Demonstration Plans? How does Cal MediConnect fit with the hospital's physician alignment strategies? Alternatively, will physicians with whom the hospital is aligned wish to contract with the Demonstration Plans or seek to have their dual eligible patients opt out and remain in fee-for-service Medicare?

- Specific services: What will the impact be on specific service lines that currently treat a significant number of dual eligibles under fee-for-service Medicare and Medi-Cal? Post-acute services, such as DP/NF, subacute, inpatient rehabilitation, long term acute care, home health and hospice will face particular challenges, as will behavioral health services (including acute inpatient services, partial hospitalization programs and other hospital outpatient mental health services). Authorizations will be required where none were required previously. Demonstration Plans may be reluctant to authorize these services, leading to utilization declines and appeals. The approach to behavioral health services in the MOU leaves many questions currently unanswered, creating uncertainty about how these services will be coordinated and authorized. On the other hand, hospitals with post-acute and/or behavioral health services may be in a position to offer the Demonstration Plans a compelling continuum of care through which they can control costs and improve quality.

- Out-of-network services: Out-of-network emergency services will be covered by the Demonstration Plans at Medicare fee-for-service rates for Medicare benefits and presumably Medi-Cal "Rogers Rates" for Medi-Cal benefits. If a hospital does not contract with the Demonstration Plans, will it continue to see a significant volume of dual eligibles, either because it is located in a remote area or because it operates an emergency room? Is being out-of-network a viable approach? How will out-of-network post-stabilization services be treated?

- Hospital team: Who should be involved with developing and implementing a hospital's approach to Cal MediConnect? Because of the pervasive and potentially substantial impacts of the demonstration project affecting many components of a hospital, consider involving senior management (such as the hospital's CEO and CFO); payor contracting staff; administrative directors of affected departments like post-acute services, patient financial services, case management and utilization review or others involved in authorizations and appeals; reimbursement personnel; legal counsel and compliance personnel.

These topics and others are discussed in detail below.

III. Status of Cal MediConnect

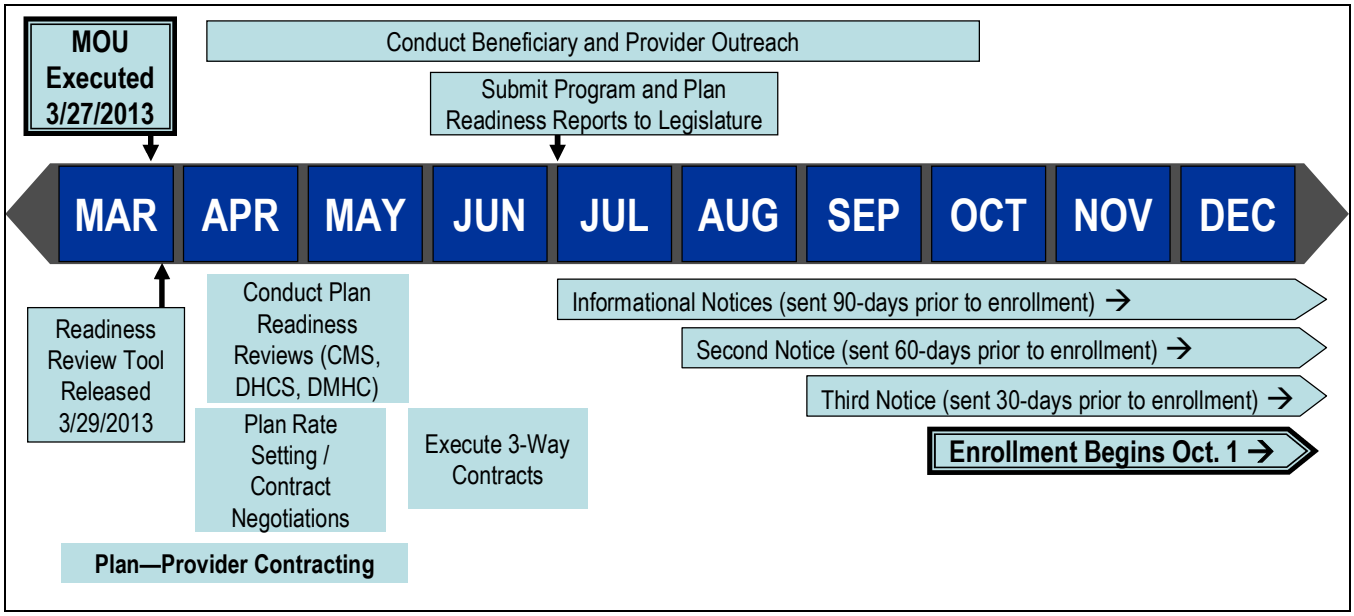
The Affordable Care Act created the Medicare-Medicaid Coordinated Care Office (MMCO) within CMS. It is tasked with aligning and coordinating programs and benefits for the dual-eligible population. In July 2011, the MMCO announced a state demonstration to test two models of care delivery aimed at aligning Medicare and Medicaid financing and to integrate primary, acute, behavioral health and LTSS for Medicare-Medicaid enrollees. California was one of 15 states awarded a $1 million planning grant from CMS to develop a proposal to improve care coordination and integration for this vulnerable population.

In California, DHCS began evaluating new models for coordinating care delivery to dual eligible beneficiaries after the passage of SB 208 in 2010. In January 2012, Governor Brown announced California's plans to apply for the CMS demonstration and submitted a proposal entitled *California's Coordinated Care Initiative ("CCI")* for consideration in May 2012. On June 27, 2012, the Legislature passed and the Governor signed CCI-enabling legislation as part of the budget trailer bills (SB 1008 and SB 1036). It was originally anticipated that enrollment under the CCI would begin as early as May 2013, but enrollment has been pushed back to a start date of no earlier than October 1, 2013. The CCI has two components: Cal MediConnect and Managed Medi-Cal LTSS.[3]

A. Remaining Steps

The MOU is a significant milestone in the creation of Cal MediConnect in that it represents the framework in which the state and federal government will operate as we move forward in implementing the demonstration. There remain, however, a number of next steps in the implementation process (see Figure 1). Many of these forthcoming steps provide opportunities for stakeholder engagement and further clarification.

Figure 1. Estimated 2013 Cal MediConnect Timeline



Plan readiness review and provider negotiations. Prior to the implementation of Cal MediConnect, each Demonstration Plan must pass a comprehensive joint CMS-California readiness review. The readiness review tool was released on April 1, 2013 (see Appendix A, Resource List). As part of the readiness review, CMS, DHCS and DMHC will undertake a desk review, site visits and a separate network validation review. The readiness review tool sets forth criteria and suggested evidence for evaluating provider networks, but the criteria largely focus on the existence of appropriate policies and procedures. The readiness review tool does not include specific information on the separate network validation review.

Negotiation and execution of three-way contracts. While the MOU establishes the general parameters of the federal-state Cal MediConnect partnership, it does not reveal key details concerning Demonstration Plans' obligations and the program's administration. These issues will be addressed in upcoming three-way contracts between CMS, DHCS, and the Demonstration Plans. Nationwide, no such three-way contracts have been finalized in a state that is undertaking a capitated financial alignment demonstration model. Final three-way contracts will not only clarify plan obligations, but may also result in the public availability of useful information concerning plan rates.[4]

Development of beneficiary enrollment materials. Eligible beneficiaries will receive three rounds of official notices concerning Cal MediConnect:

- An informational notice sent 90 days in advance of the effective enrollment date;
- An enrollment packet and for beneficiaries subject to passive enrollment, a notice indicating the Demonstration Plan in which they may be enrolled, sent 60 days in advance of the effective enrollment date; and
- A reminder notice sent 30 days in advance of the effective enrollment date.

With enrollment beginning as soon as October 1, 2013, some beneficiaries will likely receive information by July 3, 2013 and enrollment packets by August 2, 2013. These materials must be developed with stakeholder input and made public at least 60 days in advance of their use. During this time period, DHCS must work with stakeholders to incorporate public comment into the materials.[5] CMS must also approve all beneficiary communications before distribution.

Continued legislative engagement. California law requires DHCS to periodically report to the Legislature on the establishment, implementation, and assessment of Cal MediConnect. In particular, DHCS must submit reports on both the Demonstration Plans' and its own readiness by July 2013. DHCS must assess and report on the readiness of the Demonstration Plans. Key dates and reports are highlighted in Table 1. Once Cal MediConnect is in place, the DHCS will have additional, ongoing legislative reporting obligations over the duration of the program.

Table 1. Cal MediConnect Legislative Reporting Requirements

	Report	Timing
Pre-Implementation Reports	Programmatic Transition Plan	Submitted September 28, 2012
	Health Plan Readiness Report	By July 2013
	First Program Readiness Report	Submitted March 13, 2013
	Program Readiness Report	By July 2013
Post-Implementation Reports	Evaluation Outcome Report	Annually
	Duals Enrollment, Quality Measure and Cost Report	Annual
	Health Plan Quality Compliance Report	Annual
	Plan Audit and Financial Examination Summary Report	Annual
	First MSSP Waiver Transition Plan	January 1, 2014
	Second Multipurpose Senior Services Program (MSSP) Waiver Transition Plan	90-days prior to implementation
	LTSS Enrollment, Quality Measure and Cost Report	Annually
Note: Reporting requirements may be subject to change through future legislation. *Source: Cal. Welf. & Inst. §§ 14132.275, 14182.17, 14186.3, 14186.4.*		

IV. Analysis of the MOU

A. Overview of Cal MediConnect and the MOU

The MOU sets forth the parameters of the federal-state partnership necessary to establish and implement Cal MediConnect, including but not limited to beneficiary eligibility and enrollment, shared savings targets, network adequacy standards and continuity of care requirements, reimbursement, appeals and oversight and evaluation processes.

The MOU reflects a few significant modifications to Cal MediConnect from the May 2012 proposal submitted to CMS. First, the MOU does not include a stable enrollment period. California had requested a six-month stable enrollment period, during which time beneficiaries would be barred from disenrolling or changing plans. CMS declined to approve this lock-in period. The MOU confirms that beneficiaries will be free to disenroll or opt out of Cal MediConnect on a monthly basis. Those who opt out will receive their Medicare benefits on a fee-for-service (FFS) basis or through a Medicare Advantage plan, but they will still be required to enroll in a Medi-Cal managed care plan under the Managed Medi-Cal LTSS program. Where multiple Cal MediConnect plans are available, enrollees may also change plans on a monthly basis. Additionally, the MOU limits Cal MediConnect's size in Los Angeles County by adopting a 200,000 beneficiary enrollment cap in that county. This change, along with others, brings the estimated number of participating beneficiaries to 456,000.

While one of the major purposes of Cal MediConnect and similar projects in other states is to coordinate and integrate Medicare and Medicaid benefits for the dual eligibles, the MOU makes it clear that, in many respects, the Medicare and Medi-Cal benefits will be subject to different rules. For example, there will be different appeals processes with respect to the Medicare and Medi-Cal benefits at the outset, different out-of-

network payment rules for Medicare and Medi-Cal services, and likely different Medicare and Medi-Cal in-network provider rates for certain hospital services.

While the MOU provides greater clarity on the federal-state partnership underlying Cal MediConnect, many key issues for providers are not addressed in the MOU or other guidance that has been released. For example, the MOU provides some methodological details on the blended capitated payments that will fund coverage by the plans, but it does not provide similar details about applicable rules for network provider rates. Based on other CMS and DHCS guidance that has been issued, there is some information regarding the parameters for provider reimbursement, as discussed in Part IV.E, but other important details remain unresolved. In addition, the MOU does not address provider appeals, aside from noting that California and Demonstration Plans must both implement and maintain a provider appeal process that will address "provider enrollment issues." Finally, while the MOU sets forth broad standards for network adequacy, specific access standards remain unclear.

B. Beneficiary Enrollment

Of the 1.22 million Californians currently eligible for both Medi-Cal and Medicare benefits, approximately 456,000 will be eligible to participate in Cal MediConnect during the three-year demonstration. Figure 3 in Appendix B provides a graphic representation of the eligibility criteria and the proportion of dually eligible beneficiaries that meets the eligibility criteria for Cal MediConnect. To be eligible to participate, a beneficiary must:

- Reside in one of the eight demonstration counties (see Table 2);
- Be age 21 or older;
- Have full Medicare-Medicaid benefits (*i.e.*, entitled to benefits under Medicare Part A, enrolled in Medicare Parts B and D and receiving full Medi-Cal benefits); and
- If the beneficiary has a Medi-Cal share of cost, meet it each month by being in a Medi-Cal-funded nursing facility or receiving IHSS.

To be eligible, IHSS recipients must have met their share of cost on the first day of the month in the fifth and fourth months prior to their respective passive enrollment dates for Cal MediConnect.

Table 2. Cal MediConnect Counties, Plans and Eligible Beneficiaries

Counties	Medi-Cal Managed Care Plan Type	Demonstration Plans*	Eligible Beneficiaries
Alameda	Two-Plan Model	Alameda Alliance for Health Anthem Blue Cross	31,076
Los Angeles	Two-Plan Model	L.A. Care Health Net	Capped at 200,000 of 271,072
Orange	County Organized Health System	CalOptima	57,060
Riverside	Two-Plan Model	Inland Empire Health Plan Molina Health Care	34,477
San Bernardino	Two-Plan Model	Inland Empire Health Plan Molina Health Care	36,368
San Diego	Geographic Managed Care	Care 1st Community Health Group Health Net Molina Health	50,952
San Mateo	County Organized Health System	Health Plan of San Mateo	10,652
Santa Clara	Two-Plan Model	Anthem Blue Cross Santa Clara Family Health Plan	35,245

*Demonstration Plans may subcontract with other plans not listed on this table.

Sources: CalDuals.org and Research and Analytic Studies Branch, DHCS, Medi-Cal Statistical Brief (November 2012) (see Appendix A, Resource List)

1. Cal MediConnect Exclusions and Passive Enrollment Exemptions

Some otherwise eligible individuals are excluded from participation altogether or are exempted from passive enrollment in a Demonstration Plan.

Table 5 in Appendix B provides a detailed list of excluded and exempted groups. Individuals who are *excluded* will be unable to participate in Cal MediConnect—they cannot choose to enroll in a Demonstration Plan. These excluded individuals will not receive informational mailings or enrollment information concerning Cal MediConnect. For example, individuals in some rural zip codes of San Bernardino, Los Angeles and Riverside counties are excluded from enrollment. Individuals with end-stage renal disease (ESRD) will be excluded in all counties except San Mateo and Orange; individuals with an ESRD diagnosis in San Mateo and Orange counties, however, are subject to passive enrollment. On the other hand, individuals *exempted from passive enrollment* are free to enroll in a Demonstration Plan and will receive an enrollment packet. Exempted individuals who do not enroll in a plan will not be passively enrolled to receive integrated coverage for Medicare and Medi-Cal benefits through a Demonstration Plan. Notably, all eligible individuals enrolled in Medicare Advantage will be passively enrolled beginning January 1, 2014 with the exception of Kaiser enrollees, who are exempt from passive enrollment.

The MOU also addresses enrollment and beneficiary and provider participation in other programs and initiatives, including Accountable Care Organizations (ACOs) under the Medicare Shared Savings Program. A beneficiary enrolled in a Demonstration Plan will not have costs attributed to an ACO or any other shared savings initiative for the purposes of calculating Medicare savings under those initiatives. Therefore, if a provider participates in an ACO and also has a significant patient base among Cal MediConnect participants, the exclusion of these beneficiaries might impact the amount of Medicare shared savings realized through the ACO. For additional information regarding similar programs, see the July 2, 2012 guidance from CMS — Principles for Beneficiary Alignment in Medicare Fee for Service Models (see Appendix A, Resource List).

2. Enrollment Options and Disenrollment

Eligible beneficiaries will be able to enroll with a Demonstration Plan or opt out of Cal MediConnect once they receive notification of the right to select a Demonstration Plan. Those who opt out of Cal MediConnect will not receive integrated Medicare and Medi-Cal benefits through a Demonstration Plan and will receive their Medicare benefits on a FFS basis or through a Medicare Advantage plan. However, they will still be required to enroll in a Medi-Cal managed care plan under the Managed Medi-Cal LTSS portion of the CCI. Nonexempted beneficiaries who fail to select a Demonstration Plan or opt out of the program within 60 days will be passively enrolled in a Demonstration Plan. Passive enrollment will generally be phased in for beneficiaries beginning no sooner than October 1, 2013.

Once enrolled in a plan, beneficiaries will be permitted to disenroll (opting out of Cal MediConnect) or transfer between Demonstration Plans on a month-to-month basis, with changes taking effect on the first day of the month following the request. Passive enrollment will generally be phased in by enrollees' birth months starting October 1, 2013. Enrollment, however, will not be phased in for beneficiaries enrolled in MSSP. Beneficiaries enrolled in Medicare Advantage will have a passive enrollment date of January 1, 2014.

Table 3. Passive Enrollment Phase-In Dates, By County

Passive enrollment in Demonstration Plans begins no sooner than October 1, 2013.				
County	**Medicare FFS and Medi-Cal Managed Care**	**Medicare FFS and Medi-Cal FFS**	**MSSP****	**Medicare Advantage***
Alameda	Oct. 1, 2013	Birth month	Oct. 1, 2013	Jan. 1, 2014
Riverside	Birth month	Birth month	Oct. 1, 2013	Jan. 1, 2014
San Bernardino	Birth month	Birth month	Oct. 1, 2013	Jan. 1, 2014
San Diego	Birth month	Birth month	Oct. 1, 2013	Jan. 1, 2014
Santa Clara	Oct. 1, 2013	Birth month	Oct. 1, 2013	Jan. 1, 2014
San Mateo	Oct. 1, 2013	Oct. 1, 2013	Oct. 1, 2013	Jan. 1, 2014
Orange	Birth month	Birth month	Oct. 1, 2013	Jan. 1, 2014
Los Angeles	TBD (starting Jan. 1, 2014)***	TBD (starting Jan. 1, 2014)***	Jan. 1, 2014	Jan. 1, 2014

** Beneficiaries included in Medicare reassignment to a different Medicare Prescription Drug Plan effective January 1 of a given year will be eligible for passive enrollment into a Demonstration Plan. For example, beneficiaries identified as requiring reassignment effective January 1, 2014 will be eligible for passive enrollment January 1, 2014, unless they are eligible for passive enrollment by birth month in 2013.*
*** Passive enrollment based on MSSP status supersedes the county-specific phase in dates.*
****The passive enrollment approach for Los Angeles County is still under development, but passive enrollment will begin no sooner than January 1, 2014. The MOU indicates that Los Angeles County's passive enrollment process will be preceded by a three-month opt-in only period.*
Source: CMS and DHCS Memorandum of Understanding, March 27, 2013

3. "Intelligent Assignment"

In the six counties with multiple plan benefit packages (Alameda, Los Angeles, Riverside, San Bernardino, San Diego and Santa Clara), California will finalize an "intelligent assignment" process for passive enrollment into Demonstration Plans. This intelligent assignment process is subject to CMS review and approval and must prioritize continuity of care. California will use the most recent 12 months of Medicare and Medi-Cal claim history data to identify those providers most frequently used by a beneficiary. The providers evaluated in this process may be physicians, medical groups and/or clinics. A Demonstration Plan will be selected based on matching between a beneficiary's frequently used providers and the providers in each Demonstration Plan's network. If an individual resides in a long-term care facility, the intelligent assignment process should ensure that the individual will not need to change facilities.

Further details of the intelligent assignment process remain to be confirmed. For example, it is unclear how the intelligent assignment will work for beneficiaries who only see non-contracted physicians, medical groups and/or clinics. The MOU also does not indicate the timing of the assignment process or the source of Demonstration Plan network data. The use of up-to-date network data will be important to assure that assignments accurately match beneficiaries' current circumstances. The enrollment packet that must be sent to beneficiaries at least 60 days before each beneficiary's passive enrollment date must identify the plan to which the beneficiary will be assigned unless he or she opts out or enrolls in a different plan. Intelligent assignment must take place at least 60 days before a beneficiary's enrollment date, but it is not clear how far in advance it will occur. In light of the Cal MediConnect timeline (see Figure 1), the intelligent assignment process must be finalized, approved by CMS and implemented by July 2013 at the latest.

C. Covered and Excluded Services

Demonstration Plans must provide an integrated benefit package that includes all required Medicare and Medi-Cal-covered benefits. The integrated benefit package must also include the following additional benefits:

- Dental, including preventive, restorative and emergency oral health benefits;
- Vision, including preventive, restorative and emergency; and
- Non-emergency transportation enabling timely access to scheduled and unscheduled medical care appointments.

The minimum requirement for each benefit will be defined in the three-way contract. Demonstration Plans also have the flexibility to use the capitated payments to offer additional benefits. In particular, plans have the discretion to offer coverage for home and community-based services and behavioral health services beyond those covered by Medicare and/or Medi-Cal.

D. Network Adequacy and Continuity of Care Requirements—Implications for Providers

Demonstration plans are required to provide adequate networks of providers to their enrollees. Network adequacy is critical to the success of Cal MediConnect, and it serves as an important incentive for Demonstration Plans to contract with providers on reasonable terms. The MOU does note that Demonstration Plans must ensure that beneficiaries have access to an adequate network and sets forth broad rules as to the applicability of Medicare and Medi-Cal network adequacy standards. The MOU also summarizes continuity of care requirements for beneficiaries who have ongoing treatment relationships with out-of-network providers.

On its face, the network adequacy rules are fairly simple: Medi-Cal network adequacy standards will be used for services for which Medi-Cal is exclusive or where the applicable Medi-Cal standards are more stringent, and Medicare standards will be used in all other cases. Additional clarification of the network adequacy requirements in the three-way contracts will be necessary to clarify the sources of such standards as well as the methodology for determining which standard is more stringent in a particular situation. Because the MOU refers to "standards" rather than laws, Medi-Cal network adequacy standards likely encompass the specific requirements incorporated into the DHCS Medi-Cal managed care contracts. Explicit confirmation that Medi-Cal standards include statutes, regulations and DHCS contracts will be necessary.

In general, Medicare network adequacy standards are more specific than Medi-Cal standards. Medicare Advantage plans must have a specified number of primary care providers, individual specialists and inpatient hospital beds in each county where they operate. The ratio of providers and facilities to beneficiaries is based on standardized beneficiary numbers and Medicare Advantage enrollment in a county and the county demographics (e.g., large metro, metro, rural). In addition, Medicare Advantage plans must meet both time and distance standards. Over 50 types of providers, facilities, programs and suppliers must be available and accessible to beneficiaries under the Medicare standards. In contrast, Med-Cal contracts require primary care and general physician-to-member ratios. While it appears that Medicare standards will largely apply given their quantitative specificity, it is not clear how regulators will determine the appropriate standards to apply when verifying network adequacy.

Before finalizing three-way contracts with Demonstration Plans, CMS, DHCS and DMHC will complete a readiness review of each plan. Network adequacy is a component of this review, and the review will include a separate network validation review in addition to a desk review and site visits. The readiness review tool addresses network adequacy, but the criteria for evaluating network adequacy focus on Demonstration Plans' policies, procedures and personnel training rather than actual validation of the provider network.

Where a beneficiary has an ongoing treatment relationship with a provider that is not contracted with his or her Demonstration Plan, the plan will be required to allow the beneficiary to continue seeing that provider and maintain their service authorizations for six months (Medicare services) or 12 months (Medi-Cal services). Demonstration Plan must provide out-of-network access for Medicare and Medi-Cal services if:

1) the beneficiary demonstrates an existing relationship with the provider prior to enrollment;

2) the provider is willing to accept payment from the Demonstration Plan based on the following: (a) for Medicare services, the current Medicare fee schedule or (b) for Medi-Cal services, the higher of the Demonstration Plan's rate for the service or the applicable Medi-Cal rate; and

3) the Demonstration Plan would not otherwise exclude the provider from its network based on quality of care concerns or state or federal exclusion requirements.[6]

The continuity of care provisions do not apply to IHSS providers, DME suppliers, transportation and other providers or suppliers of ancillary Medi-Cal services. Beneficiaries will be informed of their continuity of care rights in their enrollment choice packet.

E. Provider Payment Rules

1. In-network Services

Payments for Medicare services will be the contract rates negotiated between the provider and the Demonstration Plan. Although, California law states that Medicare FFS rates are a floor for Medicare-covered nursing facility services, which would include DP/NF and subacute services, and indicates an intent that hospital services savings should result from reduced utilization and not reduced provider rates,[7] CMS has indicated that Medicare Advantage payment rules will apply.[8] Under Medicare Advantage, the rates for contracted providers are the amounts set forth in the contracts between the provider and the plan, and CMS will not require a particular price structure.[9]

The capitation rates paid to the Demonstration Plans take into account "add-on" payments such as Medicare DSH and outlier payments. Accordingly, hospitals may reasonably expect that their contract payments will take these amounts into account. The MOU states that indirect and graduate medical education payments will be made separately, consistent with the current process under Medicare Advantage.

DHCS has indicated that payments for Medi-Cal nursing facility services cannot be less than the applicable Medi-Cal FFS rates as required by California law. Bonuses may be paid in addition to the Medi-Cal FFS rates "to encourage quality improvement and promote appropriate utilization incentives, including reduced rehospitalization and shorter length of stay. . . "[10] Nursing facility services include DP/NF services and appear also to include subacute services.

Medi-Cal in-network payment rates for hospital services other than nursing facility services will be the rates set forth in the contracts between the hospital and the plan without any rate floor.

There are no new limitations imposed under the MOU or California law on the structure of rates between hospitals and the Demonstration Plans, except potentially with respect to nursing facility services. California law specifically provides that reimbursement policies shall not prevent the Demonstration Plans and providers "from entering into payment arrangements that allow for the alignment of financial incentives and provide opportunities for shared risk and shared savings in order to promote appropriate utilization shifts, which encourage the use of home- and community-based services . .."[11] Thus, subcapitation and blended rate arrangements should be permissible. However, California law also requires the Demonstration Plans to pay no less than Medicare and Medi-Cal FFS rates for nursing services, and this provision may require payments for nursing facilities to be made on a fee-for-service basis, at least with respect to Medi-Cal services.[12]

2. Out-of-network Services

The MOU requires that the Demonstration Plans reimburse providers Medicare or Medi-Cal FFS rates for services furnished in urgent or emergency situations. It is anticipated that, in the large majority of situations, the covered out-of-network hospital services provided to duals will be Medicare inpatient services. As under Medicare Advantage, the out-of-network urgent or emergency rates for Medicare services should include all payment amounts, such as the applicable MS-DRG rates and "add-on" payments like DSH and outlier payments.[13] However, Medicare indirect and graduate medical education payments will continue to be made separately. Out-of-network Medicare hospital outpatient services would be reimbursed using Medicare Outpatient Prospective Payment System rates.

The Medi-Cal FFS rates for inpatient hospital services will be the rates under the new APR-DRG system (assuming it is in place). Presumably, the current "Rogers Rates" (the regional average rate under Selective Provider Contracting Program contracts, computed separately for tertiary and nontertiary facilities) will be paid if the new system is not in effect. The Medi-Cal rates for hospital outpatient services will be the Medi-Cal fee

schedule rates for hospital outpatient. It is unclear what amounts the public hospitals that are reimbursed based on certified public expenditures will be reimbursed for out-of-network Medi-Cal services.

Also unaddressed is whether the rates the Demonstration Plans must pay for urgent and emergency out-of-network services are net of Medicare Part A and B copayment amounts. If they are, we would anticipate that the Demonstration Plans will be required to pay the portion of the copayments that would be paid by the state if fee-for-service Medi-Cal were secondary.

Although not entirely clear from the MOU, it appears that the Demonstration Plans will have to follow Medicare Advantage rules with respect to out-of-network services. These rules provide that the treating physician's determination of when the patient is stable for transfer is binding on the plan. They also require the plans to pay for post-stabilization services where they are pre-approved by the plan; are furnished to maintain the patient's stable condition within one hour of requesting plan approval for additional post-stabilization services; or are necessary to maintain, resolve or improve the patient's stable condition and the plan does not respond to the provider's request for approval within one hour, cannot be contacted, or the plan's representative and the treating physician cannot reach an agreement concerning the patient's care and a plan physician is not available for consultation.

3. Medicare Copayments and Bad Debt

The Demonstration Plans may not assess any cost sharing for Medicare Part A and B services, although they may assess certain copayments for items covered under Medicare Part D. The MOU further provides that no enrollee may be balanced billed by any provider for any reason for covered services. This proscription should not apply to dual eligibles who opt out of Cal MediConnect to receive their Medicare benefits under FFS Medicare, since these individuals will not be enrollees of a Demonstration Plan.

Providers may not claim Medicare bad debts (if there are any) in their cost reports arising from the provision of services to Cal MediConnect enrollees. However, Medicare bad debt payments are included in the computation of the capitation rates paid to the Demonstration Plans. Accordingly, providers have a basis for contending that their contract rates should take into account Medicare bad debt reimbursement.

4. Dual Eligibles who Remain in FFS Medicare

Some dual eligibles will opt out of Cal MediConnect and remain in traditional FFS Medicare. These individuals will be mandatorily enrolled in a Medi-Cal managed care plan for their Medi-Cal benefits. Providers will bill the Medi-Cal managed care plans for Medicare copayments arising from services furnished to such individuals. The Medi-Cal managed care plans will be obligated to pay the portion of the copayment amount that would have been paid under FFS Medi-Cal if the individual was not enrolled in a Medi-Cal managed plan. Frequently, this amount is zero, since it is the Medi-Cal program's policy to pay Medicare copayments only to the extent that the amount Medi-Cal would have paid if it were primary exceeds the amount paid by Medicare net of copayments. The amount of the copayment not paid by Medi-Cal potentially may be included in reimbursable Medicare bad debt.

F. Capitation Rates, Risk Adjustment and Risk Corridors

The MOU sets forth the basic parameters for the joint-rate setting process that will produce the total capitation payment received by Demonstration Plans. Capitation payments will be based on projected Medicare and Medi-Cal payments for the population covered by a Demonstration Plan and incorporate risk adjustment methodologies for both the Medicare and Medi-Cal portion of the payment. The capitation payment will reflect the minimum savings percentage of 1 percent (October 1, 2013, to December 31, 2014), 2 percent (January 1, 2015, to December 31, 2015), and 4 percent (January 1, 2016, to December 31, 2016) and will also be subject to a quality withhold, as described in the following section. The MOU provides Demonstration Plans, CMS and California with some protection from the uncertainties of the rate-setting process by providing limited upside and downside "risk corridors," which reallocate excess costs and savings between Demonstration Plans, Medicare, and Medicaid. The risk corridors vary by county and by Demonstration Year. The details of the risk corridor

formulae are unclear from the MOU, but the limited downside risk corridor will allow for Demonstration Plan reimbursement at 67 percent of excess costs above the initial capitation rate (including an additional county-specific savings percentage). This risk corridor payment, however, is capped at the total capitation amount using the minimum savings percentages. In the MOU, CMS and California specifically reserve the right to adjust a Demonstration Plan's costs down (thus limiting the impact of the downside risk corridor) for "any excessive payment to Plan-affiliated providers." The MOU does not indicate when provider payments would be considered excessive.

The upside risk corridor allows Demonstration Plans to retain most of the excess savings if costs are lower than the initial capitation rates (including an additional county-specific ratings percentage). The upside risk corridor contains three bands based on the county-specific savings percentages in the MOU. Where rates exceed costs in this band, the Demonstration Plan will retain 100 percent of the excess. In the next band (which starts at the upper limit of the first band), the Demonstration Plan will retain 50 percent of the savings, and the other 50 percent would be shared between Medicare and Medicaid. Any additional savings would fall within the third band, and the Demonstration Plan would retain 100 percent of the excess.

G. Quality Metrics

CMS and DHCS will conduct a joint comprehensive performance and quality monitoring process that is at least as rigorous as Medicare Advantage, Medicare Part D and Medi-Cal managed care requirements. Appendix E outlines core quality measures under the Demonstration for plan reporting. These core measures will be updated and refined in later years of the demonstration. The reporting frequency and monitoring process will be specified in the three-way contracts.

Pursuant to the MOU, both CMS and DHCS will withhold a percentage of their respective components of the capitation rates paid to the Demonstration Plans. Upon the Demonstration Plans' meeting of specific quality thresholds, these withheld amounts will be paid to the Demonstration Plans. In year one of the demonstration, the withhold amounts will be 1 percent. This amount will increase to 2 percent in year two and 3 percent in year three.

Appendix F outlines the quality withhold measures for year one, and Appendix G outlines the quality withhold measures for years two and three. At this time, it is not known how the Demonstration Plans will implement or monitor their compliance with these quality withhold measures. However, hospitals may consider these quality measures in mind when presenting themselves as potential partners for the Demonstration Plans. Additionally, Demonstration Plans may seek additional reporting from hospitals and increased auditing rights in order to monitor their compliance with these quality withhold measures.

H. Role of CMS and Role of State in Evaluation and Plan Oversight

The Cal MediConnect program will include Demonstration Plan monitoring and oversight that is designed to be at least as rigorous as existing procedures for Medicare Advantage, Medicare Part D and the Medi-Cal program. In the MOU, CMS and California agree to establish a contract management team that will be responsible for the day-to-day oversight, evaluation and monitoring of Demonstration plans. This contract management team will be composed of representatives from CMS and California agencies, including DHCS and DMHC. Poor performance may result in the removal of a Demonstration Plan, and standards for removal will be articulated in the three-way contract. The contract management team will also have general responsibility for ensuring access, quality, program integrity, program compliance and financial solvency in accordance with the three-way contracts.

In California, DHCS, DMHC and the Department of Social Services all bear oversight responsibilities under current regulations. At the federal level, the MOU makes specific mention of the Medicare Drug Benefit Group's oversight responsibilities. The contract management team will, however, assure coordination of oversight activities for Demonstration Plans. Neither CMS nor California may take a unilateral enforcement action relating to day-to-day plan oversight and Demonstration Plan requirements under the three-way contract without first notifying the other party. Like other demonstration projects coordinated through the Center for

Medicare and Medicaid Innovation, judicial and administrative review of Cal MediConnect is limited under the ACA.[14]

V. Implications/Considerations

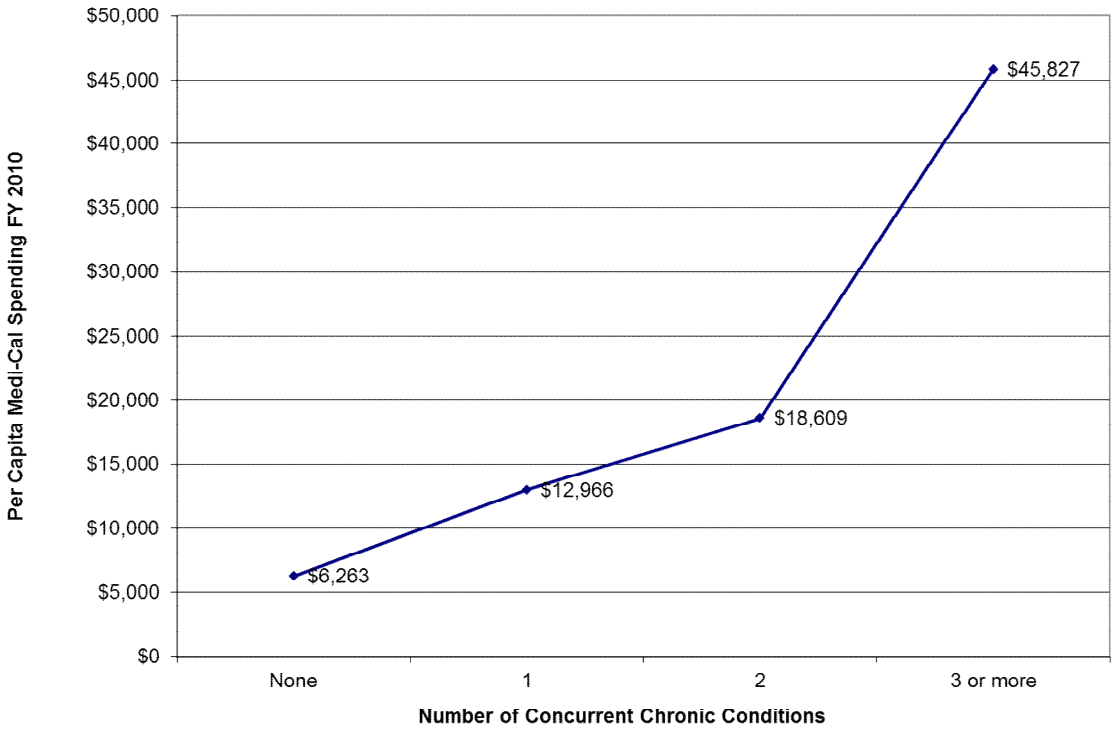
A. Why is Cal MediConnect Important to Your Hospital?

1. The Significance of Dual Eligible Services to Hospitals

Cal MediConnect marks a significant change to care payment and coordination for the dual eligible population in the eight pilot counties. While the dual eligible population is relatively small in number, they tend to report poorer health status, suffer from more chronic conditions and more multiple conditions (co-morbidities) than either the Medi-Cal-only or Medicare-only population. As a result, they tend to utilize a proportionately high level of health care services, including hospital inpatient and outpatient services.

An estimated 456,000 beneficiaries who may participate in Cal MediConnect in the eight pilot counties.[15] The dual eligible population is especially concentrated in Los Angeles County, where nearly one in three dual eligibles (~373,941) in the entire state reside.[16] Many of the counties selected for Cal MediConnect have sizable populations of dual eligible individuals.

Figure 2. Medi-Cal Spending and Comorbidities



Dual eligible beneficiaries in the eight pilot counties tend to have high rates of chronic disease and co-morbidity. Approximately 19 percent of the target population suffers from one chronic condition, approximately 18 percent suffers from two concurrent chronic conditions and approximately 44 percent suffer from three or more concurrent chronic conditions.[17] The five most prevalent chronic conditions are: (1) diabetes (41.6 percent), (2) arthritis (31.8 percent), (3) ischemic heart disease, (4) depression (19 percent) and (5) cataracts (18.7 percent).[18]

While the dual eligible population appears to be a relatively small proportion of all Medi-Cal beneficiaries (~11 percent) and Medicare beneficiaries (27 percent)[19], their relatively worse health condition results in higher health care utilization than other Medi-Cal-only or Medicare-only beneficiaries. In 2007, the Medicare and Medi-Cal spending for each dual eligible was approximately $2,132 per month ($1,301 Medicare, $831 Medicaid) compared to Medicare spending of $725 a month for each Medicare-only beneficiary.[20] Medi-Cal spends approximately four times more annually on the average dual eligible beneficiary than the average Medi-Cal beneficiary.[21] The per-person health care spending for these individuals increases dramatically with each additional chronic condition.[22]

Currently, the average per-person spending on hospital inpatient and outpatient services for a dual eligible beneficiary currently receiving his/her benefits through the Medi-Cal FFS program is approximately $7,966.[23] The average per-person FFS spending for nursing facilities is approximately $5,086; for home health,$858; and for pharmacy benefits, $4,682.[24]

Table 4. Cal MediConnect Population and Inpatient & Outpatient Spending by County

Area	Inpatient Per Capita Spending	Outpatient Per Capita Spending
All Eight Pilot Counties	$6,771	$1,195
Alameda	$6,484	$1,542
Los Angeles	$7,258	$1,043
Orange*	$8,787	$985
Riverside	$5,923	$1,213
San Bernardino	$7,072	$1,285
San Diego	$6,205	$1,634
San Mateo*	$6,255	$1,929
Santa Clara	$4,656	$1,307

* COHS counties estimates are made on smaller subsets of beneficiaries 407 beneficiaries in Orange and 163 in San Mateo. As such, the results may not reflect the utilization patterns of the larger duals beneficiaries in their respective counties

Source: DHCS, Profiles of Medi-Cal's FFS CCI Population in the Eight Pilot Counties, located at www.dhcs.ca.gov/dataandstats/statistics/Documents/County%20Profiles%20Overview_PerCapita.pdf.

2. Anticipated Savings

The state anticipates that the implementation of Cal MediConnect will provide savings to both the Medi-Cal and Medicare programs. The MOU establishes minimum savings percentages of 1 percent for year one, 2 percent for year two and 4 percent for year three. These savings percentages will be applied to baseline spending amounts to establish payment rates to the Demonstration Plans.

The state expects that greater coordination of care for this population will lead to a reduction in institutional services, specifically hospital inpatient services and nursing facility services. In at least one state that enrolled its dual eligible population into an integrated managed care plan, the dual eligible population utilized 43 percent fewer inpatient hospital days, 31 percent fewer discharges, 19 percent lower average lengths of stay, 21 percent lower readmission rates and 9 percent fewer ED visits.[25]

With the implementation of Cal MediConnect, the state has projected a reduction of Medicare-covered inpatient hospital utilization by 15 percent in the first year of the pilot program and 20 percent for subsequent years.[26] The state also anticipates a reduction of Medicare-covered nursing facility utilization by 5 percent through this program.[27] The state has not projected any savings associated with Medicare-covered outpatient utilization.[28] Projected changes in Medicare utilization and savings estimates from the CCI from the Governor's 2012-13 budget are included as Table 7 and Table 8 in Appendix D. These numbers may be revised as part of the Governor's May budget revision later this spring.

3. Determining Implications for Your Hospital

It is critical that hospitals assess the potential implications of Cal MediConnect on their organization in order both to plan for the future and to decide the approach to take when the Demonstration Plans come calling. Should you contract? Under what terms? What will happen if you do not contract?

As discussed above, the individuals eligible to participate in Cal MediConnect are more likely to utilize general acute care hospital services (and other health care services) than other segments of the population. Moreover, they tend to present with more complex health problems, which require more visits with health care providers and more health care services per visit.

An analysis of the impact of Cal MediConnect is important for hospitals in the eight pilot counties. This is not a "onesize-fits-all" analysis, but is unique to each hospital's situation. Some hospitals may treat a larger number of dual eligibles than others. The number of dual eligible patients a hospital serves may be affected by the demographics in its service area and the service lines it provides. A hospital may see patients from areas within the county that are excluded from Cal MediConnect, or dual eligibles who are otherwise excluded from Cal MediConnect (see Appendix B, Table 5 for exclusions). A hospital may be able to identify its dual eligible patients by identifying patients with primary and secondary insurance that are Medi-Cal and/or Medicare. Hospitals should remember to include Medi-Cal and Medicare managed care payors when identifying the dual eligible population and to include all service lines so they can assess the impact on all their service lines. Additionally, if a hospital participates in the Medicare Shared Savings Program ACO, it should be recalled that the Cal MediConnect enrollees will not be included in the MSSP calculations. Dual eligibles currently enrolled in Medicare Advantage Plans should also be considered in the analysis, as these enrollees will be moved into a Demonstration Plans beginning January 1, 2014.

Some hospitals may conclude that the loss of a significant portion of their dual eligible population will have a negligible financial impact and not otherwise significantly affect operations. For others, the loss of the dual eligible population may be devastating. And some organizations may determine that Cal MediConnect provides an opportunity to increase their ability to provide services to these eligible beneficiaries.

However, there are common factors to take into account. Some are apparent; others are more subtle but still quite important. Key factors facilities should consider include:

- **Historical volume of services to duals.** What has the dual eligible patient volume been? Consider number of patients, days, net revenue, gross revenue as a percentage of total. Remember that duals are heavy users of hospital services.

- **Profitability of services to duals.** Compare expenses of treating duals to net revenue.

- **Contribution to net margin.** Do the duals make a positive contribution to the net margin even if payments have not covered total costs due to full coverage of variable costs and some coverage of fixed costs?

- **Reduced overall utilization.** As discussed above, it is anticipated that there will a significant drop in utilization of hospital services by the duals. Through care management, the Demonstration Plans may be able to reduce the number of dual eligible patients presenting at a hospital, whether through the emergency room or for scheduled care. Upon admission at a hospital, the Demonstration Plans are likely incentivized to discharge these patients to their homes or to a lower level of care to achieve savings.

- **Further reduced utilization if a hospital does not contract.** What is likely to happen to the dual utilization if a hospital does not contract? What is the volume of duals admitted through the emergency room that a hospital may continue to see? Consider the non-contract rates and Demonstration Plans being more proactive to transfer patients when stabilized. Will a hospital

continue to see non-emergency patients because there are not adequate alternative facilities in the area or it provides specialty services not otherwise available in the area?

- **Out-of-network rates.** Medicare fee-for-service rates are paid for out-of-network Medicare emergency and urgent services, which should include DSH and outlier payments. It is unclear from the MOU whether the Demonstration Plans will be required to pay the FFS rates without deducting for FFS copayments, and if they may deduct the copayments, whether they will be required to pay the amount of the copayments that FFS Medi-Cal would pay. It would seem unreasonable if the Demonstration Plans were permitted to pay the Medicare FFS rates net of copayments, particularly if they were not required to pay the amount of the Medicare copayments that FFS Medi-Cal would pay and the hospitals were prohibited from including the unreimbursed amount in reimbursable Medicare bad debt.

- **Hospital mission.** Would it be inconsistent with the hospital's mission if it were not to contract with the Demonstration Plans?

- **Impact on specific hospital services.** Does the hospital offer programs that are heavily utilized by duals, such as certain geriatric programs? Are different programs and services affected differently? How are acute medical-surgical services affected as compared to post-acute and mental health services?

- **Impact on Medicare DSH.** The hospital's overall DSH factor may decline, and potentially by a large amount, because duals usually are on SSI and help increase the Medicare fraction of the Medicare DSH calculation. A reduction in dual days could affect the Medicare DSH factor. Additionally, the conversion of dual days from Medicare FFS days to managed care days will have to be coordinated with your hospital's approach to Medicare DSH in terms of reporting and appeals.

- **Payment delays.** Under normal circumstances, FFS Medicare and Medi-Cal currently make payments to hospitals relatively quickly. It is anticipated that payments by the Demonstration Plans may be much slower.

- **Authorizations, denials and appeals.** Increased requirements for prior authorizations, utilization review, and care level determinations will likely require increases in case management and admitting personnel. Unlike Medicare FFS, nonemergency services will likely require prior authorization, leading to denials and appeals. This process will reduce utilization, delay payment and increase overhead costs.

- **Potential for increased market share.** Some organizations may view Cal MediConnect as presenting an opportunity to increase market share by contracting with the Demonstration Plans under terms that incentivize the plans and the plan physicians to utilize the organization's services rather than the services of other hospitals.

- **Impact on medical staff.** Are members of the medical staff likely to contract with Demonstration Plans? If so, will these physicians continue to practice at the facility if it does not contract with the Demonstration Plans?

- **Improved care coordination and population management.** This is a major objective of Cal MediConnect and may also be consistent with the hospital's objectives.

4. Impact on Other Services, including Post-Acute, Behavioral Health, and Certain Part B Services

Cal MediConnect presents significant challenges, and potential opportunities, to providers of post-acute and behavioral health services. The Demonstration Plans will be responsible for providing or arranging for services outside of acute care. After discharge from an acute setting, the Demonstration Plans may more closely follow the progress of the beneficiaries to prevent readmissions. Hospitals should take these additional service lines into account as an integral part of their evaluation of Cal MediConnect and their overall approach to the program.

Organizations that offer a continuum of services may be in a good position to negotiate with the Demonstration Plans by demonstrating that they can provide high-quality and cost-effective care seamlessly at the appropriate level, and to assist the Demonstration Plans with their obligations to develop adequate networks. Additionally, a concern for acute care providers is that it may be difficult to discharge patients to lower levels of care because appropriate providers may not be available. This could cause payment issues for the acute stay if the hospital is reimbursed on a per-discharge basis as under FFS Medicare. A provider that maintains it own continuum of services will likely be in a better position to address this issue.

Hospitals will now have to obtain authorizations for post-acute and other services, where none were required previously under FFS Medicare. While this will vary for post-acute and behavioral health, it is anticipated that hospitals will require additional staff and processes to handle the authorizations, as well as denials and appeals.

Issues for specific post-acute and other services include:

- **Distinct-Part Nursing Facility (DP/NF) Services**

  Rates: For Medicare services, rates will be negotiated without a rate floor. Plans may or may not offer Medicare RUG rates. Rates for Medi-Cal services likely cannot be less than the Medi-Cal FFS rates.[29] The Medicare Part A requirement for a qualifying three-day acute inpatient stay for the Medicare benefit to be available likely will not apply, although it is not clear how this will affect payment by the Demonstration Plans.

  Utilization: Plans will likely seek to direct patients to freestanding units for Medi-Cal covered stays since they will be required to pay Medi-Cal FFS rates and those rates are much higher for DP/NFs than freestanding facilities. Plans also may deny care, and determine patients can be transitioned to home. Depending on availability of freestanding facilities, utilization may decline particularly for lower acuity services.

  Opportunities: Plans will likely prefer to use skilled nursing facilities for post-acute rehabilitation care to higher cost acute inpatient rehabilitation facilities. Additionally, DP/NFs often provide higher acuity care than freestanding facilities enabling earlier discharge from acute care settings. DP/NFs may want to take this opportunity to educate the Demonstration Plans about the importance of the services they provide and how DP/NF services are distinct from freestanding nursing facility services.

- **Subacute Services**

  Rates: Medi-Cal FFS rates will likely be the floor for Medi-Cal subacute benefits.[30] The payments for Medicare benefits will be a negotiated rate. (Subacute services are not a separate Medicare benefit, but when provided in a skilled nursing facility are covered under FFS Medicare as skilled-nursing services and reimbursed under the RUG system.) It may be a challenge to determine whether subacute days for the duals are covered under Medicare or Medi-Cal. Unlike other services furnished by hospitals, subacute services are often covered by Medi-Cal rather than Medicare because the patients have exhausted their Medicare Part A days.

Utilization: The Medi-Cal subacute benefit was developed as a lower cost alternative to acute care, often in an intensive care unit. The question is whether the Demonstration Plans will authorize this level of care or try and direct the patients to regular skilled nursing care.

Opportunity: There is inadequate capacity for subacute services in many areas of the state. Subacute providers may be able to use this fact to their advantage in negotiating with the Demonstration Plans. Part of the challenge will be to demonstrate that the use of subacute services is cost effective as the alternative is often acute care, and that quality is enhanced by using subacute services where appropriate.

- **Acute Inpatient Rehabilitation (IRF) Services**

  Rates: Negotiated rates for both Medicare and Medi-Cal services. There is no assurance that FFS rates will be paid.

  Utilization: A substantial portion of IRF utilization for many facilities is comprised of duals. IRF services are covered benefits that must be provided by the Demonstration Plans. However, managed care plans, including Medicare Advantage plans, have often been unwilling to authorize IRF care, opting instead for skilled nursing or home care. Today, duals are admitted to IRFs without prior authorization under FFS Medicare. Prior authorization will almost certainly be required for IRF services under Cal MediConnect. Where there is a denial of an IRF admission for a patient being discharged from an acute medical-surgical setting, the appeal process may be ineffective as it will likely not be resolved until days after discharge from the acute medical-surgical unit. The bottom line is that IRFs are likely to experience decreased utilization unless they can convince the Demonstration Plans that they are cost-effective in the long run and improve the quality of care.

  Opportunities: If a facility can demonstrate that its IRF reduces cost by discharging patients to home much quicker than if the patient were admitted directly to a skilled-nursing facility, and that it improves quality and outcomes, it may be possible to convince the Demonstration Plans to authorize IRF services more liberally.

- **Home Health Services**

  Rates: Negotiated rates for contract services. Note the Medicare FFS rates are based on a 60 day episode of care while Medi-Cal FFS rate are paid on a per-visit basis. The Demonstration Plans may attempt to replicated the FFS systems, or, contract for a single rate methodology for home health services regardless of whether the Medicare or Medi-Cal benefit is applicable.

  Utilization: The utilization of home health services may increase for the duals given the incentives to furnish care at the lowest appropriate level and to avoid institutional services in favor of home-based services. Home health services will likely be subject to prior authorization for a specific number of visits.

  Opportunity: The Demonstration Plans will likely have a significant need for quality home health services. Hospital organizations providing this service may have a contracting advantage.

- **Long Term Care Hospitals (LTCH)**

  Rates: Negotiated rates for contract services.

  Utilization: Medicare and Medi-Cal managed care plans often have not used or authorized LTCH services to a significant extent. LTCHs whose utilization includes duals may experience a reduction in utilization.

  Opportunity: LTCHs face the challenge of educating the Demonstration Plans about their services and demonstrating that they can provide care to patients with certain medical conditions in a more cost-effective manner with better outcomes than other levels of care.

- **Behavioral Health Services**

  Background: The incorporation of behavioral health and substance abuse services into Cal MediConnect raises unique challenges. Currently, behavioral health services where Medicare is primary are typically covered under Medicare Parts A and B. Inpatient hospital services are reimbursed under the inpatient psychiatric prospective payment system. Outpatient hospital services, including partial hospitalization, are reimbursed under the Medicare outpatient prospective payment system.

  Mental health services where Medi-Cal is primary, however, are largely the operational and financial responsibilities of the counties. The counties receive state realignment funding and contract with hospitals and other providers to furnish services. Contracts with hospitals for inpatient services are generally on a per diem basis. Partial hospitalization services are not covered, although other outpatient mental health services may be covered.

  Under Cal MediConnect, the Demonstration Plans will be responsible for all services where Medicare is primary, which would include most acute inpatient mental health services, and partial hospitalization services. The Demonstration Plans will not be responsible for the "specialty mental health services" that are currently the responsibility of the counties, such as the portion of acute inpatient mental health services where Medicare is not primary (e.g., the patient has exhausted his or her Medicare days).

  The Demonstration Plans will be required to enter into a local Behavioral Health Memorandum of Understanding and may contract with county agencies "to ensure seamless access and delivery of services to enrollees." Much of the detail as to how services will be furnished will be contained in these memoranda, which are not yet available and will be reviewed by both the state and CMS in the readiness review process. The memoranda are supposed to address service coordination, administrative coordination, information exchange, performance and tracking measures, and shared accountability.

  It is anticipated that many of the admissions of dual eligibles to acute psychiatric units will be emergency admissions. Given the lack of availability of acute psychiatric beds in many areas, the Demonstration Plans may have difficulty transferring enrollees from noncontract hospitals. As discussed above, the noncontract hospitals would be entitled to be reimbursed at Medicare and Medi-Cal FFS rates.

  Rates: Contracted rates with the Demonstration Plan for inpatient, hospital outpatient and partial hospitalization services where Medicare is primary. The Demonstration Plan is to be billed for covered Medicare services. Contracted rates with county mental health plans apply when Medi-Cal is primary. Hospitals should continue to bill the county mental health plan for services when Medi-Cal is primary. It is expected that Medicare will usually be the primary payer for hospital mental health services provided under Cal MediConnect.

  Utilization: Much acute inpatient psychiatric care begins with an emergency admission, so prior authorization is not necessary, although authorization of post-stabilization services may be required and admissions that are not emergent will likely require prior authorization. It would appear reasonable to anticipate that inpatient utilization will not be significantly affected by prior authorization requirements, given the high acuity of psychiatric inpatients generally. Outpatient mental health and partial hospitalization services will be subject to prior authorization. It is reasonable to anticipate that utilization of these services may decline, particularly utilization of partial hospitalization programs. Hospitals with partial hospitalization programs will be faced with the challenge of convincing the Demonstration Plans that the programs save money and improve outcomes by preventing patients from deteriorating and requiring acute inpatient care. The Demonstration Plans and the county mental health plans are supposed to coordinate clinical decision making. We would anticipate, however, that the Demonstration Plans will authorize

services where Medicare is primary and the county mental health plans will authorize services where Medi-Cal is primary.

Dual eligible in Medicare FFS: Where a dual eligible opts out of Cal MediConnect for Medicare benefits, Medicare FFS rules and rates will apply for Medicare benefits. Medi-Cal benefits would be provided by the Medi-Cal managed care plan in which the beneficiary is enrolled for Medi-Cal benefits. For hospitals, it would be expected that Medicare benefits would predominate.

Out of county placement: Because of the shortage of acute psychiatric patients, dual eligibles residing in one of the pilot counties may be admitted to a hospital in a different county. Under these circumstances, the beneficiaries Demonstration Plans would remain liable for the care to the extent of the Medicare benefits, and the out-of-county hospital would have to enter into an arrangement with the Demonstration Plan for payment. This suggests that hospitals regularly receiving admission of inpatient psychiatric patients from other counties in the demonstration project may wish to contract with the Demonstration Plans operating in those counties.

Opportunities: Hospitals providing behavioral health services may be able to demonstrate to the Demonstration Plans the cost savings and improved quality and outcomes that result from partial hospitalization and other outpatient programs in order to encourage the plans to authorize and reimburse these services. Hospitals may wish to show the Demonstration Plans how these programs keep patients from needing acute inpatient behavioral health services. Note that the Demonstration Plans are scored for reducing emergency department use for seriously mentally ill and substance use disorder enrollees.

- **Hospice**

  Demonstration Plan enrollees who elect to receive the Medicare hospice benefit will remain enrolled in the Demonstration Plan, but will receive the Medicare hospice benefit through FFS Medicare and not through the Demonstration Plan. Medicare hospice services and all other original Medicare services would be paid under FFS Medicare. The Demonstration Plans are required to coordinate these services with the rest of the enrollee's care, including Medi-Cal and Medicare Part D.

- **Prescription Drugs**

  Rates: Negotiated rates for prescription drugs.

  Utilization: demonstration plans will be responsible for providing, either directly or through subcontracted drug plans, prescription drugs covered by Medicare Parts A, B or D and Medi-Cal. They will establish an integrated formulary, which will include any Medi-Cal-covered drugs that are excluded by Part D. Generally, Part D requirements apply to prescription drugs, although some exceptions may be set forth in the MOU and the three-way contract.

  Opportunity: Currently, nearly a quarter of Medicare per capita spending on dual eligible beneficiaries is for prescription drugs.[31] Demonstration Plans will likely seek partners who can help them better coordinate and reduce costs associated with prescription drugs. Because a number of quality measures are related to prescription drugs (see Appendix E, Appendix F, and Appendix G), hospitals that can produce better quality outcomes may better position themselves for contracts with the Demonstration Plans. Hospitals should also monitor how their contracts treat reimbursement for drugs that would typically be covered under Medicare Part A to confirm whether these are included in the rates negotiated for inpatient services.

- **Physical Therapy, Occupational Therapy and Speech-Language Pathology Services**

  Rates: Negotiated rates for contracted services.

Utilization: Therapy services for dual eligible beneficiaries that meet the requirements for coverage under Medicare or Medi-Cal will be a covered benefit under Cal MediConnect. While not specifically addressed in the MOU, the Demonstration Plans will be responsible for coordinating the therapy benefit. Currently, Medicare does not require prior authorizations for therapy services covered under Part B, but does require certification of the plan of care. These services will now likely be subject to prior authorization by Demonstration Plans.

Opportunity: Hospital outpatient departments provide therapy services currently covered under Medicare Part B. Hospitals may seek to include these outpatient therapy services in their contracts with Demonstration Plans. The ability to continue to provide outpatient therapy services to patients after discharge may allow hospitals to continue to monitor the progress of discharged patients and potentially improve the outcomes for these patients.

B. Contract Negotiations

1. Contracting Overview

The Demonstration Plans will seek to meet a number of key considerations in their contracting with health care providers, including hospitals:

- Network adequacy: The Demonstration Plans will contract with providers, such as hospitals, to meet the network adequacy standards in the MOU. These network adequacy standards are discussed in Part IV.D and Appendix C.
- Quality of care: The Demonstration Plans will seek to contract with providers that can help the Demonstration Plans meet the quality standards in the MOU. These quality standards are outlined in Appendix E, Appendix F and Appendix G.
- Operational efficiencies: The Demonstration Plans will seek to contract with providers that can help them meet their goals of care coordination and improvement of care transitions. Current California state law states that the intent of the program is to achieve through operational efficiencies, not from reductions in the rates paid to providers.
- Limitation of risk exposure: The Demonstration Plans are likely to seek to contract with providers in a manner that can limit the Demonstration Plans' risk exposure for the dual eligible population.

2. Contracting Process

Now that the MOU has been released, the Demonstration Plans will seek to have contracts in place with hospitals in preparation for the readiness review. This may happen through a combination of the use of existing contracts, amendments to existing contracts and new contracts with hospitals.

Some Demonstration Plans may close their networks once they have established networks sufficient to meet their projected enrollment. However, other Demonstration Plans may continue to contract with hospitals after readiness review and throughout the demonstration project.

Many Demonstration Plans will likely offer new contracts or amendments to existing contracts to hospitals to cover care provided under the demonstration. However, hospitals may want to review its current contracts with the Demonstration Plans to assess whether the terms in those contracts may apply to services provided to beneficiaries enrolled in Cal MediConnect. Hospitals should assess their ability to serve the dual population under those terms. Hospitals should consider proactively reaching out to the local Demonstration Plan(s) to propose amendments to the current contracts to accommodate the Cal MediConnect program. Hospitals should seek to avoid circumstances where a Demonstration Plan(s) assumes that the hospital has agreed to serve Cal MediConnect patients pursuant to the terms in your current contract without consideration for whether the hospital believes those contracts can accommodate the Cal MediConnect patients.

Some Demonstration Plans will subcontract with other plans or providers to meet their obligations under the demonstration. Hospitals should be aware of the identity of the relevant subcontracted entities in their local areas. In some areas, hospitals seeking to be in a network may have to contract with both the demonstration plans and various subcontracted entities.

3. Contracting Strategy Considerations

Hospitals may highlight the ways in which they can help the Demonstration Plans meet their goals when requesting inclusion in a Cal MediConnect network. Despite advocacy by stakeholders, the MOU does not include any requirement on Demonstration Plans to contract with any willing provider. Accordingly, some Demonstration Plans may seek to keep their networks "narrow," i.e., contracting with the minimum number of providers necessary for them to meet their obligations pursuant to the Demonstration. Some areas that hospitals may promote include:

- Network adequacy: A hospital serving an essential role in a geographic area may have a stronger bargaining position, as it can help a Demonstration Plan meet its network adequacy requirements. Moreover, Demonstration Plans are required to contract with traditional and safety net providers, as defined in state regulations. State regulations define a "traditional" provider as "any physician who has delivered services to Medi-Cal beneficiaries within the last six months" and a "safety net" provider as "any provider of comprehensive primary care or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the provider."[32]
- One-stop shop: A Demonstration Plan may seek to work with a hospital or health system that operates a number of service lines (e.g., clinics, nursing facilities, rehab services, home health, hospice) and has the ability to direct patients to the least intensive and expensive level of care owned by the same provider.
- Established relationships with other providers: A Demonstration Plan may have a greater incentive to contract with a hospital that has well established relationships with other providers for care coordination. These hospitals may be better positioned to ensure that patients are directed to the least costly level of care.
- Physician integration: A hospital with strong physician integration will situate itself well for an active role in Cal MediConnect as those physicians can closely manage the care of Cal MediConnect enrollees to reduce operational inefficiencies.
- Quality metrics: A demonstration plan may seek to direct utilization to a hospital that meets specific quality metrics, such as those established in the MOU (e.g., low readmission rates). Having good quality metrics and methods to identify and address quality gaps may position a hospital for inclusion in Cal MediConnect networks.
- Information technology: A plan may prefer to contract with a hospital that has an EHR system that can be shared easily with the plan and other providers for care coordination purposes.

4. Substantive Contracting Considerations

A hospital's contract will govern the its relationship with the Demonstration Plan. It is important that a hospital understand the terms of its contracts in order to ensure that it is able to comply for the length of the contract. It is typically better to clarify contractual language before the contract is executed than to have to resolve a dispute about the meaning of the contract after the fact.

Some of the primary terms to be aware of in a contract include:

- Services covered: The contract should explicitly identify which services (acute hospital, post-acute, mental health, clinic, etc.) the hospital is agreeing to provide to Cal MediConnect beneficiaries. These services will often be defined with reference to the scope of benefits under

Medicare Parts A, B and D and Medi-Cal to match the scope of coverage by the Demonstration Plans.

- What documents make up the contract: The contract should clearly define whether the hospital will be subject to any external documents that are not within the "four corners" of the contract. Examples of such documents are the three-way contracts between CMS, DHCS and the Demonstration Plans, provider manuals and member manuals. The hospital should be given copies of these external documents and be aware of the substance of each of these external documents. Hospitals should be certain that they are willing to incorporate these documents into their contracts. The contracts should also clearly define a process for a hospital to agree to future changes to these external documents; the contracts should not permit a Demonstration Plan to unilaterally amend its contracts with a hospital by amending these documents without the consent of the hospital.

- Notice of Medicare non-coverage: The MOU establishes that no enrollee may be balanced billed by any provider for any reason for covered services. However, proposed contracts may require providers to give beneficiaries an advance, completed copy of a notice to beneficiaries that they may be held personally liable for certain non-covered services.

- Verification of eligibility: Typically, health care contracts require that the provider verify eligibility of a member prior to the provision of services, where possible. However, the contract should also establish the availability of the plan to verify eligibility 24 hours a day, seven days a week, and establish what happens if a provider cares for a patient upon receiving incorrect information from a Demonstration Plan that that patient is an enrolled member.

- Authorizations: Hospitals should expect that contracts with a Demonstration Plan will require hospitals to obtain advance authorization from the Demonstration Plan, except for emergency and certain urgent care. The contract should also prohibit the rescission or modification of authorization for any reason if the provider renders the health care services in good faith and pursuant to the authorization.[33] Contracts may also identify the standards to be followed by the Demonstration Plan in determining authorization (e.g., Medicare standards for authorization of Medicare-covered services; Medi-Cal standards in Title 22, California Code of Regulations, section 51003 for Medi-Cal-covered services). The timing of the authorization may be governed by the contract, keeping in mind the standards discussed in Part V.D.1, below.

- Rate structure: Hospitals may consider a number of different rate structures with the Demonstration Plan, including fee-for-service, capitation and bundled payments.

  Under a fee-for-service arrangement, a Demonstration Plan will pay a hospital based on a set fee schedule per service provided to a member. In this type of an arrangement, the Demonstration Plan retains the responsibility for coordinating the care of the member as well as the risk for any excess utilization of services. State law intends to provide some rate protection for nursing facilities (i.e., Medicare FFS rates for Medicare services and Medi-Cal FFS rates for Medi-Cal services)[34]. In the absence of a three-day qualifying acute inpatient stay requirement for Medicare coverage of nursing facility services, nursing facilities may seek to more explicitly define which nursing facility stays should be paid at a Medicare rate and which should be paid at a Medi-Cal rate.

  Under a capitation arrangement, a Demonstration Plan will pay a hospital a set per-member, per-month fee in order for the hospital to take responsibility for the provision or payment for all hospital services utilized by the member. This takes the risk away from the Demonstration Plan. A hospital will want to consider whether its case managers can work closely with its physician network to coordinate the care of the member to reduce hospital utilization by its capitated members and to reduce out-of-network utilization.

  Under a bundled arrangement, a hospital may consider accepting a bundled payment to cover a specific set of services, (e.g., inpatient stay plus a certain set of post-acute facility services). This type of a payment arrangement may work well for a hospital that owns or has close relationships

with a spectrum of post-acute services so that it may be able to effectively maintain the member at the appropriate level of care, while monitoring the member's continued recovery post-discharge from the acute care setting. Also, where the hospital owns or has close relationships with post-acute service providers, it may also be able to more effectively and consistently provide quality of care and improve outcomes.

One consideration that a hospital contracting with a Demonstration Plan may want to raise is how the hospital may be paid for extended stays where the plan is unable to transfer the member out of the hospital, even though acute care services are no longer necessary. In these situations, the hospital should ensure it continues to be entitled to payment. This will be particularly important if the Demonstration Plans contract for inpatient services on a per case basis.

Another issue that may arise when contracting rates is discounts and bonuses to the base rate negotiated by the provider. State law specifically prohibits nursing facility discounts, rebates or refunds as compensation for the referral of patients or residents.[35] State law further specifically permits bonus payments to encourage quality improvement and promote appropriate utilization incentives for nursing facilities.[36] Hospitals may also be offered bonus payments for other service lines.

- Timing of payment/clean claims: The contract should establish the timing of payment by the Demonstration Plan for bills by the hospital for services rendered. While the MOU and the Knox Keene Act establish some timely payment requirements,[37] a contract between a hospital and Demonstration Plan may establish more stringent timeframes.
- Denials and appeals: The contract will set forth the process for any denials and appeals, discussed in further detail in Part V.D.3, below.
- Audits, records and reporting: The contract will set forth the rights of the Demonstration Plan to audit claims by the hospital and inspect records. Some contracts may also include promises by the hospital to report specific information to the Demonstration Plans. The hospital should be careful to review these provisions to ensure that the hospital can comply with any reporting requirements and that the Demonstration Plans are not seeking to improperly broaden the scope of the reporting requirements.
- Term and termination: The contract should clearly set forth the term of the contract, how it may be continued and how it may be terminated by either party.
- Continuity of care: The contract should establish how the parties will handle the transition if the agreement is terminated. These provisions may include notices to beneficiaries, continued access to services for a limited period of time and payment rates for services provided during that transition period.
- Access to contract: The contract should be explicit whether other entities that contract with the Demonstration Plan may access the provider's rates in the provider's contract with the Demonstration Plan. For example, Demonstration Plan A contracts with Hospital B for inpatient and outpatient services. Demonstration Plan A also subcontracts with Plan C. If Hospital B treats dual eligible beneficiaries assigned to Plan C, should Plan C treat Hospital B as a contracted provider and pay pursuant to the Hospital B's contract with Demonstration Plan A? Or should Plan C pay Hospital B the out-of-network rates?

C. Impact on Physician Alignment Strategies

Hospital organizations should consider Cal MediConnect within the context of their physician alignment strategies. Issues to consider include:

- Does the hospital have aligned physicians with significant dual eligible clientele? If so, are they interested in participating in Cal MediConnect?

→ If they are, the hospital may wish to become a contracted Cal MediConnect provider and may want to develop a coordinated approach with these physicians toward Cal MediConnect.

- Does the hospital have a vehicle, such as a medical foundation, community clinics, section 1206(d) clinics, or an affiliated IPA that would be an appropriate partner with which to participate in Cal MediConnect?

  → Should the existing arrangements with the physicians be modified to take Cal MediConnect into account?

  → Are the current physician compensation models appropriate? Do they provide the correct incentives with respect to productivity, efficiency, and quality?

  → Are any risk pools appropriately structured?

  → Does the hospital have the right mix of physicians involved?

- Although enrollees in the Demonstration Plans will not be included in Medicare ACOs, does the hospital have a commercial ACO solution that might be expanded to Cal MediConnect?

- Does the organization have, or is it pursuing, a limited Knox-Keene licensed plan that could take full risk for duals?

D. Case Management/Care Transitions: Authorizations, Denials and Appeals

1. Prior Authorization

The Demonstration Plans will be coordinating the care provided to the dual eligible population through means such as utilization review. Through their contracts with providers, Demonstration Plans will likely be requiring prior authorization for most services, except for emergency services and out-of-network urgent care. All providers should familiarize themselves with the prior authorization process detailed in their contracts and likely in the relevant Demonstration Plans' provider manuals. The MOU also requires the Demonstration Plans to maintain certain current providers and service authorizations for continuity of care. (Continuity of care requirements are discussed in Part IV.D, above.)

The requirement for prior authorization of services may pose special challenges for post-acute and behavioral health providers. For example, historically, the Medicare FFS program has not required prior authorization for admission to an inpatient rehabilitation facility (IRF) or a long-term acute care hospital (LTCH). As previously noted, under the demonstration, these services will be subject to prior authorization and utilization review for continued care authorization. For SNF services, prior authorization will now be required for nursing facility services, and no three-day qualifying acute inpatient stay will be required if the nursing facility services are otherwise necessary. Moreover, some Demonstration Plans in their Medi-Cal lines of business have established more stringent utilization management controls on nursing facilities than the Medi-Cal FFS program, e.g., requiring submission of authorization requests on a shorter timeframe, approval of fewer days in a single authorization, etc.

Historically, many Medi-Cal managed care plans have little familiarity with the long term care services and supports, as these services have been carved out of their contracts like behavioral health. Some post-acute providers, such as inpatient rehab facilities and long term care hospitals, may find that they need to educate the Demonstration Plans about the types of services they provide and where these services fall within the post-acute spectrum in order to explain the medical necessity for their services. This is a process that some nursing facility service providers have already undertaken to help establish their position in the right time and right place continuum of care.

Providers should also be cognizant of the possible delays that the prior authorization requirement may present into the current system. The MOU does not establish timeframes for prior authorization determinations. Current Medicare Advantage rules require plans to respond to authorization requests in 14 calendar days with the

possibility of a 14 calendar day extension.[38] Current Medi-Cal managed care regulations do not establish specific timeframes for authorization denials, but Medi-Cal managed care plans subject to the Knox-Keene Act must respond to authorization requests within five days in the absence of an imminent or serious risk to the enrollee's health and 72 hours in the presence of an imminent or serious risk to the enrollee's health.[39] Providers' contracts with the Demonstration Plans (or the plans' provider manuals) may establish alternative timeframes for the Demonstration Plans to respond to authorization requests. The three-way contracts may also establish alternative timeframes for prior authorization determinations.

Providers seeking prior authorization should request authorization well in advance of the anticipated date of providing services. Hospitals seeking to discharge a patient to post-acute care may have to work with post-acute providers well before discharge in order to ensure authorization is obtained prior to discharge.

2. Prompt Payments

The MOU does not address prompt payment requirements for the Demonstration Plans after the submission of bills. The California Readiness Review document establishes several prompt payment standards:

- The Demonstration Plans must pay 90 percent of clean medical and LTSS claims within 30 days and 99 percent within 90 days.

- The Demonstration Plans' pharmacy benefit managers must pay electronically submitted pharmaceutical claims within 14 days of receipt and all other claims within 30 days of receipt.

The three-way contracts will likely clarify these requirements. However, these requirements do not appear to apply to hospital inpatient and outpatient claims. The Demonstration Plans or hospitals may consider "borrowing" from other existing prompt payment requirements in establishing prompt payment deadlines. For example, the current Medicare Advantage regulations establish that: 1) the payment of contracted claims are governed by the contract; 2) 95 percent of non-contracted "clean claims" must be paid within 30 days of receipt; and 3) all other non-contracted claims must be paid within 60 days of receipt.[40] The Medi-Cal managed care provisions do not establish any timeframe for plans to pay claims submitted by institutional providers, but establish that 90 percent and 99 percent of claims by non-institutional health care practitioners must be paid within 30 and 90 days of receipt, respectively.[41] For Medi-Cal plans governed by the Knox Keene Act, health care service plans must pay uncontested claims within 30 working days of receipt of the claim and health maintenance organizations must pay uncontested claims within 45 working days.[42]

3. Appeals

When a plan denies, reduces or otherwise amends a request for services, the Demonstration Plan must send the beneficiary a notice of the right to appeal the decision. The MOU provides some details on the appeals process, but this is likely to be further developed in the three-way contracts. For the first year of the demonstration, there will be separate appeals procedures for Medicare and Medi-Cal managed care appeals, following current processes. Some Medi-Cal managed care plans are required to comply with Knox Keene Act requirements with respect to appeal processes. As both Medicare Advantage and Medi-Cal managed care grievance requirements permit providers to stand in the shoes of members to challenge authorization and payment denials, providers should be able to continue to file appeals for authorization and payment denials on behalf of beneficiaries.

While the MOU states that "individuals, their authorized representatives and providers will have the same number of days to file an appeal as allowed under current applicable laws[,]" it also states that initial appeals must be filed within 90 days. It is advisable that you meet whichever timeframe is shorter between the current applicable laws and 90 days.

In the later years of the demonstration, the Demonstration Plans will develop a streamlined dispute resolution process based on the Medicare Advantage appeals process. Beneficiaries will then receive a single, integrated notice of their appeal rights. Individuals, their authorized representatives and providers will have a 90-

day timeframe for requesting an appeal. Beneficiaries will not have access to the state fair hearings process until after they had exhausted their first level of appeal with the Demonstration Plans. More details will likely be introduced in the three-way contracts.

(i) Current Laws Governing Medicare Advantage Appeals

Medicare Advantage regulations classify both authorization denials and payment denials as organizational decisions. They permit the provider to submit a request for reconsideration within 60 calendar days from the date of the notice of the organizational decision.[43] The Medicare Advantage plan then has 30 calendar days (with the possibility of a 14-day extension) to make a determination on the appeal for a request for services or 60 calendar days for a claim denial.[44] There is also a process for an expedited reconsideration that must be completed within 72 hours. Additional levels of appeal are typically available if the provider/beneficiary is unsuccessful in the first level of reconsideration.

(ii) Current Laws Governing Medi-Cal Managed Care Appeals

Each Medi-Cal managed care plan must have a system in place that includes a grievance process, an appeal process and access to the State's fair hearing system.[45] Typically, the appeal process may be used for both authorization denials and payment denials. DHCS may establish reasonable timeframe for filing an appeal (between 20 and 90 days after notice of action).[46] Medi-Cal managed care appeals must be resolved within 30 days of the written request or written record of a verbal grievance, unless notice is given of a longer time to adjudicate.[47]

Current Medi-Cal managed care contracts also borrow in part from the Knox Keene Act. The Knox-Keene Act requires that managed care plans permit members to submit grievances at least 180 calendar days following any incident or action that is the subject of the grievance.[48] Plans must generally respond to grievances in 30 calendar days.[49] Each plan must have a procedure for expedited review of grievances.[50]

Additional appeal processes are available for authorization denials. The beneficiary or provider can initiate the state fair hearing system by submitting a grievance or complaint within 90 days.[51] In addition, a claimant can submit a request for an independent medical review with the Department of Managed Health Care within six months of the denial.[52]

VI. Conclusion

Cal MediConnect represents another in an avalanche of changes that hospitals will have to navigate as they move toward the full implementation of health care reform as envisioned in the Affordable Care Act. It remains to be seen whether the laudable goals of improved patient care and reduced costs can be achieved, or whether this experiment will lead to confusion and bureaucracy that decreases access to care for beneficiaries as a result of inadequate provider payments and networks.

Endnotes

[1] Governor's Budget Summary – 2013-14, Health and Human Services, located at http://www.ebudget.ca.gov/pdf/BudgetSummary/HealthandHumanServices.pdf, accessed on April 18, 2013.

[2] 2012 – 2013 Governor's Budget, Care Coordination Initiative Savings; Estimates and Methodology, at http://www.dhcs.ca.gov/provgovpart/Documents/Duals/TBL/Coordinated%20Care%20Initiative%20Fiscal%20Methodology.pdf.

[3] Somewhat confusingly, the MOU also refers to LTSS as part of Cal MediConnect. The MOU describes these services as including In-Home Supportive Services, Community-Based Adult Services, Multipurpose Senior Services Program services, and skilled nursing facility and subacute services. These services are included in Cal MediConnect. However, the state will also begin to require enrollment of Medi-Cal beneficiaries who are not enrolled in a Demonstration Plan to obtain LTSS services through a managed care plan, which appears to be how the state currently uses the term LTSS services.

[4] The CCI trailer bill requires that plan rates and contract structure be made readily available to the public to the extent permitted by CMS. Welf. & Inst. Code § 14182.17(e)(4)(E)(iii). Thus far, CMS has not indicated its intent with regard to the release of plan rates and contract structure.

[5] Welf. & Inst. Code § 14182.17(d)(1)(H).

[6] Welf. & Inst. Code § 14132.275(k)(2)(A) (Medicare); Welf. & Inst. Code § 14182.17(d)(5)(G).

[7] "Demonstration sites that contract with hospitals for hospital services on a fee-for-service basis that otherwise would have been traditionally Medicare services will achieve savings through utilization changes and not by paying hospitals at rates lower than prevailing Medicare fee-for-service rates." (Welfare and Institutions Code § 14132.275(o)(7).)

[8] "Joint Rate Setting Process for the Capitated Financial Alignment Model (FAQs Updated February 8, 2013)" issued by CMS, p. 6.

[9] 42 C.F.R. § 422.256(a)(2)(ii). Important to note, while federal Medicare Advantage regulations state that CMS will not impose a particular price structure on Medicare Advantage Plans, they do not expressly prohibit the imposition of a rate floor, and do not prohibit states, as opposed to CMS, from imposing rate requirements. Accordingly, the rate floor in California law appears at least potentially to be permissible

[10] Welfare and Institutions Code § 14132.276(f).

[11] Welfare and Institutions Code § 14132.275(o)(3).

[12] See note 9.

[13] It has been brought to the authors' attention that Medicare Advantage Plans in practice may not be making outlier payments for out-of-network emergency services. While it may be that there are relatively few occasions where Medicare Advantage enrollees who receive out-of-plan emergency services become outliers, the Medicare Advantage regulations would appear to require that outlier payments be made when they would have been made under FFS Medicare. *See* 42 C.F.R. § 422.214(b).

[14] 42 U.S.C. § 1315a(d)(2).

[15] DHCS Dual Eligibles Fast Facts, available at http://www.calduals.org/background/fast_facts/.

[16] As noted above, the enrollment of dual eligibles in Cal MediConnect for Los Angeles County will be capped at 200,000.

[17] DHCS, Profiles of Medi-Cal's FFS CCI Population in the Eight Pilot Counties, located at www.dhcs.ca.gov/dataandstats/statistics/Documents/County%20Profiles%20Overview_PerCapita.pdf.

[18] *Id.*

[19] Kaiser Family Foundation, Dual Eligibles as a Percent of Total Medicare beneficiaries, 2009; Dual Eligibles as a Percent of Total Medicaid beneficiaries, 2009 available at , www.statehealthfacts.org.

[20] DHCS California Dual Eligible Profile, located at http://www.calduals.org/2012/06/13/profile-of-ca-medicare-medi-cal-enrollees/.

[21] raiser Family Foundation, www.statehealthfacts.org, Medicaid Payments per Enrollee, FY 2009; Medicaid Spending per Dual Eligible per Year, 2009.

[22] DHCS, Profiles of Medi-Cal's FFS CCI Population in the Eight Pilot Counties, located at www.dhcs.ca.gov/dataandstats/statistics/Documents/County%20Profiles%20Overview_PerCapita.pdf. The data available in this analysis are gathered from dual eligible beneficiaries receiving their Medi-Cal benefits through the fee-for-service program in the eight pilot counties.

[23] *Id.*

[24] *Id.*

[25] Washington, B., , "Integrated Managed Care Model for Dual Eligibles Reduces Readmissions", available at Health Affairs Blog http://healthaffairs.org/blog/2012/07/18/integrated-managed-care-model-for-dual-eligibles-reduces-readmissions/

[26] 2012-13 Governor's Budget: Care Coordination Initiative Savings; Estimates and Methodology, located at http://www.dhcs.ca.gov/provgovpart/Documents/Duals/TBL/Coordinated%20Care%20Initiative%20Fiscal%20Methodology.pdf.

[27] *Id.*

[28] *Id.*

[29] The MOU is silent with respect to provider rates for in-network services. California law indicates that Medi-Cal and Medicare FFS rates will be the rate floor for skilled nursing services. However, the Medicare Advantage regulations probably require the rates to be established pursuant to a negotiation between the health plan and the provider. Recent DHCS comments indicate that Medi-Cal FFS rates are the floor for Medi-Cal skilled nursing services, including DP/NF services, but that the rates for Medicare skilled nursing services are to be established based on the contract between the plan and the provider without a rate floor.

[30] California law requires that Medi-Cal FFS rates be the floor for Medi-Cal "nursing facility" services furnished under Cal MediConnect. (Welf. and Inst. Code § 14132.276). The Medi-Cal regulations indicate that subacute services, including hospital-based services, are nursing facility services. (22 Cal. Code Regs. §§ 51335.5 and 51511.5.)

[31] DHCS, Profiles of Medi-Cal's FFS CCI Population in the Eight Pilot Counties, located at www.dhcs.ca.gov/dataandstats/statistics/Documents/County%20Profiles%20Overview_PerCapita.pdf.

[32] Cal. Code Regs., tit. 22, § 53810.

[33] *See* Health & Saf. Code § 1371.8.

[34] Welf. & Inst. Code § 14132.276(c).

[35] Welf. & Inst. Code § 14132.276(d).

[36] Welf. & Inst. Code § 14132.276(f)(1).

[37] *See* Health & Saf. Code § 1371.

[38] 42 C.F.R. § 422.568(b).

[39] Health & Saf. Code § 1367.01(h).

[40] 42 C.F.R. § 422.590(b).

[41] 42 U.S.C. §1396a(a)(37).

[42] Health & Saf. Code § 1371.

[43] 42 C.F.R. § 422.582.

[44] 42 C.F.R. § 422.590.

[45] 42 C.F.R. § 438.402.

[46] *Id.*

[47] *Id.*

[48] Cal. Code Regs., tit. 28, § 1300.68(b).

[49] Cal. Code Regs., tit. 28, § 1300.68(d)(3).
[50] Cal. Code Regs., tit. 28, § 1300.68.
[51] Cal. Code Regs., tit. 22, §§ 51014.1, 51015.
[52] Cal. Code Regs., tit. 28, §§ 1374.30-1374.35.

Appendix A. Resource List

Key Websites

- CalDuals (not an official state website)
  Maintained under contract with DHCS to provide news, updates, and key resources
  http://www.calduals.org/
- CMS, Financial Alignment Initiative
  Includes background, proposals from states, Memoranda of Understanding, and readiness review tools
  http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html
- CMS, State Demonstrations to Integrate Care for Dual Eligible Individuals
  Includes background information
  http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.html
- DHCS, Dual Eligibles Coordinated Care Demonstration—Cal MediConnect
  Includes key demonstration documents and resources
  http://www.dhcs.ca.gov/Pages/DualsDemonstration.aspx

Key Documents

- California Memorandum of Understanding
  http://www.dhcs.ca.gov/Pages/demoMOU.aspx
- California Readiness Review Tool
  https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CARRTool.pdf

Additional Documents

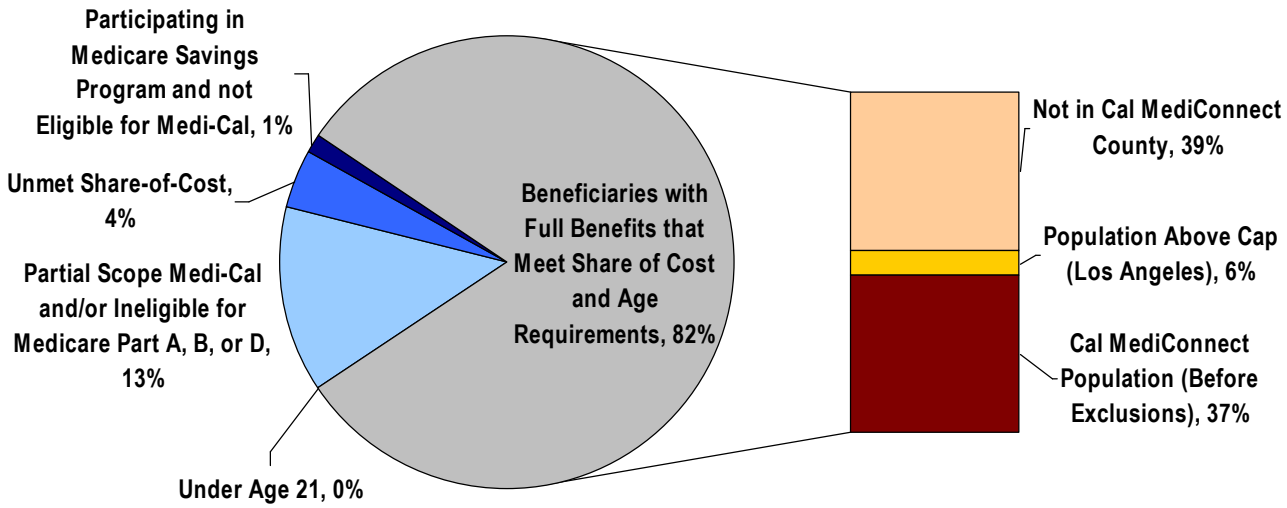
- CCI Trailer Bill SB 1008
  http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_1001-1050/sb_1008_bill_20120627_chaptered.html
- CCI Trailer Bill SB 1036
  http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_1001-1050/sb_1036_bill_20120627_chaptered.html
- CMS, Principles for Beneficiary Alignment in Medicare Fee for Service Models (July 2, 2012)
  http://innovation.cms.gov/Files/x/external_guidance.pdf
- DHCS, All Plan Letter 13-003, Coordination of Benefits: Medicare and Medi-Cal (Feb. 8, 2013)
  http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-003.pdf
- DHCS, All Plan Letter 13-004, Rates for Emergency and Post-Stabilization Acute Inpatient Services Provided by Out-of-Network General Acute Care Hospitals based on Diagnosis Related Groups Effective July 1, 2013
  http://www.dhcs.ca.gov/provgovpart/Documents/DRG/ReplacementofRogersRateAPL13-004.pdf
- DHCS, Draft Long-Term Services and Supports Network Standards (Jan. 22, 2013)
  http://www.calduals.org/wp-content/uploads/2013/01/LTSS-Standards-Draft-1.22.13.doc
- DHCS, Research and Analytic Studies Branch, *Medi-Cal Statistical Brief* (Nov. 2012)
  http://www.dhcs.ca.gov/dataandstats/statistics/Documents/CCI%20Population%20Brief.pdf
- DHCS, Revised Local Behavioral Health MOU Template (Feb. 14, 2013)
  http://www.calduals.org/wp-content/uploads/2013/02/Local-BH-MOU-Template-02-15-13.pdf

- Governor's Budget Summary—2013 – 14, Health and Human Services
  http://www.ebudget.ca.gov/pdf/BudgetSummary/HealthandHumanServices.pdf
- Governor's Budget, 2012 – 2013, Care Coordination Initiative Savings; Estimates and Methodology
  http://www.dhcs.ca.gov/provgovpart/Documents/Duals/TBL/Coordinated%20Care%20Initiative%20Fiscal%20Methodology.pdf

Links are current as of April 18, 2013

Appendix B. Eligibility, Exclusions, and Exemptions

Figure 3. California's 1.22 Million Dual Eligible Beneficiaries and the 456,000 Eligible for Cal MediConnect



Source: Research and Analytic Studies Branch, DHCS, Medi-Cal Statistical Brief (November 2012) (modified by author in light of the MOU) (see Appendix A).

Table 5. Cal MediConnect Exclusions and Exemptions

Excluded from Cal MediConnect	Passive Enrollment Exemptions
Cannot enroll in a Demonstration Plan and will not receive enrollment materials	*May enroll in a Demonstration Plan and will receive an enrollment packet, but will not be passively enrolled in a Demonstration Plan*
• Beneficiaries with other private or public health insurance. • Beneficiaries with developmental disabilities receiving services through a Department of Developmental Services (DDS) 1915(c) waiver; regional center; state developmental center; or intermediate care facilities for the developmentally disabled (ICF/DD). • Beneficiaries enrolled in the following 1915(c) waivers: nursing facility/acute hospital waiver service, HIV/AIDS waiver services, assisted living waiver services, and In-Home Operations waiver services. • Beneficiaries residing in 20 designated rural zip codes in San Bernardino, Los Angeles, and Riverside counties.* • Beneficiaries residing in a Veterans' Home of California. • Beneficiaries with end stage renal disease (ESRD) in all counties except for San Mateo and Orange. If a beneficiary develops ESRD after enrolling in a Cal MediConnect plan, he or she may stay enrolled in that plan.	• Beneficiaries enrolled in a Program of All-Inclusive Care for the Elderly (PACE).** • Beneficiaries enrolled in the AIDS Health Care Foundation.** • Beneficiaries in specified rural zip codes in San Bernardino County in which only one prime contractor operates.*** • Individuals enrolled in a prepaid health plan that is a non-profit health care service plan with at least 3.5 million enrollees statewide, that owns or operates its own pharmacies and that provides medical services to enrollees in specific geographic regions through an exclusive contract with a single medical group in each specific geographic region in which it operates to provide services to enrollees (e.g. Kaiser). • During 2013, individuals enrolled in a Medicare Advantage plan. (Note, these beneficiaries are subject to passive enrollment on January 1, 2014.)

*Designated rural zip codes excluded from Cal MediConnect—San Bernardino County: 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 92280, 93592, and 93558; Los Angeles County: 90704; and Riverside County: 92225, 92226, 92239.

**Must disenroll from these programs before enrolling in Cal MediConnect.

***Rural zip codes in San Bernardino exempted from passive enrollment: 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304, 92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92326, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, and 92398.

Source: CMS and DHCS Memorandum of Understanding, March 27, 2013.

Appendix C. Network Adequacy

Table 6. Sample Network Adequacy Standards

	Medicare Standards	Medi-Cal Standards
Applicability for Demonstration Plans	• Services for which Medicare is primary (e.g., pharmacy benefits), unless Medi-Cal standards are more stringent • Services where Medicare and Medi-Cal overlap (e.g., home health and DME) and Medicare standards are more stringent	• Services for which Medi-Cal is exclusive (e.g., LTSS) • Services where Medicare and Medi-Cal overlap (e.g., home health and DME) and Medicare standards are more stringent
Calculations	• Ratio based on standardized beneficiary numbers for a county, not enrolled beneficiaries • Accessibility standards (both time *and* distance) must be met for 90 percent of beneficiaries residing in the county	• Requirements apply on a per-member basis
General Requirement	• Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically used in the network as primary care providers (PCPs), specialists, hospitals, skilled-nursing facilities, home health agencies, ambulatory clinics, and other providers	• *Two-Plan and Geographic Models:* Ensure and monitor an appropriate provider network, including primary care physicians, specialists, professional, allied, supportive paramedical personnel, and an adequate number of accessible inpatient facilities and service sites within each service area. • *County-Operated Health System:* Submit a complete provider network that is adequate to provide required covered services for members in the service area. Increase the capacity of the network as necessary to accommodate enrollment growth. • Total physician network—at least 1 physician per 1,2000 members
Primary Care	• *Providers included:* Primary Care (including PAs and NPs), General Practice, Family Medicine, Internal Medicine, and Geriatrics*	• *Providers included:* Primary Care, General Practice, Family Medicine, Internal Medicine, Pediatrics, and Obstetrics/Gynecology
	• *Ratio:* 1.67 providers per 1,000 beneficiaries (*e.g.*, 75 providers in San Diego County and 12 providers in San Mateo County)	• *Ratio:* 1 provider per 2,000 members
	• *Accessibility:* 10 minutes and 5 miles	• *Accessibility:* 30 minutes or 10 miles
Hospital Inpatient	• *Ratio:* 12.2 beds per 1,000 beneficiaries	• No quantitative requirement
	• *Accessibility:* 20 minutes and 10 miles (large metro) or 45 minutes and 30 miles (metro)**	
Skilled Nursing	• *Accessibility:* 20 minutes and 10 miles (large metro) or 45 minutes and 30 miles (metro)**	• No quantitative requirement
Inpatient Psychiatric	• *Accessibility:* 30 minutes and 15 miles (large metro) or 70 minutes and 45 miles (metro)**	• No quantitative requirement

*Obstetrics/Gynecology is subject to separate standard (ratio: 0.04/1,000, accessibility: 30 minutes and 5 miles) under the Medicare Advantage network adequacy standards.

**All of the Cal MediConnect counties are designated as "large metro" counties with the exception of Riverside, San Bernardino, and San Diego, which are each designated as "metro" counties.

Source: CMS and DHCS Memorandum of Understanding, March 27, 2013; 42 C.F.R. § 422.112(a)(1); CMS, Contract Year 2014 Health Service Delivery Reference Table, http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2014_HSD_Reference_File.zip; DHCS, Medi-Cal Managed Care Boilerplate Contracts, http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.

Appendix D. Utilization and Cost-Savings

Table 7. Projected Changes in Medicare Utilization from Coordinated Care Initiative

	2012 – 13	2013 – 14	2014 – 15	2015 – 16
Inpatient	0.85	0.80	0.80	0.80
Outpatient	1.00	1.00	1.00	1.00
Skilled-Nursing Facility*	0.95	0.95	0.95	0.95
Home Health Agency	1.00	1.00	1.00	1.00
Hospice	1.00	1.00	1.00	1.00
Durable Medical Equipment	1.00	1.00	1.00	1.00
Physician	1.04	1.05	1.05	1.05
Prescription Drug	1.02	1.02	1.02	1.02

* For the Long-Term Care aid category, there is no projected change in utilization of skilled-nursing facility services.

Note: These estimates are from the 2012-13 Governor's budget, based on the implementation of the dual eligibles demonstration project in 10 counties. The estimated savings from 2012-13 and 2013-14 will likely be reduced due to the delayed implementation of the CCI.

Source: 2012 – 2013 Governor's Budget, Care Coordination Initiative Savings; Estimates and Methodology (see Appendix A, Resource List).

Table 8. Medicare Savings Estimates for Select Service Lines from Coordinated Care Initiative

	2012 – 13	2013 – 14	2014 – 15	2015 – 16
Inpatient	$(106,483,862)	$(968,777,580)	$(1,332,356,601)	$(1,561,505,961)
Outpatient	$-	$-	$-	$-
Skilled-Nursing Facility	$(4,789,587)	$(34,366,725)	$(44,374,567)	$(51,201,537)

Note: These service-line estimates are from the 2012-13 Governor's budget, based on the implementation of the dual eligibles demonstration project in 10 counties. These estimates are total projected Medicare savings, which the federal and state governments will share. Because the MOU only permits the implementation of the demonstration in only 8 counties and restricts enrollment in Los Angeles County, these estimates are likely to be higher than what will actually be achieved. The estimated savings from 2012-13 and 2013-14 will also likely be reduced due to the delayed implementation of the CCI.

Source: 2012 – 2013 Governor's Budget, Care Coordination Initiative Savings; Estimates and Methodology (see Appendix A, Resource List).

Table 9. County-Specific Interim Saving Percentages (for Risk Corridors)

	Demonstration Year 1 (10/1/2013 – 12/31/2014)	Demonstration Year 2 (1/1/2015 – 12/31/2015)	Demonstration Year 3 (1/1/2016 – 12/31/2016)
Minimum Savings Percentages	1.0%	2.00%	4.00%
County-specific interim savings percentages: the sum of the minimum savings percentages and the county-specific addition			
Alameda	+0.19%	+1.41%	+0.97%
Los Angeles	+0.00%	+1.50%	+1.50%
Orange	+0.42%	+1.50%	+1.50%
Riverside	+0.22%	+1.50%	+1.14%
San Bernardino	+0.44%	+1.50%	+1.50%
San Diego	+0.23%	+1.50%	+1.10%
San Mateo	+0.47%	+0.33%	+0.00%
Santa Clara	+0.23%	+1.45%	+0.95%

Source: CMS and DHCS Memorandum of Understanding, March 27, 2013.

Appendix E. Core Quality Measures under the Demonstration

1. ***Antidepressant Medication Management.*** Percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.

2. ***Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.*** The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following.

   - Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
   - Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit

3. ***Follow-up After Hospitalization for Mental Illness.*** Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.

4. ***Screening for Clinical Depression and Follow-up.*** Percentage of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.

5. ***SNP1: Complex Case Management.*** The organization coordinates services for members with complex conditions and helps them access needed resources.

   - Element A: Identifying Members for Case Management.
   - Element B: Access to Case Management.
   - Element C: Case Management Systems.
   - Element D: Frequency of Member Identification.
   - Element E: Providing Members with Information.
   - Element F: Case Management Assessment Process.
   - Element G: Individualized Care Plan.
   - Element H: Informing and Educating Practitioners.
   - Element I: Satisfaction with Case Management.
   - Element J: Analyzing Effectiveness/Identifying Opportunities.
   - Element K: Implementing Interventions and Follow-up Evaluation.

6. ***SNP 6: Coordination of Medicare and Medicaid Benefits***. The organization coordinates Medicare and Medicaid benefits and services for members.

   - Element A: Coordination of Benefits for Dual Eligible Members.
   - Element B: Administrative Coordination of D-SNPs.
   - Element C: Administrative Coordination for Chronic Condition and Institutional Benefit

   Packages (may not be applicable for demos).

   - Element D: Service Coordination.
   - Element E: Network Adequacy Assessment.

7. ***Care Transition Record Transmitted to Health Care Professional***. Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

8. ***Medication Reconciliation After Discharge from Inpatient Facility.*** Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing ongoing care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.

9. ***SNP 4: Care Transitions.*** The organization manages the process of care transitions, identifies problems that could cause transitions and where possible prevents unplanned transitions.

    - Element A: Managing Transitions.
    - Element B: Supporting Members through Transitions.
    - Element C: Analyzing Performance.
    - Element D: Identifying Unplanned Transitions.
    - Element E: Analyzing Transitions.
    - Element F: Reducing Transitions.

10. ***CAHPS, various settings including: Health Plan plus supplemental items/questions (including: Experience of Care and Health Outcomes for Behavioral Health (ECHO)); Home Health; Nursing Home (People with Mobility Impairments, Cultural Competence, Patient Centered Medical Home).*** Depends on Survey.

11. ***Part D Call Center – Pharmacy Hold Time.*** Average time spent on hold when pharmacists call the drug plan's pharmacy help desk.

12. ***Part D Call Center – Foreign Language Interpreter and TTY/TDD Availability.*** Percent of the time that TTY/TDD services and foreign language interpretation were available when needed by members who called the drug plan's customer service phone number.

13. ***Part D Appeals Auto–Forward.*** How often the drug plan did not meet Medicare's deadlines for timely appeals decisions.

    - This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the plan. This is calculated as: [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000.

14. ***Part D Appeals Upheld.*** How often an independent reviewer agrees with the drug plan's decision to deny or say no to a member's appeal.

    This measure is defined as the percent of IRE confirmations of upholding the plans' decisions. This is calculated as: [(Number of cases upheld) / (Total number of cases reviewed)] * 100.

15. ***Part D Enrollment Timeliness.*** The percentage of enrollment requests that the plan transmits to the Medicare program within seven days.

16. ***Part D Complaints about the Drug Plan.*** How many complaints Medicare received about the drug plan.

    For each contract, this rate is calculated as: [(Total number of complaints logged into the CTM for the drug plan regarding any issues) / (Average contract enrollment)] * 1,000 * 30 / (Number of days in period).

17. ***Part D Beneficiary Access and Performance Problems.*** To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it

finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.

18. ***Part D Members Choosing to Leave the Plan.*** The percent of drug plan members who chose to leave the plan in 2013.

19. ***Part D MPF Accuracy.*** The accuracy of how the Plan Finder data match the PDE data.

20. ***Part D High Risk Medication.*** The percent of the drug plan members who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices.

21. ***Part D Diabetes Treatment.*** Percentage of Medicare Part D beneficiaries who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes.

22. ***Part D Medication Adherence for Oral Diabetes Medications.*** Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication.

23. ***Part D Medication Adherence for Hypertension (ACEI or ARB).*** Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication

24. ***Part D Medication Adherence for Cholesterol (Statins).*** Percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication.

25. ***Plan Makes Timely Decisions about Appeals.*** Percent of plan members who got a timely response when they made a written appeal to the health plan about a decision to refuse payment or coverage.

26. ***Reviewing Appeals Decisions.*** How often an independent reviewer agrees with the plan's decision to deny or say no to a member's appeal.

27. ***Call Center – Foreign Language Interpreter and TTY/TDD Availability.*** Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by members who called the health plan's customer service phone number.

28. ***Percent of High Risk Residents with Pressure Ulcers (Long Stay).*** Percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (three-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s).

29. ***Risk Assessments.*** Percent of members with initial assessments completed within 90 days of enrollment.

30. ***Individualized Care Plans.*** Percent of members with care plans by specified timeframe.

31. ***Real Time Hospital Admission Notifications.*** Percent of hospital admission notifications occurring within specified timeframe.

32. ***Risk Stratification Based on LTSS or Other Factors.*** Percent of risk stratifications using BH/LTSS data/indicators.

33. ***Discharge Follow-Up.*** Percent of members with specified timeframe between discharge to first follow-up visit.

34. ***Self-Direction.*** Percent of care coordinators who have undergone state-based training for supporting self-direction under the Demonstration.

35. ***Care for Older Adults – Medication Review.*** Percent of plan members whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.

36. ***Care for Older Adults – Functional Status Assessment.*** Percent of plan members whose doctor has done a ―functional status assessment to see how well they are doing ―activities of daily living (such as dressing, eating, and bathing).

37. ***Care for Older Adults – Pain Screening.*** Percent of plan members who had a pain screening or pain management plan at least once during the year.

38. ***Diabetes Care – Eye Exam.*** Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.

39. ***Diabetes Care – Kidney Disease Monitoring.*** Percent of plan members with diabetes who had a kidney function test during the year.

40. ***Diabetes Care – Blood Sugar Controlled.*** Percent of plan members with diabetes who had an A-1-C lab test during the year that showed their average blood sugar is under control.

41. ***Rheumatoid Arthritis Management.*** Percent of plan members with rheumatoid arthritis who got one or more prescription(s) for an anti-rheumatic drug.

42. ***Reducing the Risk of Falling.*** Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.

43. ***Plan All-Cause Readmissions.*** Percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.

44. ***Controlling Blood Pressure.*** Percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.

45. ***Comprehensive Medication Review.*** Percentage of beneficiaries who received a comprehensive medication review (CMR) out of those who were offered a CMR.

46. ***Complaints about the Health Plan.*** How many complaints Medicare received about the health plan.

    - Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the CTM) / (Average contract enrollment)] * 1,000 * 30 / (Number of days in period).

47. ***Beneficiary Access and Performance Problems.*** To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.

48. ***Members Choosing to Leave the Plan.*** The percent of plan members who chose to leave the plan in current year.

49. ***Getting Information From Drug Plan.*** The percent of the best possible score that the plan earned on how easy it is for members to get information from their drug plan about prescription drug coverage and cost.

    - In the last six months, how often did your health plan's customer service give you the information or help you needed about prescription drugs?
    - In the last six months, how often did your plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs?
    - In the last six months, how often did your health plan give you all the information you needed about prescription medication were covered?
    - In the last six months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine?

50. ***Rating of Drug Plan.*** The percent of the best possible score that the drug plan earned from members who rated the drug plan for its coverage of prescription drugs.

    Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs?

51. ***Getting Needed Prescription Drugs.*** The percent of best possible score that the plan earned on how easy it is for members to get the prescription drugs they need using the plan.

    - In the last six months, how often was it easy to use your health plan to get the medicines your doctor prescribed?
    - In the last six months, how often was it easy to use your health plan to fill a prescription at a local pharmacy?

52. ***Getting Needed Care.*** Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists.

    - In the last six months, how often was it easy to get appointments with specialists?
    - In the last six months, how often was it easy to get the care, tests, or treatment you needed through your health plan?

53. ***Getting Appointments and Care Quickly.*** Percent of best possible score the plan earned on how quickly members get appointments and care.

    - In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? (In the last 6 months, not counting the times when you needed care right away).
    - How often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?

54. ***Overall Rating of Health Care Quality.*** Percent of best possible score the plan earned from plan members who rated the overall health care received.

    - Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last six months?

55. ***Overall Rating of Plan.*** Percent of best possible score the plan earned from plan members who rated the overall plan.

    - Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

56. ***Breast Cancer Screening.*** Percent of female plan members aged 40-69 who had a mammogram during the past two years.

57. ***Colorectal Cancer Screening.*** Percent of plan members aged 50-75 who had appropriate screening for colon cancer.

58. ***Cardiovascular Care – Cholesterol Screening.*** Percent of plan members with heart disease who have had a test for bad (LDL) cholesterol within the past year.

59. ***Diabetes Care – Cholesterol Screening.*** Percent of plan members with diabetes who have had a test for bad (LDL) cholesterol within the past year.

60. ***Annual Flu Vaccine.*** Percent of plan members who got a vaccine (flu shot) prior to flu season.

61. ***Improving or Maintaining Mental Health.*** Percent of all plan members whose mental health was the same or better than expected after two years.

62. ***Monitoring Physical Activity.*** Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.

63. ***Access to Primary Care Doctor Visits.*** Percent of all plan members who saw their primary care doctor during the year.

64. ***Access to Specialists.*** Proportion of respondents who report that it is always easy to get an appointment with specialists.

65. ***Getting Care Quickly.*** Composite of access to urgent care.

66. ***Being Examined on the Examination Table.*** Percentage of respondents who report always being examined on the examination table.

67. ***Help with Transportation.*** Composite of getting needed help with transportation.

68. ***Health Status/Function Status.*** Percent of members who report their health as excellent.

69. ***Transition Record with Specified Elements.*** Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other sites of care, or their caregivers(s), who received a transition record at the time of discharge including, at a minimum, all of the specified elements.

70. ***Behavioral Health Shared Accountability Process Measure. Phase A (9/1/13 – 12/31/13) and Phase B (1/1/14 – 12/31/14).***

    - Phase A: Policies and procedures attached to an MOU with county behavioral health department(s) around assessments, referrals, coordinated care planning and information sharing.
    - Phase B: Percent of demonstration enrollees receiving Medi-Cal specialty mental health and/or drug Medi-Cal services receiving coordinated care plan as indicated by having an individual care plan that includes the evidence of collaboration with the primary behavioral health provider.

71. ***Behavioral Health Shared Accountability Outcome Measure.*** Reduction in Emergency Department Use for Seriously Mentally Ill and Substance Use Disorder enrollees (greater reduction in demonstration Year 3).

72. ***Complaints and Appeals.*** Utilization measure.

73. ***Physician Access.*** Utilization measure.

74. ***Psychiatric Bed Days.*** Utilization measure.

75. ***ER Utilization Rates.*** Utilization measure, potentially revised to reflect avoidable ER visits.

76. ***IHSS Utilization.*** Utilization measure.

77. ***Nursing Facility Utilization Measures.*** Utilization measure.

78. ***Unmet Need in LTSS.*** Unmet need in ADLs/IADLs, and IHSS functional level.

79. ***Case Manager Contact with Member.*** Ability to identify case manager or contact case manager.

80. ***LTSS Consumer Satisfaction Measures.*** Satisfaction with case manager, home workers, personal care.

81. ***Encounter Data.*** Encounter data submitted accurately and completely in compliance with contract requirements.

82. ***Consumer Governance Board.*** Establishment of consumer advisory board or inclusion of consumers on governance board consistent with contract requirements.

83. ***Customer Service.*** Percent of best possible score the plan earned on how easy it is to get information and help when needed.

84. ***Access to Care.*** Percent of respondents who always or usually were able to access care quickly when they needed it.

Appendix F. Quality Withhold Measures for Demonstration Year 1

1. ***Encounter Data.*** Encounter data submitted in compliance with contract requirements.

2. ***Assessments***. Percent of enrollees with initial health assessments completed within 90 days of enrollment.

3 ***Beneficiary Governance Board.*** Establishment of beneficiary advisory board or inclusion of beneficiaries on governance board consistent with contract requirements.

4 ***Getting Appointments and Care Quickly.*** Percent of best possible score the plan earned on how quickly members get appointments and care.

- In the last six months, when you needed care right away, how often did you get care as soon as you thought you needed?
- In the last six months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?
- In the last six months, how often did you see the person you came to see within 15 minutes of your appointment time?

5 ***Customer Service (for CY 2014 only).*** Percent of best possible score the plan earned on how easy it is to get information and help when needed.

- In the last six months, how often did your health plan's customer service give you the information or help you needed?
- In the last six months, how often did your health plan's customer service treat you with courtesy and respect?
- In the last six months, how often were the forms for your health plan easy to fill out?

6 ***Behavioral Health Shared Accountability Process Measure: Phase A: 9/1/13 – 12/31/13.*** Policies and procedures attached to an MOU with county behavioral health department(s) around assessments, referrals, coordinated care planning and information sharing.

7 ***Behavioral Health Shared Accountability Process Measure: Phase B: 1/1/14 – 12/31/14.*** Percent of Demonstration enrollees receiving Medi- Cal specialty mental health and/or drug Medi-Cal services receiving coordinated care plan as indicated by having an individual care plan that includes evidence of collaboration with the primary behavioral health provider.

8 ***Documentation of Care Goals.*** Percent of enrollees with documented discussions of care goals.

9 ***Ensuring Physical Access to Buildings, Services and Equipment.*** The health plan has an established work plan and identified an individual who is responsible for physical access compliance.

10 ***Case Manager Contact with Member.*** Percent of members who have a case manager and have at least one case manager contact during the measurement year.

Appendix G. Quality Withhold Measures for Demonstration Years 2 and 3

1. ***Plan All-cause Readmissions.*** Percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.
2. ***Annual Flu Vaccine.*** Percent of plan members who got a vaccine (flu shot) prior to flu season.
3. ***Follow-up After Hospitalization for Mental Illness.*** Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.
4. ***Screening for Clinical Depression and Follow-up Care.*** Percentage of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.
5. ***Reducing the Risk of Falling.*** Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.
6. ***Controlling Blood Pressure.*** Percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.
7. ***Part D Medication Adherence for Oral Diabetes Medications.*** Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication.
8. ***Behavioral Health Shared Accountability Outcome Measure.*** Reduction in emergency department use for seriously mentally ill and substance use disorder enrollees.
9. ***Documentation of Care Goals.*** Percent of enrollees with documented discussions of care goals.
10. ***Case Manager Contact with Member.*** Percent of members who have a case manager and have at least one case manager contact during the measurement year.