
# Cal MediConnect

# HEALTH PLAN QUALITY AND COMPLIANCE REPORT

**Demonstration Year 2019**

## Contents

## Executive Summary

In 2014 the Department of Health Care Services (DHCS), in partnership with the Centers for Medicare & Medicaid Services (CMS) implemented Cal MediConnect, a managed care Financial Alignment Demonstration for individuals dually eligible for Medicare and Medicaid.

Welfare and Institutions Code section 14182.17(e)(1)(C) requires DHCS to report to the Legislature, effective January 10, 2014, and for each subsequent year of Cal MediConnect, on the degree to which Medicare-Medicaid Plans (MMPs) operating in the Coordinated Care Initiative (CCI) counties have fulfilled their quality requirements.

This report describes the degree to which MMPs in counties participating in Cal MediConnect have fulfilled quality requirements as set forth in the contract (three-way contract), in addition to providing the following updates:

- The three-way contract was updated with a September 1, 2019 effective date.[1]
- In September 2019, DHCS further announced that, effective January 1, 2021, the Multipurpose Senior Services Program would no longer be covered as a Medi-Cal managed care benefit in CCI counties and would instead operate as a waiver benefit, as it did prior to the implementation of the CCI in 2014.

DHCS and CMS are committed to addressing areas for improvement, and have ongoing efforts underway to monitor and improve enrollee satisfaction and health outcomes in Cal MediConnect.

[1] The current three-way contract template can be found at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAContract.pdf

# 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 dually eligible for Medicare and Medicaid (Duals) under the Financial Alignment Initiative through two different demonstration models:

1. **Managed fee-for-service (FFS)** 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.

California is testing the capitated model, under the Cal MediConnect program. 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.

## Coordinated Care Initiative

The Coordinated Care Initiative (CCI) is authorized by Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012), SB 1036 (Chapter 45, Statutes of 2012), SB 94 (Chapter 37, Statutes of 2013), SB 75 (Chapter 18, Statutes of 2015), and SB 97 (Chapter 52, Statutes of 2017).[2]

The CCI initially included three major components, in seven counties:[3]

1. Cal MediConnect, a capitated model Financial Alignment Initiative;
2. Mandatory Medi-Cal managed care enrollment for all Duals for their Medi-Cal benefits, and
3. The integration of all 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; therefore, in accordance with state law, the program was discontinued.

[2] California legislation authorizing the CCI is searchable here: http://leginfo.legislature.ca.gov/faces/billSearchClient.xhtml

[3] The seven counties where CCI was implemented are: Los Angeles, Orange, San Diego, San Mateo, Riverside, San Bernardino and Santa Clara

Resulting changes included:

- In-Home Supportive Services (IHSS) would no longer be included as a Medi-Cal managed care benefit in the CCI counties, but would continue to be available to eligible beneficiaries through local counties.
- The transition of the Multipurpose Senior Services Program (MSSP) from a FFS benefit to a benefit fully supported in Medi-Cal managed care would be delayed for two years.
- The state would not proceed with the Universal Assessment Tool.

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 continued in the seven counties: Cal MediConnect; mandatory Medi-Cal managed care enrollment of Duals for their Medi-Cal benefits; and the integration of LTSS, including nursing facility care, and Community Based Adult Services, but with the exception of IHSS, into managed care.

In September 2019, DHCS further announced the intention that MSSP would no longer be covered as a Medi-Cal managed care benefit in CCI counties and would instead operate as a FFS benefit, as it did prior to the implementation of the CCI in 2014. The effective date for the MSSP transition to FFS was anticipated to be January 1, 2021, but has been subsequently delayed. This transition requires an amendment to DHCS' Medi-Cal 2020 1115 waiver. DHCS is currently working with CMS to establish a new transition date.

## Cal MediConnect

Through Cal MediConnect, enrollees have access to a wider scope of benefits than many traditional Medicare Advantage 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 the high level of care coordination. DHCS and CMS contract with Medicare-Medicaid Plans (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 |
| 6 | January 1, 2020 – December 31, 2020 |
| 7 | January 1, 2021 – December 31, 2021 |
| 8 | January 1, 2022 – December 31, 2022 |

## 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 amongst 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.[4]

[4] CMS updated the three-way boilerplate contract in 2019 and the updated version can be found here: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAContract.pdf
A summary document of changes made to the three-way contract is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAContractSummaryOfChanges.pdf

## Quality Monitoring and Quality Withholds

To verify that enrollees in Cal MediConnect receive high quality care and to encourage quality improvement, both Medicare and Medicaid withhold a percentage of the respective components of the capitation rate paid to each MMP participating in Cal MediConnect. MMPs are eligible for repayment of the withheld amount subject to their performance on a combination of CMS Core and State-Specific Quality Withhold Measures. All of the metrics selected for the quality withhold are part of the larger set of quality metrics used for ongoing health plan monitoring. The quality measures are discussed later in this report.

CMS and DHCS developed the benchmarks that the MMPs are required to meet, which vary depending on the measure and the year. For each measure, MMPs earn a “met” or “not met” designation. MMPs receive the quality withhold payment according to a tiered scale based on the total number of measures met. For example, MMPs that meet 80-100% of measures receive 100% of the withheld amount, and MMPs that meet 60-79% of measures receive 75% of the withheld amount.

In DY 1, the quality withhold was equal to one percentage point based on ten performance measures. These measures focused on key structure and process improvements, including the proportion of initial health assessments completed within the specified timeframe, evidence of the establishment of a consumer governance board, and evidence of appropriate access to services. The quality withholds increased to two percentage points in DY 2, three percentage points in DYs 3 - 5, and four percentage points in DYs 6 - 8 based on different quality measures focused on clinical processes and outcomes. The three-way contract includes more details about the quality withhold measures, including performance standards.

Starting in DY 2, MMPs could meet a quality withhold measure in two ways: (1) If the MMP met the established benchmark for the measure, or (2) If the MMP met the established goal for closing the gap between its performance in the DY prior to the performance period and the established benchmark by a stipulated percentage (typically 10%).

The CMS Core and State-Specific Quality Withhold Measures are listed in Tables 1 and 2 below along with results that are presently available. Future years’ quality withhold measures, benchmarks, and standards may be subject to reviews and updates by CMS and DHCS.

Each MMP is required to report data for quality metrics selected by CMS and DHCS for ongoing monitoring during the demonstration period. There are 85 metrics listed in the MOU that form the quality monitoring efforts of Cal MediConnect. These metrics are similar to those for other states that have approved MOUs for Duals integration efforts. The quality metrics selected are derived largely from standard measurement sets including the Healthcare Effectiveness Data and Information Set (HEDIS), the Health Outcomes Survey (HOS), and the Consumer Assessment of Healthcare Providers and

Systems (CAHPS), as well as measurement sets used to evaluate quality in Special Needs Plans. In addition, DHCS identified a selected set of metrics to evaluate LTSS quality.

Table 1: CMS Core Quality Withhold Measures[5]

| CMS Core Quality Withhold Measures | | | | | | |
|---|---|---|---|---|---|---|
| **Measure Name** | **Metric #** | **Measure Steward/ Data Source** | **Measure Name** | **Description** | **Quality Withhold Measure** | **Additional notes on the measure** |
| CW1 | 2.1 | CMS Defined | Assessments | Members with an assessment completed within 90 days of enrollment. | DY 1 | |
| CW2 | 5.3 | CMS Defined | Consumer Governance Board | Establishment of consumer advisory board or inclusion of consumers on a pre-existing governance board consistent with contractual requirements. | DY 1 | |
| CW3 | N/A | Agency for Health Research and Quality (AHRQ)/ CAHPS (Medicare CAHPS-CAHPS 4.0) | Customer Service | Percent of the best possible score the plan earned on how easy it is for members to get information and help from the plan when needed:<br>· In the last 6 months, how | DY 1 | |

[5] The Medicare-Medicaid capitated financial alignment model quality withhold technical notes (DY 2 - 5) can be found at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/QualityWithholdGuidanceDY2-503142018.pdf

| CMS Core Quality Withhold Measures | | | | | | |
|---|---|---|---|---|---|---|
| **Measure Name** | **Metric #** | **Measure Steward/ Data Source** | **Measure Name** | **Description** | **Quality Withhold Measure** | **Additional notes on the measure** |
| | | | | often did your health plan's customer service give you the information or help you needed?<br>· In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect?<br>· In the last 6 months how, often were the forms for your health plan easy to fill out? | | |
| CW5 | N/A | AHRQ/ CAHPS (Medicare CAHPS — CAHPS 4.0) | Getting Appointments and Care Quickly | Percent of best possible score the plan earned on how quickly members get appointments and care:<br>· In the last 6 months, when you needed care right away, how often did you get care as | DY 1 | |

| CMS Core Quality Withhold Measures | | | | | | |
|---|---|---|---|---|---|---|
| **Measure Name** | **Metric #** | **Measure Steward/ Data Source** | **Measure Name** | **Description** | **Quality Withhold Measure** | **Additional notes on the measure** |
| | | | | soon as you thought you needed?<br>· In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?<br>· In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time? | | |
| CW6 | N/A | National Committee for Quality Assurance (NCQA)/ HEDIS | Plan all-cause readmissions | The ratio of the plan's observed readmission rate to the plan's expected readmission rate. The | DYs 2 - 8 | Lower measure rates mean that readmissions are occurring less often. Therefore reflect better quality of care. |

| CMS Core Quality Withhold Measures | | | | | | |
|---|---|---|---|---|---|---|
| **Measure Name** | **Metric #** | **Measure Steward/ Data Source** | **Measure Name** | **Description** | **Quality Withhold Measure** | **Additional notes on the measure** |
| | | | | readmission rate is based on the percent of plan members discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason. | | This measure will be removed from the quality withhold analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will also be removed if the MMP's total number of index stays is 10 or fewer. |
| CW7 | N/A | AHRQ/ CAHPS (Medicare CAHPS – Current Version) | Annual Flu Vaccine | Percent of plan members who got a vaccine (flu shot) prior to flu season. | DYs 2-8 | If an MMP's score for this measure has very low reliability (as defined by CMS and its contractor in the CAHPS report), this measure will be removed from the quality withhold analysis. |
| CW8 | N/A | NCQA/ HEDIS | Follow-up after hospitalization | Percentage of discharges for plan members | DYs 2 - 8 | This measure will be removed from |

| CMS Core Quality Withhold Measures | | | | | | |
|---|---|---|---|---|---|---|
| **Measure Name** | **Metric #** | **Measure Steward/ Data Source** | **Measure Name** | **Description** | **Quality Withhold Measure** | **Additional notes on the measure** |
| | | | for mental illness | 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days of discharge. | | the quality withhold analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will also be removed if the MMP's HEDIS audit designation is "NA," which indicates that the denominator is too small (<30) to report a valid rate. |
| CW10 | N/A | NCQA/ HEDIS | Reducing the risk of falling | Percent of plan members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year. | DYs 2 - 8 | |
| CW11 | N/A | NCQA/ HEDIS | Controlling blood pressure | Percentage of plan members 18 - 85 years of age who had a diagnosis of | DYs 2 - 8 | This measure will be removed from the quality withhold |

| CMS Core Quality Withhold Measures | | | | | | |
|---|---|---|---|---|---|---|
| **Measure Name** | **Metric #** | **Measure Steward/ Data Source** | **Measure Name** | **Description** | **Quality Withhold Measure** | **Additional notes on the measure** |
| | | | | hypertension and whose blood pressure was adequately controlled (<140/90) for members 18 - 59 years of age and 60 - 85 years of age with diagnosis of diabetes or (150/90) for members 60 - 85 without a diagnosis of diabetes during the measurement year. | | analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will also be removed if the MMP's HEDIS audit designation is "NA," which indicates that the denominator is too small (<30) to report a valid rate. |
| CW12 | N/A | CMS Prescription Drug Event Data | Medication adherence for diabetes medications | Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. | DYs 2 - 8 | This measure will be removed from the quality withhold analysis if the MMP has 30 or fewer enrolled member-years in the denominator. |
| CW13 | N/A | Cal Medi-Connect health plan | Encounter Data | Encounter data for all services covered under | DYs 2 - 8 | If the submission standards |

| CMS Core Quality Withhold Measures | | | | | | |
|---|---|---|---|---|---|---|
| **Measure Name** | **Metric #** | **Measure Steward/ Data Source** | **Measure Name** | **Description** | **Quality Withhold Measure** | **Additional notes on the measure** |
| | | Encounter Data | | the demonstration, with the exception of Prescription Drug Event Data, submitted in compliance with demonstration requirements. | | cited in an MMP's three-way contract are more stringent than those described in the schedule/ criteria above, MMPs will be required to adhere to their contract's standards. This will be noted in the state specific attachments, if applicable. |
| *CW4 - Encounter Data was removed due to delays in clarifying encounter submission requirements for California Cal MediConnect health plans | | | | | | |
| *CW9 - This measure was retired, and therefore will not be included in the quality withhold analysis. | | | | | | |
| *CW 13 - Encounter Data analysis may be modified for California Cal MediConnect health plans contingent upon the status of encounter submission | | | | | | |
| *Measures with N/A in the Metric # column are based on CAHP, AHRQ, or other national data standards. | | | | | | |

The table below includes data for DYs 1 - 8.

Table 2: Demonstration Years Two through Eight State-Specific Quality Withhold Measures[6]

| Quality Withhold Measures – State Specific | | | | | | |
|---|---|---|---|---|---|---|
| **Measure Name** | **Metric #** | **Measure Steward/Data Source** | **Measure Name** | **Description** | **Quality Withhold Measure** | **Additional notes on the measure** |
| CAW1 | CA1.6 | State-defined process measure | Documentation of Care Goals | Percent of members with documented discussions of care goals | DYs 1-8 | |
| CAW8 | | | | | DYs 1-8 | |
| CAW6 | CA1.7 | State-defined process measure | Behavioral health shared accountability process measure | Percent of members receiving Medi-Cal specialty mental health services that received care coordination with the primary mental health provider | DY 3 | |
| CAW4 | CA1.12 | State-defined process measure | Interaction with care team | Members who have a care coordinator and have at least one care team contact during the reporting period | DY 1 | |
| CAW9 | | | | Percent of members who have a care coordinator and have at least one | DYs 2 - 8 | |

[6] The Medicare-Medicaid capitated financial alignment model quality withhold technical notes (DY 2 - 5): California-specific-measures can be found at: https://www.cms.gov/files/document/caqualitywithholdguidancedy2-503162018.pdf

| Quality Withhold Measures – State Specific | | | | | | |
|---|---|---|---|---|---|---|
| **Measure Name** | **Metric #** | **Measure Steward/Data Source** | **Measure Name** | **Description** | **Quality Withhold Measure** | **Additional notes on the measure** |
| | | | | care team contact during the reporting period | | |
| CAW2 | CA2.2 | State-defined process measure | Behavioral Health Shared Accountability | Policies and procedures attached to the MOU with county behavioral health agency(ies) around assessments, referrals, coordinated care planning, and information sharing | DY 1 | |
| CAW5 | CA3.1 | State-defined process measure | Ensuring Physical Access to Buildings, Services and Equipment | Cal MediConnect health plans with an established physical access compliance policy and identification of an individual who is responsible for physical access compliance | DY 1 | |
| CAW7 | CA4.1 | State-defined process measure | Behavioral health shared accountability outcome measure | Reduction in emergency department (ED) use for members who are seriously mentally ill or | DYs 2 - 8 | For DY 2 through 5, Calendar Year (CY) 2015 will serve as the baseline year, except for |

| Quality Withhold Measures – State Specific | | | | | | |
|---|---|---|---|---|---|---|
| **Measure Name** | **Metric #** | **Measure Steward/Data Source** | **Measure Name** | **Description** | **Quality Withhold Measure** | **Additional notes on the measure** |
| | | | | have a substance use disorder | | MMPs that began operating in CY 2015 or added a new service area in CY 2015. For those MMPs, this measure will apply as a quality withhold starting in DY 3, with CY 2016 serving as the baseline year for DY 3 through 5. |

For each measure, MMPs earn a "met" or "not met" designation depending on their achieved rate relative to the benchmark level, or where applicable, the gap closure target. Based on the total number of measures met, MMPs receive a quality withhold payment according to the following tiered scale:

| Percent of Measures Met | Percent of Withhold MMP Receives |
|---|---|
| 0-19% | 0% |
| 20-39% | 25% |
| 40-59% | 50% |
| 60-79% | 75% |
| 80-100% | 100% |

As shown in Tables 3A and 3B below, of the ten MMPs that reported data in CY 2017, nine of the MMPs with data reported performed at a level that qualified them to receive 100 percent of their quality withhold payments. [7]

Table 3A: Cal MediConnect Quality Withhold Summary for CY 2017 (1 of 2)

| Cal MediConnect Quality Withhold Summary for CY 2017 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | CW 6 – Plan All-Cause Readmissions | CW 7 – Annual Flu Vaccine[2] | CW8 – Follow-Up After Hospitalization for Mental Illness[2] | CW11 – Controlling Blood Pressure[2] | CW12 – Medication Adherence for Diabetes Medications[2] | CW13 – Encounter Data | CAW6 – Behavioral Health Shared Accountability Process Measure | CAW7 – Behavioral Health Shared Accountability Outcome Measure[2] |
| Benchmark | 1.00 | 69% | 56% | 56% | 73% | 80% | 90% | 10% Decrease |
| **Blue Cross** | Met | Met | Met | Met | Met | Met | Not Met | Met |
| **Blue Shield Promise** | Met | Not Met | Not Met | Met | Met | Not Met | Met | Not Met |
| **Community Health Group (CHG)** | Met | Met | Met | Met | Met | Met | Not Met | Met |
| **Health Net** | Met | Not Met | Met | Met | Met | Not Met | Met | Met |
| **Inland Empire Health Plan (IEHP)** | Met | Not Met | Not Met | Met | Met | Not Met | Met | Met |
| **LA Care** | Met | Met | Met | Met | Met | Met | Met | Not Met |
| **Molina** | Met | Met | Not Met | Met | Met | Met | Not Met | Met |
| **CalOptima** | Met | N/A | Not Met | Met | Met | Met | Not Met | Met |

[7] CMS released information publically for CY 2017 quality withhold measures and may be reviewed here: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/QualityWithholdResultsReportCADY3.pdf

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Health Plan of San Mateo (HPSM)** | Met | Met | Met | Met | Met | Met | Not Met | Met |
| **Santa Clara Family Health Plan (SCFHP)** | Met | Met | Met | Met | Met | Met | Not Met | Met |

Table 3B: Cal MediConnect Quality Withhold Summary for CY 2017 (2 of 2)

| **Cal MediConnect Quality Withhold Summary for CY 2017** | | | | | | |
|---|---|---|---|---|---|---|
| | CAW8 – Documentation of | CAW9 – Interaction with Care Team[2] | Total Number of Measures | Total Number of Measures Met | Measures Passed | Withhold MMP Receives |
| Benchmark | 55% | 78% | Total | Total | Percent | Percent |
| **Blue Cross[3]** | Met | Met | 10 | 9 | 90% | 100% |
| **Blue Shield Promise[3]** | Not Met | Not Met | 10 | 4 | 40% | 100%[4] |
| **CHG[3]** | Met | Met | 10 | 9 | 90% | 100% |
| **Health Net[3]** | Not Met | Met | 10 | 7 | 70% | 100%[4] |
| **IEHP** | Met | Not Met | 10 | 6 | 60% | 75% |
| **LA Care[3]** | Met | Met | 10 | 9 | 90% | 100% |
| **Molina[3]** | Met | Not Met | 10 | 7 | 70% | 100%[4] |
| **CalOptima[3]** | Met | Not Met | 10 | 7 | 70% | 100%[4] |
| **HPSM** | Met | Met | 10 | 9 | 90% | 100% |
| **SCFHP** | Met | Not Met | 10 | 8 | 80% | 100% |

Notes:

1. A “Met” designation can be earned by meeting the benchmark or the gap closure target. The gap closure target measures closing the gap between the MMP’s performance in the prior CY and the benchmark by a stipulated improvement percentage (typically 10%).
2. Indicates that measure also utilizes the gap closure target methodology.
3. Indicates MMPs that were eligible for a quality withhold adjustment due to an extreme and uncontrollable circumstance. For MMPs that are affected by an extreme and uncontrollable circumstance, such as a major natural disaster, CMS and the state remit the full quality withhold payment for the year in which the

extreme and uncontrollable circumstance occurred, provided that the MMP fully reports all applicable quality withhold measures. Affected MMPs are identified according to the methodology utilized for Medicare Part C and D Star Ratings for the applicable measurement year.

4. Indicates that the MMP's percent of withhold received was increased to 100% due to the quality withhold adjustment for extreme and uncontrollable circumstance. The MMPs qualified for the adjustment due to the wildfires in California during 2017.

As shown in Tables 4A and 4B below, of the MMPs that reported data in CY 2016, four of the ten MMPs with data reported performed at a level that qualified them to receive 100 percent of their quality withhold payments. [8]

Table 4A: Cal MediConnect Quality Withhold Summary for CY 2016 (1 of 2)

| Cal MediConnect Quality Withhold Summary for CY 2016 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | CW 6 – Plan All-Cause Readmissions | CW 7 – Annual Flu Vaccine* | CW8 – Follow-Up After Hospitalization for Mental Illness* | CW11 – Controlling Blood Pressure* | CW12 – Medication Adherence for Diabetes | CW13 – Encounter Data | CAW7 – Behavioral Health Shared Accountability Outcome Measure* |
| Benchmark | 1.00 | 69% | 56% | 56% | 73% | 80% | 10% Decrease |
| **Blue Cross** | Met | Met | Not Met | Met | Met | Met | N/A |
| **Care 1st** | Not Met | Met | Met | Met | Met | Met | Not Met |
| **CHG** | Met | Met | Not Met | Met | Met | Met | Met |
| **Health Net** | Met | Not Met | Not Met | Met | Met | Met | Met |
| **IEHP** | Met | Met | Met | Met | Met | Not Met | Met |

[8] CMS released information publically for CY 2015 and CY 2016 quality withhold measures and may be reviewed here: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/QualityWithholdResultsReport_CA_DY1DY2_06192018.pdf

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **LA Care** | Met | Not Met | Met | Met | Met | Met | Met |
| **Molina** | Met | Met | Met | Met | Met | Met | Met |
| **CalOptima** | Met | N/A | Met | Met | Met | Not Met | N/A |
| **HPSM** | Met | Met | Met | Met | Met | Met | Met |
| **SCFHP** | Met | Met | Met | Met | Met | Not Met | N/A |

Table 4B: Cal MediConnect Quality Withhold Summary for CY 2016 (2 of 2)

| **Cal MediConnect Quality Withhold Summary for CY 2016** | | | | | | |
|---|---|---|---|---|---|---|
| | CAW8 – Documentation of Care Goals* | CAW9 – Interaction with Care Team* | Total Number of Measures | Total Number of Measures Met | Measures Passed | Withhold MMP Receives |
| Benchmark | 55% | 78% | Total | Total | Percent | Percent |
| **Blue Cross** | Met | Met | 8 | 7 | 88% | 100% |
| **Care 1st** | Met | Met | 9 | 7 | 78% | 75% |
| **CHG** | Not Met | Met | 9 | 7 | 78% | 75% |
| **Health Net** | Met | Met | 9 | 7 | 78% | 75% |
| **IEHP** | Met | Met | 9 | 8 | 89% | 100% |
| **LA Care** | Met | Not Met | 9 | 7 | 78% | 75% |
| **Molina** | Met | Met | 9 | 9 | 100% | 100% |
| **CalOptima** | Not Met | Not Met | 7 | 4 | 57% | 50% |
| **HPSM** | Met | Met | 9 | 9 | 100% | 100% |
| **SCFHP** | Met | Not Met | 8 | 6 | 75% | 75% |

Notes:

1. N/A items are not applicable due to low enrollment or inability to meet other reporting criteria.
2. A “Met” designation can be earned by meeting the benchmark or the gap closure target. The gap closure target measures closing the gap between the MMP’s performance in the prior CY and the benchmark by a stipulated improvement percentage (typically 10%).
3. An “*” indicates measures that also utilize the gap closure target methodology.

## California Evaluation Design Plan

CMS contracted with Research Triangle Institute (RTI) International to evaluate and monitor the implementation of demonstrations under the Financial Alignment Initiative for impacts on a range of outcomes including beneficiary experience, quality, utilization, and cost for the eligible population as a whole, as well as to evaluate and monitor for impacts on specific subpopulations (beneficiaries 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.[9]

To achieve these goals, RTI International collects qualitative and quantitative data from California each quarter; analyzes Medicare and Medicaid enrollment, claims, and encounter data; conducts site visits, beneficiary focus groups, and key informant interviews; and incorporates relevant findings from any beneficiary surveys conducted by other entities.

RTI International published the Financial Alignment Initiative California Cal MediConnect: First Evaluation Report November 2018.[10] The Evaluation Report provides overviews, processes, successes, and challenges in the areas of: Integration of Medicare and Medi-Cal; Eligibility and Enrollment; Care Coordination; Beneficiary Experience; Stakeholder Engagement; Financing and Payment; Quality of Care; and Medicare Savings Calculation. The following findings are summarized from the report:

- About a third of enrollees have received care coordination under Cal MediConnect, during the first two demonstration periods. Those receiving this benefit have responded with positive feedback in a number of surveys and focus groups to say their access to care and quality of life have improved.
- The demonstration calls for MMPs to pay for IHSS services; however, MMPs have had no authority to assess or authorize these important LTSS services. Estimates of charges were not provided in advance for planning purposes, charges occurred after the fact and were delayed, and MMPs were at full risk. All MMPs interviewed through 2016 stated this was challenging for their financial planning. In the nearly three years since the California demonstration began, MMPs and county agencies have been developing ways to work together and share information, and develop processes to provide integrated care to enrollees. Promising practices have been emerging, such as co-location of staff, targeted dementia training, and strategic use of data systems to support integration. Some MMPs have made headway in transitioning beneficiaries from long term care

[9] 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

[10] The Financial Alignment Initiative California Cal MediConnect: First Evaluation Report November 2018 is available at: https://innovation.cms.gov/Files/reports/fai-ca-firstevalrpt.pdf

facilities back to the community, which is a fundamental goal of the demonstration.

- The varied county and MMP approaches and previous county and health plan experience within the California demonstration have led to varied successes and challenges. The evaluation of the demonstration is designed to be model-wide. However, the design of the California demonstration—with its varied types of counties, delivery systems, and MMPs—does not lend itself easily to one overall assessment.
- Communicating policies and educating delegated and out-of-network providers has been a struggle for the state, CMS, MMPs, and stakeholders. In counties with multiple MMPs, county LTSS and behavioral health agencies found that they must adapt their systems in order to work with each of the plans; this has not always worked easily. Because of their county and historical linkages, county-operated MMPs generally have made more progress towards integration with other county-based LTSS and behavioral health agencies than had commercial plans. Commercial plans that previously had extensive Dual Eligible Special Needs Plan experience also made progress at integrating LTSS because of their understanding of this population and these services. However, early stakeholder concerns of plan readiness have endured. Other MMPs, inexperienced with this population and with the provision of LTSS, have struggled to understand the needs of the dual eligible population and negotiate the complexities of LTSS and behavioral health systems.
- The state and most MMPs have seen lower than expected enrollment as a problem and they have been working to increase enrollment through streamlining processes, improving continuity of care provisions, new deeming periods, and other program improvements. The demonstration's complex enrollment schedule generated multiple challenges and negative attention, including legal actions. Although many missteps were corrected in the first year of the demonstration, the negative effects lingered. Even in 2016, when explaining the low enrollment rate and the reluctance of providers to participate in the demonstration, interviewees pointed to systems inadequacies, general reluctance of providers to participate in managed care, and to concerns over the transfer of seniors and persons with disabilities to managed care that took place prior to the demonstration.
- MMPs reported they were attracted to the demonstration by the potential of 456,000 beneficiaries estimated to be eligible for Cal MediConnect. While some opt-outs and disenrollments were expected, as of December 2016, enrollments numbered 113,600. MMPs noted that they had made considerable investments in staff and infrastructure with the expectation that high enrollments would allow them to recoup their upfront investments.
- The provision of flexible benefits and the rate structure that rewards MMPs for achieving lower institutional rates are designed to promote care in the community, rather than in institutional settings. Some MMPs have been using flexible Care Plan Options funds strategically to support enrollees at home and divert institutionalizations and to transition enrollees from long-term care facilities to the community. Other MMPs appeared to use these benefits ad hoc, or not at

all. Without data showing institutionalization rates, it has not been possible to evaluate the overall effectiveness of these nursing facility diversions or transitions. RTI will analyze institutionalization rates and other measures in future reports as data become available.

- The demonstration continues to evolve in 2017 and beyond. The state has stepped up activities designed to improve Cal MediConnect and bolster enrollments. These actions have included fine-tuning enrollee supports, facilitating MMPs to share best practices to improve quality of care, strategic contact with providers linked to high opt-out rates, and reengineering enrollment methods. The state has also undertaken efforts to strengthen health assessment linkages to LTSS referrals by standardizing LTSS Health Risk Assessment questions and monitoring the use of flexible benefits.

In addition to RTI International's November 2018 Evaluation Report, monitoring and evaluation activities will also be reported in subsequent evaluation reports, and in an upcoming final aggregate evaluation report. As of the writing of this report, the November 2018 Evaluation Report is the only evaluation report released . Future evaluation reports will be included in updated legislative reports as they become available.

## Cal MediConnect Reporting Requirements

### Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements and California Specific Reporting Requirements

In November 2013, CMS published the "Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements," which contain the quality evaluation measures that all states participating in the Financial Alignment Initiative are required to report. These core measures address the full range of services and benefits for Cal MediConnect, including medical, pharmacy, LTSS, and behavioral health, as well as care coordination and consumer satisfaction.

In addition to these core reporting requirements, there is a separate reporting appendix for state-specific measures that have been developed with stakeholder input over the course of the planning and implementation phases of Cal MediConnect.[11]

A subset of these quality reporting metrics are included in the Cal MediConnect Performance Dashboard, which shares data on Cal MediConnect MMPs' performance in six areas related to care coordination, quality, and service utilization including: (1)

[11] Core measures and state-specific measures are available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes.html

Health Risk Assessments; (2) Appeals by Determination; (3) Hospital Discharge; (4) Emergency Utilization; (5) LTSS Utilization; and (6) Case Management.[12] CMS and DHCS collectively monitor this data and provide clarifying and technical guidance to MMPs, as necessary, to support MMPs in maintaining correct and consistent interpretation of the reporting requirements.

In the first quarter of 2018, DHCS finalized the combination of the enrollment and performance dashboards into a single dashboard. The new dashboard contains plan performance results on the National Opinion Research Center quality measures that monitor Health Risk Assessments, ICPs, and reassessments. The dashboard has been released quarterly with updates since the initial report. Additional measures, based on stakeholder feedback, will be added into the dashboard as data becomes available. For example, throughout 2019, LTSS data has been added to the dashboard.

In addition to the quality measures, per the three-way contract, MMPs are also required to submit all HEDIS, HOS, and CAHPS data, as well as all other measures. HEDIS, HOS and CAHPS data must be reported consistent with Medicare requirements. CMS also collects existing Medicare Part D metrics.

## Quality Improvement Project Requirements and Activities

The three-way contract specifies that MMPs are required to conduct a "Chronic Care Improvement Program" (CCIP) as well as a Quality Improvement Program (QIP) following the Plan-Do-Study-Act (PDSA) methodology. MMPs are following all Medicare requirements for these efforts.

The Health Plan Management System CCIP Module serves as the means for MMPs to submit and report on their CCIPs and QIPs to CMS and the state. The CCIP and QIP modules allow MMPs to report on the CCIP and QIP throughout the entire life cycle of the CCIP and QIP as defined below:

- **Plan**: Describes the processes, specifications, and outcome objectives used to establish the CCIP. The Plan section of the CCIP is only submitted once (in the fall of the MMP's first operational year). Once approved by both CMS and the state, MMPs begin implementation of the CCIP, including collecting data that will subsequently be used in the Annual Update, which includes the "Do, Study, and Act" sections.

- **Annual Update:** This consists of the "Do," "Study," and "Act" sections and is completed annually, beginning the first year of CCIP implementation and each year thereafter for the duration of the project:

[12] The Cal MediConnect Dashboard is available at: https://www.dhcs.ca.gov/Pages/Cal_MediConnectDashboard.aspx

- **Do**: Describes how the CCIP is conducted, the progress of the implementation, and the data collection plan.
- **Study**: Describes and analyzes findings against the benchmark(s) or goal(s), as determined by the MMP, and identifies trends over several PDSA cycles that can be considered for the "Act" stage.
- **Act**: Summarizes the action plan(s) based on findings and describes the differences between the established benchmarks and the actual outcomes, providing information regarding any changes based on actions performed to improve processes and outcomes, including a short description of actions performed.

The topic for the MMP QIP was "Reducing inpatient hospital readmissions within 30 days of discharging from a hospital."

Per the QIP and CCIP Resource Document 2018/2019, the CCIP focus area is Promote Effective Management of Chronic Disease. [13]

Since the planning documents were submitted in early 2015, MMPs conducted the Do-Study-Act portions of the methodology by testing their interventions, studying the results, and making changes to interventions, when appropriate, to better achieve their expected outcomes. At the end of each CY, MMPs submitted their annual updates to their initial planning documents, describing the actions taken throughout the year and what modifications, if any, were implemented to meet their expected outcomes.

Since the last report in early 2018, CMS discontinued requiring MMPs to report on CCIPs and QIPs. CMS and DHCS reviewed the QIP submissions and DHCS conducted another round of reviews and then validated the findings in early 2019. As of 2018, CMS is no longer formally reviewing QIPs; however, per the three-way contract, MMPs are still required to submit their QIPs for review and validation by the state. CMS will retain the ability to audit the QIPs as necessary.

## Performance Improvement Projects

### 2016 – 2017 Performance Improvement Project – Improving Care Coordination

In addition to the CCIP and QIP, in 2016, DHCS began Performance Improvement Projects (PIP) on the topic of improving care coordination with a focus on the integration of the LTSS programs, as required by the three-way contract requirements. This was formerly referred to as the statewide collaborative.

[13] The CMS QIP and CCIP requirements are located in the 2018/2019 QIP and CCIP Resource Document, located on the MA Quality website at: https://www.cms.gov/Medicare/Health-Plans/Medicare-Advantage-Quality-Improvement-Program/Overview.html

MMPs commenced a rapid-cycle PIP process in January 2016 that required the submission of five modules. DHCS' External Quality Review Organization (EQRO) conducted module-specific trainings and technical assistance calls to guide MMPs through the process and CMS contracted with Health Services Advisory Group, Inc. (HSAG) to validate the results. MMPs were required to submit and pass Module 1 (PIP initiation) and Module 2 (Specific, Measureable, Attainable, Relevant Time-Bound (SMART)) Aim Data Collection prior to submitting Module 3 (Intervention Determination). The EQRO reviewed module submissions and provided feedback to MMPs, offering multiple opportunities to fine-tune Modules 1 through 3. Module 4, titled, "Intervention Testing," utilized PDSA cycles and was the longest phase of the five modules. Module 5 concluded the PIP process by summarizing the project.

This rapid-cycle PIP concluded as of June 30, 2017. All MMPs submitted their PIP modules 4 and 5 in September 2017 for HSAG validation. HSAG disseminated PIP validation results to eight MMPs as of October 30, 2017 (two MMPs' PIP validation results are currently pending). As part of Module 5 validation, HSAG assessed the validity and reliability of the results based on CMS validation protocols and assigned the following final confidence levels for each PIP:

- High confidence – The PIP was methodologically sound, achieved the SMART Aim goal, and the demonstrated improvement was clearly linked to the quality improvement processes implemented.
- Confidence – The PIP was methodologically sound, achieved the SMART Aim goal, and some of the quality improvement processes were clearly linked to the demonstrated improvement; however, there was not a clear link between all quality improvement processes and the demonstrated improvement.
- Low confidence – Either: (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.
- Not credible – The PIP methodology was not executed as approved.

Following are final confidence levels for MMP PIPs that HSAG validated as of October 30, 2017. This table is final with no updates for this legislative report.

Table 5: Performance Improvement Project Confidence Levels

| MMP | PIP Topic | Final Confidence Level |
|---|---|---|
| Anthem/CareMore | Improving Care Coordination by LTSS Programs with a Focus on Community-Based Adult Services (CBAS) | Low Confidence |
| CalOptima | Improving IHSS Care Coordination | Low Confidence |

| MMP | PIP Topic | Final Confidence Level |
|---|---|---|
| Care1st | Transitioning Cal MediConnect Members from Long-Term Care Facilities Safely Back to the Community | Low Confidence |
| CHG | Reducing Inappropriate Acute Hospitalization Admissions from a Nursing Facility | Confidence |
| Health Net | Electronic Communication of Care Plans to Providers for Members Who Are in CBAS and MSSP | Low Confidence |
| HPSM | Reducing Readmissions from Skilled Nursing Facilities | Low Confidence |
| IEHP | Health Risk Assessments | Confidence |
| L.A. Care | Managed LTSS | Not Credible |
| Molina | Improving Care Coordination and Integration of LTSS for Members Receiving IHSS Services by Facilitating Their Enrollments in a CBAS Program | Confidence |
| SCFHP | Decreasing Potentially Preventable Readmissions LTSS | Not Credible |

The follow up to the 2016-2017 PIP on improving care coordination included DHCS and CMS providing technical assistance, and holding, at a minimum, monthly conversations with MMPs to discuss topics of concern that relate to the PIP such as care coordination and MMP performance against California and national health care measures. DHCS and CMS sent questions to the MMPs before the calls about process and outcomes. In each call, best practices were discussed and opportunities for improvement were identified. Based on the efforts initiated in the 2016-2017 care coordination improvement PIP, it was determined that the follow-on 2017-2018 PIP would continue the focus on care coordination through the perspective of ICPs in order to improve the rates of both completed ICPs and ICPs with documented care goals.

When MMPs are not meeting performance targets and are not improving quality, there are financial consequences related to the quality withhold measures (discussed above in this report). For the 2016-2017 PIP, there were related quality withhold measures in the areas of care coordination and interaction with the care team. The 2017-2018 ICP PIP specifically relates to the quality withhold measures, and substandard quality and performance negatively impacted MMP financial compensation.

**2018 – 2019 Performance Improvement Project – Individualized Care Plan**

Beginning in November 2017, all MMPs engaged in a new PIP based on two California-specific reporting measures: (1) CA1.5 Members with an ICP Completed, and (2) CA1.6 Members with Documented Discussions of Care Goals.

DHCS' EQRO conducted specific trainings and technical assistance calls to guide MMPs through the process and CMS contracted with HSAG to validate the results.

Unlike the previous MMP PIPs, which used HSAG's rapid-cycle PIP approach, MMPs are implementing the new PIPs using HSAG's outcome-focused PIP methodology. The outcome-focused methodology places emphasis on study indicator outcomes and targets for statistically significant improvement over baseline on an annual basis. This PIP methodology is in alignment with CMS PIP Protocols.

Key phases of the study include: study design; baseline measurement; implementation of quality improvement activities; and re-measurement and evaluation, summarized as: I) Design; II) Implementation and Evaluation; and III) Outcomes.

MMP PIP activities in 2018-2019 included:

- MMPs submitted the first annual PIP summary form.
- HSAG validated and scored the submitted PIPs and provided the completed tools.
- Selected MMPs resubmitted PIPs to correct any deficiencies and HSAG validated the resubmissions.
- MMPs completed and submitted their first and second progress updates, and HSAG reviewed the submissions, provided feedback and technical assistance as needed.

The results of HSAG's review of the ICP PIP November 2019 Progress Update are summarized in the table below. In addition to the information provided, HSAG outlined feedback and recommendations in areas such as: being clear on when the initiative started for the applicable population; providing the evaluation data results and analysis for each intervention; ensuring goals are set to achieve statistically significant improvement from the baseline; revising the baseline, and reporting the revised baseline, in appropriate circumstances; and considering not implementing an intervention due to lack of quantitative data on effectiveness. MMPs were asked to address any applicable recommendations when submitting the March 2019 annual submission.

Table 6: ICP MMP PIP Progress Review Update Tool Summary – November 2019

| Criteria | Anthem | CalOptima | Care 1st | CHG | Health Net | HPSM | IEHP | LA Care | Molina | SCFHP |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. The MMP provided an overall progress summary for the PIP that was comprehensive and aligned with the topic. | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| 2. The MMP provided an interim rate for all PIP study indicators. | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| 3. The MMP provided an analysis of results that included whether there has been improvement as the PIP has progressed. | Yes | Yes | Yes | Yes | Inc | Yes | Yes | Yes | Yes | Yes |
| 4. The MMP provided an update on interventions for the PIP that were active, logically linked to a priority barrier, and can impact outcomes. | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| 5. The MMP specifically explained how it is evaluating each intervention. | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| 6. The MMP included documentation regarding PDSA. | N/A | Yes | Yes | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 7. The MMP documented lessons learned. | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Inc | Yes |
| 8. The MMP reported next steps that encompassed | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |

| Criteria | Anthem | CalOptima | Care 1st | CHG | Health Net | HPSM | IEHP | LA Care | Molina | SCFHP |
|---|---|---|---|---|---|---|---|---|---|---|
| identified needs and made sense for the PIP. | | | | | | | | | | |
| 9. The MMP requested technical assistance. | No | No | Yes | No | No | No | No | No | No | No |
| 10. HSAG recommends a technical assistance call with the MMP. | No | No | Yes | No | No | No | No | No | No | No |

Key: Inc = Incomplete; N/A = Not Applicable / Not Assessed

A similar process to 2019 will take place in 2020 including MMPs submitting their third annual PIP Summary Form in April 2020 (which will include the first and second re-measurement), the third annual PIP submission will be their final submission for this cycle. HSAG will validate and score the submitted PIPs for the final validation results.

## Quality Improvement Strategy – Los Angeles and Orange Counties

MMPs in Los Angeles and Orange counties have also begun a quality improvement strategy, as of April 2017, aimed at reducing hospital admissions for nursing home residents. Through this CMS-led initiative, participating MMPs must develop and implement interventions to reduce avoidable hospitalizations and other adverse events for nursing facility residents.[14]

MMPs provide quarterly reports to CMS and DHCS. Since interventions are different for each MMP, comparisons across plan reports are not practical. However, CMS and DHCS regularly monitor the MMPs in these counties to help them determine if the quality of care has improved and resulted in reductions in overall hospitalizations within the scope of each of the plans' interventions. In Spring 2020, the MMPs will submit their third annual PIP summary and, as is the standard practice, feedback as appropriate will be provided to and discussed with MMPs. Within the quality improvement initiative, MMPs have the discretion to focus improvements in areas that make best sense for their member population. This approach has led to concentration in areas such as infectious disease prevention, fall prevention and post admission focus and education. In addition, MMPs have identified that, in some cases, a small number of members

[14] CMS provided a press release on this initiative at the beginning of January 2017. The press release is available at: http://www.calduals.org/2017/01/05/new-initiative-announced-by-state-federal-agencies/

have accounted for multiple hospital admissions and readmissions in a single year, and have responded by directing resources and efforts to those members.

## Consumer Assessment of Healthcare Providers and Systems Results

### 2019 Survey Results

CMS is committed to measuring and reporting consumer experience and satisfaction. Under the Medicare-Medicaid Financial Alignment initiative, CMS measures consumer experience in multiple ways, including through beneficiary surveys such as the CAHPS survey.

Under the capitated Financial Alignment Model, MMPs are required to annually conduct a Medicare Advantage Prescription Drug (MA-PD) CAHPS survey. The MA-PD CAHPS survey is designed to measure important aspects of an individual's health care experience, including the access to and quality of services. MMPs are also required to include ten additional supplemental questions as part of their annual survey in order to assist with RTI International's independent evaluation of the Financial Alignment Initiative. These supplemental questions delve further into areas of greater focus under the demonstrations including care coordination, behavioral health, and HCBS.

Highlights of the 2019 survey findings include these results:

- Respondent characteristics indicated the capitated financial alignment models continue to serve individuals with a range of needs.
- For demonstrations with at least two years of measurement, overall views of MMPs and quality of health care improved over time, with respondents more likely to give high ratings (9 or 10) and less likely to give low ones (0 to 6). When asked to rate their MMP on a scale from 0 to 10 (with 0 being the worst possible and 10 being the best possible), 66% of all demonstration respondents rated their MMP a 9 or 10 in 2019, compared to 65% in 2018, 63% in 2017, and 59% in 2016. When asked to rate their health care on the same 0 to 10 scale, 61% of demonstration respondents rated their health care a 9 or 10 in 2019, compared to 61% in 2018, 60% in 2017, and 59% in 2016. Close to 90% of respondents rated their MMP and health care at a 7 or higher on a scale of 0 to 10 in 2019.
- Respondents reported high levels of access to needed care and prescription drugs, but were less positive about getting appointments and care quickly.
- The majority of respondents reported their doctor communicated well and they found customer service helpful.
- Respondents receiving care coordination support expressed satisfaction with the assistance they received.

Survey results for 2019 are available for review.[15]

[15] The complete survey report is available at: https://www.cms.gov/files/document/faicahpsresults.pdf