

## **Persons with Dual Medi-Cal and Medicare Eligibility**

### ***Background and Problem Statement***

The combination of poor health status and low incomes makes dual eligibles highly dependent on the two public programs for the care they need. Nationally, in 2005, dual eligibles accounted for an estimated \$215 billion in federal and state spending. This represents almost 25 percent of total Medicare spending and 46 percent of Medicaid spending. Dual spending in California is also substantial. Medi-Cal spending on its 1.1 million dual eligibles was \$7.6 billion in California Fiscal Year 2007-08, representing 23 percent of total Medi-Cal expenditures. In 2007, Medi-Cal spending on Long Term Care (LTC) for duals was \$3.2 billion, representing 75 percent of total Medi-Cal LTC expenditures. It is estimated that in 2007, total expenditures for dual eligible beneficiaries in California, for both Medicare and Medi-Cal spending, was \$20.9 billion.

Dual eligible beneficiaries are the most chronically ill patients within both Medicare and Medicaid, requiring a complex array of services from multiple providers. Despite the complexity of their needs, the vast majority of dual eligibles remain in the fragmented Fee-for-Service (FFS) system. While managed care plans provide a coordinated system of care for a number of Medi-Cal beneficiaries, only 174,000 of California's 1.1 million dual eligibles are in managed care plans, leaving over 80 percent in fragmented FFS. There is a critical need for new organized systems of care, including flexible payment systems, which allow for more tailored and supportive benefit packages. Furthermore, considering the state and federal government are investing almost \$21 billion annually on dual eligibles, there is also an opportunity to achieve significant federal and state savings through better coordination of benefits and elimination of the incentives to cost shift between Medicare and Medicaid.

As noted at the beginning of this paper, an essential element of California's overall strategy is to move the highest-need, most vulnerable populations into organized, cost effective systems of care; one such population is the group of individuals dually eligible for Medicaid and Medicare. In addition to improving care for over 1 million duals, the implementation strategies outlined below will lead to broader system reform by enhancing Medi-Cal's ability to drive other payers in the same direction on payment reform and delivery system redesign. Implementation of organized systems of care will

also reduce the long-term rate of growth of Medicare and Medicaid expenditures for this population.

### ***Implementation Objectives and Options***

California seeks to develop an integrated care model option for duals that:

- creates one point of accountability for the delivery, coordination, and management of health care and long-term supports and services;
- promotes and measures improvements in health outcomes;
- maintains appropriate consumer involvement and safeguards;
- uses performance incentives to providers to improve coordination of care;
- promotes the use of home and community based long term care services;
- blends and aligns Medicare and Medicaid's services and financing to streamline care and, through shared savings approaches, eliminates cost shifting;
- slows the rate of both Medicare and Medicaid cost growth.

California is considering a range of approaches for developing such a model: contract with Special Needs Plans; expand PACE sites; enter into shared savings arrangements; or request authority to act as an integrated care entity. The state proposes to develop an approach that would provide the ability to capitalize on its existing and emerging delivery system infrastructure in various regions of the state.

### ***Common Model Components***

Integrating Medicare and Medicaid services can help ensure that dual eligible beneficiaries receive the right care in the right setting, rather than receiving care driven by conflicting state and federal rules, siloed funding streams (including Medi-Cal carve outs of home and community based services such as In Home Supportive Services), and the FFS system's inherent incentives for over-provision of services and cost shifting. The core components of an integrated model must include:

- strong patient-centered care based in accountable primary care homes;

- multi-disciplinary care teams that coordinate the full range of medical, behavioral and supportive service needs;
- comprehensive provider network capable of meeting that full range of needs;
- robust data sharing and information systems to promote just-in-time care coordination;
- strong home and community based service (HCBS) options, including personal care services, that are better integrated into the organized delivery model;
- greater flexibility for providers to integrate behavioral health services through a single integrated funding stream;
- strong consumer protections that assure access to longstanding providers and involve consumers in program design;
- financial alignment that impels integration of care.

These types of integrated systems of care provide the following benefits for dual eligibles:

- One set of comprehensive benefits: primary, acute, behavioral, prescription drug, and long-term care supports and services (vs. three different sets of benefits);
- Single administrative elements – ID card, Evidence of Benefits, Provider Directory, etc. (vs. separate materials for Medicaid, Medicare services, Rx);
- Single and coordinated care team/care home (vs. multiple providers with few incentives or pathways to communicate);
- Health care decisions based on the patient's needs and preferences (vs. health care decisions uncoordinated and not made from the patient centered perspective);
- Availability of flexible, non-medical benefits – from savings generated by greater integration - that help individuals stay in the community (vs. absence of these opportunities);
- A rebalancing of care with greater emphasis on HCBS and care in the community (vs. heavier reliance on both acute and long term care institutional settings).

By incorporating the components listed above, California can create an integrated system of coordinated care for those receiving publicly financed care who need it the most. Medi-Cal is both positioned and prepared to:

(1) establish the proper beneficiary safeguards and quality/performance standards; and (2) fulfill its obligation as administrator of the integrated system to actively monitor and enforce them.

### ***Project Timeline***

The State is in the process of evaluating a spectrum of options that improve the integration of services to this highly vulnerable population while reducing overall costs and providing care across the complete medical and social services spectrum. Based on the goals described above, a set of options will be developed for further evaluation, refinement, and selection:

- Testing implementation of dual integration proposal in the context of County Organized Health Systems to take advantage of opportunities presented by these entities that operate both Medi-Cal managed care plans and Medicare special needs plans.
- Continued consultation with stakeholders and CMS regarding how to develop an integrated funding approach;
- Additional discussions with stakeholders on the considerations required to implement the proposed options;
- Development of a strategy for expanding beyond the initial sites

### ***Framework for Evaluation***

DHCS will seek support for an evaluation of the initial two county proposals by assessing outcomes for enrollees compared to similar beneficiaries enrolled in plans in other counties. Additional evaluation efforts will depend on the nature and scope of the models tested and will be developed in conjunction with the design and implementation of those models.