

# CHCS

Center for  
Health Care Strategies, Inc.

## Options for Integrated Care for Duals in Medi-Cal: *Themes from Interviews with Key Informants and Community Dialogues*

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*Prepared for:*

State of California, Department of Health Care  
Services

*Made possible through support from The SCAN  
Foundation*

April 2010

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## Waiver Renewal Background

From time-to-time, the Medicaid federal-state partnership creates significant opportunities to step back, assess and improve the program. In this vein, California is currently seeking to renew its federal Medicaid waiver with the broad goals of enhancing Medi-Cal (California's Medicaid program) services for its more than seven million beneficiaries and improving access to care for additional low-income Californians. This comes at an extraordinary crossroad for all states as they deal with significant budget crises and the major new opportunities presented by national health care reform.

David Maxwell-Jolly, Director, California Department of Health Care Services (DHCS), introduced the waiver renewal process in August 2009 with this statement:

*“The DHCS’s current section 1115 Medicaid waiver entitled Medi-Cal Hospital/ Uninsured Care Demonstration (Waiver 11-W-00193/9), which restructured the state’s hospital financing system, expires on August 31, 2010. The state must submit to the federal Centers for Medicare & Medicaid Services (CMS) a concept paper on California’s proposal for its next 1115 waiver submission this fall to allow sufficient time to reach agreement with CMS on the terms of a renewal. These are the goals that have been guiding our work on the waiver:*

- (1) Strengthen California’s health care safety net, which includes disproportionate share hospitals, for low-income and vulnerable Californians.*
- (2) Maximize opportunities to reduce the number of uninsured individuals.*
- (3) Optimize opportunities to increase federal financial participation and maximize financial resources to address uncompensated care.*
- (4) Promote long-term, efficient, and effective use of state and local funds.*
- (5) Improve health care quality and outcomes.*
- (6) Promote home- and community-based care.*

*Recently Assembly Bill 6, Fourth Extraordinary Session (ABx4 6), was passed by the Legislature. This bill codifies these key goals and lays out the overall approach for the waiver in Article 5.4. Health Care Coordination, Improvement, and Long-Term Cost Containment Waiver or Demonstration Project, starting with Welfare and Institutions Code Section 14180. This bill sets out the framework for continued planning and consultation that is underway to construct California’s waiver. The key element of the waiver is establishing organized delivery systems that ensure better coordination of care. ABx4 6 authorizes the development of new care coordination approaches to assist seniors, persons with disabilities, and children with special health care needs so that they have access to effective health care. There are a variety of models we could advance to establish organized delivery systems that improve the overall delivery of care.”*

Over the past several months, the DHCS has engaged stakeholders to gain their insights regarding opportunities for reform inherent in the waiver renewal process. For the 1.1 million seniors and persons with disabilities (SPD) who are eligible for both Medicare and Medi-Cal (“dual eligibles”), the fragmentation of the current system can pose enormous challenges. California is geographically and demographically diverse, resulting in considerable variation in how care is delivered and the resources that are available for beneficiaries. Keeping that in mind, other states are developing different approaches for integrating Medicare and Medicaid services and financing, which may provide valuable insights for California. It is worth noting that California covers 13 percent of the nation’s total dual eligible beneficiaries.

With support from The SCAN Foundation (TSF) and in collaboration with DHCS, the Center for Health Care Strategies (CHCS) developed the *Options for Integrating Care for Dual Eligible Beneficiaries*.<sup>1</sup> This document describes four broad policy options for integration as well as the core elements necessary for successful implementation. The document was presented and discussed at a webinar on March 30, 2010, kicking off a stakeholder input process supported by TSF that focuses on the needs of duals. The remainder of this document describes the stakeholder engagement process and summarizes key themes gathered from the stakeholder community.

## Collecting Stakeholder Input

Two processes were used for collecting input from stakeholders. First, CHCS conducted a series of interviews in Sacramento. Interviewees encompassed a broad range of stakeholders, including: consumer advocates, health plans, union officials, and representatives of medical, mental health, and long-term care providers. (See Appendix A for participant list.) The following statement established the starting place for each interview: “As the Department of Health Care Services (DHCS) seeks to establish more integrated and accountable systems of care for its dually eligible beneficiaries, the ultimate goal should be clear: to provide beneficiaries with the right care at the right time in the right places.” (See Appendix B for interview guide.)

To augment the interviews, two community dialogue meetings were also conducted — one in Sacramento and the other in Irvine. These meetings included consumer advocates, providers, health plans, county government officials, state administration representatives, legislative staff, and other interested stakeholders. The meetings started with an abbreviated presentation of the four options and key themes from the stakeholder interviews; however, the meetings were designed to generate an open discussion on a broad range of topics related to caring for dual eligible beneficiaries, including the options for integration. Both the interviews and the community dialogues emphasized that by improving the quality of care, efficiencies may be achieved that could lead to cost savings in the long-term. However, cost-savings is not the driver in integrating care for duals — rather, it is the state’s commitment to establishing more organized and coordinated systems for caring for this population.

Although the stakeholder interviews and community dialogues were not designed to achieve consensus and opinions were quite varied, certain themes emerged with which there was wide agreement. The themes fell into the following general categories: (1) strengths of the current system, including essential providers for duals; (2) weaknesses of the current system; (3) core elements of the ideal system; and (4) the infrastructure required to address the needs of patients and providers. Several interviewees also responded specifically to the model options for integrating Medicare and Medicaid services. In the description below, both general themes reflecting opinions held in common by many stakeholders, and, where indicated, minority views or solo opinions are included.

## Strengths of the Current System

In creating a new program for duals, many stakeholders recommended that DHCS build on the variations in the current system, thereby leveraging the strengths that exist across the regions and among rural and urban counties. This includes county organized health systems (COHS) and two-plan counties, as well as the public safety net entities from which they draw much of their strength. These and other private entities may be willing to adapt or partner to create new structures of care delivery. Stakeholders mentioned several strengths of the current infrastructure that could serve as building blocks:

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<sup>1</sup> To download a copy of *Options for Integrating Care for Dual Eligible Beneficiaries*, visit [http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=1186550](http://www.chcs.org/publications3960/publications_show.htm?doc_id=1186550).

- **Long-Term Supports and Services (LTSS).** Key programs include, but are not limited to, the Multipurpose Senior Services Program (MSSP); In-Home Supportive Services Program (IHSS); and Adult Day Health Care (ADHC). These programs serve several thousand duals, embody important care practices (e.g., low client to care manager ratio; care delivery based on a client-centered care plan; etc.), and are locally-based.
- **Public Safety Net.** California’s safety net organizations (e.g., hospitals, clinics, etc.) already provide care for large segments of the duals population.
- **Managed Care.** Several plans (e.g., COHS) currently provide care for duals on a regional basis, two of which are working toward including the full range of LTSS in their rates. In addition, some are Medicare Advantage Special Need Plans (SNPs).
- **Integrated Programs.** These programs offer comprehensive Medicaid and Medicare services to duals. The two most prominent examples are the Program of All-Inclusive Care for the Elderly (PACE) and an integrated program operated by SCAN Health Plan, which started as a social HMO demonstration.

## Weaknesses of the Current System

As in most states, care for duals in California is highly fragmented. Today, no one person or entity is accountable for making sure that dually eligible beneficiaries get the care they need, including both medical and non-medical services. LTSS operate largely in isolation, the exception being those local areas in which individual care managers have developed relationships to bridge the silos. LTSS are also disconnected from medical providers and health plans in many counties. In addition to the fragmentation of the system, access to mental health services is an issue in most counties. Access is also problematic for other outpatient services, such as geriatric primary and specialty care. The issue of the complex rules for covering needed services for duals came up many times. In one of the meetings, a provider of LTSS described the “nightmare” that occurs when a dually eligible beneficiary has care paid for by separate health plans for Medi-Cal, Medicare, and prescription drugs.

## Core Elements of Integrated Programs

Stakeholders were invited to comment on a set of core elements critical to a delivery system that provides integrated care for duals. The bolded items below represent additions or enhancements suggested by stakeholders.

- **Comprehensive assessment to determine needs, including screening for cognitive impairment/dementia;**
- Personalized (**person-centered**) plan of care, including a flexible range of benefits;
- Multidisciplinary care team **that puts the individual beneficiary at the center;**
- **Involvement of the family caregiver, including an assessment of needs and competency;**
- Comprehensive provider network, including strong primary care base;
- Strong home- and community-based service options, including personal care services;
- Adequate consumer protections, **including ombudsperson;**
- Robust data-sharing and communications system; and
- Aligned financial incentives.

## Building an Infrastructure that Addresses the Needs of Consumers and Providers

At the outset, many stakeholders agreed that the goal of an integrated system should be a single accountable entity responsible for each dual eligible beneficiary. Any contracted organization would be held to standards for quality of care and service, and outcomes would be measured against those standards. In addition to the need for accountability, near-consensus was achieved on two themes: flexibility and choice need to be built into any integrated care system for duals. An important way to support those objectives is to assure the ongoing involvement of consumers and advocates in the design and planning of the new system.

Performance measurement and the need to design measures that reflect the needs of seniors and persons with disability (e.g., fall prevention; medication management; skin breakdown, etc.), was an important area of discussion. The field needs development of more appropriate performance measures; traditional HEDIS measures focus almost exclusively on the younger, healthier Medi-Cal population. The work that has been undertaken in the Technical Workgroup for Seniors and Persons with Disabilities has laid the groundwork for that effort, but the paucity of national measures (from HEDIS/NCQA or elsewhere) relevant to LTSS is a broader challenge deserving the attention of policymakers.

In the absence of national LTSS performance measures, many stakeholders said that California needs a single accountable entity to set statewide standards for delegated entities (both organizations and individual providers). This view was expressed by representatives of plans, providers, and consumer advocacy organizations alike. There was variation among the stakeholders about which standards would be most important. For example, some requested overall network standards that would define the range of providers that must be available to duals, from physician specialties to behavioral health and LTSS. These could be tied to access standards that are typically in place in managed care systems, e.g., wait times for appointments or distance standards for providers. Others felt that specific standards for provider training and qualifications should be in place for any provider who serves duals, e.g., training standards that cover personal care attendants. One stakeholder suggested that incentive payments could be built on achieving such standards once they are in place, so that providers or plans could be rewarded for timely access to services and the delivery of preventive care and services.

Again and again, stakeholders brought up the need to put the individual beneficiary's needs at the center of assessment, care planning, and service delivery. One stakeholder asked for a system that created "one house" that the beneficiary would go to, with the assessment serving as the "door" to all needed services. A number of stakeholders cautioned that a system that has a robust assessment process is not sufficient without an adequate set of medical and non-medical home- and community-based services (HCBS) to which to refer beneficiaries. Several stakeholders expressed similar support for a single point of entry to all services for duals. Care management in the ideal system would be delivered close to the individual, i.e., locally-based, where the care manager knows the local resources that are available. One provider was especially drawn to a model in which a single entity would know all the available services (acute, outpatient, and LTSS) and could authorize the full range of benefits.

In designing a flexible package of benefits, another theme that emerged was the perceived imbalance of the current system in favor of acute care (medical) needs over LTSS (non-medical) needs. It was recognized that HCBS and social supports can help beneficiaries avoid institutional care, and there were many stakeholders who expressed concern about threats to these services in the current budget crisis. Even so, one stakeholder interviewee mentioned that the current rules can promote over-utilization.

Another topic raised by many stakeholders was that integration presents an opportunity to achieve system efficiencies through streamlining care processes and sharing data on services delivered. Examples of these opportunities include:

- Management of care transitions between institutional and community settings, such as hospital and home, hospital and nursing facility, nursing facility and home. Transitional care is above and beyond traditional discharge planning, in that these models typically provide continuity of care management oversight over a 60-day period post-discharge.
- Medication management, with special attention to drug-drug interactions and drugs to be avoided among the elderly. A few stakeholders mentioned that a pharmacist should be part of the multidisciplinary team in order to provide oversight of the typically complex medication regimen for duals.

Finally, representatives of the COHS and other health plans, which have wrestled with the complex sets of regulations that govern the care of duals, requested that the integrated system tackle the important work of streamlining CMS and Medi-Cal regulations. These stakeholders mentioned the challenge of trying to comply with sometimes conflicting or duplicative rules for appeals and grievances, HEDIS reporting and auditing, and performance improvement or quality improvement projects.

## Comments on Model Options

While the interviews and meetings avoided focusing on the specific model options,<sup>2</sup> comments were welcomed on how the DHCS should frame its thinking. On this topic, there were again some common themes; the one stated most often was that, in considering model options, a “one size fits all approach” will not work. There were also many differing opinions. For example, there was considerable divergence regarding the locus of accountability for integrating care — whether it should be the state, county, health plan, or health system. Stakeholder opinion also diverged with regard to preferences for contracting only with public safety net entities or with both those public sector organizations and private entities that have demonstrated their commitment to this population. Taking responsibility for Medicare funds is obviously a daunting proposition and stakeholders would need to be assured that there was sufficient capacity and infrastructure to do so, at whichever level became responsible.

The current fiscal conditions at the state and county government levels were repeatedly mentioned as cause for considerable concern. Stakeholders would need assurances that: (1) the legislature would not divert any savings to plug the gaps in the general state budget; and (2) the capacity exists to plan and implement such a complex new program. Several interviewees noted that state staff have been reduced through lay-offs and furloughs, and that additional expertise would be needed in areas such as rate-setting and program administration. Providers expressed concern that technical glitches and/or delays in payment could put them at financial risk.

Several of those who commented on the option of the state serving as the integrating entity were intrigued by the possibility of creating an independent, quasi-governmental authority. Stakeholders acknowledged that this potential solution would accomplish dual objectives of trying to guard against diverting Medicare funding to offset budget shortfalls and keeping savings within the system of care for duals.

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<sup>2</sup> The four options described in the earlier referenced *Options for Integrating Care for Dual Eligible Beneficiaries* are: Special Need Plans (SNPs); Program for All-Inclusive Care for the Elderly (PACE); Shared Savings Models; and States as Integrated Care Entities.

Regarding the other models, no consensus emerged. Many stakeholders did not view the SNP model as the best alternative, due to concerns about volatility in the Medicare Advantage (MA) market, mostly related to the prospect of reductions in MA rates. However, some health plans expressed the opinion that adding Medi-Cal funding to the mix could provide some stability, and that duals might be attracted to health plan enrollment if the plans can offer services that are being cut elsewhere in the Medi-Cal program.

Several stakeholders expressed their belief in the importance of keeping counties in the center of planning for this new system. Some suggested that the larger counties be offered the option to serve as the integrating entity, even going so far as being the direct recipients of Medicare funds. On the other hand, many stakeholders expressed the same concern about counties' current budget situations, and the possibility that any savings achieved would be diverted to plug other holes in their budgets. Counties may need a shared-savings model with protections similar to those that would be necessary at the state level to address reinvesting savings in services for duals.

A few stakeholders suggested that the two-plan model in many counties offers the best choice on an individual consumer level, and hoped that option could be expanded to serve duals in additional counties. In rural areas, some felt an administrative services organization (ASO) model might achieve this goal of consumer choice, and it could serve as the care management entity that links primary care and other acute medical services to LTSS. In short, many stakeholders supported approaches that would build on and leverage diverse state and local assets through piloting and demonstrations. Thus, many different models could be implemented that recognize the diversity of the different regions of California.

There was consensus that no matter which model or models are adopted, clear rules and roles should be established. Under any of these options, two key roles for DHCS were suggested by many stakeholders:

- DHCS should conduct readiness reviews of any contracted/delegated entities prior to enrolling beneficiaries. The readiness reviews would encompass the standards described above for provider training and network adequacy, and coordination with behavioral health and HCBS. In addition, contractors would have to show their readiness to implement the core elements described above.
- A second role brought up by a few providers/plans was rate-setting, especially for rarely needed services and for acute hospital services. This was seen by many as helping to move the discussion between plans/COHS and providers to a needed focus on quality of care and access to services for duals, rather than arguing over rates.

## **Additional Suggestions for DHCS Consideration**

Many stakeholders offered additional suggestions to help the state prepare for the transition to the new system of integrated care. These represent diverse opinions, not uniformly shared, but they are included here to show the wide range of stakeholder opinion on enabling beneficiaries to navigate the complex world of Medicare and Medi-Cal.

### ***Lessons from pilots and other models:***

- Examine the lessons offered by other transitions, such as Medicare Part D. For example, one stakeholder felt that Part D implementation would have been less disruptive with a more gradual transition.
- Learn from counties that have successfully managed to coordinate services through the use of liaisons, which do a good job of problem-solving for consumers.

- Look to other care coordination models in the state, e.g., within Departments of Rehabilitation and Education.
- Start small and slow using demonstrations and pilots, and ensure any lessons from the pilots are incorporated in the design of any new models.

#### ***Workforce issues:***

- Ensure that the workforce needed for the future is built into the model, including an increasing supply of providers with expertise in geriatrics.
- Create new opportunities for qualified non-licensed providers of personal care services to provide health education and coaching as needed.

#### ***Support for new models:***

- Bring in the range of stakeholders to be affected, especially if there will be any “losers” in the new model.
- Prepare people carefully for the transition. Tell them what the new system will look like and help them adapt to it before it is put in place.
- Build a strong “medical home” or “care home” model that seniors will be reluctant to leave because it provides them higher quality and access to services.

#### ***Infrastructure and financing issues:***

- Recognize that data-sharing and communication among providers are essential. Create an integrated data system by adding HCBS to the existing data warehouse. In addition, real-time data exchange is needed for communication across HCBS, mental health and medical providers.
- Create transparent provider-access policies within health plans that enable beneficiaries to go outside the network for subspecialty care as needed.
- Consider bundled payment at the provider level as a strategy to achieve efficiency.
- Set rates for managed care that are adjusted for the acuity of beneficiaries and create incentives for keeping beneficiaries in the community.
- Require plans to reinvest savings in the program, particularly to build home- and community-based supports for duals.
- Recognize the challenges rural areas face and the need to develop an infrastructure that can work in rural parts of the state (e.g., enhanced primary care case management or ASO model).

#### ***Eligibility issues:***

- Consider options for addressing needs of the “pre-dual” population, including those individuals who are not yet eligible for Medi-Cal and have significant share-of-cost; these individuals often experience difficulty accessing the necessary services and supports.

#### ***Efficiencies inherent in integration:***

- Focus on preventing expensive service use in the future as well as on those who are expensive now. This could include transition planning for people who are in Medicare nursing facilities who are not yet qualified for Medicaid.
- Rely on the rule, or set of rules, (Medicare or Medicaid) that make the most sense when there is a rule conflict. As an example, Durable Medical Equipment (DME) rules under Medi-Cal for SPDs, which allow equipment to support community living, are more logical than Medicare rules, which have much more strict conditions for approval.
- Emphasize the reduction of fragmentation and duplication by having as few carve-outs as possible, which could improve quality and result in savings.

In closing, a stakeholder attending one of the Community Dialogue meetings may have said it best when he observed that “everything will never be totally aligned in California” (i.e., *the perfect is the enemy of the good*), so it makes tremendous sense to take advantage of the momentum created by the 1115 waiver renewal opportunity and the national momentum around health care reform to create a better system for duals. Without a coordinated system, beneficiaries will continue to get the wrong services at the wrong time, at great cost to them personally in terms of quality of care and quality of life, as well as to the publicly financed health care system as a whole.

## Appendix A: Stakeholder Interviews – Participant List

This list includes key contacts from organizations that participated in the stakeholder interview process. Two additional interviews are pending.

### **AARP**

Lynda Flowers  
Strategic Policy Advisor

Casey Young  
Senior Legislative Representative

### **AltaMed Health Services**

Jennifer Spalding  
Vice President, Senior Care Operations

### **Alzheimer’s Association**

Katie Maslow  
Policy Development Director

Jackie McGrath  
State Public Policy Director

### **California Congress for Seniors**

Gary Passmore  
Executive Assistant to the State President

### **California Association of Adult Day Services**

Lydia Missaelides  
Executive Director

### **California Association of Physician Groups**

Sarah Takahama  
Government Affairs Director

### **Disability Rights California**

Marilyn Holle  
Senior Attorney

### **Harbage Consulting LLC**

Peter Harbage  
Consultant

### **Health Plan of San Mateo**

Maya Altman  
Executive Director

### **HealthCare Partners**

Stuart Levine, MD  
Corporate Medical Director

Robert Margolis, MD  
Chairman and CEO

### **Molina Healthcare of California**

April Alexander  
Regional Director of State Affairs

Richard Bock, MD  
Chief Medical Officer

### **SCAN Health Plan**

Denise Likar  
Director of Programs, Independence at Home

Timothy Schwab, MD  
Chief Medical Officer

### **SEIU Healthcare**

David Kieffer  
Director, Strategic Initiatives

### **SynerMed**

Peter Winston  
Executive Vice President

### **UC Davis Care Management**

Janet Heath  
Director

### **UnitedHealth Group**

Catherine Anderson  
Vice President, Business Development,  
Americhoice/United

Ken Anderson  
Vice President, Business Development,  
OptumHealth/United

Joy Higa  
Vice President, Government Affairs

### **Yolo Adult Day Health Center**

Dawn Myers Purkey  
Program Manager

## Appendix B: Stakeholder Interview Guide

As the Department of Health Care Services (DHCS) seeks to establish more integrated and accountable systems of care for its dually eligible beneficiaries, an important starting point is to talk with stakeholders about the main goals and key elements of integration. The ultimate goal should be clear: to provide beneficiaries with the right care at the right time in the right places.

### *General questions about concept and core elements:*

- How do you think the current system is working? What features should be preserved? What features should be changed?
- Integrated care models arrange for all Medicaid and Medicare services (including long-term supports and services). In general, what are your thoughts about integrated programs?
  - » Do you have experience with or knowledge of any successful programs that offer integrated services for duals? (If so, please describe.)
  - » Core elements of integrated programs are listed below. Have we left off any elements that you think are critical to a successful program for dual eligible beneficiaries?
    - Strong primary care base
    - Multidisciplinary care team that puts the individual at the center
    - Personalized plan of care, including a flexible range of benefits
    - Comprehensive provider network
    - Strong home and community based service options, including personal care services
    - Adequate consumer protections
    - Robust data-sharing and communications system
    - Aligned financial incentives
  - » What are the most critical issues the state should be mindful of in implementing an integrated care delivery system?

### *Provider role:*

*(Note please think of providers in the broadest sense: e.g., care managers, home care workers, physicians, hospitals, etc. and specify if your responses vary.)*

- Which providers should be included in the integrated care system networks, considering the characteristics of beneficiaries to be enrolled: seniors, persons with complex physical health conditions, persons with serious mental illness, persons with developmental disabilities, etc.? Which essential providers need to be involved in the design and implementation of an integrated program for duals?
- Which are the critical HCBS services, and what would be the best methods to integrate HCBS care and financing?
- What types of contract requirements/incentive agreements should be in place?
- What kind of infrastructure supports for providers (i.e., training, IT, additional staffing) would be needed to facilitate implementation?

- What education will be necessary to bring providers up to speed on this approach, and how should it be offered?
- What role should providers play in educating beneficiaries (and vice versa) about integrated care and beneficiary options?
- DHCS considers the medical care home to be an essential component of care delivery for seniors and persons with disabilities. This means ensuring that every beneficiary has an assigned primary care provider (PCP) or clinic. What is the appropriate role for a PCP in the integrated care system for duals? Who should be able to serve in this role?

***Enrollee supports:***

- DHCS proposes that certain essential supports be provided to all SPD beneficiaries, such as care management/coordination and telephonic assistance for enrollment, medical advice, and program information. How should the special needs of dual eligible seniors and persons with disabilities be taken into account in the development of such supports?
- How would DHCS best go about ensuring that dual eligible beneficiaries are well informed about the option of integrated services?
- What special concerns would you have for dual eligible beneficiaries whose primary language is other than English, have mental illness, are non-ambulatory, or may be homeless, etc.?
- How would essential carved-out services best fit into this effort (e.g., mental health and substance abuse services)?

***Options for integration:***

- Options for integration can be grouped into four broad categories: Special Needs Plans (SNPs); Program for All-Inclusive Care for the Elderly (PACE); Shared Savings Models; and States as Integrated Care Entities. (If interested in additional details prior to interview, please see “Options for Integrating Care for Dual Eligible Beneficiaries” at [www.chcs.org](http://www.chcs.org)). Do you have any comments about any of the particular options?