



Rethinking PARIS Data Match: Connecting Veterans on Medi-Cal to Federal Benefits

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Summary

There are approximately 170,000 military veterans enrolled in Medi-Cal, the state-federal program providing medical and long-term care services to low-income persons. Of these veterans, more than 150,000 served in World War II, the Korean War, and/or the Vietnam War, and likely qualify for their Medi-Cal coverage as seniors and persons with disabilities (SPDs). Since 2009, the Department of Health Care Services (DHCS) has used a computer data matching process known as the Public Assistance Reporting Information System (PARIS) to identify certain veterans who receive Medi-Cal services and may be able to voluntarily shift to health care services provided by the U.S. Department of Veterans Affairs (USDVA).

California Does Not Pursue a Major Source of PARIS Veterans Savings

State's Current Treatment of USDVA Monetary Benefits and Medi-Cal Estate Recovery in the In-Home Supportive Services (IHSS) Program Limits Potential Savings From PARIS Veterans Activities. The state of Washington achieves the majority of its savings from the PARIS Veterans activities by counting a type of USDVA monetary award known as aid and attendance (A&A) toward the costs of providing home- and community-based services (HCBS) through Medicaid. In contrast, California does not count A&A toward the costs of the state's largest Medi-Cal HCBS program, IHSS. Relatedly, the state does not include the IHSS costs of certain IHSS recipients when it recovers Medi-Cal costs from the estates of deceased beneficiaries. The state would need to change both its treatment of A&A in the IHSS program as well as its approach to estate recovery for IHSS recipients in order to achieve savings similar to Washington. There are fiscal and policy implications to consider before making such a change.

Recommend Reexamination of Treatment of A&A and Medi-Cal Estate Recovery in IHSS Program. We recommend that the Legislature require DHCS and the Department of Social Services (DSS) to jointly report to the Legislature with information that addresses the issues we

raise regarding the state's treatment of A&A in the IHSS program and the state's approach to estate recovery for IHSS recipients. The information reported should specifically provide (1) the policy and legal rationale for the state's current approach as well as (2) an analysis of the fiscal and policy implications of changing the state's approach in a manner conducive to realizing additional savings from PARIS Veterans activities.

Additional Benefits From Expanding Current PARIS Veterans Activities

State Can Realize Savings From Transfer of Certain Veterans Receiving Medi-Cal Skilled Nursing Facility (SNF) Care to USDVA SNF Care. The PARIS Veterans activities can be used to identify veterans who are receiving SNF care paid for by Medi-Cal but who may also be eligible to receive SNF care paid for by USDVA. By facilitating the voluntary transfer of such veterans to SNF care funded by USDVA, the state would realize General Fund savings and the veteran would likely experience certain financial benefits.

PARIS Veterans Activities Are Constrained by Resource Limitations and Problematic Approach. While the state currently pursues the above voluntary health care transfers through PARIS Veterans activities, it has not provided additional resources to DHCS, the state Department of Veterans Affairs (DVA), or County Veteran Service Offices (CVSOs) to conduct the outreach necessary for such transfers to occur. When outreach to PARIS Veterans clients does occur, the state presently intends for it to focus on encouraging veterans to voluntarily discontinue Medi-Cal coverage and rely solely on USDVA health care. This can be problematic for certain veterans who may need services that are difficult to access through USDVA health care, making it difficult for CVSOs—which are advocates for veterans—to make the case for discontinuing Medi-Cal coverage.

Recommend Modified Pilot With Additional Resources. We recommend that the Legislature establish a new pilot of PARIS Veterans activities, with additional staff resources at DHCS, DVA, and three CVSOs to pursue a modified outreach approach. To achieve General Fund savings, the outreach conducted by DVA and CVSOs should focus on facilitating transfers of certain veterans to SNF care funded by USDVA. To provide policy benefits to the state, the outreach should also assist PARIS Veterans clients in receiving USDVA monetary benefits.

INTRODUCTION

There are approximately 170,000 military veterans enrolled in California’s Medicaid program (known as Medi-Cal), the state-federal program providing medical and long-term care services to low-income persons. Of these veterans, more than 150,000 served in World War II, the Korean War, and/or the Vietnam War, and most likely would qualify for Medi-Cal coverage as seniors and persons with disabilities (SPDs). About 5,000 of these wartime veterans receive long-term care in SNFs funded by Medi-Cal, and over 4,000 have difficulty performing activities of daily living (ADLs) such as bathing, eating, and toileting.

In our *2007-08 Analysis of the Budget Bill*, “Data Match Increases Veterans’ Access to Benefits and Reduces State Costs,” we recommended that the state participate in a computer data matching process known as PARIS to (1) identify certain veterans who receive Medi-Cal services, and (2) facilitate a voluntary shift, or transfer, of these veterans to the USDVA health care system. (Hereafter, we collectively refer to PARIS data matching, identification, and outreach activities related to veterans as “PARIS Veterans.”) The state currently tracks Medi-Cal savings from such a

transfer when the veteran discontinues his or her Medi-Cal coverage and relies solely on USDVA health care. As part of the 2008-09 budget, the Legislature authorized a two-year pilot program to evaluate PARIS’ effectiveness.

This report contains our updated analysis of PARIS Veterans in light of findings from (1) the pilot evaluation and (2) our own research and discussions with state and local agencies involved in PARIS Veterans activities. Our findings incorporate best practices from Washington State, which uses PARIS to mutually benefit that state’s general fund and resident veterans who are enrolled in Medicaid.

In the first part of the report, we provide an overview of USDVA health care and monetary benefits that are available to certain veterans and their family members—especially to those who are aged or disabled and who may also qualify for Medicaid as a result of their low-income status. In the second part, we examine the potential level of state savings associated with certain types of PARIS Veterans outreach. Finally, we present our recommendations regarding the future implementation of PARIS Veterans.

BACKGROUND

OVERVIEW OF MEDI-CAL

Medicaid Is a Joint Federal-State Program.

Medicaid is a joint federal-state program that provides health coverage to low-income populations. In California, the Medicaid program is primarily administered by DHCS and is known as Medi-Cal, although some benefits are administered by other state departments such as DSS. The federal government pays for a share of

the cost of each state’s Medicaid program. The Medi-Cal Program generally receives one dollar of federal funds for each state dollar it spends on those services.

Medi-Cal Provides a Wide Range of Health-Related Services. Federal law establishes some minimum requirements for state Medicaid programs regarding the types of services offered and who is eligible to receive them. Required

services include hospital inpatient and outpatient care, SNF stays, emergency services, and doctor visits. California also offers an array of medical services considered optional under federal law, such as coverage of prescription drugs, durable medical equipment (DME), HCBS, hearing aids, and dental services.

Medi-Cal Operates Under a State Plan and Several Waivers. Generally, states must obtain federal approval for changes to a state’s Medicaid program using one of two methods: (1) State Plan amendments or (2) waivers. The State Plan is the state’s primary contract with the federal government. Waivers allow states to waive federal Medicaid requirements in order to have the flexibility to modify their Medicaid programs in ways that are favorable to beneficiaries.

Services Are Provided Through Two Main Systems. Medi-Cal provides health care through two main systems: fee-for-service (FFS) and managed care. In a FFS system, a health care provider receives an individual payment for each medical service provided. In a managed care system, managed care plans receive a capitated rate in exchange for providing health care coverage to enrollees. For a large proportion of Medi-Cal beneficiaries, enrollment in managed care is mandatory.

Some Medi-Cal Beneficiaries Pay a Share of Cost. The income threshold used to determine Medi-Cal eligibility varies depending on several factors, including age, disability status, or whether an individual is pregnant. Beneficiaries who meet the basic eligibility standards have little or no cost-sharing for services provided through Medi-Cal. However, beneficiaries with incomes too high to qualify for Medi-Cal may be eligible for share-of-cost Medi-Cal. These individuals must pay for a predetermined amount of health care expenses—or their “share of cost”—in each month the individual incurs health care expenses.

Medi-Cal will then pay for any additional covered expenses once the share of cost has been met.

Medi-Cal Long-Term Services and Supports (LTSS)

Medi-Cal provides LTSS to Medi-Cal beneficiaries who meet certain eligibility requirements. The LTSS are commonly categorized into two types: (1) institutional care such as SNFs that provide nursing, rehabilitative, and medical care, and (2) HCBS to maintain people in their homes and communities.

IHSS Is the Largest HCBS Program. The IHSS program, which offers personal care as well as domestic and related care services in the home, is by far the most commonly utilized form of HCBS among SPDs. All IHSS recipients are eligible to receive up to 283 hours per month of assistance with tasks such as bathing, housework, meal preparation, and dressing. The DSS oversees the IHSS program at the state level.

The IHSS program is comprised of four subprograms. Three of these—Personal Care Services Program (PCSP), Community First Choice Option (CFCO), and the IHSS Plus Option (IPO)—receive federal Medicaid matching funds and are included in California’s Medicaid State Plan. Currently, about one-half of the IHSS caseload (or 225,000 recipients) receive services through PCSP, 40 percent (or 176,000 recipients) receive services through CFCO, and 7 percent (or 32,000 recipients) receive services through IPO. (The small remaining percentage of IHSS recipients receive services through the IHSS Residual program, which does not receive federal financial participation.)

Medi-Cal Third Party Liability (TPL) and Estate Recovery

Medi-Cal Is the Payer of Last Resort. Federal law requires Medicaid to be the payer of last resort. If another insurer or program has the responsibility

to pay for health care or long-term care costs incurred by a Medicaid beneficiary, that entity is generally required to pay all or part of the costs prior to Medicaid making any payment—a concept known as TPL. If, for instance, a Medi-Cal enrollee has another source of health coverage, the other health coverage (OHC) is the primary payer for the enrollees' health care, with Medi-Cal covering costs and services that are not otherwise covered.

Medi-Cal Pursues Estate Recovery Against Certain Beneficiaries. Federal law requires all state Medicaid agencies to recover health care costs paid on behalf of certain Medicaid beneficiaries from a deceased's estate. In particular, Medicaid beneficiaries who were either (1) age 55 and older when they received Medicaid benefits or (2) permanently institutionalized—regardless of age—are subject to the state's estate claim. In California, DHCS pursues an estate claim for the amount of the Medi-Cal benefits paid or the value of the estate—whichever is less—upon the death of a Medi-Cal beneficiary, with exceptions in the event that the deceased is survived by a spouse, a minor child, or a disabled adult child. Federal law requires that states recover costs for the following services: (1) SNF or other long-term institutional services; (2) HCBS provided under a Medicaid waiver; (3) hospital and prescription drug services provided while the recipient was receiving SNF care or HCBS; and (4) at the state's option, any other items covered by the Medicaid State Plan, such as optional personal care services (PCSP, CFCO, or IPO within IHSS).

IHSS Costs of PCSP Recipients Are Exempt From Estate Recovery. In California, the IHSS costs of recipients receiving services through PCSP have been exempt from estate recovery since 2000. The state's policy of exempting PCSP from estate recovery is allowed under federal law that grants states the *option* to recover costs from certain items covered by the Medicaid State Plan. The DHCS has

indicated to us that they seek to recover IHSS costs through estate recovery for recipients who receive IHSS through subprograms besides PCSP. We note that IHSS recipients are generally unaware of the subprogram in which they are enrolled and are therefore unaware of whether their IHSS costs will be included in the Medi-Cal estate claim.

OVERVIEW OF USDVA MONETARY BENEFITS

The USDVA administers and delivers two major types of cash benefits to certain veterans and, upon these veterans' deaths, their eligible surviving spouses, children, and dependent parents. The first type of benefit, known as *compensation*, is paid to veterans on the basis of disabilities that were caused or aggravated by specific events that occurred during their military service (hereafter referred to as "service-connected disabilities"). The second type of benefit, known as *pension*, is paid to wartime veterans with limited income and resources who are aged and/or disabled from conditions that are not service related. An individual who is potentially eligible for both compensation and pension payments cannot receive both types of benefits at the same time.

Compensation

The basic compensation paid to each veteran varies according to the combined degree of the veteran's service-connected disabilities, rated by USDVA as a percentage of total function lost. The current monthly payment for basic compensation ranges from \$129 to \$2,816 for a single veteran with no children.

Pension

Disability/Age-Based Pension for Veterans. Basic pension is a needs-based benefit intended to provide certain wartime veterans a minimum level of income to raise their standard of living. Pension may be available to veterans with qualifying

wartime service who are (1) age 65 or over, and/or (2) totally and permanently disabled from conditions that are not related to military service. To receive pension, a wartime veteran who meets age and/or disability requirements must also meet financial requirements regarding income and net worth. The current maximum annual pension rate (MAPR) for a single veteran with no dependents is \$12,465, or \$1,039 per month.

Survivors Pension. The survivors pension benefit is available to a low-income surviving spouse who has not remarried and/or the unmarried children of a deceased veteran with qualifying wartime service. Eligibility for survivors pension is also subject to income and net worth limitations. The current MAPR for a surviving spouse with no dependents is \$8,359, or \$697 per month.

Enhanced Monetary Benefits From A&A

Veterans and surviving spouses who meet nonfinancial criteria for basic forms of compensation or pension may also be eligible for the enhanced forms of these benefits if they meet certain additional disability requirements. In order to receive a type of enhanced benefit known as A&A, the claimant must meet at least one of the following disability criteria.

- The claimant requires A&A of another person to perform ADLs.
- The claimant is required to remain bedridden due to disability.
- The claimant is in a SNF due to mental or physical incapacity.
- The claimant is blind or has certain visual impairments.

Below, we briefly describe how USDVA applies these A&A enhancements to basic compensation and pension payments.

Enhanced Compensation for Veterans and Spouses Needing A&A. A single veteran who requires A&A to perform ADLs due to his or her service-connected disability may receive an enhanced compensation rate that ranges from \$3,504 to \$8,059 per month, depending on the veteran's level of service-connected disability. Veterans who receive compensation may also receive an additional payment for spouses who require A&A. This monthly payment ranges from \$43 to \$144 depending on the veteran's level of service-connected disability.

Enhanced Pension From A&A Payments. The USDVA offers enhanced pension rates for veterans and surviving spouses who meet the disability criteria for A&A and pension as well as the nonfinancial criteria for basic pension. The A&A benefit increases the effective MAPR—and therefore the income eligibility limits—for receiving a pension. Thus, a claimant whose income is too high to qualify for basic pension may still qualify for an enhanced pension from A&A.

The difference between the basic and enhanced monthly pension rates for a given claimant is also known as the A&A payment. Currently, the maximum A&A payment for a single veteran with no dependents is \$694. Figure 1 compares the MAPRs for the basic pension and the enhanced pension under A&A and provides the corresponding maximum A&A payment.

CVSOs

The CVSOs—located in 56 of California's 58 counties—are staffed by local veterans service representatives whose mission is to advocate for veterans and their family members and provide assistance in accessing state and federal veterans' benefits. While CVSOs have a cooperative relationship with DVA, CVSO representatives are county employees. The CVSO representatives assist veterans and their family members in accessing

Figure 1

MAPR for Basic and Enhanced Pension by Family Composition

	Basic Pension MAPR	Enhanced Pension MAPR	Maximum Monthly Pension Enhancement From A&A
Single veteran	\$12,465	\$20,795	\$694
Veteran with spouse/dependent	16,324	24,652	694
Two veterans married to each other	16,324	32,115	1,316
Surviving spouse	8,359	13,362	417
Surviving spouse with one dependent	10,942	15,940	417

MAPR = maximum annual pension rate and A&A = aid and attendance.

USDVA pension, compensation, A&A, and other benefits.

THREE FORMS OF FEDERAL MILITARY-RELATED HEALTH CARE

There are three forms of federally funded health care related to military service: (1) USDVA health care available to certain veterans; (2) TRICARE available to active duty personnel, reservists, and retirees with 20 or more years of military service and their dependents and survivors; and (3) the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) available to dependents and survivors of deceased or disabled veterans. Below, we provide an overview of USDVA health care, which operates under a unique system in which certain veterans receive priority for certain services. Later in this report, we address how the state may realize Medi-Cal savings by transferring certain veterans to USDVA long-term care.

USDVA Health Care System Not Intended to Be a Veteran’s Sole Source of Health Coverage.

Unlike health care plans like TRICARE, CHAMPVA, or Medi-Cal, the USDVA health care system is not considered a health insurance plan because it does not provide a standard set of benefits to all enrolled beneficiaries. Access to certain benefits—including SNF care, dental care, hearing aids, eyeglasses, and DME—vary

from individual to individual, depending on each veteran’s unique eligibility status. Generally, an individual who served in active military service—for two years or for the full period for which they were called to active duty—and who was discharged or released under conditions other than dishonorable qualifies for some level of USDVA health care benefits.

The USDVA assigns a veteran to one of eight enrollment priority groups based primarily on veteran status, service-connected disability, and income. Pursuant to federal law, the priority groups serve as a means for USDVA to balance demand for services with limited funds appropriated by Congress. If Congress does not appropriate sufficient funds for USDVA to provide care for veterans enrolled in all eight priority groups, then veterans enrolled in lower priority groups may lose coverage. Eligibility for the eight priority groups is described in Figure 2 (see next page).

The eligibility restrictions that the USDVA health care system imposes on access to certain services means that veterans cannot necessarily depend on USDVA health care as their sole source of health care coverage. For example, certain veterans enrolled in priority group one may still not receive SNF care since this benefit has strict eligibility requirements that we describe later in the report. Further, HCBS administered by USDVA (such as home health aide services) may not be

available for veterans who need such services because of the high demand for this type of care. For these reasons, USDVA advises veterans in its benefits materials to consider their total health care needs and to keep any existing health coverage they have. Veterans residing in rural areas or in communities that are geographically distant from the nearest USDVA health facility also face challenges in relying on USDVA as their primary or sole source of health coverage.

USDVA Health Care Not Considered OHC by Medi-Cal. The state realizes Medi-Cal savings from OHC by entering “OHC codes” into its Medi-Cal Eligibility Data System, which enables the OHC to be billed prior to Medi-Cal for the provision of health care services. In the case of USDVA health care, DHCS has not attempted to create an OHC code because of a perception that Medi-Cal savings would be limited, either because (1) a Medi-Cal beneficiary could not access a USDVA health

care facility (in order for USDVA to be billed) or (2) because a Medi-Cal beneficiary already accessing a USDVA health care facility would be unlikely to incur significant Medi-Cal costs. We note that the state is able to use OHC to realize some Medi-Cal savings from beneficiaries enrolled in FFS, but generally not from those enrolled in managed care.

OVERVIEW OF PARIS

PARIS consists of three types of computer matches—Interstate, Veterans, and Federal—involving data on individuals who receive or have applied for (1) certain public assistance benefits provided by state-administered programs, and/or (2) certain federally administered benefits. States submit the data on recipients of and applicants for certain public assistance benefits provided by state-administered programs. These include major programs that are jointly funded by the states

Figure 2

USDVA Health Care Enrollment Priority Groups for Veterans

Ranked Highest to Lowest Priority

- Group 1:** Veterans with service-connected disabilities rated 50 percent or more and/or veterans determined by the U.S. Department of Veterans Affairs (USDVA) to be unable to work due to service-connected conditions.
- Group 2:** Veterans with service-connected disabilities rated 30 percent or 40 percent.
- Group 3:** Veterans with service-connected disabilities rated 10 percent or 20 percent, veterans who are former prisoners of war or were awarded a Purple Heart medal or the Medal of Honor, veterans awarded special eligibility for disabilities incurred by treatment or vocational rehabilitation, and veterans whose discharge was for a disability incurred or aggravated in the line of duty.
- Group 4:** Veterans receiving aid and attendance or housebound benefits and/or veterans determined by USDVA to be catastrophically disabled.
- Group 5:** Veterans receiving USDVA pension benefits or eligible for Medi-Cal, and veterans with zero percent service-connected disabilities but with income below USDVA's established means tests.
- Group 6:** Veterans of World War I, veterans exposed to ionizing radiation in Vietnam, veterans of the Persian Gulf War, for any illness associated with combat service in a war after the Gulf War or during a period of hostility after November 11, 1998, for any illness associated with participation in tests conducted by the Defense Department as part of Project 112/Project SHAD, and veterans with zero percent service-connected disabilities who are receiving compensation benefits.
- Group 7:** Veterans with gross household income below the geographically-adjusted income threshold for their resident location and who agree to pay co-pays.
- Group 8:** All other veterans with gross household income above USDVA's means tests who agree to pay co-pays.

and the federal government, such as Medicaid. Federal agencies submit the data on recipients of and applicants for certain federally administered benefits. These benefits include pension income for former civilian and military employees of the federal government (the subject of the Federal match), and USDVA monetary benefits for veterans (the subject of the Veterans match).

The Defense Manpower Data Center (DMDC), a computing facility operated by the U.S. Department of Defense (USDOD), receives all data submissions from states and federal agencies and conducts all PARIS matches at no cost to the states. The DMDC may match each state's data against data submitted by other states. This process, which describes the Interstate matches, identifies any individual who appears in data submitted by more than one state. The DMDC may also match states' data against data submitted by federal agencies. This process, which describes the Veterans and Federal matches, identifies any individual who appears in both the states' data and federal agencies' data.

Reasons for States to Participate in PARIS

Savings From Reducing Improper Benefit Payments. When PARIS began as a federal-state partnership in 1993, the original intent was for both states and the federal government to achieve savings from detecting and reducing improper benefit payments. For example, an individual's eligibility for Medicaid and other state-administered benefit programs is based on his or her state of residence. A state may participate in the Interstate match to identify beneficiaries in its Medicaid program who are simultaneously enrolled in other states' Medicaid programs. The state may further determine that some of these individuals no longer reside in the state, and move to terminate their Medicaid eligibility. This action may result in (1) reduced costs for the state and (2) discontinued

federal matching payments for duplicate benefits.

Similarly, states may participate in the Veterans and Federal matches to identify any payments from USDVA or USDOD received by—but incorrectly recorded for—beneficiaries of state-administered programs. Federal or state rules may require that a portion of these payments be considered income for the purpose of determining an individual's eligibility or share of cost for public assistance benefits. Again, both the state and the federal government may benefit fiscally from any subsequent adjustment or termination of the individual's public assistance benefits.

Increasing Residents' Participation in Federal Benefits, Potentially Creating State Savings.

A state may also use the Veterans and Federal matches to identify individuals potentially eligible for—but not yet receiving—federal monetary or health care benefits. The state may use this information to help connect these individuals to benefits fully funded by the federal government. While such activities generally do not create federal savings and may increase federal costs, they may also (1) offset state costs for providing public assistance benefits to these individuals, and/or (2) promote policy goals of the state to improve residents' access to federal benefits.

How PARIS Matches Operate

Quarterly Data Submissions Contain Two Types of Information. Data submissions for PARIS occur in February, May, August, and November of each year. Generally, the state or federal agency responsible for administering a benefit program submits a dataset that includes the following information on the program's recipients and applicants.

- Identifying information, such as each individual's name, address, phone number, and Social Security number (SSN). The SSN, as the unique identifier for the

recipient or applicant across data from multiple sources, forms the basis of each PARIS match.

- Administrative information specific to the benefit program, such as the case number assigned to an individual and his or her eligible dependents, the type and amount of benefits received, and the category of eligibility.

DMDC Sends Match Files to States. Each state receives a file of results known as the “match file” for each Interstate, Veterans and/or Federal match that the state has signed an agreement to

participate in. The file contains all matched SSNs, or “hits,” that the state received from the match, as well as administrative information pertaining to these hits from other benefit programs. Figure 3 illustrates the process for generating each type of match file.

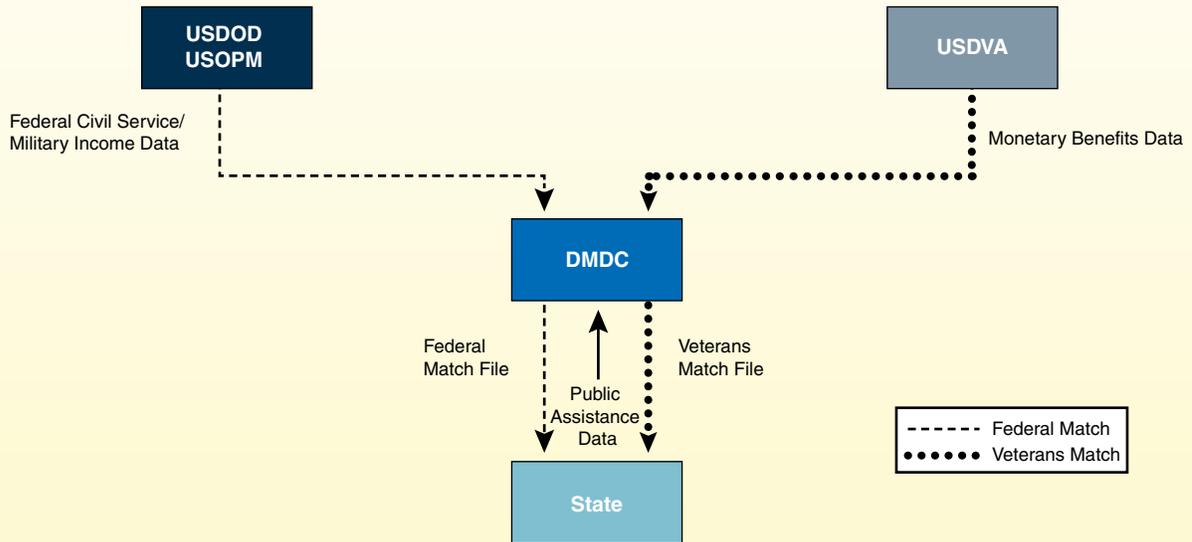
Three Types of Match Files. Below, we briefly describe the match files specific to each of the three types of PARIS matches.

- **Interstate Match File.** This match file identifies individuals listed in the state’s data who are also listed in the data submitted by other states.

Figure 3

PARIS Matching Processes

Federal and Veterans Matches



Interstate Match



PARIS = Public Assistance Reporting Information System; USDOD = U.S. Department of Defense; USOPM = U.S. Office of Personnel Management; USDVA = U.S. Department of Veterans Affairs; and DMDC = Defense Manpower Data Center.

- ***Veterans Match File.*** This match file provides USDVA monetary benefit records associated with individuals listed in the state’s data. This includes whether the individual receives compensation or pension and the total amount of the award.
- ***Federal Match File.*** This match file provides federal payment records from USDOD and/or the U.S. Office of Personnel Management associated with individuals listed in the state’s data. The Federal match file also identifies individuals in the state’s data who are listed in the federal data as active duty members or retirees of the military, and thus likely eligible for health coverage under TRICARE.

While this report focuses on the analysis and use of results from the Veterans match file, we also discuss the use of results from the Federal match file as they relate to TRICARE eligibility.

Only Claimants for USDVA Monetary Benefits Are Included in Veterans Match. All information that USDVA discloses to DMDC

comes from its records system on claimants for monetary, educational, vocational rehabilitation, and employment assistance benefits. These records do not directly address USDVA health care benefits. Because the data submitted by USDVA cover only veterans, dependents, or survivors who are listed in this records system, the Veterans match is unable to identify any individual who, although eligible for USDVA monetary benefits, does not have a recorded history of submitted claims for such benefits. Moreover, PARIS does not match state public assistance data against health care records maintained by USDVA. Any discovery of an individual’s eligibility for or enrollment in USDVA health care is usually based on inferences made from monetary benefit information in the match files. For example, a claimant with a high compensation award likely has a high level of service-connected disability and may be eligible for USDVA-funded long-term care. Despite these limitations, the state of Washington has pioneered—and attributed significant savings to—various applications of the Veterans match, as we describe in the next section.

VETERANS BENEFIT ENHANCEMENT (VBE) IN WASHINGTON STATE

Since 2002, the state of Washington has explored and refined many activities related to the Veterans match. Washington currently conducts these activities under a concerted effort known as VBE to generate state savings in its Medicaid program.

In Washington, the total number of Medicaid enrollees is approximately 1.2 million, including 17,000 individuals receiving SNF care and 26,000 individuals receiving HCBS. By way of comparison, there are currently about 7.9 million beneficiaries enrolled in the Medi-Cal Program, including

62,000 individuals receiving SNF care and about 440,000 receiving HCBS through IHSS. Like California, Washington generally receives one dollar of federal funds for each state dollar it spends on services covered by its Medicaid program.

VBE Is an Interagency Collaboration That Receives Ongoing Resources

The VBE began in 2003 as a pilot initiative of the Washington State Health Care Authority (HCA), the state Medicaid agency. For purposes of the pilot, HCA entered into an interagency contract

with the Washington State Department of Veterans Affairs (WDVA) to provide outreach to certain individuals identified in the Veterans match. Based on the success of the pilot, the Washington State Legislature subsequently provided ongoing resources for WDVA to continue its partnership with HCA, including:

- A continuous appropriation of \$1.5 million biennially to WDVA (Washington enacts budgets on a two-year cycle), partly to support contracts with local Veterans Service Organizations (VSOs) that assist with VBE outreach and claims filing.
- Four full-time staff positions at WDVA to work exclusively on VBE activities.

Three Components of VBE Create Savings for Washington

The VBE focuses on aged and disabled Medicaid recipients in Washington who use LTSS—particularly HCBS—and who may be eligible for USDVA benefits. Below, we describe the three principal components of VBE in descending order of savings attributed to them. These savings are summarized in Figure 4.

Substantial Savings From Treating A&A Payments as TPL. Based on information from the Veterans match file, HCA refers to WDVA any Medicaid beneficiaries who may not be receiving their maximum entitlement to USDVA monetary benefits. The WDVA provides outreach to facilitate new or increased compensation, pension, or A&A awards for these beneficiaries.

Two key Medicaid policies in Washington allow the state to realize substantial savings from facilitating A&A payments through VBE. First, in 2004 the Washington Medicaid program adopted a policy of treating A&A as TPL for LTSS. Thus, Washington requires that any A&A payments to beneficiaries must be used to offset state costs

for LTSS—usually HCBS. Second, the costs of all HCBS are subject to Medicaid estate recovery in Washington, along with the cost of institutional care. This provides the incentive for Medicaid HCBS recipients to apply for A&A, thereby reducing the amount of possible claims against their estates.

For Washington's state fiscal year of 2011-12, VBE program staff reported facilitating monetary benefit enhancements, such as A&A, for 220 Medicaid recipients, and estimated \$4 million in state savings from the portion of these enhancements counted as TPL for LTSS. Since 2006, Washington has facilitated monetary enhancements for 1,600 recipients—and recorded \$18.9 million in cumulative TPL-related LTSS savings—as a result of this component of VBE.

Modest Savings From Shifting State Medicaid Costs to Federal Payers. The VBE program staff at HCA identifies Medicaid beneficiaries who are potentially eligible for TRICARE and CHAMPVA from the Federal and Veterans match files, respectively. The VBE staff refers these cases to the TPL division at HCA, which confirms whether any beneficiaries are already enrolled in TRICARE or CHAMPVA and updates their records for OHC accordingly. As a result, providers must bill TRICARE or CHAMPVA before Medicaid will pay for any services provided to these beneficiaries. Finally, HCA performs outreach activities, such as mailing notification letters to individuals who are eligible but not enrolled in TRICARE or CHAMPVA.

For Washington's state fiscal year of 2011-12, VBE program staff reported establishing OHC from TRICARE or CHAMPVA for 975 Medicaid recipients, resulting in an estimated \$2.3 million in state savings. Since 2006, Washington has established OHC for 4,000 Medicaid recipients—and recorded \$11.4 million in cumulative savings—as a result of this component of VBE.

Limited Savings From Discontinuing Medicaid for Veterans With High Service-Connected Disability. The HCA uses the Veterans match file to identify Medicaid recipients who are veterans with service-connected disabilities rated at 70 percent or higher. Because these veterans usually qualify for full USDVA coverage of long-term care—including institutional care—they may not require Medicaid coverage. Washington reports that around 30 veterans in this category have discontinued their Medicaid coverage as a result of VBE to date, and estimates annual state savings from shifting each individual to USDVA long-term care coverage at \$24,000 per individual.

Washington State Model for PARIS Veterans Implementation

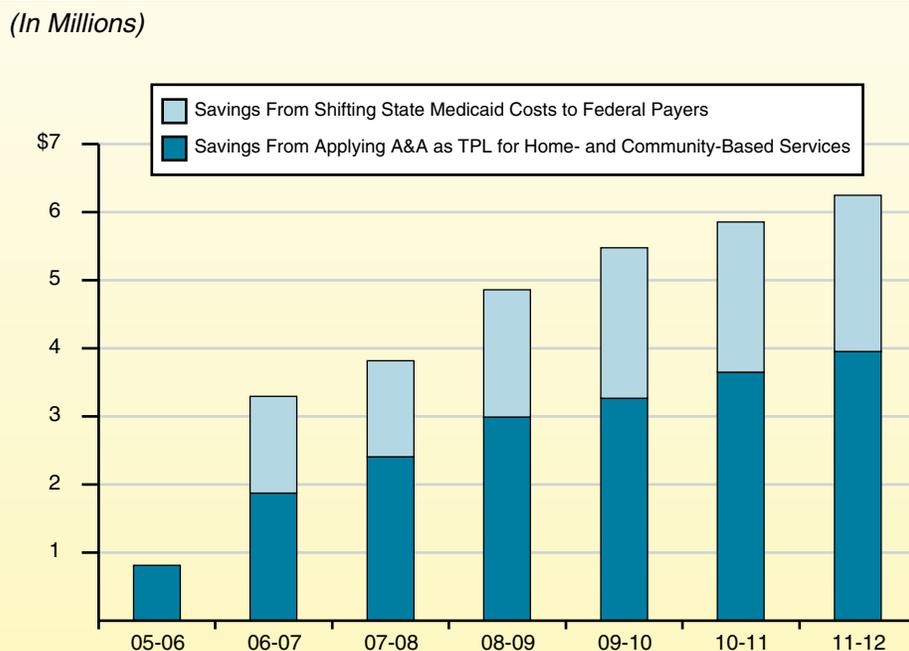
The implementation model used in Washington State for PARIS Veterans can best be understood as a coordinated partnership among three entities: HCA, WDVA, and local VSOs providing assistance to veterans in filing USDVA claims. As explained below, each of these entities perform distinct functions to ensure that veterans, dependents, and survivors identified by the PARIS Veterans match (hereafter

collectively referred to as “PARIS Veterans clients”) receive USDVA benefits for which they are eligible.

HCA Is the Lead Agency for Sending and Receiving Veterans Match Data. The HCA—the lead entity responsible for the state’s PARIS Veterans activities—conducts some initial filtering of the PARIS Veterans file before sending it to WDVA. Broadly, two HCA staff members conduct two main activities: (1) overseeing PARIS Veterans activities and (2) tracking the amount of savings resulting from PARIS Veterans.

WDVA Manages PARIS Veterans Outreach. Four full-time WDVA staff conduct two main activities: (1) outreaching to PARIS Veterans clients who appear to be eligible but not enrolled in CHAMPVA and (2) conducting initial outreach to clients who appear to be eligible for additional USDVA monetary benefits. In terms of outreaching

Figure 4
Majority of PARIS Veterans Savings in Washington State Come From Monetary Enhancements



PARIS = Public Assistance Reporting and Information System, A&A = aid and attendance; TPL = third-party liability.

to PARIS Veterans clients who appear to be eligible for CHAMPVA, the WDVA staff generally make phone calls to these individuals and provide assistance in completing the USDVA application. In terms of PARIS Veterans clients who appear to be eligible for USDVA monetary benefits, WDVA staff will make initial phone calls to these clients. Information ascertained about a client in this manner constitutes a “warm lead” that is sent to local VSOs who follow up with clients to file USDVA monetary claims.

VSOs Assist PARIS Veterans Clients by Filing USDVA Monetary Claims on Their Behalf. The VSOs have entered into performance contracts with WDVA, which compensates these groups for the administrative costs associated with all claims they file on behalf of veterans and their family members.

By providing warm leads that are likely to result in an award, WDVA creates an incentive for VSOs to develop and file claims for PARIS Veterans clients.

HCA Tracks Amount of Savings Resulting From All PARIS Veterans Activities. The HCA staff receive results from all PARIS Veterans activities conducted by WDVA and VSOs. In terms of the PARIS Veterans clients enrolled in CHAMPVA by WDVA, the TPL division of HCA will code this coverage as OHC and then track any reduction in utilization of Medicaid-covered services in order to quantify the resulting amount of Medicaid savings. In terms of the PARIS Veterans clients who are awarded A&A, the HCA staff track the amount of Medicaid savings that result from counting A&A as TPL for HCBS.

PARIS VETERANS IN CALIFORNIA: PILOT AND CURRENT OPERATION

Chapter 758, Statutes of 2008 (AB 1183, Committee on Budget) directed DHCS to establish a two-year pilot program to use PARIS to (1) identify veterans, dependents, and survivors enrolled in Medi-Cal; and (2) assist these individuals in obtaining USDVA health care benefits. If DHCS determines the pilot is cost-effective, then the legislation gives DHCS the option to implement the program statewide at any time and continue the operation of PARIS indefinitely.

The legislation also required DHCS to evaluate outcomes and savings from the pilot and provide the Legislature with a report on the findings and recommendations. In April 2012, DHCS released this report, which covered the period between July 2009 and June 2011. We first review the report’s description of the main activities and results from

the pilot and then describe how PARIS Veterans continues to operate in select counties.

HIGHLIGHTS FROM DHCS PILOT REPORT

DHCS Set Up Pilot as Required by Legislation . . . Per Chapter 758, DHCS pursued the following activities to implement the PARIS Veterans pilot.

- Entered into a Memorandum of Understanding with DVA to perform pilot outreach activities through DVA’s connection with CVSOs. Under the terms of this agreement, DHCS was responsible for filtering match results and sending outreach referrals to DVA. The DVA in turn was responsible for forwarding these referrals to CVSOs and reporting any outcomes to DHCS.

- Delegated to DVA the selection of three consenting counties where USDVA medical centers were located to participate in the pilot—Fresno, San Bernardino, and San Diego.
- Focused on beneficiaries identified by the match who were receiving high-cost Medi-Cal services, including long-term care.

... With Some Additional Activities ... The report also discusses DHCS’ use of the match file to identify family members and survivors who appeared to be eligible for CHAMPVA.

... And Counties ... Halfway through the pilot, seven additional counties requested to participate in PARIS Veterans. However, as we explain below, the final outcomes and savings in the report were concentrated within the three original counties.

... Using Existing Resources. The Legislature did not appropriate additional funding or positions to implement the pilot. Thus, DHCS redirected analytical staff and information technology resources to complete PARIS Veterans workload on an as-needed basis. The report estimated that over the course of the pilot, the department redirected a total of \$75,000 General Fund in administrative resources.

Pilot Outcomes and Savings

According to the report, DHCS submitted to the federal government about 5.6 million Medi-Cal records over the eight quarterly match periods occurring within the pilot. From these records, DHCS received 16,387 hits in the match files, including some duplicate hits of beneficiaries who were identified repeatedly over multiple quarters. (A “hit” is a SSN that was identified in both the Medi-Cal and USDVA data.)

Over 16,000 Hits Translated Into 24 Discontinued Medi-Cal Cases ... Figure 5 (see next page) illustrates how the number of cases decreased at each stage of referrals and outreach. Out of the 16,387 hits received, DHCS made 3,933 referrals to CVSOs for outreach (including duplicate referrals). These resulted in:

- 990 attempts by CVSOs to contact beneficiaries based on these referrals, including letters and telephone calls.
- 158 beneficiaries contacted by CVSOs who were found to be already enrolled in both Medi-Cal and USDVA health care.
- 24 of these 158 individuals discontinuing their Medi-Cal coverage before the end of the pilot.

It is our understanding from the report that the 158 beneficiaries contacted by CVSOs with both Medi-Cal and USDVA health coverage were mainly distributed among the three original pilot counties—117 in San Bernardino, 24 in San Diego, and 10 in Fresno. The report did not include any further results for the remaining 832 CVSO contacts. The report estimated General Fund savings of just over \$700,000 for the two-year pilot period from the 24 individuals contacted by CVSOs who discontinued their Medi-Cal coverage.

... And Three Cases With OHC Updated for CHAMPVA. The DHCS identified and established OHC for three Medi-Cal FFS beneficiaries who were already enrolled in CHAMPVA, for an estimated \$112,000 in General Fund savings over the two-year pilot period. The DHCS report does not cover savings from establishing TRICARE OHC through the Federal match.

Nature of Outreach

The report states that 24 discontinued Medi-Cal cases came about “as a result” of CVSO outreach.

The report also claims that during outreach, CVSOs explained how USDVA health care may be able to provide specialty services for veterans that may be harder to obtain through Medi-Cal, such as specific treatments for service-connected conditions. Furthermore, CVSOs contacted veterans with information about Medi-Cal estate recovery requirements, and this information appeared to be a “powerful reason” for veterans to consider discontinuing Medi-Cal and/or enrolling in USDVA health coverage.

Resource Constraints

According to the report, DHCS lacked the necessary staff resources to produce an unduplicated count of unique hits and referrals for the report, making it difficult to evaluate the effectiveness of the referral and outreach process. The report also attributes the pilot’s limited amount of state savings and limited number of successful contacts on inadequate resources at the state level, such as:

- Limited project management did not allow the pilot to achieve “maximum success.”
- Existing workload does not permit DHCS and DVA to redirect staff to operate PARIS Veterans to its “fullest potential.”

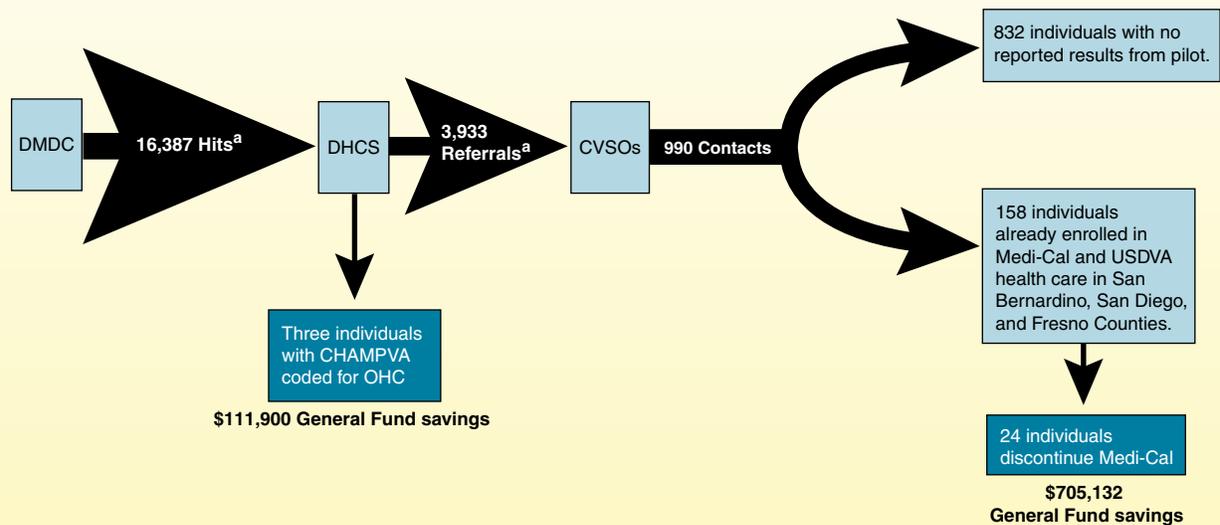
The report also cites budget constraints, staffing shortages, and workload pressures at CVSOs as factors limiting the pilot’s effectiveness. For example, the report notes that CVSOs contacted only 25 percent of the nearly 4,000 referrals from DHCS.

Report Suggests More Could Be Done With Additional Resources. The report suggests the Legislature could (1) provide new positions at DHCS and DVA dedicated to PARIS Veterans and (2) consider a statewide expansion of the match with these resources. The report also claims that with additional resources, CVSOs could follow up on the remaining 832 contacts that were not accounted for in the final pilot results.

Figure 5

Pilot Activities and Results From PARIS Veterans

2009-10 Through 2010-11, Eight Quarterly PARIS Matches



^a Includes duplicate individuals over multiple quarters.
 PARIS = Public Assistance Reporting and Information System; DMDC = Defense Manpower Data Center; DHCS = Department of Health Care Services; CVSO = County Veterans Service Offices; USDVA = U.S. Department of Veterans Affairs; CHAMPVA = Civilian Health and Medical Program of the Department of Veterans Affairs; OHC = other health coverage.

CURRENT OPERATION OF PARIS VETERANS

DHCS Has Not Requested Resources or Indicated Expansion Plans for PARIS Veterans.

Despite the pilot’s reported benefit of \$810,000 General Fund over two years—as well as the report’s suggestion that more resources could improve outcomes for PARIS Veterans—DHCS has not formally requested additional funding or positions to operate PARIS Veterans. Nor has the department signaled any plans to exercise its broad authority to expand PARIS Veterans statewide on the basis of cost-effectiveness.

Post Pilot, PARIS Veterans Continues in 11 Counties. Currently, DHCS receives Veterans

match file results for Medi-Cal beneficiaries in 11 counties, and refers a subset of the hits for CVSO outreach in these counties. Aside from Napa, these are the same 10 counties that participated in the pilot. Figure 6 shows the total number of hits received and targeted referrals from the February 2013 Veterans match files. According to DHCS, other ongoing activities include (1) establishing OHC for additional beneficiaries identified with CHAMPVA and (2) income verification for USDVA monetary benefits by county welfare departments. However, we have not obtained savings estimates related to these activities.

LAO FINDINGS

CALIFORNIA DOES NOT PURSUE WASHINGTON’S MAJOR SOURCE OF SAVINGS

As noted earlier, Washington State realizes the majority of its PARIS Veterans savings by counting A&A as TPL for Medicaid HCBS. The Washington example suggests that the ability to recover the costs of HCBS (such as personal care services) through A&A can serve as a financial incentive for recipients to seek A&A, which—when counted as TPL—reduces the amount of the Medicaid estate claim. In California, however, A&A is not counted as TPL for IHSS—our largest HCBS program—because of reasons unclear to us. In order to pursue Medicaid savings from PARIS Veterans on the order of those achieved

in Washington, the state would first need to begin counting A&A as TPL for IHSS. Second, the state would need to examine its inconsistent treatment of IHSS costs for the purpose of Medi-Cal estate recovery. As we note in the background, the IHSS costs of certain recipients are exempt from the Medi-Cal estate claim while the costs of other recipients are not. Below, we further explain the

Figure 6
Medi-Cal Hits and Referrals
From February 2013 Veterans Match

County	Hits	Referrals to CVSOs
Alameda	490	61
Fresno	430	41
Orange	635	108
Sacramento	633	59
San Bernardino	789	175
San Diego	915	133
San Francisco	401	47
San Mateo	130	9
Santa Clara	299	26
Solano	211	29
Napa	118	31
Totals	5,051	719

CVSOs = County Veterans Service Offices.

lessons from Washington’s experience, the state’s treatment of A&A in the IHSS program, and why the Medi-Cal estate recovery policy is relevant to PARIS Veterans.

Policies Align to Achieve Savings in Washington State

In Washington, where A&A is counted as TPL for Medicaid HCBS and where the costs of such services are included in the state’s estate claim, there is a clear financial incentive for the Medicaid beneficiary to seek A&A in order to reduce the amount of the claim that the state may seek against the Medicaid beneficiary’s estate. For VSO representatives, who serve as advocates for veterans and their family members in Washington, assisting clients in seeking A&A aligns with their core mission. Further, the state of Washington has a financial incentive to devote staff resources to help Medicaid beneficiaries access A&A, since the benefit functions as TPL for HCBS. This alignment of incentives among PARIS Veterans clients, the VSO, and HCA enables Washington State to realize the majority of its PARIS Veterans savings from counting A&A as TPL for Medicaid HCBS.

Policies Do Not Align to Achieve Savings in California

In California, A&A is *not* counted as TPL in the IHSS program. Further, IHSS costs incurred by PCSP recipients—approximately one-half of the IHSS caseload—are *excluded* from the Medi-Cal estate claim. In order for California to align its policies to achieve Medicaid savings on the order of those achieved in Washington (adjusting for California’s larger size), the state would need to make the following two policy changes in tandem.

- **Count A&A as TPL for IHSS Recipients.** The state would need to begin counting the A&A award as TPL for IHSS recipients eligible for federal Medicaid matching funds.

- **Consistent Inclusion of IHSS Costs in Medi-Cal Estate Claim.** The state would need to begin including IHSS costs incurred by PCSP recipients in the Medi-Cal estate claim.

If the state were to pursue these two policies, all IHSS recipients eligible for A&A would have a personal financial incentive to seek the award as a means of minimizing their Medi-Cal estate claim.

Unclear Why California Does Not Count A&A as TPL for IHSS

IHSS Program Became Subject to Federal Medicaid Law Beginning in 1993. The IHSS program shifted from an independent program funded solely by state and county funds to a Medi-Cal benefit covered under the Medicaid state plan in 1993. Today, close to 99 percent of IHSS recipients are eligible for federal Medicaid matching funds. As such, the program is subject to federal Medicaid law stipulating that Medicaid is the payer of last resort. If another insurer or program (such as A&A) has the responsibility to pay for health care or long-term care costs incurred by a Medicaid beneficiary, that entity is generally required to pay all or part of the costs prior to Medicaid making any payment—a concept known as TPL.

Case Law Affirms That A&A May Be Counted as TPL for IHSS. Courts in various jurisdictions—including Washington State—have ruled that a state Medicaid agency may count A&A as TPL. Our informal consultation with staff of Legislative Counsel leads us to find that the state may count A&A as TPL for IHSS recipients receiving this USDVA monetary benefit.

A&A Currently Counts in California as TPL in Institutional Care Settings. Currently in California, a Medi-Cal beneficiary’s A&A award can be counted as TPL when the beneficiary enters

a SNF. Based on our understanding of the IHSS program as a Medi-Cal benefit governed by federal Medicaid requirements, it appears to us to be inconsistent for the state to pursue A&A as TPL in institutional settings but not for IHSS.

State’s Estate Recovery Policy Raises Concerns

As we note, IHSS costs incurred by PCSP recipients—who are about one-half of the IHSS caseload—are *excluded* when the state seeks to recover Medi-Cal costs from estates. The DHCS *does* recover costs for recipients who receive IHSS through subprograms besides PCSP. If DHCS begins to count A&A as TPL for IHSS, then the state’s estate recovery policy for IHSS must also be evaluated to ensure that recipients’ incentives are appropriately aligned. Currently, the state’s inconsistent treatment of IHSS costs means that certain recipients have a financial incentive to seek A&A to reduce the Medi-Cal estate claim while others—whose IHSS costs are exempt from estate recovery—do not have such an incentive.

State Could Achieve Savings by Mirroring Washington State Policies

If the state were to align financial incentives facing IHSS recipients (related to TPL and estate recovery policies) in a manner similar to Washington, we estimate Medi-Cal savings from counting A&A as TPL to yield at least \$5 million to \$10 million annually in state General Fund savings.

MODEST SAVINGS MAY BE ATTAINABLE FROM EXPANDING CURRENT ACTIVITIES

In this section we (1) review PARIS Veterans activities that the state has pursued since the start of the pilot and (2) provide a rough estimate of the potential General Fund benefit from expanding these current activities statewide. We note this estimate—which includes optimistic assumptions about the success rate of these activities and

excludes their cost of implementation—replaces the savings estimate from our *Analysis of the 2007-08 Budget Bill*. (In the box on the next page, we discuss how we have revised our view on PARIS Veterans savings with respect to the *Analysis of the 2007-08 Budget Bill*.)

Long-Term Care Veterans Represent Major Portion of Savings From Pilot . . .

Around half of the savings achieved during the pilot was due to just four long-term care beneficiaries discontinuing their Medi-Cal coverage. If these beneficiaries (1) were residing in SNFs when they or their family members were contacted by CVSOs, and (2) discontinued their Medi-Cal coverage as a result of this contact, then presumably they are veterans with a high level of service-connected disability who are eligible for SNF care provided by USDVA. However, we were unable to confirm from DHCS whether any of the four long-term care beneficiaries who discontinued their Medi-Cal coverage during the pilot actually transferred to USDVA-operated or -contracted SNFs.

Clearly, small numbers of long-term care beneficiaries represent disproportionate amounts of the total Medi-Cal savings to date from PARIS Veterans. However, these amounts are also small in practical terms—roughly \$180,000 General Fund annually estimated from the pilot.

. . . But Potential Statewide Savings From These Veterans Are Highly Uncertain, Likely Less Than \$10 Million Annually

The Legislature’s decisions about whether to expand PARIS Veterans activities statewide—and/or whether to invest more resources in the program—should be informed by some plausible range of savings that are potentially available from the current mainstay activity: shifting long-term care costs from Medi-Cal to USDVA. One key

question is the size of the population of long-term care veterans with Medi-Cal who are potentially suitable for transfer to USDVA long-term care.

Using survey data collected by the U.S. Census Bureau between 2009 through 2011, we estimate there are around 5,000 veterans over the age of 65 who receive Medi-Cal-funded SNF care in California. Most of these beneficiaries likely would not meet the service-connected disability requirements for USDVA-funded long-term care. We believe at most 10 percent of all veterans over age 65 with Medi-Cal coverage are rated 70 percent or more disabled from service-connected conditions, which means they are in priority group one and receive the most access to USDVA care. (We were unable to obtain a reliable estimate of this percentage specifically for veterans with Medi-Cal coverage residing in SNFs.)

We estimate potential General Fund savings from pursuing institutional long-term care transfers to USDVA statewide may be as high as

\$7 million annually, assuming (1) there are roughly 500 veterans in California receiving Medi-Cal-funded SNF care who meet the 70 percent service-connected disability threshold, and (2) up to 50 percent of these individuals successfully transfer to USDVA long-term care. We note that 50 percent may represent an optimistic scenario. The limiting factors on the actual rate of transfers include the specific criteria for when such transfers are possible or appropriate, and the effectiveness of CVSO outreach and other steps necessary to implement these transfers. We examine both of these issues further below.

CONSIDERATIONS FOR VETERANS ENROLLED IN BOTH MEDI-CAL AND USDVA HEALTH CARE

In our *Analysis of the 2007-08 Budget Bill*, we recommended that the state implement use of PARIS Veterans to facilitate a voluntary “transfer” of certain veterans from Medi-Cal to USDVA health care. Such a transfer implies that

Previous LAO Estimate of Potential Savings From Shifting Medi-Cal Costs to USDVA No Longer Applies

Our *Analysis of the 2007-08 Budget Bill* estimated that the state could save as much as \$250 million annually if all veterans enrolled in Medi-Cal transferred to the U.S. Department of Veterans Affairs (USDVA) health care. This estimate was partly based on assumptions that (1) many veterans were seniors and persons with disabilities (SPDs) receiving care through Medi-Cal fee-for-service (FFS) and (2) the state would achieve savings not necessarily from these veterans discontinuing their Medi-Cal coverage, but rather from avoiding FFS costs when veterans chose to obtain health care services from USDVA instead of Medi-Cal.

Since 2010, the state has enacted policies to shift many SPDs—including those who are veterans—into Medi-Cal managed care. The state makes monthly capitated payments for each managed care enrollee, regardless of whether that enrollee actually uses health care services. Thus, a veteran who is enrolled in both USDVA health care and Medi-Cal managed care generally would have to discontinue his or her Medi-Cal coverage for the state to realize savings. Because this method of achieving savings conflicts with our view—elaborated later in this report—that veterans living in the community should generally maintain their Medi-Cal coverage, we recognize that our previous savings estimates generally do not apply in the current managed care environment.

a veteran enrolled in USDVA health care either (1) discontinues Medi-Cal coverage completely and solely utilizes USDVA health care or (2) retains Medi-Cal coverage but primarily utilizes USDVA health care.

The USDVA advises veterans against discontinuing coverage and relying solely on USDVA health care. This advice makes sense from a veteran's perspective, given the fact—previously discussed—that USDVA health care coverage is not designed to be a veteran's sole health coverage. While we have concerns about veterans' ability to access certain needed services through USDVA—particularly SNF care and HCBS—we do find that there are certain veterans who are receiving SNF care through Medi-Cal who may be able to successfully transfer to SNF care provided by USDVA. This provides the eligible veteran with certain financial benefits (discussed further below).

Veterans Living in the Community Should Maintain Medi-Cal Coverage

Generally, it is not appropriate for veterans living in the community to discontinue their Medi-Cal coverage because the USDVA benefits for which they may be eligible may not provide comprehensive health care coverage. Take, for instance, the case of an aging veteran who suffers from conditions that affect his or her ability to perform ADLs but does not suffer from service-connected disabilities. Such an individual would not be given priority for USDVA health services, including HCBS, which the veteran may need to remain safely in his or her home and community. In contrast, Medi-Cal would provide long-term care, such as IHSS or other HCBS, to such an individual based on clinical and functional need.

We recognize that, in some cases, USDVA provides superior care when compared to Medi-Cal. In particular, specialized services for veterans, such as military sexual trauma services or

talk therapies for post-traumatic stress disorder, as well as certain surgeries or other treatments, may be more appropriately administered by USDVA. Ultimately, the services that a veteran may wish to seek from Medi-Cal or USDVA will be determined by several factors: his or her eligibility for and access to USDVA benefits, individual preferences, health care needs, and other considerations such as cost and quality of care. We believe it is a worthwhile activity for CVSO representatives and other veteran advocates to continue to assist veterans in enrolling in USDVA health care and for veterans to access USDVA benefits as appropriate. However, given the variability in USDVA benefits provided to veterans based on their priority group, veterans living in the community are appropriately advised not to discontinue Medi-Cal coverage altogether. This view has consequences for the state's ability to realize Medi-Cal savings from PARIS Veterans.

It May Be Appropriate for Some Veterans in SNFs to Transfer From Medi-Cal to USDVA Long-Term Care . . .

Conditions for Transferring to USDVA Long-Term Care. We find that there are three conditions that, if met, reflect circumstances where it may be appropriate for a veteran receiving SNF care through Medi-Cal to transfer to a SNF funded by USDVA.

- **Condition One.** The veteran is eligible to receive SNF care through USDVA due to having a clinical need for SNF care and also meeting at least one of the following eligibility criteria: (1) 70 percent or more service-connected disability, or (2) 60 percent or more service-connected disability and inability to work, or (3) a service-connected condition that makes SNF care necessary.

- **Condition Two.** The USDVA has a SNF bed available in a community preferred by the veteran.
- **Condition Three.** The veteran is willing and able to transfer to the USDVA-funded SNF bed.

Financial Benefits From Transferring to USDVA Long-Term Care. By transferring to a USDVA-funded SNF bed, a veteran would avoid the potentially adverse financial consequences of accessing SNF care through Medi-Cal. Specifically, a veteran who is required to pay a share of cost each month in order to qualify for SNF care under Medi-Cal would no longer face such a payment in a USDVA-funded facility. Further, USDVA does not have an estate recovery policy similar to Medi-Cal.

... But Whether These Veterans Should Also Retain Medi-Cal Coverage Depends on Their Individual Situations

Veterans in FFS Generally Should Retain Medi-Cal Coverage. Veterans enrolled in FFS Medi-Cal who transfer to USDVA-operated or -contracted facilities would be appropriately advised not to discontinue their Medi-Cal coverage, but rather retain it as a safety net in the event that they return to the community and require HCBS or other services that may be difficult to obtain through USDVA. Otherwise, they would have to reenroll in Medi-Cal following discharge from the USDVA-funded SNF, and may experience disruptions to care while waiting to receive HCBS. Moreover, during their stay at the USDVA facility, they would still be able to avoid estate recovery for the cost of most health care and long-term care services while remaining enrolled in FFS Medi-Cal. Later in the report, we describe how DHCS could track Medi-Cal savings from veterans who maintain their FFS Medi-Cal coverage following their transfer to USDVA long-term care.

Veterans in Managed Care May Face Trade-Offs From Retaining Medi-Cal Coverage.

If a veteran is enrolled in managed care and retains his or her Medi-Cal coverage, the state would continue to make managed care payments following the veteran's transfer to USDVA long-term care. Moreover, the state could potentially pursue claims against the veteran's estate for the cost of these managed care payments, which may be relatively high since they include the average cost of institutional care. (As part of an enacted state policy known as the Coordinated Care Initiative [CCI], LTSS—including SNF care—will become managed care benefits in eight counties, with capitated payments to plans reflecting the average long-term care cost per enrollee rather than actual utilization of services.) Therefore, the only way for veterans in managed care to avoid estate recovery (and for the state to realize savings from their transfer to USDVA long-term care) is to discontinue their Medi-Cal coverage entirely.

We recognize that some veterans residing in SNFs have little possibility of returning to their home or community. For example, some of these veterans may be institutionalized due to a terminal illness or a debilitating condition from which recovery is highly unlikely. Because these veterans would not likely require HCBS in the future, maintaining their Medi-Cal coverage may not be necessary once they transfer to USDVA long-term care. These veterans may consider discontinuing their Medi-Cal coverage, since they could benefit from avoiding estate recovery of managed care payments while sacrificing little in the way of services they actually require for the foreseeable future. However, veterans who are likely to transition back to their home and community would have to weigh the trade-offs of having continuous Medi-Cal coverage versus avoiding the estate claim when deciding whether to remain enrolled in Medi-Cal.

LACK OF DEDICATED RESOURCES AND OTHER FACTORS CONSTRAINED PILOT AND ITS EVALUATION

We find the implementation of the pilot, including the evaluation of outcomes from the pilot, was constrained by a lack of resources and other factors that we describe below. We base our findings on (1) our discussions with program staff who oversee PARIS Veterans at DHCS and DVA, (2) our discussions with representatives of CVSOs from the original three pilot counties, and (3) DHCS' report on the pilot.

DHCS Lacked Dedicated Resources to Effectively Implement Pilot

The DHCS did not receive or request additional resources to implement PARIS Veterans. According to DHCS, the lack of resources constrained its ability to more effectively implement the pilot in the following ways.

- ***Duplicate Data Obscured Evaluation of Pilot.*** The DHCS was unable to produce an unduplicated count of the number of submissions, hits, referrals, and CVSO contacts over all eight quarters of the pilot. This makes it difficult to evaluate the actual success rate of outreach efforts.
- ***Non-Updated Referral Lists Hindered Outreach.*** The DHCS was unable to update referral lists for errors identified by CVSOs during previous quarters. As a result, some CVSOs complained that they received referral lists that contained the same errors over multiple quarters, including deceased recipients, incorrect contact information, and individuals who are not veterans or dependents.
- ***Transfers to USDVA Went Unconfirmed.*** The DHCS assumes state savings from

PARIS Veterans from long-term care clients discontinuing their Medi-Cal coverage and relying instead on their USDVA coverage. However, DHCS did not confirm whether discontinued Medi-Cal recipients successfully transferred to a USDVA long-term care facility, thereby failing to confirm a basic policy premise of PARIS Veterans.

- ***Certain Outreach and Monetary Benefit Enhancements Obtained Went Unmeasured.*** To our knowledge, there are no official measures of (1) outreach to individuals who may be eligible for USDVA health care but are not yet enrolled, and (2) monetary benefit enhancements obtained by veterans as a result of PARIS outreach.

DHCS Does Not Track All FFS Cost Avoidance Resulting From PARIS

Cost avoidance refers to expected payments on FFS claims that Medi-Cal would otherwise have to make over a given period of time if an individual who discontinued coverage or used alternative coverage had instead obtained care through Medi-Cal during that same period. Because it is impossible to track which services the beneficiary would have used in this alternate scenario, cost-avoidance calculations may be based on the beneficiary's actual prior utilization of services, or the average expenditures for all FFS beneficiaries in the same aid category. In contrast, managed care savings are only tracked by DHCS when a beneficiary disenrolls from the managed care plan and the department ceases to make known monthly capitated payments for that beneficiary.

According to our conversations with program staff, DHCS does not regularly track such cost avoidance to include as official savings within the Medi-Cal budget in cases when individuals remain

in FFS Medi-Cal but use alternative coverage. Therefore, DHCS was unable to provide an estimate of potential fiscal benefits from individuals who shift to USDVA long-term care but do not discontinue their FFS Medi-Cal coverage.

CVSO Outreach Was Constrained by Lack of Resources

Through conversations with CVSO representatives, it is our understanding that they faced several challenges in performing outreach activities related to PARIS Veterans. The CVSOs reported that they were only able to conduct PARIS Veterans outreach to the extent that staff had time available after they completed their routine duties. Further, the need for a veterans service representative to have some level of knowledge about Medi-Cal eligibility in order to conduct the requisite outreach meant that only certain individuals were qualified to do so. The one-on-one nature of the outreach also made it labor-intensive.

DHCS and CVSOs Did Not Share Same Policy Priorities for PARIS Veterans

The DHCS report to the Legislature regarding the PARIS Veterans pilot indicates that the primary focus of DHCS during the pilot was to use the Veterans match to identify clients who would voluntarily supplant their Medi-Cal coverage with USDVA health care, yielding Medi-Cal savings. However, the primary focus of CVSOs is to advocate and assist veterans and their family members to obtain benefits, such as monetary benefits. The CVSOs were expected to make the case to veterans to discontinue Medi-Cal coverage on the basis that (1) USDVA health care is superior to Medi-Cal and (2) the veteran could potentially avoid the Medi-Cal estate claim. In our conversations with CVSO representatives, they expressed a belief that counseling veterans to discontinue Medi-Cal coverage generally went against their mission to help veterans. Accordingly, CVSO outreach may not have been as robust as DHCS intended.

RECOMMENDATIONS

REEXAMINE HOW TPL AND ESTATE RECOVERY POLICIES APPLY TO IHSS RECIPIENTS

Require DHCS and DSS to Jointly Report to the Legislature

In this report, we describe the legal basis for counting A&A as TPL in the IHSS program and note that it appears to be inconsistent for the state to count A&A as TPL in SNF settings but not for IHSS since both SNF care and the IHSS program are Medi-Cal LTSS. In addition, the rationale for why certain IHSS recipients receive an A&A award intended for IHSS-like services that the state does not count toward IHSS costs is unclear to us. In

effect, the IHSS recipient receiving A&A is provided more services (in the form of the A&A award *and* IHSS hours) than the assessed need may warrant.

If the Legislature passed legislation to change the state's current TPL policy and require DHCS to begin counting A&A as TPL for IHSS, then the state would realize Medi-Cal savings. (The amount of savings would depend upon the number of IHSS recipients currently receiving A&A and the average award amount received by these individuals.) However, we recognize that such a change in state policy has implications—for example, IHSS recipients who receive the A&A award would now, in effect, be contributing to a greater share of cost for their IHSS benefits.

Aside from the state's current treatment of A&A for IHSS, there is a second policy issue that we identify as preventing the state from realizing Medi-Cal savings from PARIS Veterans on the order of those achieved by Washington's Medicaid program. In California, since 2000, IHSS costs incurred by PCSP recipients—approximately one-half of the caseload today—have been exempt from the state's Medi-Cal estate recovery claim. Even if the state changed its policy to count A&A as TPL for IHSS, this exclusion means that only some IHSS recipients would have a financial incentive to seek A&A to reduce the amount of their Medi-Cal estate claim. There does not appear to be a policy basis for this inconsistent treatment of IHSS recipients for the purpose of estate recovery.

To assist the Legislature in re-evaluating the state's current TPL and estate recovery policies, we recommend that the Legislature require DHCS and DSS to jointly report to the Legislature by hearings on the 2014-15 budget on the following three issues.

- ***Policy and Legal Rationale for Current Approach.*** The DHCS and DSS should provide a policy and legal rationale for the current approach in which (1) A&A is not counted as TPL for IHSS and (2) the IHSS costs of PCSP recipients are exempted from estate recovery while the IHSS costs of recipients of other subprograms are not.
- ***Assessment of Policy Implications of Changing Approach.*** The DHCS and DSS should provide an assessment of the policy implications of changing the current approach to (1) count A&A as TPL for IHSS and (2) include the IHSS costs of PCSP recipients in the Medi-Cal estate claim.
- ***Assessment of Fiscal Implications of Changing Approach.*** The DHCS and DSS should provide an estimate of General

Fund savings for changing the current approach to (1) count A&A as TPL for IHSS and (2) include the IHSS costs of PCSP recipients in the Medi-Cal estate claim.

Upon receiving this information prepared jointly by DHCS and DSS, we believe the Legislature would then have sufficient information to determine whether changes to current state policies are appropriate in order to facilitate greater Medi-Cal savings from PARIS Veterans.

ESTABLISH NEW PILOT OF PARIS VETERANS WITH MODIFIED OUTREACH APPROACH AND ADDITIONAL RESOURCES

Earlier, we indicated that modest General Fund savings may be attainable from statewide implementation of PARIS Veterans to transfer certain veterans from Medi-Cal-funded SNFs to USDVA long-term care. We also noted the potential financial benefits to certain veterans from such transfers, as well as from linking veterans with USDVA monetary benefits for which they are eligible. However, our savings estimates are highly uncertain and assume that (1) around 500 veterans in the state meet eligibility requirements for such transfers and (2) a combination of effective CVSO outreach and other factors result in half of these veterans successfully transferring to USDVA long-term care. In our view, the PARIS Veterans pilot did not demonstrate the level of outreach necessary for maximizing such transfers, due to resource constraints, a problematic approach, and other issues. Moreover, because CVSOs only acted on 25 percent of the referrals from DHCS, the pilot yielded little information about the potential size of the veteran population that may be suitable for transfer.

We have not seen evidence to suggest that ongoing implementation of PARIS Veterans in 11 counties—which continues to operate without additional resources—has improved significantly

from the pilot. Thus, we believe that any expansion of PARIS Veterans beyond these 11 counties—which increases workload for the involved departments and CVSOs and may not generate much fiscal or policy benefit due to the current problems we highlighted above—is premature. However, we think that there is enough potential for fiscal and policy benefits to justify a second pilot, if the pilot is refocused with a better outreach approach and provided with additional resources as we recommend below. If the Legislature provides modest resources to support the operation and evaluation of this second pilot, we believe there is a reasonable chance for it to accomplish the following objectives.

- Demonstrate how much (1) a refined approach to outreach and (2) dedicated resources will actually improve implementation and outcomes.
- Provide more data to inform estimates of the potential level of savings from expanding PARIS Veterans—under improved implementation—to other counties.
- Improve the financial situation of aging and disabled veterans by helping them avoid (or reduce) a Medi-Cal estate claim and access their entitlements to USDVA monetary benefits.
- Generate sufficient savings within the pilot to cover the cost of additional resources.

Accordingly, we recommend the state (1) pilot for two years what we believe to be an improved approach to PARIS Veterans outreach, and (2) provide dedicated two-year limited-term staff resources at DHCS, DVA, and CVSOs to conduct and evaluate this second pilot. The DHCS would again be required to produce a report of the pilot's findings and recommendations. Based on the

report's updated assessment of the level of savings available, the Legislature could consider whether to expand PARIS Veterans statewide and/or whether to maintain or augment these additional resources.

Besides Pursuing Transfers to USDVA Long-Term Care, Positions Would Also Connect Veterans to Monetary Benefits. Besides pursuing long-term care transfers that fiscally benefit the state, these positions would also support activities that yield mainly policy benefits to the state: facilitating USDVA monetary awards for veterans, dependents, and survivors identified in the Veterans match. Increasing veterans' access to their entitled compensation and pension benefits has been a consistent priority for the Legislature. However, the DHCS report suggests that monetary benefit enhancement may have been underemphasized during the original pilot due to lack of resources. The VBE setup in Washington—on which we model many aspects of our recommendation—demonstrates how the Veterans match may help the state reach aging, disabled, and/or housebound veterans and survivors who may not be able to regularly access CVSO services.

Modified Outreach Approach

Continue to Pursue Transfers to USDVA Long-Term Care When Appropriate . . . We explained earlier that Medi-Cal savings may be realized—when appropriate—from transferring eligible veterans to USDVA-funded SNF care. Furthermore, if a USDVA-funded SNF bed is available and a veteran is willing and able to make this transfer, then such an individual would potentially experience the financial benefits of (1) no longer making a Medi-Cal share-of-cost payment for SNF care and (2) avoiding a higher Medi-Cal estate claim amount. Therefore, we believe that facilitating these transfers continues to be an appropriate state objective for the second pilot.

. . . But Modify Outreach Approach to Address CVSOS Concerns About Veterans' Best Interests.

The previous pilot's outreach may have been hindered by CVSOS' reluctance or unwillingness to counsel veterans in long-term care to discontinue their Medi-Cal coverage altogether. In our findings, we argued that discontinuing Medi-Cal is usually not appropriate for veterans with FFS coverage, but may be appropriate for certain veterans enrolled in Medi-Cal managed care. Under CCI, 6 of the 11 counties that currently participate in PARIS Veterans are scheduled to shift LTSS—including SNF care—from FFS to managed care benefits for most SPDs. In these six counties, CVSOS may alter their views about whether veterans in long-term care should always keep their Medi-Cal coverage.

We recommend a modified approach to CVSOS outreach that differs depending on whether the veteran receives SNF care under FFS or managed care. We believe this approach will ease the tension between the state's fiscal interest and CVSOS' current reservations about advising veterans to discontinue their Medi-Cal coverage, and thereby foster greater cooperation from CVSOS in performing PARIS outreach and follow-up.

In FFS Counties, CVSOS Should Not Advise Veterans to Discontinue Medi-Cal Coverage.

Under this approach, CVSOS would continue to contact veterans who may be willing and able to transfer to USDVA long-term care. However, in counties where LTSS remain FFS benefits, CVSOS would not ask these veterans to consider discontinuing their Medi-Cal coverage. As we explain later, DHCS would receive additional staff resources to track FFS cost-avoidance for any veterans who transfer to USDVA long-term care while maintaining their Medi-Cal coverage.

In Managed Care Counties, CVSOS Should Present Veterans With Trade-Offs of Discontinuing Medi-Cal Coverage. In contrast

to veterans enrolled in FFS Medi-Cal, there are certain instances in which veterans enrolled in Medi-Cal managed care may benefit financially from discontinuing their Medi-Cal coverage. This is because Medi-Cal managed care payments, which are relatively high for SPDs, may be included in the Medi-Cal estate claim if the veteran remains enrolled in Medi-Cal after switching to a USDVA-funded SNF bed. This financial benefit, however, comes with a potential trade-off—discontinuing Medi-Cal coverage may restrict a veteran's access to certain HCBS if the veteran eventually returns to the community. In counties where LTSS become managed care benefits under CCI, CVSOS would inform veterans and their family members about the trade-offs between keeping and discontinuing their Medi-Cal coverage so that they can make informed decisions.

Additional Staffing Positions

We recommend the addition of the following dedicated two-year limited-term positions at DHCS, DVA, and three CVSOS to continue outreach to transfer veterans to USDVA long-term care—using the modified approach that we outlined above.

One Position at DHCS to Support Department's Role as Lead Agency for PARIS Veterans. We recommend one staff position at DHCS dedicated solely to supporting operations and oversight of the second PARIS Veterans pilot. This additional position would consistently track cost-avoidance associated with veterans in FFS counties who transfer to USDVA long-term care but retain their Medi-Cal coverage. The additional position would also work on improving the collection and reporting of outcomes from PARIS Veterans. In particular, the position would support activities to (1) provide an accurate count of unduplicated hits over the entire pilot period

and (2) confirm and document the actual transfers to USDVA long-term care that result from CVSO outreach.

Similar to the Washington VBE model, the DHCS position would also coordinate regularly with the two DVA positions that we describe below. The DHCS position would help refine the initial filtering of the match file results and update the referral lists to remove previously detected errors so that DVA and CVSOs have more opportunity to establish successful contacts with veterans. To further the policy goal of facilitating USDVA monetary benefits, we also recommend that DHCS—prior to submitting Medi-Cal enrollment data to DMDC for PARIS matching—direct this position to merge the data with information from DSS about the number of IHSS hours that a Medi-Cal beneficiary receives. This would allow DHCS to identify recipients who may easily qualify for A&A benefits due to overlapping criteria for IHSS.

Two Positions at DVA to Conduct Initial Outreach to PARIS Veterans Clients. We describe in this report that WDVA conducts initial outreach to PARIS Veterans clients by (1) outreaching to clients who appear to be eligible but not enrolled in CHAMPVA and (2) conducting initial outreach to clients who appear to be eligible for USDVA monetary benefits. We recommend that DVA receive two additional staff resources to conduct activities similar to WDVA staff. This initial outreach to PARIS Veterans clients would involve making phone calls to ascertain basic information about clients, such as whether they are alive and whether they are interested in seeking USDVA monetary enhancements.

We further recommend that DVA staff ascertain key information about the potential for an individual to transfer from a SNF bed funded by Medi-Cal to a SNF bed funded by USDVA.

This information would likely include whether the PARIS Veterans client is currently in SNF care and whether the individual has a service-connected disability rating from USDVA. Such screening by DVA staff of PARIS Veterans clients would allow CVSOs to focus their outreach on veterans who have a high likelihood of receiving USDVA benefits.

One Position at Each of Three CVSOs to Conduct Follow-Up Outreach to PARIS Veterans Clients. In this report, we explained how the previous pilot sought to realize Medi-Cal savings by tasking CVSO representatives with outreaching to clients to discontinue Medi-Cal coverage. Our findings reveal that this objective was problematic on two fronts. First, in many cases, it may not be appropriate for a veteran to discontinue his or her Medi-Cal coverage altogether and rely solely on USDVA health care because the veteran may not be eligible for certain needed services through USDVA. Second, helping the state realize Medi-Cal savings is not the primary mission of CVSOs. We therefore recommend that the three CVSOs that conducted the greatest amount of outreach to PARIS Veterans clients during the first pilot—Fresno, San Bernardino, and San Diego—each receive one position on a two-year limited-term basis to enhance PARIS Veterans outreach using our modified approach, which we believe aligns with their core mission. The PARIS Veterans staff position in each of these three CVSOs would (1) assist clients by filing USDVA claims for monetary benefits and (2) outreach to clients in SNF care who may be able to successfully transfer to USDVA-funded SNF care.

Positions May Pay for Themselves Through Modest Improvements in Outcomes. We estimate the combined General Fund cost for these positions at around \$340,000 annually. This estimate assumes that federal matching funds are available for about two-thirds of the cost for DVA and CVSO

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positions. (In order to receive these matching funds, the state would have to demonstrate that a portion of the workload for the non-DHCS positions is reasonably related to Medi-Cal

cost-avoidance.) Furthermore, to cover their collective cost, these positions need only facilitate 12 additional transfers of veterans to USDVA long-term care each year.

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