



Cal MediConnect

EVALUATION OUTCOME REPORT

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Executive Summary

In January 2012, Governor Brown announced his intent to enhance health outcomes and enrollee satisfaction for low-income seniors and persons with disabilities through shifting service delivery away from institutional care to home- and community-based settings. Governor Brown enacted the Coordinated Care Initiative (CCI) by signing Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012),¹ SB 1036 (Chapter 45, Statutes of 2012),² SB 94 (Chapter 37, Statutes of 2013),³ SB 75 (Chapter 18, Statutes of 2015),⁴ and SB 97 (Chapter 52, Statutes of 2017).⁵

The CCI included three major components:

1. Cal MediConnect, a Demonstration Project for individuals who are eligible for Medicare and Medicaid (Duals)
2. Mandatory Medi-Cal managed care enrollment for Duals for their Medi-Cal benefits, and
3. The integration of Long-Term Services and Supports (LTSS) into Medi-Cal managed care.

The CCI-enabling legislation included a provision to discontinue the CCI should the Director of Finance determine it was not cost-effective. It was determined during the 2017-18 Governor's budget that the CCI was no longer cost-effective, and; therefore, in accordance with state law, the program was discontinued. Although CCI was not cost-effective during the initial demonstration period, the Administration determined that certain aspects of the CCI, such as Cal MediConnect, provided the potential to reduce the cost of health care for affected individuals and improve health outcomes. Therefore, based on the lessons learned from CCI, the following components of the CCI have been continued: Cal MediConnect; mandatory Medi-Cal managed care enrollment of Duals for their Medi-Cal benefits; and the integration of LTSS (with the exception of In-Home Supportive Services) into managed care.

Welfare and Institutions Code Section 14132.275(m) requires the Department of Health Care Services (DHCS) to conduct an evaluation, in partnership with the Centers for Medicare and Medicaid Services, to assess outcomes and the experience of Duals enrolled in Cal MediConnect. DHCS is required to provide a written report to the Legislature after the first full year of demonstration operation, and annually thereafter, and must consult with stakeholders regarding the scope and structure of the evaluation.

¹ SB 1008 is available at:

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB1008

² SB 1036 is available at:

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB1036

³ SB 94 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB94

⁴ SB 75 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB75

⁵ SB 97 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB97

This report describes the ongoing monitoring activities and evaluations of Cal MediConnect, including an evaluation of impact on the enrollee experience, quality, utilization, and cost; a rapid-cycle polling project; and an evaluation focusing on the coordination of medical health care, behavioral health care, and LTSS.

Background

The Financial Alignment Initiative – Partnerships to Provide Better Care

In July 2011, the Centers for Medicare and Medicaid Services (CMS) announced the opportunity for states and CMS to better coordinate care for individuals who are eligible for Medicare and Medicaid (Duals) under the Financial Alignment Initiative through two different demonstration models:

1. **Managed fee-for-service** in which a state and CMS enter into an agreement by which the state would be eligible to benefit from savings resulting from initiatives to improve quality and reduce costs for both Medicare and Medicaid.
2. **Capitated model** in which a state and CMS contract with health plans (three-way contract) that receive a prospective, blended payment to provide enrolled Duals with coordinated care.

The Financial Alignment Initiative is designed to align the financial incentives of Medicare and Medicaid to provide Duals with a better health care experience. All state demonstrations under the Financial Alignment Initiative are evaluated to assess their impact on enrollee care experience, quality, coordination, and costs. California is testing the capitated model, which is known as Cal MediConnect.

Coordinated Care Initiative

In January 2012, Governor Brown announced the Coordinated Care Initiative (CCI), which is designed to enhance health outcomes and enrollee satisfaction for low-income seniors and persons with disabilities while shifting service delivery away from institutional care to home- and community-based settings. To implement that goal, the Legislature passed, and Governor Brown signed, Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012),⁶ SB 1036 (Chapter 45, Statutes of 2012),⁷ SB 94 (Chapter 37, Statutes of 2013),⁸ SB 75 (Chapter 18, Statutes of 2015),⁹ and SB 97 (Chapter 52, Statutes of 2017)¹⁰ to authorize the CCI.

The three major components of the CCI are:

1. A Duals Demonstration Project called Cal MediConnect (California's Financial Alignment Demonstration) that combines the full continuum of acute, primary, institutional, and behavioral health, along with home- and community-based services (HCBS) into a single benefit package, delivered through an

⁶ SB 1008 is available at:

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB1008

⁷ SB 1036 is available at:

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB1036

⁸ SB 94 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB94

⁹ SB 75 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB75

¹⁰ SB 97 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB97

- organized service delivery system comprised of Medicare-Medicaid Plans (MMPs).
2. Mandatory Medi-Cal managed care enrollment for Duals for their Medi-Cal benefits; and
 3. Integration of Long-Term Services and Supports (LTSS) into Medi-Cal managed care.

Enrollment in the CCI began on April 1, 2014, as described in the implementation schedule titled, "CCI Enrollment Timeline by Population and County."¹¹

Cal MediConnect

Through Cal MediConnect, enrollees have access to a wider scope of benefits than many traditional health plans. For example, Cal MediConnect covers dental, vision, non-medical transportation services, and non-emergency medical transportation services.

Access to care and utilization of benefits under Cal MediConnect is convenient due to *it* utilizing a high level of care coordination. The Department of Health Care Services (DHCS) and CMS contract with MMPs that oversee and are accountable for the delivery of covered Medicare and Medicaid services for Duals in seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. MMPs are responsible for providing a comprehensive assessment of enrollees' medical and behavioral health, LTSS, functional, and social needs, and for ensuring care coordination for enrolled Duals based on these assessments.

Cal MediConnect is designed to offer opportunities for enrollees to self-direct services, to be involved in care planning, and to live independently in the community. Enrollees and their caregivers work with interdisciplinary care teams to develop person-centered, individualized care plans (ICPs).

Cal MediConnect includes protections that verify enrollees receive high-quality care. CMS and DHCS established a number of quality measures that evaluate overall enrollee experience, care coordination, and support of community living, among many other factors.

Cal MediConnect Demonstration Years (DYs) are listed below:

Cal MediConnect DY	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017
4	January 1, 2018 – December 31, 2018
5	January 1, 2019 – December 31, 2019

¹¹ The CCI Enrollment Timeline by County and Population is available at: <http://www.calduals.org/wp-content/uploads/2014/11/CCI-enrollment-by-County-11.20.14.pdf>.

Memorandum of Understanding and the Three-Way Contract

DHCS executed a Memorandum of Understanding (MOU) with CMS on March 27, 2013. The MOU provides federal authority and outlines the parameters for implementing Cal MediConnect.

Specific requirements are outlined in the three-way contracts between the state, CMS, and the MMP(s). These three-way contracts require MMPs to offer quality, accessible care as well as improved care coordination among medical care, behavioral health, and LTSS for enrolled Duals, including a contracting process that facilitates coordinated program operation, enforcement, monitoring, and oversight. The three-way contract includes provisions requiring CMS and DHCS to evaluate the performance of primary-contracted MMPs and their subcontractors. MMPs are held accountable for ensuring that their subcontractors meet all applicable state and federal laws and requirements.

CMS is currently reviewing the three-way boilerplate contract. Updates to the boilerplate contract will be available on the CMS website in early 2019.

Evaluation Activities of Cal MediConnect

Annual Evaluation Report

CMS contracted with Research Triangle Institute (RTI) International to evaluate and monitor the implementation of state demonstrations under the Financial Alignment Initiative for impacts on a range of outcomes including enrollee experience, quality, utilization, and cost for the eligible population as a whole, as well as to evaluate and monitor for impacts on specific subpopulations (enrollees with mental illness and/or substance use disorders, LTSS recipients, etc.). This includes an aggregate evaluation and state-specific evaluations. California's state-specific evaluation is outlined in the California Evaluation Design Plan.¹²

The goals of the evaluation are to monitor demonstration implementation, evaluate the impact of the demonstration on enrollee experience, monitor unintended consequences, and monitor and evaluate the demonstration's impact on a range of outcomes for the eligible population as a whole and for subpopulations (e.g. people with behavioral health and/or substance use disorders, LTSS recipients, etc.). To achieve these goals, RTI International is collecting qualitative and quantitative data from the state demonstration projects each quarter; analyzing Medicare and Medicaid enrollment and claims data; and conducting site visits, enrollee focus groups, and key informant interviews. RTI International is also incorporating relevant findings from any enrollee surveys provided by other entities. Information from monitoring and evaluation activities will be provided by RTI to CMS and DHCS in annual reports, followed by a final evaluation report.

¹² The California Evaluation Design Plan is available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAEvalPlan.pdf>.

As of the writing of this report, an annual evaluation report is currently in process with RTI International and CMS.

Implementation and Ongoing Monitoring

CMS' contractor, the National Opinion Research Center (NORC) at the University of Chicago, receives data on behalf of CMS from all MMPs. NORC is responsible for ensuring that the data received from MMPs is submitted in accordance with federal and state-specific reporting requirements. NORC checks the data submitted based on edits and validation checks that were developed for each core and state-specific MMP quality reporting measure.

A subset of these quality reporting metrics are included in the Cal MediConnect Performance Dashboard, which shares data on MMPs' performance in six areas related to care coordination, quality, and service utilization including: (1) Health Risk Assessments (HRA); (2) appeals by determination; (3) hospital discharge; (4) emergency utilization; (5) LTSS utilization; and (6) case management.¹³ CMS and DHCS collectively monitor this data and provide clarifying and technical guidance to MMPs, as necessary, to support them in maintaining correct and consistent interpretation of the reporting requirements.

DHCS' Cal MediConnect Performance Dashboard Metrics Summary contains enrollment and demographic information as well as plan performance results on NORC quality measures that monitor HRAs, ICPs, and reassessments. DHCS releases dashboard updates one month following the completion of each quarter.¹⁴ Additional measures, based on stakeholder feedback, will be added into the dashboard as data becomes available.

The SCAN Foundation Funded Evaluations

The SCAN Foundation funded two evaluations of the Cal MediConnect program: a Rapid Cycle Polling Project and a longer-term University of California Evaluation, as described below. DHCS worked collaboratively with the SCAN Foundation and stakeholders to develop the content of both evaluations.

Rapid Cycle Polling Project

The SCAN Foundation contracted with Field Research Corporation (FRC) to conduct a Rapid Cycle Polling Project to quantify the impact of Cal MediConnect on California's Duals population in as close to real time as possible. The study compares the levels of confidence and satisfaction of Cal MediConnect enrollees to that of Duals who were eligible for Cal MediConnect, but have chosen not to participate (opt-outs), or who live in a non-Cal MediConnect county. The polling project has completed six waves. FRC completed the first four waves of the polling project, and the University of California, San Francisco, completed the fifth and sixth waves.

¹³ The Cal MediConnect Dashboard is available at: <http://calduals.org/background/cci/evaluations/cal-mediconnect-performance-dashboard/>

¹⁴ Dashboards are available at: https://www.dhcs.ca.gov/Pages/Cal_MediConnectDashboard.aspx.

In June 2018, the University of California, San Francisco completed the sixth wave of the Cal MediConnect Rapid Cycle Polling Project. This survey included over 2,900 interviews with enrollees who were asked about their confidence and satisfaction with health care, as well as any problems encountered. Enrollees were also asked about their needs for and use of LTSS. The results of the sixth wave were released on October 3, 2018, and the full report for this wave, as well as the full report for previous waves, can be accessed online.¹⁵

A summary of the findings show that Cal MediConnect enrollees' confidence in navigating their health care continues to increase. This increase shows a large majority of enrollees who express confidence that they know how to manage their health conditions (82 percent), how to get questions about their health needs answered (84 percent), and who to call if they have a health need or question (89 percent). In alignment with the first finding, enrollee satisfaction with their health care continues to increase, similar to the results in previous waves. In addition, enrollees were asked about the length of time they had been seeing their current personal doctor. Having a shorter (one year or less) relationship with a personal doctor could be interpreted as a sign of problems with continuity of care. The results of the sixth wave reflected that Cal MediConnect enrollees are reporting longer relationships with their personal doctor, which is a key indicator of the care continuum that is especially important when transitioning to managed care. Lastly, only a small percentage, between 10 and 16 percent of Cal MediConnect enrollees, reported that they encountered problems with their health service (e.g. misunderstandings about their health care services or coverage, doctor they had been seeing was no longer available through their plan).

University of California Evaluation of Cal MediConnect

In 2014, an evaluation team comprised of researchers from the University of San Francisco, Institute for Health and Aging and the University of California, Berkeley School of Public Health, designed and implemented a three-year research brief of Cal MediConnect. The evaluation team engaged stakeholder input and built upon the national evaluation, and developed, pilot tested, and finalized data collection instruments, and obtained approval from California's Committee for the Protection of Human Subjects. The following research briefs, which often include data from previous years, were conducted for calendar year 2018 and are outlined below.

In January 2018, the SCAN Foundation released a research brief conducted by researchers from the University of California, San Francisco and Berkeley on the provider perspectives of Cal MediConnect.¹⁶ This research brief built upon a July 2016 evaluation of the early impact of Cal MediConnect on various health systems stakeholders, but primarily Cal MediConnect health plans. Data collected for this research brief included 19 interviews with additional provider stakeholders, including

¹⁵ The full reports on the polling project findings for waves one through six can be accessed at: <https://www.thescanfoundation.org/evaluating-medicare-medicaid-integration>

¹⁶ The presentation for these findings and additional information can be found at: http://www.thescanfoundation.org/sites/default/files/provider_perspectives_final_010818.pdf

physician providers, provider groups, MMP directors of provider networks, Federally Qualified Health Centers, hospitals, management services organizations, and Long-Term Care providers. Findings included the following general themes:

1. Providers perceived Cal MediConnect to be part of a general trend toward more integrated systems of care.
2. Cal MediConnect's additional benefits added value, though awareness of them could be improved, and access more consistent.
3. For some providers, Cal MediConnect introduced more complexity into their client population, presenting challenges with time and resource management.
4. Many providers experienced challenges navigating enrollee eligibility data, as well as the Cal MediConnect referral and authorization processes.
5. Providers struggled with care transitions without assistance from MMPs.
6. Data collection and reporting processes created challenges for some providers.
7. Low MMP reimbursement rates led some providers to decline participation.
8. Provider contracting arrangements with MMPs varied, sometimes including risk-sharing agreements.
9. Some barriers remained in aligning financial incentives between and across MMPs and providers.
10. Cal MediConnect has facilitated data sharing, though progress varies among MMPs and providers.

In May 2018, the SCAN Foundation released an evaluation conducted by researchers from the University of California, San Francisco and Berkeley on coordinating care for Duals through Cal MediConnect, including the progress made and challenges that remain in coordinating care for Duals.¹⁷ Ninety-four key informant interviews were conducted with health system stakeholders, including Cal MediConnect plans, physicians, provider groups, hospitals, Long-Term Care facilities, and HCBS providers. Key findings include:

1. State and federal policies recognize that care coordination is an essential part of integrating care for Duals.
2. There is great variation in how MMPs are organizing and delivering care coordination benefits.
3. The Cal MediConnect care coordination benefit encourages collaboration across health system stakeholders.
4. The Cal MediConnect care coordination requirement could improve care transitions across health care settings.
5. The Cal MediConnect care coordination benefit could improve access to HCBS.

¹⁷ The presentation for these findings and additional information can be found at: http://www.thescanfoundation.org/sites/default/files/uc_coordinating_care_for_duals_through_cal_mediconnect_may_2018.pdf

6. The Cal MediConnect care coordination benefit has affected California's health care workforce.
7. Awareness about the Cal MediConnect care coordination benefit varies among MMPs, providers, and enrollees.
8. Data sharing barriers remain a significant challenge to successful, non-duplicative care coordination efforts.

In September 2018, the SCAN Foundation released a partnered evaluation from the University of California, San Francisco Community Living Policy Center and the Institute for Health and Aging to assess Cal MediConnect enrollees' experiences with care, including access, quality, and coordination over time.¹⁸ A total of 2,100 Duals completed the first telephone survey in 2016. Of those, 1,291 Duals completed a second survey in both 2016 and 2017. Key findings included:

1. Very few people (less than half of one percent) changed MMPs or disenrolled from Cal MediConnect after one year in the program.
2. Cal MediConnect satisfaction overall was very high (94 percent) with enrollees reporting they were "very" or "somewhat" satisfied with their benefits. Satisfaction with benefits was highest among Cal MediConnect enrollees compared to Duals who opted out or those in non-CCI counties.
3. In both 2016 and 2017, one in five Cal MediConnect enrollees reported delays or disruptions in getting care or services. Those who experienced delays or disruptions in care were asked to describe the delays/disruptions they experienced. Reported delays/disruptions included, but are not limited to, delays in receiving medical equipment, medication, appointments, difficulty accessing specialists and primary care providers, and trouble finding a primary care provider. Of those who reported delays/disruptions, 61 percent reported the problems were unresolved. However, those using specialty care were more likely to see problems resolved.
4. Primary care visits decreased among Cal MediConnect enrollees between 2016 and 2017, from 3.5 visits down to 2.9 average visits in a six-month period.
5. Two-thirds of Cal MediConnect enrollees used specialty care.
6. Over 70 percent of Cal MediConnect enrollees reported the ability to go to their hospital of choice all the time, and almost 90 percent of those hospitalized reported being ready to go home when discharged.
7. One in five Cal MediConnect enrollees used behavioral health services, and a majority of those took medication for mental health conditions.
8. Cal MediConnect enrollees took an average of six prescription medications. About two-thirds reported having paid out-of-pocket for prescriptions; this is lower than the out-of-pocket expenses reported by non-Cal MediConnect enrollees, of whom three-quarters reporting paying out of pocket.

¹⁸ The presentation for these findings and additional information can be found at: https://www.thescanfoundation.org/sites/default/files/assessing_the_experiences_of_dually_eligible_beneficiaries_in_cal_mediconnect_final_091018.pdf

9. Less than one-third of Cal MediConnect enrollees reported having a care coordinator.
10. Over three-quarters of Cal MediConnect enrollees said their primary care provider seemed informed and up-to-date about their care from specialists; and about 54 percent said their providers usually or always share information with each other.
11. Compared to opt-outs, more Cal MediConnect enrollees reported getting a ride from their MMP to medical appointments.
12. Half of non-English speaking Cal MediConnect enrollees reported they could “never” get a medical interpreter when they needed one.
13. Among Cal MediConnect enrollees, those who need LTSS had lower satisfaction overall, and were almost four times more likely to rate their overall quality of care as fair or poor.
14. Approximately 37 percent of Cal MediConnect enrollees who needed help with routine needs (e.g., household chores, doing necessary business, shopping, getting around outside the home) reported they needed more help, or got no help at all with those activities.

As outlined above, many findings displayed positive trends in the measures observed, as well as high beneficiary satisfaction ratings. In addition there are areas of dissatisfaction including instances of delays or disruptions in getting care or services, and lower satisfaction overall for members requiring LTSS.

DHCS and CMS are addressing these areas for improvement in a number of ways. First, if an issue is identified for an individual including transportation and interpretation services, DHCS and CMS work directly with the MMP and the beneficiary to solve the issue. Next, a key to minimizing delays and disruptions in care is for each member to have a completed health risk assessment (HRA), a completed individual care plan (ICP), and an engaged care team. Performance measures established for MMPs support the achievement of these member-focused goals and establish Quality Withholds which objectives are not met. Additionally, DHCS and CMS hold, at minimum, monthly conversations with MMP to discuss topics of concern such as those above. DHCS and CMS pose questions to the MMPs before the calls about process and outcomes. In each call, best practices are discussed and opportunities for improvement are identified. Further, MMPs are required to do on-going Performance Improvement Projects (PIP) based on two California-specific reporting measures: Members with an Individualized Care Plan Completed; and Members with Documented Discussions of Care Goals. Many of the specific areas of delay and disruption in getting care and services outlined above are being addressed by a comprehensive ICP, more frequent care team interaction, and more active care coordination.

As mentioned above, the SCAN Foundation findings included lower satisfaction overall for members requiring LTSS. DHCS and CMS are actively involved in initiatives to improve the delivery of LTSS in the areas of skilled nursing facility services and Multipurpose Senior Services Program (MSSP) services.

In 2017 and 2018, DHCS created and published dual plan letters (DPLs) to the MMPs that provide guidance and clarification in areas that can decrease delay or disruption in care in areas including: non-emergency medical and non-medical transportation services; performance improvement projects; care plan option services; and health risk assessment.

Based on the initiatives outlined above and many others, DHCS is working closely with MMPs and CMS to address the issues raised in the SCAN Foundation findings and through other sources, and improve coordination and integration of care for dual eligible beneficiaries.