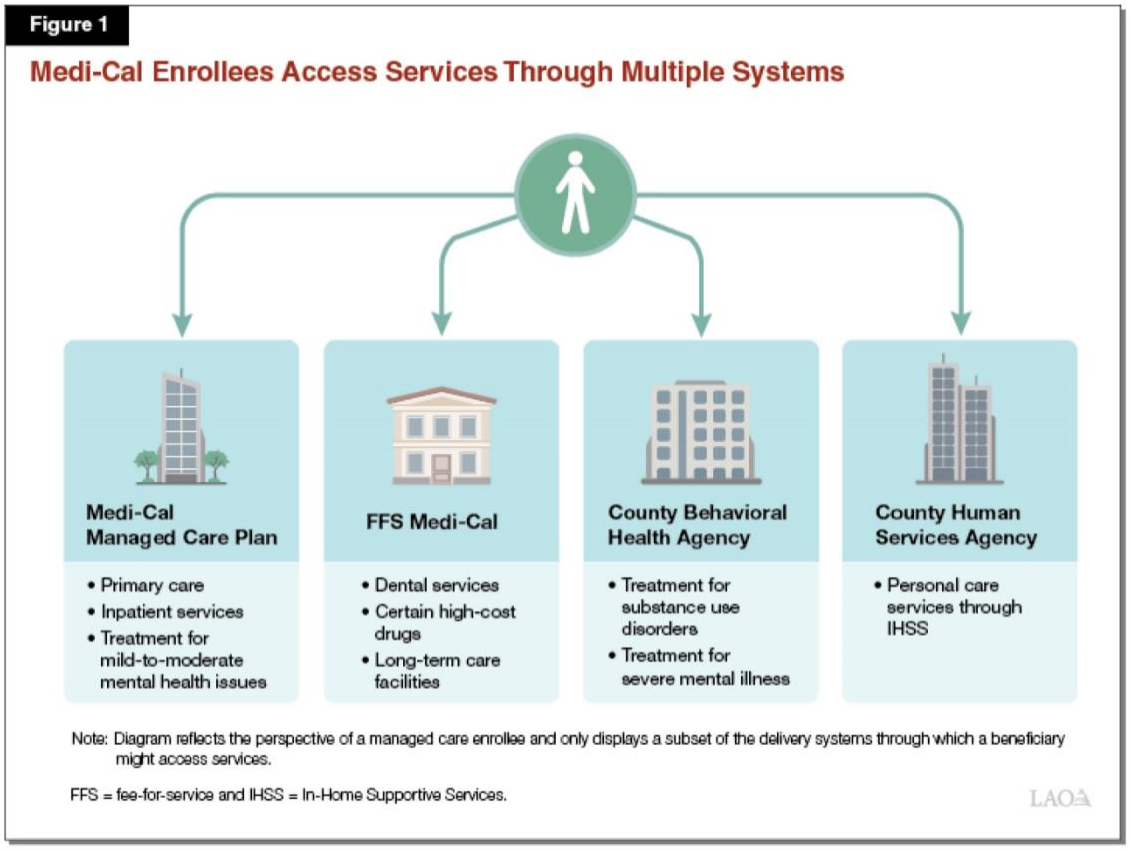
Guideposts and a New Roadmap: CalAIM offers new ways to provide cost-efficient care to California's dual-eligibles when the program begins in January 2022.

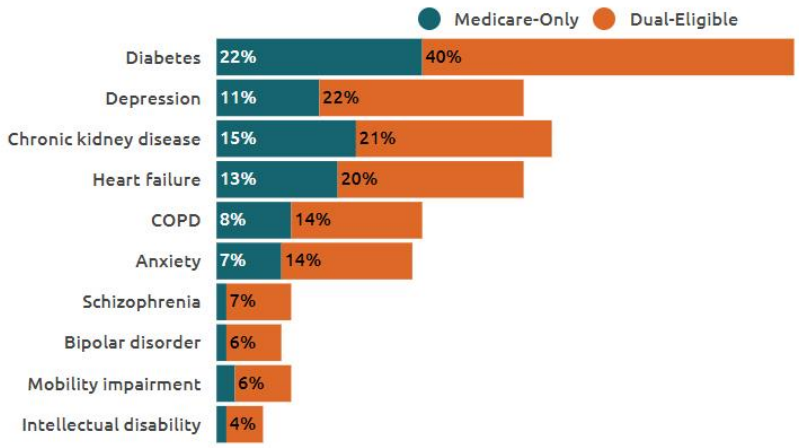
By Jason Bloome

There are approximately 1.4 million dual-eligibles in California who receive Medicare and full benefit Medi-Cal. Dual-eligibles are recipients who are over 65 or, if under 65, have been receiving disability benefits from the social security administration for more than 24 months. More than 60% of dual-eligibles are the elderly (65+). Providing care for these members is complex, expensive and involves multiple state programs (See **Figure 1**).



Many dual-eligibles have chronic care needs and require help with multiple activities of daily living (ADLs) such as help with ambulation, dressing, bathing and incontinence, etc. This population also includes many who have mental illness, cognitive impairments, physical limitations or require care for a combination of these issues. As a group, dual-eligibles consist of recipients with the highest needs and highest costs to the state and require more care and are sicker than their Medicare-only counterparts. (See **Figure 2**).

Conditions of California Medicare Enrollees, by Coverage Type, 2012 (data released 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.

California's system of providing care to dual-eligibles is fragmented, costly and, for many recipients, inefficient. The care model and number of available private and public plans that provide services to dual-eligibles varies depending on the geographic area. Accessing care for beneficiaries is complicated since Medicare and Medi-Cal have different rules and medical standards. Many Medicare providers (e.g. doctors) do not accept Medi-Cal as payment and agencies that provide Medi-Cal services (e.g. dentists, In Home Support and Services, mental health professionals) do not participate with Medicare.

The California Coordinated Care Initiative (CCI)

In 2014, California began a demonstration program, called the California Coordinate Care Initiative (CCI) in 8 counties to test a more streamline, cost efficient approach to providing care to dual-eligibles. CCI has two components - Managed Long Term Support and Services (MLTSS): mandatory enrollment with a CCI MCO to provide Medi-Cal services, including provider visits, medicines, hospital care, and special equipment and Cal MediConnect (CMC): voluntary enrollment for Medicare benefits to be administered by the same CCI MCO managing MLTSS.

The Center for Medicare and Medicaid Services 2nd Evaluation Report for CCI

Despite overall member satisfaction with CCI, the September 2021 2nd Evaluation Report of CCI published by the Centers for Medicare and Medi-Cal Services (CMS) found that CCI had significant problems:

1. **Statistically higher Medicare costs for CCI members than when compared to non-CCI counterparts.**

Instead of the expected Medicare savings, CCI cost the state more rather than less Medicare dollars. The gross costs for all eligible CCI beneficiaries Year 1-3 of the demonstration period increased, on average, by $57.85 per member per month (PMPM) when compared to counterparts in a comparison group. **(**See **Figure 3**)

MEDICARE EXPENDITURES

Regression analyses of the demonstration impact on Medicare Parts A and B costs found statistically significant increases in gross costs for all eligible beneficiaries (including those enrolled in MMPs, and those who are eligible but not enrolled), relative to their counterparts in a comparison group.

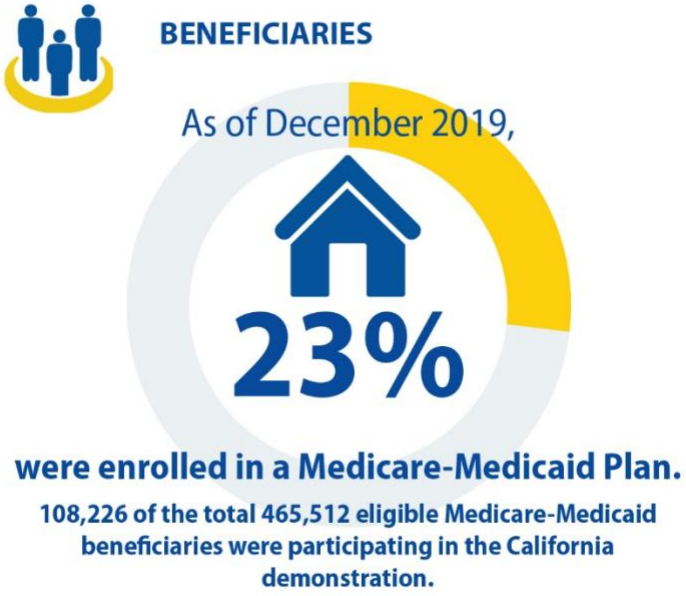
Monthly demonstration effect on Medicare Parts A and B costs, by demonstration year

Demonstration Period	Average Demonstration Effect on Medicare Expenditures, PMPM
DY 1 (April 2014 – December 2015)	$61.93*
DY 2 (2016)	$53.89*
DY 3 (2017)	$60.80*
Demonstration period (Years 1–3, cumulative)	$ 57.85*

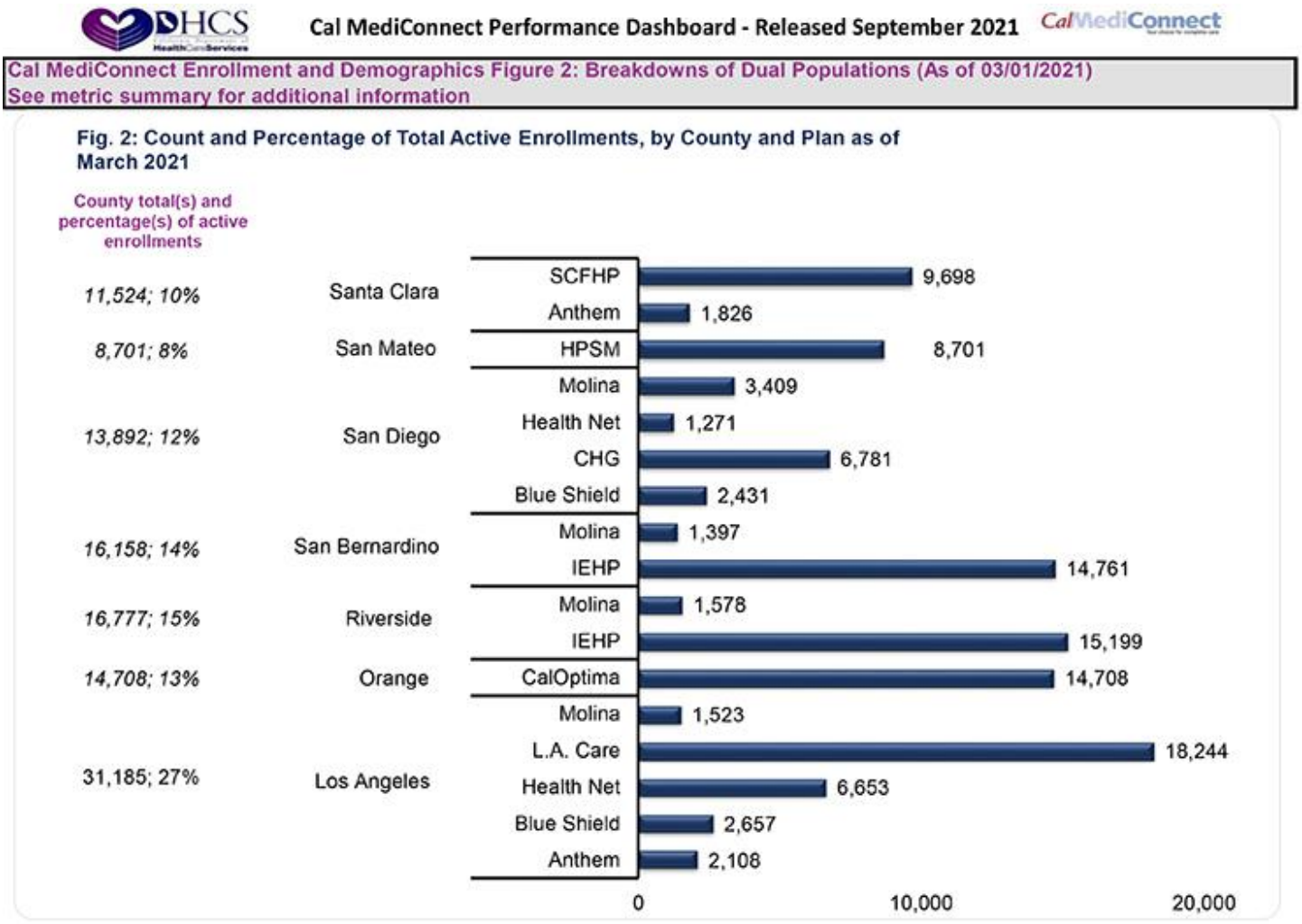
Notes: DY = Demonstration Year; PMPM = per member per month; * = p-value <0.05.
Cost analyses are considered preliminary because of a delay in cost corridor data.

2. **CMC low enrollment.**

Despite a robust marketing effort by MCOs and the state to promote the program, most dual-eligibles chose not to enroll with CMC. Out of 456,000 eligible dual-eligibles only 108,226 choose to participate with CMC: about 23%. **(**See **Figure 4**)



Asking dual-eligibles to switch from their established and trusted Medicare providers (e.g. family physicians) to a CCI MCO with a different provider network was always an uphill battle for the state. Competing Medicare Advantage plans fearing the loss to their business also encouraged their members not to enroll with CMC. In Los Angeles, the largest CCI demonstration site, only 27% of eligible participants chose to enroll with CMC. In all other counties, CMC enrollment was less than 15%. (See **Figure 5**)



3. **The inability of CCI MCOs to manage the care needs of their members as they progressed along the care continuum due to the carve-out of other existing Medi-Cal waiver programs.**

   Numerous Medi-Cal waiver program removals (carve-outs) from CCI disrupted the continuity of care for CCI providers as members transferred back and forth from one care setting (e.g. home to skilled nursing, hospital to home, home to assisted living, etc.).

In Home Support and Services (IHSS) was originally included as part of CCI but was carved-ou in 2018 due to difficulties in cost sharing, administration, care coordination and logistical challenges between the two programs.

The Assisted Living Waiver (ALW) carve out prevented CCI MCOs from developing programs that would prevent the unnecessarily institutionalization of members. Instead of promoting skilled nursing facility (SNF) diversion/transition, the ALW carve out created perverse fiscal incentives that encouraged CCI MCOs to keep members in expensive SNFs rather them allowing them to reside in more affordable assisted living homes (aka residential care facilities for the elderly or RCFEs).

4. **Uncertain fiscal sustainability.**

   Despite their investments into improving the program, CCI MCOs raised concerns with the state about the lack of transparency in results of blended Medi-Cal rates and risk corridor calculations, and about significant delays in Medi-Cal rate-setting, reconciliation, and payments. These ongoing issues plagued the program, caused uncertainty about future revenue, and made it difficult to manage care to a specific dollar target.

California Advancing and Innovating Medi-Cal (Cal AIM)

In January 2022, California will begin California Advancing and Innovating Medi-Cal (Cal AIM): a 5-year plan to transform California's Medi-Cal delivery system to integrate it more seamlessly with social service programs and to advance key priorities by leveraging Medi-Cal to help vulnerable populations including the homeless, the mentally ill, children with complex health needs, justice involved populations and the aged. CalAIM will fully replace CCI and CMC by December 2022.

California is budgeting more than $6 billion for CalAIM: $1.6 billion ($650.7 million General Fund) in 2021-22, $1.5 billion ($812.5 million General Fund) in 2023-24 and a decrease to $900 million ($480 million General Fund) in 2024-25 and ongoing.

Among CalAIM's many working parts are two significant components: Enhanced Care Management (ECM) and In Lieu of Services (ILOS):

Enhanced Care Management (ECM): a collaborative and interdisciplinary approach to provide comprehensive case management for clinical and non-clinical needs for high need Medi-Cal recipients with the goals of improving care coordination, integrating services, facilitating community resources, improving health outcomes, addressing social determinants of health, and decreasing inappropriate utilization; and

In Lieu of Services (ILOS): flexible rate categories not traditionally covered by current state Medi-Cal waivers that allow CalAIM plans to offer services "in lieu of" nursing homes to focus on combined social and medical determinants of health and to avoid higher levels of care. For example, ILOS might be used to avoid or provide a substitute

to avoid hospital or SNF admission, discharge delays and emergency department use. Some examples of permissible ILOS include:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- SNF Transition/Diversion to Assisted Living Facilities
- Community Transition Services/SNF Transition to Home Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

CalAIM plans have the option of picking and choosing the ILOS they offer to their members. For example, some plans might offer ILOS to help the homeless population (e.g. Housing Transition Services and Housing Deposits) while others might choose to implement measures to allow assisted living options to prevent unnecessarily institutionalization (e.g. SNF Transition/Diversion to Assisted Living). The number of ILOS offered by a plan is expected to increase over time (e.g. a CalAIM plan might choose to offer a handful of ILOS options in 2022 and add new ones in subsequent years).

A New Step Forward

The creative use of CalAIM components, including ECM and ILOS, will be critical in providing health care services to California's most vulnerable populations, including dual-eligibles. Providing cost-efficient, streamlined care for their Medicaid recipients is a priority for every state in the nation. California has the most dual-elgibles of any state (see **Figure 6**) and a large role to play in proving how this country provides care to the medically needy low-income. CalAIM, if successful, will provide a roadmap with critical guideposts and directions for other states to follow in the future.

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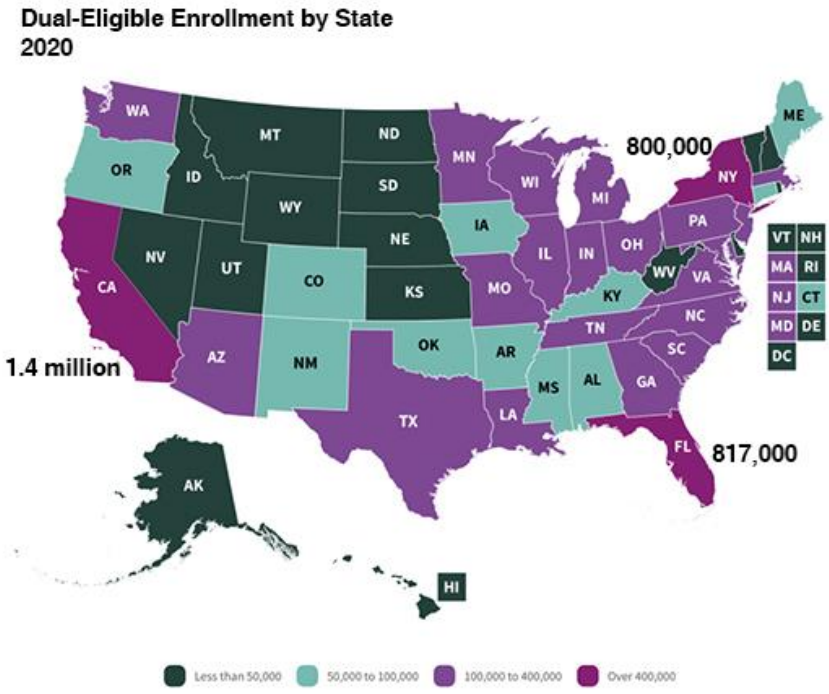

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