Cal MediConnect

Fiscal Year 2019-2020
Enrollment Status, Quality Measures, and State Costs Report

Contents

Executive Summary

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

Welfare and Institutions Code Sections 14132.275(q)(1) and 14186.4(f)(1) require DHCS to submit written reports to the Legislature, beginning with the May Revision to the fiscal year 2013-14 Governor's Budget and annually thereafter, on the enrollment status, quality measures, and state costs related to Cal MediConnect. This Legislative report contains activities, updates, and data relative to the reporting period of July 1, 2019 to June 30, 2020. Data provided is thought to be that which is most relevant and pertinent to understanding how the Cal MediConnect plans have progressed through Cal MediConnect.

Introduction

Coordinated Care Initiative

The Coordinated Care Initiative (CCI) was enacted by Senate Bill (SB) 1008 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012), SB 1036 (Committee on Budget and Fiscal Review, Chapter 45, Statutes of 2012), SB 94 (Committee on Budget and Fiscal Review, Chapter 37, Statutes of 2013), SB 75 (Committee on Budget and Fiscal Review, Chapter 18, Statutes of 2015) and SB 97 (Chapter 52, Statutes of 2017).[1]

The CCI initially included the following three major components, in the seven counties of Los Angeles, Orange, San Diego, San Mateo, Riverside, San Bernardino and Santa Clara (demonstration counties):

1. Cal MediConnect, which combines the full continuum of acute, primary, institutional, and home and community-based services into a single benefit package, delivered through Medicare-Medicaid Plans (MMPs);
2. Mandatory Medi-Cal managed care enrollment for individuals dually eligible for Medicare and Medicaid (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.

Resulting changes included:

- In-Home Supportive Services (IHSS) would no longer be included as a Medi-Cal managed care benefit in the seven demonstration counties, but would continue to be available to eligible beneficiaries through local counties.
- The transition of the Multipurpose Senior Services Program (MSSP) from a fee-for-service (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 demonstration 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 (CBAS), with the exception of IHSS, into managed care.

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

In September 2019, the Department of Health Care Services (DHCS) further announced the intention that MSSP would no longer be covered as a Medi-Cal managed care benefit in the seven demonstration 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 Demonstration Waiver. Given the current COVID-19 public health emergency, it was determined that it was not feasible to amend the waiver at this time. DHCS is currently working with the Centers for Medicare and Medicaid Services (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 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 MMPs that oversee and are accountable for the delivery of covered Medicare and Medicaid services for Duals in the seven demonstration counties. 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

Cal Mediconnect DY	Calendar Dates
6	January 1 2020 – December 31, 2020
7	January 1, 2021 – December 31, 2021
8	January 1, 2022 – December 31, 2022

Enrollment

Beneficiaries must meet the following criteria to be eligible for Cal MediConnect enrollment:

- Live in one of the seven demonstration counties.
- Be age 21 or older.
- Have full benefits, meaning they have full Medicaid (Medi-Cal) coverage, are enrolled in Medicare Parts A and B (including those individuals who receive Parts A and B through a Medicare Advantage Plan), and are eligible for Part D.[2]

The following groups of beneficiaries may voluntarily enroll in Cal MediConnect:

- Beneficiaries enrolled in a Program of All-Inclusive Care for the Elderly (PACE).
- Beneficiaries enrolled in the AIDS Healthcare Foundation.
- Beneficiaries in certain rural zip codes in San Bernardino County (different than the excluded zip codes).

Even if a beneficiary meets the above criteria, the following Duals are not permitted to enroll in Cal MediConnect:

- Beneficiaries with other private or public health insurance.
- Beneficiaries with developmental disabilities receiving services through a Department of Developmental Services 1915(c) waiver; regional center; state developmental center; or intermediate care facility for the developmentally disabled, except in San Mateo County, beginning January 1, 2016.
- Beneficiaries enrolled in the following 1915(c) waivers: Nursing Facility (NF)/Acute Hospital, HIV/AIDS, Assisted Living, and In-Home Operations.
- Beneficiaries residing in designated rural zip codes in Los Angeles, Riverside, and San Bernardino Counties.

[2] Medicare Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care. Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services. Part C, also referred to as a MA Plan, is a type of Medicare health plan offered by a private company that contracts with Medicare to provide the individual with all of the Part A and B benefits. There are several Medicare Advantage Plans available. Part D adds prescription drug coverage to several of the Medicare plans.

- Beneficiaries residing in a Veterans' Home of California.
- Beneficiaries with end stage renal disease (ESRD) in all counties except San Mateo and Orange. If an enrollee develops ESRD while enrolled in an MMP, the enrollee may stay enrolled in that MMP.
- Beneficiaries in Los Angeles if Los Angeles has met or exceeded its enrollment cap of 200,000 participants.

Cal MediConnect Enrollment Approach[3]

In the first phase of enrollment, DHCS used a passive enrollment process for individuals eligible for Cal MediConnect. This means that DHCS enrolled eligible Duals into MMPs unless the individual chose not to join (i.e. opted out) and notified the state of this choice. Beneficiaries who enrolled in an MMP could opt out or change MMPs at any time. Eligible beneficiaries who opted out of passive enrollment were still required to choose a Medi-Cal managed care health plan (MCP) for their Medi-Cal benefits, including LTSS.

In April 2014, DHCS began passive enrollment of Duals into Cal MediConnect in San Mateo County. Beneficiaries already enrolled in an MCP began to receive LTSS benefits in Los Angeles, Riverside, San Bernardino, San Diego, and San Mateo Counties.

In May 2014, DHCS began passive enrollment of Duals into Cal MediConnect, and mandatory enrollment of beneficiaries from Medi-Cal FFS into Medi-Cal managed care for their Medi-Cal benefits, in Riverside, San Bernardino, and San Diego Counties.

In July 2014, DHCS began passive enrollment of Duals into Cal MediConnect in Los Angeles County.

In January 2015, DHCS began passive enrollment of Duals into Cal MediConnect in Santa Clara County.

In July 2015, DHCS began opt-in enrollment in Orange County.

In August 2015, DHCS began passive enrollment in Orange County.

As part of the CCI comprehensive strategy released in June 2016, DHCS implemented streamlined enrollment, which allows MMPs to submit enrollment changes to DHCS on behalf of their enrollees. This provides a simpler method for beneficiaries to enroll in Cal MediConnect, since beneficiaries are no longer required to contact DHCS' enrollment broker, Health Care Options (HCO), to complete their enrollment choices.

[3] Enrollment was phased in on a monthly basis according to the implementation schedule titled "CCI Enrollment Timeline by County and Population" on the CalDuals website at the following link: http://calduals.org/background/enrollment/.

In June 2018, CMS released the 2019 Agent/Broker Training and Testing Guidelines for Calendar Year (CY) 2019.[4] DHCS and CMS agreed to allow MMPs the opportunity to participate in an agent/broker-facilitated enrollment pilot as a strategy to encourage enrollment in MMPs. MMPs that were interested in participating in the agent/broker-facilitated enrollment pilot were required to submit deliverables to demonstrate their capability and readiness to implement based on the requirements set forth within the CMS released guidance. The requirements included trainings, policy development, and reporting to which MMPs must adhere. In addition, MMPs must attest that their contracted agent/brokers abide by these same requirements. One MMP, LA Care, which operates in Los Angeles County, was approved for implementation of the enrollment pilot, effective in February 2019. DHCS and CMS are monitoring the effectiveness of the pilot and LA Care's compliance with the use of contracted agent/brokers for processing enrollment into the Duals product.

As of December 2019, approximately 108,412 beneficiaries were enrolled in Cal MediConnect.[5]

Although Cal MediConnect remains a voluntary choice for all Duals in the seven demonstration counties, beneficiaries who opt-out of Cal MediConnect must still enroll in an MCP for their Medi-Cal benefits, including LTSS. Individuals who become an eligible Dual in the seven demonstration counties are sent Welcome Packets that include the list of MMPs and MCPs from which they can choose to enroll.

Mandatory Medi-Cal Managed Care Enrollment

DHCS mandatorily enrolled nearly all Medi-Cal beneficiaries into MCPs in the seven demonstration counties. A majority of these beneficiaries were already enrolled in MCPs and therefore continued to receive LTSS through their existing MCPs. LTSS includes skilled nursing and home and community-based services (HCBS), CBAS, and MSSP services.

For those Duals who choose to opt-out of Cal MediConnect, the state requires them to enroll in MCPs to receive Medi-Cal services, including LTSS (referred to **as** Managed Medi-Cal Long-Term Supports and Services (MLTSS)). This enrollment does not alter their Medicare benefits and they can continue to receive health care services from their current Medicare hospitals and providers.

Enrollment Notices and Education Materials

At least 90 days prior to passive enrollment, Duals received written notification explaining how and when their health care would change, and whom they could contact for assistance when choosing an MMP or MCP. Sixty days prior to a beneficiary's effective enrollment date, DHCS mailed an enrollment packet that included: (1) a letter describing pending changes and actions required of the beneficiary; (2) a resource

[4] The 2019 Agent/Broker Training and Testing Guidelines are located at the following link: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/2019-Agent-Broker-Training-Guidelines_Revised-082018.pdf.

[5] The Cal MediConnect Performance Dashboard can be found at the following link: https://www.dhcs.ca.gov/Pages/Cal_MediConnectDashboard.aspx.

booklet describing what a health plan is and what it means to be enrolled in a health plan, particularly enrollee rights and responsibilities; and (3) a choice book that included an enrollment choice form and a pre-stamped envelope, a detailed plan benefit comparison chart, and details for in-person presentations. For beneficiaries who did not actively make a health plan choice, DHCS mailed a reminder notice approximately 30 days prior to the enrollment effective date. All beneficiaries were sent a letter just prior to the enrollment effective date confirming their health plan choice or to inform them of their DHCS assigned plan. DHCS, in accordance with statutory requirements, verified enrollment notices were made available to the public at least 60 days prior to the first mailing of notices to beneficiaries.

DHCS developed the enrollment notices, choice book, and other materials for Cal MediConnect and mandatory Medi-Cal managed care enrollment with extensive stakeholder involvement. In February 2014, DHCS began working with a group of stakeholders to develop the notices and choice form. These stakeholders met with DHCS senior leadership to discuss the notices and other issues on March 6, April 16, and May 6, 2014. Following this process, and in partnership with CMS, the choice form and 60-day notice went through beneficiary testing and a stakeholder review process. In response to feedback from this review process, DHCS made changes and provided the revised 90-, 60-, and 30-day notices and the choice form to the California Collaborative for another stakeholder comment period in June 2014. The California Collaborative includes 37 statewide advocacy and stakeholder groups and is connected to local collaborative coalitions of stakeholders in the seven demonstration counties. Comments received from the California Collaborative were incorporated into the final notices and choice form. As a result of these activities, DHCS revised the notices and materials for consistent messaging across different materials and to more clearly explain the following:

- Plan choices and instructions for opting out.
- Continuity of care provisions.
- How to determine which providers are part of each plan’s network.
- Covered services and benefits.
- Contact information for assistance.

All notices were written at a sixth-grade reading level and provided in all of the required Medi-Cal threshold languages, as well as in alternative formats that were culturally, linguistically, and physically appropriate. DHCS posted all final notices and related materials, including the choice book, choice form, and the Cal MediConnect and the MLTSS Guidebooks on the CalDuals website; however, since passive enrollment has ended, these notices and materials are no longer actively used. Note that San Mateo and Orange Counties are County Organized Health System (COHS) counties, and the COHS MMPs were responsible for developing and mailing their own enrollment materials.

DHCS created a new guide and choice book that is currently mailed to two groups of Duals: 1) individuals in the seven demonstration counties who become dually-eligible;

and 2) existing Duals who move into the seven demonstration counties. These materials also went through a stakeholder comment period and were released in summer 2016. They were subject to extensive user testing and revisions in partnership with Health Research for Action at UC Berkeley's School of Public Health and a series of literacy reviews to verify that they met readability standards and were not above a sixth-grade reading level. The materials are available in all required Medi-Cal threshold languages as well as accessible formats, as required. The materials are mailed to beneficiaries as a part of the regular enrollment process. These new materials incorporate lessons DHCS has learned about how to communicate with Duals concerning Cal MediConnect, including lessons learned through stakeholder input and beneficiary testing of previous materials.

In addition, DHCS released a beneficiary toolkit.[6] This comprehensive toolkit contains stand-alone fact sheets that cover various topics and aspects of Cal MediConnect in more depth. The fact sheets address questions that currently enrolled beneficiaries and eligible beneficiaries often have, including:

- Can I keep my current doctor?
- How do I keep seeing my current doctors?
- How does Cal MediConnect help me get the care I need?
- What is a Health Risk Assessment (HRA) and a Care Coordinator?

Another included fact sheet helps explain some of the particulars related to MCPs, such as the definition of a network. This toolkit helps eligible beneficiaries understand their options and how Cal MediConnect may benefit them. For those who choose to opt-out of Cal MediConnect, the toolkit helps them to better understand how to navigate their MCPs. The toolkit went through stakeholder review and user testing in partnership with the Health Research for Action at UC Berkeley's School of Public Health. As with other materials, these documents were subject to a final literacy review process and were translated into all of the required Medi-Cal threshold languages. The toolkit is an easy-to-use resource for enrolled beneficiaries and eligible beneficiaries, caregivers, and stakeholders. It is available online as well as in hard copy, and is being distributed during outreach activities.

As part of the enrollment notice development process, DHCS developed training materials for contracted MAXIMUS call center staff to help familiarize staff with choice packets and to prepare them to answer questions. DHCS and MAXIMUS leadership have been working together since October 2014 to improve the beneficiary call center experience by monitoring and resolving issues more quickly and by identifying opportunities for improvement. DHCS has made these training materials available in some variation at all potential intake points for a provider and/or enrollee/beneficiary, such as the Cal MediConnect and Medi-Cal Ombudsman offices and local Health Insurance Counseling and Advocacy Programs (HICAPs).

[6] The beneficiary toolkit is available online at the following link: http://calduals.org/learn-more-resources/toolkits/beneficiary-toolkit/.

Beneficiary and Provider Outreach

DHCS developed the Beneficiary and Provider Outreach Plan (Appendix A), which was shared with stakeholders. The primary goal of the outreach plan is to provide beneficiaries, including those in nursing care and their caregivers, providers, family enrollees, conservators, and/or other authorized representatives, with the information they need about Cal MediConnect. This outreach plan emphasizes the important role that providers and their staff play as key outreach targets in informing and guiding beneficiaries. The outreach plan recognizes the diversity of Cal MediConnect target population and the variety of languages spoken by beneficiaries. Also, per statutory requirements, specific provisions have been made to educate beneficiaries on PACE options. DHCS has been implementing the outreach plan since late 2013 in each of the seven demonstration counties.

DHCS works closely with other state entities serving this population as part of the outreach effort. DHCS continues to work with the California Department of Aging (CDA) to encourage effective communications between the state and the local HICAPs. In addition, DHCS and the Department of Managed Health Care (DMHC) established an Ombudsman program to assist beneficiaries. The Ombudsman program went live on April 1, 2014, and is operated by the Legal Aid Society of San Diego and several experienced subcontractors located in the seven demonstration counties. The Legal Aid Society of San Diego and its subcontractors are highly experienced in providing consumer assistance services. Originally the Ombudsman program was managed by DMHC; however, effective July 1, 2017, DHCS assumed management of the Ombudsman program. The subcontractors now report their concerns and issues directly to DHCS. DHCS holds meetings with the Legal Aid Society of San Diego to work on ongoing issues and to exchange information about Ombudsman work; these meetings, previously held on a bi-monthly basis, continue as needed. In addition, DHCS attends and participates in bi-annual Spring Collaborative conferences with the Ombudsman program and other state programs participating in Cal MediConnect.

DHCS continues to work extensively on developing new materials as needed to increase outreach to health care providers, beneficiaries, and other stakeholders, including developing three educational toolkits.[7]

- The CCI Physician Toolkit provides information on how providers can work with health plans and how they can participate in care coordination activities.
- The Cal MediConnect Beneficiary Toolkit provides a cohesive story of the program and provides stand-alone fact sheets that cover various aspects of the CCI in more depth. It was designed to support beneficiaries and to act as a resource for health plans, advocates, and community organizations (including HICAPs and the Ombudsman) that engage directly with beneficiaries.
- The Cal MediConnect Hospital Case Manager Toolkit provides guidance, answers common questions, and relays important information about Cal MediConnect to

[7] The physician, beneficiary and hospital case manager toolkits are located at the following link: http://calduals.org/learn-more-resources/toolkits/.

hospital case managers and discharge planners. The goal of this toolkit is to facilitate beneficiary transitions out of the hospital and back into the community.

In January 2015, DHCS hosted two provider summits, one in Los Angeles County, and one in the Inland Empire, to increase communication between providers, health plans, and health plan delegates.

Additionally, DHCS and MMPs participated in several best practice sessions as follows to support program improvements:

- *Coordinating LTSS:* During the spring of 2018, MMPs participated in a survey regarding best practices to examine their own internal operations for connecting enrollees to LTSS. MMPs responded to the survey questions in writing and discussed their answers with their contract management teams. DHCS identified key best practices, and convened plan representatives for an in-person meeting to share those best practices and promote shared learnings. CMS published a summary of those best practices and lessons learned on their website in September 2018.[8]

- *Integrating and Coordinating Behavioral Health Services:* Similar to the LTSS coordination process discussed above, in the fall of 2018, DHCS asked MMPs to share related internal processes, operations, and best practices for integrating behavioral health services into Cal MediConnect. MMPs then shared details of their findings and best practices with one another during a March 2019 convening hosted by DHCS. In January 2020, DHCS released a summary report that discusses the complexities and nuances of integrating behavioral health into the care delivery system.[9]

- *LTSS Referrals:* DHCS worked with MMPs to identify best practices regarding referrals for two key LTSS services: MSSP and Care Plan Options (CPOs). CPO services are a subset of LTSS that may be delivered either under Medi-Cal or an applicable waiver beyond what is required by law.[10] In January 2019, DHCS and CMS asked MMPs to describe their referral processes for enrollees who qualify for MSSP. Based on the MMPs' responses, DHCS and CMS summarized a list of best practices for enhancing care coordination for enrollees that meet MSSP criteria. DHCS and CMS shared the list of best practices with MMPs and MSSP sites. DHCS and CMS surveyed MMPs about CPOs in April 2019 to better understand how MMPs are leveraging these services within the Cal MediConnect program.

[8] The summary, titled "Improving Care Coordination for Members of Long-Term Service and Supports", is located at the following link: http://calduals.org/wp-content/uploads/2018/08/CMC-BP-LTSS-Summary-Report_Final.pdf.

[9] The summary report, titled "Improving Behavioral Health Integration and Coordination for Cal MediConnect (CMC) Members," is located at the following link: https://calduals.org/wp-content/uploads/2020/03/Improving-Behavioral-Health-Integration-Coordination-for-CMC-Members-Final-.pdf

[10] For more information regarding CPOs, please see Duals Plan Letter 18-003, which can be located at the following link: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2018/DPL18-003.pdf

Separately, DHCS also reached out to MMPs to ask detailed questions about their quarterly reporting on CPO services. DHCS and CMS then compiled a summary based on each of the MMP's responses, which will be shared with all of the MMPs, that discusses general findings, best practices, and current challenges that MMPs face when providing supplemental CPO services to Cal MediConnect enrollees.

Finally, in January 2019, DHCS requested stakeholder feedback on cost-neutral initiatives and activities to help improve Cal MediConnect. In total, DHCS received 23 comment letters representing input from 43 organizations and individuals. In March 2019, DHCS released a complete summary of the stakeholder input on CalDuals.org and outlined several improvement efforts that will take place to better serve Cal MediConnect enrollees. [11] In the summer of 2019, DHCS had planned to create several workgroups to address duplicative reporting requirements and establish solutions to provide enrollees better access to Durable Medical Equipment (DME). The DME workgroup was convened in early 2020 and met several times to identify a set of recommendations for DHCS to consider implementing. As a result of the public health emergency, this workgroup's efforts were paused; however, a recommendations document is planned to be developed in the future. Additionally, DHCS will increase regulatory oversight of interpretation services in MCPs as related to timely access metrics, and look to lessons learned from this effort for potential improvements to the Cal MediConnect program. DHCS will continue to add data metrics to the quarterly Cal MediConnect dashboard based on stakeholder feedback and will include additional LTSS utilization and referral data.

Overall Performance

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 area related to care coordination, quality, and service utilization including: (1) HRAs; (2) appeals by determination; (3) hospital discharge; (4) emergency utilization; (5) LTSS utilization; and (6) case management. 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.

In 2018, DHCS began releasing quarterly updates to the Cal MediConnect Performance Dashboard. DHCS' Cal MediConnect Performance Dashboard Metrics Summary

[11] The summary of the Cal MediConnect stakeholder input is available at the following link: http://calduals.org/wp-content/uploads/2019/03/CMC-Stakeholder-Survey-Summary_March-2019.pdf.

contains enrollment and demographic information as well as plan performance results on NORC quality measures that monitor HRAs and ICPs.

DHCS releases the Cal MediConnect Performance Dashboard updates following the completion of each quarter. The dashboard displays data reported for the latest four quarters. Additional measures, based on stakeholder feedback, will be added into the dashboard as data becomes available. In March 2020, DHCS released the latest version of the dashboard, which includes the following information:[12]

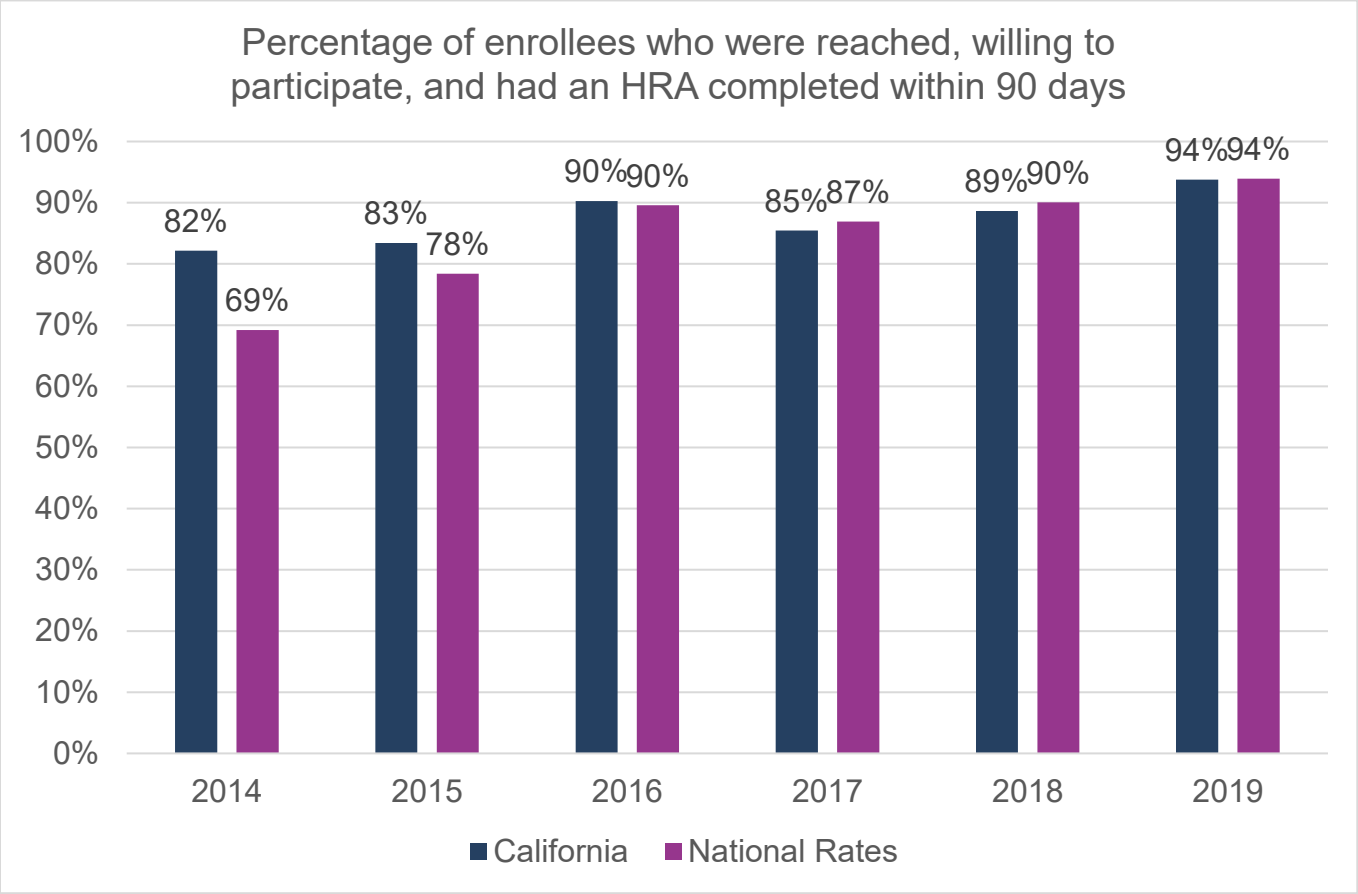
- Enrollment and demographic data on Cal MediConnect enrollees including race/ethnicity, primary language, and gender;
- Completion of quality withhold measures;
- Care coordination measure performance, including HRAs, ICPs, care coordinator ratios, and whether enrollees have documented discussions of care goals or post-discharge follow-up visits;
- Measures on grievances and appeals; and
- Behavioral health performance measures, including utilization metrics and, in particular, emergency room metrics.

Below are updated highlights of the NORC data reported as of the first quarter of 2019. Data is displayed by CY, which correspond to DY. Data charts from 2014 - 2018 have been included in this report to provide a more comprehensive view of performance trends than would be shown by data from a single year. Additionally, data reported in previous years may be retroactively adjusted due to late or corrected data submissions by MMPs.

As a whole, MMPs have performed better than or on par with other demonstrations in the nation since the pilot began.

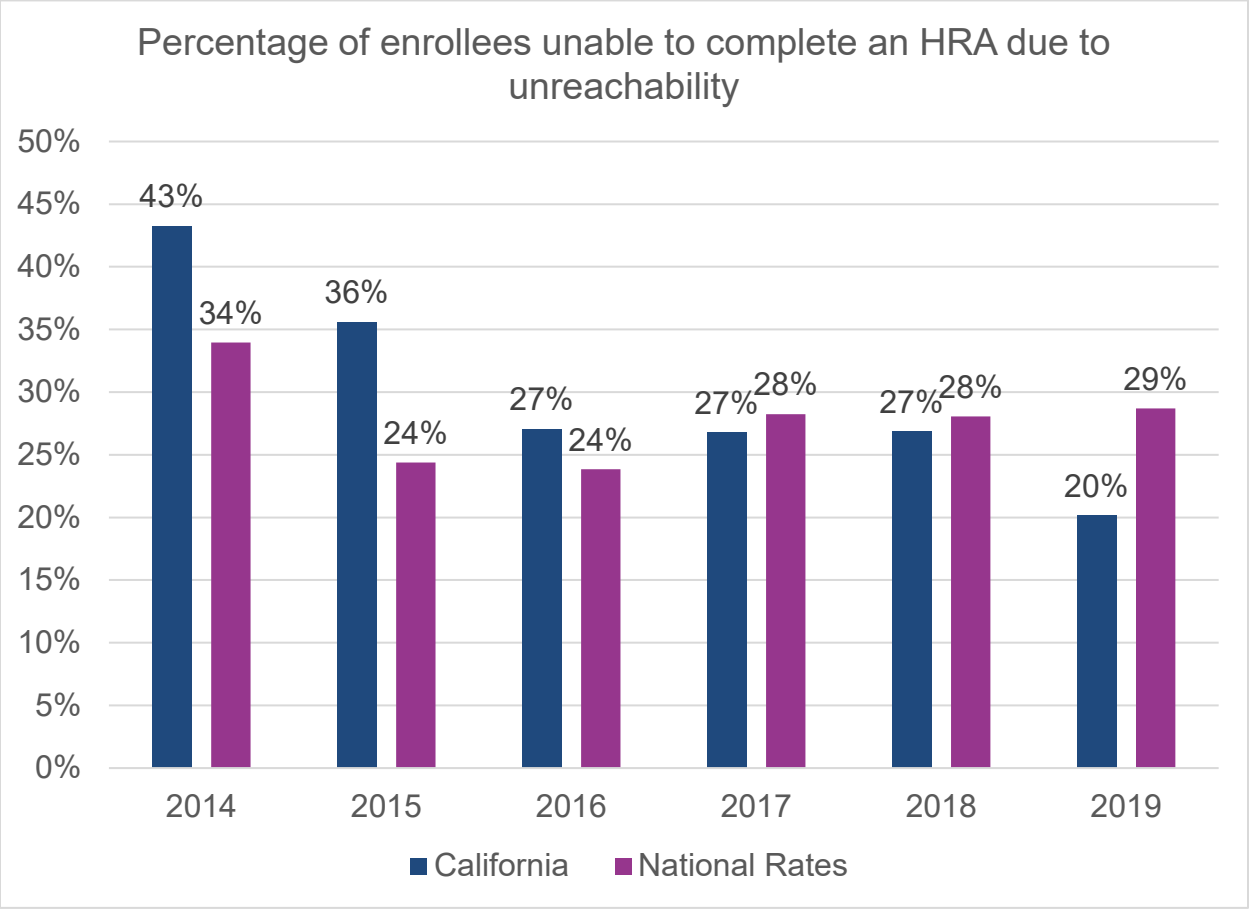
[12] The March 2020 Cal MediConnect Performance Dashboard is located at the following link: https://www.dhcs.ca.gov/Documents/CMCDashboard3.20.pdf.

Chart 1A: Health Risk Assessment Completion – Completed



Source: NORC data, Core Measure 2.1, Element D.

Chart 1B: Health Risk Assessment Completion – Unable to Reach



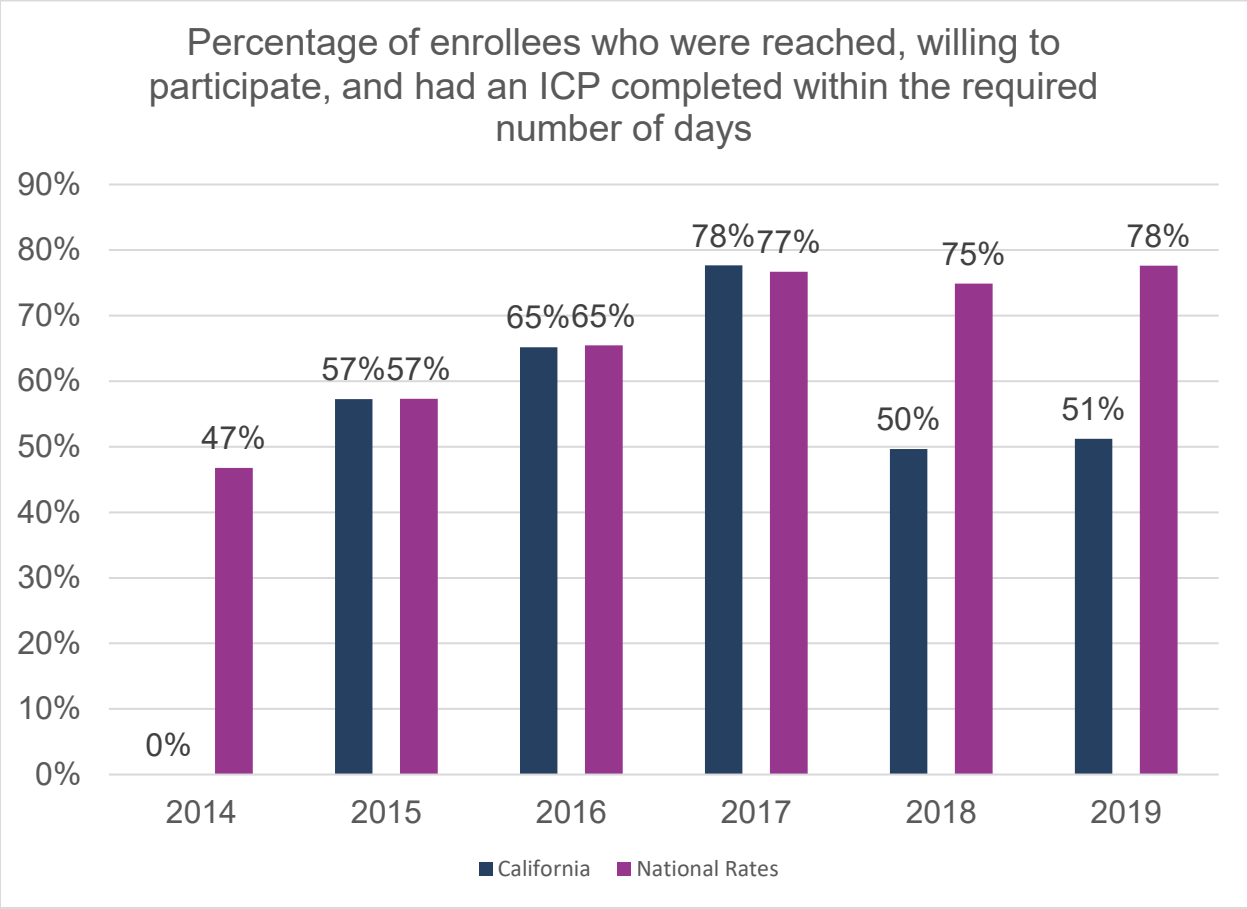
Source: NORC data, Core Measure 2.1. Element C.

HRAs are designed to assess health risks by asking enrollees about social determinants, functional capacity, medical conditions, and behavioral health conditions. The MMPs use the HRA to identify what level of care coordination enrollees may need including further assessments, or referrals to services. The HRA measures on which Charts 1A and 1B are based were effective and in place starting in 2014, when the Cal MediConnect began. Data from 2014 comes only from the MMPs that were fully operational that year. Chart 1A shows that, in the first two years of the demonstration, California slightly outperformed the national average for HRAs completed within 90 days. In the third year of the demonstration, California's average was close to the national average. A slight dip below the national average occurred in 2017. In 2018, California's percentage of HRA completions within 90 days of enrollment was slightly higher than the national average. Chart 1B shows that the percentage of enrollees that were unable to complete an HRA due to unreachability remained the same from 2017 to 2018.

To increase enrollee participation in 2017, DHCS and MMPs worked together to enhance the MMPs' outreach processes. Actions included shortening the duration for HRA assessment call times to focus on the most critical information. This allowed

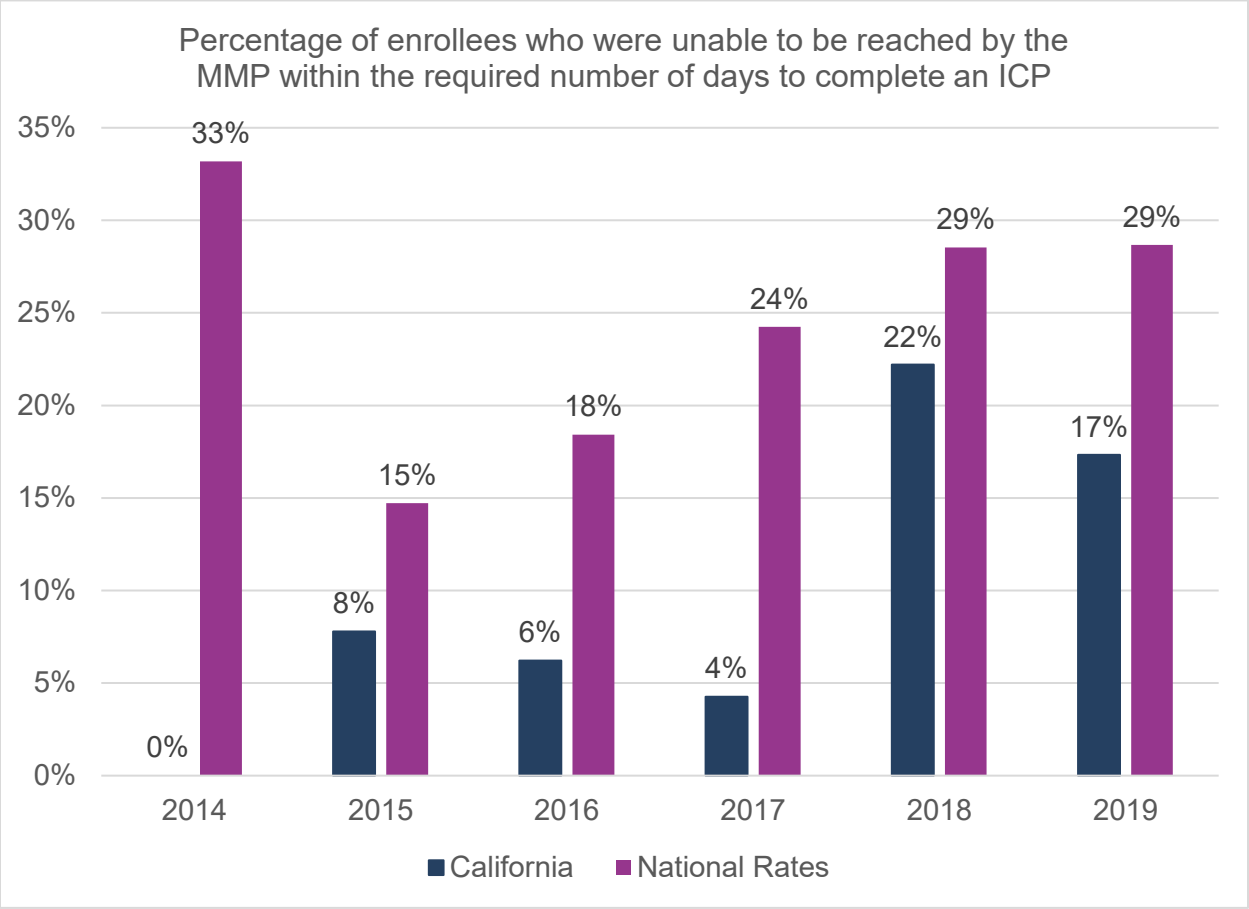
MMPs to collect the information that is needed to best meet the enrollee's needs, while avoiding unnecessarily burdensome time demands on the enrollee. In addition, MMPs added explicit identifying information to their toll-free phone numbers so that enrollees are more likely to accept incoming calls from the MMP. Through 2018 and 2019, DHCS, in collaboration with the MMPs, were able to evaluate that these actions have resulted in improved levels of enrollee participation. DHCS will continue to monitor progress to determine if further adjustments are needed to continue to improve enrollee participation.

Chart 2A: Individualized Care Plan Completion – Completed



Source: NORC data, Core Measure 3.2, Element D. The ICP measures on which the data in Chart 2A were based were effective in late 2014. MMPs first began reporting on these measures with the 2015 data.

Chart 2B: Individualized Care Plan Completion – Unable to Reach



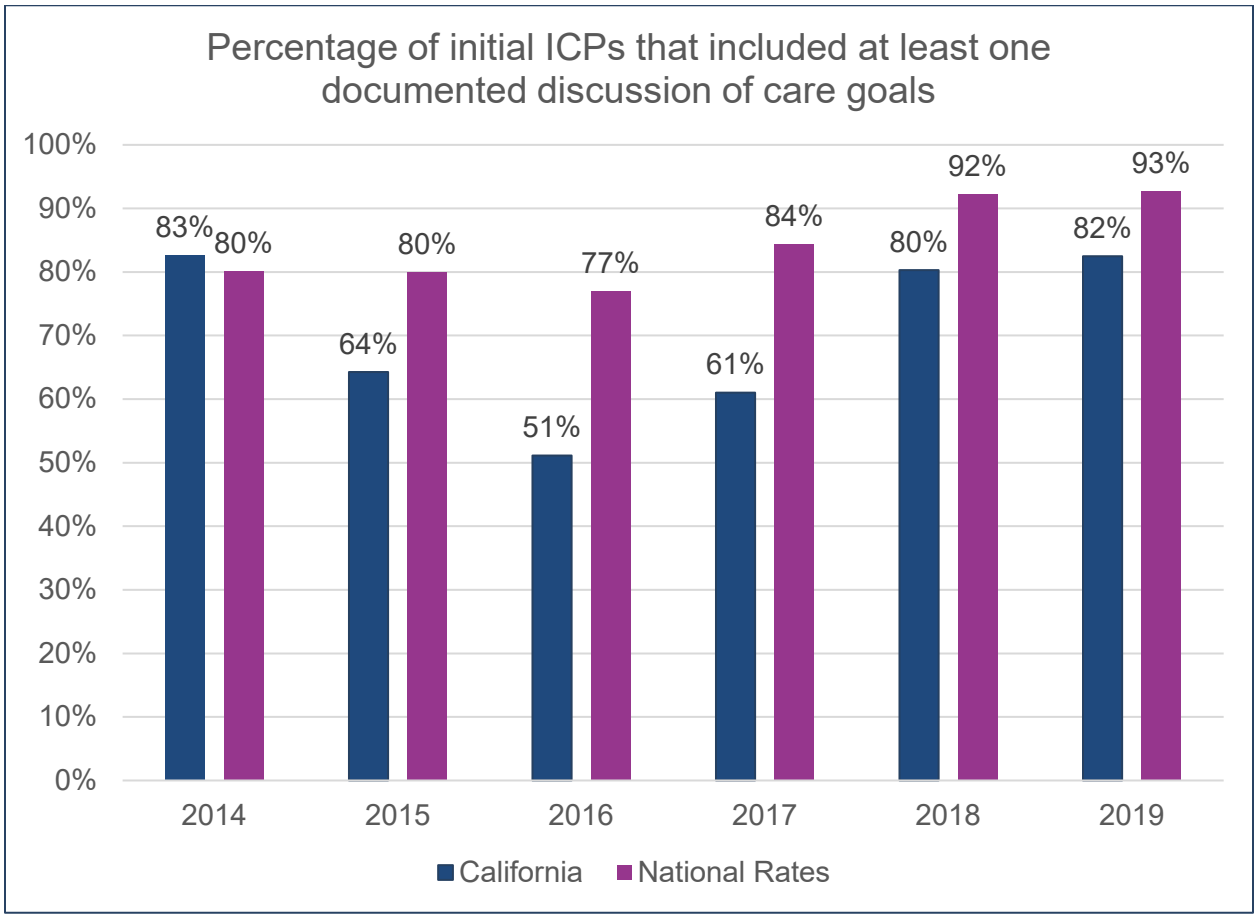
Source: NORC data, Core Measure 3.2, Element C. The ICP measures on which the data in Chart 2B was based were effective in late 2014. MMPs first began reporting on these measures with the 2015 data.

After the HRA, the ICP is the next key component of a enrollee's enhanced care coordination. Based on the HRA results, and in consultation with the enrollee, MMPs develop an ICP for enrollees to help direct the care, and create interdisciplinary care teams for providing specialized care for each enrollee. The ICP usually starts with gathering pertinent medical information to understand the health of the enrollee. Then discussions are conducted with the enrollee to determine what the enrollee's most important health goals are and record those goals in the ICP.

Beginning in the first quarter of 2018, CMS retired several of the state-specific measures that assess timely ICP completion and transitioned to Core 3.2. Core 3.2 is a CMS core measure that captures the number of enrollees who had an ICP completed within their first 90 days of enrollment. The transition from the state-specific measures to Core 3.2 resulted in a significant drop in ICP completion rates that CMS and DHCS had not anticipated. Once new data became available, DHCS and CMS began discussions with the MMPs regarding the decrease in ICP completion rates and how the transition of the measures had so significantly impacted the data. As shown in Chart 2A, California

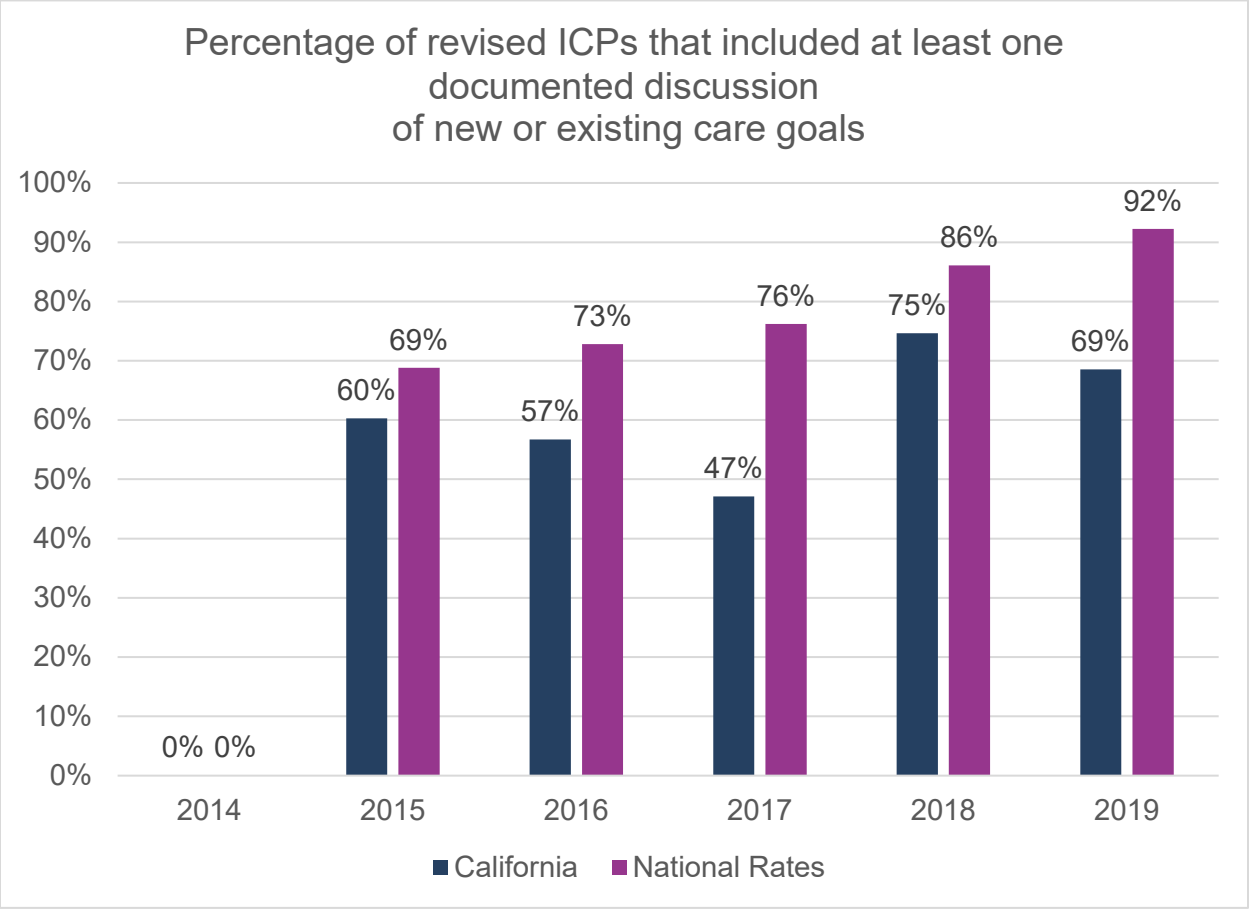
saw a decline in ICP completions for 2018 due to the measure transition and the number of days allotted for MMPs to complete care coordination efforts. While California saw a significant drop in ICP completions, MMPs were more successful on average when attempting to reach enrollees, as shown in Chart 2B.

Chart 3A: Discussion of Care Goals – Initial Individualized Care Plans



Source: NORC data, State-Specific Measure 1.6, Element E.

Chart 3B: Discussion of Care Goals – Revised ICPs



Source: NORC data, State-Specific Measure 1.6, Element F. MMPs that were operational in 2014 reported ICP data for 2014. MMPs that were operational in 2015 began reporting with 2015 data. Care plans were based on the ICP data.

Chart 3A and 3B show a big improvement for MMPs in the percentage of initial and revised ICPs that included at least one documented discussion of care goals. Goals were more difficult to document for revised ICPs, which began in 2015. At the end of 2016, the Contract Management Team (CMT), a joint CMS and DHCS team, met with each of the MMPs to review sample ICPs (with goals), ICP processes, and the systems used to document and update those ICPs and goals. The CMT developed a set of promising practices based on observations from the reviews, which the MMPs were encouraged to use through the year. A review was conducted in early 2018 to monitor progress and address any outstanding issues that MMPs may have had. DHCS supports and monitors the MMPs as they continue to move through the demonstration.

CMS no longer tracks enrollee reassessment data due to the CMT monitoring ICPs and other activities that assist in determining the status of enrollees' care coordination services.

Quality Measures

DHCS monitors MMPs by using approximately 100 measures[13] relating to overall experience, care coordination, and the fostering and support of community living, among many other factors. These measures build on the required Healthcare Effectiveness Data and Information Set (HEDIS), Medicare Health Outcome Survey, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, which are already required to be reported under Medicare and Medicaid. These measures also include measures related to LTSS. CMS also collects all existing Medicare Parts C and D metrics.

CMS and DHCS utilize the reported measures in the combined set of core and state-specific quality measures for various purposes, including implementation and ongoing monitoring, assessing plan performance and outcomes, and allowing quality to be evaluated and compared between MMPs.

Approximately nine to ten quality measures have been identified annually as "quality withhold measures." These measures are associated with a withhold of the MMP's capitation payment annually. They are outlined in Tables 2 and 3 below.

CMS and DHCS have developed the benchmarks that the MMPs are required to meet. These benchmarks vary depending on the measure and the year.

For each measure, MMPs earn a "met" or "not met" designation depending on their achieved rate relative to the benchmark level. Based on the total number of measures met, MMPs receive a quality withhold payment according to a tiered scale (e.g., MMPs that meet 80-100 percent of measures earn back 100 percent of the withheld amount, MMPs that meet 60-79 percent of measures earn back 75 percent of the withheld amount, and so on).

Starting in DY 2, MMPs have two ways to pass a quality withhold measure: (1) the MMP meets the established benchmark for the measure, or (2) the MMP meets the established goal for closing the gap between its performance in the CY prior to the performance period and the established benchmark by a stipulated percentage (typically 10 percent). If the MMP meets the benchmark or the gap closure target, it will earn a "met" designation for that measure. If the MMP does not meet the benchmark or the gap closure target, it will receive a "not met" designation for that measure.

[13] The reporting requirements for these measures can be found at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/CoreReportingReqsCY2020.pdf and https://www.cms.gov/files/document/careportingrequirements02282020.pdf.

MMPs varied in their performance for the CY 2017 and 2018 quality withholds. All MMPs received 75 percent or higher of the withhold amount for the quality withhold measures for these two CYs.

In CY 2017, nine of the ten and in CY 2018, eight of the ten plans' data reported performed at a level that qualified them to receive 100 percent of their quality withhold payments.[14]

The quality withhold measures for DY 2 were associated with a withhold of the MMP's capitation payment annually. For DY 2, the withhold was two percent.

The quality withhold measures for DY 3 were also associated with a withhold of the MMP's capitation payment annually. For DY 3, the withhold was three percent.

For DY 2, CMS and DHCS continued to work collaboratively to analyze the quality withhold data to determine the percentage of the capitation payment that each MMP would receive when they successfully meet the associated threshold benchmarks.[15] This continued into DY 3. CMS and DHCS jointly, along with stakeholder feedback, refined and updated the quality measures for DYs 2 – 5. Since the last update of this report, CMS has published the quality withhold analyses for DY 3 and 4. These results are included below.

[14] CMS publicly released information 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/QualityWithholdResultsReport_CA_DY2_06192018.pdf. For CY 2018 quality withhold results can be reviewed here: https://www.cms.gov/files/document/qualitywithholdresultsreportcady4.pdf.

[15] The complete details regarding the core quality withhold measures across all demonstrations for DY 2 and DY 3 can be found at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY2and3QualityWithholdGuidance042916.pdf

Table 1A: Cal MediConnect Quality Withhold Summary for CY 2017[16]

Medicare-Medicaid Plan	# of Measures in Analysis			# of Measures Met			% of Measures Met			% of Withhold Received
	Core	State	Total	Core	State	Total	Core	State	Total	
Blue Cross of California Partnership Plan Inc.	6	4	10	6	3	9	100%	75%	90%	100%
Care1st Health Plan+	6	4	10	3	1	4	50%	25%	40%	100%^
Community Health Group+	6	4	10	6	3	9	100%	75%	90%	100%
Health Net Community Solutions, Inc.+	6	4	10	4	3	7	67%	75%	70%	100%^
IEHP Health Access	6	4	10	3	3	6	50%	75%	60%	75%
Local Initiative Health Authority for L.A. County+	6	4	10	6	3	9	100%	75%	90%	100%
Molina Healthcare of California+	6	4	10	5	2	7	83%	50%	70%	100%^
Orange County Health Authority+	6	4	10	5	2	7	83%	50%	70%	100%^
San Mateo Health Commission	6	4	10	6	3	9	100%	75%	90%	100%
Santa Clara County Health Authority	6	4	10	6	2	8	100%	50%	80%	100%
California Averages	**6**	**4**	**10**	**5**	**3**	**8**	**83%**	**63%**	**75%**	**98%**

For MMPs that are affected by an extreme and uncontrollable circumstance, such as a major natural disaster (indicated by a "+" in Table 1A), 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. These MMPs qualified for the adjustment due to the wildfires in California during 2017.

[16] For comparison, the Quality Withhold Summary for CY 2015 can be found in the Fiscal Year 2017-2018 Enrollment Status, Quality Measures, and State Costs Report at the following link: https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/CCI-EnrollmentStatusQualityMeasuresStateCosts-FY2017-18.pdf

Table 1B: Cal MediConnect Core Measures Quality Withhold Details for CY 2017

Medicare-Medicaid Plan	CW6 – Plan All- Cause Readmissions	CW7 – Annual Flu Vaccine*	CW8 – Follow-Up After Hospitalization for Mental Illness	CW11 – Controlling Blood Pressure*	CW12 – Medication Adherence for Diabetes Medications*	CW13 – Encounter Data
	Benchmark: 1.00	Benchmark: 69%	Benchmark: 56%	Benchmark: 56%	Benchmark: 73%	Benchmark: 80%
Blue Cross of California Partnership Plan, Inc.	Met	Met	Met	Met	Met	Met
Care1st Health Plan	Met	Not Met	Not Met	Met	Met	Not Met
Community Health Group	Met	Met	Met	Met	Met	Met
Health Net Community Solutions, Inc.	Met	Not Met	Met	Met	Met	Not Met
IEHP Health Access	Met	Not Met	Not Met	Met	Met	Not Met
Local Initiative Health Authority for L.A. County	Met	Met	Met	Met	Met	Met
Molina Healthcare of California	Met	Met	Not Met	Met	Met	Met
Orange County Health Authority	Met	Met	Not Met	Met	Met	Met
San Mateo Health Commission	Met	Met	Met	Met	Met	Met
Santa Clara County Health Authority	Met	Met	Met	Met	Met	Met

Table 1C: Cal MediConnect California State-Specific Measures Quality Withhold Details for CY 2017

Medicare-Medicaid Plan	CAW6 - Behavioral Health Shared Accountability Process Measure	CAW7 – Behavioral Health Shared Accountability Outcome Measure*	CAW8 – Documentation of Care Goals*	CAW9 – Interaction with Care Team*
	Benchmark: 90%	Benchmark: 10% Decrease	Benchmark: 55%	Benchmark: 78%
Blue Cross of California Partnership Plan, Inc.	Not Met	Met	Met	Met
Care1st Health Plan	Met	Not Met	Not Met	Not Met
Community Health Group	Not Met	Met	Met	Met
Health Net Community Solutions, Inc.	Met	Met	Not Met	Met
IEHP Health Access	Met	Met	Met	Not Met
Local Initiative Health Authority for L.A. County	Met	Not Met	Met	Met
Molina Healthcare of California	Not Met	Met	Met	Not Met
Orange County Health Authority	Not Met	Met	Met	Not Met
San Mateo Health Commission	Not Met	Met	Met	Met
Santa Clara County Health Authority	Not Met	Met	Not Met	Met

Notes:

1. A “Met” designation is earned by meeting the benchmark or 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. Quality withhold measure results indicated with “*” represent measures that also utilize the gap closure target methodology. A “**” indicates that the MMP used the gap closure target methodology to meet that specific measure for CY 2017.

Table 1D: Cal MediConnect Quality Withhold Summary for CY 2018

Medicare-Medicaid Plan	# of Measures in Analysis			# of Measures Met			% of Measures Met			% of Withhold Received
	Core	State	Total	Core	State	Total	Core	State	Total	
Blue Cross of California Partnership Plan Inc.	4	3	7	4	1	5	100%	33%	71%	100%^
Blue Shield of California Promise Health Plan+	5	3	8	3	2	5	60%	67%	63%	100%^
Community Health Group+	5	3	8	3	3	6	60%	100%	75%	75%
Health Net Community Solutions, Inc.+	5	3	8	2	3	5	40%	100%	63%	100%^
IEHP Health Access	5	3	8	4	1	5	80%	33%	63%	75%
Local Initiative Health Authority for L.A. County+	5	3	8	4	2	6	80%	67%	75%	100%^
Molina Healthcare of California+	5	3	8	4	3	7	80%	100%	88%	100%
Orange County Health Authority+	5	3	8	4	3	7	80%	100%	88%	100%
San Mateo Health Commission	5	3	8	5	2	7	100%	67%	88%	100%
Santa Clara County Health Authority	5	3	8	5	3	8	100%	100%	100%	100%
California Averages	**5**	**3**	**8**	**4**	**2**	**6**	**78%**	**77%**	**77%**	**95%**

For MMPs that are affected by an extreme and uncontrollable circumstance, such as a major natural disaster (indicated by a “+” in Table 1D), 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. These MMPs qualified for the adjustment due to the wildfires in California during 2018.

Table 1E: Cal MediConnect Core Measures Quality Withhold Details for CY 2018

Medicare-Medicaid Plan	CW6 – Plan All-Cause Readmissions	CW7 – Annual Flu Vaccine*	CW8 – Follow-Up After Hospitalization for Mental Illness	CW12 – Medication Adherence for Diabetes Medications*	CW13 – Encounter Data
	Benchmark: 1.00	Benchmark: 69%	Benchmark: 56%	Benchmark: 73%	Benchmark: 80%
Blue Cross of California Partnership Plan, Inc.	Met	Met	N/A	Met	Met
Blue Shield of California Promise Health Plan	Met	Met	Not Met	Met	Not Met
Community Health Group	Met	Met	Not Met	Met	Not Met
Health Net Community Solutions, Inc.	Met	Not Met	Not Met	Met	Not Met
IEHP Health Access	Met	Met	Met	Met	Not Met
Local Initiative Health Authority for L.A. County	Met	Not Met	Met	Met	Met
Molina Healthcare of California	Met	Not Met	Met	Met	Met
Orange County Health Authority	Met	Met	Not Met	Met	Met
San Mateo Health Commission	Met	Met	Met	Met	Met
Santa Clara County Health Authority	Met	Met	Met	Met	Met

Notes:

1. A “Met” designation is earned by meeting the benchmark or 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. Quality withhold measure results indicated with “*” represent measures that also utilize the gap closure target methodology. A “**” indicates that the MMP used the gap closure target methodology to meet that specific measure for CY 2018.

Table 1F: Cal MediConnect California State-Specific Measures Quality Withhold Details for CY 2018

Medicare-Medicaid Plan	CAW7 – Behavioral Health Shared Accountability Outcome Measure*	CAW8 – Documentation of Care Goals*	CAW9 – Interaction with Care Team*
	Benchmark: 10% Decrease	Benchmark: 60%	Benchmark: 83%
Blue Cross of California Partnership Plan, Inc.	Not Met	Met	Not Met
Care1st Health Plan	Not Met	Met	Met
Community Health Group	Met	Met	Met
Health Net Community Solutions, Inc.	Met	Met	Met
IEHP Health Access	Not Met	Met	Not Met
Local Initiative Health Authority for L.A. County	Met	Met	Not Met
Molina Healthcare of California	Met	Met	Met
Orange County Health Authority	Met	Met	Met
San Mateo Health Commission	Met	Not Met	Met
Santa Clara County Health Authority	Met	Met	Met

Table 2: 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	Enrollees 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 Healthcare Research and Quality (AHRQ)/ CAHPS (Medicare CAHPS-CAHPS 4.0)	Customer Service	Percentage of the best possible score the plan earned on how easy it is for enrollees to get information and help from the plan when needed: · In the last 6 months, how often did your health plan's customer service give you the information or help you needed? · In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? · In the last 6 months how, often were the forms for your health plan easy to fill out?	DY 1	
CW5	N/A	AHRQ/ CAHPS (Medicare CAHPS—CAHPS 4.0)	Getting Appointments and Care Quickly	Percentage of best possible score the plan earned on how quickly enrollees get appointments and care: · In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?	DY 1	

Measure Name	Metric #	Measure Steward/ Data Source	Measure Name	Description	Quality Withhold Measure	Additional notes on the measure
				· 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? · 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	NCQA/ HEDIS	Plan all-cause readmissions	Percentage of plan enrollees 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.	DYs 2 - 5	Lower measure rates mean that readmissions are occurring less often and therefore reflect better quality of care.
CW7	N/A	AHRQ/ CAHPS (Medicare CAHPS – Current Version)	Annual Flu Vaccine	Percentage of plan enrollees who got a vaccine (flu shot) prior to flu season.	DYs 2 - 5	If an MMP's score for this measure has very low reliability (as defined by CMS and its contractor in the MMP CAHPS report), this

Measure Name	Metric #	Measure Steward/ Data Source	Measure Name	Description	Quality Withhold Measure	Additional notes on the measure
						measure will be removed from the total number of withhold measures on which the MMP will be evaluated.
CW8	N/A	NCQA/ HEDIS	Follow-up after hospitalization for mental illness	Percentage of discharges for plan enrollees 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.	DYs 2 - 8	
CW10	N/A	NCQA/ HEDIS	Reducing the risk of falling	Percentage of plan enrollees with a problem falling, walking, or balancing who discussed it with their doctor and received treatment for it during the year.	DYs 2 - 8	

Measure Name	Metric #	Measure Steward/ Data Source	Measure Name	Description	Quality Withhold Measure	Additional notes on the measure
CW11	N/A	NCQA/ HEDIS	Controlling blood pressure	Percentage of plan enrollees 18 - 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) for enrollees 18 - 59 years of age and 60-85 years of age with a diagnosis of diabetes or (150/90) for enrollees 60 - 85 years of age without a diagnosis of diabetes during the measurement year.	DYs 2 - 8	
CW12	N/A	CMS Prescription Drug Event (PDE) Data	Medication adherence for diabetes medications	Percentage of plan enrollees 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	
CW13	N/A	MMP Encounter Data	Encounter Data	Encounter data for all services covered under the demonstration, with the exception of PDE data, submitted timely in compliance with demonstration requirements.	DYs 2 - 8	To qualify for the quality withhold in CY 2015, the MMPs in California were required to begin submitting encounters no later than November 15, 2015.

Measure Name	Metric #	Measure Steward/ Data Source	Measure Name	Description	Quality Withhold Measure	Additional notes on the measure
						80% of encounters are submitted according to the criteria identified above timely, unless otherwise specified in the three-way contract and state-specific attachment. CMS and the states will monitor progress and reserve the right to revisit the benchmark as appropriate. For DY 3, completeness of the encounter submissions may be factored

Measure Name	Metric #	Measure Steward/ Data Source	Measure Name	Description	Quality Withhold Measure	Additional notes on the measure
						into the analysis. Additional information regarding this update will be provided at a later date. Stakeholders will have the opportunity to comment on the new criteria and benchmark prior to finalization.

Notes:
1. CW4: Encounter Data was removed due to delays in clarifying encounter submission requirements for MMPs.
2. CW9: Screening for Clinical Depression was removed since the measure is currently suspended.
3. CW13: Encounter Data analysis may be modified for MMPs contingent upon the status of encounter submission.
4. Measures with “N/A” in the Metric # column are based on CAHPS, AHRQ, or other national data standards.

Table 3: State-Specific Quality Withhold Measures[17]

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

[17] CMS information for California-specific measures for DY 2 through DY 8 is available at: https://www.cms.gov/files/document/caqualitywithholdguidance.pdf https://www.cms.gov/files/document/caqualitywithholdguidance.pdf

Measure Name	Metric #	Measure Steward/Data Source	Measure Name	Description	Quality Withhold Measure
CAW2	CA2.2	State-defined process measure	Behavioral Health Shared Accountability	Policies and procedures attached to the Memorandum of Understanding (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	MMPs 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 use for seriously mentally ill and substance use disorder enrollees	DYs 2 - 8
CAW10	Core 3.2	State-defined process measure	Care Plan Completion	Percent of enrollees with a care plan completed within 90 days of enrollment	DYs 2 - 8

DHCS, DMHC, and the California Department of Social Services (CDSS) are implementing monitoring requirements by doing the following:

- DMHC and DHCS will submit an annual joint report to the Legislature on financial audits performed on MMPs.
- DHCS continues to coordinate with DMHC, CDSS, CDA, and CMS to monitor MMPs and will institute Corrective Action Plans (CAPs) when appropriate. The CMT oversees the performance of MMPs. If the CMT determines that a MMP is not meeting a performance standard, the CMT sends a series of notices to the MMP, with each subsequent notice increasing in severity. The MMP must respond with a detailed CAP explaining how and when the MMP will come into compliance with the performance standard. Failure to implement the agreed upon CAP may result in the CMT terminating the contract or issuing other sanctions. Once the MMP successfully completes the corrective actions, the CMT sends a formal letter detailing the MMP's compliance.
- DHCS continues to work with stakeholders and CMS to develop and refine ongoing quality measures for MMPs that include primary and acute care, LTSS, and behavioral health services.
- DHCS will continue to contract with an External Quality Review Organization (EQRO) to support the activities of the Performance Improvement Project (PIP); formerly referred to as the Statewide Collaborative.

DHCS awarded the current EQRO contract to Health Services Advisory Group (HSAG). As part of the contract, DHCS began collaborating with the EQRO to work with the MMPs regarding the PIP process, which began in January 2016.

The purpose of the most recent ICP PIP is to assess and improve processes and outcomes of health care provided by MMPs. Unlike the previous MMP PIPs, which used HSAG's rapid-cycle PIP approach, MMPs will conduct the new PIPs using HSAG's outcome focused PIP methodology. The outcome focused methodology places emphasis on a study question and the linked study indicator outcomes. It then examines the outcomes and targets for statistically significant improvement, as assessed by the re-measurement over baseline annually.

The study question is: "Do targeted interventions increase the percentage of eligible enrollees with an ICP completed (CA 1.5) and the percentage of eligible enrollees with documented discussions of care goals (CA 1.6)?"

The first part of the question, *Do targeted interventions increase the percentage of eligible enrollees with an ICP completed* (CA 1.5), has two study indicators because the *high*-risk and *low*-risk enrollee requirements differ in length of continuous enrollment. The *high*-risk enrollee need to be enrolled 90 days or more and the *low*-risk enrollees need to be enrolled 135 days or more. MMPs will follow the *Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements* for this measure, except for changing the measurement period to a CY instead of a quarter.

The second part of the study question, *do targeted interventions increase the percentage of eligible enrollees with documented discussions of care goals,* will follow the *Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements* without any changes. This measure is an annual measure and will therefore work with the annual measurement periods required in the outcome focused PIP methodology.

This PIP methodology is in alignment with the CMS PIP Protocols. HSAG provides the PIP overview document, PIP Companion Guide, and submission forms. The PIP measurement periods are:

- Baseline: 1/1/2017–12/31/2017
- Re-measurement 1: 1/1/2018–12/31/2018
- Re-measurement 2: 1/1/2019–12/31/2019

In addition to the PIPs, MMPs are required to participate in one CMS-led quality improvement program (QIP), which focuses on reducing hospital readmissions. CMS and DHCS reviewed the current QIP annual submissions in March 2017, and the final reviews were concluded in April 2018.

Each MMP was also required to undertake one CMS-required chronic care improvement project (CCIP), which is focused on reducing the incidence and severity of cardiovascular disease. Since the last report, CMS has ceased requiring MMPs to report on CCIPs.

DHCS and CMS are also working with the MMPs on a new quality improvement strategy to improve health outcomes and lower costs for NF residents in Los Angeles and Orange Counties by providing preventative care and treatment, and improving quality of overall care to decrease the need for emergency department visits. Through this initiative, MMPs must develop and implement interventions to reduce avoidable hospitalizations and other adverse events for NF residents. MMPs are in the planning phase and were scheduled to begin implementation of their reviewed and updated plans in April 2017, and were required to provide their first quarterly report by the end of July 2017. The first quarterly report was submitted and adjustments to modify interventions were suggested to each MMP to improve results based on the interventions.

CMS provided a press release on this initiative at the beginning of January 2017.[18]

In accordance with the requirements of SB 1008, DHCS releases the Cal MediConnect Performance Dashboard on a quarterly basis. The latest dashboard includes performance metrics on quality withhold measures, care coordination, grievances and appeals, behavioral health and LTSS, and includes select data and measures on key aspects of the Cal MediConnect program such as:

[18] The press release is located at the following link: http://www.calduals.org/2017/01/05/new-initiative-announced-by-state-federal-agencies/.

- Enrollment and demographic data on Cal MediConnect enrollees including race/ethnicity, primary language, and gender;
- Completion of quality withhold measures;
- Care coordination measure performance, including HRAs, ICPs, care coordinator ratios, whether enrollees have documented discussions of care goals or post-discharge follow-up visits;
- Measures on grievances and appeals; and
- Performance measures on behavioral health, including utilization metrics and information around appeals.

For the MLTSS transition, the MMPs in the seven demonstration counties will follow the existing Medi-Cal managed care reporting requirements, which include the annual reporting of 15 HEDIS measures, participating in a tri-annual CAHPS survey, and participating in PIPs. DHCS monitors the MMPs, provides technical assistance and policy guidance, and supports MMPs in competing CAPs and improving HEDIS scores.

MLTSS Monitoring Items

Table 4 below displays the MCP measures that are used to monitor plans' fulfillment of their obligation to provide covered MLTSS services to their enrollees in the seven demonstration counties in accordance with state and federal law. The results are publicly reported in summary format by health plan and by county. DHCS works with CMS to publish details as they become available. CMS and DHCS may at any time agree to delete, modify, or add new metrics to improve reporting. There are several evaluation activities underway on the metrics. For example, the Senior Care Action Network (SCAN) Foundation has funded two projects. One is a Rapid Cycle Polling Project, which is being conducted by the Field Research Corporation. The other is a three-year evaluation of Cal MediConnect, which is comprised of researchers from the University of California San Francisco Institute for Health and Aging and the University of California, Berkeley School of Public Health. These evaluations, as well as other evaluation activities, are described in further detail in the annual CCI Evaluation Outcomes Report.[19]

[19] The CCI Evaluation Outcomes Report is located at the following link: https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/2019_Cal_MediConnect_Evaluation_Outcome_Report.pdf.

Table 4: MLTSS Monitoring Items

Criteria	Metric	Frequency	Data Source	Expected Outcome
Enrollment Status	MCP selection and mandatory enrollment numbers and percentages for beneficiaries eligible for MLTSS will be tracked in each MLTSS county	Monthly	Medi-Cal Eligibility Database System (MEDS) Data	100 percent of beneficiaries eligible for MLTSS will either make a MCP selection, or be passively enrolled in each MLTSS county
MCP Changes	Number of beneficiaries who changed MCPs in Geographic Managed Care and Two-Plan model counties	Monthly	MEDS Data	Number of plan changes by MCP and county will be monitored. No more than 10 percent auto-assigned to a MCP will change plans due to access to care or continuity of care concerns
PCP Assignment	Number of MLTSS beneficiaries assigned to a PCP	Monthly	Monitoring Report from MCPs	100 percent of Medi-Cal only and partial duals without Medicare Part B beneficiaries who are mandatorily enrolled or make a plan choice will be assigned a PCP within 30 days
Benefit Package	DHCS will monitor, through ongoing surveys and readiness and implementation monitoring, that MCPs provide for enrollees LTSS in care settings appropriate to their needs	Quarterly	DHCS	DHCS will assure compliance with the characteristics of home and community based settings, per Section 1915(c) and 1915(i) (Title 42, United States Code, Section 1396n) regulations and in accordance with implementation/effective dates published in the Federal Register
Plan Readiness –	DHCS shall submit to CMS its plan for	Quarterly, with assessment	DHCS	• Network adequacy will be verified on a

Criteria	Metric	Frequency	Data Source	Expected Outcome
Initial and Ongoing	ongoing monitoring of MCPs	and reports on network adequacy submitted to CMS no later than 60 days after the close of each calendar quarter		quarterly basis for the first year • Plan readiness will be conducted similarly to Healthy Families and Geographic Expansion • Readiness assessments will be aligned with the Cal MediConnect reporting where possible; DHCS will complete a network certification for each county • DHCS will assess and monitor MCP capacity for the MLTSS population
Participant Rights and Safeguards, Information, and Network Adequacy Requirements	For network adequacy, in addition to Title 42, Code of Federal Regulations, Section 438, DHCS must: • Require MCP to refer everyone eligible for IHSS to the county social services agency and support enrollee transition • Require MCPs to refer all IHSS recipients to the Public Authorities network of IHSS workers/providers who will be providing services while the recipient waits for a county IHSS worker or the normal IHSS	Information is due to CMS prior to implementation and every six months afterward for the term of the demonstration	DHCS	DHCS will monitor the following: • That MCPs maintain and provide the Public Authority contact information for the adequate network of IHSS workers/providers to support enrollee transition • Adequate MOUs are in place to facilitate access to care between plan, county, and MSSP sites • That MCPs refer all those eligible for MSSP to all contracted MSSP sites • Availability of MCP care coordinators for enrollees waiting for MSSP slot • That MCPs refer IHSS recipients awaiting a caregiver to other HCBS benefits (CBAS,

Criteria	Metric	Frequency	Data Source	Expected Outcome
	worker cannot provide services • Have MCPs submit MOUs between the plan, the counties and MSSP sites • Require MCP to offer a care coordinator to everyone on a MSSP waitlist when the MLTSS enrollee is waiting for an MSSP slot with a contracted MSSP site • Require MCP to refer IHSS recipients who are awaiting a caregiver to other HCBS benefits (CBAS, MSSP) or work with community-based organizations (CBOs) and resources to help bridge the gap to meet their needs. • Require DHCS to identify all NFs that house MLTSS enrollees • MCPs should demonstrate adequate capacity in their contracted nursing homes			MSSP) to help meet/bridge their needs • That MCPs will work with CBOs and resources to help IHSS recipients bridge the gap to meet their needs until they begin to receive IHSS DHCS will monitor NFs that house MLTSS enrollees and show the percent that have been contracted by each MCP. MCPs will track and monitor all facilities that house MLTSS enrollees including the number and percent of facilities contracted per MCP to ensure adequate capacity in contracted NFs
Quality Oversight and Monitoring – Measurement Activities	DHCS shall collaborate with CDSS to develop mandatory MCP reports related to	Annually	DHCS	DHCS will oversee ongoing monitoring of individual wellbeing and plan performance and use this information in

Criteria	Metric	Frequency	Data Source	Expected Outcome
	the critical elements of MLTSS, including network adequacy, timeliness of assessments, MLTSS authorizations, service plans and service plan revisions, plan changes, utilization data, call monitoring, quality of care performance measures, fraud and abuse reporting, participant health and functional status, complaint and appeal actions. These reporting requirements must be specified in the MCP contract. DHCS must provide reports to CMS to demonstrate their oversight of the key elements of the MLTSS program. DHCS shall collaborate with CDSS to measure key experience and quality of life indicators for MLTSS			ongoing monitoring and quality improvement efforts, in addition to quality reporting efforts DHCS will analyze MCP reports as part of its quality oversight and based on the results, take corrective action as needed to enforce compliance. DHCS will obtain, monitor, and evaluate key experience and life indicator information, including information on actions taken by DHCS. The information will be made available to advisory groups and publically posted. DHCS will use performance measures Quality Strategy/reports to develop MCP report cards that are public, transparent, easily understandable and useful to participants in choosing a MCP.

Criteria	Metric	Frequency	Data Source	Expected Outcome
	participants. The measures must be specific to the needs of MLTSS participants and data must be collected using best practices for reaching special populations (e.g., phone or in person). Survey results must be maintained by DHCS and reported to CMS, along with any action(s) taken or recommended based on the survey findings. The EQRO should validate the survey results. DHCS must analyze the results, discuss them with stakeholder advisory groups, post the results on its website, and provide the results in print upon request.			
Complaints/ Appeals	Number/percent of appeals or complaints	Monthly	MCPs	Complaints and grievances will be consistent with what was experienced by MLTSS enrollees prior to transition.

Criteria	Metric	Frequency	Data Source	Expected Outcome
				MCPs must resolve grievances within required timeframes
Provider Network Changes	Additions/deletions of participating providers by MCP	Quarterly	MCPs submit quarterly reports to DHCS	MCP's provider network will remain consistent with the network assessed during readiness.
Continuity of Care	Number of continuity of care requests and outcomes for MLTSS enrollees	Monthly	MCPs	MCPs will report all cases of transitioning MLTSS enrollees receiving or requesting continuity of care
Consumer Satisfaction with MCP	MCP Call Center Report for MLTSS enrollees by type of inquiry	Quarterly	MCPs submit quarterly reports to DHCS	MCPs will ensure the number of complaints and types of complaints related to access to care and continuity of care, with consideration to the transition, are taken into account. The expectation is that there will be a decrease each month following the transition.
Support and Retention of Community Placement	Enrollees referred to the HCBS waivers are assessed for the HCBS waiver. Enrollees referred to IHSS are assessed by the county social services agency for IHSS. Enrollees newly admitted to NFs without a discharge plan in place were first afforded supports	Quarterly	MCPs	MCPs will do the following: • Refer enrollees to appropriate services that support retention of community placement • Track and monitor the number of referrals made to HCBS waivers and the number of completed assessments performed by the HCBS providers • Track and monitor the number of IHSS referrals made to the county social services agency and the number

Criteria	Metric	Frequency	Data Source	Expected Outcome
	and services in the community. Number and proportion of enrollees who transitioned to the community from an institution and did not return to the institution, excluding post hospital rehabilitation, within a year. Number and proportion of enrollees receiving LTSS in the community along with number and proportion of beneficiaries receiving LTSS in an institution.			of completed assessments performed by the county social services agency. DHCS shall collaborate with CDSS to address outcomes regarding tracking and monitoring the number of referrals made and the number of completed assessments performed. • Track and monitor the number of referrals made to HCBS programs for newly admitted NF residents without discharge plans in place. If the evaluation indicates an increase in NF placement rather than community replacement, the rates will be adjusted to create an incentive to keep enrollees in community placement

State Costs

The state procured assistance through Federal Grant Funding and Social Security Act Title XIX for the CCI implementation activities in the areas of outreach and education, Medi-Cal capitation rate setting, quality improvement and rapid-cycle quality improvement, Medicare data analysis, information technology (IT) system designing and mapping, operational planning and management, and CCI project management. Through a cooperative agreement with CMS, the first of the funding came from a fixed price contract dedicated to the development and initial activities of the CCI. After the initial stages of the CCI were completed, the state applied for the Federal Grant Funding to support the CCI implementation.

The following illustrates funding under the grant period as well as ongoing funding for the demonstration program:

- Year 2 (September 1, 2014 – August 31, 2015): CMS contributed 75 percent federal financial participation (FFP) and the state contributed 25 percent from the State General Fund. The unobligated funding from Year 1 was made available for Year 2 and CMS paid 100 percent FFP.
- Year 3 (September 1, 2015 – July 31, 2016): CMS contributed 50 percent FFP and the state contributed 50 percent from the state General Fund.
- Year 4 (August 1, 2016 – June 30, 2017): CMS contributed 50 percent FFP and the state contributed 50 percent from the state General Fund.
- Year 5 (July 2, 2017 – June 30, 2018): CMS contributed 50 percent FFP and the state contributed 50 percent from the state General Fund.
- Year 6 (July 1, 2018 – June 30, 2019): CMS contributed 50 percent FFP and the state contributed 50 percent from the state General Fund.

Detailed scopes of work for each funded implementation activity are provided below:

- Ongoing stakeholder engagement and communication that includes the development and execution of a communications plan to engage health plans, CBOs such as Centers for Independent Living or Aging and Disability Resource Centers, physician offices, hospitals and clinics, CBAS providers, county behavioral health agencies, public authorities, county IHSS workers, MSSP sites, and consumers.
- Beneficiary and provider outreach and education that includes the development and dissemination of fact sheets, enrollment notices, educational and informational materials, and choice packets.
- Rate development and actuarial analyses that include rate setting, risk adjustments, cost distributions, and the development of savings targets and outcome reporting.
- Medicare data analyses and reporting that include processes and systems to link historical Medicare and Medi-Cal data for dissemination to health plans to conduct HRAs, integration of data for use in determining health plan assignments, assessing acuity and risk stratification and reporting of outcomes and trends.
- Operational planning and transition management services that include strategic network management and integration of Cal MediConnect policies, coordinating and conducting health plan and state operational readiness activities, and assessments of post-implementation activities and operational training needs.
- Project management support that includes the development and maintenance of project plans, tasks, activities, programmatic roles and responsibilities, and timelines. It also includes the development and implementation of processes to identify, mitigate, and resolve project issues and risks, along with the preparation and dissemination of project progress and tracking reports for various state and federal agencies.
- Orchestrate and facilitate the implementation and successful accomplishment of all components of the transition of the MSSP from a 1915(c) HCBS waiver to a managed care benefit, including the development and implementation of a project

management plan.

The following contractors conduct the activities listed above: Harbage Consulting, LLC; Public Consulting Group, LLC; and Mercer Health and Benefits, LLC.

Budget

The following background information highlights various contract managers (leads) working on the CCI. The number of staff ranges from 3 to 23 employees spending 30 to 100 percent of their time on the demonstration program, approximately 150 hours per month.

- Hilary Haycock, Harbage Consulting, LLC: Ms. Haycock is President of Harbage Consulting and has more than ten years of experience working to improve health policy at the federal, state, and local levels. Ms. Haycock has published extensively on health reform concepts with a focus on health care policy communications and stakeholder engagement.
- Carolyn Hubbert, Project Management Professional (PMP), Public Consulting Group, LLC: Ms. Hubbert is a Senior Information Technical and Project Management Consultant with Public Consulting Group and has more than 20 years of experience in health care, business, and IT. Her extensive expertise includes large-scale implementation and management, all phases of the System Development Life Cycle from requirements to testing through project closure, Independent Verification and Validation, Project Oversight and Contract Turnover, and Takeover.
- Tracy Meeker, PMP, Public Consulting Group, LLC: Ms. Meeker is a certified PMP and has over 20 years of progressive responsibility in project management, business intelligence, and data integration in government health care consulting, including more than 15 years on Medi-Cal programs, and commercial health care consulting. Her most recent experience includes providing Health Insurance Portability and Accountability Act and Health Information Exchange Consulting Support Services for the State of California, Office of Health Information Integrity eHealth branch.

Appendix A: Coordinated Care Initiative Beneficiary and Provider Outreach Plan

CMS is working with DHCS to implement a health reform project in seven California counties to promote coordinated care and enhance health outcomes and the quality of life for Duals through a new health plan option that combines Medicare and Medi-Cal benefits, an MMP. In addition, most Medi-Cal beneficiaries in these counties will choose MCPs for their Medi-Cal benefits, including LTSS. These two policy transitions make up CCI and are taking place in: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

The state is committed to the implementation of a robust outreach and education plan specifically for the CCI that allows eligible beneficiaries and their supports to have accurate, actionable information for the decision-making process. The state and federal governments have taken unprecedented steps to make additional resources available at the state and local levels to help assist beneficiaries, caregivers, providers, and others through this transition. This document outlines an iterative version of that plan, which is adaptable as implementation of the CCI moves forward.

After multiple years of policy, outreach, and stakeholder engagement work, DHCS has completed the first phase of passive enrollment and noticing for all counties.

Purpose and Scope of Outreach and Education Plan

The goal of the outreach work is to help beneficiaries make informed choices based on their needs and to establish that they have a good understanding of their options. At the same time, this plan acknowledges that there is an existing infrastructure for reaching beneficiaries, which beneficiaries, their caregivers, and providers already know and trust. California's network of existing support for this population—through providers and provider organizations, CBOs, advocacy organizations, and social service agencies—also must have access to the information they need about the CCI. This plan aims to build on that foundation: to amplify and support existing work and provide additional work when needed.

The outreach and education plan is designed specifically for the CCI. It integrates aspects of communications and marketing strategies, including tools such as earned media and targeting. However, it is not a marketing strategy, as its goal is to increase awareness among beneficiaries and providers about their options under the program. Part of providing these populations with action-oriented information about their options involves relaying the benefits of the program as well as what has been traditionally defined as and is legally considered insurance plan marketing information, such as details about differences in plan benefits. The state, its employees, and its consultants will not advise beneficiaries on which plans to select but will provide resources to assist with these decisions.

Target Audiences and Clarity of Reference

The outreach approach recognizes that the CCI-eligible population receives their information from established and trusted routes of communication. The state is

supporting and supplementing those existing pathways with accurate information and a focus on facilitation and coordination with other important stakeholders at the state and local levels.

Key Audiences

Beneficiaries and Caregivers	Beneficiaries are the primary direct-action takers under the CCI. They, and their caregivers and representatives, are responsible for making decisions about health plans and how to receive their care. As such, this outreach plan is designed around the best way to provide the information they need, whether they receive that information from HCO, HICAP, a CBO, or a CCI outreach coordinator.
Providers	The CCI represents a change for many providers serving eligible beneficiaries, including non-traditional providers, such as CBOs, which are or might become providers under the program, hospital discharge planners, and LTSS providers (CBAS, Public Authorities, MSSP, Assisted/Independent Living Facilities, Skilled Nursing Facilities [SNFs]). To help support positive transitions for beneficiaries, these providers need information about what the CCI means to their practice/work. Providers are also often the person or entity that beneficiaries look to for health care advice, so providers need to be educated about the CCI and what it means for the people they serve.
Local "Guides" and Stakeholders	"Guides" are organizations already supporting the population. They need continued access to information and other resources about the CCI to fulfill their missions. This includes collaboration on events to educate beneficiaries, as well as creating and providing materials such as fact sheets, presentations, etc. for guides to use for outreach purposes. These organizations include CBOs, unions, medical groups, and associations, Area Agencies on Aging (AAAs), HICAPs, legal aid societies, local advocacy organizations, legislative aides (all offices, including regional), insurance agents/brokers, county governments and agencies, and tribes and tribal leaders.
Leadership	Advocates, policymakers in the executive and legislative branches (in California and nationally) and opinion leaders. This group needs to understand the CCI as it continues through implementation.
Health Plans	Health plans are as much an audience as they are a key partner in this outreach and education effort.

Implementation: DHCS Project Lead from Sacramento
DHCS is executing the following tasks at a leadership level to support appropriate infrastructure and support for all outreach activities:

- Beneficiary-friendly notices and other noticing materials
- User-friendly website
- Regular calls/meetings with key

- Interagency coordination
- Support for local agencies
- Outreach toolkit development
- "Train the trainer" program
- HCO training and staffing
- stakeholders
- Beneficiary outreach
- Provider outreach
- Population-specific outreach

Beneficiary-Friendly Notifications

Verifying that all beneficiary notifications and related materials are in clear, consumer-friendly language is a critical part of the outreach effort. This includes updating the "What Are My Medi-Cal Choices?" booklet and required enrollment notices that target the Duals population. As in all outreach materials, close attention is paid to cultural competency and the development of accessible materials, including the availability of alternative formats.

Status: DHCS led a stakeholder process on each of the state notifications, resulting in notices that are significantly more beneficiary-friendly. Building on beneficiary testing done in 2013, CMS and DHCS tested key notices and the Cal MediConnect Choice Form in focus groups with beneficiaries, caregivers and information intermediaries in May 2014. The notices and choice form were revised based on recommendations from that testing process, and put through further stakeholder review. DHCS began mailing revised notices during the summer of 2014. DHCS translated all notices into the required Medi-Cal threshold languages and made all the notices available in accessible formats.

While all beneficiaries who have Medicare first and later gain Medi-Cal coverage are already required to enroll into a MCP for their MLTSS in order to receive their Medi-Cal benefits, DHCS has developed the materials required to inform these beneficiaries of their options. The materials were released in August 2016. Notification materials for beneficiaries are needed so that all eligible beneficiaries are aware of the program and understand they will be defaulted into a MCP if they do not make an active choice to join a MCP or Cal MediConnect. Beneficiaries that wish to remain in fee-for-service Medicare need to enroll into a MCP in order to keep their Medi-Cal services.

Status: In the summer of 2016, DHCS released a new Medi-Cal Managed Care Plan Guide and Choice Book to be sent to two groups of Duals: 1) new Duals who have Medicare first and later gain Medi-Cal eligibility in CCI counties; and 2) existing Duals who move into a CCI county. These materials went through a stakeholder comment period in September 2015. They also underwent extensive user testing and revisions in partnership with the Health Research for Action at UC Berkeley's School of Public Health and a series of literacy reviews to verify that they meet readability standards and are not above a sixth-grade reading level. Further, the materials are available in Medi-Cal threshold languages and available in accessible formats, as required. DHCS

continues to send materials to Duals who have Medicare first and then later gain Medi-Cal, as well as to existing Duals who move into a CCI county.

Interagency Coordination

A unique aspect of the CCI is the coordination among several state entities in supporting outreach and education for beneficiaries. While DHCS manages Medi-Cal, CDSS, CDA, DMHC, and the Department of Rehabilitation (DOR) all have important roles. For example, CDSS oversees IHSS, a critical service for many Duals. CDA oversees the HICAPs, which play a key role in counseling beneficiaries about their plan options. Information sharing among these agencies and creating appropriate feedback loops are a part of this outreach effort.

Status:

- DHCS, CDA, CDSS, and DOR conducted weekly calls on policy and outreach items during initial implementation periods;
- DHCS and CDA worked closely on several outreach-related activities related to passive enrollment, including:
    - A call-triage strategy so that beneficiaries face “no wrong door” when contacting state and local agencies.
    - Verifying that HICAP staff have the proper materials to use in answering beneficiary questions.
    - Verifying that county-specific materials are available for beneficiaries on who to call with CCI and Cal MediConnect questions and when they need assistance.
    - Refining established feedback mechanisms so that beneficiary issues and questions arising in HICAPs or HCO are shared among agencies, allowing the agencies to work together on solutions.
- DHCS and DMHC worked together to develop a special Cal MediConnect Ombudsman program to help beneficiaries enrolled in Cal MediConnect with complaints about their health plans and to educate beneficiaries about their rights and responsibilities as plan members. The Cal MediConnect Ombudsman program has provided services since the program went live in April 2014.

Support for Local Agencies

Supporting and coordinating with local agencies, such as the local HICAPs and AAAs, in their efforts are key parts of this plan. Many local agencies serve as important sources of information for beneficiaries. For example, HICAPs already serve as trusted sources of information for Medicare beneficiaries. In addition, other local agencies need materials, assistance with coordination of outreach efforts, support in their outreach efforts, and assistance in training their staff.

Status:

- The state helped secure CMS grant funding to support HICAP capacity for the CCI. This grant funding requires quarterly data reporting on call volume and other selected indicators, which helps the state monitor beneficiary access of HICAP counseling.
- California Health Advocates delivered additional trainings to HICAPs;
- DHCS and CDA continue to partner to provide updated materials and other resources to HICAPs including up-to-date fact sheets and frequently asked question (FAQs) documents.
- DHCS partnered with private organizations, including the SCAN Foundation, to provide additional support to the HICAPs.
- DHCS and CDA continue to partner to provide updated materials and other resources to HICAPs including up-to-date fact sheets, frequently asked question documents, and other materials.
- Local outreach coordinators continue building and maintaining relationships with local organizations, coalitions, and workgroups to coordinate outreach efforts and to support outreach efforts already underway in the CCI counties.

Outreach Toolkit

DHCS developed an outreach materials toolkit to educate health plan staff, beneficiaries, CBOs, advocate groups, and providers and provider groups. The toolkit also supplements the enrollment notices. See Attachment 1 for more details on the toolkit. There is a special focus on providing materials for community groups that support limited English proficiency individuals.

Status: Fact sheets and other materials are available on CalDuals.org. DHCS released a comprehensive set of toolkit materials concurrently with this version of the outreach plan, including:

- Presentation slide decks for beneficiaries, advocates, and providers.
- Beneficiary fact sheets on eligibility, continuity of care, plan member rights and responsibilities, IHSS services, and PACE.
- Provider fact sheet on payment policies under the CCI.
- General brochure on the CCI.

DHCS released a companion physician toolkit to help providers understand continuity of care, contracting and billing processes, and other information they need to communicate with patients about the CCI. DHCS developed this toolkit in part to address misconceptions physicians have about how their practices may change under the CCI, and to help physicians continue to treat their patients whether they join or opt out of Cal MediConnect. The toolkit also includes information for physicians to share with their patients who are eligible for Cal MediConnect.

Toolkit materials will continue to be developed and revised with stakeholder input. Materials are translated and provided in Medi-Cal threshold languages and in county-specific formats as appropriate. DHCS will develop additional and county-specific toolkit materials, as needed.

"Train the Trainer" Program

Understanding that DHCS does not have outreach capacity to reach all beneficiaries, DHCS created an educational program and materials to support local organizations in training their staffs to assist beneficiaries and providers.

- This program includes assisting and developing a plan for outreach through Benefits Counselors and Legal Advocates.
- This program includes an effort to educate stakeholders on how the substance abuse/mental health benefits are administered.
- This program also supports CBOs and provider coordination. Support and help existing communication channels that are available through local AAAs and other CBOs. Examples include: Meals on Wheels Programs, Para-transit agencies, Senior Centers and Senior Centers without Walls.

Status: DHCS outreach coordinators continue to work directly with CBOs to provide materials and support as needed and requested. DHCS continues to provide "Train the Trainer" presentations in CCI counties.

Health Care Options Training and Staffing

HCO, which was established in April 2014, is run by DHCS with MAXIMUS as the contractor, serves as a primary contact for beneficiaries as they make their plan choices, and the sole entity handling beneficiary enrollment. The call center is dedicated to the CCI and DHCS has developed materials to train DHCS/MAXIMUS call center staff so they are familiar with the CCI and how it works. The state also has secret shoppers call the call center about various topics and hot button issues on a regular basis.

Status:

- DHCS periodically refines the CCI-specific FAQ guide for HCO customer service representatives and provides daily, weekly, and as needed training for the representatives; and
- DHCS previously secret shopped the call center and used the feedback for training purposes to improve beneficiary and stakeholder experience, and to inform FAQ guide updates.
    - DHCS has since discontinued secret shopping the HCO call center. While DHCS may resume secret shopping if necessary, DHCS has not heard concerns that would indicate the need for secret shopping, and DHCS agreed that the ongoing shopping calls did not provide enough additional value to justify continuing the calls.

User-Friendly Website

DHCS continues to update and refine CalDuals.org, a consumer- and stakeholder-friendly website through which beneficiaries, advocates, providers, and other stakeholders access relevant CCI information.

Status: CalDuals.org is an important source of information for advocates, beneficiaries, stakeholders, and providers. DHCS refined the website to include beneficiary and provider portals that provide targeted, audience-specific materials. Content in major Medi-Cal threshold languages is available on the website as well. In April 2017, the website was refreshed with the help of a key group of stakeholders that represent the various groups' interests. The website is continually updated with relevant information and data.

Regular Outreach to Key Stakeholders

Coordination with stakeholders is key to successful outreach to CCI-eligible beneficiaries. Clear lines of communication between stakeholders and DHCS help to flag implementation issues and provide feedback from advocates.

Status: DHCS is hosting or participating in regularly-scheduled stakeholder meetings and continues to identify opportunities to increase communications:

- DHCS hosts quarterly stakeholder update calls.
- DHCS participates, as invited, in weekly Sacramento-based and monthly local collaborative meetings of stakeholders to provide updates and solicit feedback.
- DHCS hosts calls with health plans on policy and outreach issues.
- DHCS engages key stakeholders, as needed, to solicit feedback on program changes and ways to improve the program.

Beneficiary Outreach

DHCS educates many beneficiaries through local outreach coordinators and is using existing methods of informing consumers of program changes and their choices. Beneficiaries who must choose a Cal MediConnect or Medi-Cal MCP receive notices 90, 60, and 30 days ahead of their coverage date. In addition, HCO made calls to beneficiaries following receipt of their 60-day packet throughout the passive enrollment period, which included information on their plan choices.

DHCS always works to expand on this outreach, always respecting privacy protections.

Status: Existing methods of beneficiary outreach are ongoing. In addition:

- The first phase of passive enrollment has ended in each county.
- Throughout passive enrollment for all counties except for Orange County, DHCS hosted monthly tele-town hall calls with beneficiaries who had received 60-day notices with their plan choices. During these calls, beneficiaries were able to ask questions of DHCS staff.

- Outreach coordinators continue working with local groups to deliver presentations to beneficiaries where they are, such as senior centers, senior housing, various CBOs, and nursing homes for example.
- DHCS has developed a CCI beneficiary toolkit. This comprehensive toolkit tells a cohesive story of Cal MediConnect and contains stand-alone fact sheets that cover various topics and aspects of Cal MediConnect and the CCI in more depth. This toolkit helps eligible beneficiaries understand their options and how Cal MediConnect may benefit them. It also helps these beneficiaries better understand how to navigate their Medi-Cal MCPs when choosing not to participate in Cal MediConnect. The toolkit was released for stakeholder comment and underwent extensive user testing in partnership with Health Research for Action at UC Berkeley's School of Public Health. The toolkit is an easy-to-use resource for enrolled and eligible beneficiaries, caregivers, and stakeholders. It is available online and in hard copy in all of the Medi-Cal threshold languages and is being distributed during outreach activities.
- DHCS continues to create beneficiary-friendly outreach materials as needed.
- DHCS continues to engage directly with beneficiaries where they live, congregate, and receive health-related information. This includes health fairs, community-based organizations, senior and disability-related housing organizations, senior centers, and provider offices.

Provider Outreach

Providers are a trusted source of information for beneficiaries, and their participation in and knowledge of the CCI is key to facilitating the long-term success of the program and positive transitions for beneficiaries. DHCS is working with provider groups, provider associations, and various other providers so that information flows in a timely manner for gatherings and publications, as well as working to assist with provider inquiries and clarification.

Status: DHCS is in regular contact with provider associations, medical groups, independent practice associations, hospitals, and other providers to share information, provide materials and updates, and answer questions. The CalDuals.org website offers easy access to provider-specific information, including a CCI Physician Toolkit and a Hospital Case Managers Toolkit. In addition, the state continues, as opportunities arise, to partner with associations like the California Association of Physician Groups (CAPG) to deliver key information, webinars, and other resources to members on key Cal MediConnect topics, and would welcome similar partnerships with other provider associations. DHCS also continues to partner with the California Medical Association (CMA) Foundation (and similar organizations) and their various members and membership organizations to engage physicians to assess their understanding of the CCI and information needs, as well as to distribute physician-focused educational materials and provide trainings for physicians and their staff.

Population Specific-Outreach

Given the wide range of beneficiaries affected by the CCI, DHCS developed several population-specific outreach approaches for the following groups:

- Ethnic/minority and limited English proficiency beneficiaries
- Ethnic/minority physicians
- Beneficiaries with disabilities
- Beneficiaries in nursing facilities and their authorized agents
- Beneficiaries who are homeless or are living in low-income housing
- Beneficiaries accessing nutritional programs and other social services and community based programs.
- Beneficiaries with mental and behavioral health needs
- Faith-based groups

The goal is to monitor that information about the CCI reaches these populations through their unique communications touch points.

Status: DHCS continues population-specific outreach, which began in late 2014. DHCS has worked extensively with the Network of Ethnic Physician Organizations and is looking for more opportunities to work with that group. In addition, DHCS worked with New America Media to host an ethnic media roundtable in each CCI county, and the roundtables have reached a number of ethnic media outlets including those serving the Chinese, Korean, Pilipino, Vietnamese, and Spanish-speaking communities, among others. In addition, outreach coordinators are delivering presentations in low-income housing complexes, in senior centers, and to CBOs that serve beneficiaries. Further, the outreach team has developed materials for Meals on Wheels programs, is working with unions, public authorities, and local counties to engage IHSS beneficiaries and caregivers, and is engaging in other targeted outreach on a daily basis.

Implementation: Outreach Coordinators and Technical Advisors
At the heart of the local outreach effort are two teams of people based across the seven CCI counties: outreach coordinators and technical advisors (technical advisors worked on the program between July 2014 and June 2015). Both groups are supported by federal funds through DHCS, just as CalDuals consultants are supported today. Although the coordinators and advisors have some overlapping objectives and coordinate their efforts, they have distinct roles and responsibilities. Outreach coordinators and technical advisors build bridges between the local resources, CBOs, various stakeholders, health plans, and the individual decision-makers. They operate under the established approach of inclusiveness and accessibility and help support community work and educate beneficiaries and providers in the community. Their roles are designed to allow for the availability of accurate information that will allow beneficiaries to make an informed decision—not to “sell” the CCI.

Outreach coordinators work in specifically assigned counties. One of their primary functions is to support local county groups and, as requested, establish that they have the information and assistance they need. These groups include but are not limited to: health plans, provider organizations, CBOs, advocacy organizations, and social service agencies.

Coordinators also play a role in direct beneficiary and provider engagement. Coordinators know how to answer and refer beneficiary, caregiver, and provider questions to relevant sources and supplement any knowledge gaps.

The role of the coordinator is slightly different in each county to meet the needs in that county. Different activities can include:

- Participating in local stakeholder coalitions, particularly as they relate to communications and outreach to the beneficiary and provider populations.
- Providing informational presentations (in-person and via webinar) to beneficiaries, providers, and other stakeholders.
- Delivering “train the trainer” presentations to organizations who regularly interact with the beneficiary population and need support understanding and explaining the CCI.
- Facilitating good information flow between the counties and the state, particularly to identify information and outreach needs in local communities.

Outreach coordinators generally have backgrounds in community organizing and/or communications and many have experience reaching out to elderly, disabled, and/or provider populations. Experience with health policy – on an advocate or personal level – is preferred but not required. Outreach coordinators go through an intensive training program on the relevant policy and outreach principles.

Technical advisors were individuals who worked for or were recruited from local stakeholder groups within the counties. The advisors worked in their specific county and participated in developing and refining county-specific outreach plans, review materials such as components of the toolkit, and served in a critical role within the community relaying information to the public and working with the management team on troubleshooting issues.

Technical advisors had backgrounds in Medi-Cal policy, beneficiary counseling on health coverage options, local advocacy work, and/or direct experience with the DHCS 2011 SPDs transition. Advisors participated in sessions intended to debrief stakeholder groups on the current status of policy and the overall outreach plan – as well as to share their on-the-ground experiences with other advisors and management.

More specifically, technical advisors and outreach coordinators do the following:

- Assisted with an initial landscape assessment. This activity primarily consisted of outreach coordinators meeting with local stakeholders to understand the unique needs of each county, and to best determine how DHCS outreach efforts could amplify and complement existing work (see Attachment 2 for more information).

- Developed local, county-specific outreach plans. Using the overall outreach plan context, enrollment information for each county, and the landscape assessment, technical advisors and outreach coordinators developed a tailored county outreach plan, which operates in tandem with the overall state outreach plan.
- Support local groups and CBOs. Technical advisors and outreach coordinators support groups such as local health plans, HICAP agencies, AAAs, Independent Living Centers, Aging and Disability Resource Centers, Caregiver Resource Centers, Public Authorities, and Health Consumer Centers, as well as local CBOs, advocates, senior centers, and county agencies. They are also familiar and work with referral/informational services such as 2-1-1 through the United Way.
- Work in cooperation with health plans and PACE programs. Outreach coordinators support these groups' beneficiary and provider outreach.
- Work with and inform provider groups. Outreach coordinators work with groups such as the CMA, CMA county affiliates, CAPGs, ethnic and specialty medical societies, local medical groups and independent practice associations, local hospital associations, DME suppliers, pharmacies and pharmacists, and CBOs that act in a provider capacity (such as transportation support services).
- Conduct direct outreach employing various mechanisms. These activities include:
    - Discussions and presentations with key stakeholders, beneficiaries, and providers in their "home" settings, including places like senior centers, low-income housing complexes, churches, care centers, and nursing homes.
    - Attendance at health fairs and other pre-organized events to offer presentations or materials.
    - One-on-one listening sessions for relationship building purposes.
- Create a meeting structure for county leaders. In counties where it is needed and not duplicative around existing local initiatives, the team develops an infrastructure to support leadership meetings for representatives of all major areas of interest—including but not limited to hospitals, physicians, county health/mental/social services leaders, representatives from the health plans, PACE programs, and advocates. The goal is for each local group to become self-sustaining.
- Assist with media events as needed. There are efforts to reach people though the media.

Note: Technical advisors and outreach coordinators also conduct outreach to ethnic/minority communities, particularly by working with CBOs that are crucial community influences and touch points for vital services. Efforts are made to hire coordinators with appropriate language capabilities throughout the regions.

Status: Since December 2014, a team of outreach coordinators have been providing outreach to beneficiaries, providers, advocates, and other stakeholders across the CCI counties. Outreach coordinators are extensively trained and are very knowledgeable about the CCI. Coordinators provide outreach and education, deliver presentations, participate in local stakeholder events, and work on local communications workgroups.

In addition, technical advisors were hired in each county through local stakeholder coalitions. The outreach team currently consists of a group of seven individuals with social work, community organizing, and provider engagement backgrounds. Some members of the team also speak languages represented by the beneficiary audience: Korean, Spanish, and Chinese.

Outreach Plan Refinement Timeline

The outreach and education plan will be revised as necessary throughout the process of policy finalization and enrollment and program implementation. Refinement will take place in the course of the mentioned outreach activities while taking into consideration any relevant policy shifts.

Any updates to the plan may be re-released for stakeholder and plan input. Certain portions of the plan, such as sections of the toolkit, may be released for input throughout implementation.

Attachment 1: Coordinated Care Initiative Toolkit

The toolkit is available for download online and selected materials are available at events and presentations. The toolkit includes a series of fact sheets that explain policy issues, such as the enrollment policy, changes to LTSS, and other topics, as needed. In addition, the toolkit includes audience-specific presentation slide decks and general informational materials.

The toolkit has tailored materials for different levels of audiences:

- Beneficiaries
- Providers
- Advocates and “Guides” (i.e., CBOs, HICAP staff)

As appropriate, toolkit materials are circulated for stakeholder input prior to finalization. Where possible, toolkit materials are provided in languages other than English, in accessible formats, and in county-specific versions.

Basic Toolkit

DHCS has released a set of toolkit materials, which includes:

- Slide decks for beneficiaries, providers, and advocates
- Beneficiary fact sheets on the following topics:
    - Eligibility
    - Continuity of care
    - Member rights and responsibilities
    - Balance billing
    - Benefits of CCI
    - IHSS services
    - PACE programs
- Provider fact sheet on payment under the CCI
- County-specific fact sheets
- Language-specific fact sheets in Medi-Cal threshold languages
- Educational videos

Previous materials released publically include county-specific beneficiary fact sheets on who to call for more information on enrollment, health plan options and problems with your plan, as well as fact sheets on a number of policy topics, available on CalDuals.org.

In addition to the general set of materials outlined above, DHCS has developed targeted toolkits for physicians, beneficiaries and hospital case managers, and continues to evaluate stakeholder needs for potential future toolkits. Each toolkit is outlined below.

Physician Toolkit

DHCS developed a physician toolkit that includes information about the CCI and sample materials for physicians to share with their patients. This toolkit was developed in part to address misconceptions physicians may have about how their practices may change under the CCI, and to help physicians continue to see their patients whether they join Cal MediConnect or opt out. The toolkit, which is updated as necessary, is posted online and available in hard copy. The toolkit contains the following components:

- Cover letter to physicians
- CCI overview
- Accessibility requirements for providers
- Information on how to submit crossover claims
- Sample letters for physicians to provide to their patients
- Information on how to bill
- Physician fact sheets on the following topics:
    - Care coordination
    - Payments
    - Working with dual eligibles in Medi-Cal plans
    - Contracting with MMPs
    - Continuity of care

Beneficiary Toolkit

DHCS has developed a CCI Beneficiary Toolkit. Prior to its release, the toolkit went through extensive user testing to facilitate beneficiary understanding. The comprehensive toolkit tells a cohesive story of Cal MediConnect and also contains stand-alone fact sheets that cover various topics and aspects of Cal MediConnect and the CCI in more depth. For example, the toolkit includes fact sheets that address many of the questions that currently-enrolled and eligible beneficiaries often have, including:

- Can I keep my current doctor?
- How do I keep seeing my current doctors?
- How does Cal MediConnect help me get the care I need?
- What are the benefits provided by Cal MediConnect?
- What is care coordination and how does it help me?
- What is a Health Risk Assessment and a Care Coordinator?

Many Duals are new to managed care in general, so the toolkit also includes a fact sheet that helps explain some of the particulars related to Medi-Cal managed care health plans (MCPs), such as the definition of a network. The toolkit helps eligible beneficiaries understand their options and how Cal MediConnect may benefit them. It also helps these beneficiaries better understand how to navigate their MCPs.

Cal MediConnect Case Manager Toolkit

Acknowledging that beneficiaries often need extra support during hospitalizations and in the transition from the hospital back into the community or into a NF, DHCS worked with the California Hospital Association and MMPs to develop the Cal MediConnect Hospital Case Manager Toolkit. This toolkit is a resource that can be used in CCI counties to support Cal MediConnect members before, during, and after hospitalization. This toolkit gives guidance, answers common questions, and provides important information about Cal MediConnect to hospital case managers and discharge planners. The toolkit can support hospital case managers as they work with beneficiaries through the admissions and discharge processes and also includes details on how to access and build upon care coordination services provided by MMPs.

DHCS continues to identify topics for toolkit materials, including fact sheets, presentations, videos, infographics, and other media. The state welcomes public input on the development of any future toolkit materials.

Attachment 2: Landscape Assessment

A CCI-related landscape assessment began in the spring of 2013 by collecting an inventory of assets, resources and partnership opportunities within: DHCS, other departments of the California Health and Human Services Agency, CMS, CBOs, and CCI health plans. As part of DHCS's ongoing outreach efforts, assessing the CCI-county landscape is an ongoing part of the process and began with interviews with beneficiary- and provider-related groups.

The initial beneficiary audience assessment began with interviews with many groups, including the following:

- Health plan and PACE program executives including but not limited to individuals in the following areas: marketing, member services, community education, provider relations
- County officials, particularly those involved in providing social services
- HICAP managers
- AAA directors
- Centers for Independent Living managers
- Case management and enrollment staff from MCPs
- Leaders of key consumer advocacy organizations
- Duals
- Nursing homes

The initial provider audience assessment was composed of interviews with many providers, including the following:

- Physicians
    - Groups
    - Specialty physician societies
    - County medical societies
    - Ethnic medical societies
    - Any other opportunities to speak with independent physicians
- Hospitals
    - Private
    - County public hospitals
    - Community clinic associations
- DME suppliers
- CBOs who act in provider capacity at times (transportation)

- Pharmacies
- Nursing homes/SNFs
- IHSS workers and their unions
- County agencies
- CBAS providers and staff
- MSSP site directors and staff
- Ancillary sites and providers such as hospital associated pharmacies, outpatient physical therapy clinics
- Case management and enrollment staff from MCPs and PACE programs

As potential new relationships are identified with similar beneficiary and provider groups, and/or changes occur with the program, assessment and refinement takes place on an ongoing basis so that effective outreach is meeting the needs of beneficiaries, providers, and other stakeholders.