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A Primer on Dual-Eligible Californians:
How People Enrolled in Both Medicare and Medi-Cal Receive Their Care

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About the Authors

Justice in Aging is a national nonprofit organization that uses the power of law to fight senior poverty by securing equitable access to affordable health care and economic security for older adults with limited resources. Amber Christ, JD, and Georgia Burke, JD, are directing attorneys at Justice in Aging.

About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

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Introduction

California is home to nearly 20% of the country's older adults with low incomes and persons with disabilities who receive health care coverage from both Medicare and Medicaid. These 1.4 million Californians enrolled in Medicare and full-benefit Medi-Cal, California's Medicaid program, are known as dual-eligible enrollees.[1]

Restructuring administration of the delivery of health care benefits to this population is a priority for the Medi-Cal program. On average, dual-eligible enrollees constitute the highest-need, highest-cost segment of both the Medicare and Medi-Cal enrollee populations, with wide variation in need and cost within the population. Because these enrollees receive health care services through two programs, each with its own complex rules, accessing services and integrating care present unique challenges. Further, variations in program design, particularly on the Medi-Cal side, exist in different regions in California, complicating both delivery of services and state oversight functions. For enrollees, the result is that the systems they currently navigate and the options available to them depend largely on where they live and what services they need to access.

In 2019, California's Department of Health Care Services (DHCS) announced a Medi-Cal restructuring initiative, Advancing and Innovating Medi-Cal (CalAIM).[2] The initiative included proposals to develop program options that would integrate Medicare and Medi-Cal benefits available throughout the state, to mandate enrollment in Medi-Cal managed care for virtually all dual-eligible enrollees, and to realign a number of programs affecting the dual-eligible population.[3]

Because of the COVID-19 emergency, the CalAIM proposal has been put on hold for a minimum of 12 months.[4] COVID-19 has had a disproportionate and devastating impact on the dual-eligible population. Initial data show that dual-eligible enrollees, for example, are more than four times more likely to be diagnosed with and hospitalized for COVID-19 compared with Medicare-only enrollees.[5] When the state reexamines ways to reform how dual-eligible enrollees receive their care, learnings from the pandemic will be a critical element in that review.

This paper seeks to assist policymakers and stakeholders when the state revisits and reassesses the CalAIM proposal by providing a comprehensive overview of the characteristics of the dual-eligible enrollee population in California and the current structures for administration and delivery of services. The goal of the paper is to help stakeholders understand the complexities of service delivery for dual-eligible enrollees and to assess the impact of proposed changes on how enrollees can access care under both Medicare and Medi-Cal. The paper identifies transition challenges and areas of complexity and suggests measures to protect enrollees from interruptions in care during any change.

Specifically, the paper presents information on the current landscape of delivery of benefits for dual-eligible enrollees, including variations within the state. The following topics are discussed:

- **Characteristics of California's dual-eligible enrollees.** The paper reviews demographic and health data on California's dual-eligible population compared with enrollees who qualify only for the Medicare benefit, as well as data on dual-eligible enrollees' cost to both programs.

- **Current benefit delivery structures for dual-eligible enrollees.** The paper describes the different ways dual-eligible enrollee groups currently receive both Medicare and Medi-Cal services, including more granular data, where available, showing the numbers enrolled in various models. This section looks at the complex array of enrollment options for both Medicare and Medi-Cal that vary depending on which services the enrollee needs and where an enrollee resides. This section also identifies benefits available in Medi-Cal managed care and those that are carved out of the managed care model.

- **Policy and operational imperatives to reduce disruption to dual-eligible enrollees in transitions.** This discussion draws from the experience of the transition of dual-eligible enrollees in California's Coordinated Care Initiative to identify areas of particular importance for ensuring enrollee protection and access to care during transitions to new systems.

Characteristics of California's Dual-Eligible Enrollees

Demographics

In California, seven in 10 dual-eligible enrollees are age 65 and over, and nearly six in 10 are female (Figure 1).[6] Populations of color in California are disproportionately more likely to be dually eligible in comparison with the state's total Medicare population (Figure 2).[7] Factors contributing to the overrepresentation of women and people of color among dual-eligible enrollees include systemic racial and gender discrimination, which contribute to lower incomes and less access to health care and other services, and the economic burdens of women's longer life span.[8] Dual-eligible enrollees are also more likely to have limited English proficiency.[9]

Dual-Eligible Enrollees Defined

In this paper, dual-eligible enrollees are those individuals who qualify for both Medicare and full Medi-Cal benefits. (Some people qualify for Medicare and partial Medi-Cal benefits; they are not included in the data in this paper.) Accordingly, dual-eligible enrollees must be age 65 and over, or, if under age 65, have been receiving disability benefits for 24 months from the Social Security Administration. In order to qualify for Medi-Cal, dual-eligible enrollees also must have low incomes and limited assets. In California, those eligible for Medi-Cal must have assets below $2,000 and monthly income below 123% of the federal poverty level.[10] Some Medi-Cal programs have higher income limits, including, for example, Medi-Cal for long-term care and certain home and community-based waiver services.

Figure 1. Proportion of California Dual-Eligible Enrollees, by Demographic, 2012 (data released in 2019)

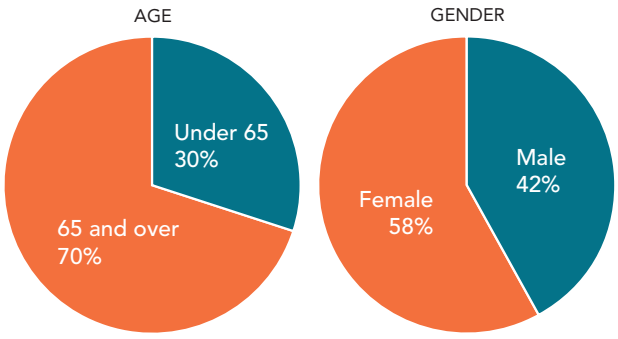
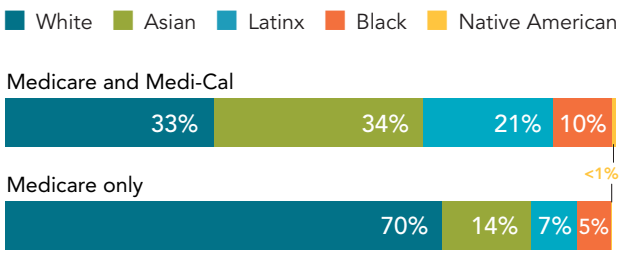


Figure 2. Coverage Type, California's Medicare Enrollees, by Race, 2012 (data released in 2019)



Notes: Data source uses *Non-Hispanic White, Asian or Pacific Islander, Hispanic, African American,* and *American Indian or Alaska Native.* Segments do not sum to 100% due to rounding and omission of *Other* (less than 2.5% in both categories).

FIGURES 1 AND 2:

Source: "PUF_2012" tab in *Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) Public Use File (PUF) Version 2.0 (2006–2012) (02/2019) (XLSX)*, Centers for Medicare & Medicaid Services (CMS), "MMCO Statistical & Analytic Reports."

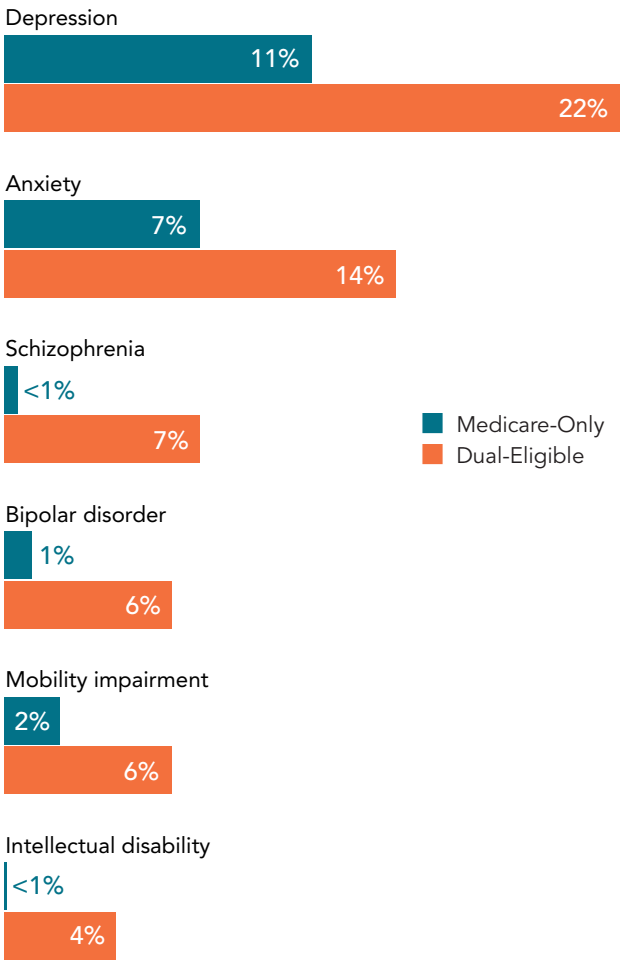
Health Status

Under most measures, compared with the general Medicare population, dual-eligible enrollees are in poorer health. For example, dual-eligible enrollees are nearly twice as likely to have three or more chronic conditions compared with Medicare-only enrollees (48% versus 27%).[11] Dual-eligible enrollees are also more likely to have a condition resulting in a functional limitation or disability, including, for example, mobility impairments, intellectual disabilities, depression, anxiety, bipolar disorder, and schizophrenia (Figure 3).[12]

COVID-19, as noted previously, has had a disproportionate impact on dual-eligible enrollees, particularly for certain subpopulations. Preliminary national Medicare data show that, compared with Medicare-only enrollees, people who are dually enrolled in Medicare and Medicaid are more than four times as likely to be diagnosed with and hospitalized for COVID-19.[13] Among dual-eligible enrollees, Black enrollees are nearly two times as likely and Latinx enrollees 1.5 times as likely as white enrollees to be hospitalized. (Source data uses the term *Hispanic*.)[14] COVID-19 diagnosis and hospitalizations increase with age. Dual-eligible enrollees age 85 and over, for example, are nearly four times more likely to be hospitalized than dual-eligible enrollees under age 65.[15]

California's dual-eligible enrollees are also more likely to have underlying health conditions making them more susceptible to COVID-19. National data show that 76% of COVID-19 decedents had an underlying health condition.[16] The most common conditions among COVID-19 decedents are cardiovascular disease, diabetes mellitus, chronic kidney disease, and chronic lung disease, all of which are more prevalent among dual-eligible enrollees compared with Medicare-only enrollees.[17] For example, 40% of dual-eligible enrollees in California are diagnosed with diabetes compared with 22% of Medicare-only enrollees, and 21% of dual-eligible enrollees have chronic kidney disease compared with 15% of Medicare-only

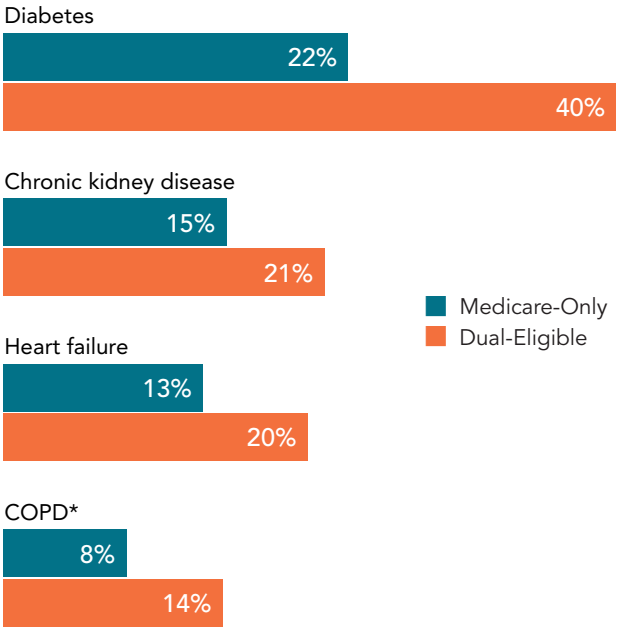
Figure 3. Conditions of California Medicare Enrollees, by Coverage Type, 2012 (data released in 2019)



Source: "PUF_2012" tab in *Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) Public Use File (PUF) Version 2.0 (2006–2012) (02/2019) (XLSX)*, CMS, "MMCO Statistical & Analytic Reports."

enrollees (Figure 4).[18] Twice as many dual-eligible enrollees in California use dialysis facilities compared with Medicare-only enrollees.[19] The kidney disease statistics for California's dual-eligible enrollees raise particular concerns because, nationally, dual-eligible enrollees with end-stage renal disease are 2.5 times more likely to be hospitalized for COVID-19 than Medicare-only enrollees with the disease.[20]

Figure 4. Underlying Conditions Connected to COVID-19 Risk Among California Medicare Enrollees, by Coverage Type, 2012 (data released in 2019)



*Chronic obstructive pulmonary disease.

Source: "PUF_2012" tab in *Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) Public Use File (PUF) Version 2.0 (2006–2012) (02/2019) (XLSX)*, CMS, "MMCO Statistical & Analytic Reports."

Financing and Spending

Financing and Oversight Responsibilities

Medicare is a federal program, and costs are borne entirely by the federal government. For Medi-Cal, federal matching funds cover more than half of the state's expenditures (exact matching percentages can vary depending on the Medi-Cal program involved). The Medicare program is administered and overseen by the Centers for Medicare & Medicaid Services (CMS). Medi-Cal is also overseen by CMS and administered in California through DHCS. DHCS delegates certain aspects of the program's operation to county entities. California's Department of Managed Health Care (DMHC) also provides oversight of managed care plans in the state, including Medicare plans and most Medi-Cal plans.[21]

In California, dual-eligible enrollees represent just 25% of all Medicare enrollees, but account for 39% of Medicare expenditures.

Payment and Spending

Medicare is the primary payer for most services for dual-eligible enrollees, including most hospital and medical services and prescription drugs. Medicare also pays for limited long-term services and supports (LTSS), including up to the first 100 days in a nursing facility and home health care when an individual is deemed home-bound (see Appendix A). In California, dual-eligible enrollees represent just 25% of all Medicare enrollees, but account for 39% of Medicare expenditures.[22]

Medi-Cal is the payer of last resort for dual-eligible enrollees and fills in gaps for services not covered by Medicare, the most costly of which are long-term services and supports, including longer stays in nursing facilities and home and community-based services.[23] Examples of other Medi-Cal services that Medicare does not cover include nonemergency transportation to medical services; certain durable medical equipment and supplies; some behavioral health services; and dental, hearing, and vision services. Medi-Cal also helps to pay for Medicare premiums and cost sharing so that dual-eligible enrollees generally have no responsibility for out-of-pocket costs for any Medicare or Medi-Cal covered benefit, with the exception of small copayments for some Medicare-covered drugs.

Dual-eligible enrollees make up just 11% of Medi-Cal enrollees but account for 32% of total Medi-Cal expenditures.

Dual-eligible enrollees make up just 11% of Medi-Cal enrollees but account for 32% of total Medi-Cal expenditures.[24] Medi-Cal spending is lower for enrollees whose eligibility for Medicare is based on age (65 and over) compared with those whose eligibility for Medicare is based on disability.[25] These data are consistent with the findings of national research looking at the highest-cost dual-eligible enrollees. Those studies have found that only 5% of dual-eligible enrollees account for persistently high costs and that persistently high spending is primarily for individuals with disabilities with significant long-term care needs.[26] While most cost containment efforts have historically focused on reducing hospitalizations and emergency department use, research on high-cost dual-eligible enrollees suggests that costs would better be controlled by more effectively coordinating care and utilizing strategies that help individuals live independently in the community with proper supports.[27]

How Dual-Eligible Enrollees Receive Their Benefits

While dual-eligible enrollees have fairly comprehensive coverage for health services, they often face barriers to receiving those services because their benefits are delivered through two different programs with different provider networks, standards of medical necessity, and means of delivering covered benefits.

Provider networks. Many Medicare providers (particularly physicians) who serve dual-eligible enrollees do not participate in Medi-Cal, and many providers of Medi-Cal services — such as home and community-based service providers, dentists, mental health professionals, and others — do not participate in Medicare. Having different providers operating in and paid by two different, complex insurance programs contributes to lack of coordination between providers and services, creating barriers for enrollees to access care.

Standards. The two programs also have different rules and standards of medical necessity, so issues can arise when both programs cover a service but coverage criteria differ. For example, Medicare coverage of wheelchairs and other durable medical equipment is limited to what is needed for functioning in the home, while Medi-Cal will also consider whether an item is needed so an individual can function in the community. A dual-eligible enrollee needs to navigate both sets of criteria, first trying Medicare before seeking Medi-Cal coverage, because Medicare is primary and Medi-Cal is the payer of last resort.[28]

Similarly, the intersection between the Medicare home health benefit and Medi-Cal's home and community-based services, which are meant to wrap around Medicare coverage, also can be particularly challenging, because qualifying criteria for program services differ both between Medicare and Medi-Cal and also among different Medi-Cal program options.

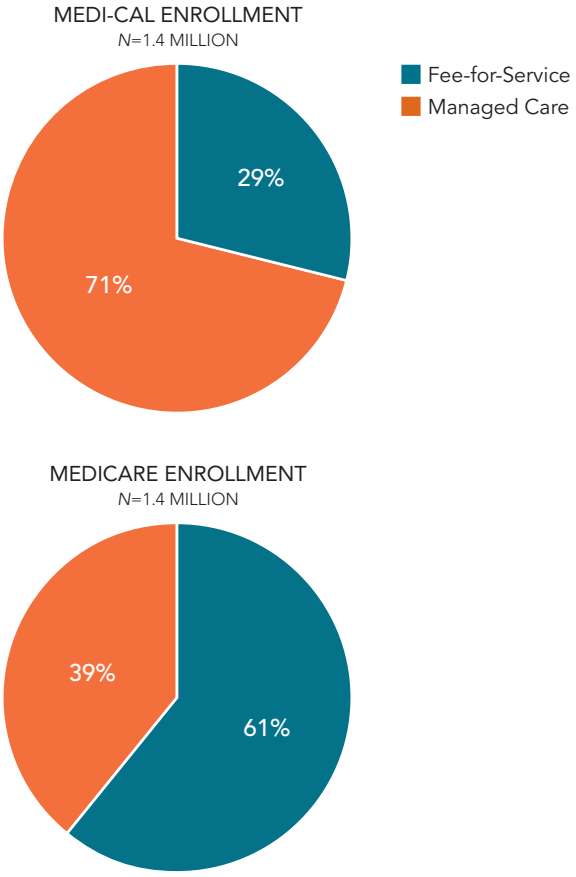
Delivery of benefits. Compounding this complexity is the fact that dual-eligible enrollees receive their Medicare and Medi-Cal benefits in different ways depending on where they live, what services they are receiving, and their own enrollment choices. In both Medicare and Medi-Cal, there are two basic models: fee-for-service and managed care health plans. Currently, an estimated 60% of California's dual-eligible enrollees receive their Medicare benefits through fee-for-service Medicare, but 71% receive their Medi-Cal benefits through managed care health plans (Figure 5).

Medi-Cal Models for Administering Benefits

California has been transitioning the Medi-Cal program from fee-for-service to managed care over the past 40 years. California was the first state to enter into contracts with health plans to deliver the Medicaid benefit in the early 1970s,[29] and California is now predominantly a managed care state: As of September 2019, 82% of California's 12.4 million Medi-Cal recipients[30] and an estimated 71% of dual-eligible enrollees were enrolled in managed care plans responsible for delivering the bulk of their Medi-Cal benefits (see Figure 5).[31]

For dual-eligible enrollees, a significant driver for transitioning to Medi-Cal managed care came in 2014 with the launch of the Coordinated Care Initiative (CCI) in seven of the state's most populous counties: Los Angeles, Orange, San Diego, San Mateo, Riverside, San Bernardino, and Santa Clara Counties. In those counties, with limited exceptions, Medi-Cal managed care enrollment became mandatory for dual-eligible enrollees.

Figure 5. Fee-for-Service and Managed Care Enrollment Among Dual-Eligible Californians, by Coverage Type, 2020 Estimates



Sources: California Health and Human Services (CHHS) Open Data Portal, "Month of Eligibility, Dual Status, by County, Medi-Cal Certified Eligibility" (June 2020 data); CHHS Open Data Portal, "Medi-Cal Managed Care Enrollment Report" (May 2020 data); CMS, *Special Needs Plan Comprehensive Report* (June 2020) (n.d.); and Integrated Care Resource Center, *Program of All-Inclusive Care for the Elderly (PACE) Total Enrollment by State and by Organization* (June 2020 data).

The Coordinated Care Initiative

In 2014, California implemented the Coordinated Care Initiative (CCI) to better integrate and coordinate health benefits (including behavioral health benefits) and long-term services and supports (LTSS) to dual-eligible enrollees and other seniors and persons with disabilities living in seven California counties:[32]

- Los Angeles
- Orange
- Riverside
- San Bernardino
- San Diego
- San Mateo
- Santa Clara

The CCI features three core aspects:

Mandatory enrollment in Medi-Cal managed care. When California began mandatory enrollment of many Medi-Cal enrollees into managed care in 2011, certain populations were excluded from mandatory enrollment, including enrollees living in nursing facilities, those responsible for paying a portion of their Medi-Cal costs, and dual-eligible enrollees. The CCI expanded mandatory enrollment into Medi-Cal managed care by requiring those previously excluded groups living in the seven CCI counties to enroll in a managed care plan to receive Medi-Cal benefits.

Long-term services and supports integration. Long-term services and supports (LTSS) historically have not been included in the Medi-Cal managed care benefit package, with the exception of Community-Based Adult Services (CBAS) and the nursing facility benefit in County Organized Health System (COHS) counties. Under the CCI, Medi-Cal managed care plans in CCI counties became responsible or partly responsible for financing or coordinating nursing facility care, In-Home Supportive Services (IHSS), and the Multipurpose Senior Services Program (MSSP). As a practical matter, however, LTSS integration has largely remained the same as it was prior to the CCI. IHSS integration was ended in 2017, and to date only one health plan has fully integrated MSSP. Only institutional long-term care has become a newly integrated LTSS benefit in all CCI counties. (For a more detailed description of LTSS programs, see Appendix A.)

Cal MediConnect. The CCI created a new type of managed care program in the seven CCI counties, known as Cal MediConnect, which combines a dual-eligible enrollee's Medi-Cal and Medicare benefits into one integrated managed care plan. Cal MediConnect was initially a three-year demonstration program, which the state subsequently opted to extend through December 2022.[33] Dual-eligible enrollees in the seven CCI counties have the option to enroll in a Cal MediConnect plan. For more information on Cal MediConnect, see the section on integrated delivery models on page 14.

Medi-Cal Delivery Models: Managed Care and Fee-for-Service

Dual-eligible enrollees receive their Medi-Cal benefits through fee-for-service Medi-Cal or through a managed care plan. California has six managed care models operating in different counties: County Organized Health System (COHS); Geographic Managed Care; Regional Model; Two-Plan Model; San Benito Model; and Imperial Model.[34] Enrollment of dual-eligible enrollees in Medi-Cal plans differs among these managed care models. Figure 6 describes the six models of managed care in California.

Dual-eligible enrollees are *required* to enroll in a Medi-Cal plan in all 22 COHS counties and in the seven CCI counties (two of which — Orange and San Mateo Counties — are also COHS counties). As of June 2020, 1,011,086 dual-eligible enrollees reside in the 27 counties in which Medi-Cal enrollment is mandatory.[35]

In the remaining 31 counties, most dual-eligible enrollees have the *option* to enroll in a Medi-Cal plan. The approximately 410,000 enrollees who reside in these counties largely continue to receive their Medi-Cal through fee-for-service.[36] (See Appendix B: Table B1 provides dual-eligible enrollee residence by county as of June 2020; Table B2 provides enrollment by Medi-Cal plan and county as of 2017; and Table B3 provides enrollment by Medi-Cal plan parent company as of 2017.)

Figure 6. Medi-Cal Managed Care Models in California

- **County Organized Health System**
  The Medi-Cal plan is operated by the county and there is only one plan serving the entire Medi-Cal population.
- **Geographic Managed Care**
  The state contracts with multiple plans.
- **Two-Plan**
  The state contracts with one county-organized plan, called a local initiative plan, and with one commercial plan.
- **Regional**
  For these rural counties, the state contracts with two commercial plans serving two or more contiguous counties.
- **Imperial**
  In Imperial County, the state contracts with two commercial plans.
- **San Benito**
  In San Benito County, the state contracts with one commercial plan.

Note: *CCI* is Coordinated Care Initiative.

Sources: DHCS *Medi-Cal Managed Care Models* (PDF) (June 3, 2019); and DHCS, "Coordinated Care Initiative Overview" (last modified June 16, 2020).

Carve-Outs and Carve-Ins of Medi-Cal Plan Benefits

Medi-Cal managed care plans do not provide all Medi-Cal benefits to their members. Some significant benefits are carved out of managed care, meaning managed care plans are not responsible for providing or paying for these services, and they are instead provided or paid for by other state or local entities. (See Table 1.) The carve-out picture is particularly complex for certain long-term services and supports for which some carve-outs depend on the county. (For a more detailed description of the LTSS programs listed, see Appendix A.)

Three major Medi-Cal benefits are carved out of, or provided separately from, Medi-Cal managed care and from Cal MediConnect in all counties.

- **In-Home Supportive Services (IHSS).** The state's personal care service is delivered through fee-for-service in all counties and administered through the Department of Social Services rather than DHCS, which oversees the Medi-Cal program.
- **Dental benefit.** Oral health services are provided through fee-for-service Medi-Cal except in Sacramento and Los Angeles Counties.[37] In those two counties, Medi-Cal enrollees are either required or have the option to enroll in separate dental managed care plans.[38]
- **Specialty Mental Health.** County mental health departments provide services related to serious behavioral health conditions. Behavioral health services for mild to moderate conditions are included services in Medi-Cal plans and in fee-for-service Medi-Cal.

The following two benefits are provided by Medi-Cal managed care plans in some counties but are available through fee-for-service in others.

- **Long-term care benefit.** This benefit, which covers nursing home and other institutional care, is part of the Medi-Cal managed care plan benefit package in COHS counties and in the seven CCI counties. In all other counties, enrollees needing nursing home or other institutional placement are disenrolled from Medi-Cal managed care one month after the month of admission to a facility and placed in fee-for-service Medi-Cal for all their Medi-Cal benefits.
- **Multipurpose Senior Services Program (MSSP).** MSSP is available through Medi-Cal plans in the seven CCI counties. In the rest of the state, this

Table 1. Medi-Cal Plan Carve-Ins/Carve-Outs: Who Is Responsible

	CCI COUNTIES	COHS COUNTIES (NON-CCI)	OTHER COUNTIES
Core Medi-Cal services	MC	MC	Both FFS and MC
Specialty Mental Health	Counties	Counties	Counties
IHSS	DSS	DSS	DSS
Dental	FFS (DMC available in Los Angeles)	FFS	FFS (DMC required in Sacramento County)
LTC institutional benefit	MC	MC	FFS after first month following admission
MSSP	MC	FFS	FFS (not available in all counties)
CBAS	MC	MC	MC
HCBS waivers	FFS (MC responsible for coordination)	FFS	FFS (some services not available in all counties)

Definitions: *CBAS* is Community-Based Adult Services; *DMC* is dental managed care; *DSS* is Department of Social Services; *FFS* is fee-for-service; *HCBS* is Home and Community-Based Services; *IHSS* is In-Home Supportive Services; *LTC* is long-term care; *MC* is Medi-Cal managed care; *MSSP* is Multipurpose Senior Services Program.

Source: Author analysis.

program is available only through fee-for-service Medi-Cal. Dual-eligible enrollees who are already enrolled in a Medi-Cal plan remain enrolled but receive MSSP through fee-for-service.

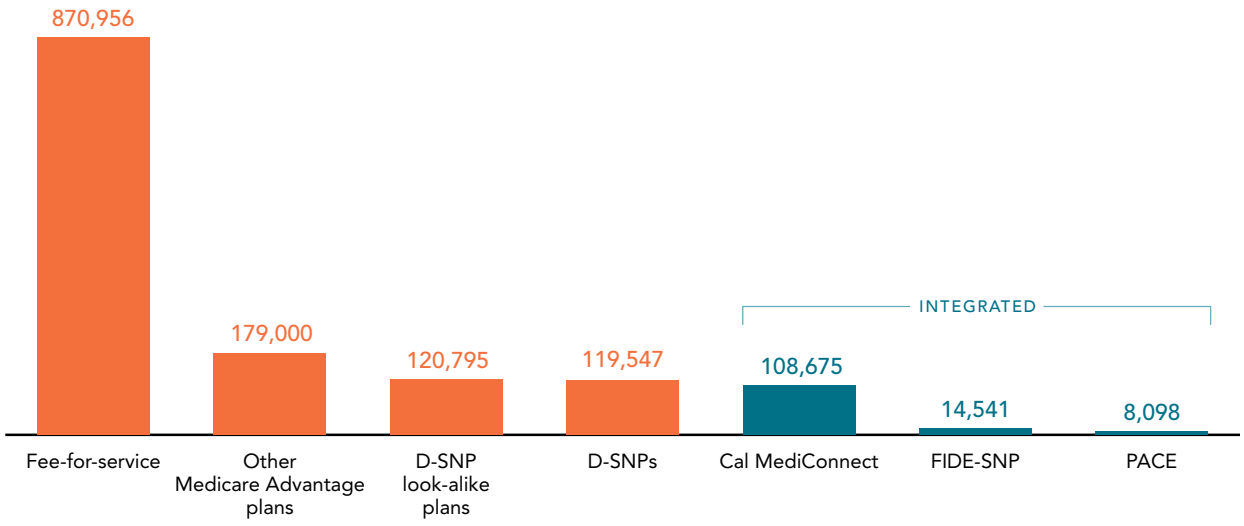
One Medi-Cal benefit, **Community-Based Adult Services (CBAS)**, is available *only* through Medi-Cal managed care. Dual-eligible enrollees living in counties where Medi-Cal managed care enrollment is not mandatory must enroll in a Medi-Cal managed care plan in order to access CBAS services.[39]

Individuals enrolled in **Medi-Cal Home and Community-Based Services (HCBS) waivers**, including the Assisted Living Waiver, Home and Community-Based Alternatives Waiver, AIDS Waiver, and HCBS Waiver for the Developmentally Disabled, receive services through the contracted waiver agency. In CCI and COHS counties, enrollees can remain in a Medi-Cal managed care plan and also receive waiver services separately outside the plan through the contracted waiver agency. In these cases, the Medi-Cal plans have no responsibility to coordinate with the waiver agency, except in CCI counties.[40] In CCI counties, however, dual-eligible enrollees cannot be enrolled in both a waiver and Cal MediConnect, because simultaneous enrollment would result in duplication of services.[41]

Medicare Models for Administering Benefits

Medicare is the primary payer for most inpatient and outpatient medical costs, prescription drugs, and post-acute skilled care services (e.g., home health, limited nursing facility stays) for dual-eligible enrollees. Under federal law, dual-eligible enrollees have freedom to choose how they want to receive their Medicare benefits: through original fee-for-service Medicare or through private health plan options called Medicare Advantage plans. Dual-eligible enrollees also can enroll in highly integrated models, which in California include Cal MediConnect plans, Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), and Programs of All-Inclusive Care for the Elderly (PACE). Figure 7 provides enrollment estimates for these

Figure 7. California Dual-Eligible Enrollee Enrollment Estimates, by Medicare Delivery Model, 2020



Sources: CHHS Open Data Portal, "Medi-Cal Managed Care Enrollment Report" (May 2020); CMS, *SNP Comprehensive Report* (June 2020) (n.d.); and Integrated Care Resource Center, *Program of All-Inclusive Care for the Elderly (PACE) Total Enrollment by State and by Organization* (June 2020 data).

Medicare models and Table 2 (see page 16) provides enrollment estimates in the various Medicare and Medi-Cal models.

Fee-for-Service Medicare

More than 60% of dual-eligible enrollees in California, or approximately 871,000 Californians (see Figures 5 and 7), receive their Medicare benefits through fee-for-service Medicare.[42] In fee-for-service Medicare, a dual-eligible enrollee may obtain Medicare-covered services from any Medicare provider. There are no network restrictions, generally no prior authorization requirements, and no requirement that the provider participate in Medi-Cal. All dual-eligible enrollees, including those in fee-for-service Medicare, are protected by federal and state law from any liability for co-insurance and deductibles, and Medi-Cal acts as a secondary payer after Medicare.[43]

The freedom to use any Medicare provider, however, is limited in practice. Many dual-eligible enrollees in fee-for-service Medicare report that providers, particularly specialists, refuse to serve the enrollees because the providers are unable to collect the co-insurance for their Medicare services to dual-eligible enrollees.[44] Though Medi-Cal will process their charges as a secondary payer, federal law permits the state to cap its reimbursement at Medi-Cal rates, which usually are lower than what Medicare has already paid, leaving the provider with no additional payment.

Dual-eligible enrollees in fee-for-service Medicare must enroll in a Medicare Part D prescription drug plan for prescription drug coverage. They automatically receive the Low-Income Subsidy, which offers premium protection and sets modest copayments for prescription drugs.[45]

Medicare Advantage

Enrollment in Medicare Advantage plans among dual-eligible enrollees has been growing.[46] Dual-eligible enrollees participating in a plan, in contrast to fee-for-service Medicare, generally must use providers within the plan's network, and many plan benefits require preauthorization. Medicare Advantage plans often offer additional benefits that are not covered by fee-for-service Medicare, including, for example, gym memberships and supplemental dental and vision packages. Medicare Advantage plans typically include the Part D prescription drug benefit as part of the plan offering. As in fee-for-service Medicare, dual-eligible enrollees in Medicare Advantage are protected from all deductible and copayment responsibility.[47] The enrollee is responsible for plan premiums, if any. In contrast to fee-for-service Medicare, Medicare Advantage providers may not deny services to dual-eligible enrollees because of their Medi-Cal status.[48]

Different Medicare Advantage products are available to dual-eligible enrollees, including Dual Eligible Special Needs Plans (D-SNPs), which limit enrollment to dual-eligible enrollees, and standard Medicare Advantage plans, which are available to all Medicare enrollees. Standard Medicare Advantage plans include some that have been marketed almost exclusively to dual-eligible enrollees and have become known as D-SNP look-alike plans.

Dual Eligible Special Needs Plans (D-SNPs)

D-SNPs are specialized Medicare Advantage plans that have contracts with the state and are intended to meet the special needs of dual-eligible enrollees. D-SNPs are responsible only for the delivery of Medicare benefits, but D-SNPs are required to coordinate Medi-Cal services for their members. These care coordination requirements and the level of integration requirements have been expanded through federal legislation and Medicare regulations that will be effective in plan year 2021.[49] As of June 2020, 32 D-SNPs were available in 25 California counties, with 119,547 dual-eligible enrollees.[50] (See Appendix B, Table B4 for the service area of each D-SNP and its plan enrollment.)

Medi-Cal's policy is that dual-eligible enrollees who enroll in a D-SNP should be in an "aligned" Medi-Cal plan to facilitate coordination of Medicare and Medi-Cal benefits. Typically, an aligned Medi-Cal plan is operated by the same plan sponsor; however, in some circumstances, the aligned plan is operated by a different plan sponsor that has entered into an agreement to work together to coordinate services.[51] As a general matter, dual-eligible enrollees who enroll in a D-SNP that is not aligned with their Medi-Cal managed care plan are disenrolled from the Medi-Cal plan and get their Medi-Cal benefits through fee-for-service. In CCI and COHS counties, however, such enrollees continue in Medi-Cal managed care despite the misalignment and are therefore enrolled in two different managed care plans operated by different sponsors.

Standard Medicare Advantage Plans

Dual-eligible enrollees can enroll in other Medicare Advantage products that are not subject to D-SNP requirements. Standard Medicare Advantage plans are available to any Medicare enrollee. These plans are not required to coordinate benefits for dual-eligible enrollees and have no contractual obligation to the state with respect to care coordination. Despite these limitations, nearly 300,000 dual-eligible enrollees in California are enrolled in standard Medicare Advantage plans.[52] A variety of factors may play a role in decisions by dual-eligible enrollees to join standard Medicare Advantage plans, including marketing by brokers and agents; attractive supplemental benefits; and networks that include providers preferred by the enrollee. Further, in some areas, particularly in rural parts of the state, few or no D-SNPs are available. Enrollees who are concerned that fee-for-service providers will not serve them sometimes join Medicare Advantage plans to obtain access to providers, because Medicare Advantage plans have to abide by network adequacy standards.

More than 40% of dual-eligible enrollees in standard Medicare Advantage plans (approximately 121,000 Californians) are enrolled in plans known as *D-SNP look-alike plans*, a term now used by both federal and state agencies.[53] While available to any Medicare enrollee, these plans have premium and co-insurance features that make them unattractive to anyone without the co-insurance payment protections dual-eligible enrollees have, and their supplemental benefits package is likely to attract dual-eligible enrollees.[54] From 2017 to 2020, the number of look-alike plans operating in California doubled (from 19 to 38) and the number of dual-eligible enrollees grew from 90,294 to 120,975, an increase of 34%.[55] Despite significant dual-eligible enrollment, the look-alike plans are not subject to any of the federal D-SNP requirements regarding integration and coordination of Medicare and Medi-Cal benefits and are not required to enter into contracts with the state.[56] Both the state and CMS have expressed concern that look-alikes undermine D-SNP requirements, impede efforts to improve care coordination, and confuse enrollees.[57] In response, CMS recently finalized regulations designed to curb look-alikes and to transition current enrollees out of look-alike plans.[58]

Medicare-Medicaid Integrated Models

There are currently three options in California to enroll in health plans that are responsible for delivering both Medicare and Medi-Cal benefits for members: Cal MediConnect; Program of All-Inclusive Care for the Elderly (PACE); and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs). (See Figure 7, page 12.) Enrollees in these plan options receive the bulk of their benefits through a single health plan. Approximately 9% of dual-eligible enrollees in California are in an integrated Medicare-Medicaid plan type.[59]

Cal MediConnect

Cal MediConnect, part of the CCI initiative (see page 9), is available in seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara Counties. These plans deliver both Medicare and Medi-Cal benefits, including long-term services and supports, with the goal of better integrating and coordinating care to improve health

outcomes for plan members. Additionally, plans can provide services not generally covered by Medi-Cal aimed at helping plan members to continue living in their communities, like meal delivery, home modifications, and additional services. Plans are specifically required to coordinate care across the spectrum of benefits — including carved-out benefits that the plans do not deliver. These carved-out benefits include Medi-Cal specialty mental health and substance use disorder services, which are managed by the counties; Medicare-covered hospice services; dental benefits; and IHSS. Cal MediConnect members cannot enroll in waiver services; instead, the plans have the flexibility to provide services that are similar to those offered in the waivers. Cal MediConnect is currently scheduled to expire in December 2022. As of May 2020, Cal MediConnect plan enrollment was 108,675 enrollees.[60] (See Appendix B, Table B5.)

FIDE-SNPs

Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) are, as the name implies, fully integrated, providing both Medicare and Medi-Cal services. These plans differ from Cal MediConnect plans in that FIDE-SNPs have no carve-outs. FIDE-SNP plans contract with all provider types, including medical, behavioral (including specialty mental health and substance use treatment), long-term services and supports, dental, transportation, and the plans' own contracted personal care assistants in lieu of IHSS. California's FIDE-SNPs, SCAN Connections and SCAN Connections at Home, operate in three California counties: Los Angeles, Riverside, and San Bernardino Counties. The SCAN plans currently operating are available only to dual-eligible enrollees age 65 and over who need a nursing home level of care, although CMS rules do not require those limitations.[61] A primary difference between FIDE-SNPs and Cal MediConnect plans is financing: FIDE-SNPs have separate contracts with CMS for Medicare services and DHCS for Medi-Cal services. In contrast, Cal MediConnect plans have a three-way contract with CMS and DHCS and have flexibility to use the combined funding stream for either service. As of June 2020, 14,541 dual-eligible enrollees were enrolled in a FIDE-SNP.[62] (See Appendix B, Table B6.)

PACE

Programs of All-Inclusive Care for the Elderly (PACE) are integrated managed care plans available to enrollees age 55 or older who live within a PACE center's service area and meet the level of care requirement for skilled nursing facility coverage but can live safely in the community with PACE services. PACE provides its members with almost all Medicare and Medi-Cal services and uses an interdisciplinary team to coordinate the care of each participant. PACE is similar to a FIDE-SNP in terms of financial integration, but PACE differs in that it integrates care delivery by directly employing physicians and other frontline clinicians and provides most care on-site at a PACE center. PACE is the oldest of the integrated program options, having begun more than 40 years ago.[63] Though PACE has grown over time, its reach remains relatively small. There are 17 PACE plans available in 16 California counties.[64] As of June 2020, 8,098 dual-eligible enrollees were enrolled in PACE plans in California.[65] (See Appendix B, Table B7.)

Table 2 summarizes the availability and enrollment of dual-eligible enrollees in each of the Medicare, Medi-Cal, and integrated Medicare-Medi-Cal benefit delivery models described above. (See page 16.)

Table 2. Availability of and Enrollment in Benefit Delivery Models for Dual-Eligible Californians

	AVAILABILITY	ENROLLMENT
Medi-Cal		
Fee-for-service	31 counties	410,526
Medi-Cal managed care	22 COHS* counties and CCI† counties (enrollment mandatory)	1,011,086
Medicare		
Fee-for-service	Statewide	870,956
D-SNP	25 counties‡	119,547
D-SNP look-alike	Unknown	120,795
Other Medicare Advantage	Unknown	179,000
Integrated Medicare-Medi-Cal Plans		
Cal MediConnect	7 CCI counties	108,675
FIDE-SNP	3 counties§	14,541
PACE	14 counties#	8,098

*COHS counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, Yolo.

†CCI counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, Santa Clara.

‡D-SNP counties: Alameda, Contra Costa, Fresno, Imperial, Kern, Kings, Los Angeles, Madera, Marin, Napa, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Ventura.

§FIDE-SNP counties: Los Angeles, Riverside, San Bernardino.

#PACE counties: Alameda, Contra Costa, Fresno, Humboldt, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare.

Source: Author analysis; sources noted in endnotes in text descriptions in preceding sections.

Policy and Operational Imperatives During Program Transitions

Although the CalAIM proposal for system changes that would affect all of California's 1.4 million dual-eligible enrollees has been postponed, California remains committed to a broad restructuring of systems serving dual-eligible enrollees. Policymakers and stakeholders can take several steps to plan for the implementation of any changes in systems or benefits serving dual-eligible enrollees and to ensure that changes are implemented in a manner that would minimize disruption and harm to dual-eligible enrollees. In particular, the state's experience with transitions in the CCI offers guideposts for planning for major benefit delivery system changes specific to older adults and people with disabilities.

Elevating equity to drive system changes. Experience with COVID-19 has brought racial inequities and health disparities into sharp focus. As California determines how it will move forward with programs to serve dual-eligible enrollees, who are disproportionately people of color, it is critical that the state apply a racial justice and health equity lens to its planning.

Planning focused on how dual-eligible enrollees will experience the transition. Simple transition processes that are easy for enrollees to navigate with reasonable timelines are critical to success. Incorporating dual-eligible enrollees meaningfully in the planning process and testing planned procedures with enrollees can help ensure that the enrollee perspective stays in the forefront. It also is important to think through special obstacles that persons with disabilities and those with limited English proficiency may have in getting assistance and information that will facilitate understanding of the changes and smooth their transitions.

Transparent planning process and evaluation. Extensive and transparent work with all stakeholders throughout the process — including planning at the front end, implementing accountability metrics

throughout, and evaluating outcomes at the back end — helps to ensure transitions proceed smoothly. Experience has shown that any changes in Medicare and Medicaid systems have ripple effects that, if not anticipated and addressed, can harm enrollees. An open process with opportunities for meaningful and sustained stakeholder participation throughout the process, from conception to evaluation, including public reporting of data on an ongoing and frequent basis, offers the best opportunity to ensure that the transitions and changes work as designed without adverse impact on enrollees.

Systems testing and readiness reviews. The initial months in any delivery system transition are when enrollee access to care can be most at risk; issues often arise from systems errors, such as the failure of data transfers among participating entities to function properly, coding errors, or unanticipated communication issues between systems or programs. Rigorous and extensive systems testing before the start of a significant transition can help prevent these types of failures and disruptions in care. Such testing is particularly critical in California because the state is also implementing a massive upgrade in its benefits computer network used to determine eligibility for a wide range of programs, including Medicaid. Robust readiness review procedures for participating providers, plans, and the state can also help ensure the transition proceeds smoothly. Readiness reviews that address computer systems and personnel as well as assess providers' understanding of new processes are essential.

Safety nets, backstops, and overrides. It is inevitable that some unexpected anomalies will occur during a major transition, no matter how rigorous the preparation. Developing backstops, overrides, and safety nets with staff assigned to be responsible for implementation in both the state and health plans can significantly minimize interruptions in care for enrollees because of systems issues, particularly during the first months of a transition. For example, during the CCI implementation, DHCS set up an email address for certain provider types to report issues, created a portal for advocates and enrollees to submit health care coverage problems, and provided for retroactive disenrollments when enrollment was improper.[66]

Consumer protections and robust oversight. Strong consumer protections, including effective appeals and grievance processes, adequate and accurate provider directories, and strong quality and safety standards, have proved effective in ensuring enrollees are not harmed by changes. Such protections are most effective when accompanied by robust oversight and enforcement by DHCS and CMS.

Ombudsman. Experience with the CCI has demonstrated that an adequately funded ombudsman program with specific expertise in Medicare and Medi-Cal issues for dual-eligible enrollees can play an important role in identifying systemic issues, both during transitions and beyond, as well as in resolving many issues that otherwise would require appeals.[67] In the first year of the CCI implementation alone, the CCI ombudsman program identified 52 systemic issues impacting tens of thousands of enrollees.[68]

Continuity of care. Even with notices, many enrollees are caught unaware when elements of their care delivery change. Having care continuity protections in place is essential so enrollee health is not endangered: for example, allowing dual-eligible enrollees to retain access to providers for a minimum of 12 months regardless of whether the providers are contracted with their new plan. For protections to work, providers must be well educated on the mechanics of how they can participate in care continuity, and the protections must be easy for both providers and enrollees to navigate.

Clear communication and outreach with enrollees and providers. An important learning in both the CCI and Medicare-Medicaid demonstration projects in other states has been that clear and straightforward notices to enrollees and physicians are essential for trust in and support of the changes. Notices and communications should be written in plain language. Drafting schedules should build in adequate time for

consumer testing of all notices. It is also particularly important that providers, including Medicare providers, fully understand all changes so misunderstandings do not disrupt care or result in improper billing of dual-eligible enrollees for covered services. In the transition to Medi-Cal managed care in the CCI, for example, many Medicare providers refused to continue to serve their Medi-Cal patients, erroneously believing that they could not get paid unless they were part of the Medi-Cal managed care plan's network. Provider mistrust also played a role in the high opt-out rate for Cal MediConnect plans.

Conclusion

Dual-eligible enrollees constitute a heterogeneous population that differs substantially from the general Medicare population in demographics and health status. How these enrollees currently access their benefits varies according to where they live in the state, which benefits they receive, and personal choice. Understanding the characteristics of California's dual-eligible population, the complex current system that serves them, and areas in particular need of attention is an important first step in analyzing and planning for any changes in benefit design and delivery for dual-eligible enrollees. This information is essential for successful transitions that minimize disruptions in needed care and ensure that enrollees fully understand changes so they can use new programs effectively.

Appendix A. Glossary of Medi-Cal Long-Term Services and Supports

Long-term services and supports (LTSS) are a wide range of services provided in the home, in community-based settings, or in nursing homes or other facilities such as those for individuals with developmental disabilities. The following are the most common Medicare- and Medi-Cal-funded LTSS programs and services, organized alphabetically, with approximate enrollment figures if known. Note that all waiver programs (ALW, HCBA, HCBA AIDS, HCBS-DD, MSSP) have enrollment caps but only the Assisted Living Waiver (ALW) and the Home and Community Based Alternatives Waiver (HCBA) have current waiting lists.

Assisted Living Waiver (ALW). This waiver provides a limited number of slots for dual-eligible enrollees and other Medi-Cal recipients to receive services in a Residential Care Facility (RCF), an Adult Residential Care Facility (ARF), or public subsidized housing, utilizing ALW services. The waiver is available in 15 counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, and Sonoma Counties. The waiver is available to individuals age 21 and over. *Approximate number of participants: 4,685. Number on waiting list: 4,670.*[69]

California Community Transitions (CCT). This program is supported by federal funding through the Money Follows the Person rebalancing demonstration. The program transitions individuals out of skilled nursing facilities into the community using contracted CCT lead organizations throughout the state.[70] The program pays for pre- and post-transition coordination, home setup, home modifications, habilitation, personal care services, family and informal caregiver training, vehicle adaptation, and assistive devices. Individuals eligible for services must reside in a nursing facility (for a period of not less than 90 days); must be receiving Medicaid benefits during the facility stay; and, but for the receipt of home and community-based services, would need the level of care received in a nursing facility.[71] The program is currently funded to provide transitions through December 31, 2021.[72]

Community-Based Adult Services (CBAS). This Medi-Cal benefit, formerly known as adult day health care, is offered to eligible seniors and persons with disabilities age 18 and over who require a nursing facility level of care. Services are provided at CBAS centers and include, for example, nursing services; mental health services; social services; nutritional counseling; family caregiver training; and occupational, speech, and physical therapy services. CBAS replaced the adult day health care benefit in 2012, and, with few exceptions, the benefit is available only through enrollment in a Medi-Cal managed care plan. *Approximate number of participants: 38,304.*[73]

Home and Community-Based Alternatives (HCBA) Waiver. This waiver has a limited number of slots and is administered by DHCS, which contracts with waiver providers. These contracted providers offer care management services to people at risk of nursing home or institutional placement, including a multidisciplinary care team that coordinates and arranges for other long-term services and supports available in the local community. The waiver is available to individuals of any age. *Approximate number of participants: 4,688. Number on waiting list: 836.*[74]

Home and Community-Based Services AIDS (HCBS AIDS) Waiver. This waiver is operated by DHCS in collaboration with the Department of Public Health and provides case management and a range of health and care services, home-delivered meals, nutrition counseling and supplements, and transportation and other services for enrollees who have an HIV or AIDS diagnosis and require a nursing home level of care. Services are available for individuals of any age. *Approximate number of participants: 1,500.*[75]

Home and Community-Based Services for the Developmentally Disabled (HCBS-DD) Waiver. This waiver is administered by the California Department of Developmental Services (DDS) and authorizes home and community-based services for developmentally disabled persons who are regional center consumers. The 21 regional centers throughout the state purchase and coordinate services and supports

for individuals with developmental disabilities of any age. The DD waiver is currently the largest HCBS waiver program in California as well as in the nation. *Approximate number of participants: 120,000.*[76]

Home health. Medicare pays for home health services when an individual is deemed homebound and requires skilled intermittent nursing care or physical therapy, speech-language pathology, or continued occupational therapy services. Home health services can include part-time skilled nursing care, therapy, medical social services, and part-time or intermittent home health aide services. Medicare does not pay for 24-hour care, meal delivery, homemaker services (cleaning, shopping), or assistance with activities of daily living if this is the only care needed.[77] Medi-Cal also must provide home health services to any individual who is entitled to skilled nursing facility services.[78] There is no homebound requirement for Medi-Cal home health benefits.[79] Medi-Cal coverage of home health includes intermittent skilled nursing care; in-home medical care services; physical, occupational, or speech therapy; medical social services; services of a home health aide; medical supplies; and medical appliances.[80]

In-Home Supportive Services (IHSS). This program, administered through the California Department of Social Services, provides personal care services to qualified Medi-Cal enrollees that allow them to remain safely in the home. Some of the services offered through IHSS include housecleaning, shopping, meal preparation, laundry, personal care services, accompaniment to medical appointments, and protective supervision for individuals with cognitive impairments. Seniors and people with disabilities (including children) are eligible for IHSS. The local county Department of Social Services assesses the enrollee's level of dependence and determines how much time should be allotted for each needed service. IHSS is a fee-for-service benefit and is not provided by Medi-Cal plans. People enrolled in managed care can enroll in IHSS without having to disenroll from their plan. IHSS is available for individuals of any age. *Approximate number of participants: 630,000.*[81]

Long-term care benefit. Medicare provides coverage for nursing facility care for up to 100 days following an acute care hospital stay as long as the enrollee needs skilled care.[82] Medi-Cal covers longer nursing facility stays, subacute facility stays, and stays in intermediate care facilities. Medi-Cal pays for room and board as well as needed medical care in the facility, including skilled therapy. The long-term care benefit is available to individuals of all ages.

Multipurpose Senior Services Program (MSSP). MSSP is a waiver program with a limited number of slots that provides social and health care management to frail seniors 65 and over to enable them to remain living in the community rather than being placed in a nursing facility or other institution. MSSP is predominantly delivered through fee-for-service Medi-Cal. In CCI counties, Medi-Cal plans had been in the process of transitioning the benefit into managed care. However, under the currently postponed CalAIM proposal, the Department of Health Care Services announced that it would carve this benefit back out of managed care. *Approximate number of participants: 11,789.*[83]

Appendix B. Tables

Table B1. Dual-Eligible Enrollee Residence, by County, June 2020

	NUMBER OF DUAL-ELIGIBLE ENROLLEES	MANAGED CARE MODEL
Alameda	57,103	Two-Plan
Alpine	43	Regional
Amador	1,017	Regional
Butte	10,149	Regional
Calaveras	1,407	Regional
Colusa	956	Regional
Contra Costa	29,893	Two-Plan
Del Norte	1,600	COHS
El Dorado	4,258	Regional
Fresno	40,751	Two-Plan
Glenn	1,452	Regional
Humboldt	6,296	COHS
Imperial	14,142	Imperial
Inyo	662	Regional
Kern	31,792	Two-Plan
Kings	4,998	Two-Plan
Lake	4,756	COHS
Lassen	1,011	COHS
Los Angeles	451,208	Two-Plan
Madera	5,259	Two-Plan
Marin	5,289	COHS
Mariposa	677	Regional
Mendocino	4,376	COHS
Merced	11,248	COHS
Modoc	486	COHS
Mono	158	Regional
Monterey	12,560	COHS
Napa	4,025	COHS
Nevada	2,961	Regional
Orange	96,990	COHS
Placer	7,558	Regional
Plumas	914	Regional
Riverside	73,784	Two-Plan
Sacramento	61,975	Geographic
San Benito	1,510	San Benito
San Bernardino	74,728	Two-Plan
San Diego	94,111	Geographic
San Francisco	47,489	Two-Plan
San Joaquin	26,856	Two-Plan
San Luis Obispo	6,515	COHS
San Mateo	17,376	COHS
Santa Barbara	12,238	COHS
Santa Clara	56,605	Two-Plan
Santa Cruz	8,136	COHS
Shasta	9,252	COHS
Sierra	164	Regional
Siskiyou	2,686	COHS
Solano	13,702	COHS
Sonoma	13,250	COHS
Stanislaus	21,912	Two-Plan
Sutter	4,721	Regional
Tehama	3,562	Regional
Trinity	688	COHS
Tulare	20,625	Two-Plan
Tuolumne	1,991	Regional
Ventura	22,038	COHS
Yolo	6,132	COHS
Yuba	3,571	Regional
Total	**1,421,612**	

Note: *COHS* is County Organized Health System.

Source: CHHS Open Data Portal, "Month of Eligibility, Dual Status, by County, Medi-Cal Certified Eligibility" (June 2020 data).

Table B2. Dual-Eligible Enrollment, by Medi-Cal Managed Care Model, Plan, and County, 2017

MODEL / MEDI-CAL PLAN	COUNTY	ENROLLMENT
COHS		**231,199**
Cal Optima*	Orange	78,365
CenCal*	San Luis Obispo	6,529
	Santa Barbara	12,076
Central California Alliance for Health*	Merced	10,720
	Monterey	12,333
	Santa Cruz	7,818
Gold Coast*	Ventura	21,569
Health Plan of San Mateo*	San Mateo	9,059
Partnership Health Plan*	Del Norte	1,568
	Humboldt	5,941
	Lake	4,682
	Lassen	955
	Marin	5,294
	Mendocino	4,459
	Modoc	456
	Napa	3,702
	Shasta	8,944
	Siskiyou	2,539
	Solano	13,333
	Sonoma	14,114
	Trinity	652
	Yolo	6,091

MODEL / MEDI-CAL PLAN	COUNTY	ENROLLMENT
Two-Plan		**595,176**
Alameda Alliance for Health	Alameda	19,997
Anthem Blue Cross		2,573
Anthem Blue Cross	Contra Costa	827
Contra Costa Health Plan		10,273
Anthem Blue Cross	Fresno	3,778
CalViva Health		10,050
Health Net	Kern	2,974
Kern Family Health Care		6,776
Anthem Blue Cross	Kings	575
CalViva Health		886
Health Net*	Los Angeles	139,007
LA Care*		231,201
Anthem Blue Cross	Madera	470
CalViva Health		1,038
Inland Empire Health Plan*	Riverside	32,718
Molina*		9,989
Inland Empire Health Plan*	San Bernardino	33,593
Molina*		8,084
Anthem Blue Cross	San Francisco	2,435
San Francisco Health Plan		11,423
Health Net	San Joaquin	516
Health Plan of San Joaquin		9,041
Anthem Blue Cross*	Santa Clara	13,477
Santa Clara Family Health Plan*		30,690
Health Net	Stanislaus	2,437
Health Plan of San Joaquin		3,824
Anthem Blue Cross	Tulare	3,118
Health Net		3,406

*These Medi-Cal Plans are responsible for the delivery of long-term services and supports (LTSS).

Note: *COHS* is County Organized Health System.

Table B2. Dual-Eligible Enrollment, by Medi-Cal Managed Care Model, Plan, and County, 2017, *continued*

MODEL / MEDI-CAL PLAN	COUNTY	ENROLLMENT
Geographic Managed Care		**92,395**
Anthem Blue Cross	Sacramento	7,083
Health Net		5,565
Kaiser		5,946
Molina		3,925
Care1st* (now Blue Shield Promise)	San Diego	14,133
Community Health Group*		19,178
Health Net*		15,054
Kaiser*		6,473
Molina*		15,038
Regional Managed Care		**9,135**
Anthem Blue Cross	Alpine	10
California Health and Wellness		2
Anthem Blue Cross	Amador	188
California Health and Wellness		26
Kaiser		2
Anthem Blue Cross	Butte	1,061
California Health and Wellness		1,212
Anthem Blue Cross	Calaveras	120
California Health and Wellness		203
Anthem Blue Cross	Colusa	104
California Health and Wellness		51
Anthem Blue Cross	El Dorado	210
California Health and Wellness		659
Kaiser		42
Anthem Blue Cross	Glenn	119
California Health and Wellness		156
Anthem Blue Cross	Inyo	40
California Health and Wellness		65
Anthem Blue Cross	Mariposa	99
California Health and Wellness		29
Anthem Blue Cross	Mono	32
California Health and Wellness		17
Anthem Blue Cross	Nevada	463
California Health and Wellness		269
Anthem Blue Cross	Placer	833
California Health and Wellness		306
Kaiser		161
Anthem Blue Cross	Plumas	114
California Health and Wellness		101
Anthem Blue Cross	Sierra	24
California Health and Wellness		8
Anthem Blue Cross	Sutter	607
California Health and Wellness		242
Anthem Blue Cross	Tehama	259
California Health and Wellness		347
Anthem Blue Cross	Tuolumne	152
California Health and Wellness		178
Anthem Blue Cross	Yuba	413
California Health and Wellness		211
Imperial		**2,662**
California Health and Wellness	Imperial	2,004
Molina		658
San Benito		**79**
Anthem Blue Cross	San Benito	79

*These Medi-Cal Plans are responsible for the delivery of long-term services and supports (LTSS).

Note: *COHS* is County Organized Health System.

Source: CMS, *Medicaid Managed Care Enrollment and Program Characteristics, 2017* (PDF) (Winter 2019).

Table B3. Dual-Eligible Enrollment, by Medi-Cal Parent Company, 2017

MEDI-CAL PARENT COMPANY	ENROLLMENT
Alameda Alliance for Health	19,997
Anthem Blue Cross	39,263
CalOptima	78,365
CalViva Health	11,974
Care 1st (now Blue Shield Promise)	14,133
CenCal	18,605
Centene (Health Net & California Health & Wellness)	175,045
Central California Alliance for Health	30,871
Community Health Group	19,178
Contra Costa Health Plan	10,273
Gold Coast	21,569
Health Plan of San Joaquin	12,865
Health Plan of San Mateo	9,059
Inland Empire Health Plan	66,311
Kaiser	12,624
Kern Family Health Care	6,776
LA Care	231,201
Molina	37,694
Partnership Health Plan	72,730
San Francisco Health Plan	11,423
Santa Clara Family Health Plan	30,690

Source: CMS, *Medicaid Managed Care Enrollment and Program Characteristics, 2017* (PDF) (Winter 2019).

Table B4. Dual-Eligible Enrollment in Dual Eligible Special Needs Plans (D-SNP), by Contract Number, June 2020

	PLAN ID	PLAN NAME	COUNTIES OF OPERATION	ENROLLMENT
H0524	029	Kaiser Senior Advantage Medicare Medi-Cal Plan South	Los Angeles, Kern, Riverside, San Bernardino, San Diego, Ventura	29,510
	030	Kaiser Senior Advantage Medicare Medi-Cal Plan North	Alameda, Contra Costa, Fresno, Marin, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus	43,518
H0544	003	Anthem MediBlue Connect	Los Angeles and Santa Clara	178
	052	Anthem MediBlue Dual Advantage	Fresno, Kings, Madera, Tulare	884
	053	Anthem MediBlue Dual Advantage	Kern County	776
	054	Anthem MediBlue Dual Advantage	San Francisco, Sacramento	4,851
	055	Anthem MediBlue Dual Advantage	Ventura	880
	087	Anthem MediBlue Dual Plus	Fresno, Kings, Madera, Tulare	771
	088	Anthem MediBlue Dual Plus	Kern	504
	089	Anthem MediBlue Dual Plus	San Francisco, Sacramento	4,217
	090	Anthem MediBlue Dual Plus	Ventura	456
	100	Anthem MediBlue Dual Advantage	San Joaquin	525
H0562	055	Health Net Seniority Plus Amber I	Los Angeles, Kern, Orange, Riverside, San Bernardino, Fresno, San Diego, San Francisco, Tulare	928
	121	Health Net Seniority Plus Amber II	Parts of southern and northern California	3,966
H0571	005	CCHP Senior Select Program	San Francisco	2,848
H0838	024	Brand New Day Dual Access Plan	Fresno, Imperial, Kern, Kings, Los Angeles, Orange, Riverside, San Bernardino, Tulare	2,167
H1375	001	UnitedHealthcare Dual Complete	Alameda	314
	002	UnitedHealthcare Dual Complete	Fresno, Kings, Madera	397
H3561	001	Health Net Seniority Plus Amber II Premier	Fresno	99
H5087	001	WellCare Freedom	Select counties	3,910
H5433	001	OneCare	Orange	1,431
H5619	038	Humana Gold Plus SNP-DE H5619-038	Select counties in California	7,895
H5649	002	Central Health Medi-Medi Plan	Los Angeles, San Bernardino	3,409
	009	Central Health Ventura Medi-Medi Plan	Ventura	434
	014	Central Health Elite	San Joaquin	16
H5810	001	Molina Medicare Complete Care	Los Angeles, San Diego, parts of Riverside and San Bernardino	1,121
	013	Molina Medicare Complete Care	Imperial	1,029

Table B4. Dual-Eligible Enrollment in Dual Eligible Special Needs Plans (D-SNP), by Contract Number, June 2020, *continued*

	PLAN ID	PLAN NAME	COUNTIES OF OPERATION	ENROLLMENT
H5928	001	Blue Shield Promise TotalDual Plan	Los Angeles	504
	005	Blue Shield Promise TotalDual Plan	Orange, San Bernardino	172
	009	Blue Shield Promise TotalDual Plan	San Diego	244
	054	Blue Shield Promise TotalDual Plan	Fresno, San Joaquin, Stanislaus	32
H8552	030	Anthem MediBlue Dual Access	Select counties	1,561
			Total D-SNP Enrollment	**119,547**

Source: *SNP Comprehensive Report* (June 2020), CMS (n.d.).

Table B5. Cal MediConnect Plan Enrollment, by County, May 2020

	PLAN NAME	ENROLLMENT
Los Angeles	Anthem	2,208
	Promise Health Plan	2,730
	Health Net	7,332
	LA Care	16,302
	Molina	1,710
Orange	Cal Optima	14,184
Riverside	IEHP	14,388
	Molina	1,620
San Bernardino	IEHP	13,821
	Molina	1,496
San Diego	Promise Health Plan	2,209
	Community Health Group	6,328
	Health Net	1,296
	Molina	3,963
San Mateo	Health Plan of San Mateo	8,538
Santa Clara	Anthem	1,999
	Santa Clara Family Health Plan	8,551
	Total Cal MediConnect Plan Enrollment	**108,675**

Source: CHHS Open Data Portal, "Medi-Cal Managed Care Enrollment Report" (May 2020 data) (last updated September 2, 2020).

Table B6. Dual-Eligible Enrollment in Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNP) Contract Number H5425, June 2020

PLAN ID	PLAN NAME	COUNTIES OF OPERATION	ENROLLMENT
010	SCAN Connections	Los Angeles, Riverside, San Bernardino	12,236
029	SCAN Connections at Home	Los Angeles	1,509
030	SCAN Connections at Home	Riverside	476
031	SCAN Connections at Home	San Bernardino	320
		Total FIDE-SNP Enrollment	**14,541**

Source: *SNP Comprehensive Report* (June 2020), CMS (n.d.).

Table B7. PACE Plan Enrollment, by County, June 2020

PLAN NAME	COUNTIES OF OPERATION	ENROLLMENT
AltaMed Health Services	Los Angeles	2,116
Brandman Centers for Senior Care	Los Angeles	223
CalOptima PACE	Orange	208
Center for Elders' Independence	Alameda, Contra Costa	698
FamilyHealth-Center for Older Adults	San Diego	36
Innovative Integrated Health (Fresno PACE; Bakersfield PACE)	Fresno, Kern, Tulare	484
Gary and Mary West PACE	San Diego	59
InnovAge California PACE	Riverside, San Bernardino	734
LA Coast PACE	Los Angeles	≤10
On Lok Lifeways	Alameda, San Francisco, Santa Clara	1,392
Pacific PACE	Los Angeles	58
Redwood Coast PACE	Humboldt	185
San Diego PACE	San Diego	601
St. Paul's PACE	San Diego	811
Stockton PACE	San Joaquin, Stanislaus	123
Sutter SeniorCare PACE	Sacramento	360
	Total PACE Enrollment	**8,098**

Source: Integrated Care Resource Center, *Program of All-Inclusive Care for the Elderly (PACE) Total Enrollment by State and by Organization* (June 2020 data).

Endnotes

1. As of June 2020, there are 1,421,612 full-benefit dual-eligible enrollees in California. California Health and Human Services (CHHS), CHHS Open Data Portal, "Month of Eligibility, Dual Status, by County, Medi-Cal Certified Eligibility," 2010 to the Most Recent Reportable Month (June 2020).
2. California Department of Health Care Services (DHCS), *California Advancing & Innovating Medi-Cal (CalAIM) Proposal* (PDF) (October 28, 2019).
3. DHCS, *Expanding Access to Integrated Care for Dual Eligible Californians* (PDF) (December 9, 2019).
4. DHCS, *Proposed 12-Month Extension Request to Medi-Cal 2020 Section 1115 Waiver* (PDF) (July 22, 2020); see also DHCS, *2020–21 May Revision Highlights* (PDF) (May 14, 2020).
5. Centers for Medicare & Medicaid Services (CMS), *Preliminary Medicare COVID-19 Data Snapshot* (PDF).
6. "PUF_2012" tab in *Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) Public Use File (PUF) Version 2.0 (2006–2012) (02/2019) (XLSX)*, Centers for Medicare & Medicaid Services (CMS), "MMCO Statistical & Analytic Reports."
7. CMS, "Medicare-Medicaid Linked."
8. Amber Christ and Tracey Gronniger, *Older Women & Poverty*, (PDF) Justice in Aging (December 2018); and sources cited therein.
9. DHCS, *Medi-Cal's Coordinated Care Initiative Population Combined Medicare & Medi-Cal Cost, Utilization, and Disease Burden* (PDF) (November 2012).
10. The income limit will increase to 138% of the federal poverty level pursuant to California Senate Bill 104 (Chapter 67, Statutes of 2019) effective December 2020. DHCS, *Stakeholder Communication Update*, August 3, 2020.
11. CMS, *Medicare-Medicaid Enrollee Information: California, 2011* (PDF) (n.d.).
12. CMS, Medicare-Medicaid Linked.
13. CMS, *Preliminary Medicare*.
14. CMS, *Preliminary Medicare*.
15. CMS, *Preliminary Medicare*.
16. Jonathan M. Wortham et al., "Characteristics of Persons Who Died with COVID-19 — United States, February 12–May 18, 2020" (PDF), *Morbidity and Mortality Weekly Report* 69, no. 21 (July 17, 2020): 923.
17. Wortham et al., "Characteristics of Persons."
18. CMS, Medicare-Medicaid Linked.
19. CMS, Medicare-Medicaid Linked.
20. CMS, *Preliminary Medicare*.
21. County Organized Health Systems (COHS) plans are not required to obtain Knox-Keene licensure. Those that have not obtained such licensure are not overseen by the Department of Managed Health Care. Abbi Coursolle and Rachel Landauer, *County Organized Health System Medi-Cal Plans* (PDF) (National Health Law Program, September 2014).
22. CMS, *Medicare-Medicaid Enrollee Information*.
23. CMS, *Medicare-Medicaid Enrollee Information*; see also CMS, *Medicare-Medicaid Enrollee State Profile, California* (PDF), accessed July 18, 2020.
24. CMS, *Medicare-Medicaid Enrollee Information*.
25. KFF (Kaiser Family Foundation), "Medicaid Spending per Dual Eligible per Year," (FY 2013) (n.d.).
26. CMS, *Medicare-Medicaid Enrollee State Profile, California* (PDF) (n.d.); see also Teresa Coughlin, Timothy Waidmann, and Lokendra Phadera, "Among Dual Eligibles, Identifying the Highest-Cost Individuals Could Help in Crafting More Targeted and Effective Responses," *Health Affairs* 31, no. 5 (May 2012), doi:10.1377/hlthaff.2011.072.
27. Jose Figueroa et al., "Persistence and Drivers of High-Cost Status Among Dual-Eligible Medicare and Medicaid Beneficiaries: An Observational Study," *Annals of Internal Medicine* 169, no. 8 (October 2018): 528, doi:10.7326/M18-0085.
28. Justice in Aging, *Durable Medical Equipment: What You Need to Know* (PDF) (April 2016).
29. Margaret Tater, Julia Paradise, and Rachel Garfield, *Medi-Cal Managed Care: An Overview and Key Issues* (KFF, March 2016).
30. DHCS, *Medi-Cal Monthly Enrollment Fast Facts* (PDF), March 2020 data (released June 2020).
31. CHHS Open Data Portal, "Month of Eligibility, Dual Status, by County, Medi-Cal Certified Eligibility" (June 2020 data), accessed July 19, 2020. Note that this is likely an undercount of dual-eligible enrollment in Medi-Cal managed care. Available data only capture the number of dual-eligible enrollees who reside in counties in which Medi-Cal enrollment is mandatory. Dual-eligible enrollment in managed care in counties where enrollment is optional is not available.
32. For an extensive discussion of the elements of the CCI, see Amber Christ, *Advocates Guide to California's Coordinated Care Initiative*, Justice in Aging (December 2017).
33. CMS, *Contract Between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with California Department of Health Care Services* (PDF) (September 1, 2019).
34. DHCS, *Medi-Cal Managed Care Program Fact Sheet – Managed Care Models* (PDF) (January 2, 2020).

35. CHHS Open Data Portal, "Month of Eligibility."

36. CHHS Open Data Portal, "Month of Eligibility."

37. In Sacramento County, Medi-Cal enrollees must enroll in a separate dental managed care plan. In Los Angeles County, Medi-Cal enrollees have the option to enroll in a dental managed care plan or receive dental benefits through fee-for-service. In both counties, there are three dental managed care plans available: HealthNet, Liberty, and Access.

38. In 2018, legislation was enacted (Cal. Welf. & Inst. Code § 14184.90) to pilot the integration of the Medi-Cal dental benefit for the Health Plan of San Mateo. Health Plan of San Mateo, *HPSM Dental Integration Program* (PDF) (January 27, 2020). The pilot is in the planning stage.

39. For background on the CBAS program, see Settlement Agreement in *Darling v. Douglas* (PDF) (N.D. CA, Dec. 13, 2011), which preserved adult day health care by transitioning the program to the Community-Based Adult Services program available only through Medi-Cal managed care.

40. The Home and Community-Based Services Waiver for the Developmentally Disabled is an exception. Enrollees in the HCBS-DD waiver do not enroll in Medi-Cal managed care except in San Mateo County. See DHCS, "Home and Community-Based Services Waiver for the Developmentally Disabled," last modified December 17, 2019.

41 CMS, *Memorandum of Understanding, California Demonstration to Integrate Care for Dual Eligible Beneficiaries Between CMS and the State of California* (PDF), (n.d.).

42. Data note: The Medicare enrollment figures for California dual-eligible enrollees are estimates. The Medicare managed care enrollment estimate is based on several data sets and represents an estimate of total dual-eligible enrollees in Medicare managed care. The fee-for-service estimate is derived from subtracting dual-eligible enrollment in D-SNPs, D-SNP look-alike plans, other Medicare Advantage plans, FIDE-SNPs, Cal MediConnect plans, and PACE from the June 2020 total number of dual-eligible enrollees. The fee-for-service number as presented is an overestimate, because the look-alike and other Medicare Advantage data are not current and are estimates.

43. 42 U.S.C. § 1396a(n)(3)(B); and Cal. Welf. & Inst. Code § 14019.4

44. CMS, *Access to Care Issues Among Qualified Medicare Beneficiaries (QMB)* (PDF) (July 2015), 50.

45. 42 C.F.R. § 423.782.

46. Gretchen Jacobson et al., "A Dozen Facts About Medicare Advantage in 2019" (KFF, June 6, 2019).

47. 42 C.F.R. § 422.504(g)(1)(iii).

48. "Anti-Discrimination," chap. 4, sec. 10.5.2 in CMS, *Medicare Managed Care Manual* (PDF) (April 2016).

49. Bipartisan Budget Act of 2018 (Public Law No. 115–123), § 50311 (February 9, 2018) (amending 42 U.S.C. § 1395w-28(f)); and 84 Fed. Reg. 15, 680 (April 16, 2019): 15,696–744. See also Justice in Aging, *CMS Regulations Set Ground Rules for D-SNPs* (PDF) (April 2019).

50. CMS, *SNP Comprehensive Report — February 2020* (n.d.).

51. DHCS, *2013 MA/SNP Matching Plans* (PDF) (n.d.).

52. Data note: The Medicare Advantage enrollment estimate in this paper is derived from data obtained from the Medicaid and CHIP Payment Access Commission (MACPAC), by custom data request, *Availability of and Projected Total Enrollment in Medicare Advantage Plan Types in California, 2019 and 2020*, received April 27, 2020, available from the authors. The estimate used MACPAC's analysis of 2019 and 2020 Medicare Advantage bid data from CMS and, based on historical enrollment, the authors estimated that dual-eligible enrollees constituted 10% of enrollment in Medicare Advantage plans, excluding D-SNP look-alikes. The D-SNP look-alike exclusion was calculated using a conservative estimate that dual-eligible enrollees represented 80% of enrollment in D-SNP look-alike plans.

53. MedPAC, *Managed Care Plans for Dual-Eligible Beneficiaries*, June 2018, 274.

54. MedPAC, *Managed Care Plans,* 273.

55. MedPAC, *Managed Care Plans,* 274.

56. MedPAC, *Managed Care Plans,* 274. In California, look-alike plans were first introduced by plan sponsors in 2014 as a way around state restrictions on D-SNP enrollment in counties where Cal MediConnect plans were offered. These restrictions were intended to promote enrollment in Cal MediConnect. Instead, look-alike plans increased from 4 at that time to 38 today.

57. See, e.g., 85 Fed. Reg. 9002, 9020 (PDF) (February 18, 2020).

58. 85 Fed. Reg. 9002, 9020.

59. Numerator is total number enrolled in integrated products and denominator is total number of dual-eligible enrollees: 131,314 ÷ 1,421,612 = 9%.

60. CHHS Open Data Portal, "Month of Eligibility."

61. 42 C.F.R. § 422.2.

62. CMS, *SNP Comprehensive Report.*

63. National PACE Association, "The History of PACE" (n.d.).

64. DHCS, "California Program of All-Inclusive Care for the Elderly Plans" (last modified June 16, 2020).

65. Integrated Care Resource Center, *Program of All-Inclusive Care for the Elderly (PACE) Total Enrollment by State and by Organization* (June 2020 data).

66. Justice in Aging, *Coordinated Care Initiative Fix List* (PDF) (last modified March 9, 2015).

67. The CalAIM proposal did not discuss funding for an ombudsman program, indicating only that the state would provide education and training to the long-term care ombudsman. DHCS, *Expanding Access to Integrated Care for Dual Eligible Californians*.

68. Justice in Aging, *Coordinated Care*.

69. DHCS, *Assisted Living Waiver (ALW) Year to Date Enrollment and Waitlist January 2019 Through March 2020* (PDF) (data as of March 1, 2020).

70. DHCS, *California Community Transitions (CCT) Lead Organizations and Contact Information* (PDF) (updated March 19, 2020).

71. DHCS, *Money Follows the Person Rebalancing Demonstration: California Community Transitions Operational Protocol 1.5* (PDF) (updated February 2017).

72. CARES Act, H.R. 748, 116th Cong. § 3811 (March 27, 2020).

73. California Department of Aging, *Community-Based Adult Services (CBAS): Program Statistical Fact Sheet* (February 2020).

74. DHCS, *Home and Community-Based Alternatives Waiver (HCBA) Monthly Dashboard: March 2020* (PDF).

75. California Department of Public Health, "AIDS Medi-Cal Waiver Program" (updated June 11, 2018).

76. DHCS, *Overview of Medi-Cal Home and Community-Based Services* (copy available from the author).

77. CMS, "Home Health Services" (n.d.).

78. 42 C.F.R. § 440.220(a)(3).

79. 42 C.F.R. § 440.70.

80. 22 C.C.R. § 51337.

81. California Department of Social Services, "IHSS Program Data" (June 2020 data).

82. CMS, "Skilled Nursing Facility (SNF) Care" (accessed July 19, 2020).

83. DHCS, *Overview of Medi-Cal Home*.