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Financial Alignment Initiative California Cal MediConnect: First Evaluation Report

Prepared for

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FINANCIAL ALIGNMENT INITIATIVE
CALIFORNIA CAL MEDICCONNECT
FIRST EVALUATION REPORT

by

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Executive Summary

The Medicare-Medicaid Coordination Office (MMCO) and the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) have created the Medicare-Medicaid Financial Alignment Initiative to test, in partnerships with States, integrated care models for Medicare-Medicaid enrollees. The goal of these demonstrations is to develop person-centered care delivery models integrating the full range of medical, behavioral health, and long-term services and supports (LTSS) for Medicare-Medicaid enrollees, with the expectation that integrated delivery models will address the current challenges associated with the lack of coordination of Medicare and Medicaid benefits, financing, and incentives. CMS contracted with RTI International to monitor the implementation of the demonstrations under the Financial Alignment Initiative and to evaluate their impact on beneficiary experience, quality, utilization, and cost. The evaluation includes an aggregate evaluation (Walsh et al., 2013) and State-specific evaluations.

This report analyzes implementation of the California capitated model demonstration under the Medicare-Medicaid Financial Alignment Initiative, called Cal MediConnect from April 1, 2014 through December 2016.

Specifically, this report describes the California Cal MediConnect demonstration's approach to integrating the Medicare and Medicaid programs; providing care coordination to enrollees; enrolling beneficiaries into the demonstration; and engaging stakeholders in the oversight of the demonstration; and provides information on financing, payment, and Medicare savings. Data sources include key informant interviews (through December 2016), focus groups (through March 2016), the 2015 and 2016 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey (data collected through mid-2016), plan-reported data submitted to CMS' implementation contractor (through December 2016), Medicare savings data (through December 2016), other demonstration data, and evaluation reports contracted by the California Department of Health Care Services (DHCS). This report also includes data on beneficiaries eligible and enrolled, geographic areas covered, and status of participating Medicare-Medicaid Plans (hereafter referred to as Cal MediConnect plans or MMPs).

This report does not contain quantitative results on utilization measures (e.g. inpatient, emergency department, physician visit, personal care, nursing facility, behavioral health) derived from encounter data. Although Medicare-Medicaid Plans in the State have begun submitting Medicare encounter data when this report was produced, a complete set was not available to conduct analysis. Future reports will include Medicare and Medicaid encounter analysis, pending data availability. RTI and CMS are assessing Medicare encounters for completeness and accuracy before analyzing them for future reports. Because such analyses are at the demonstration level rather than the plan level, RTI will begin analyses of Medicare or Medicaid encounters for the first and second demonstration years only after all Medicare or Medicaid encounters for a particular performance period are complete. When all encounters for a particular performance period are complete, RTI will provide descriptive and regression-based utilization analyses in future reports.

Demonstration Overview

The Cal MediConnect demonstration is a capitated model of service delivery in which CMS, the State of California, and Cal MediConnect plans enter into three-way contracts to provide comprehensive, coordinated care for beneficiaries who are dually eligible for Medicaid and Medicare services. Each plan receives monthly capitated payments from Medicaid and Medicare to manage the care and services of enrollees.

The goals of the California demonstration are to improve the beneficiary experience in accessing care, promote person-centered planning, promote independence in the community, assist beneficiaries in getting the right care at the right time and place; and achieve cost savings for California and the Federal government through improvements in care and coordination.

Cal MediConnect began implementation on April 1, 2014. Eligible Medicare-Medicaid beneficiaries could opt into the demonstration or be passively enrolled. Enrollment into the demonstration was by a phased passive enrollment process by county and by population group, and continued through July 2016. The demonstration was originally slated to operate in eight counties, including Alameda County. In November 2014, the State made the decision to implement it in the following seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

Before the demonstration, most Medicare-Medicaid enrollees received Medicare services from fee-for-service providers or through Dual Eligible Special Needs Plans (D-SNPs); Medi-Cal services were provided either by fee-for-service or through managed care organizations, depending on the county of residence, and long-term services and supports (LTSS) were authorized and provided through separate entities in each county. All of these services, along with nursing facility and subacute services, specialty mental health and substance use services, are now coordinated through Cal MediConnect plans.

Individuals eligible for Cal MediConnect include full-benefit Medicare-Medicaid beneficiaries aged 21 or older who are enrolled in Medicare Parts A and B and eligible for Medicare Part D and have no other comprehensive private or public health insurance. Individuals participating in the following programs are not eligible to enroll in the demonstration, but may do so after disenrolling from their current program: Program of All-Inclusive Care for the Elderly (PACE), the AIDS Healthcare Foundation, or any of the following 1915(c) waivers: Nursing Facility/Acute Hospital, HIV/AIDS, Assisted Living, and In-Home Operations.

The demonstration was designed to bring together the State's In-Home Supportive Services (IHSS) program, and two waivers, the Multipurpose Senior Services Program (MSSP) and Community-Based Adult Services (CBAS). New benefits include vision, nonemergency transportation services, and flexible benefits, known as Care Plan Option (CPO) services. The coordination of medical and LTSS and behavioral health services is a core feature of the demonstration. Coordinators assess each enrollee and, with interdisciplinary care teams, develop care plans that reflect the enrollee's preferences and needs.

Prior to the demonstration, the State expanded mental health benefits to all Medi-Cal beneficiaries in managed care plans which are available to Cal MediConnect enrollees. In May

2014, previously limited Medi-Cal dental benefits were reinstated and therefore available to Cal MediConnect beneficiaries.

Demonstration Changes Announced in California's 2017–18 Budget

Background

Cal MediConnect initially began as a 3-year demonstration and was authorized from April 1, 2014 through December 31, 2017. In July 2015, CMS notified the State of the opportunity to extend the demonstration by 2 years; CMS and the State effectuated the extension of the demonstration through December 31, 2019. Cal MediConnect was authorized under the State's Coordinated Care Initiative (CCI) within the Bridge to Reform 1115(a) Medicaid Demonstration. In addition to Cal MediConnect, the CCI included a plan to transition Medicare-Medicaid enrollees into Medi-Cal managed care, include Medicare wraparound benefits, and integrate managed long-term services and supports (MLTSS) into Medi-Cal. Both parts of the CCI, the demonstration and MLTSS, are operating in the same counties, on generally the same enrollment schedule, and with generally the same plans. All plans participating in the demonstration are also providing services to Medi-Cal managed care enrollees through different products.

In authorizing the CCI, California law SB 94 included a provision that all components of the CCI would become inoperative if the CCI did not provide net savings to the State's general fund. This savings would be calculated annually by the California Department of Finance; the State would disclose at the beginning of each calendar year whether the demonstration would continue the following year.

Announcement

The Governor's 2017–2018 budget disclosed on January 10, 2017, stated that the Department of Finance had determined the following: (1) the CCI was not fiscally viable; (2) Cal MediConnect will continue through calendar year 2019; and (3) MLTSS will continue with mandatory enrollment of dually eligible beneficiaries into managed care; these beneficiaries will have integrated LTSS, with the exception of In-Home Supportive Services (IHSS). The budget announcement stated in part, "Although CCI was not cost-effective during the initial demonstration period, the duals demonstration program provided the potential to reduce the cost of health care for the affected individuals and improve health outcomes."

The ramifications of this announcement on the demonstration will be discussed in future reports. This report covers the start of the demonstration through December 2016. However, we note these changes would have the following effects on the demonstration: (1) IHSS benefits would be removed from MMP capitation rates effective January 2018; (2) subsequently, IHSS services would be provided to demonstration enrollees on a fee-for-service basis; (3) IHSS workers would continue to participate in care plan teams of demonstration enrollees; (4) one of the LTSS entities included in the demonstration, the Multipurpose Services and Supports Program (MSSP), would continue as a waiver program and not transition to a managed care benefit in 2017 as planned. This transition would occur no sooner than 2020. The three-way contracts between CMS, the State, and each Cal MediConnect plan would end at the end of

calendar year 2017 and new contracts would be in place before the beginning of calendar year 2018.

The annual budget review has had a negative effect on Cal MediConnect. Each fall, there has been intense apprehension about the uncertainty of the demonstration's renewal, affecting providers who may have been reluctant to learn a new system that may not continue beyond the next year, beneficiaries who may have chosen to opt out or disenroll rather than learn a new system of care that may not continue, and State staff who may have sought stable positions within State government. MMPs, which have made considerable investments to provide services to enrollees, were concerned about the continuation from year to year. Though this provision was dropped in the Governor's 2017 budget, in future reports the RTI evaluation team will explore the implications of this amendment, known in California as "the poison pill" amendment.

The integration of IHSS into the MMPs—an important aspect of Cal MediConnect—also presented numerous challenges in the demonstration. Plans were required to pay for these services, but had no oversight for assessment or authorization of services, which were retained by counties, thereby creating an inherent tension between plans and the counties. Budget and payment reconciliations for these services took place on an extremely delayed schedule, which compromised plans' ability to assess their financial standings. However, as a major service to beneficiaries, plans and stakeholders were committed to integrating IHSS into Cal MediConnect. Future reports will assess the effect of these changes on the demonstration and will include perspectives of enrollees and stakeholders. Findings in this report cover the period from April 2014 through December 2016.

Integration of Medicare and Medi-Cal

The Cal MediConnect demonstration integrates most Medicare and Medicaid services and adds care coordination to provide coordinated delivery of all medical, acute, behavioral health, and pharmacy services, and LTSS. Each enrollee is covered for all Medi-Cal services (including LTSS and behavioral health services), Medicare medical and acute services (including physician and hospital services), and all pharmacy benefits. Cal MediConnect plans are responsible for ensuring that enrollees have seamless coordination and access to all necessary services, including specialty mental health and substance use services. Medicare and Medi-Cal are integrated in the enrollment process and grievances and appeals processes. The Medicare and Medi-Cal aspects of the demonstration's continuity of care provision was harmonized in 2016. Previously, enrollees could continue to see their former Medicare provider for 6 months. In 2016, enrollees may continue for a period of 12 months to see former Medicare or Medi-Cal providers who do not participate in the demonstration.

The Contract Management Team (CMT), made up of State staff and CMS Medicare and Medicaid staff, jointly provide oversight of the demonstration. The CMT coordinates policies and processes of Medicare and Medi-Cal and works as a team to oversee the three-way contracts with the Cal MediConnect plans. The CMT is responsible for day-to-day monitoring to ensure that State and CMS policies are integrated, to respond to plans' questions, and to identify areas for technical assistance to plans. In the beginning of the demonstration, the CMT met frequently with plans to answer plans' questions and address concerns. As the demonstration unfolded, topics changed from marketing concerns in the beginning, to complaints and grievances,

reporting requirements, and, in 2016, best practices of Cal MediConnect plans. CMS organizes presentations by MMPs in other demonstration states to share best practices of activities common to all MMPs.

Counties have different delivery systems in California, which adds complexity to the integration. Each county has a county-operated plan; in two of the seven demonstration counties, this health plan is the only MMP. The other five demonstration counties have one to four more commercial MMPs that serve demonstration enrollees. California counties also operate agencies that contract with providers to deliver specialty mental health and substance use disorder services and agencies that authorize and monitor LTSS services. These agencies have historically operated completely independent of the health delivery system. However, many county-operated health plans in the demonstration have developed linkages with them that predate the demonstration. To integrate all LTSS and behavioral health services, a main feature of the demonstration, plans must build relationships with various county agencies to identify enrollees in common, share data, and coordinate care. While county-based plans may have had a head start on creating those relationships, this is a new endeavor for commercial plans.

Delegation is another important factor influencing integration. Counties in Southern California have highly delegated models, meaning that MMPs contract with multiple independent practice associations (IPAs) that each have their own networks of hospitals, nursing facilities and other providers, known as downstream entities. Although an enrollee is enrolled with one MMP, he or she is generally also enrolled in an IPA, which means that the enrollee must obtain services only from providers within the IPA's network. In the first year of the demonstration, as balance billing and when some denials of services occurred, it became clear that not all downstream providers were aware of Cal MediConnect or its policies and procedures. Incorrect billing, a widespread issue in the State, also may have been exacerbated by these downstream entities.

Training and outreach to providers began prior to the start of the demonstration and the State, plans, and stakeholders have all spent considerable time educating providers about the rules of the demonstration through 2016. The State developed toolkits directed to primary care providers (PCPs) and specialists in the first year of the demonstration and refined them in subsequent years. In 2016, the State, in collaboration with stakeholders, developed materials directed to hospital case managers to explain the processes of the demonstration within a hospital context. Throughout the demonstration, the State has continued to educate MMPs and providers by issuing policy clarifications in dual plan letters (DPLs) and all plan letters (APLs) on salient topics as needs arise. For example, in 2016, after inappropriate nursing facility discharges occurred, the State released an APL on provider and subcontractor suspensions, terminations, and decertifications.

Successes and Challenges

Cal MediConnect plans expressed enthusiasm for the model of care and confidence that the demonstration would prove successful. Although they had concerns about many issues—including whether the demonstration would be extended from year to year, questions about profitability due to delayed rate-setting adjustments, and other challenges—plans reported that they were committed to making the demonstration a success.

The CMT model, which provides real-time technical assistance to plans, has proven successful according to all participants. Plans were positive about efficiently resolving cross-cutting issues with State, Medicare and Medi-Cal representatives all in the same meeting. CMS CMT members remarked that this was an innovative and effective approach to oversight.

Although State officials and MMP officials in delegated counties believe that the delegated model works well, reports from some enrollees, stakeholders, and ombudsman representatives described numerous enrollee challenges resulting from delegation. It is not clear whether enrollees in delegated counties have adequate access to care, given the challenges associated with obtaining services outside IPA networks, as stakeholders have reported. It appears that not all, demonstration policies have not filtered down to all downstream entities, given the issues of inappropriate incorrect billing. Plans are responsible for quality oversight (including training and auditing) of all contracted providers; however, it is unclear how comprehensively plans are monitoring all these providers. Provider outreach is an ongoing challenge; the State, its contractors, and stakeholders provide policy clarifications, additional materials, and trainings to providers. RTI will continue to monitor this topic.

Eligibility and Enrollment

The demonstration began in April 2014, with passive enrollment taking place in staggered phases by birth month, program type, and by county from April 2014 through July 2016 in seven counties. In addition to passive enrollment, eligible beneficiaries could opt in at any time. The enrollment process was hampered by timelines that were adjusted frequently as late as November 2014, a very complicated enrollment schedule, DHCS' outdated and inefficient enrollment data system requiring multiple workarounds, and enrollment materials that did not clearly explain the benefits of Cal MediConnect. Many beneficiaries who did not understand the enrollment notices or who had not updated their addresses with Medi-Cal learned they had been enrolled when they attempted to obtain services from their current provider. Beneficiary assistance organizations and the demonstration Ombudsman Program reported having an unusually high number of calls from beneficiaries asking for explanations and assistance. Negative publicity about the demonstration—including two legal cases designed to stop the demonstration—characterized enrollment in 2014.

By the 6th month of the demonstration, 34 percent of beneficiaries who had received passive notices remained in the demonstration, with the remainder choosing to opt out or disenroll. Potential enrollees with complex needs, who were pleased with their current PCP and specialists and who knew the costs of those services, were reluctant to be enrolled into a demonstration with unknown providers. In 2014 and 2015, stakeholders and plans reported that some providers had encouraged their patients to opt out of the demonstration. California's eligible population is highly diverse, particularly in Los Angeles County. In 2015, the State's analysis of beneficiaries who had opted out confirmed that opt-out rates among beneficiaries who spoke languages other than English were especially high—as high as 94 percent for certain linguistic groups in some counties (actual numbers were not reported by the State). In 2016, the State's cluster analysis confirmed earlier suspicions that a relatively small number of providers were associated with a high number of beneficiary opt outs. Non-English-speaking providers who serve large minority ethnic communities tend not to participate in managed care networks. Beneficiaries who use IHSS services also opted out at a very high rate across the demonstration

counties—61 percent on average. Subsequent disenrollments occurred, and by March 2016 (when the State froze enrollment reporting metrics [except for San Mateo and Orange counties]), only 18 percent of eligible IHSS recipients were enrolled in the demonstration.

As of December 2016, of the 475,000 enrollees who were ever eligible and received passive enrollment notices, 113,600 were enrolled at that time. According to the State, the overall opt-out rate through the final month of passive enrollment in July 2016 was 50 percent, ranging from 10 percent in San Mateo County to 58 percent in Los Angeles County; another 20 percent had disenrolled. Orange County, the last county to begin passive enrollment in August 2015, had the second highest opt-out rate. State officials and stakeholders were surprised because many of the enrollment notice and operations challenges had been corrected in other counties by the time this county began passive enrollment. The State had revised and improved beneficiary notices with useful information to prospective enrollees, conducted extensive outreach to providers by that point, and much of the negative press had subsided.

In 2016, to address low enrollment, the State proposed a variety of enrollment strategies, including that passive enrollment be required for newly eligible beneficiaries. Although the MMPs supported the renewal of passive enrollment, stakeholders did not and the State's proposal was withdrawn. The State moved forward with a opt-in enrollment strategy, including streamlined enrollment that began in fall 2016. Through streamlined enrollment, MMPs may facilitate enrollment into the demonstration by eligible beneficiaries in their Medi-Cal line of business. The State also revised its MLTSS resource guide and choice books to include substantial information about Cal MediConnect, prompting an influx of enrollments into the demonstration.

DHCS took another step to safeguard enrollments by working with MMPs to improve the deeming process. Without a grace period in which he or she is “deemed eligible,” a Cal MediConnect enrollee who appeared to have lost Medi-Cal eligibility or was not able to provide timely annual recertification paperwork is disenrolled from the demonstration. From the beginning of the demonstration, all MMPs noted this was a challenge. In July 2015, DHCS announced that all Cal MediConnect plans had selected a deeming period of 30 days with the exception of Health Plan of San Mateo which requested a 60-day deeming period. Enrollees may also request a separate protection, Aid Paid Pending, should they receive a notice of termination of their Medi-Cal benefits. In September 2016, CMS revised its enrollment guidance to States participating in the Financial Alignment Initiative and specified that States may rapidly re-enroll enrollees back into their original MMP due to temporary loss of Medicaid. This could occur if the enrollee regains Medicaid within 2 months after the effective date of disenrollment. However, California has not yet indicated it will be able to move forward with this proposal.

Successes and Challenges

As of December 2016, about one-quarter of beneficiaries who received passive enrollment notices at some point since the start of the demonstration were enrolled; the rest had opted out or disenrolled. This was substantially lower than the State and plans had anticipated. Los Angeles County, which originally had an ambitious cap of 200,000 during the demonstration design, had 36,000 enrollees as of December 2016. Beneficiaries in various

groups—those participating in IHSS, and ethnic and linguistic minorities—opted out at high rates.

The State implemented various strategies to enhance enrollment and minimize disruptions for enrollees. Deeming and continuity of care adjustments improved enrollees' access to care. DHCS and CMS adjustments to deeming and continuity of care, in 2015 and 2016, respectively, allow enrollees to remain in the demonstration and receive health care while their Medi-Cal renewal is pending or when they require services of a provider not in the demonstration. During the continuity of care period, MMPs conduct outreach to the provider to encourage participation in the demonstration. Both adjustments were praised by stakeholders and plans as major improvements to Cal MediConnect.

In spring 2016, DHCS instituted additional initiatives to boost enrollment, such as streamlined enrollment and program improvements to encourage opt-in enrollment. DHCS hosted meetings with plans to share their best practices on a variety of topics so they can learn from each other and improve operations.

A complicated schedule and enrollment processing system contributed to a repeat of many challenges that had occurred with a similar population in an earlier initiative—the 2012 transition of 400,000 seniors and persons with disabilities (SPDs) to mandatory managed care. That previous process served as a lesson learned for the 2014 enrollment in Cal MediConnect and the State had taken a number of measures to prevent earlier missteps. Both transitions initially had complex enrollment materials; however, demonstration enrollment materials were refined several times, with input from stakeholders, during the demonstration. While continuity of care disruptions occurred with both populations, there were fewer in the demonstration, due in part to the efforts of the Ombudsman Program. Stakeholders and providers noted that both initiatives were marked with complex enrollment materials; plans' difficulty reaching passively enrolled beneficiaries because of incorrect contact information; stakeholders' inability to answer beneficiary questions correctly; and lack of plan experience in serving a very impaired population with complex care needs. The similarities were noted by providers and plans in every site visit. Many providers—especially in Orange County, which had the second highest opt-out rate—cited the SPD transition as the reason they did not want to become involved with Cal MediConnect and why they encouraged their patients to opt out of the demonstration.

Beneficiaries had little awareness or understanding of the demonstration, the effect on their services, or even that they had been enrolled. In the first year of the demonstration, Ombudsman Program staff reported that beneficiaries who called for assistance typically had discovered they had been enrolled after visiting a pharmacy or attempting to visit their usual provider. Some learned they had been enrolled when their surgeries were canceled. Beneficiaries wanted to know how and why this had occurred, what the demonstration was, and to understand the ramifications of their enrollment. In 2016 focus groups, enrollees remarked on their confusion with demonstration materials and difficulty with differentiating the demonstration, plans, and benefits.

Care Coordination

Care coordination is a key function of the Cal MediConnect demonstration. Plans are required to employ health risk assessments (HRAs), care coordinators, interdisciplinary care teams, and individualized care plans to provide care coordination to enrollees. Plans work with State and county agencies to coordinate LTSS and behavioral health care for enrollees who qualify for these services. The State's requirements in the three-way contract allow plans flexibility in their implementation; therefore, although the major components of the care coordination model are common across the Cal MediConnect demonstration, plans vary widely in their approaches to providing this benefit. Some plans have achieved more success than others in delivering care coordination in the demonstration, but only 35 percent of enrollees, report receiving this benefit.

Care coordination begins with the health plan using new enrollees' historical utilization data to apply a risk-stratification method. At a minimum, plans are required to classify enrollees as higher or lower risk. This designation determines how soon plans must reach enrollees and complete the HRA. Although there is not a standardized assessment tool across Cal MediConnect, all plans were required to develop and use a tool meeting State specifications. Risk-stratification determined by the HRA may also determine whether or not enrollees are assigned a care coordinator, although any enrollee may request one. A few plans reported assigning all enrollees a care coordinator, though most plans only provide care coordination for higher risk enrollees (for example, enrollees who need LTSS or behavioral health services).

Care coordinators occupy a variety of roles, depending on the health plan organizational structure and model for care coordination. Plans reported using care coordinators to visit enrollees in their homes, provide assistance by telephone, work on care teams focusing on special populations, and liaise with county-based agencies and providers. Although enrollee caseload varies from plan to plan, most plans interviewed in 2016 reported ranges of 200 to 350 for higher-risk enrollees. In many cases these care coordinators were supported by additional staff working to support the care coordination effort. Care coordinators also play a key role in ensuring HRAs are completed, developing individualized care plans that reflect enrollees' goals and preferences, and assembling interdisciplinary care teams to implement the care plans. These processes are often hindered by care coordinators' inability to reach and engage enrollees. Across the demonstration, the percentage of enrollees that Cal MediConnect plans were unable to reach within 90 days of enrollment ranged from 15 to 48 percent in 2014; by 2016 it was 24 to 35 percent. Plans reported investing heavily in efforts to make contact with enrollees who are difficult to reach; using claims data, they visit places where enrollees receive services, such as dialysis centers, pharmacies, senior centers, and community-based providers.

In order to coordinate LTSS and behavioral health services for the enrollee population, Cal MediConnect plans integrated into their existing services two LTSS waiver programs (CBAS and MSSP), the IHSS program, county-based behavioral health care, services for individuals with Alzheimer's disease and related dementias (ADRD), and services for individuals receiving institutional LTSS. Although county-operated plans usually had preexisting relationships prior to the demonstration, most plans had to build new relationships with entities operating these programs and providing these services. For behavioral health services, plans developed memoranda of understanding with county behavioral health agencies to delineate each entity's

role. Successful integration and coordination of LTSS and behavioral health services varies from plan to plan, though State officials, stakeholders, and plans report that coordination across agencies and providers has improved over the course of the demonstration.

Successes and Challenges

Care coordination introduces opportunities for improvements in enrollees' care, quality of life, and ability to navigate the health care system. It also provides greater efficiency and cost savings. Although State officials, stakeholders, and plans view integration of primary, acute, LTSS, and behavioral health service systems across agencies and providers as a major strength of the demonstration, coordinating across systems that have historically existed separately requires commitment by all parties, and high investments in staffing and financial resources for plans. Despite complex operational challenges, some plans have made progress in forging these linkages.

Plans are committed to delivering care coordination to enrollees, and some have adopted unique practices in doing so. One plan deploys physicians to make house calls to high risk enrollees who are not receiving regular health care. Another has a comprehensive approach to engaging nursing facility staff, physicians, and enrollees. Plans are also participating in a demonstration-wide program to train care coordinators and family caregivers to provide care coordination to enrollees with Alzheimer's disease and related dementias. This program, led by the California Department of Aging, was recognized as one of the best practices in care coordination nationwide with the 2016 Rosalinde Gilbert Innovations in Alzheimer's Disease Caregiving Legacy Award. Care coordinators and plan staff have also implemented various initiatives with goals of keeping enrollees in community settings, transitioning enrollees out of institutional settings, and connecting enrollees who are homeless to housing, health, and social services. Plans reported using flexible Care Plan Options benefits to meet short-term needs to enable enrollees to remain in their homes.

The biggest barrier to providing care coordination that plans report is difficulty reaching enrollees, particularly for enrollees who are homeless. Obtaining updated contact information, reaching the enrollee, and engaging them in assessments and care planning processes are ongoing challenges as the demonstration progresses. In cases where plans are able to successfully contact enrollees and maintain a relationship, care coordination seems to be unfolding as planned. RTI focus groups and State evaluations indicated high levels of satisfaction with care coordination services under the demonstration. Enrollees report that care coordinators are committed to meeting their needs, and have proven helpful in facilitating referrals and authorizations, setting up medical appointments, and educating them about benefits available under Cal MediConnect.

Although valuable to enrollees, care coordination is not reaching all enrollees who could benefit from the service. Despite satisfaction with care coordination services among those receiving it, State evaluators found that not all enrollees are receiving care coordination. One State evaluation survey showed that between 34 and 36 percent of Cal MediConnect enrollees reported having a care coordinator. A similar proportion was reported among surveyed enrollees who opted out of the demonstration or who live in non-demonstration counties. Another State evaluation survey revealed that 35 percent of Cal MediConnect enrollees were receiving care

coordination, whereas 22 percent reported that they could use more assistance to coordinate their care. These findings are supported by RTI focus groups, in which only a small proportion of participants reported receiving care coordination services or knowing their assigned care coordinator.

State officials and stakeholders reported that since the demonstration began in 2014, all plans have developed a deeper understanding of the different systems being integrated under Cal MediConnect (CBAS, MSSP, IHSS, behavioral health services, Alzheimer's support services, and institutional LTSS) and have worked closely with stakeholders and providers to establish lines of communication and data sharing methods, and to agree on procedures for care coordination. However, some plans have had more success working across agencies than others. Most county-operated plans, with a history of working with other county-operated entities, have responded more quickly to liaising with county agencies and developing co-location of staff to facilitate communication with agencies and coordination of enrollees. Commercial plans, which need to first build relationships with county LTSS and behavioral health agencies, had a slower start but have made progress. LTSS and behavioral health agencies in counties with multiple plans experienced some frustration with adapting to the needs of multiple plans.

Across plans, coordinating IHSS and behavioral health services has proven most challenging because plans must rely on these agencies to provide information on services they provide to enrollees. IHSS services are assessed and authorized by county agencies and newly established lines of communication between IHSS and the plans have enabled plan care coordinators to coordinate care for enrollees who receive these services. However, developing information exchanges has been slower to take place between plans and county behavioral health agencies. County agencies and providers are vigilant in protecting beneficiary data under HIPAA and other privacy-related regulations relating to mental health and substance use services, and are working with plans to develop procedures for obtaining enrollee authorizations and to establish common data processes so that plans may provide care coordination for these enrollees. All parties are working to bridge the gap, but interviewees noted that progress is slower than they anticipated.

Beneficiary Experience

Improving the experience of beneficiaries is an overarching goal of Cal MediConnect; many of the demonstration features are designed expressly with this goal in mind, including working with beneficiaries to develop person-centered care plans and providing access to new and flexible services. Beneficiaries offered opinions and responses on these topics through a wide range of formats. RTI conducted a series of focus groups in 2016, and State evaluators conducted focus groups and multiple telephone surveys in 2015 and 2016. Enrollees also completed the Consumer Assessment of Health Plans Survey (CAHPS) in 2015 and 2016.

Focus group participants and survey respondents reported a range of satisfaction experiences with their care under Cal MediConnect; in focus groups, levels of satisfaction were associated with familiarity and understanding of the demonstration. Specifically, RTI focus group data indicated that individuals who understood the demonstration and had established relationships with their Cal MediConnect coordinators expressed high levels of satisfaction with their care. State evaluators reported multiple factors that contributed to beneficiary satisfaction

with Cal MediConnect : (1) having a simplified health insurance, (2) establishing continuity with providers and services, (3) having lower out-of-pocket expenses, (4) being satisfied with care coordination, (5) having someone to call at the plan, (6) receiving good quality of care from their providers, (7) having better access to care, (8) improved behavioral health services, and finally, (9) improved coordination across providers. Many beneficiaries reported that they kept their original PCP after enrolling in the demonstration, which contributed to their overall satisfaction with Cal MediConnect. CAHPS survey data of 2015 also indicated that Cal MediConnect enrollees were generally satisfied with their care. Extensive State efforts to provide culturally appropriate care paid off, as linguistic minority Cal MediConnect enrollees reported general satisfaction with care, ability to find and access language-concordant providers, and materials.

According to State evaluators' surveys, the level of satisfaction among Cal MediConnect enrollees was similar to that of beneficiaries they surveyed in non-demonstration counties and among those who opted out of Cal MediConnect. Therefore, it appears overall that Medicare-Medicaid beneficiaries reported being satisfied with the care they receive.

RTI focus group data indicated that enrollees appreciate new and added services and are grateful to receive them. Some focus group participants reported that they are not able to distinguish between standard Medi-Cal benefits and new benefits provided by MMPs as part of Cal MediConnect. Transportation emerged as an essential service for the Cal MediConnect population; the availability and quality of this service has a major effect on beneficiary quality of life and access to health care services. However, only about one-half of enrollees surveyed by State evaluators knew about this benefit. In addition to expanded benefits, Cal MediConnect MMPs also use the flexible CPO benefit for a range of services, including meals, home modifications such as ramps and other wheelchair accommodations, and non-covered durable medical equipment (DME). In general, Cal MediConnect enrollees appreciated the opportunity to obtain non-medical items that made their lives easier and allowed them to function better in their homes.

RTI focus groups included Cal MediConnect enrollees who reported various experiences with the demonstration. Among enrollee focus group participants who understood the demonstration and have established a relationship with their care coordinator, satisfaction with their overall care was high. This, however, was a small proportion of RTI focus group participants. Overall, participants provided mixed messages about the impact of services on their health, well-being, and quality of life. While some reported high levels of satisfaction and improved outcomes, several reported that their experiences were about the same as they were before and that their health and health care services remained unchanged. RTI focus group data also revealed low levels of enrollee involvement in their care.

There was a lack of awareness and understanding of the demonstration among most of the RTI focus group participants. Several Cal MediConnect enrollees participating in RTI focus groups also described some negative incidents and encounters and expressed general dissatisfaction with Cal MediConnect and a lack of understanding of the demonstration. Moreover, only a few participants in RTI focus groups recognized Cal MediConnect as the entity responsible for their health coverage. Passively enrolled beneficiaries often discovered they had been enrolled in Cal MediConnect a few months after passive enrollment had occurred; these enrollees had more misconceptions about the demonstration. Consistent with RTI findings, State

evaluators found that enrollees expressed feelings of disempowerment and resignation related to the passive enrollment and perceptions of lack of choice. Specific complaints about the demonstration included: (1) having to switch doctors or DME providers, (2) losing access to specific prescription drugs, (3) receiving bills for provider visits or services not covered by Cal MediConnect, (4) decreased access to specialty care, (5) needing service authorizations that delayed care, and (6) lack of communication between the plan and providers.

Focus group participants' knowledge of care coordination was also limited. Individuals who understood the demonstration and had established relationships with their coordinators expressed satisfaction with their care coordinators and the help they received from them. Most State survey respondents and RTI and UC Berkeley focus group participants reported not being familiar with care coordination benefits, and some reported relying on LTSS or behavioral health care managers to coordinate their care.

In terms of experiences of special populations, MMPs' lack of knowledge about nursing facility services resulted in serious missteps with repercussions for nursing facility residents, according to multiple stakeholders. There were some isolated but significant negative experiences for nursing facility residents early in the demonstration that stemmed from lack of MMP experience with nursing facility care.

Cal MediConnect has a robust process of collecting and reporting data related to beneficiary protections: enrollees may make a complaint through any venue in accordance with the State's "no wrong door" policy as well as directly to CMS for any service. They are encouraged to first address the issue at the plan level, but if that is unsatisfactory, they may make a complaint with the State or with the demonstration's Ombudsman Program. The Cal MediConnect Ombudsman Program was designed to assist enrollees with complaints and appeals, investigate, and negotiate with plans and providers when necessary to resolve enrollee complaints. The Ombudsman Program leverages existing county-based ombudsman offices that have substantial experience working with beneficiaries. Ombudsman contact information is provided with enrollment and other beneficiary materials. In the early days of the demonstration, many complaints to the Ombudsman Program originated from enrollees' and providers' lack of understanding of demonstration policies in general, and lack of understanding of continuity of care policies in particular. Although Ombudsman Program data are collected separately for Cal MediConnect enrollees and other Medicare-Medi-Cal beneficiaries, some of the reported complaints may have also affected individuals who had disenrolled or opted out of demonstration. For example, inappropriate provider billing, a widespread and long-standing challenge, has been a consistent complaint made by both demonstration enrollees and non-demonstration Medicare-Medi-Cal beneficiaries.

According to the data collected by tracking calls to the Ombudsman Program, complaints made by enrollees directly to MMPs stemmed from inability or excessive wait time to get an appointment with a PCP or specialist. Enrollees are encouraged to first address their complaints directly with MMPs and to proceed to ombudsman offices or the State if they are not satisfied. This appears to be occurring because the number of complaints made to MMPs is substantially higher than the number made to the State for all other lines of business for the same MMP (Medi-Cal only products).

Successes and Challenges

According to all RTI and State evaluation data, most enrollees reported being generally satisfied with their care under Cal MediConnect. Levels of satisfaction often related to familiarity and understanding of the demonstration. Cal MediConnect enrollees reported access to and satisfaction with culturally appropriate care and their ability to retain their PCPs. However, the level of satisfaction among Cal MediConnect enrollees was similar to that of beneficiaries in non-demonstration counties and among those who opted out of Cal MediConnect. Therefore, it appears that Medicare-Medicaid beneficiaries are generally satisfied with the care they receive.

Care coordination is valued by those Cal MediConnect enrollees who receive it. Enrollees who have established relationships with care coordinators reported valuing the service and using care coordinators as their advocates to resolve problems and get services and medical equipment they needed. However, enrollee knowledge of care coordination is limited. Most focus group participants reported not being familiar with care coordination benefits, and some reported relying on LTSS or behavioral health care managers to coordinate their care.

Enrollees appreciate new and added services provided by MMPs under Cal MediConnect. In particular, transportation was noted as an essential service that allows frail and impaired beneficiaries to access their care and reach their health care providers. While enrollees reported challenges with this service, they were very appreciative of it. About one-half of enrollees were unaware of the new benefit.

Beneficiary protection systems are working for those who access these systems. Enrollees may lodge complaints through multiple venues through the “no wrong door” approach. The Cal MediConnect Ombudsman Program is active in all counties and provides valuable assistance to beneficiaries by explaining demonstration rules and helping to resolve issues with providers. Most of the Cal MediConnect complaints and grievances had to do with billing and enrollees and providers not understanding Cal MediConnect rules.

Despite being generally satisfied, Cal MediConnect enrollees expressed difficulty understanding the concept of managed care and some of the new services delivered under the demonstration. Enrollees were generally confused between regular Medi-Cal benefits and coverage provided by MMPs as part of Cal MediConnect.

Beneficiaries also reported disruptions in continuity of care due to passive enrollment in Cal MediConnect, with providers refusing treatment and disruptions in prescription medications and DME supplies. MMPs’ lack of knowledge about nursing facility services resulted in serious missteps with repercussions for nursing facility residents. There were some isolated but significant negative experiences for nursing facility residents early in the demonstration stemming from a lack of MMP experience with nursing facility care.

Stakeholder Engagement

California has an active stakeholder community involved in the demonstration and the broader move toward managed care, more so than in past health care initiatives in the State. Two primary stakeholder entities involved in Cal MediConnect are Harbage Consulting (DHCS’s

contractor for stakeholder engagement) and the California Collaborative for LTSS. Harbage Consulting is the primary liaison to stakeholder groups and develops and provides outreach in forums, including bimonthly stakeholder calls, the CalDuals website, and presentations to stakeholder and beneficiary groups in all seven counties. The California Collaborative for LTSS, supported by the SCAN Foundation, functions as an unofficial stakeholder advisory group to DHCS. The group includes approximately 35 organizations, including disability rights groups, home care provider unions, medical and hospital associations, area agencies on aging, assisted living, and nursing facility associations. CMS plays a crucial role in supporting the implementation of the demonstration and works closely, on an ongoing basis, with the Collaborative and other stakeholders. MMPs also engaged in significant outreach and worked with downstream entities to educate them about the demonstration, specifically about billing, authorizations, and other detailed processes.

In the beginning of the demonstration, the California Collaborative responded to policies announced by the State and focused much of its attention on educating beneficiaries and advocacy groups about the policies of the demonstration and the complex enrollment schedule. In general, the California Collaborative's overall concerns have always focused on beneficiary protections and rights. The Collaborative supports the demonstration's goal of providing care coordination and integration of services within one plan to beneficiaries with complex needs. Justice in Aging, which provided technical assistance to Cal MediConnect Ombudsman Program about the demonstration, played a vital role by conducting multiple public webinars and trainings and produced the Cal MediConnect Advocacy guide that explains demonstration policies in detail.

According to stakeholder interviews, several factors complicated the Cal MediConnect outreach efforts. First, State resources were stretched thin by multiple initiatives, including Medicaid expansion and the simultaneous rollout of Cal MediConnect along with MLTSS. Second, there was substantial turnover among demonstration leadership. Third, from the very beginning, there was a significant and well-organized provider resistance against the demonstration. Finally, these efforts were hampered by the complexity of the State's managed care environment, particularly in the southern counties. Providers interviewed for the evaluation, on the other hand, perceived the State's early outreach and education efforts as insufficient and felt disengaged. This lack of early engagement with stakeholders contributed to the broad opposition and lack of understanding of the demonstration. It is important to note that the State—and Southern California in particular—has a uniquely dynamic and competitive market with many forces at play; even with a higher level of engagement, the stakeholder opposition to the demonstration could have been quite significant.

The lack of provider and stakeholder buy-in during the initial stages of Cal MediConnect implementation may have contributed to massive opt-outs, the lack of participation by many providers, particularly ethnic minority providers, and opposition to the demonstration among stakeholders. In response, the State intensified its efforts. In 2015, after State leadership stabilized and many challenges of the complex enrollment were resolved, the State began engaging the Collaborative and other stakeholders in more meaningful ways. By 2016, Collaborative participants noted that MMPs had joined their meetings, contributed to the discussions, and solicited advice from the group.

The level of Harbage’s outreach and stakeholder involvement evolved in a similar way with demonstration implementation. The outreach efforts in 2013 and early 2014 included outreach to provider organizations across the State. In 2014, outreach efforts focused on educating prospective enrollees, improving beneficiary materials, and connecting with newly enrolled beneficiaries to provide further education and information. In 2015, Harbage developed materials and provided outreach to educate providers about the demonstration, with a particular focus on incorrect billing education. In 2016, Harbage’s efforts expanded to assisting MMPs with outreach to providers that had been identified in the State’s 2016 analysis of providers linked to high beneficiary opt-out rates, and refining beneficiary and provider outreach and training materials. Harbage Consulting continued to be the liaison between the Collaborative and the State and provided policy documents to the Collaborative for review and feedback and incorporated the group’s concerns into the policy documents prior to finalization. This increase in stakeholder outreach and productive involvement has resulted in significant improvements in the demonstration design. After the State’s meaningful engagement with the Collaborative, as well as MMP involvement and Harbage’s continuing collaboration, the group has become an important partner with the State in shaping the Cal MediConnect experience for enrollees.

Although different stakeholder groups wanted to see various benefits strengthened, stakeholders remarked on the “sea change” in communication that began taking place among plans, providers, and LTSS—“for the first time in some counties, community-based providers and plans are sitting down together...to learn each other’s languages.” This sentiment was repeated by plan representatives, who noted that stakeholders generally have changed from trying to halt the demonstration to working very hard to try to improve it.

However, some stakeholders—nursing facilities and hospitals in particular—reported a lack of State outreach, and consequently a lack of understanding of the demonstration and the role of the MMP care coordinator in these facilities. The lack of clarity of demonstration policies was compounded by the concurrent roll-out of MLTSS in the demonstration counties. Many hospital discharge planners and nursing facility administrators were working with managed care plans for the first time. By 2016, after individual providers, provider organizations, and members of the California Collaborative raised awareness of these concerns, the State issued policy clarifications and Harbage assisted stakeholders in developing training materials to address their needs.

Successes and Challenges

California’s stakeholder community has been actively involved in the demonstration, with the main focus on protecting beneficiary rights and improving care and access to services. The California Collaborative for LTSS serves as a valuable sounding board for the State, which routinely seeks members’ feedback on new demonstration policies and initiatives. Harbage Consulting provides the main outreach function to current and prospective enrollees, stakeholders, and MMPs in all seven counties. They continue to conduct outreach to providers and develop training materials. In 2016 Harbage began working with plans to conduct targeted outreach to providers linked to high beneficiary opt outs.

Despite early efforts by the State to engage providers, provider buy-in was low throughout the start-up and early implementation stages of the demonstration. Some providers,

provider organizations, and stakeholders were resistant to managed care in general; others cited insufficient outreach and education as a contributing factor to broad opposition to the demonstration among health care providers. Lack of understanding of the demonstration and low buy-in among providers and stakeholders may have contributed to substantial opt-outs and disenrollments: during early implementation, some providers actively discouraged their patients from participating in Cal MediConnect.

In response to requests from stakeholders to improve outreach efforts, outreach to all types of providers, particularly hospital providers, has been strengthened in 2016; increased State collaboration with providers and stakeholders in the last year was particularly productive. By engaging stakeholders in more meaningful ways and recognizing the value of their contributions, stakeholder opposition has turned into substantive involvement. However, institutional long-term care providers, particularly nursing facilities, did not feel adequately involved in early stakeholder engagement efforts. Nursing facility stakeholders reported low awareness and understanding of long-term care services among some MMPs. To address this challenge, members of the California Collaborative provided education to MMPs on nursing facility services, billing and payment practices, and MMP responsibilities for covering long-term care services.

Financing and Payment

All covered Medicare and Medicaid services are paid on a capitated basis, and Cal MediConnect plans receive three monthly capitation payments from CMS and DHCS. CMS makes a monthly payment reflecting coverage of Medicare Parts A and B services and a separate amount reflecting Part D services. Both Medicare capitation payments were adjusted for risk using methodology common to Medicare Advantage plans. DHCS makes a monthly payment reflecting coverage of Medicaid services. Plans receive a single blended Medicaid rate reflecting the composition of LTSS needs among the plans' enrolled populations. During the period covered by this report, the State made payments for IHSS directly to providers, withholding that portion of the Medi-Cal capitation payment from the plans with the promise of later reconciling those payments with the plans.

From the planning stage through the implementation, plans have embraced the goals and model of integrated care in a capitated payment arrangement. However, the implementation period has presented health plans with multiple sources of frustration concerning financing and payment. Although some of these frustrations have been resolved, plans reported lingering uncertainty whether the rate structure was sustainable. Central to their concerns is low enrollment relative to expectations. Without increased volume, most Cal MediConnect plans reported they are unlikely to recover the fixed investment costs necessary to launch and manage the product. Plans also felt that the State and CMS were overly optimistic in the assumptions that plans could divert members with LTSS needs away from institutional nursing facility care and provide the necessary services in a community setting for substantially less money. Other major sources of uncertainty for plans include the delay in updating Medi-Cal rates over the course of the demonstration, the delay in accounting for IHSS costs, and the delay in establishing the Medicaid risk profiles of each plan's enrollee population.

Successes and Challenges

Financing and payment issues have been a major source of concern for the MMPs. Plans have continued to express their commitment to the goals and broad outlines of the demonstration, but they have been disappointed by low enrollment. This low enrollment has been viewed as a threat to financial viability, because revenue was considered insufficient to cover the up-front investments made to launch the new product. Although plans were disappointed that passive enrollment for newly eligible beneficiaries was not approved by the State in 2016, they were hopeful that streamlined enrollment would bolster enrollments.

State officials have noted that setting correct rates was one of the biggest challenges in designing the demonstration, and plans have continued to express significant uncertainty about whether the Medicaid rates are sufficient to cover their costs. From the beginning of the demonstration, plans have expressed frustration with the length of time it has taken for the State to complete the tasks necessary to establish how much plans will be paid for the care they have provided their members. Sources of this delay include turnover in State staff, and uncertainty at DHCS over the near-term status of the demonstration, which at the time was renewed from year to year after the State determined Medi-Cal cost savings from the demonstration.

There are also delays in the reconciliation of IHSS payments. Although Cal MediConnect was implemented in April 2014, as of the time this report was written, reconciliation of IHSS expenditures had only been completed through the third quarter of 2014 as of December 2016. This concern has been exacerbated by the fact that Cal MediConnect plans, by design, do not determine the amount of IHSS services for each beneficiary enrolled, even though the plans are at risk for the IHSS payments. The beneficiaries are assessed and the service amount is determined by the county IHSS agencies. Despite the challenges associated with IHSS, plans were reportedly disappointed with the State's January 2017 announcement that the demonstration will continue after December 2017 without IHSS. IHSS has been a major benefit that enrollees have depended upon for LTSS and the plans have considered it an essential feature of the demonstration.

Cal MediConnect plans had originally understood that Medicare and Medi-Cal administrative and financial processes would be more integrated in the demonstration than they have been in existing models, whose requirements are different (e.g., D-SNPs, which don't provide Medicaid benefits). Plan interviewees told the evaluation team they had "expected a consistent set of regulations like in Medicare Advantage plans." Several plan representatives were surprised by the need for separate processes for Medicare and for Medi-Cal claims and multiple claims adjudications. Appeals processes, encounters, and quality measures are all in parallel systems. They explained that it was necessary to reprogram processes they had thought would be integrated; thus, they characterized the demonstration as coordinated, rather than integrated administratively (i.e., from the plans' internal, administrative point of view).

Cal MediConnect plans report that Medicaid payment incentives to promote transitions from institutions to the community may not be adequate beyond the actual calendar year of transition, and that the assumptions about their success in promoting transitions are overly optimistic yet locked into the rate methodology. These incentives are based on the difference between the per member per month (PMPM) payments the plans receive for nursing facility

residents (the institutional PMPM) vs community residing members (the community PMPM) and on assumptions about a shift in case mix toward fewer enrollees residing in nursing facilities over time. For transitions that occurred during the first calendar year of the demonstration, plans continued to receive the higher institutional rate for a limited time after the enrollee had returned to the community. In later years of the demonstration, the share of the plan's enrollees garnering higher payment rates associated with institutionalization is assumed to decline during a plan year, whether or not plans are successful in making these transitions. Plans contend that not only are start-up costs high for returning an enrollee to the community, but that maintaining these frail beneficiaries in the community with supports in the subsequent years will continue to be costly when the plans will be paid a community-based rate for those beneficiaries. Therefore, the degree of savings to the plans for beneficiaries who have transitioned to the community may not materialize as expected.

Quality of Care

CMS and DHCS designed a robust set of core reporting measures and financial incentives to ensure quality of care for all enrollees. Plans are required to submit regular reports on several quality metrics, and their reimbursement is tied to both the timeliness of these reports and plans' performance relative to CMS and State-established benchmarks. While MMPs have complied with these new reporting requirements, they note that the requirements are burdensome and at times duplicative of other requirements.

In the three-way contract, CMS and the State outlined multiple safeguards to ensure quality of care and demonstration oversight. These protections include oversight of downstream entities in delegated counties by plans. Some plans have also replicated quality controls, such as withholds, for their downstream entities. However, not all downstream providers are providing the timely quality and encounter data necessary to generate plan level quality metrics.

Beyond the metrics reported by plans, DHCS also engaged independent evaluators to conduct extensive focus groups and surveys of the demonstration population. While the evaluators found a generally high degree of satisfaction among enrollees who receive care coordination services, their report highlighted several gaps in quality of care. Upon receiving results, DHCS responded by instituting multiple new initiatives designed to improve quality of care to enrollees.

Successes and Challenges

CMS and the State designed extensive quality monitoring processes to ensure enrollee quality of care; however, all plans stated that this data reporting effort was burdensome. New reporting metrics for the demonstration placed an additional burden on Cal MediConnect plans, according to MMP officials. They felt that it took time away from implementation and diverted resources away from enrollee care. The HRA reporting was particularly difficult—and often low—due to the additional unplanned effort needed to locate enrollees in order to conduct the HRA. The delegation model has presented challenges for quality oversight. Several demonstration counties in southern California use extensive delegated models. Some plans have reported rigorous oversight while others admit that small providers cannot provide quality reporting.

In January 2017, CMS announced the portion of the Medicare capitation rate that would be repaid to plans on the basis of their performance on Year 1 quality metrics. Every plan that was in operation during 2014 would receive at least 75 percent of the quality withhold and three plans would receive the full amount that had been withheld. Repayments have been made to plans for calendar years 2015 and 2016. The next evaluation report will discuss these repayments in greater detail.

The State has designed extensive qualitative evaluations with its evaluators. California engaged two organizations to provide feedback from enrollees and to compare those results to experiences of non-enrollees. DHCS then acted on those findings with initiatives to improve plan performance and quality of care.

DHCS has attempted to make demonstration data transparent to the public. The enrollment and opt-out dashboards have been produced monthly from the start of the demonstration. Data on other measures (HRA, hospitalizations, and LTSS utilization) have not been produced regularly thus far.

Medicare Savings Calculation

RTI conducted preliminary analyses of the impact of the Cal MediConnect program on Medicare Parts A and B savings for the first 33 months of the demonstration period (demonstration period 1 and demonstration period 2) using an intent-to-treat (ITT) analytic framework, which included beneficiaries eligible for demonstration rather than only those who enrolled. Cost analysis was conducted from the perspective of the Medicare program and, therefore, focused on the capitation and FFS expenditures by the Medicare program, and not the actual payments that plans made to providers for services. The results of the preliminary multivariate analyses presented here do not indicate Medicare savings or losses as a result of the first 33 months of the California demonstration in aggregate at the 0.05 level. These results should be considered preliminary without Medicaid, final risk corridor and quality withhold data. Future reports will include final results for this period of performance.

One potential reason that savings were not identified in these analyses is that there was not sufficient time for the program to demonstrate impact. For example, limited enrollment could limit the potential impact on costs. It is also important to note that given the ITT framework used to calculate savings, all eligible beneficiaries, regardless of their enrollment status, were included in the calculation. However, enrollment in California was modest. It is possible that there was some favorable selection in enrollment where lower risk beneficiaries may have been more likely to enroll. While the ITT framework helps mitigate selection bias in evaluating the impact of an intervention, it may be more challenging to detect savings in an ITT framework where enrollment penetration is low. Demonstration eligible beneficiaries enrolled in Medicare Advantage were removed from the evaluation cost analysis because at the time when the evaluation determined who would be included in quantitative analysis for the Cal MediConnect demonstration, it was not known what proportion of the demonstration eligible or enrolled population they would represent. Only one passive crosswalk wave included Medicare Advantage beneficiaries, representing a one-time uptick in Medicare Advantage enrollment in January 2015. Given that this very large group of beneficiaries did not receive opt-in notices and was not included in passive enrollment closer to the beginning of the demonstration, RTI

considered them as too different from the remaining beneficiaries to be included in the evaluation, and they were removed from both the demonstration and comparison groups. Managed care penetration in California is significant, and Medicare Advantage beneficiaries comprise a meaningful portion of demonstration enrollment in some counties, so it is important to consider the results in this context. That said, the majority of eligible beneficiaries were not enrolled in a Cal MediConnect plan and therefore were receiving usual FFS Medicare.

RTI will continue to examine these results and will rerun the analyses when complete information on quality withhold repayments and risk corridors becomes available. Once Medicaid data become available and a similar calculation can be conducted on the Medicaid savings, it will be possible to have a more complete understanding of potential savings for the first and second demonstration periods of the Cal MediConnect program. RTI will conduct additional Medicare and Medicaid savings analyses for each year of the demonstration as data are available.

Conclusion

The State of California, with CMS, has created an ambitious and complex demonstration under the Financial Alignment Initiative. Health plans, county agencies, stakeholders, and advocates support the fundamental principle that coordinated, integrated care will improve enrollees' lives and ultimately reduce health care costs. About a third of enrollees have received care coordination under Cal MediConnect, during the first two demonstration periods. Those receiving this benefit have responded with positive feedback in a number of surveys and focus groups to say their access to care and quality of life have improved. LTSS, behavioral health, and primary care, each with its own language, systems, and priorities, have long existed in separate silos. Bringing them together under one structure, in a relatively short period of time, has been a huge undertaking and challenging for all concerned. Plans' three-way contracts provide flexibility, rather than a consistent statewide system. Consequently, each plan has forged its own approach to develop new systems and processes across multiple State, CMS, and county systems.

In the nearly 3 years since the California demonstration began, plans and county agencies have been developing ways to work together and share information, and develop processes to provide integrated care to enrollees. Promising practices have been emerging, such as co-location of staff, targeted dementia training, and strategic use of data systems to support integration. Some plans have made headway in transitioning beneficiaries from long term care facilities back to the community, which is a fundamental goal of the demonstration.

The varied county and MMP approaches and previous county and health plan experience within the California demonstration have led to varied successes and challenges. The evaluation of the demonstration is designed to be model-wide. However, the design of the California demonstration—with its varied types of counties, delivery systems, and plans—does not lend itself easily to one overall assessment. Counties chosen for the demonstration are diverse in size, population, and delivery models. Two counties have one plan each, one in which provider delegation is a factor. Two counties with highly delegated models have only two plans; another has four. Additional plans were added to Los Angeles County to accommodate its large, highly diverse population and highly delegated model. Communicating policies and educating delegated and out-of-network providers has been a struggle for the State, CMS, plans, and stakeholders. In

counties with multiple plans, county LTSS and behavioral health agencies found that they must adapt their systems in order to work with each of the plans; this has not always worked easily. Because of their county and historical linkages, county-operated plans generally have made more progress towards integration with other county-based LTSS and behavioral health agencies than had commercial plans. Commercial plans that previously had extensive D-SNP experience also made progress at integrating LTSS because of their understanding of this population and these services. However, early stakeholder concerns of plan readiness have endured. Other plans, inexperienced with this population and with the provision of LTSS, have struggled to understand the needs of the dual eligible population and negotiate the complexities of LTSS and behavioral health systems.

The State and most MMPs have seen lower than expected enrollment as a problem and they have been working to increase enrollment through streamlining processes, improving continuity of care provisions, new deeming periods, and other program improvements. The demonstration's complex enrollment schedule generated multiple challenges and negative attention, including legal actions. Although many missteps were corrected in the first year of the demonstration, the negative effects lingered. Even in 2016, when explaining the low enrollment rate and the reluctance of providers to participate in the demonstration, interviewees pointed to systems inadequacies, general reluctance of providers to participate in managed care, and to concerns over the transfer of seniors and persons with disabilities to managed care that took place prior to the demonstration.

Plans reported they were attracted to the demonstration by the potential of 456,000 beneficiaries estimated to be eligible for Cal MediConnect. While some opt-outs and disenrollments were expected, as of December 2016, enrollments numbered 113,600. Plans made considerable investments in staff and infrastructure with the expectation that high enrollments would allow them to recoup their upfront investments. State staff contend they were transparent with their enrollment assumptions; however, continuously declining enrollments in many counties have made some plans doubt their financial viability. Moreover, since the demonstration began, the State has not provided final Medicaid rates beyond calendar year 2014. Without those finalized rates, the State has been unable to provide Medicaid reconciliations for 2014 and beyond for the quality withhold and risk corridor. Whether commercial or non-profit, plans need to understand their financial position and determine the sustainability of their products to prepare for the future.

Together, the provision of flexible benefits and the rate structure that rewards plans for achieving lower institutional rates, are designed to promote care in the community, rather than in institutional settings. Some plans have been using the flexible Care Plan Options funds strategically to support enrollees at home and divert institutionalizations and to transition enrollees from long term care facilities to the community. Other plans appeared to use these benefits ad hoc, or not at all. Without data showing institutionalization rates, it has not been possible to evaluate the overall effectiveness of these nursing facility diversions or transitions. RTI will analyze institutionalization rates and other measures in future reports as data become available.

The demonstration continues to evolve in 2017 and beyond. The State has stepped up activities designed to improve Cal MediConnect and bolster enrollments. These actions have

included fine-tuning enrollee supports, facilitating plans to share best practices to improve quality of care, strategic contact with providers linked to high opt-out rates, and reengineering enrollment methods. The State has also undertaken efforts to strengthen health assessment linkages to LTSS referrals by standardizing LTSS HRA questions and monitoring the use of flexible benefits. A little more than one-third of enrollees have received care coordination, which is vital to the integration of services; State and MMP efforts to extend the reach of this benefit to all enrollees who need it have not yet begun at the time of this report.

California legislation authorizing the demonstration as part of the CCI called for an annual review by the California Department of Finance to determine the CCI's viability for the following year. The uncertainty of whether Cal MediConnect would continue from year to year caused those involved in the demonstration to be cautious in moving forward. The State's announcement on January 10, 2017, to continue Cal MediConnect even while terminating the CCI, provided an opportunity for the State, plans, and providers to strengthen their engagement in the demonstration.

Next Steps

The RTI evaluation team will continue to collect information on a quarterly basis from California officials through the online State Data Reporting System, covering enrollment statistics and updates on key aspects of implementation. The RTI evaluation team will continue conducting quarterly calls with the California State and CMS staff and will request the results of any evaluation activities conducted by the State or other entities, such as results from the Consumer Assessment of Healthcare Providers and Systems and State-specific demonstration measures the plans are required to report to CMS. RTI will conduct additional site visits and focus groups during the course of the demonstration.

As noted previously, CMS and DHCS have extended the California demonstration through 2019, which will provide further opportunities to evaluate the demonstration's performance. As data become available, future reports will include descriptive and regression-based analyses of quality and utilization measures for those eligible for the demonstration and for an out-of-State comparison group and implementation updates.

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1. Overview

1.1 Evaluation Overview

1.1.1 Purpose

The Medicare-Medicaid Coordination Office (MMCO) and the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) have created the Medicare-Medicaid Financial Alignment Initiative to test, in partnerships with States, integrated care models for Medicare-Medicaid enrollees. The goal of these demonstrations is to develop person-centered care delivery models integrating the full range of medical, behavioral health, and long-term services and supports (LTSS) for Medicare-Medicaid enrollees, with the expectation that integrated delivery models would address the current challenges associated with the lack of coordination of Medicare and Medicaid benefits, financing, and incentives.

This report on the California capitated model demonstration under the Medicare-Medicaid Financial Alignment Initiative, called Cal MediConnect, is one of several reports that will be prepared over the next several years to evaluate the demonstration. CMS contracted with RTI International to monitor the implementation of the demonstrations under the Financial Alignment Initiative and to evaluate their impact on beneficiary experience, quality, utilization, and cost. The evaluation includes an aggregate final evaluation (Walsh, Anderson, and Greene, 2014) and State-specific evaluations.

The goals of the evaluation are to monitor demonstration implementation, evaluate the impact of the demonstration on the beneficiary experience, monitor unintended consequences, and monitor and evaluate the demonstration's impact on a range of outcomes for the eligible population as a whole and for special populations (e.g., people with mental illness and/or substance use disorders, LTSS recipients). To achieve these goals, RTI collects qualitative and quantitative data from California each quarter; analyzes Medicare and Medicaid enrollment, claims, and encounter data; conducts site visits, beneficiary focus groups, and key informant interviews; and incorporates relevant findings from any beneficiary surveys conducted by other entities. In addition to this report, monitoring and evaluation activities will also be reported in subsequent evaluation reports, and a final aggregate evaluation report for the Financial Alignment Initiative.

This report does not contain the results of impact analyses using utilization data. Such analyses require not only fee-for-service (FFS) utilization data for nonenrollees and comparison group beneficiaries, but also enrollee encounter data from MMPs during the demonstration period. MMPs were unable to submit all encounters in time for RTI International to conduct the utilization analyses for this report. Future evaluation reports will contain impact analyses on utilization if all MMP encounter data are submitted on time. Such analyses would include results for prior demonstration years if encounter data for those years were complete.

1.1.2 What It Covers

This report analyzes implementation of the Cal MediConnect demonstration from its initiation on April 1, 2014 through December 2016. It describes the key design features of the California Cal MediConnect demonstration; examines the extent to which the demonstration was implemented as planned; identifies any modifications to the design; and discusses the challenges, successes, and unintended consequences encountered during the period covered by this report. It also includes data on the beneficiaries eligible and enrolled, geographic areas covered, and status of the participating Medicare-Medicaid Plans (hereafter referred to as Cal MediConnect plans or MMPs). Finally, the report includes data on care coordination, the beneficiary experience, stakeholder engagement activities, and, to the extent that data are available, analyses of quality and cost data. This report does not contain quantitative results on utilization measures (e.g. inpatient, emergency department, physician visit, personal care, nursing facility, behavioral health) derived from encounter data. Although Medicare-Medicaid Plans in the State have begun submitting Medicare encounter data when this report was produced, a complete set was not available to conduct analysis. RTI and CMS will assess Medicare and Medicaid encounters for completeness and accuracy before analyzing them for future reports.

Data Sources and Methods

A wide variety of information informed this first Evaluation Report of the Cal MediConnect demonstration. Data sources used to prepare this report include the following:

Key informant interviews. The RTI evaluation team conducted site visits in California in September 2014, October 2015, and September 2016. The team interviewed the following types of individuals either during the site visits or during subsequent telephone interviews: State and county policy makers and agency staff, CMS and State contract management team (CMT) members, Ombudsman Program officials, MMP officials, MMP care coordinators, hospital and nursing facility providers, advocates and other stakeholders.

Focus groups. The RTI evaluation team conducted eight focus groups in California: two focus groups in Los Angeles on February 29, 2016; two focus groups in San Bernardino on March 1, 2016; one focus group in San Diego on March 2, 2016; one focus group in Carlsbad on March 2, 2016; and two focus groups in Los Angeles on March 3, 2016. A total of 18 enrollees and nine proxies participated in the RTI focus groups. Participants were assigned to groups based on their LTSS and behavioral health services use, race, ethnicity, and primary language. Focus groups were not conducted with beneficiaries who opted out of the demonstration or who disenrolled.

California contracted researchers at Health Research for Action at the University of California at Berkeley and the Community Living Policy Center at the University of California at San Francisco (hereafter referred to as UC Berkeley) to conduct 14 focus groups and interviews with enrollees who receive behavioral health services. A total of 120 beneficiaries or proxies participated in the focus groups and interviews from May 2015 through November 2015 in six of the seven demonstration counties. Two focus groups (16 participants) were conducted in English with beneficiaries who had disenrolled or opted out of the demonstration. Three of the focus groups were conducted in Spanish, one was in Cantonese, one was in Mandarin, and the

remainder were in English. Participants were assigned to groups based on their service use, age, and primary language.

Surveys. Medicare requires all Medicare Advantage plans, including Medicare-Medicaid Plans, to conduct an annual assessment of the experiences of beneficiaries using the Medicare Advantage Prescription Drug Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instrument. The 2015 survey for Cal MediConnect was conducted in the first half of 2015 with members of eight plans and measured enrollees' experiences with the plan over the previous 6 months. Plans operating in Santa Clara and Orange counties are not included in 2015 data because they began operations in January 2015 and July 2015, respectively. Plans in all counties except Orange County are included in the 2016 survey which was conducted in the first half of 2016.

The survey included the core Medicare CAHPS questions and 10 supplemental questions added by the RTI evaluation team. Survey results for a subset of 2015 and 2016 core Medicare Advantage CAHPS survey questions are incorporated in this report. Findings are available at the Cal MediConnect plan level and not at the county level. For example, findings for Molina Health Plan include survey results from the four counties in which that plan operates; survey results from Anthem are those for Anthem's Care More members in Los Angeles County in 2015 and for both Anthem in Santa Clara County and Care More in 2016. The frequency count for some survey questions may be suppressed because too few enrollees responded to the question. Comparisons with findings from all Medicare Advantage plans are available for core CAHPS survey questions but not for the RTI supplemental questions. Survey response rates varied by plan as follows: Anthem Blue Cross, 2015—6 percent, 2016—10 percent; Care1st, 2015—22 percent, 2016—18 percent; Community Health Group, 2015—22 percent, 2016—27 percent; Health Net, 2015—16 percent, 2016—21 percent; Health Plan of San Mateo, 2015—36 percent, 2016—33 percent; Inland Empire Health Plan, 2015—28 percent, 2016—29 percent; LA Care, 2015—19 percent, 2016—23 percent; Molina Healthcare, 2015—16 percent, 2016—24 percent; Santa Clara, 2016—16 percent.

Results from two telephone surveys conducted by State evaluators are also included in this report. Field Research Corporation conducted four waves of rapid cycle polling from June through September 2015, October through November 2015, February through April 2016, and July through September 2016. Approximately 2,500 to 3,200 beneficiaries were interviewed in each wave, which included both individuals who had opted out of the demonstration and enrollees. Results compare enrollees to those who opted out of the demonstration and to dual eligible beneficiaries in counties where the demonstration is not operational.

Another survey was conducted by State evaluators at Health Research for Action at the University of California at Berkeley and the Community Living Policy Center at the University of California at San Francisco (hereafter referred to as UC Berkeley) from January through March 2016. This survey included 774 demonstration enrollees, 659 beneficiaries who had opted out of the demonstration, and 736 dually eligible beneficiaries in non-demonstration counties. This survey will be repeated in early 2017. This survey also compares the experiences of demonstration enrollees to beneficiaries who had disenrolled or opted out of the demonstration, and to dual eligible beneficiaries in counties where the demonstration is not taking place.

Medicare cost savings data. RTI performed a Medicare savings calculation for the first 33 months of the demonstration (through December 2016) using an intent-to-treat (ITT) analytic framework that included beneficiaries eligible for the demonstration rather than only those who enrolled. The data sources included Medicare claims data and the capitation rates for beneficiaries enrolled in Cal MediConnect plans. Capitation payments paid to Cal MediConnect plans during the demonstration period were obtained for all demonstration enrollees from CMS Medicare Advantage and Part D Inquiry System (MARX) data. The capitation payments were the final reconciled payments paid by the Medicare program after taking into account risk score reconciliation and any associated retroactive adjustments. Fee-for-service (FFS) Medicare claims were used to calculate expenditures for all comparison group beneficiaries, demonstration beneficiaries in the baseline period, and demonstration eligible beneficiaries who were not enrolled during the demonstration period. FFS claims included all Medicare Parts A and B services.

Demonstration data. The RTI evaluation team reviewed data provided quarterly by California through the State Data Reporting System (SDRS). These data included eligibility, enrollment, and information reported by California on its stakeholder engagement process, accomplishments on the integration of services and systems, any changes made in policies and procedures, and a summary of successes and challenges. This report also used data for quality measures reported by Cal MediConnect plans and submitted to CMS' implementation contractor, NORC at the University of Chicago (hereafter referred to as NORC).^{1,2} Data reported to NORC includes core quality measures that all Medicare-Medicaid Plans are required to report, as well as State-specific measures that Cal MediConnect plans are required to report. Due to some reporting inconsistencies across plans in 2014 and 2015, plans occasionally resubmit data for prior demonstration years; therefore, these data are considered preliminary.

Demonstration policies, contracts, and other materials. This report used several data sources, including the Memorandum of Understanding (MOU) between the State and Centers for Medicare & Medicaid Services (CMS) (Centers for Medicare & Medicaid Services and State of California, 2013; hereafter, MOU, 2013); the three-way contract (Centers for Medicare & Medicaid Services and State of California, 2014; hereafter, California three-way contract, 2014); and State-specific documents, e.g., the California Bridge to Reform Waiver (Centers for Medicare & Medicaid Services, 2014a), Dual Plan Letters and other materials available on the California Department of Health Care Services website; documents available on CalDuals, the demonstration website (<http://www.calduals.org>); data reported through the State Data Reporting System [RTI, SDRS]), and documents on the CMS Medicare-Medicaid Coordination website (Centers for Medicare & Medicaid Services, 2016a).

Conversations with CMS and California Department of Health Care Services officials. To monitor demonstration progress, the RTI evaluation team has engaged in periodic phone conversations with the California Department of Health Care Services (DHCS) and CMS.

¹ Data are reported for calendar quarter 2 of 2014 through quarter 3 of 2016 (April 2014 to September 2016).

² The technical specifications for reporting requirements are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html>.

These might include new policy clarifications designed to improve plan performance, quality improvement work group activities, and contract management team actions.

Complaints and appeals data. Complaint (also referred to as grievance) data are from three separate sources: (1) complaints from beneficiaries reported by Cal MediConnect plans to the California Department of Managed Health Care (DMHC), and separately to CMS' implementation contractor, NORC; (2) complaints received by the DMHC or 1-800-Medicare and entered into the CMS electronic Complaint Tracking Module (CTM);³ and (3) complaints received by the Cal MediConnect Ombudsman Program and reported to the DMHC and the Administration for Community Living (ACL),⁴ the Federal agency that provides technical assistance to Ombudsman programs under the dual demonstrations. Appeals data are based on data reported by MMPs to the DMHC and NORC, for Core Measure 4.2, and the Medicare Independent Review Entity (IRE). Data on critical incidents and abuse reported to the DMHC and CMS' implementation contractor by Cal MediConnect plans are also included in this report.

Although a discussion of the 10 California Medicare-Medicaid Plans is included, this report presents information primarily at the Cal MediConnect demonstration level. It is not intended to assess individual plan performance, but individual plan information is provided where plan-level data are the only data available, or where plan-level data provide additional context.

1.2 Demonstration Changes Announced in California's 2017–2018 Budget

1.2.1 Background

Cal MediConnect initially began as a 3-year demonstration and was authorized from April 1, 2014 through December 31, 2017. In July 2015, CMS notified the State of the opportunity to extend the demonstration by 2 years; however, the State was unable to commit to extending the demonstration at that time. Cal MediConnect was authorized under the State's Coordinated Care Initiative (CCI) within the Bridge to Reform 1115(a) Medicaid Demonstration. In addition to Cal MediConnect, the CCI included a plan to transition Medicare-Medicaid enrollees into Medi-Cal managed care, include Medicare wraparound benefits, and integrate managed long-term services and supports (MLTSS) into Medi-Cal. Both parts of the CCI—the demonstration and MLTSS—are operating in the same counties, on generally the same enrollment schedule, and with generally the same plans. All plans participating in the demonstration are also providing services to Medi-Cal managed care enrollees through different products.

In authorizing the CCI, California law SB 94 included a provision that all components of the CCI would become inoperative if the CCI did not provide net savings to the State's general fund. This savings was calculated annually by the California Department of Finance; the State disclosed at the beginning of each calendar year whether the demonstration would continue the following year.

³ Data are presented for the time period April 2014 through November 2016.

⁴ Data are presented for the time period April 2014 through August 2016.

1.2.2 Announcement

The Governor's 2017–2018 budget disclosed on January 10, 2017, stated that the Department of Finance had determined the following: (1) the CCI was not fiscally viable; (2) Cal MediConnect would continue through calendar year 2019; and (3) MLTSS would continue with mandatory enrollment of dually eligible beneficiaries into managed care; these beneficiaries will have integrated LTSS, with the exception of In-Home Supportive Services (IHSS). The budget announcement stated in part, "Although CCI was not cost-effective during the initial demonstration period, the duals demonstration program provided the potential to reduce the cost of health care for the affected individuals and improve health outcomes" (State of California, 2017).

The ramifications of this announcement on the demonstration will be discussed in a future report. This report covers the start of the demonstration through December 2016. However, we note these changes would have the following effects on the demonstration: (1) IHSS benefits would be removed from MMP capitation rates effective January 2018; (2) subsequently, IHSS services would be provided to demonstration enrollees on a fee-for-service basis; (3) IHSS workers would continue to participate in care plan teams of demonstration enrollees; (4) one of the LTSS entities included in the demonstration, the Multipurpose Services and Supports Program (MSSP), would continue as a waiver program and not transition to a managed care benefit in 2017 as planned. This transition would occur no sooner than 2020. The three-way contracts between CMS, the State, and each Cal MediConnect plan would end at the end of calendar year 2017 and new contracts would be in place before the beginning of calendar year 2018.

A major finding of our evaluation thus far has been the negative effect the annual budget review has had on Cal MediConnect. Each fall there was intense apprehension about the uncertainty of the demonstration's renewal, affecting providers who may have been reluctant to learn a new system that may not continue beyond the next year, beneficiaries who may have chosen to opt out or disenroll rather than learn a new system of care that may not continue, and State staff who may have sought stable positions within State government. MMPs, which have made considerable investments to provide services to enrollees, were concerned about the continuation from year to year. In future reports the RTI evaluation team will explore the implications of the termination of this legislation, known in California as "the poison pill" amendment.

An important feature of Cal MediConnect, IHSS also presented numerous challenges in the demonstration. Plans were required to pay for these services, but had no oversight for assessment or authorization of services, which were retained by the counties, thereby creating an inherent tension between plans and the counties. Budget and payment reconciliations for these services took place on an extremely delayed schedule, which compromised plans' ability to assess their financial standings. However, as a major service to beneficiaries, plans and stakeholders were committed to integrating IHSS into Cal MediConnect. Future reports will assess the effect of these changes on the demonstration and will include perspectives of enrollees and stakeholders. Findings in this report cover the period from April 2014 through December 2016.

1.3 Model Description and Demonstration Goals

Cal MediConnect is part of the State's Coordinated Care Initiative (CCI) under the Bridge to Reform 1115(a) Medicaid Demonstration (CMS, 2014) that will also transition Medicare-Medicaid enrollees into Medi-Cal managed care, include Medicare wraparound benefits, and integrate managed long-term services and supports (MLTSS) into Medi-Cal. As noted in **Section 1.2**, Cal MediConnect will continue through 2019. Before the demonstration, most Medicare-Medicaid enrollees received Medicare services from fee-for-services (FFS) providers or through Dual Eligible Special Needs Plans (D-SNPs); Medi-Cal services were provided either by FFS or through managed care organizations, depending on the county of residence, and LTSS were authorized and provided through separate entities in each county. All of these services, along with nursing facility, subacute, specialty mental health, and substance use services are now coordinated through Cal MediConnect plans. Vision, nonemergency transportation, and Care Plan Option services (flexible benefits offered by each plan) are new services provided under the demonstration and coordinated within Cal MediConnect. The coordination of medical services and LTSS is a core feature of Cal MediConnect.

The goals of the California demonstration are to improve the beneficiary experience in accessing care; promote person-centered planning and independence in the community; assist beneficiaries in getting the right care at the right time and place; and achieve cost savings for California and the Federal government through improvements in care and coordination. Improving the quality of care, reducing health disparities, and meeting beneficiary needs are central goals of this initiative (MOU, 2013, p. 2).

Integration of Medicare and Medicaid functions. The Cal MediConnect demonstration integrates most Medicare and Medicaid services and adds care coordination to provide coordinated delivery of all medical, acute, behavioral health, and pharmacy services, and LTSS. Each enrollee is covered for all of his or her Medicaid services (including LTSS and behavioral health services), Medicare medical and acute services (including physician and hospital services), and all pharmacy benefits. Cal MediConnect plans are responsible for ensuring that enrollees have seamless coordination and access to all necessary services, including specialty mental health and substance use services financed and provided by county-based providers.

Financial model. The Cal MediConnect demonstration is a capitated model of service delivery in which CMS, the State of California, and Cal MediConnect plans enter into three-way contracts to provide comprehensive, coordinated care for beneficiaries who are dually eligible for Medicaid and Medicare services. Each plan receives monthly capitated payments from Medicaid and Medicare to manage the care and services of enrollees.

Implementation. Cal MediConnect began implementation in San Mateo County on April 1, 2014, followed by a phased enrollment process by county and by population group that continued through July 2016. Please see **Table 2** and **Section 3.2.3, Passive Enrollment Process**, for details of the enrollment schedule. Cal MediConnect began as a 3-year demonstration; however, in July 2015, CMS notified DHCS of the opportunity to extend the demonstration by 2 years. DHCS expressed interest; however, the State was unable to extend the demonstration at that time (California Department of Health Care Services, n.d.).

Eligible population. Individuals eligible for Cal MediConnect include full-benefit Medicare-Medicaid beneficiaries age 21 or older who are enrolled in Medicare Parts A and B, are eligible for Medicare Part D, and have no other comprehensive private or public health insurance. Beneficiaries enrolled in any of the following programs also are eligible for the demonstration if they disenroll from the program and meet the other eligibility criteria: a Medicare Advantage plan; Program of All-Inclusive Care for the Elderly (PACE); or the CMS Independence at Home demonstration. The following groups are not eligible to enroll in the demonstration: individuals with other private or public health insurance; beneficiaries receiving services through California’s regional centers or State developmental centers or intermediate care facilities for the developmentally disabled; beneficiaries with a share of cost who do not meet share-of-cost requirements; those residing in one of the Veterans’ Homes of California or in certain rural ZIP codes in San Bernardino, Los Angeles, and Riverside counties; or individuals with a diagnosis of end stage renal disease at the time of enrollment (MOU, 2013, p. 8). The MOU stated that residency was required in Alameda, Los Angeles, Riverside, San Bernardino, San Diego, or Santa Clara counties; however, on November 13, 2014, the Department of Health Care Services announced that Alameda County would no longer be included in the demonstration. One of the two prospective Cal MediConnect plans in that county had not passed a joint CMS/State readiness review to begin enrolling beneficiaries and the State made the decision to continue the demonstration in seven counties.

Individuals who are eligible to opt into the demonstration, but are not eligible for passive enrollment, include those who reside in certain rural ZIP codes in San Bernardino County in which only one Cal MediConnect Plan operates; and beneficiaries who are enrolled in a prepaid health plan that is a nonprofit health care services plan with at least 3.5 million enrollees statewide, that owns and operates its own pharmacies. Individuals participating in the following programs are not eligible to enroll in the demonstration (but may do so after disenrolling from their current program): Program of All-Inclusive Care for the Elderly (PACE), the AIDS Healthcare Foundation, or any of the following 1915(c) waivers: Nursing Facility/Acute Hospital Waiver, HIV/AIDS Waiver, Assisted Living Waiver, and In Home Operations Waiver (MOU, 2013, p. 9). Beneficiaries enrolled in these 1915(c) waivers are transitioning to Medi-Cal managed care under the CCI (California Department of Health Care Services, 2013c).

Cal MediConnect plans. To participate in the demonstration, plans had to meet the State’s requirements set forth in California’s Request for Solutions, and CMS requirements outlined in the Medicare Advantage plan application process and in multiple sets of capitated Financial Alignment Demonstration guidance; and had to pass a joint CMS/State readiness review (Centers for Medicare & Medicaid Services, 2012). Eleven plans were initially selected to participate in the demonstration; however, with the decision that Alameda County would no longer be included in the demonstration, the demonstration continued with 10 plans covering seven counties. *Table 1* in *Section 2.2.2* lists the plans in each county.

Geographic coverage. The demonstration operates in 7 of California’s 58 counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties.

Care coordination. A central feature of the California demonstration is the addition of care coordination services for medical, behavioral health, and LTSS. Cal MediConnect plans offer care coordination to all enrollees through a care coordinator by or under contract with the

plan. Cal MediConnect plans are responsible, through an interdisciplinary care team, for developing an individualized care plan (ICP) for each enrollee that reflects the enrollee's preferences and needs as well as how services and care will be integrated and coordinated among providers. **Section 4** provides detailed information on care coordination under Cal MediConnect, including the roles and responsibilities of care coordinators.

Benefits. Under Cal MediConnect, eligible beneficiaries enroll in a single Cal MediConnect plan that covers most Medicare and Medicaid services. New benefits available under the demonstration include care coordination and flexible benefits, known as Care Plan Options (CPOs), provided at the discretion of the health plan.

In January 2014, prior to the demonstration, the State expanded mental health benefits to all Medi-Cal beneficiaries in managed care plans (California Department of Health Care Services, 2013b). These benefits are available to Cal MediConnect enrollees and include assessments of potential mental health disorders and outpatient mental health services to enrollees with mild to moderate impairment of mental, emotional, or behavioral functioning. In May 2014, Denti-Cal benefits that had previously been withdrawn because of State budget reductions were reinstated to all Medi-Cal beneficiaries, including Cal MediConnect beneficiaries; therefore, dental benefits are available to demonstration enrollees through Denti-Cal providers (California Department of Health Care Services, 2013a).

In addition to care coordination services, two new benefits—nonemergency medical transportation and vision services—are included in Cal MediConnect. The transportation benefit provides 30 one-way trips per beneficiary per year, typically for provider appointments. The new vision benefit, similar to that provided in D-SNP products, includes an annual eye examination and \$100 toward a pair of glasses or contact lenses every 2 years.

Care Plan Option. The Care Plan Option benefit (CPO) is an important and flexible tool that Cal MediConnect plans can use to provide discretionary services to postpone institutionalization or prevent higher levels of care for frail beneficiaries. CPOs are discretionary services such as home modifications, including ramps or grab bars, Meals on Wheels, authorization of additional home care worker hours, or similar services to ensure enrollees can remain in the community and that plans may elect to provide from their capitated payments. Plans may authorize services not otherwise available through local agencies or other means.

During 2014, none of the plans reported providing this benefit; however, in the 2015 and 2016 site visit interviews, most plans provided the RTI evaluation team with many examples of these benefits. See **Section 4, Care Coordination**, for more information on these benefits.

Continuity of care. The demonstration initially allowed for 6 months of Medicare and 12 months of Medi-Cal continuity of care services from the enrollee's previous provider. This provision was valid if the enrollee had one visit with the primary care provider (PCP) or two visits with a specialist in the previous 12 months. In August 2016, this was amended to 12 months for Medicare providers (California Department of Health Care Services, 2016l). Preexisting relationships with specialists were also valid if the enrollee had one appointment within the past 12-month period.

New service delivery models. New benefits provided under Cal MediConnect and the capitation rate structure provide the opportunity and incentives for plans to create new service delivery options to meet the needs of beneficiaries.

Stakeholder engagement. California has an active participatory stakeholder community involved in both the demonstration and the broader CCI move toward managed care. The State contracted Harbage Consulting early in the development of the demonstration to be the primary liaison to stakeholder groups and to provide outreach forums, including monthly stakeholder calls, the CalDuals website, and presentations to stakeholder and beneficiary groups. The California Collaborative for LTSS, with more than 30 members and affiliates, has been supporting advocacy organizations and beneficiaries long before the demonstration. This group is the sounding board and advisory group for Cal MediConnect and works directly with Harbage and DHCS on Cal MediConnect (see *Section 6, Stakeholder Engagement*, for more information).

1.4 Changes in Demonstration Design

The design of the care model of Cal MediConnect has not changed substantively since implementation began; however, as noted in *Section 1.2*, the model would change January 2018 when IHSS would no longer be included in the capitation rate. The timing of the rollout of the demonstration in 2014 was modified multiple times as discussed in *Section 3*.

From time to time, DHCS issued policy clarifications and additional detail related to the three-way contract. After the demonstration began, DHCS provided clarification of contract requirements for certain functions such as the health risk assessment, interdisciplinary care teams, incorrect billing, and various reporting requirements through dual plan letters (DPLs). More recently, in summer 2016, DPLs have specified the roles and responsibilities of MMPs in discharge planning.

1.5 Administrative Supports for the Demonstration

DHCS is responsible for the State's Medicaid program and has primary responsibility for administering the CCI, which includes the demonstration. DHCS is supported in this task through interagency agreements with other departments that share responsibility for certain functions. The Department of Social Services administers the IHSS program for the entire State; its interagency agreement covers the administration for IHSS activities within Cal MediConnect and data sharing with DHCS. Likewise, the Department of Aging manages the two waiver programs included in the demonstration—Community-Based Adult Services (CBAS) and the Multipurpose Senior Service Program (MSSP)—and works with the Long-Term Care Division within DHCS to monitor and administer these services.

The Department of Managed Health Care (DMHC) has responsibility for ensuring the adequacy of provider networks and financial viability of plans, provides overall consumer assistance, including complaints tracking, and oversees the Cal MediConnect Ombudsman Program. DMHC's oversight of plans is designed to ensure that all Cal MediConnect plans are in compliance; this department provides DHCS with quarterly reports based on its auditors' findings.

1.5.1 State Management of the Demonstration

Within DHCS, demonstration activities such as enrollment, quality monitoring, and oversight of long-term care services are mostly divided among functional areas in the Long-Term Care Division, the Managed Care Quality and Monitoring Division (formerly the Division of Medi-Cal Managed Care), the Managed Care Project Management and Operations Division, and Mental Health and Substance Use Disorder Services. The latter division had moved into DHCS in July 2013. All the divisions involved in the demonstration report to the current DHCS chief deputy director with the Deputy Director of Health Care Delivery Systems overseeing the CCI including the demonstration. The deputy director is the official spokesperson for the demonstration, leads stakeholder calls, and signs relevant policy letters, but the management of the operational functions is dispersed among the functional areas, with each manager responsible for his or her area. In the beginning of the demonstration, there was considerable turnover of key staff with the first Deputy Director leaving the position when the demonstration began. This key position turned over several times, stabilizing in late 2015. Staff and departments managing the demonstration were also heavily involved in other projects, most notably Medicaid expansion; these demands on staff time compromised their attention to the demonstration.

DHCS contracted or hired consultants to oversee major demonstration tasks, including stakeholder outreach (Harbage Consulting) and various midlevel management roles, including quality monitoring and enrollment management (Public Consulting Group). State officials explained that hiring consultants could be done more quickly than obtaining approval for new positions, posting the positions, and hiring permanent staff.

Initially, DHCS convened weekly management meetings with all State departments involved in the demonstration to share current information. It also held weekly operational meetings with all the health plans to discuss policy issues, and separate weekly meetings with the five health plans operating in Los Angeles County. Since 2016, as the demonstration has matured, these meetings have been held on an ad hoc basis. If an issue arises from discussions with all the plans, DHCS may elevate it to the contract management team (CMT) that oversees the demonstration or to the legal department, or the issue may be reviewed to determine whether plans would benefit from technical assistance on the topic. State staff use these meetings to present draft versions of guidance documents such as DPLs, and plans have an opportunity to provide feedback.

State officials reported that this system has functioned well; additionally, because of the State staff's initial lack of Medicare expertise, these meetings served to educate State staff on Medicare processes and procedures. Because the plans had Medicare expertise from their experiences with other products, issues they raised with State staff served to inform State staff about the nuances of Medicare processes. In site visits, plan representatives noted the need to explain details regarding Medicare policies and processes to State staff, and they noticed improvement as State staff gained experience over the years. The California Association of Health Plans is another resource for both the plans and the State for guidance on policies and procedures.

1.6 Overview of State Context

This section discusses historical and current context of other State activities and initiatives, including relevant policy changes, Medicaid expansion, and California's delegated model. For a summary of predemonstration and demonstration design features for Medicare and Medicaid beneficiaries in California, see *Appendix A*.

Bridge to Reform. Cal MediConnect began as part of California's larger Coordinated Care Initiative (CCI) under the Bridge to Reform 1115(a) Medicaid Demonstration (Centers for Medicare & Medicaid Services, 2014a) that also transitions Medicare-Medicaid enrollees into Medi-Cal managed care, includes Medicare wraparound benefits, and integrates managed long-term services and supports (MLTSS) into Medi-Cal in the demonstration counties. The CCI was enacted in July 2012 through [SB 1008](#) (Chapter 33, Statutes of 2012) and [SB 1036](#) (Chapter 45, Statutes of 2012). Further updates and clarifications to this initiative were enacted in June 2013 through [SB 94](#) (Chapter 37, Statutes of 2013). Under the MLTSS requirement of the CCI, nearly all Medi-Cal beneficiaries age 21 or older, including Medicare-Medicaid enrollees, are transitioned into a Medi-Cal managed care health plan to receive their Medi-Cal benefits (California Department of Health Care Services, 2014b; Centers for Medicare & Medicaid Services, 2014b).

According to DHCS's APL summarizing the bill (California Department of Health Care Services, 2013c), "It establishes a provision known as the 'Poison Pill' where all components of the CCI would become inoperative, if the CCI does not provide net savings to the state General Fund." This savings would be calculated by the California Department of Finance at the end of each calendar year to determine whether the demonstration would continue the following year. The State acted upon this legal provision on January 10, 2017 by announcing that it had determined that the CCI was not cost effective, but that Cal MediConnect would continue through 2019 (please see *Section 1.2*).

Managed care expansion for seniors and persons with disabilities. Though managed care in general has been a prevalent part of the health care delivery landscape in the State, California has previously implemented initiatives that shaped public and stakeholder perspectives and in many ways defined the reaction to Cal MediConnect. For example, in June 2011, as part of the Bridge to Reform 1115(a) Medicaid Demonstration, California expanded mandatory managed care enrollment for medical services to Medi-Cal-only seniors, Medicare-Medicaid enrollees in County Organized Health System (COHS) counties, and seniors and persons with disabilities (SPDs) in all Medi-Cal managed care counties. This transition, spanning 16 counties and more than 400,000 SPDs, was completed in May 2012. During the RTI evaluation team's first site visit, State officials and stakeholders discussed this transition, which was a source of "lessons learned" for Cal MediConnect. The following problems occurred during the SPD transitions: complex enrollment materials that were difficult to understand; plans' struggles to reach passively enrolled beneficiaries because of incorrect contact information; stakeholders' inability to answer beneficiary questions correctly; continuity of care disruptions; and lack of experience by plans in serving a very impaired population with high levels of severe mental illness, and other complex care needs (Wunsch and Linkins, 2012). In 2016, stakeholder interviewees cited this experience as the main reason providers advised their patients to opt out of the Cal MediConnect demonstration.

Medicaid expansion. Significant Medicaid expansion has taken place in the State concurrently with the rollout of Cal MediConnect. Before the Affordable Care Act, California had already extended Medi-Cal eligibility to adults with incomes above 138 percent of the Federal poverty level under 1115(a) waiver authority; however, with Affordable Care Act Medicaid expansion, the State eliminated the Medicaid waiver coverage for this category of adults and folded them into the new Medicaid expansion adult group (Smith, Gifford, and Ellis, 2014). Medicaid expansion is a major factor contributing to the growth of managed care enrollment in the State. From January through August 2014—the same timeframe as MediConnect rollout—DHCS enrolled 2.2 million new enrollees in Medi-Cal (Gorman, 2014), bringing the total to 11.2 million people (Kaiser Family Foundation, n.d.). The same DHCS divisions that support Cal MediConnect, particularly enrollment and eligibility, also support Medicaid expansion operations.

According to interviewees, this expansion added significantly to the State’s tasks of overseeing plans and monitoring their quality. To address the latter challenge, the California DHCS developed a comprehensive publicly available Dashboard of Medi-Cal Managed Care that presents data, including beneficiary enrollment by category, financial information on the plans, grievances and State fair hearings stratified by type, requests for continuity of care, and several standard Healthcare Effectiveness Data and Information Set (HEDIS)-derived quality measures, including total quality scores (California Department of Health Care Services, 2016j). In September 2014, State officials told the RTI evaluation team they view the introduction of this dashboard as a major accomplishment and intend to expand it to monitor Cal MediConnect plans. As of fall 2016, a similar dashboard was released once, in March 2016, with 2014 and 2015 data showing the following measures: HRA completion, appeals, hospital discharges, emergency department utilization, LTSS utilization, and case management metrics (California Department of Health Care Services, 2016e).

Managed care environment. Overall, Medicare managed care penetration in California is among the highest in the nation—39 percent in 2016, according to the Kaiser Family Foundation (California Department of Health Care Services, 2016i; Jacobson et al., 2016; Kaiser Family Foundation, 2017). Moreover, as of March 2016, 10.5 million individuals were enrolled in Medi-Cal managed care programs including nearly one million dual eligible beneficiaries. Approximately 3.1 million individuals have fee-for-service Medi-Cal (California Department of Health Care Services, 2016j). Counties differ significantly in the choice and profit status of Medicaid managed care plans operating in the area, as well as the overarching managed care delivery model. Counties with County Organized Health Systems (COHS) have only one plan, which is operated by the county; some counties have two plans (known as two-plan counties); and others have four or more plans (geographic managed care counties). Two of the Cal MediConnect counties are COHS counties, four are two-plan counties and one is a geographically-managed county (Tatar, Paradise, and Garfield, 2016). Please see *Section 2.1* for more on this topic).

Delegated model under managed care. The managed care delivery system in the State is structured around a delegated managed care model. Health plans in California have a tradition of delegating medical and other responsibilities—including utilization management, credentialing, claims payment, transportation, and other services—to other plans, medical groups, independent practice associations (IPAs), and/or to other providers, in a variety of

combinations. Medical groups represent physicians who are in a partnership, which typically is a financially integrated entity; IPAs have contracts in place with independent physicians who are paid on an FFS basis, but the IPA itself is at risk and controls utilization via administrative means. The level and extent of delegation varies significantly among counties and across plans. Managed care entities in the southern part of the State delegate significantly more than those in northern California.

Several factors historically encouraged the development of delegated models in California: predominance of large medical groups with close ties to hospitals that allowed for development of efficient management structures, strong competition with large Kaiser networks, and the desire of physician groups to escape tight constraints of plans' utilization management (Ginsburg et al., 2009). According to Ginsburg, delegated models played an important role in shaping health care delivery in California and may have contributed to lower costs, better efficiency, and higher health maintenance organization (HMO) enrollment than in other States. However, the study also finds that, although prevalent, there is some erosion of the delegated model in the State attributed to (1) a general shift from the HMO to the preferred provider organization (PPO) model, (2) a consolidating trend of major plans being managed by out-of-State entities that are "less interested in supporting a provider contracting model distinctive to California," and (3) a decline of provider leverage over health plans (Ginsburg et al., 2009, p. 1).

Federal funding for the demonstration. In 2011, California received \$1 million in demonstration design funding through a contract with CMS to develop a State proposal for a demonstration under the Financial Alignment Initiative. In June 2013, California received a 3-year \$2 million award from CMS to develop the State's capacity for enrollee options counseling through the State Health Insurance Program and Aging and Disability Resource Centers, known in California as the Health Insurance Counseling and Advocacy Program (HICAP).

Subsequently, the State received implementation funds of \$8.3 million in September 2013 and \$3.25 million in September 2014 from CMS to further develop supports for the demonstration. This was augmented by approximately \$1 million in matching funds from the State. The State used these funds for development of rates, actuarial support, and funding of staff and consultants to implement the demonstration, in addition to the following:

- *Outreach and engagement.* Consultants were hired to expand the demonstration website, develop an outreach and communications plan, develop materials, and conduct outreach activities in the eight demonstration counties for beneficiaries, stakeholders, and providers, in all threshold languages. This also included development of county-specific enrollment notices and choice books.
- *Encounter data system improvement project.* Previously, the State's encounter data system was proprietary and outdated. The State utilized implementation funds to modernize its encounter systems, improve timeliness and accuracy of plan-reported data, and bring key functions in house, rather than subcontract to third parties. This project also included the development of key performance metrics and dashboards. The project was completed in 2015, but a variety of issues were still being resolved at the time of the site visit. For example, at that time (fall 2016) MMPs were not yet allowed to submit Medicaid encounters to the system.

- *Quality improvement functions.* These functions include contracting with an External Quality Review Organization (EQRO) to develop systems for collecting, compiling, and analyzing State-specific quality measures.

Federal funding from CMS and the Administration for Community Living supports the Cal MediConnect Ombudsman Program, which is operated by the Health Consumer Alliance. This network of ombudsman offices, located in each demonstration county, received a total of \$3 million in the first 3 years of Cal MediConnect. In April 2014, ombudsman staff received training about the demonstration with Year 1 funding of \$708,000; Year 2 funding of \$1,145,817 was awarded in September 2014 to support ongoing operations, and the same amount was awarded the following year. In August 2016, the Ombudsman Program received \$250,000 to support their activities assisting beneficiaries. Please refer to ***Section 6*** for further discussion of Ombudsman Program activities.

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2. Integration of Medicare and Medicaid

This section provides an overview of the management structure that was created to oversee the implementation of the demonstration and discusses in greater detail the organization, geographic coverage areas, and enrollment experience of the 10 Cal MediConnect plans that were selected to integrate and deliver the Cal MediConnect benefits. It also provides a general description of the other functions (e.g., care coordination, eligibility, enrollment, quality management, and financing) that the Department of Health Care Services, CMS, and the plans had to coordinate or integrate as part of the implementation of the demonstration. Later sections provide more in-depth discussion of the implementation successes and challenges associated with the integration of these functions.

2.1 Joint Management of the Demonstration

CMS and the State jointly provide oversight of Cal MediConnect through the Contract Management Team (CMT) that works to coordinate policies and processes of Medicare and Medi-Cal. Each group designates representatives who work as a team to oversee the three-way contracts with the Cal MediConnect plans. The CMT is responsible for day-to-day monitoring to ensure that State and CMS policies are integrated, to respond to plans' questions and concerns, and to identify areas for technical assistance (California three-way contract, p. 132). State representatives on the CMT include the Medicaid director and deputy director, 10 key staff responsible for quality and enrollment functions, and 10 plan contract managers. The contract managers oversee all lines of business for which the plan is contracted with the State.

CMS representatives include two Medicare-Medicaid Coordination Office (MMCO) staff, nine Consortium for Medicare Health Plans Operations (CMHPO) staff, and two Consortium for Medicaid and Children's Health Operations (CMCHO) staff. Five of the CMHPO staff align with the State staff to form two-person plan teams assigned among the Cal MediConnect plans; all interactions with the plans include both CMS/DHCS plan team members. During the early phases of implementation, the CMT met on a weekly basis. By 2016, these meetings occurred biweekly, with different sections of the CMT meeting as frequently as needed. The plan contract managers working with plans meet separately as a group.

The CMT's focus varies as issues emerge and are resolved over the course of the demonstration. For example, harmonizing beneficiary marketing materials to accommodate CMS and State requirements was a focus before the demonstration began. During the first year, the CMT responded to questions from plans regarding health risk assessments (HRAs) and integrated care plans as the care coordination process got under way. During the period leading up to the complex January 2015 enrollment, to avoid issues that emerged in the first 8 months, the CMT focused on ensuring that enrollment problems were resolved accordingly. During that period, CMT members participated in a standing meeting held every 48 hours to ensure that effort was on track. In 2015, the CMT became involved and worked with the LTC Ombudsman and MMPs when some plans transferred nursing facility residents without their consent (see **Section 5.2.8** for more information on this topic). In 2016, the CMT topics included best practices (e.g., of care plan development, reaching enrollees, HRA completion), coordination of mental health services, and data reporting.

CMT leadership has encouraged contract managers to attend stakeholder meetings and spend time listening to informal feedback from advocates and LTSS providers, including nursing facility staff, in addition to their regular contacts with the plans. Despite substantial turnover in State MMP contract manager positions, DHCS has been committed to maintaining support to the MMPs. Through an interagency agreement between the DMHC and DHCS, DMHC oversees the Cal MediConnect Ombudsman Program and conducts certain oversight functions for the demonstration. The CMT does not include representatives from the Ombudsman Program, which plays an integral role in complaints and grievances processes, or from DMHC, which is responsible for plan compliance more broadly throughout the State. Consequently, interviewees reported that when issues relating to complaints, grievances, appeals, and other related activities arise, State members of the CMT are not always aware of these issues.

The difference in the size and experience of the plans is also a factor in CMT oversight; smaller plans tend to require more oversight and support, according to CMT interviewees. In the beginning, it had taken more time than anticipated for plans to understand both the needs of the Medicare-Medicaid enrollee population and the supports and requirements of CMS and the State. CMT members provide benchmarks to plans to help them understand how they fare compared with their peers regarding the percentage of health risk assessments completed, for example.

Both CMS and State CMT members reported challenges when they were learning to work together to understand each other's requirements. Both cited challenges in communication, understanding each other's point of view, and establishing a method for collaborating. When State staff discovered that CMS staff could, in certain cases, adjust certain Medicare policies to accommodate the needs of the demonstration, that flexibility helped to lessen State concerns that it would be a one-sided partnership, with the State always adapting policies to fit CMS requirements. For example, in preparation for the Medicare Advantage D-SNP, enrollment into the demonstration in January 2015, CMS agreed to suppress certain Medicare Advantage marketing notices normally triggered by various enrollment actions. These additional Medicare Advantage marketing notices, originally designed to ensure that beneficiaries are informed of their status, would have caused confusion given the volume of demonstration notices and other outreach to beneficiaries that was occurring at the same time.

MMPs credit the CMT for helping to establish dialog pathways and real time technical assistance that was never present before the demonstration. Having all relevant decision makers (CMS Medicare, CMS Medicaid, CMS MMCO, and the State) at the same telephone meeting to troubleshoot issues is unique, according to both plan and CMS officials. Although MMPs generally appreciate the willingness of the CMT to work with them on various issues, some plans reported that it would have been helpful for the CMT to have more substantive conversations with them individually about possible course corrections when operational issues arose, particularly during early implementation. During interviews in 2016, plans and providers noted that CMT guidance and support from CMS MMCO members was particularly helpful.

Best practices and resolutions to challenges are discussed on quarterly national CMT calls attended by all Financial Alignment Initiative States, MMPs, and CMS representatives. This provides a learning opportunity for all States participating in the Financial Alignment Initiative demonstrations.

2.2 Integrated Delivery System

Through the Cal MediConnect demonstration, State officials saw an opportunity to bring together separate community-based services, provide improved and coordinated care to Medicare-Medicaid enrollees, and reduce costs. Two waiver services and a State program—Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), and In-Home Services and Supports (IHSS), respectively—offer related services that had been administered and provided separately and are now included in Cal MediConnect. The State expects health outcomes to improve with an annual HRA and coordination of all medical care, long-term services and supports (LTSS), and behavioral health services that will lead to better preventive care and improved condition and disease management. Improved coordinated care that is person centered enables beneficiaries to reside in their home and/or community, rather than in long-term care facilities. The State anticipates improved quality of life and lower costs through reduced emergency department use, fewer and shorter hospitalizations, and a reduction of skilled nursing facility and long-term care facility stays.

2.2.1 Cal MediConnect Plans

DHCS and CMS contracted with 10 plans to provide integrated Medicare and Medicaid services to enrollees under Cal MediConnect as described in *Section 1.3*. The Cal MediConnect product line under the Coordinated Care Initiative (CCI) was designed to transition nearly all Medicare-Medicaid enrollees into Medi-Cal managed care and provide managed long-term services and supports (MLTSS). Both parts of the CCI, the Cal MediConnect demonstration and MLTSS, currently operate in the same counties. All plans participating in the demonstration are also providing services to Medi-Cal managed care enrollees through different products.

The plan selection process for participation in the Cal MediConnect demonstration required applicants to have had some previous experience in operating a Medicare Advantage plan. To be selected for participation, the two County Organized Health Systems (COHS) plans, and at least one plan in each of the other five counties, were required to have had a minimum of 3 years' experience administering a special needs plan for dual-eligible beneficiaries (D-SNP) product. Other plans were required to have begun such a product before the start of the demonstration (California Department of Health Care Services, 2012, p. 19). Representatives from plans interviewed for this report were emphatic that their significant experience administering a D-SNP plan was essential to administering their Cal MediConnect product. State officials informed the RTI evaluation team that plans in all but one county, Santa Clara, had substantial prior experience administering a D-SNP in addition to a Medi-Cal managed care product.

2.2.2 Integrated Delivery and County Variation

Of the 10 Cal MediConnect plans, five operate in only one demonstration county, four are in two counties, and one plan is in four counties. The same plans provide Medi-Cal managed care services to Medicare-Medicaid enrollees who have opted out of Cal MediConnect but who are required to enroll in a managed care plan for their Medi-Cal services. These plans also provide services to Medicare-Medicaid enrollees who are not eligible for Cal MediConnect and enrolled as part of the CCI mandatory transition to Medi-Cal managed care. Kaiser Permanente does not participate in Cal MediConnect, but is the only other plan that participates in the CCI in

six counties by serving as a Medi-Cal managed care plan for beneficiaries ineligible for the demonstration or for those who have opted out of the demonstration.

Cal MediConnect counties vary in the size of the enrollee population, the extent to which health plans delegate services to other plans and to multiple IPAs, and the number of available PACE plans. The PACE program is included in the enrollment choice form; enrollees may indicate interest in PACE by choosing both a PACE program and a Cal MediConnect plan. If they are ineligible for PACE, they will be enrolled into the managed care plan. Although PACE is an enrollment choice for members, few PACE plans are available in the demonstration counties.

Plans' previous relationships with community-based and facility-based LTSS providers also vary greatly. Some counties have a long history of linkages between plans and community-based providers, whereas others—most notably Los Angeles County—have very little, according to stakeholder interviews. Ethnic and language diversity in each county is also a factor for plans when contracting providers and developing LTSS for their demonstration enrollees. Each county has a slightly different mix of threshold languages for which plans are required to have language-appropriate providers and materials.⁵ Plans and stakeholders noted that ethnic minority providers generally do not participate in managed care plans; maintaining sufficient providers who speak languages other than English is an ongoing challenge. To communicate between staff and enrollees in other languages, plans routinely contract with telephone services that provide third-party translators.

The State recognized the unique characteristics of each county and made county-specific accommodations to aspects of the demonstration, including variation in enrollment methods, the number of plans required, and the minimum amounts of savings required for incentive payments. (Please refer to **Section 7, Financing and Payment**, in this report for more on this topic.) For example, although Los Angeles County is a two-plan Medi-Cal county, DHCS contracted with additional plans for the demonstration to ensure adequate coverage of new enrollees. When asked whether the right number of plans had been selected to participate in the demonstration and whether they provided adequate coverage for this population, State officials confirmed their confidence in the adequacy of the selected plans. In 2014, one official suggested that additional plans would seek to participate in serving the demonstration population once there was evidence of profitability in the current plans. To date, no additional plans have joined the demonstration. Please see **Section 7, Financing and Payment**, for a discussion of the plans' financial outlook.

Table 1 displays selected characteristics for each demonstration county as of December 1, 2016, including the plans serving each county, the type of county, plans that are

⁵ There are 13 threshold languages in California, including English and American Sign Language. A language is designated as threshold when the Medi-Cal Eligibility Data System reports 3,000 speakers in that language, or 5 percent of the Medi-Cal beneficiary population, whichever is lower (California Department of Health Care Services: Frequency of Threshold Language Speakers in the Medi-Cal Population by County for January 2015. Research and Analytic Studies Division. http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Threshold_Language_Brief_Sept2016_ADA.pdf. RASD Medi-Cal Statistical Brief 2016-001, September 2016.).

nonprofit and operated by counties, and the number of PACE programs operating in each county. (For a discussion of enrollment in these plans, please see *Section 3, Eligibility and Enrollment*.)

Table 1
Cal MediConnect county characteristics as of December 2016

County	Passive enrollment start date	County type	PACE plans available in county	Cal MediConnect plan	County operated nonprofit plan
Los Angeles	July 2014	Two plan	2	Anthem Blue Cross (CareMore)	
				Care1st	
				Health Net	
				LA Care	✓
				Molina Healthcare	
Orange	August 2015	COHS	1	Cal Optima	✓
Riverside	May 2014	Two plan	1	Inland Empire Health Plan	✓
				Molina Healthcare	
San Bernardino	May 2014	Two plan	1	Inland Empire Health Plan	✓
				Molina Healthcare	
San Diego	May 2014	Geographic	1	Care1st	
				Community Health Group	✓
				Health Net	
				Molina Healthcare	
San Mateo	April 2014	COHS	0	Health Plan of San Mateo	✓
Santa Clara	January 2015	Two plan	1	Anthem Blue Cross	
				Santa Clara Family Health Plan	✓

COHS = county operated health system.

NOTE: Although Los Angeles is a two-plan county under Medi-Cal, additional plans were contracted to serve the CCI population.

SOURCE: CalDuals website (<http://www.calduals.org/>).

2.2.3 Provider Arrangements and Services

Cal MediConnect plans organize their services differently depending on their delegated model (see *Section 1.6, Overview of State Context*, for more on delegated models). Some Cal MediConnect plans have physicians and other providers on staff who serve enrollees directly, and they contract with “first tier” providers such as independent provider associations (IPAs) or other health plans. Other Cal MediConnect plans delegate all services to first-tier providers to deliver health care services for their enrollees. First-tier providers have relationships with “downstream entities” such as ancillary providers, nursing facilities, and hospitals, as do the Cal MediConnect plans themselves. Cal MediConnect plans usually share part of their capitated rate with their delegated entities, although they may also have other contracting arrangements. Under the delegated model, the MMP may provide payment no lower than the fee-for-service rate. In

all types of delegated models, first-tier and downstream providers may overlap within a county. Multiple first-tier providers and/or Cal MediConnect plans may contract with hospitals and nursing facilities.

Both State officials and plans explained that it is efficient for plans to delegate services to the most appropriate providers, depending on the beneficiary's service needs. The level and extent of delegation vary; plans in southern California counties delegate more than those in the northern counties. According to plan representatives and State officials, some demonstration plans retain core services such as care coordination in-house, whereas others delegate all services. Before the demonstration, plans had historically delegated more Medicare than Medi-Cal services, thus downstream entities are more familiar with Medicare requirements than with those of Medi-Cal. This separation of service contracting continues with reports of plans delegating short-stay, Medicare-reimbursed nursing facility services but contracting directly for Medicaid, long-term custodial care services. The State holds Cal MediConnect plans responsible for the quality of services of all downstream entities through their three-way contracts and monitors that Cal MediConnect plans have oversight policies and procedures in place. However, the State does not monitor delegated or downstream entities directly. MMP officials informed the RTI evaluation team that they collect quality metrics from providers that have the reporting capability. For more discussion on this topic, please refer to **Section 8, Quality of Care**. When asked how plans would provide coordinated care through multiple networks of subcontracted and downstream providers, plan representatives pointed out that their delegated model system has been in place for their other products and they are confident it will be successful for the demonstration. State officials underscored this assertion, noting that delegation is an efficient model—particularly for care management. Regardless of the number of downstream entities from which an enrollee may receive care, interviewees reported enrollees now have one Cal MediConnect Plan with one care coordinator to deliver and coordinate Medicare, Part D supplement, and Medi-Cal services; they believe that services are seamless to the enrollees.

However, the delegation structure can be complex and create access to care issues for enrollees. Enrollees, stakeholders, and ombudsman representatives explained the difficulty when an enrollee attempts to obtain services from a provider outside of the IPA network in which he or she was enrolled. Attempting to change from one IPA to another within the same MMP also proved confusing and difficult for enrollees. MMPs in delegated counties may contract with multiple IPAs and other providers, and enrollees must obtain services within the one IPA network or disenroll from one IPA in order to join another.

RTI focus group participants were confused about where they could obtain services and how the demonstration name, the MMP name, and the IPA name all fit together. One said, “I’m very confused [by] what I have. All I know is... it’s connected with [MMP name] somehow. And I remember running across Cal MediConnect, but I don’t know what it was about. I feel as though I’m being switched. If I ask about it, [the MMP representatives say] ‘Oh, well you don’t have that now.’ The [MMPs] have been pulling switcheroos on me... then when I find out, no, I’m with a different company, then I’m out in the cold.”

Many of the incorrect billing and continuity of care issues have arisen with providers in downstream entities; demonstration policies have not always filtered down to these providers from the MMP or the State. In summary, delegation raises three main concerns: (1) oversight of

quality of care provided by downstream providers, (2) service coordination across multiple providers within or across IPAs, and (3) sufficient access to care in delegated counties.

2.2.4 Provider Engagement

During site visits, the RTI evaluation team often heard anecdotally of PCPs, specialists, and health care systems that would not work with the demonstration. Stakeholders also pointed out that there is a physician shortage in California and some providers choose to avoid managed care entirely and provide services only under Medicare FFS or to private-pay patients. Moreover, the percentage of physicians with any Medi-Cal patients decreased from 2013 to 2015 (Coffman, 2016b) while the State was expanding its Medi-Cal program (Coffman, 2016a). Physicians who provide services to non-English-speaking populations were particularly unlikely to join managed care plans. This section focuses on providers who are working within the demonstration.

Despite physician shortages, plan representatives indicated they had no difficulty contracting providers and were happy with those they had chosen. Each plan reported having sufficient numbers who were oriented to the demonstration and experienced in reporting required quality metrics and other data on a timely basis.

Initially the State and CMS focused their primary outreach, monitoring, and oversight on plans, and to a lesser extent, directly on providers. In the early months of implementation, the lack of a comprehensive outreach program to providers became evident as billing issues and questions arose about continuity of care. Within a few months of the start of the demonstration, stakeholders reported some examples of plan and provider behavior not allowed under the demonstration, including charging beneficiaries for Medicare copays and other charges from providers. There were also reports of some providers trying to move enrollees from their out-of-network nursing facilities to their contracted facilities; some nursing facilities reported substantial delays in payment from plans, or not being paid by plans. Stakeholders also reported that out-of-network providers were not providing continuity of care services or services through Medicare FFS for enrollees who had opted out of the demonstration. Most of these reports appear to stem from delegated and out-of-network providers' lack of familiarity with demonstration policies about billing and continuity of care. These issues were also compounded by the rollout of MLTSS that occurred at the same time the demonstration was being implemented. Beneficiaries who opted out of the demonstration were automatically enrolled in MLTSS, often in a different product of the MMP. Many providers and stakeholders had difficulties understanding the differences between the demonstration and the MLTSS program. Some misunderstandings seemed to stem from a lack of familiarity with managed care in general.

The uncertainty of continuity of care arrangements, billing issues, and related misunderstandings on the part of plans, providers, and delegated entities prompted DHCS to produce a provider toolkit in September 2014. Directed to delegated and nondelegated providers in the demonstration, the toolkit contains detailed instructions for billing issues, including incorrect billing, general and county-specific crossover claim submissions, and procedures for submitting claims for Medicare services and Medi-Cal covered services. Accessibility, care coordination, and continuity of care rules are outlined in fact sheets. The toolkit also includes sample letters that providers can tailor and send to their patients in anticipation of their

enrollment in the demonstration in the future. The sample letters reflect the perspective of both providers participating in Cal MediConnect and nonparticipating providers who would continue to provide services under Medicare FFS.

The RTI evaluation team found some discrepancies between how plans and the State viewed the demonstration and how stakeholders and beneficiaries experienced it. For more on this topic, please see *Section 5, Beneficiary Experience*.

2.2.5 Integrated Mental Health and Substance Use Services

Cal MediConnect plans are responsible for ensuring that enrollees have seamless coordination and access to all necessary services, including mental health services. In January 2014, prior to the demonstration, the State expanded mental health benefits to all Medi-Cal beneficiaries in managed care plans (California Department of Health Care Services, 2013b). These benefits are available to Cal MediConnect enrollees and include assessments of potential mental health disorders and outpatient mental health services to enrollees with mild to moderate impairment of mental, emotional, or behavioral functioning.

Specialty mental health and substance use services, including targeted case management and rehabilitation services, financed and provided by county-administered Mental Health Plans and Alcohol and Other Drugs Programs, are excluded from the capitated rate. However, Cal MediConnect was designed to have plans coordinate mental health and substance use services with county-administered agencies per each plan's Behavioral Health MOU, (MOU, 2013, p. 74). Historically, the county behavioral health system that provides Medi-Cal services has operated as a separate system without much interaction with other health structures, even with psychiatrists and other providers delivering Medicare behavioral health care. In Los Angeles County, the mental health and substance use services are provided by two separate agencies, but in all other demonstration counties they are provided by a single agency. Please see *Section 4, Care Coordination*, for further discussion on coordination of behavioral health and substance use services.

2.2.6 Integrated LTSS

Cal MediConnect plans are responsible for ensuring that care coordination is available to all enrollees and providing access to all LTSS. The demonstration includes a State program, In-Home Supportive Services (IHSS), and two waiver services, Community-Based Adult Services (CBAS) and Multipurpose Senior Services Program (MSSP). Plans also coordinate nursing facility stays and other LTSS as needed. As noted in *Section 1.2*, the inclusion of IHSS changed effective January 1, 2018.

In-Home Supportive Services. The IHSS program is a self-directed personal care service program that allows beneficiaries to hire, direct, and fire support workers to provide personal assistance services in their homes. In 2016, it served approximately 500,000 Medi-Cal beneficiaries statewide, including Medicare-Medicaid enrollees eligible for Cal MediConnect as well as children and other populations not eligible for the demonstration.

The California Department of Social Services (CDSS) administers this 40-year-old program, with services provided by about 400,000 workers. Allocation of hours is determined by

the county social services office. CDSS assesses beneficiaries in their homes and then determines workers' pay rates; county agencies determine and authorize workers' hours. Cal MediConnect Plans' capitated rates included IHSS services; however, the plans were required to pay the hours authorized by the county agencies at the rates authorized by CDSS, and subsequently reconcile payments with the State annually.

California residents are eligible for IHSS if they are blind, disabled, or 65 years of age or older; living in a home, apartment, or abode of their choosing (not including a hospital, nursing facility, assisted living, or licensed care facility); unable to live safely at home without care; and eligible for Medi-Cal. The IHSS program includes the 1915(k) Community First Choice (CFC) option for beneficiaries with a nursing facility level of care (though the broader IHSS program does not require nursing facility level of care). CFC is an option available to States without the need for special waiver authority; it provides a 6-percentage-point increase in States' Federal Medical Assistance Percentage (FMAP) for providing personal care services and supports. The California IHSS CFC option, the first CFC option in the country, was initially approved on December 1, 2011. After the final rule was established on July 1, 2013, California has served only beneficiaries with a nursing facility level of care under this option. In 2014, about 40 percent of IHSS recipients, including Cal MediConnect enrollees, had an institutional level of care need, and their personal care assistance services are now financed through this waiver (Department of Health and Human Services, 2014).

Preparing and implementing the Fair Labor Standards Act Extension (FLSA) has been the main challenge facing the IHSS program in 2015 and 2016. The State allocated additional funds and began paying IHSS workers for overtime hours starting January 1, 2015. The CDSS reported that the challenges have been mostly administrative: developing rules for overtime hours, putting structures in place to track overtime hours, and training providers about overtime pay. Although advocates reported a general concern that the IHSS program would be under pressure to reduce personal care hours for IHSS recipients resulting from the FLSA, CDSS reported in fall 2016 that so far this has not been the case. Since the State capped the total monthly hours for one caregiver at 283, one potential effect on beneficiaries could be the need to split their personal care between two caregivers to honor that cap. The State has also developed some programs with certain exemption categories for caregivers, allowing them to work up to 360 hours a month. These exempt categories covered parents, grandparents caring for two or more children, and those serving IHSS recipients in remote geographic areas.

All IHSS services authorized by county agencies—including payroll to providers—have been administered by the county agencies jointly with CDSS. However, county agencies cannot administer services authorized by the Cal MediConnect plans. This has led to a more limited role for MMPs in relation to the level of personal care services than originally anticipated. Initially, the intention was for the MMPs to provide additional personal care hours through the CPO benefit; however, this had not occurred as of fall 2016. MMPs have been unable to set up a structure by which they could contract with such providers independently, outside of the IHSS system. Administering such benefits is a complex undertaking. Multiple interviewees cited this as a reason why MMPs were not providing additional personal care as part of the CPO benefit. Some MMPs reported that if they found, through the HRA, that an enrollee needed an increase in personal care hours, they reached out to the county IHSS workers and asked them to reassess the beneficiary. In 2015, CDSS began tracking the instances where personal care hours were

increased as a result of the MMP request in order to track care coordination outcomes. Results from this analysis were incomplete as of the date of this report, though they will be included in future reports if available.

Community-Based Adult Services. CBAS is a day center alternative to nursing facility placement for beneficiaries who meet the State’s nursing facility level of care requirements, have a developmental or cognitive disability, or receive services from county-based mental health agencies. Centers vary in size from 20 to 160 beneficiaries; they may be for-profit or nonprofit, and may cater to beneficiaries in certain ethnic groups, with particular languages or medical needs. CBAS services begin with a comprehensive, 3-day, multi-team assessment conducted by a nurse, after which a plan of care is developed, followed by authorization by a physician or a managed care plan. Services provided in CBAS centers include meals; behavioral, physical, and occupational therapies; and social and recreational activities.

Multipurpose Senior Services Program. Through the MSSP waiver, local sites provide care management for frail elderly individuals age 65 or older who are certifiable for placement in a nursing facility but who wish to remain in the community. The waiver consists of approximately 10,000 slots statewide, with approximately 4,500 in the CCI counties as of September 30, 2016. MSSP services begin with a thorough assessment conducted in the client’s home and assignment of a case manager. Depending on the needs of the individual, MSSP services could include advocacy to ensure the beneficiary obtains appropriate services from public agencies; helping the beneficiary to understand their rights and benefits and how to navigate the system to meet their needs; referrals to community resources, including meals programs, providers of durable medical equipment (DME), and counselors to improve health behaviors; and connecting the beneficiary with needed health services such as in-home dental care or podiatry. The program may use waiver funds for needed services such as home modifications or to supplement IHSS in order to allow the beneficiary to remain in the home or community. MSSP is included in Cal MediConnect until 2019, when the MSSP waiver expires in six of the seven demonstration counties (California Department of Health Care Services, 2017). The MSSP benefit will transition into managed care as a benefit no sooner than January 1, 2020. MSSP had previously transitioned from a waiver service to a benefit in San Mateo County.

CBAS transitioned into managed care in 2012, and plans have contracted for and have some experience with these services. Incorporating MSSP, IHSS, and the array of local, community-based support services was new to most MMPs and, reportedly, challenging. One plan representative stated in 2014 interviews, “It’s a whole new world... all completely new to us.” The vast majority of MSSP waiver recipients did not enroll in the demonstration until October 2014; therefore, experience with integrating this waiver service was limited for most MMPs. None of the plans had previous experience with the IHSS program that provides in-home support workers to beneficiaries who self-direct these services. Assessment and allocation of these IHSS hours were provided by the county social services office; therefore, plans had virtually no control over the authorization of these services. In annual interviews, plan representatives noted their concern and anxiety regarding the financing for this service. Please refer to **Section 7, Financing and Payment**, for more on IHSS financing.

2.2.7 Training and Support for Plans and Providers

Plans reported conducting outreach and training to providers as they were building their networks. The State’s provider outreach began prior to the start of the demonstration and was generally focused on physician providers. Please see ***Section 6, Stakeholder Engagement***, for more on provider outreach. In the early months of the demonstration, the State continued to conduct outreach in the form of webinar presentations and postings on the CalDuals website that included explanations of LTSS programs and MSSP billing processes. DHCS also offered trainings via regularly scheduled telephone meetings and restructured the CalDuals website to designate a separate section for providers. In September 2014, DHCS issued a Provider Toolkit that included an overview of the demonstration, explanations of care coordination, physician contracting, and payment processing.

The State regularly issues All Plan Letters (APLs) as a means of conveying new policies to all plans and providers, including Medi-Cal plans not participating in the demonstration. Cal MediConnect plans receive APLs as well as Dual Plan Letters (DPLs), which the State issues to convey new policies pertinent to the demonstration. Although the majority of the APLs were issued for Medi-Cal plans, some APLs (e.g., APL 16-001) addressed issues relevant to the demonstration. Discrepancies in payment methods and other misunderstandings on the part of plans and delegated entities necessitated DPLs to clarify demonstration policies regarding nursing facility residents, payments, and procedures.

Despite such reminders and clarifications, some challenges persisted into 2016. In addition to DHCS’ directives, several stakeholder groups—especially Justice in Aging—held webinars and issued fact sheets to educate advocates and other stakeholders about the issue of incorrect billing of enrollees. Incorrect billing of beneficiaries for co-pays and other charges has been pervasive in California beyond the demonstration, and often occurred in the demonstration when downstream, contracted providers were unfamiliar with the rules of Cal MediConnect. The Ombudsman Program reported that this problem was widespread and that many enrollee complaints stemmed from incorrect billing. Data from the Ombudsman Program reports from August 2016 show that the top service problem among all dually eligible beneficiaries and among Cal MediConnect enrollees is “billing/charges, including out-of-network charges and problems with providers being paid.” Ombudsman staff contact providers directly to educate them on appropriate billing procedures. The State and CMS have stepped up efforts to identify individual providers who are responsible, and to provide education to them directly about proper billing methods.

2.2.8 Hospital and Nursing Facility Providers

According to hospital interviewees, initially, there was little outreach from the State to hospitals to introduce the demonstration and its policies. Because of the lack of outreach, the hospital case managers treated Cal MediConnect enrollees as Medi-Cal patients and did not provide Medicare benefits such as rehabilitation services. Most MMPs did not proactively provide information or assistance to hospitals, which then looked to other hospitals and organizations for information and support to understand how to provide services to demonstration enrollees in their care. Furthermore, plans with limited Medicare Advantage experience lacked understanding of Medicare rules and benefits, according to hospital

interviewees, which resulted in incorrect information, including inappropriate service authorization denials by plans. For example, one plan representative informed a hospital that 30-day readmissions are not in compliance with CMS rules; another questioned long-term care hospital (LTCH) services because they did not know the meaning of LTCH. Hospital providers remarked on the unevenness of training and basic understanding of leadership and staff in some plans in the beginning of the demonstration; in some MMPs this persisted through fall 2016. In 2016, nursing facility and hospital interviewees expressed concern about MMPs' lack of understanding and capacity to resolve such issues. (*Section 4, Care Coordination*, discusses MMPs' challenges regarding care coordination of enrollees in nursing facilities and acute hospitals.)

In June 2015, hospital representatives recommended that the State develop training materials tailored to hospital-based case managers and provide clear guidance to the MMPs. DHCS responded with a training conducted by Harbage Consulting to hospital employees, and by working with the California Hospital Association to develop a 14-page policy guidance toolkit in July 2016 that explained the demonstration, benefits covered, billing policies, and other information relevant to hospital case managers. Also, the State issued in July 2016 a DPL on MMPs' discharge planning responsibilities that was designed to clarify duties and timeframes for these activities. The DPL brought together and clarified guidance on this topic that had appeared in multiple documents. Hospital providers noticed that the guidance did not specify how these activities would be monitored or by whom.

In 2015, several stakeholders and CMT members reported nursing facility transfers that were in violation of Federal law and that were upsetting to nursing facility residents. Because some MMPs lacked experience with nursing facility operations, policies and regulations, when certain facilities were at risk of decertification, these MMPs transferred nursing facility residents to new facilities without informing the residents of the reasons, obtaining their consent, or providing them with choices. These MMPs did not realize the facilities could regain certification after implementation of the corrective actions. This was not a widespread occurrence and after MMPs were trained further in this area, there were no other reports of such transfers. Please see *Section 5.2.7, Experience of Special Populations*, for more on this topic.

Some MMPs also have had difficulty understanding nursing facility financial practices. In 2016, interviewees from multiple nursing facility chains in demonstration counties informed the RTI evaluation team that the lack of cooperation and understanding of nursing facility billing and payment policies and procedures on the part of some MMPs resulted in additional complications for enrollees and serious financial loss to the nursing facilities. One interviewee estimated the additional staff required to address the needs of the MMPs, coupled with delays in full payment, resulted in \$1 million per year in additional expenses. The crux of this issue seems to be twofold: MMPs lacked nursing facility authorization, billing, and payment expertise, and there was a high turnover rate of MMP staff liaising with nursing facilities. Nursing facility officials reported that they did not have consistent contacts at the MMPs to help resolve authorization, billing and payment issues and they felt they were training and re-training MMP financial staff in the nuances of nursing billing and authorization codes and practices. Frequently, any one facility might have enrollees from each plan (in non-COHS counties), requiring the facility to address these challenges with staff from multiple MMPs. Not having direct telephone access to MMP finance staff with whom they needed to discuss these matters

compounded the problem. Instead, nursing facility staff were required to call the main MMP number and were put on hold for up to an hour, as one nursing facility official reported. DHCS issued a DPL in 2014 stating MMPs' requirements for nursing facility prompt payment and claims handling (California Department of Health Care Services, 2014d). In 2016, facility interviewees noted that this issue had not improved from the start of the demonstration. One official characterized MMPs' lack of nursing facility knowledge as, "they're trying to fly a plane while they're building it."

Cal Optima, the one Cal MediConnect plan in Orange County, developed a very comprehensive approach to nursing facility engagement. It began enrollment more than a year after the demonstration began and perhaps benefited from some lessons learned by plans that began operations earlier. Cal Optima staggered enrollment of beneficiaries in nursing facilities in order to engage facilities individually, reach out to physicians serving nursing facility residents, and ensure good communication between the facilities and the plan. It appeared that this contributed to a slower opt out rate than in nursing facilities in other counties, although long-term data on the overall effectiveness of this approach are not available.

2.2.9 Sharing of Best Practices

From the beginning, DHCS has been interested in identifying best practices that have emerged within Cal MediConnect MMPs to share among all plans. In January and June 2015, DHCS convened Provider Summit meetings with MMPs and providers in Los Angeles, San Bernardino, and Riverside. These Provider Summits acted as a forum for MMPs and providers to begin initial conversations about best practices that had been identified thus far (California Department of Health Care Services, 2015b). Among the presentations were best practices of coordinated care teams, engaging consumers, and integrating behavioral health services (Center for Health Care Strategies, 2015b).

In April 2016, DHCS announced that MMPs would be meeting to discuss their best practices in detail and invited stakeholders to suggest topics for consideration. DHCS hoped this sharing of internal processes among plans would help to improve quality of care to enrollees. The SCAN Foundation has also convened meetings with MMPs to share best practices.

DHCS's contractor, Harbage Consulting, began facilitating best practice discussions in summer 2016. These regular meetings took place in various formats, depending upon the topic. For example, one plan representative may provide a detailed explanation of a particular service within the context of their plan's operations, and other plans may ask questions or offer examples of how they conduct similar activities. Technical experts conducted additional meetings, while allowing for plans to share their processes to ensure transparency and openness. Plan interviewees reported value in contributing and learning through these discussions, which provided an opportunity for MMPs to learn from each other and fine tune processes. Examples of best practice discussions included the following:

- One plan collaborated with nursing facilities to provide training to facility staff and family members, share HRA results, and encourage family members to participate in ICTs. Monthly visits to facilities foster communications between the plan and the facilities.

- Rather than a number of vendors and plan staff contacting a new member, leading to “member fatigue,” one plan reorganized its onboarding to have a “one touch” approach.
- Another plan conducted nursing facility site visits unannounced with the Long-Term Care Ombudsman who introduced plan staff to facility staff and residents, educated the plan about any history of deficiencies in the facility, and helped address any deficiencies or complaints during the visits.
- Utilization of a provider portal as a way to enhance care coordination and monitor LTSS integration. The uploading of CBAS and MSSP care plans through a provider portal allowed for easy viewing and access by all the enrollee’s providers. The plan monitored reporting measures, provided CBAS and MSSP sites with feedback reports, and tracked provider access of the documents.

The IHSS Caregiver Engagement Program, a pilot project in partnership with the California Long-Term Care Education Center that trains caregivers, served as a promising practice. With the enrollee’s consent, the center trained caregivers to participate as liaisons between the health plan and the member. The caregiver called the plan’s interactive voice response system weekly, to report any changes in condition or needs of the member. Any changes would allow the plan coordinator to follow up to address any concerns. A stipend of \$40/month was provided to caregivers.

Topics covered through 2016 included LTSS referrals, onboarding of new members, marketing and outreach, dementia promising practices, and grievances. Topics scheduled for 2017 included care coordination for high-risk members and outreach to communities of diverse backgrounds. Other best or promising practices are noted in *Section 4* of this report.

2.3 Successes

Plans support the demonstration and are working to make it a success. All MMPs interviewed expressed enthusiasm for the model of care and confidence that the demonstration would prove successful. Although they had concerns about many issues—including whether the demonstration would be extended from year to year because of the “poison pill amendment” and eventual profitability due to slow rate-setting—plans reported that they were committed to making the demonstration a success.

The CMT model, with real-time technical assistance to plans, has proven successful according to all participants. In the beginning, there were challenges to ensure that all entities involved in contract monitoring were aware of the actions of others. Working out modifications to policies and procedures for CMS and State systems, and conveying the results quickly to the plan managers, was more involved than originally anticipated. To address this, in the early days of the demonstration, the teams met frequently to review all policy changes and interpretations. Whenever a State contract manager spoke with a plan, a CMS counterpart was also on the call.

State staff have learned Medicare regulations while simultaneously trying to stay in compliance with Medi-Cal requirements and State regulations. According to State officials

and plans, DHCS staff did not have adequate knowledge of Medicare before the demonstration started, and there was some concern on the part of plans. Medicare expertise was reported to be “hard to acquire by reading papers.” DHCS staff acquired experience with Medicare regulations by working with other members of the CMT and managing the three-way contracts.

MMPs are meeting to share best practices. The State regularly convened meetings of plans to discuss ways to improve their operations to improve services to enrollees. MMPs also met to share best practices through foundation-funded activities.

2.4 Challenges

The delegation model raises questions. There was cognitive dissonance in reports from State officials and MMP representatives in delegated counties who believed that the delegated model worked well, compared with reports from enrollees, stakeholders, and ombudsman representatives who described numerous enrollee challenges resulting from delegation. Questions include the following:

- Did demonstration enrollees in delegated counties have adequate access to care, given the difficulty and challenges associated with obtaining services outside of an IPA network?
- Quality of care from downstream providers is the responsibility of plans, but how have plans been monitoring quality of these providers?
- How have plans ensured that services are coordinated across multiple providers and entities within or across multiple IPAs?

The model design has created inherent tension between MMPs and the counties that have retained authority for assessments and authorizations. The demonstration calls for MMPs to pay for IHSS services; however, plans have had no authority to assess or authorize these important LTSS services. Estimates of charges were not provided in advance for planning purposes, charges occurred after the fact and were delayed, and plans were at full risk. All plans interviewed through 2016 stated this was challenging for their financial planning.

Unevenness of MMP experience at the beginning of the demonstration continues to have an effect. Not all plans had substantial D-SNP experience prior to the demonstration. Those that had extensive experience with such products and that had knowledge of providing services to a very complex population, remarked on the benefit of this experience; those without such experience have struggled with the nuances of working with providers to coordinate and pay for services for the demonstration population. Some MMP staff were reported to the RTI evaluation team in 2016 to need training regarding authorizations, billing, payment practices, and Medicare regulations.

Provider education and outreach, to all types of providers, has been an ongoing challenge and had a tremendous impact on enrollees. Lack of timely information to providers and misunderstandings on the part of providers caused enrollees to pay for services unnecessarily; it disrupted beneficiaries’ continuity of care services, and it made it difficult for

beneficiaries to navigate the new system of care when providers were uncertain of demonstration policies and procedures. The provider toolkit, issued in the 6th month of the demonstration, helped to ameliorate these issues; outreach to other providers such as hospital and nursing facility providers and clarification of basic policies (e.g., discharge policies) continued in 2015 and 2016. Despite concerted efforts to educate providers regarding incorrect billing, as of fall 2016, there had been a continued need for training of all types of providers as billing and payment irregularities continued to occur.

3. Eligibility and Enrollment

Highlights

- The timelines for the initial rollout of the demonstration were adjusted to allow for plan readiness processes to be completed. The original timeline proceeded in some counties and was delayed in others; the demonstration did not proceed in one county.
- The demonstration began in April 2014, with passive enrollment taking place in staggered phases by birth month and program type from May 2014 through July 2016 in seven counties.
- Based on stakeholder feedback, enrollment materials were consumer tested and revised after the initial release. The materials were updated to be clearer and easier for beneficiaries to understand.
- According to the State, overall opt-out rates through the final month of passive enrollment in July 2016 were 50 percent, ranging from 10 percent in San Mateo County to 58 percent in Los Angeles County. The IHSS opt-out rate was 61 percent. Opt-out rates for certain ethnic, racial, and linguistic minorities were as high as 94 percent in some counties.
- In 2016, the State analyzed opt-out and disenrollment data linked to providers to target provider outreach efforts conducted by MMPs and the State.
- To address low enrollment, DHCS implemented streamlined enrollment in fall 2016, allowing MMPs to facilitate enrollment of eligible beneficiaries in MMPs' Medi-Cal product line, into the demonstration.
- Revised 2016 MLTSS enrollment materials were effective in educating beneficiaries about their choices and prompting opt-in enrollment into Cal MediConnect.

3.1 Introduction

This section provides an overview of the enrollment process for Cal MediConnect. Eligibility for the demonstration, enrollment phases, and the passive enrollment process are included in this section. Enrollment and opt-out data are presented, and factors influencing enrollment decisions and recently implemented enrollment strategies are also discussed.

The passive enrollment process was complex and differed by county and by enrollment group. Beneficiaries may opt into the demonstration by choosing a plan or be passively enrolled and be assigned to a plan. Two COHS counties have only one plan; enrollees in these counties could opt in or were passively enrolled into the one COHS plan. Cal MediConnect enrollees may change plans or disenroll from the demonstration at any time. DHCS designed a staggered enrollment process that included passive enrollment by birth month among the seven counties, with opt-in enrollment beginning in April 2014 in five counties. Passive enrollment in the demonstration ended in July 2016 in Orange County. Orange County also created a tailored enrollment process for residents of nursing facilities.

3.2 Enrollment Process

3.2.1 Eligibility

Full-benefit Medicare-Medicaid beneficiaries age 21 or older are eligible to enroll in the demonstration (MOU, 2013). Individuals who are eligible to opt into the demonstration, but are not eligible for passive enrollment, include those who reside in certain rural ZIP codes in San Bernardino County in which only one Cal MediConnect Plan operates; and beneficiaries who are enrolled in a prepaid health plan that is a nonprofit health care services plan with at least 3.5 million enrollees statewide, that owns and operates its own pharmacies. Individuals participating in the following programs are not eligible to enroll in the demonstration (but may do so after disenrolling from their current program): Program of All-Inclusive Care for the Elderly (PACE), the AIDS Healthcare Foundation, or any of the following 1915(c) waivers: Nursing Facility/Acute Hospital Waiver, HIV/AIDS Waiver, Assisted Living Waiver, and In Home Operations Waiver (MOU, 2013, p. 9). Beneficiaries enrolled in these 1915(c) waivers are transitioning to Medi-Cal managed care under the CCI (California Department of Health Care Services, 2013c).

The following groups are not eligible to enroll in the demonstration: individuals with other private or public health insurance; beneficiaries receiving services through California's regional centers or State developmental centers or intermediate care facilities for the developmentally disabled; beneficiaries with a share of cost who do not meet share-of-cost requirements; those residing in one of the Veterans' Homes of California or in certain rural ZIP codes in San Bernardino, Los Angeles, and Riverside counties; or individuals with a diagnosis of end stage renal disease at the time of enrollment who reside in Los Angeles, Riverside, San Bernardino, San Diego, or Santa Clara counties (MOU, 2013, p. 8).

CMS and DHCS determined that enrollment in Los Angeles County would be capped at 200,000 enrollees. The cap was designed to ensure the adequacy of providers for the number of enrollees in that county. None of the other six counties had enrollment caps.

3.2.2 Phases of Enrollment

After the initial start date of October 1, 2013, specified in California's MOU, the State adjusted the enrollment start dates multiple times for particular counties and for special populations in those counties, for a variety of reasons. State leadership explained these multiple changes in start dates as a sign of their flexibility in responding to unplanned events while simultaneously proceeding with implementation of the demonstration where feasible. Communicating these multiple and sometimes complex adjustments to stakeholders, adjusting and administering the mailings of the 90-, 60-, and 30-day enrollment notices (see **Section 3.2.3, Passive Enrollment Process**) by population subgroup, responding to plans' needs to provide data for prospective enrollees and clarifying policies and procedures to providers and enrollees were major activities during the first year of the demonstration, according to State staff, stakeholders and plans.

Table 2 shows the major phases of enrollment into the California demonstration. Beneficiaries in San Mateo County (except those enrolled in the D-SNP) were passively enrolled

in April 2014 at the start of the demonstration; beneficiaries in the six other counties first had an opt-in only enrollment period, followed by passive enrollment. Reasons for staggering start dates for populations or counties varied, such as (1) to prevent the need for multiple transitions of special populations within a single year, (2) to ensure sufficient time for sending enrollment notices, and (3) to confirm plan readiness. Plan readiness was a factor in the following enrollment adjustments.

- *Los Angeles County*: When LA Care received a “consistently low-performing icon” status from CMS due to poor or below-average Medicare plan ratings, the plan became unable to receive passive enrollments. The State amended its enrollment plan for Los Angeles County as follows: (1) CMS and the State contracted directly with three additional plans to bring the county total to five plans; (2) new enrollees were able to opt into LA Care but were not passively enrolled; and (3) beneficiaries who were already receiving Medi-Cal managed care services from LA Care were transferred into the demonstration on July 1, 2014. In October 2014, the State announced that LA Care’s quality measures had improved and the plan began accepting passive enrollments by birth month beginning January 1, 2015. From January 1, 2015, until June 30, 2015, LA Care received 40 percent of the passive enrollments for the entire county (including the transfer of its D-SNP enrollees) to compensate for the lack of passive enrollments in the first 9 months of the demonstration and to adjust for plan capacity among all plans in the county. Intelligent assignment (i.e., the use of claims data to assign enrollees to a Cal MediConnect plan that includes their current providers) was not reported to be affected by this adjustment.
- *Santa Clara County*: Enrollment in Santa Clara Family Health Plan was delayed until the plan had implemented a new non-pharmacy claims systems in 2014. It subsequently passed the joint CMS/State readiness review. Both plans in Santa Clara County began enrolling beneficiaries on January 1, 2015.
- *Orange County*: This COHS county operates Cal Optima, which had not passed its readiness review according to schedule due to Part D sanctions. It subsequently passed; opt-in enrollment began in July 2015 and passive enrollment began in August 2015. As a COHS county, Cal Optima was responsible for sending notifications and handling enrollments. While most beneficiaries enrolled by birth month, this county was the only county to enroll beneficiaries residing in nursing facilities in facility cohorts; this schedule began in November 2015 and continued through July 2016.
- *Alameda County*: In November 2014, DHCS announced that Alameda County would no longer be included in the demonstration because Alameda Alliance, one of two plans in Alameda County, had not yet met the financial solvency requirements to begin participating in the demonstration.

Table 2
Enrollment phases of Cal MediConnect, by start date

Aspects	Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
Start date	04/01/2014	07/01/2014	10/01/2014	01/01/2015	07/01/2015
Target population	MSSP beneficiaries and Medicare FFS, beneficiaries in San Mateo County. Medicare FFS and Medi-Cal beneficiaries in 3 other counties	Medicare FFS and Medi-Cal beneficiaries in Los Angeles County	MSSP beneficiaries	Medicare FFS and Medi-Cal and MSSP beneficiaries in Santa Clara County. DSNP/ Part D LIS beneficiaries in 6 counties	Medicare FFS, MSSP, and DSNP/ Part D LIS beneficiaries
Geographic area	San Mateo, Riverside, San Bernardino, and San Diego counties	Los Angeles County	Los Angeles, Riverside, San Bernardino, and San Diego counties	Los Angeles, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties	Orange County
Enrollment method	Passive in one wave in San Mateo county on April 1. Opt-in began April 1, passive began May 1, in Riverside, San Bernardino, and San Diego counties.	Passive enrollment on July 1, preceded by opt-in for 3 months beginning April 1.	Passive enrollment in one wave	Passive enrollment on January 1 for Santa Clara County. DSNP/Part D LIS beneficiaries passively enrolled in one wave.	Opt-in enrollment on July 1, followed by passive on August 1. DSNP/Part D LIS beneficiaries in Orange County passively enrolled in one wave January 1, 2016.
Gradual roll-out	Passive enrollment by birth month in Riverside, San Bernardino, and San Diego counties.	Passive enrollment by birth month.	Passive in one wave for MSSP beneficiaries.	Passive in one wave for DSNP/Part D LIS beneficiaries. Passive enrollment in Santa Clara County was by birth month.	Passive enrollment was by birth month except in certain nursing facilities which took place from November 2015 through June 2016.

D-SNP = Dual Eligible Special Needs Plans; MSSP = Multipurpose Senior Services Program; Part D LIS = Medicare Part D benefits for persons receiving low-income subsidies.

NOTES: There were no FFS Medi-Cal enrollees in Orange and San Mateo, the two County Organized Health System (COHS) counties. Opt-in enrollment was available for all eligible individuals while passive enrollment took place.

SOURCE: RTI International: State Data Reporting System (SDRS).

3.2.3 *Passive Enrollment Process*

DHCS was responsible for sending 90-, 60-, and 30-day enrollment notices in all demonstration counties except San Mateo and Orange counties, the two COHS counties in which the MMPs administered this process. All notices were mailed in bright blue envelopes to attract the attention of beneficiaries, and outreach efforts advised beneficiaries to anticipate receiving “the big blue envelope.” The 90-day notice provided the beneficiary with an early notice to be prepared to receive more information the following month. The 60-day notice explained the following options: (1) select a Cal MediConnect plan other than the one indicated on the Choice Form; (2) stay in Medicare FFS and select a managed care plan for Medi-Cal benefits; or (3) if no action was taken, the beneficiary would be enrolled in the assigned Cal MediConnect Plan. Beneficiaries could select a plan or change Cal MediConnect plans at any time, except in COHS counties, where there is only one demonstration plan. Beneficiaries could also apply for a PACE program in their county; however, this was done in addition to choosing either a Cal MediConnect plan or a Medi-Cal plan. If an applicant was eligible for PACE, the application was forwarded to the PACE plan and the beneficiary was assessed for possible enrollment in that program. PACE programs are currently available in several demonstration counties (see *Table 1*). A Choice Book and Choice Form, along with a detailed Health Plan Guidebook, was sent to beneficiaries a few days following the 60-day Notice. At the 60-day mark, the State sent Medicare and Medi-Cal claims and IHSS data to the plans for them to begin preparations for enrollment.

All notices were reviewed by CMS and followed stringent marketing requirements. The 30-day notice confirmed the plan selection and provided the prospective enrollee the start date of enrollment and contact details for the enrollment broker to select another plan, if desired. In addition to the enrollment broker, Health Care Options (HCO) in non-COHS counties, phone numbers were also provided for the Health Insurance Counseling and Advocacy Program (HICAP), Medicare, and the Cal MediConnect Ombudsman Program. Telephone lines with third-party translators were available if these offices do not have staff who meet enrollees’ linguistic needs. The vendor operating HCO is Maximus. HICAP serves as the Aging, Disability Resource Centers (ADRCs) in California.

The original enrollment forms, based on those used for Medicare Advantage enrollment, had not been field tested for the Cal MediConnect population and reportedly were confusing to beneficiaries and stakeholders. The State and CMS revised these forms and the Choice Book in summer 2014, but the problem was not fully resolved. The later versions contained simplified language and layout and were tested with beneficiaries, but stakeholders, the Cal MediConnect Ombudsman Program staff, and plans reported that the primary confusion had still not been addressed—that is, the forms did not contain an opt-out option for the demonstration. Because the CCI includes mandatory enrollment in a managed care plan for Medi-Cal benefits if the beneficiary did not choose to enroll in the demonstration, the form still required the selection of a managed care plan but clarified that this was how the beneficiary could “keep their Medicare” as they currently had it. The term “opt out” had been used by the State on stakeholder calls and in various documents, and beneficiaries who wanted to retain their Medicare FFS provider had been advised to opt out, yet the form did not explicitly contain this option. According to organizations assisting beneficiaries, this was a frequent reason for contact; their staff often had to explain to

beneficiaries that choosing a Medi-Cal managed care plan was the same as opting out of the demonstration.

This process proved very frustrating to beneficiaries, who reported during focus groups that they threw these notices away without opening them. Some quotes from focus group participants who discussed the enrollment process are below:

When I received the letter about the change [to] MediConnect, I got confused. Well, because they said something like this... “You have to choose between your health plan or be associated with MediConnect by this date,” and they gave you a deadline. But they never explained what MediConnect was. They said there was a new change in Medi-Cal... But they never explained how this MediConnect was going to improve the services.

I don't think there is enough information for us to really choose between this Cal MediConnect or the other options. So at the very beginning, it's really confusing. Even right now... And there's not any help group or any information group set up for us to understand the plan or how it works.

I had to try to understand what all these terms mean, and I was like, “Well, who are they? [plan name] and then who is Medi-Cal?” ... I think the senior population has a lot of information thrown at them, and it's a little bit difficult to keep track of everything.

In addition to the changes in design and language of the notices and the Choice Book, stakeholders requested a description of the planning process for sending notices to beneficiaries. In response, DHCS released a comprehensive list of steps and timelines indicating when notices would be sent to specific enrollee groups. This allowed stakeholders to educate beneficiary groups before they received the notices. As one stakeholder said, “The program is so inherently complicated... a notice would never be enough... [notices] need to be distributed earlier so we can help [beneficiaries understand] them.” HICAP and Cal MediConnect Ombudsman Program staff reported assisting beneficiaries who, after visiting a pharmacy or attempting to visit their usual provider, learned that a change had taken place in their health coverage. In their first SDRS submission, State officials reported a variety of enrollment problems that occurred within the first quarter of the demonstration that affected more than 30,000 members. The main issues were delayed notices, inappropriate enrollments (e.g., beneficiaries in waivers, receiving ESRD services, with other health insurance, residing in ICFs or regional centers), or premature enrollments. Other issues included incorrectly processing opt-out requests, or not processing them on a timely basis.

The errors were discovered by DHCS and through reports from beneficiaries, stakeholders, and Cal MediConnect Ombudsman Program staff. State representatives then contacted the affected beneficiaries, mailed updated notices, and alerted relevant parties, including participating plans, stakeholders, HICAP, and HCO. They also created fact sheets explaining the issues and posted them on relevant pages of the CalDuals website and, in the case of late notices, adjusted the enrollment start dates for some populations to maintain the 90-, 60-, 30-day notification periods.

These errors occurred because of incorrect flags in the HCO enrollment system and in the computer program that selected addresses, incorrect programming logic, system delays in creating and mailing notices, and initial lack of rigorous quality control measures. During 2014, State staff reported that these errors had been corrected, and staff were subsequently especially vigilant in their quality control processes. They also explained that the State's computer system used for eligibility and enrollments was outdated, required multiple processes and reviews by operators, and was generally labor intensive and thus prone to error.

In June 2014, shortly after the enrollment and notice issues emerged, Justice in Aging (formerly the National Senior Citizens Law Center) developed a *fix-it list*, which listed the problems noted above, as well as other enrollment issues, such as (1) reports of misinformation to beneficiaries from HCO and from Part D plans, (2) reports of Medicare providers' refusing to provide care to beneficiaries who had opted out of the demonstration and were newly enrolled in Medi-Cal managed care plans, and (3) beneficiaries who temporarily lost Medi-Cal eligibility and were then disenrolled from their Cal MediConnect plans. DHCS also created and published an ongoing list of issues and updated it as the issues were resolved.

Enrollment errors were the focus of public and the State's attention in the first 8 months of the demonstration. The State and CMS monitored the process leading up to the large and complex enrollment of January 2015, which generated relatively few concerns. Enrollment for subsequent groups and counties continued on track.

The eligibility requirements and enrollment schedule of Cal MediConnect were complex. Beneficiaries with or without certain medical conditions, and/or who received services through certain waivers or programs, or who were living in certain ZIP codes, or types of residences, were included either in the demonstration or in the MLTSS part of the CCI. Another complexity was the variation in the type of counties participating in the demonstration (e.g., those with a single plan; with many plans; the most populous, Los Angeles County) and the enrollment schedule discussed in **Section 3.2.2**. The RTI evaluation team learned that eligibility and enrollment decisions were developed and determined almost entirely by State leadership and policy staff without consulting the operations staff who were responsible for executing the eligibility and enrollment processes. Had operations staff participated in the demonstration design, the selection of special populations for eligibility may have been more manageable, considering the limitations of the State's administrative support systems. These challenges were highlighted during the initial months of the demonstration when notices were sent to subgroups incorrectly. The complex eligibility requirements also challenged staff and contractors, including the enrollment broker, responsible for programming the broker's system with eligibility criteria and for advising beneficiaries who may be cognitively impaired. Several policy and operations staff reflected that, in hindsight, inclusion of operations staff in discussions about the feasibility of some design features could have provided insights into the practicalities of the enrollment roll-out and probably would have improved outcomes of the enrollment process and limited the number of challenges that occurred.

3.3 Enrollment Data

As of December 1, 2016, approximately 113,600 beneficiaries were enrolled in the Cal MediConnect demonstration, representing approximately 24 percent of the eligible population.

Table 3 displays the number of Medicare-Medicaid beneficiaries who were eligible for passive enrollment and who were mailed 90-day notices from the beginning of the demonstration until 2016; the last passive enrollment notice was sent for an enrollment effective date of July 1, 2016. To control enrollment volume in a given month, the State implemented staggered eligibility for passive enrollment based on birth month or by population group. As discussed in **Section 3.2.2**, eligibility for passive enrollment increased steadily. Beneficiaries were sent 90-day enrollment notices monthly during the passive enrollment process by MMPs in the COHS counties or by DHCS for the remaining counties.

Cumulatively, 131,824 individuals were eligible for the demonstration for an effective enrollment date on or before September 1, 2014. That number climbed to 369,188 for an effective enrollment date on or before March 1, 2015; 425,442 for beneficiaries who would be passively enrolled by September 1, 2015; and 475,552 for an effective enrollment date the following year.

Table 3
Cumulative Cal MediConnect eligibility and enrollment
as of December 2016

Indicator	September 2014	March 2015	September 2015	March 2016	September 2016	December 2016
Eligibility						
Total eligible for enrollment	131,824	369,188	425,442	461,713	475,552	475,552
Enrollment by county						
San Mateo	2,673	10,100	9,849	9,503	9,314	9,391
Riverside	5,900	15,396	14,209	13,671	13,317	13,445
San Bernardino	5,534	15,202	14,141	13,359	13,011	13,264
San Diego	8,779	20,256	17,359	15,595	14,399	14,339
Los Angeles	21,918	54,541	48,885	41,778	37,267	36,037
Santa Clara	n/a	8,744	11,158	12,087	10,767	10,380
Orange	n/a	n/a	1,706	17,567	17,691	16,745
Total enrollment	44,804	124,239	117,307	123,560	115,766	113,601
Percentage enrolled	34.0%	33.7%	27.6%	26.8%	24.3%	23.9%

NOTES: Enrollment in the demonstration is effective on the first day of the month.

Santa Clara County began enrollment in January 2015; Orange County began enrollment in July 2015.

SOURCES: Cal MediConnect Monthly Enrollment Dashboards (California Department of Health Care Services, CalDuals website).

Because of the complex enrollment schedule by birth month, program type, and county, enrollments do not show a straightforward trend (see **Table 2**). Enrollments increased steadily from 44,804 in September 2014, after 6 months of enrollment, to 124,239 one year after Cal MediConnect had begun, as enrollees were passively enrolled by birth month or chose to opt into the demonstration. By September 2015 enrollments dipped to 117,307 due to the number of opt-

outs and disenrollments. After the January 2016 D-SNP and Part D LIS passive enrollments in Orange County, enrollments increased again to 123,560, by March 2016. Eligible beneficiaries, including those who chose to disenroll or to opt out earlier, may always opt into the demonstration; however, the State does not report opt-in enrollments separately. The demonstration had enrolled a little more than one third (34 percent) of the eligible population in the first year, but enrollments decreased to approximately 24 percent of eligible beneficiaries by December 1, 2016. DHCS did not report opt-out requests or disenrollment numbers beyond the early months of the demonstration; however, it did report percentage rates of these categories in the monthly enrollment dashboard on the Cal Duals website as discussed in *Section 3.3.1*.

3.3.1 Opt-out and Disenrollment Rates

Plan and State staff told the RTI evaluation team they anticipated that approximately 40 percent of the eligible population would opt out of the demonstration, primarily due to beneficiaries' desire to retain their current Medicare FFS provider. Within the first 6 months, it was evident that there was a higher proportion of smaller, independent providers, particularly in Los Angeles County, who encouraged their patients to opt out or disenroll from the demonstration. The State began analyzing demographic data of beneficiaries who had opted out or disenrolled from the demonstration and included these data in their monthly enrollment dashboard (California Department of Health Care Services, 2016d).

Overall, the State reported that 50 percent of those eligible for the demonstration chose to opt out. Another 21 percent had disenrolled as of March 2016, when the State froze enrollment reporting metrics except for San Mateo and Orange counties. County opt-out rates ranged from 10 percent in San Mateo County to 58 percent in Los Angeles County. In Orange County, the last county to enroll, the opt-out rate was 51 percent. The total number of those who had opted out was not reported by the State; however, cumulative percentages by county, ethnic/racial groups, and languages spoken, were reported. Among the highest opt-out rates by ethnic or racial groups are beneficiaries who identified as Chinese, Amerasians, White, and Korean, ranging from 72 to 79 percent respectively in Los Angeles County. Vietnamese and Korean beneficiaries in Orange County, the county with the second highest opt-out rate, were among the highest at 71 and 75 percent, respectively.

Analyses by the primary language spoken by those who had opted out show that the highest opt-out rates in Los Angeles County were among speakers of Farsi, Armenian, Hebrew, and Russian (82 to 94 percent). In Orange County, the analysis showed Vietnamese, Korean, Chinese, and Hindi speakers (73 to 80 percent) were the highest. Opt-out rates among eligible beneficiaries who received IHSS services were also very high. Overall, 61 percent of these beneficiaries opted out and another 21 percent disenrolled as of March 1, 2016, when the State froze enrollment reporting metrics except for San Mateo and Orange counties (California Department of Health Care Services, 2016e).

In June 2016, DHCS officials completed a comprehensive cluster analysis that linked beneficiaries who had opted out of the demonstration to providers who were linked with high numbers of beneficiaries who had opted out (California Department of Health Care Services, 2016f). The analysis showed that 1,551 providers were associated with approximately 84,000 beneficiaries. The State identified these providers for personal contact by MMPs and by DHCS

contractors for outreach and education about Cal MediConnect. Provider toolkits and beneficiary enrollment materials were among the materials provided to these providers during in-person contact or by mail in an effort to explain the demonstration goals and encourage them to participate. MMP officials informed the RTI evaluation team of their efforts to meet with these providers in the summer of 2016, noting that many were providers who participated in the MMPs' other product lines. They speculated that these providers had encouraged their patients to opt out due to a lack of understanding of the demonstration and the features that could support their patients. The analysis of these labor-intensive efforts with these providers was ongoing at the time of this report. RTI will continue to monitor these activities.

3.3.2 Factors Influencing Enrollment Decisions

Unclear enrollment materials and processes, satisfaction with current providers, and negative reports about managed care in general were the main reasons beneficiaries chose not to enroll in Cal MediConnect, according to interviewees. Although the enrollment process was extensive and included multiple notices, the materials did not clearly explain new benefits or provide a definition of care coordination, or explain the differences among plans. Potential enrollees with complex needs who were pleased with their current PCP and specialists and who knew the costs of those services were reluctant to be enrolled into a demonstration in which these aspects were unknown. Beneficiaries who had long-term relationships with their providers who knew their culture and spoke their language were reluctant to change to a new system of care with an unknown provider. Fee-for-service providers who were generally reluctant to join managed care, but wanted to retain their patients, reportedly sent form letters to their patients informing them that if they enrolled in the demonstration, the provider would cease to provide care. Other providers posted notices in their offices to this effect, and some individuals posted YouTube videos in ethnic languages explaining how to opt out.

Reluctance to participate in managed care was reported by plans and stakeholders as an underlying motivation among providers for early efforts to halt the demonstration, and later to advocate for beneficiaries to opt out. State officials, plans, and stakeholders all reported that fear of managed care was a major factor in opt-out campaigns, particularly by independent providers, including those who serve ethnic communities. Small physician practices were reported to not have the infrastructure to comply with reporting requirements of the demonstration.

Opt-out campaigns by provider groups had been a feature of the demonstration since the planning stages. Two court cases aimed at stopping the demonstration were initiated in the early months of the demonstration; one was dismissed by the courts and one was withdrawn by the plaintiffs. Some opt-out efforts appeared to be promoted by nursing facilities, provider practice groups, or individuals. The Los Angeles County Medical Association consistently recommended opt-out to beneficiaries. Press reports of demonstration activities had not been positive and may also have contributed to a negative public image of the demonstration.

Moreover, because of a change in State policy regarding D-SNPs, plans operating outside of the demonstration encouraged opt-outs and intensified their Medicare Advantage plan marketing to attract beneficiaries eligible for Cal MediConnect (California Department of Health Care Services, 2014a). This policy exempted beneficiaries from passive enrollment in the demonstration if they enrolled in a D-SNP operated by a non-Cal MediConnect plan by

December 1, 2014. Plan representatives expressed frustration that “there is a ton of negative messaging going on and we are not quite free to do positive messaging because there are rules and regs on what we can do in terms of marketing... but there are no restrictions on the other side and they can go as negative as they want.” In 2015, the RTI evaluation team learned of negative behavior of enrollment brokers. In counties with multiple plans, brokers were financially motivated to steer beneficiaries into Medicare Advantage plans in order to secure their future commissions.

RTI did not conduct evaluation activities with beneficiaries who had opted out or disenrolled from Cal MediConnect; however, two DHCS evaluators did. From June 2015 through September 2016, Field Research Corporation conducted four waves of telephone polling survey calls with Cal MediConnect enrollees and beneficiaries who had opted out of the demonstration (Field Research Corporation, 2016b). Note that passive enrollment had taken place from the start of the demonstration through July 2016. Survey findings showed the reasons given by beneficiaries who chose not to participate in Cal MediConnect generally reflected findings from RTI interviews with stakeholders and plans.

- The three most frequently cited reasons for not enrolling in Cal MediConnect were that potential enrollees were satisfied with their current health care services or they did not want to make a change (84–88 percent over four waves), they did not want to risk losing their physician (70–73 percent over four waves), or they did not want to risk losing their medicines (63 percent over waves three and four, the only waves in which this question was asked).
- Slightly less than half also said they did not understand the information they received enough to make the change (46–48 percent over four waves) or thought their benefits or services might be reduced (37–45 percent over 4 waves).
- In the first survey, 20 percent reported that their doctor or other health provider recommended that they not participate in the program. In the wave 4 survey, this was reported by 16 percent of those who had opted out.

UC Berkeley, another DHCS evaluator, conducted focus groups and telephone interviews with enrollees and with those who had opted out of the demonstration. Their findings from telephone interviews conducted in January through March 2016 show that 43 percent of those who opted out were unaware that they had opted out. Of those who were aware, 28 percent were advised by someone else—generally a health care provider—to opt out.

3.3.3 Deeming

From the beginning of the demonstration, plans and stakeholders expressed their frustration with automatic disenrollment from the Cal MediConnect plan after an enrollee’s temporary loss of Medi-Cal eligibility. The temporary loss of Medi-Cal eligibility typically resulted from a minor error, such as an incomplete renewal application. Without a “deeming” or grace period for a Cal MediConnect enrollee in which he or she is deemed eligible, enrollees are dropped from the demonstration. The beneficiary often receives the disenrollment notice from the State before the plan receives notification, compounding the confusion. The beneficiary’s

benefits change to FFS Medicare and Low Income Part D for prescription medications temporarily, but the beneficiary is not reenrolled in Medi-Cal until the error is resolved. According to plans and Ombudsman Program staff, this disruption resulted in access problems when beneficiaries tried to fill prescriptions, learned that their drug plan had changed, and could not fill their prescriptions.

This automatic shift to Medicare FFS was particularly confusing for beneficiaries who had been enrolled in a D-SNP or other Medicare Advantage plan prior to joining Cal MediConnect. When the beneficiary was eventually reenrolled in Medi-Cal, plans reported that the enrollee was reluctant to reenroll in Cal MediConnect. Outside of Cal MediConnect, Medi-Cal has a deeming period; had the beneficiary been enrolled only in Medi-Cal, and temporarily lost eligibility, Medi-Cal benefits would have continued from 3 to 6 months, depending on the county of residence.

In response to these care disruptions, in July 2015, DHCS announced that all Cal MediConnect plans had elected to implement a deeming period of 30 days with the exception of Health Plan of San Mateo, which has a 60-day deeming period. Enrollees may also request a separate protection—Aid Paid Pending—should they receive a notice of termination of their Medi-Cal benefits. Cal MediConnect enrollments and benefits are protected if enrollees apply for this protection 10 days before the effective date of their termination. As a result of continued stakeholder and plan feedback, in April 2016, DHCS announced its intention to explore a 60-day deeming period for all enrollees in the demonstration.

In September 2016, CMS revised its enrollment guidance to States participating in the Financial Alignment Initiative and specified that States may rapidly re-enroll enrollees back into their original MMP due to temporary loss of Medicaid (Centers for Medicare & Medicaid Services, 2016b). This could occur if the enrollee regains Medicaid within 2 months after the effective date of disenrollment. As of December 2016, California has not yet indicated it will be able to move forward with this proposal.

3.3.4 New Enrollment Strategies and Resources

Recognizing decreasing enrollments in Cal MediConnect, in April 2016, DHCS issued a draft strategy designed to ensure sustainable enrollment in the demonstration. The State proposed that annual passive enrollment would resume for beneficiaries who recently moved into Cal MediConnect counties, and who obtained dual eligible status, either by having Medi-Cal and reaching age 65 and becoming eligible for Medicare, or by having Medicare and becoming eligible for Medi-Cal. The MMPs were pleased with this proposed strategy that they hoped would ensure continued enrollments. However, after a public comment period and significant feedback from stakeholders who opposed passive enrollment for new dual eligible beneficiaries, the proposal was withdrawn. DHCS officials indicated that, although this was not successful in 2016, it might be possible in the future.

In addition to improved deeming discussed above (***Section 3.3.3***) and improved beneficiary materials and mailings discussed below (***Section 3.3.5***), the draft strategy also included a plan for streamlined enrollment whereby MMPs could submit enrollment changes directly to DHCS on behalf of their members, rather than the MMP member contacting the

State's enrollment broker, Health Care Options. This change would not apply to MMPs in the two COHS counties that do not use the enrollment broker; staff in these plans administer enrollments themselves. Under the new streamlined enrollment in the five counties, beneficiaries are protected in this activity because HCO and the MMP both contact the beneficiary to confirm the beneficiary's choice. New enrollees may change MMPs or disenroll from the demonstration at any time. Streamlined enrollment became effective in fall 2016; in October, DHCS announced that in the first month 400 beneficiaries were enrolled through this method. Although disappointed that passive enrollment was not approved, MMP interviewees were hopeful that streamlined enrollment would 'eliminate the middleman' and improve conversions from other MCO products to Cal MediConnect.

3.3.5 Beneficiary and Enrollee Materials

With input from the stakeholder community and consumer testing by Health Research for Action researchers at UC Berkeley, DHCS issued a beneficiary toolkit in August 2016 (California Department of Health Care Services, 2016n). The 23-page document, produced by Harbage Consulting, capitalizes on lessons learned from Field Research telephone surveys with enrollees and with beneficiaries who had opted out of the demonstration. Information focuses on reasons to join Cal MediConnect, things to consider when making a decision to opt in, and how to opt in. Explanations of all relevant services are provided as is contact information. The toolkit is available in seven languages as of December 2016.

In September 2015, DHCS released a draft resource guide, produced by Harbage, for new dually eligible beneficiaries in the demonstration counties. After stakeholder comment and consumer testing, the State issued the new Cal MediConnect and Medi-Cal Managed Care Plan Resource Guide in October 2016 (California Department of Health Care Services, 2016b). The guide complements the Managed Care Choice Book that includes sample choice forms and examples of passive enrollment notices DHCS sends to beneficiaries for the demonstration and for MLTSS (California Department of Health Care Services, 2016h). The guide provides comparisons of services in the demonstration to original Medicare and Medi-Cal managed care, describes benefits of the demonstration including continuity of care provisions, and explains the types of LTSS services available in the demonstration. According to DHCS, these materials have been responsible for increased interest and enrollment in the demonstration. Both the beneficiary toolkit and new resource guide are aimed at beneficiaries; however, they are also useful to HICAP and Ombudsman Program staff and others who are involved with eligibility and enrollment.

The California Collaborative for LTSS had long supported improved materials to beneficiaries and provided feedback on both the toolkit and the resource guide. In July 2016, this organization also recommended 11 detailed activities designed to support opt-in enrollment. These recommendations included improved training of staff involved in eligibility and enrollment activities (including the enrollment broker, HICAP, Ombudsman Program staff, etc.), enrollment materials, timing of notifications, outreach to ethnic providers and communities, and other suggestions (California Collaborative for Long Term Services and Supports, 2016). At the time of the September 2016 site visit interviews, DHCS was considering these recommendations.

3.4 Successes

In 2014, State officials identified their ability to make frequent adjustments to the enrollment schedule to accommodate unexpected events as a success, noting that it showed their flexibility. Although these adjustments enabled the State to move forward where it could, the frequent changes generated additional work to update marketing materials and to provide additional outreach and clarifications to inform beneficiaries, stakeholders, and providers. However, the frequent changes also generated concern among stakeholders and providers about plans' readiness.

After quality improvements were made, problems with enrollment notice mailings improved. These problems occurred primarily in the beginning of the demonstration. Subsequently, the State put extra checks in place and developed more robust quality improvement oversight. Consequently, few enrollment problems were noted after 2014.

Deeming and continuity of care adjustments improved enrollees' access to care. DHCS and CMS adjustments to deeming and continuity of care, in 2015 and 2016, respectively, allowed enrollees to remain in the demonstration and receive health care while their Medi-Cal renewal was pending or when they required services of a provider not in the demonstration. During the continuity of care period, MMPs conduct outreach to the provider to encourage participation in the demonstration. Both adjustments were praised by stakeholders and plans as major improvements to Cal MediConnect.

3.5 Challenges

A complicated schedule and enrollment process contributed to a repeat of many errors that had occurred with a similar population in an earlier initiative. Issues that arose during the Cal MediConnect enrollment also occurred during the transition of 400,000 seniors and persons with disabilities (SPDs) to mandatory managed care in 2012. That process served as a guide for the 2014 enrollment in Cal MediConnect. The State had taken steps to prevent the repetition of these issues by developing a more robust stakeholder and provider outreach process. It also provided historical claims data to the MMPs in advance of Cal MediConnect enrollment to improve address accuracy and HRA risk stratification, and to enable MMPs to plan for care coordination earlier in the enrollment process. After the demonstration began and it became clear that the enrollment materials could be improved, the State revised and tested them.

Despite these efforts, both the SPD transition and Cal MediConnect were marked by difficulty of plans to reach passively enrolled beneficiaries because of incorrect contact information; stakeholders' inability to answer beneficiary questions correctly; continuity of care disruptions; and lack of experience by plans in serving a very impaired population with complex care needs. Continuity of care disruptions occurred in the demonstration, although fewer than that in the SPD transition. The similarities were noted by providers who cited the SPD transition as the reason they encouraged their patients to opt out of the demonstration.

Beneficiaries had little awareness or understanding of the demonstration, the effect on their services, or even that they had been enrolled. In the first year of the demonstration, HICAP and Ombudsman Program staff reported that beneficiaries who called help lines typically discovered they had been enrolled after visiting a pharmacy or attempting to visit their usual provider. Some learned they had been enrolled when their surgeries were canceled abruptly.

Callers to help lines wanted to know how and why this had occurred, what the demonstration was, and to understand the ramifications of their enrollment. Most callers had not received notices, had not opened them, or had not understood them, according to the stakeholders. In 2016 focus groups, enrollees who had been enrolled for 9 months or more remarked on their confusion with demonstration materials and difficulty with differentiating the demonstration, plans, and benefits.

Enrollment has not transpired as expected. Opt-out rates occurred at 37 to 58 percent in all counties except San Mateo, which had an opt-out rate of 10 percent. Los Angeles County, which originally had an ambitious cap of 200,000 during the demonstration design, had 36,000 enrollees as of December 2016. Beneficiaries in various groups—those participating in IHSS, ethnic, and linguistic minorities—opted out at high rates. In spring 2016, DHCS proposed a number of initiatives to boost enrollment, including introducing passive enrollment for newly eligible beneficiaries, streamlining enrollment, and making program improvements to encourage opt-in enrollment. Though plans supported continued passive enrollment, stakeholders did not and it did not go forward.

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4. Care Coordination

Highlights

- Under Cal MediConnect, MMPs provide beneficiaries with care coordination services to align their primary, acute, behavioral health, and LTSS care needs. State officials, plan representatives, and stakeholders have widely considered care coordination to be valuable in helping to meet beneficiaries' needs.
- Only 35 percent of survey respondents enrolled in the demonstration reported receiving care coordination, and focus group participants have remained unaware that the service is available. As of 2016, care coordination fulfilled its promise for a relatively small fraction of Cal MediConnect enrollees.
- Plans have varied widely in their organizational structures and approaches to delivering care coordination services. All plans reported hiring new staff and setting up new systems during early implementation to deliver care coordination. Co-locating staff in county agencies has worked for some plans.
- Some enrollees who have worked with a care coordinator reported high satisfaction with care coordination services and using care coordinators to manage services or resolve problems. However, beneficiaries also reported a wide range of experiences with care coordination.
- With varying levels of success, plans have been working with State and county agencies and providers to coordinate LTSS and behavioral health services. Beneficiaries and stakeholders observed insufficient or duplicative care coordination under the demonstration. Information exchange and communication between some plans and agencies has been problematic as they each tried to understand each other's language, processes and procedures. Preserving confidentiality while sharing data to coordinate care has been a major challenge.
- The California Department of Aging's training program for MMP care coordinators specifically focusing on Alzheimer's disease was awarded the 2016 Rosalinde Gilbert Innovations in Alzheimer's Disease Caregiving Legacy Award for one of the best practices in care coordination nationwide.

4.1 Care Coordination Model

Coordination of care is fundamental to the California demonstration. Cal MediConnect plans are responsible for coordinating services related to enrollees' primary, acute, behavioral health, and long-term services and supports (LTSS) care needs. Implementation of the care coordination model has varied slightly across plans, but all must meet standards defined in the Memorandum of Understanding (MOU), three-way contract and dual plan letters (DPLs) (State of California, MOU, 2013, pp. 68–79; California three-way contract, 2014, pp. 46–50; California Department of Health Care Services, 2013c, d). This section provides an overview of the

demonstration requirements as well as implementation experience related to the care coordination function, including assessment processes; use of interdisciplinary care team (ICTs) and the development of individualized care plans (ICPs); delivery of care coordination services; and the role of care coordinators. The experience of Medicare-Medicaid Plans (MMPs) and beneficiaries are included in this section as is the care coordination of LTSS and behavioral health services and data exchange.

4.1.1 Assessment

After beneficiaries are enrolled, a health risk assessment (HRA) is used to identify primary, acute, behavioral health, LTSS, and functional needs of each enrollee. The demonstration's MOU and three-way contracts detail specifications for assessing enrollees' risk. Cal MediConnect plans were each required to develop a risk-stratification method for identifying newly enrolled enrollees who are at high or low risk and a tool for conducting the assessment for approval by the State.

The State uses risk stratification to classify enrollees into categories to determine how quickly an assessment should be completed. The risk-stratification method each plan employs is required to include criteria such as use of oxygen within the past 90 days, three or more emergency department visits during the past year, hospitalizations within the past 90 days, In-Home Supportive Services (IHSS) hours greater than 195 hours per month, enrollment in certain waivers, current treatment for certain diseases, and polypharmacy. Within 60 calendar days prior to enrollment, DHCS and CMS transmit historical Medicare and Medi-Cal utilization data, IHSS, and Multipurpose Senior Services Program (MSSP) assessment and utilization data, behavioral health pharmacy, Part D pharmacy, and other data to the plans for their use in this process (California Department of Health Care Services, 2013d). At a minimum, plans must be able to identify new enrollees who are at higher risk or have more complex health care needs; however, most plans reported developing multiple risk categories. Enrollees stratified as higher risk are considered to be at increased risk of having adverse or worsening health outcomes or whose health conditions require monitoring. Effective December 1, 2014, plans were required to stratify new enrollees with no historical data, or enrollees they could not reach, as higher risk (California Department of Health Care Services, 2015c). Enrollees who received LTSS and behavioral health services prior to the demonstration are also categorized as higher risk.

For higher risk enrollees, plans must complete an HRA that leads to a plan of care and care coordination within 45 days of the coverage date. All other enrollees, including those residing in nursing facilities, are required to have their assessments completed within 90 days. Reassessments are conducted at least annually for all enrollees, or as often as the enrollee's health requires (MOU, 2013, pp. 70–2; California three-way contract, 2014, p. 46). Plans are required to offer in-person HRAs to all enrollees, to document their outreach efforts to engage enrollees, to provide materials and conduct the assessment in the enrollee's language or preferred format, and to involve caregivers as requested by the enrollee. Enrollees can choose to complete the HRA in person, by telephone, or by mail.

The State did not develop a standardized health risk assessment tool; instead, DHCS specified requirements for each plan to follow in developing its own tool. Each plan's Cal MediConnect assessment tool has been approved by CMS and the State, and encompasses

primary, acute, LTSS, behavioral health, and functional needs, and incorporates standard assessment questions, such as the SF-12.

To ensure that enrollees are assessed for unmet need for personal care and for other potential gaps in housing and social services, in May 2016, DHCS released a set of standardized HRA referral questions for LTSS (California Department of Health Care Services, 2016m). Following a review of plans' existing HRA questions, DHCS identified new or revised questions to include in the standardized set. These questions assessed enrollees' functional ability, such as any need for assistance with activities of daily living; current services such as transportation, personal care, or mental health case management; health status; nutrition risk; behavioral health; and home environment. DHCS convened a workgroup to review and refine these questions and expected they would be ready for use in early 2017.

According to DHCS's requirements, plans must make at least five attempts to reach high-risk enrollees by telephone within the first 30 days of enrollment and offer an in-person HRA or, if the enrollee agrees, the HRA may be completed on the phone at that time. Plans may mail the enrollee the assessment tool during the first 10 days if the plan has made a good-faith effort to contact the enrollee. After 30 days, if a plan is unable to complete the HRA, it must mail it to the enrollee, and after 41 days, the plan must make another phone attempt. If the enrollee does not respond to the plan's outreach, the plan must mail an HRA to the enrollee 6 months following the enrollee's coverage date. For enrollees determined to be at lower risk, plans are required to make at least two phone call attempts to contact the enrollee within 30 days of enrollment; after 30 days, plans must mail the HRA to the enrollee. If the HRA is not completed by 60 days, plans must send a second mailing; after 85 days, plans must attempt another phone contact. After 6 months, plans must again mail the HRA to the enrollee if it has not been completed by that time. The evaluation team heard reports of beneficiaries receiving 12-page assessment tools through the mail; some included incentives, such as gift cards, for completing the form and returning it to the plan.

Reaching Enrollees

Conducting HRA assessments was the main goal of MMPs in the first year of the demonstration. In the 2014 site visit, plan representatives told the RTI evaluation team it was too early to provide feedback on the care planning or care coordination processes because their care coordinators were spending the majority of their time on simply reaching enrollees. When describing efforts to reach new passively enrolled beneficiaries, who may or may not be aware of their enrollment in Cal MediConnect, MMPs acknowledged that this was a greater challenge and a more time-consuming task than originally anticipated.

Plans used creative ways to make contact with this difficult-to-reach population. In addition to trying to contact beneficiaries by telephone, care coordinators contacted providers, including IHSS and other community-based providers, and visited places where beneficiaries would be receiving services, such as dialysis centers, Community-Based Adult Services (CBAS) centers, pharmacies, and senior centers. One MMP described going as far as visiting local jails and homeless shelters. Some plans contracted with commercial vendors for phone and address tracking. Care coordinators also attempt to visit enrollees in their homes and contact the providers most frequented by enrollees, as identified from claims data. One plan reported deploying a field team of unlicensed lower-level outreach coordinators to knock on doors, which

substantially improved their HRA completion rates. Another plan provided cell phones to new enrollees who had completed an assessment so that they would be able to reach each other in the future to arrange for provider appointments. In summary, across all plans, leadership staff reported high investments in staffing, time, and resources in the start-up phase of the demonstration to reach new enrollees and complete HRAs. These extensive efforts were, in part, due to the use of HRA completion rate as a quality withhold measure in the Cal MediConnect demonstration. Plans report data on HRA completion to DHCS and CMS on a quarterly basis as part of ongoing quality monitoring efforts. In order to receive their full capitation payments, plans must meet their targets for this measure.

Table 4 presents the rates for un-locatable enrollees by MMP. By the last quarter of 2014, Cal MediConnect plans were unable to reach nearly half of their enrollees (47.8 percent) following three contact attempts within 90 days of enrollment. This percentage gradually decreased in subsequent years, ranging from approximately 35 to 39 percent in 2015, and from 23 to 35 percent in 2016. Although plans became more strategic and achieved greater success at establishing contact with new enrollees, tracking enrollees and maintaining contact remained a challenge as the demonstration progressed. As of the time this report was produced, the evaluation team did not have data on the cumulative number of enrollees who have not been reached.

Table 4
Percentage of enrollees that Cal MediConnect plans were unable to reach following three attempts, within 90 days of enrollment, by quarter

Quarter	CY 2014	CY 2015	CY 2016
Q1	N/A	34.6%	23.2%
Q2	15.0%	37.2%	32.5%
Q3	43.5%	38.5%	34.5%
Q4	47.8%	37.1%	23.2%

CY = calendar year; N/A = not applicable.

NOTES: The California demonstration began in Q2 2014 with opt-in enrollment in San Mateo County, therefore Q2 data are limited. Data presented in Q2 2014 represent the seven plans that were active in calendar year 2014 (Care1st, Community Health Group, Health Net, Inland Empire Health Plan, L.A. Care, Molina Healthcare, Health Plan of San Mateo). In Q3 2014, Anthem Blue Cross began reporting data. In Q2 2015, Santa Clara Family Health Plan began reporting data. In Q3 2015, Cal Optima began reporting data. Percentages reflect number of enrollees that the MMP was unable to reach among enrollees whose 90th day of enrollment occurred within the reporting period.

SOURCE: RTI analysis of MMP reported data for Core Measure 2.1, as of May 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>.

Overall trends show HRA completion rates increasing over time. **Table 5** shows among all enrollees, rates for timely HRA completion ranged from 32 to 48 percent in 2014, 44 to 48 percent in 2015, and 47 to 61 percent in 2016. Among enrollees who were reachable and willing to participate, rates for timely HRA completion ranged from 77 to 85 percent in 2014, 81 to 87

percent in 2015, and 88 to 92 percent in 2016. These reports do not indicate whether assessments were conducted in person, by phone, or by mail. Although HRA completion rates were improving over time, plan representatives report that enrollees are often unwilling to participate or consider the full assessment unnecessary to complete.

Table 5
Total percentage of enrollees whose assessment was completed within 90 days of enrollment

Calendar quarter	Total number of enrollees whose 90th day of enrollment occurred within the reporting period	Assessment completed within 90 days of enrollment	
		All enrollees	All enrollees not documented as unreachable or unwilling to participate
2014			
Q2	3,027	48.0%	76.8%
Q3	25,122	37.2%	81.3%
Q4	17,107	32.0%	85.2%
2015			
Q1	70,378	46.9%	83.1%
Q2	18,621	47.8%	86.6%
Q3	10,713	45.7%	81.6%
Q4	6,342	44.0%	81.5%
2016			
Q1	17,574	60.9%	91.7%
Q2	5,424	48.8%	89.1%
Q3	5,562	46.5%	88.2%
Q4	17,574	60.9%	91.7%

NOTES: The California demonstration began in Q2 2014 with opt-in enrollment in San Mateo County, therefore, Q2 data are limited. Because the California demonstration began in Q2 2014, no data are available for Q1 2014. Data presented in Q2 2014 represent the seven plans that were active in calendar year 2014 (Care1st, Community Health Group, Health Net, Inland Empire Health Plan, L.A. Care, Molina, and Health Plan of San Mateo). In Q3 2014, Anthem Blue Cross began reporting data. In Q1 2015, Santa Clara Family Health Plan began reporting data. In Q3 2015, Cal Optima began reporting data.

SOURCE: RTI analysis of MMP reported data for Core Measure 2.1, as of May 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>.

4.1.2 Care Planning Process

Care Coordinator Role

The care coordinator is a clinician or other trained individual employed or contracted by the plan who is responsible for providing care coordination services. Plans have varied in the level of delegation for care coordination: some MMPs have hired care coordinators directly and some have a delegated entity responsible for various care coordination components, such as

HRAs. Care coordinators have a wide range of duties, including participating in initial assessments, coordinating ICT meetings, assuring the completion of ICPs, as well as facilitating appropriate referrals, timely information exchange between the plan and providers, and safe transitions between care settings (California three-way contract, 2014, p. 4).

The three-way contract does not specify the certification or background of care coordinators (California three-way contract, 2014, p. 32). All plan representatives interviewed reported having staff with diverse backgrounds who provide the care coordination function, including registered nurses (RNs), licensed practical nurses (LPNs), and social workers; plans match the care coordinator's education, experience level, and language to the needs of the enrollee. For example, a licensed social worker might be assigned to coordinate care for an individual with primarily behavioral needs, whereas an RN coordinates care for an individual with complex medical needs.

The three-way contract allows for flexibility in the way plans organize their care coordinators. Consequently, organizational structures for care coordination vary greatly across plans. Plan-reported data indicates that in 2015, there were 1,337 care coordinators across the demonstration, 76.8 percent of whom were assigned to care coordination and conducting assessments. Some plans have different categories and assignments for care coordinators. For example, plans reported having some care coordinators assigned to reaching and assessing beneficiaries, some assigned to administrative support (such as responding to the customer service line, helping to arrange medical appointments, and resolving issues concerning durable medical equipment), and some to care teams that focus on a particular area (e.g., behavioral health, care transitions, LTSS referrals). Care coordinators with clinical licensure may be assigned to work with higher risk enrollees, while others work primarily with lower risk enrollees. These designations may determine a care coordinator's caseload. Across several plans, staff reported a caseload of 200 to 350 enrollees for higher risk enrollees. Plans also vary in the level and type of contact their care coordinators have with enrollees. For example, routine check-ins may occur over the phone in some plans and in person for others; in-person check-ins might be by an unlicensed care coordinator or a physician, depending upon the MMP. This also varies by enrollee risk level or level of need.

Many agencies and providers, including county-based behavioral health agencies, IHSS agencies, MSSP and CBAS programs, have their own care coordinators and comprehensive assessment processes. Representatives from plans, agencies, and provider groups indicated that the boundaries or possible redundancies of the different types of care coordinators had not been entirely worked out prior to the start of the demonstration. Overlap of care coordination activities continues to be an issue, particularly with respect to county-based mental health service providers, though some plans have worked closely with agencies and provider groups to facilitate communication and delineate responsibilities for care coordinators from different entities (see **Section 4.4, Coordination of LTSS**).

Overall, enrollees, who participated in focus groups and surveys, and stakeholders described positive experiences with care coordination efforts (please see **Section 5, Beneficiary Experience** for more on this topic). Care coordinators were noted to be responsive, accessible, and often successful in meeting enrollees' care needs. Plan representatives described the advantage of having a single care coordinator who has access to the enrollee's assessment

information and care plan, and who understands which agencies or providers to contact when access issues or interruptions in services occur. When asked to share specific stories related to care coordination, plans, stakeholders, and enrollees described a variety of coordination activities, including connecting homeless enrollees to transitional housing services, transitioning enrollees out of nursing facilities and into community settings, setting up transportation for medical appointments, and coordinating applications for LTSS, such as IHSS.

Despite numerous success stories from those who have worked with a care coordinator and reports of improved access to services, results from a survey conducted by a DHCS evaluator, the University of California at Berkeley, also show that only a subset of beneficiaries are benefiting from care coordination. Among survey participants, 35 percent of Cal MediConnect enrollees reported receiving care coordination, compared to 20 percent of eligible beneficiaries who opted out. Another 22 percent reported that they could use more help with care coordination (Graham et al., 2016b). Among Cal MediConnect enrollees, 33 percent of respondents were not aware that their plans can provide a care coordinator if they needed one. RTI focus group findings were consistent, showing that only a small proportion of participants were aware of care coordination services and know who their coordinator was. Because the focus group participants were receiving LTSS and or behavioral health services, they were all considered to be high risk and should have been receiving care coordination.

These findings were consistent with survey results from the Field Research Corporation, another DHCS evaluator who found that between 34 and 36 percent of enrollees responding to the survey reported having “a single care manager.” That telephone survey also found that approximately 35 percent of those who had opted out of Cal MediConnect also reported having a care manager. A similar proportion of Medicare-Medicaid beneficiaries in non-demonstration counties also reported having a care manager (Field Research Corporation, 2016a).

The Interdisciplinary Care Team (ICT)

The three-way contract stipulates the following process: the care coordinator conducts the HRA and works with the enrollee and/or authorized representative, family, or caregiver to develop an ICT tailored to the enrollee’s needs. Each enrollee is offered an ICT; enrollees may also request an ICT. The enrollee, care coordinator, and the primary provider are the core of this team, though others may participate at the discretion of the enrollee. An ICT also might include a pharmacist or social worker, family supports, and care coordinators or providers from other agencies or provider groups. Together with the enrollee, the ICT develops an ICP that includes all clinical care, behavioral health, and LTSS needs, as appropriate. The ICT also plays a role in implementing the ICP, which may include facilitating assessments, service authorizations, transitions of care, and other care management activities. Any member of the ICT may also modify the ICP, with the permission of the enrollee. ICT meetings may occur periodically, as determined by the enrollee and/or caregiver (California three-way contract, pp. 33–5).

Finding time and assembling an actual ICT meeting proved more challenging than originally anticipated by both the State and the MMPs. According to plan interviewees, these meetings typically occurred on an ad hoc basis and by phone. Sometimes, the calls occurred between individual participants without the group meeting together for a joint conversation. In cases where the enrollee’s primary language was not English, plans employed interpretation telephone lines to ensure that the enrollee was able to communicate in their preferred language.

These meetings were described as helpful for identifying and acquiring new services the enrollee needs, or facilitating necessary transitions between care settings. Some plan representatives identified these meetings as critical in bridging communication between different agencies and providers that the enrollee may interact with.

Provider participation in the ICT was another significant challenge in delivering this component of care coordination. Although plans reported inviting primary care providers to ICT meetings, most plan representatives described provider engagement and participation as low. When primary providers are unable to participate, care coordinators may follow up or send a copy of the ICP to ensure that care planning decisions are communicated back to the provider. Some plan representatives reported that providers are appreciative of this information; however, their schedules are not conducive to arranging and participating in meetings. Other MMPs reported that providers do not have a good understanding of the Cal MediConnect care coordination benefit and need to be educated and engaged. In yet other instances, there were reports by MMPs that their ICT relied on physicians employed by the MMP as medical directors. These medical directors may serve on care teams for enrollees who have more complex care needs. According to plans, these care teams meet on monthly or biweekly basis to review and authorize referrals and recommendations made by care coordinators, in place of the enrollees' PCPs. MMP medical directors also recommended use of MMP's flexible Care Plan Options (CPOs) benefits to supplement enrollees' services and meet short-term needs to enable enrollees to remain in their homes, rather than in institutions.

The Individualized Care Plan

The individualized care plan (ICP) is a plan of care developed by an enrollee and/or an enrollee's ICT or MMP. The HRA serves as the basis of the ICP, which may include the enrollee's goals and preferences, measurable objectives, and timetables for meeting care needs and for reassessment. According to language in the three-way contract, ICPs are to be completed within 30 working days of HRA completion. For enrollees who also receive behavioral health services, the ICP must include the name and contact of the primary behavioral health provider, verification of the review and approval of the ICP by both the primary care and behavioral health provider, and record of at least one case review meeting attended by the behavioral health provider (California three-way contract, 2014, p. 36). The ICP and care coordination must be person-centered and outcomes-based, focusing on the least restrictive setting and on transitions between settings.

In some instances, the ICT uses information from the HRA and develops an initial care plan for the enrollee to review. As one plan noted:

We receive the care plans, through our secure site. We then have our management information systems department upload into our clinical management database system, and then our care navigators get a reminder stating that this member needs to review their care plan. They then call out to the member and they review the care plan with the member and then identify any healthcare needs and where the member may need to be further assisted.

At the point when the care coordinator reviews the ICP with the enrollee, modifications to the ICP are made based on the enrollee's own goals, preferences, and needs. Care plans may

be critical in helping to identify gaps in care, such as routine exams or referrals that need to be followed up. Plans reported some challenges in getting enrollees to participate in their own care planning, though some plans have found success in engaging enrollees at their place of care, such as their physician's office or adult day service provider. Following the development of the ICP, the care coordinator determines any new services that the enrollee may qualify for or benefit from. Once the care coordinator is able to review the ICP with the enrollee and agrees on what services should be accessed, the care coordinator may directly reach out to the appropriate agency or provider to access the service, or, in some plan organizational structures, make a referral to another plan clinician for further review and authorization. Some plans have worked within a clinical management database to facilitate this referral and authorization process (see **Section 4.6, Information Exchange Related to Care Coordination**).

According to DHCS, trends in ICP completion rates have closely mirrored completion rates for HRAs and track enrollment numbers. **Table 6** shows that percentages of enrollees with completed ICPs has fluctuated over time. Of high risk enrollees who had a completed HRA, approximately 11 percent were documented as unreachable or unwilling to participate in developing an ICP in Quarter 1 of 2015. By Quarter 2 of 2016, this percentage had decreased to approximately 7 percent, after peaking at a high of 25 percent in Quarter 1 of 2016 when the D-SNP beneficiaries were passively enrolled (see **Table 2**). ICP completion among high risk enrollees gradually increased over time, starting at 42 percent in Quarter 1 of 2015 and reaching a high of 68 percent in Quarter 3 of 2016. The percentage of low risk enrollees who are unreachable or unwilling to complete an ICP has ranged from 18 percent in Quarter 2 of 2015, to 8 percent in Quarter 4 of 2016. Percentage of low risk enrollees with an ICP completed decreased in 2015, but reached a high of 63 percent in Quarter 4 of 2016.

Field Research Corporation, one of the State's evaluators, included questions regarding care plans in its rapid cycle polling. The results from waves three and four, completed in the spring and fall of 2016, show similar results. One-third of demonstration enrollees in wave three reported having a care plan "designed to take into account your health goals, needs, and preferences." This increased to 36 percent in wave four. Thirty-eight percent of those who had opted out of the demonstration reported having a care plan in both waves. Forty percent of beneficiaries in non-demonstration counties reported having a care plan in wave three and 42 percent in wave four (Field Research Corporation, 2016a).

Table 6
Total percentage of enrollees who had a care plan completed within 30 days of HRA completion

Quarter	Total number of high risk enrollees with an HRA completed during the reporting period	Percentage of high risk enrollees with an HRA completed who were unreachable or unwilling to complete an ICP	Percentage of high risk enrollees with an HRA and ICP completed	Total number of low risk enrollees with an HRA completed during the reporting period	Percentage of low risk enrollees with an HRA completed who were unreachable or unwilling to complete an ICP	Percentage of low risk enrollees with an HRA and ICP completed
2015						
Q1	14,854	10.5%	42.3%	22,133	8.4%	58.6%
Q2	4,534	14.8%	54.6%	9,525	18.3%	50.7%
Q3	2,579	11.7%	49.9%	6,056	18.7%	43.2%
Q4	3,520	11.1%	45.7%	5,502	17.9%	42.5%
2016						
Q1	6,099	25.0%	39.9%	7,269	16.2%	59.3%
Q2	2,230	6.5%	58.2%	2,729	11.4%	54.2%
Q3	1,811	5.9%	67.9%	2,189	10.3%	61.2%
Q4	2,114	7.4%	64.0%	2106	8.0%	62.8%

HRA = health risk assessment; ICP = individualized care plan.

NOTES: Data for these measures are not available for calendar year 2014 or Q3 2016. Data presented for Q1 and Q2 2015 represent nine plans (Anthem Blue Cross, Care1st, Community Health Group, Health Net, Inland Empire Health Plan, L.A. Care, Molina, Health Plan of San Mateo, and Santa Clara Family Health Plan). Cal Optima began reporting these measures in Q3 2015.

SOURCE: RTI analysis of MMP reported data for State-specific measures CA 1.2 and 1.4, as of May 2018. The technical specifications for these measures are in the Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements for California document, which is available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>.

As shown in **Table 7**, among enrollees with an ICP, more than half (57 percent) had at least one care goal documented in 2014, and a less than one-third (31 percent) had at least one care goal documented in 2015. Of enrollees with a revised ICP, nearly 40 percent had at least one documented discussion of new or existing care goals.

Table 7
Average percentage of enrollees with a care plan developed who had at least one documented discussion of care goals

Calendar year	Enrollment	Total number of enrollees with ICP developed	Percentage of enrollees with ICP with at least one care goal documented	Percentage of enrollees with revised ICP with at least one documented discussion of new or existing care goals
2014	59,299	19,020	57.0%	—
2015	116,742	59,077	30.8%	39.6%

— = data not available.

NOTES: Because the California demonstration began in Q2 2014, annual data for Calendar Year 2014 only includes Q2 through Q4 data. Data presented for 2014 represent eight plans that were active in this calendar year (Anthem Blue Cross, Care1st, Community Health Group, Health Net, Inland Empire Health Plan, L.A. Care, Molina, and Health Plan of San Mateo). Data presented for 2015 represent ten plans (Anthem Blue Cross, Cal Optima, Care 1st, Community Health Group, Health Net, Inland Empire Health Plan, L.A. Care, Molina, Health Plan of San Mateo, and Santa Clara Family Health Plan).

SOURCE: RTI analysis of MMP reported data for State-specific measure CA 1.6, as of December 2016. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements for California document, which is available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html>.

In fall 2016, the California CMT initiated a process to review a sample of ICPs submitted by plans which were asked to provide sample ICPs meeting certain criteria. DHCS followed these reviews with phone conferences with each plan to discuss their ICP process. The intent of this review was for DHCS to assess the ICP process, provide feedback to plans on their ICPs, and identify best practices across plans.

Care Plan Options

Care Plan Options (CPOs) are flexible benefits that plans may use to enable enrollees to live safely in their homes. MMPs did not use CPOs in the first year of the demonstration. Moreover, in 2015 and 2016, interviews with MMPs revealed uneven use of CPOs across plans. Plans relied on CPOs' benefits for varied purposes and with varying frequency. One plan used these funds to assist residents of nursing facilities find permanent housing. Another plan told of providing one-time services of a personal care attendant to bathe and clothe an enrollee to enable that person to go to a doctor's appointment (e.g., this was a homeless man who was unable to obtain medical care because of his physical appearance and hygiene). Other plans spoke of Meals on Wheels food delivery services, respite care, additional transportation services to supplement what is regularly available under Cal MediConnect, rehabilitation, and personal care services. Several plans and beneficiaries reported installation of wheelchair ramps and other home modifications. Some plans also use these funds to provide household appliances or utilities (e.g., washers, dryers, heating). At least one plan offers medical alert systems, which were reportedly the most popular service they provide under CPOs. In many cases, plans and beneficiaries reported that these supplemental services enabled enrollees to remain in their homes or to live more safely and independently. A few plans, however, indicated they had not provided any CPOs.

In summary, benefits provided by the MMPs under the CPO option are usually one-time allocations to alleviate an enrollee's specific need. In the early years of the demonstration, the expectation of stakeholders was that CPO funds would allow MMPs to enrich the LTSS service package and increase personal assistance services. By buttressing these services more broadly, stakeholders hoped that enrollees would be able to remain in the community. The effects of CPO services on institutional diversion have not been clear. In 2016, DHCS began developing a tracking tool for MMPs to report these data; results of this data collection, compared with rates of institutionalization, will be instructive.

4.2 MMP Experience with Care Coordination

During the 2015 and 2016 site visits, representatives across several plans reported that enrollee engagement remained one of their biggest challenges. Plan representatives noted that enrollees do not initially realize the value of care coordination. The concept of care coordination may seem abstract, and some enrollees dismissed it as something they do not need or can manage on their own. One plan representative reported the following:

[M]ember engagement is one of our toughest nuts. I mean, we have systems in place to outreach to enrollees to provide them the services, preventive care, their initial health assessments, and we can set up all these processes and it's a challenge to get them to actually participate, to go to the physician. Because we find that once they meet, once they engage with their physician, everything else falls into place and then we can provide the services that they need, they can get everything they want, but getting them to that point is the key.

MMPs reported that in order to develop buy-in, care coordinators have provided continuous outreach and education to beneficiaries about what the health plan can offer, and have continued to build their relationship with beneficiaries over time. MMPs also noted that beneficiaries who frequently engaged with their care coordinators reported high satisfaction with their services. MMP staff recognized that beneficiaries may not realize the need for a care coordinator until they learn of benefits that they qualify for or encounter challenges navigating the health care system. This is supported by reports from beneficiaries and caregivers who have worked with a care coordinator. In focus groups and surveys, beneficiaries often described care coordinators who connected them to LTSS and social services that they were not previously aware of (see *Section 5.2.5, Care Coordination*).

Aside from CPOs, plans have developed internal initiatives to optimize care coordination and tackle high utilization of emergency and institutional care. Community Health Group, for example, uses a team of physicians to make house calls to very high-risk enrollees who are not fully engaged in the MMP and are not receiving regular health care. These physicians meet enrollees in their homes or, when enrollees are homeless, they meet in nearby coffee shops or restaurants, to check in with the enrollee. The goal of this effort is to assess for any immediate care these high-risk enrollees might need, to set up an appointment, transportation services for primary care or specialty services, and connect them with a care coordinator. Enrollees who are targeted for this intervention often have high emergency department use and low primary care use.

Community Health Group of San Diego also contracts with hospitalists to provide case management to enrollees residing in skilled nursing facilities. These hospitalists monitor enrollees' care and health status, and identify opportunities for care transitions or other interventions. Similarly, Inland Empire Health Plan contracts with Landmark, a local organization that provides in-home medical care to enrollees with complex care needs. Landmark providers meet regularly with enrollees in their homes and offer medical care and monitoring, as well as house calls when needed. They also participate in ICTs and the development and implementation of ICPs (Philip, Kruse, and Soper, 2016).

Several plans described leveraging community resources to meet enrollees' housing needs. Housing is a critical issue in California, which has a large homeless population among Cal MediConnect enrollees. According to interviewees in Los Angeles County, the city's homeless population is as high as 60,000 individuals, many with behavioral health needs. Inpatient stay and readmission rates are high among homeless individuals, and such initiatives have aimed to improve enrollees' living situation and at the same time reduce the need for these costly services. Instead of coordinating services for homeless individuals in-house, some plans have been engaging community organizations with expertise in working with this population. At least three plans reported contracting with or providing grants to community organizations that provide intensive case management for enrollees who need transitional housing and social services. These organizations may also link enrollees to preventive medical and behavioral health care and supports that enable them to remain in the community. One MMP also reported contracting with an independent living center to provide transitional housing for homeless enrollees with disabilities who are being discharged from nursing facilities or hospital stays. Another MMP reported using funds for short-term motel stays for Cal MediConnect enrollees while more stable housing was being arranged. Many of these initiatives were in the early stages of implementation when this report was produced, and plans were beginning to track the outcomes of their efforts. It should be noted that as plans attempted to connect enrollees with regular health care services, rather than use of emergency departments (ED), some hospital EDs encouraged use of their services for primary care. Reportedly, they depend on this income stream.

In 2015, plan representatives frequently commented on the challenges of balancing administrative responsibilities and compliance with care coordination activities. Several plans described progress in achieving their targets for HRA and ICP completion as the demonstration unfolded; however, plans had to dedicate large proportions of their staffing resources to tracking and reaching beneficiaries, completing assessments, and educating enrollees. In 2016, some plans reported that HRA and ICP completion remained a high priority for their care coordinators, even as focus shifted to providing ongoing care coordination. One representative reported the following:

[I]t's deadline driven and if you didn't do the HRA by this day and if you didn't do the ICP by this day and if you didn't do the ICT by this day... you have these big red marks because you were a little bit out of compliance by a day, two days, three days, whatever the case may be. And realistically, those days don't make a difference in terms of the healthcare that the enrollee receives. But again, we hire vendors to help us, we hire enough staff to ensure that administratively we can be within compliance for all the regulations.

Despite these challenges, plans reported early signs of positive outcomes from care coordination, such as decrease in emergency department visits, reductions in hospital readmissions, and increased primary care visits. Plans cited these events as evidence for the value of care coordination and its impact on the quality of life of plan enrollees. RTI will be analyzing service utilization patterns and impacts on health outcomes when complete MMP encounter data become available.

4.3 Beneficiary Experience with Care Coordination

One of stakeholders' hopes for the demonstration was that care coordination would improve beneficiary satisfaction with care and attract more beneficiaries to the demonstration. However, 2015 RTI site visit findings revealed that beneficiaries were not familiar with the concept of care coordination, making it difficult for them to understand its value. Advocates were concerned that even though care coordination was listed as a benefit in the demonstration enrollment package, people were not able to make informed decisions without understanding what the care coordination benefit meant. Similarly, MMPs reported that beneficiaries did not understand marketing materials that promoted care coordination as a benefit of Cal MediConnect; therefore, it was difficult for plans to communicate the value of care coordination for those who are newly enrolled. Focus groups conducted by State evaluators also suggested that many beneficiaries who could benefit from care coordination were unaware of care coordination services (Graham, 2015).

Because care coordination activities were slow to get off the ground, the first real feedback from enrollees did not become available until the end of 2015. Overall, stakeholders during the 2015 site visit noted reports of early positive experiences with care coordination efforts. Stakeholders reported that MMPs hired qualified, personable staff who were committed to meeting enrollees' needs. Enrollees interviewed as part of the MMP consumer advisory boards reported that through their care coordinators, they had been connected to LTSS and social services that they were not aware of before enrolling in Cal MediConnect. MMPs also reported that some beneficiaries appreciated having a HRA and liked having an in-person visit and someone to check in on their problems. Positive overall feedback on the care coordination benefit was also reported by the State evaluators via focus groups and surveys (Field Research Corporation, 2015; Graham, 2015). Results from State evaluations suggest that Cal MediConnect beneficiaries are most satisfied with their care coordinators, having one phone number to call, and having member services handling their problems. Moreover, when interviewed in 2015, State officials cited high satisfaction with care coordination as a top reason beneficiaries stay enrolled in the demonstration.

RTI focus groups conducted in spring of 2016 revealed a more nuanced picture and showed that Cal MediConnect enrollees' experience with care coordination varied greatly. Only a few participants were able to identify their care coordinators or knew that care coordination was a benefit under the Cal MediConnect demonstration. In contrast, other participants who had a relationship with their care coordinator reported benefiting greatly from care coordination and relying heavily on their coordinators to manage and resolve issues related to accessing their services. Others described a complete lack of coordination and the health problems that resulted from poor communication between providers. When able to identify a "helper," some participants were confused about what entity or organization these care coordinators were from.

RTI focus group participants who were able to identify their care coordinators and who had high degrees of satisfaction with the types of assistance they receive—including obtaining information about needed services and resolving conflicts and access problems—reported the following:

Besides my health plan, I have a caseworker. She's very good. We have a good rapport. And she calls me pretty often. And whenever I have a need that I see she can help with, I call her and she always helps me a lot.

Now that she's on [the MMP], I'm having a little bit better handle on things, because [my plan] has I guess you'd call them a case management person that has been a godsend. Because she's talking to me, she knows me already, she knows my mother's case. And she's kind of like the in-between person now that when I need something or something is not happening... She has been a godsend because she has fought for everything. When I don't get an answer from the doctor's office, she's on the phone with them.

Before, I... I didn't know when this [benefit] exhausted, then I would have to call these people. But my case manager [says], "Don't worry, I'll handle it."

My insurance interviewed me, and the [care coordinator] ... gave me her name and she asked me questions [about] what I would need, if I need anything—a seat for the toilet, hangers. I got all those things through her, through the [MediConnect plan]. Rails, seat for the toilet, a bath seat to sit in the bathtub. I got all of those... She took the time to try and ask for it, and they said, "Okay, the insurance said they will give it," and I'm getting help. She discussed a lot, about a half an hour with me, and she asked me what I need. If I need anything, I must call her and let her know. She gave me her name and her number.

On the other end of the spectrum, some RTI focus group participants reported not receiving any care coordination support from their MMPs, even though all focus group participants were enrollees who were receiving LTSS or behavioral health services. According to the three-way contract, enrollees receiving these services should be stratified as high risk, and therefore should receive care coordination services (see *Section 4.1, Care Coordination Model*, for a discussion of risk assignment of enrollees). These findings are consistent with the State evaluation results; most UC Berkeley focus group participants were unaware of this benefit (Graham, Liu, and Kaye, 2016). A UC Berkeley telephone survey found a higher rate reported receiving care coordination: 35 percent of Cal MediConnect enrollees reported that someone was coordinating their care; of those who reported having a care coordinator, 68 percent received this service from Cal MediConnect MMP. In contrast, only 20 percent of beneficiaries who opted out of Cal MediConnect and 18 percent of Medicare-Medicaid beneficiaries residing in non-Cal MediConnect counties reported having someone to coordinate their care.

Some RTI focus participants reported not knowing their assigned Cal MediConnect care coordinator, or having multiple case managers and not understanding how they operate together. Advocates had similar concerns about duplication of care coordination efforts, with beneficiaries having assigned care managers through other LTSS programs or county behavioral health

departments. Unexpectedly, some participants described forming lasting relationships with plan sales representatives who serve as “quasi” care coordinators answering their questions and helping them resolve various difficulties. Moreover, some focus group participants reported negative health outcomes and unmet needs that existing providers are not addressing due to lack of care coordination. The quotes below illustrate lack of awareness and confusion about care coordinators:

No, there is not [a point person or care coordinator]. It’s me. I’m the point person.

There are several places that I have to contact, and I do feel like my own ombudsman by the time I get through. I’m on the phone sometimes for 4 or 5 hours a day sorting through this whole thing. I’m going, “You know what? I should be doing this for pay.”

I just don’t know who [my mother’s] care manager is because nobody has ever informed me about that... [My mother’s] plan offers 24/7 customer service. I was unaware of that, too.

In summary, the evaluation results have pointed to a wide range of experiences with care coordination among beneficiaries with care coordination fulfilling its original promise for only a fraction of Cal MediConnect enrollees.

4.3.1 Consumer Assessment of Health Plan Survey Findings

Enrollees in eight MMPs with at least 6 months’ experience responded to the 2015 Consumer Assessment of Health Plan Survey (CAHPS). Enrollees in nine MMPs with at least 6 months’ experience responded to the 2016 CAHPS. Medicare requires all Medicare Advantage plans, including MMPs, to conduct an annual assessment of the experiences of beneficiaries using this instrument. Plans operating in Santa Clara and Orange counties are not included in these data because they began operations in January 2015 and July 2015, respectively (see ***Section 1.1.2, Data Sources and Methods***).

CAHPS results echo focus group and other survey findings. **Table 8** presents additional 2015 and 2016 CAHPS data on three measures of beneficiary experience with care coordination: the percent of enrollee respondents who had help with coordinating their care, percent of enrollee respondents reporting being very satisfied with that help, and percent of enrollees receiving the information they needed from their MMP. The percent of surveyed members who reported receiving care coordination services from their MMP was relatively small in 2015, ranging from 22 percent to 35 percent. In 2016, between 20 and 36 percent of demonstration MMP respondents reported having someone from their health plan, doctor’s office, or clinic help them coordinate their care. For three plans, a smaller proportion of respondents received care coordination services in 2016 compared to 2015.

Table 8
Beneficiary experience with care coordination, 2015 and 2016

CAHPS survey item	Year	National distribution – All MA contracts	National distribution – All MMP contracts	Anthem Blue Cross	Care1st	Community Health Group	Health Net	Health Plan of San Mateo	Inland Empire Health Plan	LA Care	Molina Health-care	Santa Clara Family Health Plan
Percent who had anyone from their health plan, doctor’s office, or clinic help them coordinate their care among doctors or other health providers	2015	N/A	N/A	35 (N=46)	24 (N=119)	28 (N=321)	26 (N=113)	26 (N=243)	30 (N=368)	22 (N=223)	26 (N=107)	N/A
	2016	N/A	N/A	#	26 (N=107)	27 (N=191)	20 (N=87)	21 (N=99)	36 (N=140)	26 (N=125)	31 (N=172)	30 (N=43)
Of those who used care coordination, the percent who were “very satisfied” with the help from the MMP or doctor’s office in coordinating their care	2015	N/A	N/A	#	#	35 (N=88)	46 (N=28)	46 (N=63)	50 (N=102)	39 (N=46)	41 (N=27)	N/A
	2016	N/A	N/A	#	50 (N=28)	54 (N=48)	#	#	43 (N=49)	67 (N=33)	36 (N=50)	#
Percent reporting that health plan “always” gave them information they needed	2015	55 ^a	47 ^a	—	—	47 (N=142)	—	52 (N=97)	53 (N=176)	48 (N=83)	—	N/A
	2016	55 ^a	52 ^a	—	43 (N=96)	50 (N=132)	37 (N=73)	58 (N=71)	59 (N=169)	57 (N=94)	53 (N=154)	33 (N=55)

Expressed in percentages. — = data not available; # = sample size 10 or less not presented; MA = Medicare Advantage; MMP = Medicare Medicaid Plan; N/A = not applicable.

^a Percent reporting that health plan “always” gave them information they needed: National Distribution of all MA contracts N=45,457 for 2015 and 42,677 for 2016; National distribution of all MMP contracts N=2,058 for 2015 and 3,669 for 2016.

SOURCE: RTI Supplemental CAHPS data for 2015 and 2016 and CAHPS data for 2015 and 2016.

Of MMPs with data available, in 2015, 35 to 50 percent of enrollee respondents who received care coordination, reported being “very satisfied.” In 2016, there were five health plans with reportable data on percentage of respondents being very satisfied with the care coordination they received, although observations were very low (28–50 respondents). Plan results varied across the 2 years, with reported respondent satisfaction increasing in some while decreasing in others.

In 2015, about half of responding members in several MMPs reported their health plan always gave them the information they needed (47 to 53 percent). All but one plan had data available for 2016 on this measure, and 33 to 59 percent of respondents reported that their health plan always gave them the information they needed. Four plans exceeded the National MMP average of 52 percent and three plans exceeded the National MA average of 55 percent. All plans had a higher proportion of respondents positively reporting on this measure in 2016 than in 2015.

4.4 Coordination of LTSS

Prior to the Cal MediConnect demonstration, LTSS were authorized and provided through separate entities and/or programs in each county; therefore, Medicare-Medicaid enrollees with LTSS needs had to coordinate with multiple agencies or providers to acquire their services. Prior to the demonstration, only a few plans were knowledgeable about and had forged relationships with community-based and institutional LTSS providers through serving their D-SNP and Medi-Cal populations; however, for others, it was a completely new area about which they knew very little. Under Cal MediConnect, LTSS—including Community-Based Adult Services (CBAS), the Multipurpose Senior Services Program (MSSP), In-Home Supportive Services (IHSS), services for individuals with Alzheimer’s, and behavioral health services—are intended to be streamlined and coordinated through the MMPs. The integration of these services reduces coordination burden for beneficiaries and caregivers, and allows care coordinators to better identify and address enrollees’ needs. MMPs are supportive of LTSS integration within the demonstration, but folding waiver, State-run, and county-run programs under one umbrella has presented operational challenges as well as greater need for outreach and education to plans and providers. State officials, plans, and stakeholders reported providing training for each entity on topics such as enrollment, billing and payment, care coordination, and grievances and appeals. Representatives for MSSP, CBAS, and county behavioral health agencies also provided education to plans on the unique needs of the special populations that access their services (e.g., individuals who are medically frail, individuals who have behavioral health needs). Before and during early implementation, agencies administering these services provided training to their own providers in order to prepare them to assist new enrollees in navigating Cal MediConnect enrollment and transition.

Plans have approached LTSS integration in diverse ways. In San Mateo County (a county-organized health system), with one MMP and one MSSP provider, the health plan was able to absorb MSSP staff into its own operations. The Health Plan of San Mateo (HPSM) also has co-located IHSS social workers, facilitating the application and authorization process for IHSS. In Orange County, which also only has one MMP, the health plan was managing MSSP and CBAS prior to the demonstration, so processes were already in place when the plan began its Cal MediConnect product. Integration is more complex in larger counties with multiple MMPs and providers. In 2015, some plans reported hiring and training staff to manage LTSS operations

and liaise with counties and providers. Other plans created teams of care coordinators dedicated to enrollees who require LTSS. At least two plans reported embedding their own staff into county agencies that provide LTSS or behavioral health services. Plans reported mixed experiences with working with county agencies and LTSS providers, with some plans achieving more success than others. According to plan representatives, co-location of MMP staff and county agency staff significantly improves the ability to coordinate services. Other plan representatives reported difficulty coordinating with county agencies and felt limited in their ability to control or manage county-based services. Overall, however, plan representatives reported improved knowledge and understanding of the LTSS system by 2015 and 2016.

Some MSSP and CBAS representatives reported in 2014 and 2015 that they were concerned about duplication of care coordination efforts. The MSSP program, for example, provides education, assessment, care planning, and referrals for individuals with a nursing facility level of care; these services overlap with the primary functions of an MMP care coordinator. Similarly, each CBAS center is required to have a social worker that provides coordination of nursing, therapy, food, and transportation services within the center. The CBAS social worker may also set up doctor's appointments, communicate with physicians, and implement the care plan. IHSS recipients also had a case manager. In theory, representatives from these providers participate on the ICT, contribute to the enrollee's care plan, and coordinate to avoid any redundancy; however, stakeholders reported that the boundaries between each entity's care coordination responsibilities are still unclear. According to focus group data, beneficiaries were also often confused. Focus group and survey data show that many enrollees continue to work with multiple care coordinators or social workers and obtain their services through different channels, rather than through their MMPs. In the 2016 UC Berkeley survey, 13 percent of Cal MediConnect enrollees who were receiving some form of care coordination, reported that their care was being coordinated by their providers or another community agency (Graham et al., 2016b).

Other challenges have related to data exchange difficulties (described in *Section 4.6*), lack of understanding of nursing facility service delivery system by MMPs (described in *Section 2.2.6*), and complexities of coordinating with behavioral health county providers (described in *Section 4.5*).

4.4.1 LTSS Referral Process

Enrollees who were already utilizing LTSS or behavioral health services at the time of enrollment into the plan were classified as high risk. Plans reported they prioritize these enrollees for assessment and enrollees received follow-up from care coordinators to ensure that they receive the appropriate level of LTSS and behavioral health care, and continue to use these services without disruption. (Please refer to *Section 4.1.1, Assessment*, which discusses improved health risk assessment questions designed to strengthen LTSS referrals.)

During an enrollee's assessment or review of the ICP, the care coordinator may identify new LTSS or behavioral health services that the enrollee may need. Alternatively, an enrollee may approach the care coordinator or MMP with an unmet need or a request for a new service. In cases where enrollees reached the allotted amount of services and still had an unmet need, MMPs could supplement existing services through CPO funds, maybe even hiring additional

LTSS providers, contracting with agencies, or paying directly for IHSS workers for additional hours. However, noting the complexities of these arrangements, MMPs reported they did not select this route and preferred to request a new assessment for additional services by the LTSS agencies. The care coordinator may directly contact the appropriate agency or service provider to advocate for the enrollee's needs and initiate the application and assessment process for the service. In some cases, the care coordinator may initiate a care conference to gather enrollees of the ICT and review the request. In other cases, the care coordinator would directly contact the PCP for approval and then pass along the request to a referral team that worked directly with the county to authorize services. One plan representative described the typical referral process for coordinating IHSS for an enrollee:

“And so we explain the program to them, make sure they fully understand and answer any questions they may have, assist them, refer them to the county, call the county and make sure they received the referral... call the enrollee back in a couple of days to make sure they received their medical certification form from the county... Answer any questions they may have about that form and talk to the doctor's offices occasionally, once in a while we'll hear about a doctor, maybe not available to sign the form or just, just helping the enrollee get that form signed because it's the first step towards getting eligibility.”

4.4.2 Transitions from Nursing Facilities to the Community

Reducing institutionalization is a major demonstration goal in terms of improving quality of life for the enrollee; selecting the least restrictive setting; and reducing costly service utilization, thereby achieving cost savings. Some plans reported assigning care teams to nursing facilities, where they monitor enrollees' status and identify opportunities for transitions back to the community. Some plans were implementing programs for this purpose. For example, by bundling financial resources from the California Community Transitions program (funding through the Money Follows the Person grant), State waiver programs, and its own resources (e.g., CPOs), HPSM developed a pilot program, Community Care Settings, to transition enrollees out of institutional care (Philip, Kruse, and Soper, 2016). Working with a network of community organizations and providers, HPSM coordinated a range of supportive services that allowed institutionalized enrollees to live in the community. These services included case management, housing assistance, and medical care. As of September 2016, 120 enrollees had been transitioned to the community through this pilot program. According to plan representatives, the goal of the program was to transition approximately 900 people over 3 years. As described by plan interviewees, Care1st implemented a similar “Care1st at Home” pilot and contracts with a vendor to transition enrollees back to the community. The vendor served as the lead organization in screening for eligible enrollees and providing wraparound services to transition enrollees back into their homes or assisted living facilities. As of fall 2016, Care1st had transitioned approximately 70 members to the community, and an additional 24 members were cleared to move and were waiting for housing. Another 27 members were in process to transition.

It is important to note that most MMPs and nursing facility providers concurred that although care transitions are worthwhile goals, they are difficult to achieve in many cases. Nursing facility providers shared that the overall impairment levels of their residents increased in the last few years resulting in many residents not being suitable for moving back to the

community. Additionally, most of the demonstration counties have the highest cost of living in the country and severe affordable housing shortages.

4.4.3 Care Coordination for Enrollees with Dementia: Alzheimer's Project

The California Department of Aging estimates that 13 percent of Cal MediConnect enrollees are being treated for Alzheimer's disease and related dementias (ADRD), and another 13 percent have dementia but are not yet diagnosed (Connolly, 2016). The average cost of care for beneficiaries with moderate to severe cognitive impairment is significantly higher than for beneficiaries without cognitive impairment (Resources for Integrated Care, 2015; Alzheimer's Association, 2016). The terms of the three-way contract specify that each plan must have a specially designated care coordination staff member trained in managing behaviors and communication problems caused by dementia, to support and provide community resources to cognitively impaired enrollees and their caregivers and help reduce caregiver stress (California three-way contract, 2014, p. 70).

In 2013, the department was awarded a \$744,000 grant by the Administration on Community Living to develop a training program for care coordinators specifically focusing on Alzheimer's disease in Cal MediConnect plans. DHCS, the Alzheimer's Association of California, and MMPs have partnered to design and implement this program. Researchers at UC San Francisco were the project evaluators. The Alzheimer's Project, which originally sought to train 100 care coordinators and educate 200 family caregivers of Cal MediConnect enrollees about dementia and how to care for individuals with this disease, had trained 30 care coordinators by summer 2014 (Connolly, 2016). The project grew over time, and as of 2016 nearly 300 care coordinators and over 500 family caregivers had received dementia education or support; over 40 Dementia Care Specialists were in-place across eight of the participating MMPs.

The components of this project include advocacy with health plans, care coordinator training and support, caregiver education and respite, support services through referrals to the Alzheimer's Association, and technical assistance to create systems change. Challenges to identifying ADRD may include lack of screening for cognitive impairment during the HRA, difficulty reaching enrollees, lack of communication between families and physicians, and cultural barriers to diagnosing and treating ADRD. To address some of these challenges, the Alzheimer's Association of California advocates reviewed the HRA to ensure inclusion of cognitive screens, use of a validated ADRD screening tool, training for care coordinators to use this tool, and development of a follow-up protocol for cases where the enrollee demonstrates some cognitive impairment. The early State evaluation by UC San Francisco researchers indicated that care coordinators expressed high levels of satisfaction with the training and provided materials and reported better knowledge about dementia and home and community-based services. As a result, the care coordinators were able to provide increased support to families in the form of increased referrals to LTSS providers, including to the Alzheimer's Association (Connolly, 2016). The project was identified as one of the best practices in care coordination nationwide by the Family Caregiver Alliance (FCA) and the Alzheimer's Association of Greater Los Angeles was awarded the 2016 Rosalinde Gilbert Innovations in Alzheimer's disease Caregiving Legacy Award (Family Caregiver Alliance, 2016).

4.5 Coordination of Behavioral Health Services

Seamless provision and coordination of behavioral health services is important for the Cal MediConnect population, which has a large number of enrollees with severe and persistent mental illness (SPMI) or substance use disorder (SUD). One plan estimated that as many as 30 percent of its enrollees have a behavioral health diagnosis. As described in **Section 2.2.5, *Integrated Mental Health and Substance Use Services***, services provided under county-administered Mental Health Plans and Alcohol and Other Drugs Programs, including targeted case management and rehabilitation services for SPMI and SUD, are excluded from the Cal MediConnect capitated rate. Under the demonstration, plans provide payment for mental health services that are reimbursable through Medicare.

In the three-way contract, MMPs are afforded flexibility in how they provide care coordination of behavioral health services. In general, MMPs contract with county agencies to provide these services, and work alongside the county to provide care coordination. These processes have been operationalized in the Behavioral Health MOU (BH-MOU) between each plan and county. Prior to the demonstration, plans delegated directly to county mental health agencies or to providers to work with these agencies. In Cal MediConnect, enrollees continued to receive services from county-administered programs, with an additional layer of oversight by the plan.

Coordination with behavioral health agencies has presented a general challenge for MMPs because of the organizational structure of behavioral health services and the historical practice patterns that kept behavioral health Medicare and Med-Cal providers operating relatively independently of each other. Some plans, for example Inland Empire Health Plan, have placed care coordinators in the county behavioral health department part-time to facilitate communication and coordination of behavioral health services. This plan began coordinating behavioral and primary care prior to the demonstration. In addition to ensuring behavioral health competency throughout the plan, it also established relationships with county agencies by providing behavioral health providers with access to member health records (Center for Health Care Strategies, 2015a).

Substantive attempts by other MMPs to work with county agencies to coordinate care for their enrollees with SPMI did not get under way until early 2015. During interviews in October 2015, there was some anecdotal evidence of successful coordination with MMP care coordinators and behavioral health providers in a few counties. County behavioral health department staff reported working with MMPs to create provider networks where providers were able to deliver both Medicare and Medi-Cal behavioral health services. Historically, the county behavioral health system that has provided Medi-Cal services has operated as a separate entity with limited interaction with other segments of the health care system. Although county behavioral health staff reported that MMPs have made an effort to increase and improve communication with behavioral health providers serving the Medi-Cal population, they also suggested that the start-up timeline for the demonstration did not allow sufficient time for counties to educate plans on the existing system or to adapt their systems to align with billing

mechanisms for the demonstration. As one official of a county behavioral health department said, “They are asking us to cram 10 years’ worth of work into a 3-year demonstration.”⁶

For county-operated MMPs such as HPSM, with more experience working with county-based mental health agencies, there have seemed to be fewer challenges coordinating behavioral health services than for commercial MMPs. County agencies reported more flexibility among smaller plans in adapting and aligning administrative processes to facilitate information exchange. In counties with multiple MMPs, county behavioral health departments report that simply identifying the appropriate contact at the plan with whom to speak can be difficult. In San Diego, one plan reported early efforts to facilitate this process. MMPs in San Diego hired one credentialing agency to provide credentialing for all four health plans during the course of the demonstration, provided a training in February 2013 to 150 executives from county behavioral health providers, and collaborated to develop a one-page document containing detailed information on behavioral health benefits, the credentialing process, and contacts at each health plan for behavioral health services. In some counties, however, it was not until 2016 that agencies had a direct telephone number for the correct plan representative. Staff at county behavioral health departments expressed frustration at inefficiencies during early implementation, such as educating each plan on their systems and processes separately, and sending and receiving data in multiple formats to accommodate each plan’s requirements.

As with other care coordination functions, plans have varied in how they provide coordination for behavioral health services. Some MMPs reported hiring specific personnel or establishing new organizational units to liaise with BH providers. One MMP representative described the coordination process as follows: “The HRA comes in and, we use the PHQ-2 depression screening on the HRA. That triggers right away, if the enrollee is depressed, kind of a referral to behavioral health... we then would reach out to the behavioral health team, do a case conference, and decide where this enrollee falls. A lot of these enrollees are managed by behavioral health for a while before we can bring them back over to the medical case management side, to take care of things like psychosis and get them stabilized. But that’s the nice part about them being in the health plan, is that we work off the same plan of care, the same medical management system, and we can see everything they do and vice versa.” Similar to this plan, some MMPs have established an in-house behavioral health unit to co-manage enrollees with county behavioral health departments. Other plans reported employing behavioral health specialists to provide care coordination or to support care coordinators working with enrollees with behavioral health needs.

County behavioral health agencies reported challenges sharing behavioral health and substance use information with other providers. Interviewees cited the Health Insurance Portability and Accountability Act (HIPAA) and the Substance Abuse Confidentiality Regulation (42 CFR Part II) as barriers to data exchanges about shared beneficiaries. The latter regulation prevents behavioral health providers from sharing sensitive information about selected diagnoses and hospitalizations, including receipt of any SUD services. Designed to protect clients, it also impedes data exchanges and coordination between behavioral health county services and MMPs’ care coordinators. State, stakeholders, and county mental health agencies all reported this has been a major barrier to care coordination. In 2016, some county behavioral health agencies

⁶ The demonstration was subsequently extended for two additional years.

reported progress in addressing these issues by developing several workarounds such as designing the specific Cal MediConnect Coordination of Care (COC) consent form allowing the release of information if signed by enrollees who are behavioral health care recipients, or generating aggregate reports for the number of Cal MediConnect clients to MMPs so they can initiate the outreach to behavioral health providers. The latter approach is HIPAA-compliant because it alerts the MMPs that they have enrollees receiving behavioral health Medi-Cal services but avoids identifying specific individuals. Because the health plan is not considered a ‘treating provider,’ county agencies cannot provide the names of enrollees. After the plan learns its enrollees are receiving services from a particular provider, the plan can contact the provider to request a release from those enrollees.

When asked if, given privacy concerns and separate county-based systems, it would be possible to not know which plan members were receiving mental health services, plan officials reported in the affirmative. In fall 2016, they noted that identifying their members and their members’ mental health providers in order to provide care coordination, continues to be a challenge. For plans operating in multiple counties, they also noted that interpretation of privacy laws varies from county agency to county agency. The BH-MOUs, signed by each plan and county agency, do not provide sufficient detail to assist in this challenge. Behavioral health providers and agencies believe the privacy laws supersede the BH-MOUs.

4.6 Information Exchange Related to Care Coordination

Each Cal MediConnect plan has organized its medical records in a specific way, driven by their business needs and historical practices. Specifically, for care coordination, each MMP has a different care coordination management system; there has been no integration with a State or county-based system. The three-way contract instructs MMPs to develop data sharing mechanisms with county behavioral health agencies (Three-way contract, p. 45). Plans have generally adapted current systems they use for other products for use in the demonstration. Plans reported expanding electronic medical records and similar systems to include historical information, medication history, assessments from all LTSS providers, and the HRA results.

MMPs’ data exchange systems have been evolving. When Cal MediConnect was implemented, very few data exchange systems were already in place for providers to exchange data to support care coordination. In 2014, MMPs reported that their work on building such systems had just begun. In 2015, most MMPs reported having these systems up and running. MMPs have built web portals accessible to providers participating in care coordination and serving on ICTs. External providers receive web access to HIPAA-compliant systems, which indicate trigger events, such as emergency department visits and transfers to hospitals or nursing facilities. Users can input updates; regular inputs from IHSS data feeds are used to keep the systems updated. Assessment results from MSSP and CBAS are very comprehensive, but because they are completed in narrative form, they are not easily translatable to plans’ systems designed to display concise data for review by multiple providers. Plans expressed regret they could not capture all this rich information in their systems, but the care coordinator can access and share it with others in narrative form. Data exchange difficulties were also reported on 2015 site visit. MMPs experienced various problems exchanging data with counties and LTSS programs such as MSSP, which still provides data for Cal MediConnect enrollees in a .pdf file

that must be entered manually every quarter. By 2016, multiple entities involved with care delivery reported improvements in data exchange.

Some of the care coordination data exchange practices have been county specific. MMPs in such counties as San Mateo and Santa Clara reported organizational structures conducive to better integration of services. For example, one MMP in Santa Clara reported that coordination with behavioral health is easier because it has established an internal behavioral health unit and actively co-manages people with dual diagnoses; this unit is connected with the county behavioral health department and shares data via a web portal.

Slow modernization of the county data systems has also created challenges for data exchange between the MMPs and mental health county agencies. County mental health departments reported that the lack of electronic medical records (EMRs) was the biggest barrier to coordination with Cal MediConnect. As of 2016, some counties were in the process of implementing EMR systems, but it is a lengthy process. Other county mental health departments already have EMRs in place, but they have not been able to find a technical interface solution that works with all MMP systems.

The California Department of Social Services (CDSS) also reported some challenges in exchanging data with MMPs. The quarterly flow of IHSS utilization data from CDSS to MMPs has worked well; the data flow in the opposite direction has remained problematic. CDSS reported having developed a new comprehensive Case Management Information (CMIPS II) system in 2016 with an extensive set of interfaces with all types of State data portals and files. The plan was for MMPs to upload utilization data such as hospitalizations and the ER visits to inform the county IHSS social workers that a client has been hospitalized, for example. However, MMP data arrived via DHCS files with too much lag for it to be useful. Unlike non-CCI counties which were able to provide timely data, data flows from MMPs, which represented 60 percent of the IHSS caseload, have been problematic.

4.7 Successes

State officials, stakeholders, and plans reported improved communication across agencies and providers as a major strength of the demonstration. Primary, acute, LTSS, and behavioral health service systems that have historically operated separately have been brought under one umbrella. This has introduced opportunities for greater efficiency and cost savings, and has improved beneficiaries' ability to navigate the health care system and plan for their care.

Over time, stakeholders report that plans have been making progress in their understanding of the different systems integrated under Cal MediConnect. State officials and stakeholders reported that plans have made an earnest effort to educate themselves about services not previously covered by the MMP organizations, such as LTSS and behavioral health care. They have also worked closely with stakeholders and providers of CBAS, MSSP, and IHSS as well as county behavioral health services to establish lines of communication and set up procedures for care coordination.

Plans, stakeholders, and enrollees provided several examples of successful care coordination. Enrollees and caregivers who have worked with care coordinators reported

positive experiences and high satisfaction in surveys and focus groups. Care coordinators routinely provided assistance to members with issues such as accessing prescription medicine, setting up medical appointments, and coordinating specialty referrals. Care coordinators and plan staff have also implemented initiatives that keep enrollees in community settings, transition enrollees out of institutional settings, and connect homeless enrollees to housing, health, and social services. Plans also reported using flexible Care Plan Options benefits to meet short-term needs to enable them to remain in their homes.

The Department of Aging’s training program for care coordinators specifically focusing on Alzheimer’s disease was identified as one of the best practices in care coordination nationwide. The program received the 2016 Rosalinde Gilbert Innovations in Alzheimer’s Disease Caregiving Legacy Award for providing training for 300 care managers and over 500 family caregivers along with ADRD education or support, and placing over 40 Dementia Care Specialists in participating MMPs.

4.8 Challenges

Although those receiving care coordination reported high satisfaction with services, only a subset of enrollees received this benefit. In one survey, only 35 percent of Cal MediConnect enrollees reported receiving care coordination services, and more than one-fifth wanted more assistance with care coordination. Surveys also revealed that some enrollees were not aware of the care coordination benefit under Cal MediConnect. Care coordination was also uneven across plans, with some providing more frequent or more hands-on support than others. A State evaluation also found similar levels of care coordination among beneficiaries who had opted out of the demonstration.

Because of the high numbers of enrollees who are homeless, and frequent relocation among Medicare-Medicaid enrollees, plans had difficulty reaching new enrollees for assessment and care planning. Even in cases where enrollees were successfully contacted, some were not interested in participating in a health risk assessment or development of a care plan, finding them unnecessary or too time-consuming.

Nursing facility diversion and transitions have been more challenging for MMPs. Improved and coordinated care, coupled with flexible benefits, was expected to enable more beneficiaries to live in the community, rather than in long-term care facilities. Some plans have made great strides to both divert enrollees from long term stays in nursing facilities and to transition enrollees from facilities to the community; however other plans have made little progress in this endeavor. Without data regarding institutionalization rates, it has not been possible to evaluate the overall effectiveness of these efforts. RTI will be analyzing institutionalization rates in the future.

Integrating county-based behavioral health services has continued to be challenging for most plans and counties. Plans have been tasked with coordinating services across the care continuum, but historically, the county-based system has been an independent and unintegrated system. Challenges have been cultural, legal, and practical. County agencies have developed systems, language, and processes unique to their expertise that do not always translate to MMPs operations. The sharing of protected confidential data has presented unique challenges to both

plans and county agencies and has been compounded in counties with multiple plans, where county agencies had to adapt their processes to accommodate each MMP's requirements. Because privacy laws supersede county-MMP agreements, the BH-MOUs have not helped ameliorate this challenge.

Information exchange between providers, agencies, and plans has remained a challenge. This was particularly problematic in the startup phase of the demonstration when systems were not yet aligned for transferring enrollee records, billing and payment information, and grievances and appeals. Although some system changes have been made as the demonstration unfolded, concerns around HIPAA and other privacy-related regulations continued to impede information exchange.

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5. Beneficiary Experience

Highlights

- Enrollees who participated in State evaluation focus groups and surveys reported being generally satisfied with their care under Cal MediConnect; in focus groups, levels of satisfaction were associated with familiarity with the demonstration. However, enrollee satisfaction findings in surveys were similar to those for beneficiaries in non-demonstration counties or among those who opted out of Cal MediConnect. Among RTI focus group participants who understood the demonstration and established a relationship with their Cal MediConnect care coordinator, the satisfaction with care was high. Those without this understanding or who were not connected with care coordinators reported confusion and dissatisfaction with enrollment process, plan choice, and disruptions in their care.
- Enrollees appreciated new and added services—particularly transportation—but were generally confused between regular Medi-Cal benefits and additional coverage provided by MMPs as part of the demonstration.
- Many beneficiaries were able to stay with their PCPs after enrolling in the demonstration; some reported disruptions in drug coverage, DME supplies, and access to specialists due to passive enrollment in Cal MediConnect.
- LTSS recipients in the community reported little effect of Cal MediConnect on their experience and no service disruptions; however, there were isolated but significant negative experiences for nursing facility residents early in the demonstration, resulting from lack of MMP experience with nursing facility care.
- Extensive State efforts to provide culturally appropriate care largely paid off; non-English-speaking Cal MediConnect enrollees reported general satisfaction with care, ability to find and access language-concordant providers, and materials.
- Most of the Cal MediConnect complaints and grievances were associated with billing/charges and enrollees not understanding Cal MediConnect rules. The Cal MediConnect Ombudsman Program has been active in all counties and has provided valuable assistance to beneficiaries by explaining the Cal MediConnect rules and helping to resolve issues.

5.1 Introduction

Improving the experience of beneficiaries who access Medicare- and Medicaid-covered services is one of the main goals of the demonstrations under the Financial Alignment Initiative. Many aspects of Cal MediConnect are designed expressly with this goal in mind, including emphases on working closely with beneficiaries to develop person-centered care plans, delivering all Medicare and Medicaid services through a single plan, providing access to new and flexible services, and aligning Medicare and Medicaid processes.

This section highlights findings from various sources that indicate the levels of beneficiary satisfaction with Cal MediConnect overall; it also describes beneficiary experience with medical and specialty services, new or expanded Cal MediConnect benefits, access to care, care coordination services, and person-centered care and patient engagement. For beneficiary experience, we have drawn on findings from the Consumer Assessment of Health Plan Survey (CAHPS), RTI focus groups and stakeholder interviews, and on State evaluation results from the Field Research Corporation rapid cycle polling, State-contracted surveys by Health Research for Action at the University of California at Berkeley (hereafter, UC Berkeley), and on UC Berkeley focus groups. Please see *Section 1.1.2, Data Sources and Methods*, for details about each data source. This section also provides information on beneficiary protections, data related to complaints and appeals, and critical incident and abuse reports. The section includes information, where available, on the experience of special populations.

5.2 Impact of the Demonstration on Beneficiaries

This section summarizes the findings of focus groups, beneficiary surveys, and stakeholder interviews reflecting beneficiary experiences with service delivery and quality of life under Cal MediConnect. Beneficiary experiences related to the early enrollment process, including experiences of beneficiaries who chose to opt in, opt out, or who were passively enrolled, are discussed as part of *Section 3, Eligibility and Enrollment*.

5.2.1 Overall Satisfaction with Cal MediConnect

As stated in the California demonstration Memorandum of Understanding (MOU), a key objective of Cal MediConnect is to introduce a delivery model that can “improve the beneficiary experience in accessing care, promote person-centered planning, promote independence in the community, assist beneficiaries in getting the right care at the right time and place” (California MOU, p. 2). Therefore, one of the important measures of beneficiary experience with Cal MediConnect is the measure of overall satisfaction with the care received under the demonstration. The data collected by CAHPS, RTI, and State evaluators has indicated a wide range of experience regarding satisfaction with Cal MediConnect. Individuals who understood the demonstration and have established a relationship with their Cal MediConnect coordinators expressed high degrees of satisfaction with their care. Other focus group participants expressed general dissatisfaction with Cal MediConnect and lack of understanding of the demonstration. Advocates also reported concerns about whether the Cal MediConnect care model has been responsive to enrollee needs and preferences.

Table 9 presents 2015 and 2016 data collected on three CAHPS measures of beneficiary satisfaction across MMPs participating in the Financial Alignment Initiative demonstration in California: rating of the health plan as a 9 or 10 (on a scale of 1 to 10, 10 being the best rating), rating of the drug plan as a 9 or 10, and reporting they were always treated with courtesy and respect.

In 2015, satisfaction ranged from 44 to 58 percent among the seven plans with reportable data. In 2016, more enrollees in all plans rated their health plan with a 9 or 10 (53 to 68 percent), indicating a positive satisfaction trend.

Table 9
Beneficiary overall satisfaction, 2015 and 2016

CAHPS survey item	Year	National distribution – All MA contracts	National distribution – All MMP contracts	Anthem Blue Cross	Care1st	Community Health Group	Health Net	Health Plan of San Mateo	Inland Empire Health Plan	LA Care	Molina Health-care	Santa Clara Family Health Plan
Percent rating health plan 9 or 10 on scale of 1 (worst) to 10 (best)	2015	62 (N=148,335)	51 (N=5,141)	—	49 (N=150)	52 (N=336)	44 (N=125)	64 (N=270)	58 (N=385)	46 (N=247)	45 (N=112)	N/A
	2016	61 (N=142,984)	59 (N=9,765)	57 (N=89)	53 (N=275)	62 (N=421)	50 (N=225)	68 (N=252)	66 (N=430)	55 (N=331)	59 (N=450)	55 (N=150)
Percent rating drug plan 9 or 10 on scale of 1 (worst) to 10 (best)	2015	62 (N=136,044)	56 (N=5,042)	—	47 (N=148)	56 (N=329)	50 (N=122)	62 (N=267)	59 (N=373)	53 (N=235)	51 (N=108)	N/A
	2016	61 (N=132,613)	61 (N=9,617)	—	55 (N=271)	62 (N=424)	53 (N=218)	59 (N=249)	64 (N=432)	60 (N=318)	60 (N=447)	51 (N=146)
Percent reporting being “always” treated with courtesy and respect	2015	79 (N=45,771)	70 (N=2,070)	—	—	69 (N=142)	—	73 (N=99)	75 (N=177)	—	—	N/A
	2016	79 (N=43,077)	75 (N=3,719)	—	—	74 (N=133)	—	—	79 (N=173)	—	73 (N=155)	—

= sample size 10 or less not presented; — = data not available; N/A = not applicable.

SOURCE: CAHPS data for 2015 and 2016.

RTI focus group data indicate that Cal MediConnect enrollees reported a range of satisfaction experiences. It appears that the degree of satisfaction was often determined by the level of familiarity with and understanding of Cal MediConnect. Specifically, individuals who understood the demonstration and have established a relationship with their Cal MediConnect coordinators expressed high degrees of satisfaction with their care. Examples from LTSS beneficiaries who provided positive feedback about Cal MediConnect in general or their Cal MediConnect plan follow:

... [T]he fact that they're combined between the Medi-Cal and the Medicare, that facilitates things. Because before you had to look at the Medi-Cal portion, then you had to do the Medicare portion, and it made it more difficult. [Things are working better now] because we're under one umbrella.

I've had different insurance in the past. But when I came across Cal MediConnect that was my lifesaver... I ran across [the MMP], which I am so blessed to come [across], which connected both [Medicare and Medi-Cal].

Cal MediConnect enrollees participating in RTI focus groups also described some negative incidents and encounters, and expressed general dissatisfaction with Cal MediConnect and lack of understanding of the demonstration; moreover, only a few participants in RTI focus groups understood or recognized Cal MediConnect as the entity responsible for their health coverage. Passively enrolled beneficiaries, particularly those who were not heavy users of medical or other services, often discovered their enrollment in Cal MediConnect a few months after passive enrollment happened, and these enrollees had more misconceptions about the demonstration. Several RTI focus group participants either did not recognize the "Cal MediConnect" name or did not understand how they were enrolled in the demonstration. Many did not really understand the concept of managed care, having only used FFS providers before.

Several RTI focus group participants described changing MMPs within the demonstration, resulting in care disruptions and losing access to their health care and adult day providers and services. As one Hispanic LTSS recipient described:

So when I went to the [adult] day care they told me, "You can't come here anymore, Mr. [name]." And I say, "Why?" They say, "Because you were changed to [MMP name] and they don't give the authorization for this." I say, "[MMP name]? But the man that came here told me that on the contrary, it would give me more benefits; it was going to be helpful, it wouldn't take things away." Same thing with my doctor. I went to see my doctor and he didn't want to see me. I tell him, "Why?" ... [He said] "Because you changed insurance that is not ours anymore."

Several additional factors contributed to dissatisfaction: (1) enrollees struggling to understand their choices and the enrollment processes, and receiving limited to no support and education on their options; and (2) passive enrollment resulting in care disruptions and enrollees losing access to their providers and services. Several focus group participants reported that MMP member services were not helpful, and that newly assigned providers and pharmacies were farther away and required more travel. Overall, participant dissatisfaction generally stemmed from a feeling of not being in control of their health care choices without support for understanding the systems' complexities. As one behavioral health care recipient shared:

Maybe it would be better if [the MMP] just come up to you and say, “Hey, this is what we’re going to do. This a simplified way of saying it.” Because this paper right there... they give you all this paperwork and then they say, “Okay, this is it, and sign it.” And then you’re looking at the paperwork and you’re like, “Whoa, what? I don’t understand this.”

State evaluators, having the opportunity to interview more Cal MediConnect enrollees, described multiple positive experiences among demonstration participants. Most enrollees polled by the Field Research Corporation (Field Research Corporation, 2016a) and surveyed (Graham, Liu, and Kaye, 2016) as part of the State evaluation, as well as UC Berkeley (Graham et al., 2016a) reported being generally satisfied with their care. For example, MediConnect enrollees participating in focus groups conducted by the State evaluators (UC Berkeley) were highly satisfied with the demonstration. The UC Berkeley focus group participants listed multiple factors that contributed to their satisfaction with Cal MediConnect (Graham et al., 2016a): (1) having a simplified health insurance, (2) establishing continuity with providers and services, (3) having lower out-of-pocket expenses, (4) being satisfied with care coordination, (5) having someone to call at the plan, (6) receiving good quality of care from their providers, (7) having better access to care, (8) improved behavioral health services, and (9) improved coordination across providers.

UC Berkeley researchers reported similar findings from their telephone survey of enrolled beneficiaries. According to the survey, 90 percent of Cal MediConnect enrollees were satisfied with their coverage, and 83 percent reported their quality of care was generally good or excellent. Over one-third (36 percent) of enrolled respondents reported that care was better in the new program. Specifically, respondents were satisfied with the fact that it was quicker and easier to get information about benefits as well as appointments or services, and their quality of care was better. Telephone survey data also indicated that longer enrollment in the demonstration resulted in higher levels of satisfaction with quality of care. Consistent with these UC Berkeley survey results, the Field Research Center polls indicated that a large majority of enrollees (between 76 percent and 86 percent) reported being satisfied with the health care services they received, with the levels of satisfaction increasing in subsequent demonstration years. In these polls, Cal MediConnect enrollees reported being satisfied with their choice of doctors, the way different providers worked together, and the information their MMPs provided to explain their benefits (Field Research Corporation, 2016b).

However, it is important to note that the results of both the State evaluation survey and the polling also indicated that the level of satisfaction with overall care among Cal MediConnect enrollees was similar to, and not higher than, satisfaction among beneficiaries who resided in non-demonstration counties or among those who opted out of Cal MediConnect. Therefore, these findings taken together may signify that although some enrollees understand the value that Cal MediConnect adds to their care, most Medicare-Medicaid beneficiaries in California generally are satisfied with their overall care regardless of their enrollment in Cal MediConnect.

Findings from State evaluations underscored the RTI evaluation results and identified several factors contributing to dissatisfaction with Cal MediConnect, including enrollees in the focus groups reporting some negative experiences with their plan as a result of the switch from Medicare fee-for-service. Specific complaints included: (1) having to switch doctors or durable medical equipment (DME) providers; (2) losing access to specific prescription drugs;

(3) receiving bills for provider visits or services not covered by Cal MediConnect; (4) decreased access to specialty care; (5) needing service authorizations which delays care; and (6) lack of communication between the plan and providers. Consistent with RTI findings, State evaluators found that enrollees expressed feelings of disempowerment and resignation related to the passive enrollment and perceptions of lack of choice. And as in the RTI focus groups, in the UC Berkeley focus groups, some Cal MediConnect enrollees reported disruptions in services. The UC Berkeley study indicates that “those disruptions were limited to the time period immediately following the transition, and that most disruptions were resolved to their satisfaction after some time in the plan” (Graham et al., 2016a, p. 22).

Personal Health Outcomes and Quality of Life

The California MOU also notes that CMS and the State expect that the Cal MediConnect model of integrated care delivery will improve beneficiary personal health outcomes and quality of life by meeting beneficiary needs, allowing them to live independently in the community, and coordinating their care across settings. (California MOU, p. 2). Effective communication with one’s doctor has been a key factor in achieving personal health outcomes. **Table 10** presents 2015 and 2016 CAHPS data on the percent of MMP members who reported that their personal doctor understands how health problems affect their day to day life. It appears that MMP physicians have generally been understanding and provided compassionate care. Over 80 percent of respondents across all MMPs in both years reported that their doctor understands how health problems affect their day-to-day lives. In 2015 this ranged between 83 and 88 percent, and in 2016 it increased to a high of 95 percent.

RTI focus group participants provided some feedback on how Cal MediConnect has affected their health outcomes. While some participants reported their health had worsened or was unchanged, other focus group participants provided examples of improved health outcomes and increased quality of life, which they ascribed to Cal MediConnect:

I think I’m doing much better than I used to be doing before they had [the MMP].

Well, definitely [my mother’s quality of life has improved] since we signed up to the program. The people that I meet, they seem like they care more. They seem like they work hard to help you with what you need, and that’s important for my mom because her health is declining. So I like that there’s that care.

Now I just deal with one [entity] from transportation to case managers, which are fabulous people. They work with me. They make sure I get everything I need. I have home visits, and I’m well taken care of... I was over 300 pounds. But with this combination, I was able to get a gastric bypass, so my mobility is much better now than it was. I was in a wheelchair. Diabetes, high blood pressure, depression, everything. Now I just take supplements and pain medication because I have disc degenerative disease and COPD, but that’s under control. That was the best thing. My life has changed.

I feel like I’m starting all over from scratch at the bottom. We’ve had issues all along the way, just fighting for everything that [my mother] needs.

Table 10
Beneficiary experience with personal health outcomes, 2015 and 2016

CAHPS survey item	Year	Anthem Blue Cross	Care1st	Community Health Group	Health Net	Health Plan of San Mateo	Inland Empire Health Plan	LA Care	Molina Healthcare	Santa Clara Family Health Plan
Percent reporting that their personal doctor understands how any health problems they have affect their day-to-day lives	2015	87 (N=47)	83 (N=117)	87 (N=330)	87 (N=120)	88 (N=257)	84 (N=368)	84 (N=239)	88 (N=109)	N/A
	2016	95 (N=39)	90 (N=110)	86 (N=188)	81 (N=86)	86 (N=105)	90 (N=148)	84 (N=132)	85 (N=175)	91 (N=43)

N/A = not applicable.

SOURCE: RTI Supplemental CAHPS data for 2015 and 2016.

Table 11
Beneficiary experience with medical services (including specialists), 2015 and 2016

CAHPS survey item	Year	Anthem Blue Cross	Care1st	Community Health Group	Health Net	Health Plan of San Mateo	Inland Empire Health Plan	LA Care	Molina Healthcare	Santa Clara Family Health Plan
Percent reporting that they had the same doctor before enrolling in the MMP	2015	67 (N=48)	62 (N=119)	62 (N=335)	69 (N=124)	60 (N=265)	58 (N=383)	67 (N=246)	52 (N=114)	N/A
	2016	70 (N=40)	58 (N=113)	62 (N=192)	53 (N=85)	62 (N=106)	51 (N=153)	54 (N=139)	50 (N=179)	56 (N=43)

MMP = Medicare-Medicaid Plan; N/A = not applicable.

SOURCE: RTI Supplemental CAHPS data for 2015 and 2016.

Without specifically focusing on personal health outcomes and quality of life, UC Berkley focus groups reported a similar range of opinions among participating beneficiaries. Several beneficiaries reported improved coverage of acute care, though others reported having visited the emergency department “specifically as a result of not being able to get timely authorization for specialty care or a prescription medication” (Graham et al., 2016a, p. 49).

5.2.2 Medical and Specialty Services

Delivering appropriate and timely medical and specialty care is important. According to the California MOU, assisting beneficiaries in getting the right care at the right time and place and improve transitions among care settings are some of the key objectives of the initiative (California MOU, p. 2). The ability of Cal MediConnect enrollees to have continuity of care with their primary care physicians (PCPs) as well as timely access to specialist care emerged as important outcomes during the evaluation. **Table 11** presents 2015 and 2016 CAHPS data related to PCP continuity of care; it reports on the percent of respondents from each MMP that had the same doctor before enrolling in the MMP. DHCS used intelligent assignment algorithms to match passively enrolled beneficiaries to their existing providers.

Table 11 shows that in all MMPs reporting these data, the proportion of beneficiaries who were able to retain their PCP equaled or exceeded 50 percent in both years, although the number of observations is small (ranging from 40–383). The percent of respondents reporting that they had the same doctor before enrolling in the MMP increased for two plans from 2015 to 2016; however, there were five plans for which this proportion decreased, and one MMP for which it stayed the same. This decrease may be explained by the fact that by 2016, most of the continuity of care provisions may have expired and Cal MediConnect enrollees may not have been able to retain their pre-demonstration providers beyond the initial 12-month period. In multiple site visit interviews, stakeholders underscored the importance of continuity of care with specialists for Cal MediConnect enrollees, especially for those involved in complex treatment such as chemotherapy or radiation for cancer or a planned surgery.

With some exceptions, RTI focus group participants expressed satisfaction and good relationships with their regular providers. State evaluation results indicated that a great majority of Cal MediConnect enrollees (96 percent) had been to a PCP at least once since enrolling in the demonstration.

A majority of RTI focus group participants reported having extensive interactions with their PCP, and reported that they often rely on these providers to coordinate their care. Only a small number of participants reported having switched PCPs while enrolled in Cal MediConnect. In general, during passive enrollment, the State used prior service utilization data and made a particular effort to assign the existing PCP, where available. Most participants reported long-standing relationships with their PCP:

I’m happy [with my PCP]; I have been with my PCP for over 5 years. I am happy because I’m being treated the right way. [The PCP and his staff] listen to my problems and they try to solve it for me...

I’m very comfortable with [doctor’s name]. He’s compassionate. He doesn’t leave me hanging with questions that I ask. He answers everything. And we got a

straight-on type of relationship, where if there's something wrong, he knows to tell me exactly what it is and don't pitter-patter around the bush trying to say it's a little bit of—we don't go through that. So I'll stay with him [until I die].

UC Berkeley reported similar findings and underscored the importance beneficiaries place on maintaining their existing PCP relationships after switching to Cal MediConnect. In fact, UC Berkeley focus group data indicated that this continuity was “one of the main factors contributing to beneficiaries’ satisfaction with Cal MediConnect” (page 43). These focus group participants also reported that with Cal MediConnect enrollment, they had better coverage of hospital and emergency department care without any copays. Most UC Berkeley focus group participants also reported adequate access to specialists.

5.2.3 New or Expanded Benefits

Cal MediConnect is intended to offer a richer service package than fee-for-service Medicare and Medicaid. As explained in **Section 1.3**, new benefits under the demonstration include supplemental coverage for nonemergency medical transportation and vision services. The original list of new services also included dental services, but after Denti-Cal (regular Medi-Cal dental coverage), was reinstated in California, some plans elected to supplement State benefits with additional funds for dental care. Similarly, there is some overlap between the regular Medi-Cal transportation benefit and what is available through the MMPs as part of the demonstration.

RTI focus groups revealed several major themes related to new and expanded services. First, beneficiaries have appreciated new and added services and have been grateful to receive them. Second, some RTI focus group participants indicated that they were not able to distinguish between standard Medi-Cal benefits and new benefits provided by MMPs as part of their Cal MediConnect. Third, transportation emerged as an essential service for the Cal MediConnect population and the availability and quality of this service has had a major effect on beneficiary quality of life and access to health care services. And finally, enrollment in Cal MediConnect resulted in some continuity of dental care issues and disruptions and changes in transportation providers for Medicare-Medicaid beneficiaries.

In general, RTI focus group participants reported that, while they appreciated new and free services, they did not have a good understanding of the demonstration and what is and is not covered by their MMPs. Specifically, beneficiaries seemed to be confused about the dental coverage. For example, one enrollee described his satisfaction with Cal MediConnect new benefits and attributed dental coverage to Cal MediConnect, when in fact it was carved out of the demonstration and was provided by Denti-Cal:

I mean, [the MMP] is very, very good... [Before enrolling in an MMP] I didn't have dental care. I didn't have vision care, hearing care. And with [current MMP], I get all of that for free. It's part of the plan.

Interviews with stakeholders and RTI focus group data indicated that the importance of transportation services in Medicare-Medicaid beneficiaries’ lives cannot be overestimated. Access to transportation services, which ensures access to health care providers, is important because many beneficiaries have disabilities and have often been unable to drive themselves

given that in most California counties providers are spread out geographically. The UC Berkeley focus groups also showed that enrollees often need to drive longer distances to reach their Cal MediConnect providers. Yet the UC Berkeley survey found that only half of enrollees surveyed were aware of the new transportation benefit (Graham, Liu, and Kaye, 2016).

RTI focus group participants reported relying heavily on transportation services and shared mixed experiences in using these providers. Some reported positive experiences, but many complained of poor quality and problems with reliability among their transportation providers. Stakeholder and ombudsman staff interviews corroborated these findings. Examples of quotes from RTI focus group participants discussing transportation services under Cal MediConnect follow:

I had trouble with [MMP name] transportation. Sometimes I'd have to sit for an hour or 2 and wait. They didn't come on time, pick me back up, and take me home. Or I'd have a crazy driver that's hitting all the potholes, and I'm hurting. And I always called and told whoever that these things happened. And then they'd send me a van that I couldn't [get in], that had a stepstool to get up into it, and I can't do that. I can't step up on—I'd have to cancel my appointment.

I talked to my caseworker and I told her that I hope this [transportation] company is much better than the other one they were using [earlier during the demonstration], because they were using a company with people that were kind of bad attitude ... so I complained a few times about the transportation... They changed to a new company now.

I would change [the transportation service] to make it more accessible, reduce the wait time and make drivers senior-friendly. Senior-friendly means give them time to get to outside from their homes.

Some MMPs provided additional funds to supplement covered services, such as \$500 to be used towards dental care—but these funds needed to be used within the MMP's network. This could have led to service disruptions or decreased the usefulness of these funds. During the 2015 RTI site visit, advocates reported that they consider MMP supplemental dental funds of little value to enrollees because their existing Denti-Cal dentists were most likely not in the MMPs' network and not eligible to participate in Cal MediConnect.

In addition to new and expanded benefits, Cal MediConnect MMPs also used the flexible CPO benefit for a range of services including meals, home modifications such as ramps and other wheelchair accommodations, and non-covered DME. In general, Cal MediConnect enrollees appreciated the opportunity to obtain “non-medical” items that made their lives easier and allowed them to function better in their homes. For example, a small number of RTI focus group participants reported that their MMP used these supplemental funds to provide household furniture and appliances: “They helped me with a bed... And they helped me with a washer and dryer.” In another example, one nursing facility owner, interviewed as part of the MMP's consumer advisory group, reported that that particular MMP used the CPO funds to pay for an airline ticket for an enrollee transitioning out of the nursing facility and moving in with relatives in another State. Although not mentioned by the RTI focus group participants, during 2015 RTI

site visit, one MMP reported using the CPO flexible benefits to provide a one-time \$150 budget per beneficiary for Multipurpose Senior Services Program (MSSP) providers to use at their discretion on personal care, home safety, and meals, expecting to enhance beneficiary experience.

The State evaluation reported similar findings about the new and expanded benefits: participants in the UC Berkeley focus groups also reported general confusion about what specific vision benefits are covered under the demonstration; they reported a range of experiences, with some getting free eye exams or glasses, and others paying more out of pocket (since enrolling in the demonstration) or not being able to find an optometrist (Graham et al., 2016a).

5.2.4 Beneficiary Access to Care

Site visit data collected in 2015 indicated that access to care issues for Cal MediConnect beneficiaries revolved around (1) continuity of care, (2) PCP choice, and (3) availability of specific prescription drugs, dental care, and DME.

Table 12 presents relevant 2015 and 2016 CAHPS data on two measures of beneficiary experience with access to services: the percent of MMP enrollee respondents needing treatment or counseling, and how easy it was to get the treatment or counseling they needed. The data for these measures are limited due to the small number of respondents (13–377). In 2015, between 7 percent and 16 percent of MMPs’ respondents reported that they needed treatment or counseling for a personal or family problem. Reports in 2016 were similar. Of those needing treatment or counseling, over 60 percent of respondents said they were usually or always able to get the care they needed. Four plans in 2015 and five plans in 2016 had sample sizes too small for reporting.

Lack of understanding of the demonstration’s continuity of care provision has been one of the major barriers to adequate access to care. According to the Cal MediConnect Ombudsman Program staff and other advocates, few enrollees and few providers understood that enrollees have the right to temporarily retain their existing provider under Cal MediConnect and continue with pre-authorized or existing treatments; as a result, existing providers turned patients away or billed the patients instead of the MMPs for these services. Stakeholders reported that providers often provided inaccurate or misleading information to their patients. For example, one elderly RTI focus group participant described being turned away at the hospital when she showed up for her knee replacement surgery; the surgeon said that he does not take her “new insurance” (Cal MediConnect). Additionally, stakeholders shared some stories where transition into Cal MediConnect resulted in cancellation of surgery and switching doctors in the middle of cancer treatment for some beneficiaries. Few enrollees tried to appeal or resolve these billing and service interruption issues early in the demonstration; Cal MediConnect Ombudsman Program data indicate that these complaints became more prominent in 2015 and 2016 (see **Section 5.2.8, Beneficiary Protections**).

Table 12
Beneficiary experience with access to services, 2015 and 2016

CAHPS survey item	Year	Care1st	Community Health Group	Health Net	Health Plan of San Mateo	Inland Empire Health Plan	LA Care	Molina Health-care
Percent who needed any treatment or counseling for a personal or family problem	2015	10 (N=122)	16 (N=329)	9 (N=117)	12 (N=241)	13 (N=377)	7 (N=234)	#
	2016	#	14 (N=192)	#	#	15 (N=146)	10 (N=128)	7 (N=176)
Of those who reported needing it, percent who report it is “usually” or “always” easy to get the treatment or counseling they needed through their health plan	2015	#	67 (N=54)	#	62 (N=26)	67 (N=46)	#	#
	2016	#	#	#	#	71 (N=21)	#	77 (N=13)

= sample size 10 or less not presented; MMPs with no reportable data or small size samples in all measures are not included in this table.

SOURCE: RTI Supplemental CAHPS data for 2015 and 2016.

Access to prescription medications and DME is also related to continuity of care, because beneficiaries prefer to continue taking familiar medications and using the DME providers to which they are accustomed. Representatives from the Health Insurance Counseling & Advocacy Program (HICAP), the Cal MediConnect Ombudsman Program, and MMP consumer advisory boards discussed challenges regarding prescription drug access for Cal MediConnect enrollees that were prevalent during the first year of the demonstration due to the lack of adequate deeming (see the description of this issue in *Section 3.3.3, Deeming*). Access to medications was interrupted for those beneficiaries who were disenrolled from the demonstration and MMP based on loss of Medi-Cal eligibility, losing MMP prescription drug coverage (beneficiaries who lose Medi-Cal coverage retain Part D coverage via FFS Medicare but need to elect another prescription drug plan to receive their medications). Medi-Cal deeming, instituted in 2015, addressed some of these concerns and has improved this situation in the subsequent demonstration years.

Authorizations that are required for some services also created additional access to care barriers. UC Berkeley focus group participants reported dissatisfaction with delays in care due to referral and authorization requirements, and problems obtaining prescriptions and DME (Graham et al., 2016a).

PCP auto-assignment was another contentious issue widely discussed by advocates during the first 2 years of the demonstration. As described above, many enrollees were able to retain their PCPs. DHCS used Medicare claims in identifying a PCP or a prior physician relationship for intelligent assignment to an MMP; beneficiaries were free to elect PCPs of their own choice. However, this did not unfold as expected; MMPs reported that identifying correct providers has proved challenging. Additionally, some beneficiaries joined Cal MediConnect after

confirming that their existing PCP was listed in the network, only to be assigned a new PCP when it was found that the original PCP was not in the delegated entity that worked with the plan in the area. This has resulted in some complaints to the Ombudsman Program representatives (see **Section 2.2.3** for the discussion of delegation under Cal MediConnect). Advocates also reported some incidents of PCP assignment in nursing facilities that were carried out without properly informing the residents.

In 2016, some of these problems remained. RTI focus group participants reported care disruptions and losing access to their providers and services when changing plans within the demonstration. In general, focus group data collected by RTI as well as MMP interviewees suggest that in counties with several MMPs, there appeared to be some churn as beneficiaries switched from one MMP to another in search of a better coverage package. One service that has been disrupted by such change has been adult day care, a service highly valued by beneficiaries because they form relationships with providers and friendships with other attendees.

5.2.5 Care Coordination

Care coordination is a centerpiece of the Cal MediConnect demonstration and is considered a key vehicle for achieving improved outcomes through comprehensive risk assessments and health action plans, person-centered planning, and navigation assistance to access services. Please see a full description of the care coordination benefit under Cal MediConnect in **Section 4, Care Coordination**.

RTI site visit and focus group data revealed a mixed picture: only some Cal MediConnect enrollees reported receiving care coordination. Beneficiaries who have established relationships with care coordinators reported valuing the service and using care coordinators as their advocates to resolve problems and obtain the services and medical equipment they need. As one elderly LTSS recipient participating in the RTI focus group reported:

I have a lot of contact with [the MediConnect plan] people. My caseworker, she comes to my house.

However, this experience was not common; several other RTI focus group participants reported not being familiar with care coordination benefits, and some reported relying on LTSS or behavioral health system care managers to coordinate their care. These focus group participants appeared to be confused about the varied roles of care coordinators across the MMPs, LTSS providers, and behavioral health providers. As one Hispanic caregiver shared:

Well, there's nobody who's really contacted [us] to say, "If you have a problem with this"—which I think the case manager should be, because [the MMP] say that there's a case manager. Well, who [is the case manager]?"

The same caregiver related her confusion about who manages care for her mother:

The social worker I think is through SSI, I believe, or [CBAS]. [My mother has] two social workers. I don't know what the difference is, because she has one that I talk to all the time. His name is [redacted], and he's the one who set up her

provider that comes on the weekends, versus the other one who is actually through In-Home Supportive Services that comes Monday through Friday.

Moreover, despite the assessment process, Cal MediConnect enrollment did not resolve some of the existing unmet need for services among some beneficiaries. Several RTI focus group participants reported a lack of care coordination that led to negative health outcomes and identified unmet needs that Cal MediConnect care coordinators are not addressing. Some LTSS recipients turned to their LTSS providers for help after being unable to find support from their MMP:

What I've done within the last year, 2 years, I tried calling [my plan]. That didn't work out because they would refer me to another department, and an hour later I was being still referred to another department and another department, another department. So then I decided this is nonsense, so I started going through my social worker, my caseworkers for IHSS and MSSP. They interceded. They were the ones who were calling [my plan] and finding out what was going on and why there was such a delay.

Similarly, although some State survey respondents and UC Berkeley focus group participants were satisfied with the care coordination benefit, most State evaluation survey respondents and UC Berkeley focus group participants reported not being familiar with care coordination benefits, and some also reported relying on LTSS or behavioral health system care managers to coordinate their care. Some UC Berkeley focus group participants also indicated unmet need for services, and voiced dissatisfaction because they lost access to specific DME and prescription medications that are not covered under Cal MediConnect. See a full description of beneficiary experience with care coordination in *Section 4.3, Beneficiary Experience with Care Coordination*.

5.2.6 Person-centered Care and Patient Engagement

A move toward person-centered care and beneficiary participation in care planning and health care decision making is an important aspect of the demonstration. The California MOU states that “Meeting beneficiary needs, including the ability to self-direct care, [and] be involved in one’s care [....], are central goals of this initiative (MOU, p. 2). RTI site visit data collected in 2015 indicated that this dimension of the care coordination benefit was lagging. According to the three-way contract, interdisciplinary care teams (ICTs) are offered for each enrollee as necessary and always at enrollee request. Enrollee participation in ICTs is intended to ensure that the team takes beneficiary preferences, wishes, and goals of care into account when they conduct a comprehensive review and discussion of the full range of the enrollee’s needs. However, although some MMPs reported that enrollees discuss their health care goals with care coordinators or providers, not all MMPs reported beneficiaries directly participating in their ICTs (i.e., being on the group conference calls or meetings with all the providers). Reports of enrollee participation in the ICTs have been sparse: one MMP reported an ICT attended by the beneficiary, and another reported that the ICTs are “member-centric” and are conducted with members. Advocates were concerned that the process of establishing a care plan, as well as other Cal MediConnect components such as passive enrollment, are not truly patient centered.

RTI focus group data also indicated low levels of enrollee involvement in their care. Only a few participants felt that they or their family members were involved in their care decisions and that their goals and preferences mattered; those who felt that way reported having a supportive and understanding PCP. Only one participant reported having in-depth discussions on her care goals with her MMP care manager. Some focus group participants reported discussing their care goals with a care coordinator outside of the MMPs. Most often, these care coordinators were from the adult day care program (CBAS). Consistent with RTI findings, State evaluators also found that few of their focus group participants remembered getting an Individualized Care Plan.

5.2.7 Experience of Special Populations

This section summarizes the beneficiary experience for Cal MediConnect special populations, including individuals with LTSS or behavioral health needs, and racial/ethnic or linguistic minorities. **Table 13** presents 2015 and 2016 CAHPS data on several survey measures describing the experiences of special populations such as MMP enrollees who use home health care or assistance.

The proportion of survey respondents who needed someone to come into their home to give them home health care or assistance varied across MMPs: in 2015, this proportion ranged from 12 percent to 30 percent. Among those needing assistance, the percent of enrollees who reported it is usually or always easy to get personal care or aide assistance at home through their MMP ranged between 46 percent and 72 percent. CAHPS data in 2015 also indicate that between 18 percent and 36 percent of all enrollees responding to the survey had a health problem for which they needed special medical equipment, such as a cane, wheelchair, or oxygen equipment. Between 52 percent and 73 percent of those who needed DME and other supplies reported it is usually or always easy to get or replace the medical equipment. In 2016, fewer MMP enrollees reported on these items; in four MMPs, the proportion of survey respondents who needed someone to come into their home to give them home health care or assistance decreased, and in three MMPs this proportion increased in comparison with 2015. From 2015 to 2016, the proportion of enrollee respondents who reported it is “usually” or “always” easy to get personal care or aide assistance at home through their care plan consistently increased for every MMP, indicating a positive trend.

Individuals receiving LTSS. Below we describe evaluation findings on the beneficiary experience separately for Cal MediConnect enrollees in both community and residential settings by their site of care (please see **Section 2.2.6, Integrated LTSS**, for the description of LTSS under Cal MediConnect).

MSSP. MSSP is an LTSS waiver program that provides extensive case management. During the period covering demonstration years 1 and 2, the number of Medicare-Medicaid beneficiaries in MSSP who were enrolled in Cal MediConnect was relatively small, around 5,000. RTI focus groups included a small number of MSSP participants who provided little feedback about the impact of Cal MediConnect enrollment on the MSSP services they were receiving. Those who provided feedback reported being confused about having both an MSSP case manager and someone from their MMP trying to perform what they perceived as a similar function.

Table 13
Beneficiary experience among special populations, 2015 and 2016

CAHPS survey item	Year	Anthem Blue Cross	Care1st	Community Health Group	Health Net	Health Plan of San Mateo	Inland Empire Health Plan	LA Care	Molina Health- care	Santa Clara Family Health Plan
Percent who needed someone to come into their home to give them home health care or assistance	2015	30 (N=47)	19 (N=122)	12 (N=333)	24 (N=246)	24 (N=123)	28 (N=376)	19 (N=232)	18 (N=115)	N/A
	2016	#	17 (N=110)	16 (N=189)	14 (N=105)	27 (N=88)	31 (N=149)	16 (N=132)	16 (N=178)	#
Percent who reported it is “usually” or “always” easy to get personal care or aide assistance at home through their care plan	2015	71 (N=14)	68 (N=22)	46 (N=46)	69 (N=55)	54 (N=26)	72 (N=95)	48 (N=42)	61 (N=18)	N/A
	2016	#	#	70 (N=27)	#	76 (N=21)	78 (N=41)	75 (N=20)	63 (N=24)	#
Percent who had a health problem for which they needed special medical equipment, such as a cane, wheelchair, or oxygen equipment	2015	23 (N=48)	26 (N=122)	24 (N=338)	26 (N=252)	20 (N=120)	36 (N=377)	21 (N=247)	18 (N=115)	N/A
	2016	#	23 (N=109)	21 (N=197)	23 (N=105)	18 (N=89)	34 (N=146)	21 (N=133)	27 (N=177)	32 (N=44)
Of those who reported needing it, percent who reported it is “usually” or “always” easy to get or replace the medical equipment they needed through their health plan	2015	#	73 (N=26)	60 (N=80)	64 (N=61)	52 (N=23)	57 (N=116)	55 (N=47)	63 (N=19)	N/A
	2016	#	55 (N=22)	61 (N=38)	#	#	60 (N=47)	62 (N=21)	55 (N=44)	#

= sample size 10 or less not presented; N/A = not applicable.

SOURCE: RTI Supplemental CAHPS data for 2015 and 2016.

IHSS. IHSS recipients opted out and disenrolled from the demonstration at high rates (please see *Section 3.3.1, Opt-out and Disenrollment Rates*). As of March 2016, when the State froze enrollment reporting metrics (except for Orange and San Mateo counties), only 18 percent of IHSS recipients were enrolled in Cal MediConnect (California Department of Health Care Services, 2016c). RTI site visit and focus group data indicated that enrollment in the demonstration did not bring many changes for those Medicare-Medicaid beneficiaries who were receiving IHSS services. Enrollees continued to receive IHSS services from the same caregivers they had predemonstration. The MMPs' responsibility for paying for IHSS services was not transparent to enrollees, who perceived IHSS as a stand-alone program unrelated to Cal MediConnect. Consistent with RTI results, UC Berkeley focus groups reported that most IHSS beneficiaries described little impact or change to IHSS, and similar lack of understanding on the relationship between IHSS and Cal MediConnect enrollment (Graham et al., 2016a).

CBAS. CBAS transitioned into managed care in 2012, prior to the Cal MediConnect implementation; advocates reported that this transition was not smooth and resulted in care disruptions and problems. In the RTI focus groups, LTSS recipients and proxies underscored the vital role that these adult day care programs play in their lives. They reported these programs reduce isolation, provide meaningful activities and social interaction, and serve as a place where recipients can get case management and nursing care. As with the MSSP recipients, RTI focus group attendees were confused and did not understand the division of responsibilities between their MMP assigned care coordinator and their CBAS case manager. Some beneficiaries reported needing to change the CBAS center as a result of passive enrollment in Cal MediConnect; some of these changes were traumatic for enrollees. Similar feedback was provided by advocates who reported a detrimental effect of changing CBAS centers among demonstration enrollees following Cal MediConnect enrollment.

Individuals with Alzheimer's disease and other dementias. Overall, caregivers participating in RTI focus groups on behalf of enrollees with cognitive impairments reported similar levels of satisfaction with Cal MediConnect as enrollees without cognitive impairment who were able to represent themselves. However, caregivers of enrollees with dementia in the 2016 RTI focus groups reported some controversial marketing practices used to entice Medicare-Medicaid beneficiaries with cognitive limitations to switch from MMPs to other Medicare Advantage plans in counties where multiple plans were operating. It appeared that these activities occurred in congregate senior housing sites and in adult day care centers. Several English and Spanish speaking beneficiary proxies reported that their family members sometimes switched plans after being attracted by small incentives, without fully understanding their actions or the consequences:

[An MMP representative or enrollment broker] invite[d] them to get a haircut or something...all of a sudden there was already this [MMP representative or enrollment broker] going to his house and describing this...program to him, but it seems that my dad had already accepted these visits. So he did the change [from one MMP to another].

Look, the place she goes to, where she gets entertained and all, this seniors' place [adult day care center] ...they let other people get in, and they convince the elders, they give them small presents, to get inside...To get them to subscribe,

yes, to get the attention, to get them to subscribe and to change from the plan they have, to a different one.

Nursing facility residents. RTI focus groups and State evaluation focus groups were conducted with community residents only, so there were no data on beneficiary experience obtained directly from nursing facility residents. However, in interviews, stakeholders and some nursing facility providers shared their observations on how Cal MediConnect has affected the experience for nursing facility enrollees.

DHCS reported implementing positive steps to specifically protect nursing facility residents from care disruptions related to passive enrollment. First, to promote continuity of care for these enrollees, the State issued a DPL in June 2014 stating that beneficiaries who are residents of nursing facilities prior to enrollment are not required to change facilities during the entire demonstration period. Along the same lines, passive enrollment rules were modified in 2015 for approximately 3,500 eligible beneficiaries residing in Orange County nursing facilities so they could be enrolled on facility-by-facility basis. To make this a better experience for residents, CalOptima, the only MMP operating in Orange County, developed a special team—composed of a case manager, personal care coordinators, a provider relations representative, an enrollment coordinator, and representatives from HICAP and the Cal MediConnect Ombudsman Program—to work directly with residents and their families.

Although the State made provisions for nursing facility residents to remain in their facilities, once enrolled, many residents were not able to retain their medical providers. According to advocates, some MMPs changed facility residents' PCPs without notice to the enrollee. As one advocate stated in a 2015 interview:

Most health plans sent notices to SNFs [skilled nursing facilities] to switch PCPs of members to a different PCP that would adopt their model of care. They were going to improve the model of care in the facilities. But the issue is changing people's PCP without notice, or passively making that change. That's not person-centered.

Providers interviewed in 2016 reported that another problem was that in counties such as Los Angeles, nursing facility residents and their families were not informed about Cal MediConnect enrollment during the passive enrollment stage.

Moreover, several stakeholders and members of the contract management team (CMT) reported a related issue that occurred in 2015, where nursing facility transfers were made without honoring a person-centered approach, and care coordinators did not get involved to advocate for enrollees. This issue was exacerbated by a lack of MMP experience and knowledge of nursing facility policies and regulations. For example, in Los Angeles County, several MMPs transferred nursing facility residents out of one facility in Pasadena at risk of being decertified, without realizing that facilities could regain certification after corrective actions. This facility was also under a criminal investigation at the time. While legal concerns and beneficiary protections are crucial in such circumstances, facility residents were transferred without proper consent procedures and notification, and without having their preferences discussed. One stakeholder reported that more than 70 enrolled residents were affected. The same stakeholder shared that similar instances may have happened in Riverside and San Bernardino counties as well. Stakeholders and CMT members reported that these transfers resulted in great personal distress

and were in violation of Federal law. These occurrences led to extensive efforts by the Long-Term Care (LTC) Ombudsman to educate MMP staff on patient rights for nursing facility residents, and to increased collaboration to resolve the consequences of these steps, such as returning beneficiaries to their original nursing facilities. The stakeholders reported that these situations were corrected, and all residents returned to facilities of their choice. According to stakeholders, the LTC Ombudsman did not have any communication or relationship with the MMPs prior to this issue. The Cal MediConnect Ombudsman Program facilitated contact between the State LTC Ombudsman program and MMPs to prevent the issue from occurring in the future. The LTC Ombudsman also worked with the State to provide education on beneficiary protections around nursing facility transitions.

Some of the issues related to MMPs' lack of knowledge of their responsibilities in the care provided to nursing facility residents remained well into 2016. Nursing facility representatives interviewed in the fall of 2016 reported that even though the demonstration had been in place for some time, MMPs continued to have difficulty providing required services such as transportation to medical appointments or ambulance trips. As one nursing facility representative noted: "Patients are not getting picked up to go to dialysis, which is supposed to be offered under Cal MediConnect."

Nursing facility providers interviewed in 2016 reported that their experience varied by MMP. In Los Angeles County, facility staff reported having a good working relationship with Molina, but not with the other MMPs. Nursing facility providers also shared that nursing facility and skilled nursing facility (SNF) residents were not receiving any meaningful care coordination:

Our feeling is that once a patient is in a nursing facility, the coordinator drops the patient like a [hot] potato. When [the demonstration] was originally rolled out, it sounded juicy, but it has not worked out. I do not see good sides. Providers and patients are suffering. Patients are not being informed of changes in their health plans.

Linguistic minorities. Demonstration counties are characterized by significant ethnic and language diversity; in 2015, MMPs reported this to be a significant factor they have considered in contracting new providers and developing LTSS for their new demonstration enrollees. Each county has a slightly different mix of threshold languages for which plans are required to have language-appropriate providers and materials (please see ***Section 2.1.2*** for a full description of threshold languages and other requirements for MMPs). In 2014, plans and stakeholders noted that ethnic minority providers generally did not participate in managed care plans; maintaining sufficient numbers of these providers was a challenge early in the demonstration. To support communication with enrollees in additional languages where there was no staff capacity to translate, MMPs reported routinely contracting with telephone services with third-party translators. All plan representatives interviewed in each site visit year reported having staff with diverse backgrounds who provide care coordination, including registered nurses (RNs), licensed practical nurses (LPNs), and social workers; plans tried to match the care coordinator's language to the needs of the enrollee. Additionally, MMPs are required to offer in-person HRAs to all enrollees, document their outreach efforts to engage enrollees, provide materials, and conduct the assessment in all threshold languages. The MMPs also shared that, in effort to reach beneficiaries

and initiate HRAs, they had to hire lower-level, non-credentialed staff with language capabilities to look for beneficiaries in the community.

Harbage Consulting reported that they used multiple languages to convey enrollment and other pertinent information to beneficiaries. Harbage also worked with other consultants to expand the demonstration website, develop an outreach and communications plan, develop materials, and conduct outreach activities in the demonstration counties for beneficiaries, stakeholders, and providers. This work also included development of county-specific enrollment notices and choice books.

The focus group data indicated that these extensive efforts paid off. To collect data on beneficiary experience among non-English speakers, RTI conducted two focus groups with Spanish-speaking Cal MediConnect enrollees. In these focus groups, participants reported general satisfaction with culturally appropriate care, ability to find and access Spanish-speaking providers, and receiving all needed materials in Spanish. Data from the UC Berkeley focus groups, conducted in Spanish, Cantonese, and Mandarin, indicated that most beneficiaries whose first language was not English received Cal MediConnect enrollment and other materials from their MMP in their primary language (Graham et al., 2016a) or were able to access interpretation services through their providers. RTI focus group participants shared the following thoughts on importance of language- concordant care:

She [proxy's mother] sees [doctor's name] about every 2 months.... And even though her hours have been reduced at this particular medical group, we continue to see her ...because my mother feels very comfortable with her. The doctor is Spanish-fluent. And she likes her very much.

[Since enrolling in an MMP] I've seen her only once, but I did find her really nice because she speaks Spanish. So I can communicate with her, she's very patient. And now she's very aware that I haven't seen her since May.

[Speaking Spanish] language can help us understand each other. When I see [my doctor] I go there to talk, to chat, to ask for information regarding my health, about what should I do, what is right and what is not.

None of the RTI focus group participants reported any problems or issues accessing care coordination services due to a language barrier. Although both RTI and UC Berkeley focus groups participants underscored the importance of access to providers who speak their languages, they also reported some situations when they could not find a language concordant provider in the network or could not obtain needed materials in their native language.

Enrollees with behavioral health needs. The RTI and the UC Berkeley focus group findings differ regarding the experience for Cal MediConnect enrollees with behavioral health needs. RTI focus group participants with behavioral health needs had little awareness of Cal MediConnect and reported receiving case management through programs affiliated with a County Department of Behavior Health. They were not aware of Cal MediConnect care coordinators and seemed unaware that their MMPs were involved in coordinating these services. Participants described their heavy reliance on other entities to coordinate behavioral health services. In contrast, UC Berkeley focus group participants described important improvements in

care for behavioral health service users under Cal MediConnect, including better access to care and better coordination between behavioral health services and other providers (Graham et al., 2016a). One UC Berkeley focus group participant reported improved access to addiction treatment services, and others reported being satisfied with new mental health providers available through Cal MediConnect.

Absence of care coordination and communication between acute care and behavioral health providers was one additional issue raised by RTI focus group participants. One recipient of behavioral health services shared the following:

One [doctor] increases the psych meds, and then it makes the neuropathy bad. One [doctor] increases the Parkinson's meds, and it makes the psych bad. I've had that happen. I've had a neurologist tell me that I had to go off of one of my psych meds in order for her to really see if my shake was from the psych med or from Parkinson's. And I actually did that and ended up in the hospital.”

5.2.8 Beneficiary Protections

This section describes the numbers and types of beneficiary complaints and appeals received about Cal MediConnect. Because Cal MediConnect integrates Medicare and Medicaid services, these data have been compiled from a number of sources, including the Cal MediConnect Ombudsman Program, the Cal MediConnect plans, DHCS, and Medicare CTM and Independent Review Entity (IRE).

Cal MediConnect Ombudsman Program. DHCS developed an interagency agreement with the Department for Managed Health Care (DMHC)—the State agency that oversees all health plans operating in the State, including the MMPs—to develop and administer a Cal MediConnect Ombudsman Program modeled after the existing Consumer Assistance Program (CAP) administered by DMHC. California has a well-established integrated network of Ombuds service providers serving each county throughout the State and organized under the Health Consumer Alliance. It has a reputation for providing local, person-centered, and linguistically and culturally competent services. Justice in Aging (JIA) provides technical support for the program.

The Cal MediConnect Ombudsman Program was designed to assist enrollees with complaints and appeals; investigate, negotiate, and resolve enrollee problems and complaints with Cal MediConnect plans; make referrals to other entities and programs; and provide objective analyses and reports on their activities. Ombudsman contact information was located in enrollment notices, in the Choice Book, and on the CalDuals website. Ombuds offices produce data reports that are standardized across all demonstration counties; they include tracking the number of calls, wait time, talk time, and types of caller issues. If a case is opened, it is detailed further and trends are identified. The Ombudsman director provides summary analyses by plan and county to the DMHC, and works closely with State officials to keep abreast of the latest policy clarifications and to disseminate those policy details to staff responding to callers. The Ombudsman director also participates in the stakeholder advisory group, the California Collaborative for LTSS.

The Cal MediConnect Ombudsman Program has a designated organization that represents the demonstration in each county and calls to the 800 number are rerouted to local offices based on beneficiary residence. Each county office tracks its specific issues, the outcomes, and the languages that beneficiaries seeking help speak. The Cal MediConnect Ombudsman Program has been closely collaborating with DMHC and other stakeholders to address problems raised by beneficiaries and work toward achieving problem resolutions. They also disseminate alerts and DPLs received from advocates and DHCS, and answer questions that partner organizations bring by phone or e-mail.

Complaints and grievances. Enrollees may make a complaint through any venue in accordance with the State's 'no wrong door' policy; complaints may also be made directly to CMS for Medicare services. Resolving a complaint through the plan is the preferred approach, according to State, plan, and Ombuds staff. The three-way contracts delineate the plans' requirements for accepting, processing, and reviewing complaints and grievances, which may be verbal or written (California three-way contract, pp. 89–97). If the complaint needs to be elevated, the beneficiary may appeal through the Office of the Patient Advocate and request a State Fair Hearing.

The Ombudsman Program director, members of the CMT, and individuals from State agencies involved in the demonstration (Departments of Aging, Social Services, Managed Health Care, and the Office of the Patient Advocate) all input complaint data into a Complaint Tracking Module (CTM) established for the demonstration and posted publicly. Other entities that can also enter complaints include Health Insurance Counseling and Advocacy Program, and the Medicare toll-free help line, 1-800-MEDICARE. Cal MediConnect plans are required to respond to all complaints in the CTM and submit monthly complaint and resolution tracking data to DHCS (California Department of Health Care Services, 2014c). Resolved enrollee complaints, displayed by Cal MediConnect plan and type of complaint, are posted monthly on the DHCS website (California Department of Health Care Services, 2016k) and combine external complaints from the CTM and complaints received directly by plans. In addition to this tracking system, there are separate systems for processing and tracking Medicare and Medi-Cal complaints through CMS and the State, respectively. There is a separate process for filing complaints and grievances for MSSP recipients; the Cal MediConnect enrollees may submit complaints or concerns directly to the MSSP provider either orally or in writing (California Department of Health Care Services, 2015a).

Following is a summary of complaint data received from each of the three previously discussed sources: (1) data reported by Cal MediConnect plans on complaints made directly to them; (2) CTM data for complaints received by DHCS and 1-800-Medicare; and (3) complaints made to the Cal MediConnect Ombudsman Program. Reporting periods vary across these sources. Some, but not all, sources report complaint data per 1,000 beneficiaries, thereby accounting for changes in enrollment. Also, the rates of complaints in some areas are extremely small (e.g., less than one complaint per 1,000 beneficiaries) and are therefore not included in this summary.

Complaints and Appeals Received by Cal MediConnect Plans

Data presented in **Table 14** cover the period from April 2014 through September 2016. In 2014, the number of complaints per 1,000 enrollees decreased from 10.524 to 8.297. After 2014,

the number of complaints per 1,000 beneficiaries increased to 13.114 in Q3 2015, which may be related to the beginning of passive enrollment in Orange County. The number of complaints then decreased in the first two quarters of 2016, and increased again to 13.455 in Q3 2016, for which the most recent data is available.

Table 14
Complaints and appeals made to MMPs directly; per 1,000 enrollees, by quarter

Quarter	Enrollment	Complaints per 1,000 enrollees	Appeals per 1,000 enrollees
2014			
Q2	17,846	10.524	0.058
Q3	44,804	7.551	0.422
Q4	58,945	8.297	0.793
2015			
Q1	124,239	11.679	0.694
Q2	122,846	11.999	0.765
Q3	117,307	13.114	1.664
Q4	115,743	12.636	1.491
2016			
Q1	123,560	12.336	1.285
Q2	119,814	12.392	2.036
Q3	115,766	13.455	2.510

NOTES: Because the California demonstration began in Q2 2014, no data are available for Q1 2014. Data presented in Q2 2014 represent seven plans that were active (Care 1st, CHG, Health Net, IEHP, L.A. Care, Molina, and HPSM). In Q3 2014, Anthem Blue Cross began reporting data. In Q1 2015, SCFHP began reporting data. In Q3 2015, Cal Optima began reporting data.

SOURCE: RTI analysis of MMP reported data for Core Measure 4.2 and State enrollment data, as of December 2016. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html>.

Complaints made to Cal MediConnect MMPs included the following: inability to get an appointment with a PCP, inability to get an appointment with a specialist, excessive wait time to get an appointment with a PCP, excessive wait time to get an appointment with a specialist, and other complaints related to areas not mentioned. For each quarter presented in **Table 14**, the vast majority of complaints fell into the last category (other complaints related to areas not mentioned).

Enrollees are encouraged to first make a complaint directly with the MMP and if they are not satisfied, to pursue the complaint with the State, through the DMHC, or with the Ombudsman Program. The data on MMP complaint rates from **Table 14** may be considered in comparison with the overall complaint rates for California managed care plans, which include MMP products (California Department of Managed Health Care, 2015). For example, in 2015, the overall complaint rate reported by the DMHC ranged from a high of 0.57 complaints per 1,000 beneficiaries for HealthNet of California and 0.53 per 1,000 for Anthem Blue Cross, to low rates of 0.004 per 1,000 for Cal Optima and no reportable complaints for Care More Health Plan. In summary, the complaint rates for Cal MediConnect products appear to be substantially higher on average.

Complaints Received by the Cal MediConnect Ombudsman Office

The MediConnect Ombudsman Program is one of many avenues enrollees use to resolve issues or report complaints. Enrollees are encouraged to resolve concerns or complaints directly with MMPs when possible and only elevate the issue to ombudsman offices if their experiences are unsatisfactory. When enrollees file complaints directly with the Cal MediConnect Ombudsman Program, they are subsequently reported to DMHC and the ACL as part of the demonstration's efforts to monitor complaints. From the beginning of the demonstration through the peak of passive enrollment, the ombudsman offices handled a very large number of monthly telephone calls from beneficiaries requesting assistance. The number of calls fluctuated over time due to the passive enrollment schedule, and ultimately decreased as enrollees learned more about the demonstration, understood their affiliation with MMPs, or opted out of Cal MediConnect.

For example, in January of 2015, the first month for which RTI received Ombudsman Program data, the Cal MediConnect Ombudsman Program received 2,201 calls from beneficiaries seeking assistance regarding the demonstration. In July 2015, there were 1,511 beneficiary calls made to ombudsman offices, and by July 2016, the number of incoming monthly calls to the program declined to 410. However, the number of opened cases increased as the demonstration unfolded: in January of 2015 the Cal MediConnect Ombudsman Program attorneys were working on 405 cases, and by July 2016 the number of opened cases stood at 1,004.

The nature of problems for which Cal MediConnect enrollees sought assistance also changed with time. In January of 2015, 72 percent of all eligibility problems were related to Medicare-Medicaid beneficiaries being unaware of Cal MediConnect and its rules, and by the same month the following year, only 8 percent of all calls were classified in this category. However, eligibility problems and coverage termination (related to Medi-Cal coverage interruptions and deeming) progressively increased with time.

Early in the demonstration, the top concern about services related to lack of care availability and accessibility, including problems with MMP network adequacy and delays in services (30 percent of all service related calls in January 2015), these concerns subsided and only represented 5 percent of all service problems reported by July 2016. Enrollment and disenrollment problems with specific MMPs and providers reached the top of the list (63 percent of all service problems reported) in July 2016. It is important to note that although 11 percent of the eligibility complaints in January 2015 were related to language, cultural, or racial barriers, these issues never made it into the top three categories in subsequent reporting periods.

Incorrect billing of enrollees for co-pays and other charges has been an ongoing challenge in and beyond the demonstration in California. Incorrect billing occurs when delegated entities or providers of continuity of care services are unaware of demonstration rules and attempt to bill enrollees for co-pays or other charges. Ombudsman program staff reported that this problem had been widespread throughout the demonstration, despite efforts by the State, MMPs, and advocacy groups to educate both enrollees and providers on this issue. When enrollees report incorrect billing, ombudsman staff contact providers directly to educate them on appropriate billing procedures.

Both RTI and UC Berkeley focus group participants and proxies reported trying to resolve their difficulties by advocating for themselves directly with individual providers or with their plans. One RTI focus group participant who had contacted the Cal MediConnect Ombudsman Program reported great satisfaction with the assistance he received and had high praise for the professionalism of the staff who quickly resolved his problem. Similarly, several UC Berkeley focus group participants reported that they had either received ombudsman program services or that they intended to use them if their first attempt at resolving their issue directly with the plan was not satisfactory (Graham et al., 2016a). Some RTI focus group participants were not aware of ombudsman services despite the fact that office locations, contact information, and descriptions of their services are located in enrollment materials.

Data on Complaints Received by DMHC and 1-800-Medicare

As described above, beneficiaries may file complaints directly with DMHC or 1-800-Medicare. The most current data available at the time of this report on the number and nature of those complaints cover the period April 2014–November 2016 are shown in **Table 15**.

In all years for which the data are available, most complaints were reported to be about enrollment and disenrollment. The number of complaints in the area of pricing/premiums/co-insurance increased between the first demonstration year and the second, while the number of complaints in all other areas decreased.

DMHC recently fined Anthem Blue Cross for a “pattern of grievance system violations (failing to identify, timely process and resolve enrollees’ grievances).” According to DMHC, no Cal MediConnect enrollees were affected by these violations.

Table 15
Number and category of beneficiary complaints filed with California and 1-800-Medicare
April 2014–December 2016

Category	April 2014 to December 2015	January 2015 to December 2016
TOTAL	297	74
Enrollment/Disenrollment	202	36
Customer Service	22	11
Benefits/Access	32	10
Marketing	16	6
Plan Administration	8	4
Pricing/Premium/Co-Insurance	1	3
Exceptions/Appeals/Grievances	9	2
Payment/Claims	7	2
Access and Availability	0	0
Confidentiality/Privacy	0	0
Contractor/Partner Performance	0	0
Quality of Care/Clinical Issues	0	0

SOURCE: CMS, Complaint Tracking Module, Report covering April 2014–November 2016.

Appeals

According to the three-way contract, MMPs must notify Cal MediConnect enrollees in writing of any adverse action related to a grievance. The enrollee must be notified of all applicable Cal MediConnect, Medicare, and Medi-Cal appeal rights through a single notice at least 10 days in advance of the date of the MMP's action. The decision notice must explain, in the appropriate language, the action the MMP is taking, the reasons for it, and the regulations supporting the action. It also includes the enrollee's or provider's rights, the procedures to file an appeal, how it could be expedited, and how an enrollee could receive health care services in the interim.

Appeals relating to Medi-Cal covered benefits are processed pursuant to the laws and regulations that govern Medi-Cal appeals. Those relating to Medicare covered benefits are governed by laws and regulations that govern Medicare appeals.

Appeals by Outcome (CMS/NORC Data)

Table 16 shows the number of initial appeals made to Cal MediConnect plans for the period from April 2014 through September 2016. In most years, 45–55 percent of all appeals resulted in a fully favorable or partially favorable outcome for beneficiaries. These appeals are categorized as denial or limited authorization of one of the following services: specialty services, home- and community-based LTSS, institutional LTSS, mental health services, and substance use treatment services. The majority of appeals made to Cal MediConnect plans were denial or limited authorization of specialty services, or other appeals related to areas not mentioned.

Appeals Referred to Medicare Independent Review Entity

As described earlier, initial appeals that result in an adverse outcome related to Medicare services are automatically referred to the Independent Review Entity (IRE) for further review. At the time this report was produced, data are available from April 2014–December 2015 on the number of appeals sent to the IRE. During this time, the IRE received 259 appeals. Of these appeals, the determination made by the Cal-Medi Connect plan was upheld in 193 cases (77 percent); 21 (8 percent) were overturned; and 2 (less than 1 percent) were partially overturned. Appeals relating to acute inpatient hospital, nursing facility, and home health represent the areas where the highest percent of appeals were overturned in favor of the beneficiary.

Critical Incident and Abuse Reports for Members Receiving LTSS

Cal MediConnect plans are required to report to DMHC and NORC on the number of critical incidents and abuse reports. Reporting requirements define “critical incident” as “any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of a member.” Abuse refers to: (1) willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish; (2) knowing, reckless, or intentional acts or failures to act which cause injury or death to an individual or which places that individual at risk of injury or death; (3) rape or sexual assault; (4) corporal punishment or striking of an individual; (5) unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and (6) use of bodily or chemical restraints on an individual which is not in compliance with Federal or State laws and administrative regulations (Centers for Medicare & Medicaid Services, 2018).

Table 16
Appeals by outcome, by quarter

Calendar quarter	Enrollment	Total appeals	Fully favorable outcomes	Partially favorable outcomes	Adverse outcomes
2014					
Q2	17,846	1	100.0%	0.0%	0.0%
Q3	44,804	19	31.6%	21.1%	47.4%
Q4	58,945	47	40.4%	6.4%	53.2%
2015					
Q1	124,239	86	48.8%	3.5%	47.7%
Q2	122,846	94	47.9%	3.2%	48.9%
Q3	117,307	195	59.5%	4.6%	35.9%
Q4	115,743	174	44.3%	9.8%	46.0%
2016					
Q1	123,560	159	44.0%	4.4%	51.6%
Q2	119,814	246	46.3%	6.9%	46.7%
Q3	115,766	294	37.8%	2.7%	59.5%

NOTES: Because the California demonstration began in Q2 2014, no data are available for Q1 2014. Data presented in Q2 2014 represent seven plans that were active (Care 1st, Community Health Group, Health Net, Inland Empire Health Plan, L.A. Care, Molina, and Health Plan of San Mateo). In Q3 2014, Anthem Blue Cross began reporting data. In Q1 2015, Santa Clara Family Health Plan began reporting data. In Q3 2015, Cal Optima began reporting data. Data presented in this table are considered preliminary.

SOURCE: RTI analysis of MMP reported data for Core Measure 4.2 and State enrollment data, as of December 2016. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html>.

Cal MediConnect plans reported data relating to the State-specific measure for critical incidents and abuse reports for enrollees receiving LTSS. The data indicate that the number and rate of those reports remained low (0 to 1.6 percent) during the period from Q2, 2014 to Q3, 2016.

5.3 Successes

- **Enrollees participating in surveys and focus groups reported being generally satisfied with their care under Cal MediConnect.** Levels of satisfaction often related to familiarity with and understanding of the demonstration. However, the level of satisfaction among Cal MediConnect enrollees was similar to that of beneficiaries in non-demonstration counties or among those who opted out of Cal MediConnect. Therefore it appears that Medicare-Medicaid beneficiaries overall are satisfied with the care they receive.
- **Enrollees appreciated new and added services.** In particular, the transportation benefit is an essential service that allows frail and impaired beneficiaries to access

their care and reach their health care providers. While enrollees reported challenges with this service, they were very appreciative of it.

- **Care coordination has been valued by those Cal MediConnect enrollees who receive it.** Enrollees who have established relationships with care coordinators reported valuing the service and using care coordinators as their advocates to resolve problems and get services and medical equipment they needed. Satisfaction with care among these enrollee RTI focus group participants was high.
- **Cal MediConnect enrollees reported access to and satisfaction with culturally appropriate care.** The extensive State efforts to provide culturally appropriate care paid off with language minority Cal MediConnect enrollees reporting general satisfaction with culturally appropriate care, ability to find and access language-concordant providers, and receiving all needed materials in their native language.
- **Beneficiary protection systems were working, for those who access these systems.** Enrollees may lodge complaints through multiple venues through the “no wrong door” approach. The Cal MediConnect Ombudsman Program has been active in all counties and provided valuable assistance to beneficiaries by explaining the Cal MediConnect rules and helping to resolve issues with providers.

5.4 Challenges

- **Cal MediConnect enrollees have had difficulty understanding the concept of managed care and some of the new services delivered under the demonstration.** Enrollees were generally confused between regular Medi-Cal benefits and coverage provided by MMPs as part of their Cal MediConnect.
- **Some beneficiaries reported disruptions in continuity of care due to passive enrollment in Cal MediConnect.** Some beneficiaries reported that some providers refused treatment. Enrollees also experienced disruptions in prescription medications and DME supplies when they were first enrolled in the demonstration.
- **Enrollee knowledge of care coordination has been limited.** Most State survey respondents and RTI and UC Berkeley focus group participants reported that they were unfamiliar with care coordination benefits, and some reported relying on LTSS or BH system care managers to coordinate their care.
- **MMPs’ lack of knowledge about nursing facility services resulted in serious missteps with repercussions for nursing facility residents.** There were some isolated but significant negative experiences that affected about 70 nursing facility residents early in the demonstration. These residents were transferred without proper consent procedures and family notifications from a facility in Pasadena, which was under a criminal investigation and was being terminated from Medicare and Medicaid. These actions stemmed from a lack of MMP experience with nursing facility care.

- **Problems with billing/charges and misunderstanding of Cal MediConnect.** Beneficiaries filed multiple complaints and grievances relating to eligibility and services. Most of the Cal MediConnect complaints and grievances have to do with billing/charges and enrollees misunderstanding Cal MediConnect rules.

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6. Stakeholder Engagement

Highlights

- California has an active, participatory stakeholder community that has been involved in both the demonstration and the broader CCI move toward managed care.
- There was significant and organized resistance against the demonstration by provider organizations, significantly hampering both the MMPs' efforts and Harbage Consulting outreach work.
- Despite the State's outreach efforts that began prior to the demonstration, some providers and stakeholders perceived demonstration outreach and education efforts as insufficient, especially in the early stages of implementation. This may have contributed to broad opposition to and lack of knowledge about the demonstration in the beginning.
- Lack of meaningful involvement of providers and stakeholders in the initial stages of Cal MediConnect implementation may have also contributed to massive opt-outs, disenrollments, and opposition to the demonstration among health care providers; however, by 2016, DHCS, working with Harbage Consulting, significantly increased outreach activities on all fronts and mostly managed to turn this opposition around.
- With more involvement, stakeholders' attitudes towards Cal MediConnect evolved over time; stakeholder engagement developed into meaningful participation and cooperation with the State in shaping of Cal MediConnect experience for beneficiaries.
- One set of stakeholders, nursing facilities, reported being particularly uninvolved in the early stages of the Cal MediConnect implementation. Individual providers, provider organizations, and members of the California Collaborative raised awareness of these concerns and were working directly with MMPs to educate them on their practices and MMPs' responsibilities about nursing facility services, billing, and payment practices. Cal Optima, which began enrollment in mid-2015, made particular efforts to reach out to nursing facility providers and physicians serving nursing facility residents to increase their buy-in.

6.1 Overview

This section describes the approach taken by California to engage stakeholders, the mechanisms for soliciting stakeholder feedback, and the impact of those efforts on the demonstration. The Medicare-Medicaid Coordination Office (MMCO) State lead plays a crucial role in supporting the implementation of the demonstration and works closely, on an ongoing basis, with a variety of stakeholders. This section focuses on the role of the State in the stakeholder process, and describes the stakeholder process and organizations involved. For information on the role of CMS in the demonstration and the ways CMS supports the demonstration implementation through the CMT, please refer to ***Section 2.1. Joint Management of the Demonstration.***

6.2 Organization and Support

According to State officials, California has an active and participatory stakeholder community involved in both the demonstration and the broader Coordinated Care Initiative (CCI) move toward managed care, more so than in past health care initiatives in the State. Two primary stakeholder entities involved in Cal MediConnect are Harbage Consulting—California Department of Health Care Services (DHCS) contractor for stakeholder engagement—and the California Collaborative for Long-Term Services and Supports (LTSS), made up of advocates and provider associations and other stakeholders.

6.2.1 *Harbage Consulting*

The State contracted with Harbage Consulting in 2011, before the demonstration began, to support the design and implementation of the demonstration and to take the lead in stakeholder engagement. The State tasked Harbage Consulting to be the primary liaison to stakeholder groups—including the California Collaborative—and to provide outreach forums, monthly stakeholder calls, the CalDuals website, and presentations to stakeholder and beneficiary groups. In addition to responding to State officials, some stakeholders reported that they interacted with the MMCO State lead and with senior MMCO leadership on a regular basis.

The State faced a challenging provider environment, with a large number of providers across the seven demonstration counties that had varied levels of delegation and Medicare Advantage plan penetration. Fee-for-service providers, resistant to managed care, and Medicare Advantage providers, concerned about protecting their market share, were initially hostile to the demonstration. Early outreach to providers was organized prior to September 2013 and included the following activities: trainings, webinars, provider newsletters, multiple direct meetings and trainings (including meetings with the California Hospital Association [CHA], Hospital Association of Southern California, California Dialysis Board, and county medical societies). Between July and September 2013, Harbage conducted seven targeted webinars to providers in partnership with CHA and the California Association of Physician Groups (CAPG), and five webinars in partnership with CAPG specifically on care coordination and LTSS. Harbage also participated in CAPG State Program Committee, the collective forum for capitated physician groups. State staff also held weekly “Wednesdays with Jane [Ogle]”—open calls to respond to provider questions.

In the period spanning late 2014–2016, Cal MediConnect outreach activities continued to be intensive and occurred in various locations throughout the demonstration counties. Harbage was responsible for all Cal MediConnect outreach and stakeholder engagement activities such as tele-town halls, regular stakeholder calls, and weekly e-mail updates and outreach events in communities in every county. According to the State Data Recording System submission, in Quarter 6 of the demonstration (July 2015–September 2015), DHCS and Harbage conducted three statewide telephone town hall meetings, 73 presentations, and four webinars across the State. In Quarter 9 of the demonstration (April 2016–June 2016), the latest data available for this report, DHCS and Harbage conducted two statewide telephone stakeholder update calls, 117 presentations, and 19 webinars across the State. In Quarter 9, DHCS and Harbage also performed over 100 other outreach activities, including distributing materials, setting up information/resource tables at events, and participating in senior health fairs and providing

updates to stakeholders. Presentations took place in a variety of settings, including provider organizations, medical centers, caregiver workshops, pharmacies, and advocacy organizations. Webinars were targeted at hospital leadership and providers. Several informational and resource tables were also set up at health fairs and conferences. In 2015, outreach efforts focused on

- supplying providers with general education about Cal MediConnect,
- alleviating a major issue with incorrect billing that affected those enrolled in the demonstration and those who opted out,
- improving materials sent to beneficiaries and continuing to educate them on Cal MediConnect’s benefits, and
- connecting with newly eligible beneficiaries (e.g., those who are aging into Medicare and already have Medi-Cal, or Medicare beneficiaries whose income qualifies them for Medi-Cal).

In 2015, DHCS and Harbage developed a beneficiary toolkit to target those with lower health literacy—explaining concepts such as managed care, co-payments, and care coordination. DHCS released a draft Cal MediConnect Beneficiary Toolkit for stakeholder comment on November 11, 2015. Working with representatives from hospitals, Harbage and DHCS developed a new hospital case manager toolkit and discharge planning guidance for hospitals and nursing facilities working with Cal MediConnect plans later in the following year. The same year, as a part of the State’s stakeholder and provider engagement strategy, Harbage Consulting designed and managed two Provider Summits to share best practices.

In 2016, Harbage efforts focused more on outreach and recruitment of providers, resolving issues with MMPs and providers related to billing practices (incorrect billing, crossover claims, etc.), sharing clients and working out billing problems with county behavioral health service agencies, and discharge planning issues with hospitals and nursing facilities. Also in 2016, they began facilitating regular meetings with the MMPs to discuss best practices. For more on this topic please see *Section 2.2.9*.

6.2.2 California Collaborative for LTSS

Structure and Membership

The California Collaborative for LTSS functions as a stakeholder advisory group to DHCS, though not in an officially sanctioned capacity. The group predates the demonstration and is composed of a range of approximately 35 organizations, including disability rights groups, home care provider unions, medical and hospital associations, area agencies on aging, assisted living, and nursing facility associations. The Cal MediConnect Ombudsman director also participated in the California Collaborative. Supported by the SCAN Foundation, the Collaborative held regular conference call meetings to discuss Cal MediConnect.

In 2015, MMPs began participating in California Collaborative meetings. Collaborative members reported this as a very positive development and shared that in these meetings, MMPs actively solicited feedback from the Collaborative, discussed issues and challenges, and

presented plans to address existing problems. Through this participation process, stakeholders' perspectives have been changing, and they acknowledged that MMPs are trying hard to serve the challenging population of Medicare-Medicaid beneficiaries. Although collaboration began midway through the demonstration's implementation, this dialog represented a positive new development and the establishment of communication channels important for the success of the demonstration.

Harbage Consulting served as the conduit between DHCS and the Collaborative, providing draft policy documents, forms, and other materials to the Collaborative for its review, and taking questions from the group back to DHCS to obtain clarifications on policies and procedures. A subset of the Collaborative, known as the "kitchen cabinet," assembled in 2014, provided feedback to CMS and to the State on key issues relevant to start-up activities. Representatives from the SCAN Foundation, Disability Rights California, LA Care, and Justice in Aging were members of this group.

During 2015 and 2016, the Collaborative continued to be very involved, providing solicited and unsolicited recommendations on wide ranging issues related to Cal MediConnect implementation. For example, they reviewed and provided feedback on beneficiary enrollment and toolkit materials. In July 2016, this organization recommended 11 detailed activities designed to support opt-in enrollment, including improved training of staff involved in eligibility and enrollment activities, timing of notifications, outreach to ethnic minority providers and communities, and other suggestions (California Collaborative for Long Term Services and Supports, 2016). At the time of the September 2016 site visit interviews, DHCS was considering these recommendations. This issue will be explored in greater detail in future reports.

6.2.3 Providers and Provider Organizations

Although the State and Harbage were involved in multiple outreach efforts that started even before the demonstration was implemented, these efforts were hampered by significant and organized resistance to the demonstration by provider organizations, primarily due to a lack of trust or interest in managed care. DHCS reported that few providers took the initiative to learn about the demonstration and to reach out to the State or to MMPs for information or materials. On the provider side, the consistent message received by RTI during site visit interviews was that the outreach was not adequate. Health care providers from various settings, as well as other stakeholders and advocates interviewed by the evaluation team reported a lack of sufficient outreach to providers in the early stages of the demonstration. In particular, little proactive work was done by the State to educate providers about managed care in general, and about Cal MediConnect in particular. As a result, providers in the community—especially primary care providers in ethnic communities such as Vietnamese and Russian communities in Los Angeles County—organized and mounted campaigns to urge their patients to opt out of the demonstration. The Los Angeles County Medical Association was one of the stakeholder groups consistently advocating against the demonstration. These campaigns were quite effective and resulted in lower than expected enrollment rates (see *Section 3.3.2* for more details). It is important to note that the State—and Southern California in particular—is a uniquely dynamic and competitive market with many forces at play; even with a higher level of engagement, the stakeholder opposition to the demonstration could have remained quite significant.

Cal MediConnect plans also played an essential role in outreach and education to providers. Plans reported conducting outreach and training to providers initially as they were building their networks. MMPs engaged in significant outreach and worked with downstream entities to educate them about the demonstration, specifically about billing, authorizations, and other detailed processes. Further MMP and Harbage outreach to providers began after the 2016 cluster analysis showing linkages between beneficiaries who had opted out and their providers (please see *Section 3.3.1* for more information on this topic). This work has continued beyond the period of time covered in this report.

Hospital and nursing facility providers noted in 2016 interviews that, from the early days of the demonstration, they were concerned about the lack of information regarding Cal MediConnect policies and procedures relating to their facilities and the uneven hospital and nursing facility experience of some MMPs. One provider noted, “[Cal MediConnect] started before anybody was ready. We are still paying the price for it.” Individual providers and provider organizations, together with members of the California Collaborative, worked to raise awareness of these concerns. In some cases, these providers worked directly with MMPs to educate them on their practices and MMPs’ responsibilities. In 2015 DHCS, together with Harbage Consulting, stepped up their outreach efforts and began working with providers in all settings to fill the remaining gaps and provide the missing guidance. However, it should be noted that Cal Optima, the one Cal MediConnect plan in Orange County, developed a very comprehensive approach to nursing facility engagement. It began enrollment more than a year after the demonstration began and perhaps benefited from some lessons learned by plans that began operations earlier. Cal Optima designed a staggered enrollment of enrollees in nursing facilities in order to engage facilities individually, reach out to physicians serving nursing facility residents, and ensure good communication between the plan and facilities.

6.2.4 Stakeholder Support

State officials, plan representatives, and stakeholders each commented that stakeholder reaction to the demonstration has evolved since 2015. Stakeholders said that in the beginning, they were unsure whether the demonstration would actually begin because of the frequent changes in start dates of the demonstration itself and of various plans, counties, and subgroups within the demonstration. Those who were engaged in providing feedback on enrollment materials were discouraged when their suggestions for improving the notices and choice books were not incorporated by the State. The State reported accepting feedback from stakeholders and then releasing preliminary versions of documents indicating acceptance of many of the stakeholders’ proposed changes. Stakeholders also expressed concerns that problems that occurred in 2010 and 2012, during the transition of Seniors and Persons with Disabilities (SPDs) into managed care, would be repeated in the Cal MediConnect transition. In the SPD transition, beneficiaries, their families, and stakeholders experienced confusion from the lack of clarity of notices, complicated enrollment methods, changes in Part D services, and policies regarding continuity of care.

When some of these issues were repeated in the beginning of the Cal MediConnect demonstration, stakeholders and providers reacted in different ways. Some stakeholders continued to make suggestions for improvements, investigated issues, and relayed concerns from their members to the State to rectify problems. Others campaigned to stop the demonstration

entirely. As described earlier, it is important to note that opt-out campaigns by provider groups and two court cases initiated in the early months of the demonstration, had been a challenge since the demonstration planning stages. The court case by the Los Angeles County Medical Association was particularly challenging.

Stakeholders who continued working to improve the demonstration also noted that they were still frustrated by the missteps that have occurred and concerned about emerging topics; however, when asked about the overarching goal of combining LTSS and medical services for this population with complicated needs, they were supportive. Although different stakeholder groups wanted to see various benefits strengthened, stakeholders remarked on the “sea change” in communication taking place among plans, providers, and LTSS—“for the first time in some counties, community-based providers and plans are sitting down together . . . to learn each other’s languages.” This sentiment was repeated by plan representatives who noted that stakeholders generally have changed from trying to halt the demonstration to working very hard to try to improve it.

In 2014 interviews, stakeholders reported that they would like to see some benefits strengthened under the demonstration, such as extending the period of continuity of care; requiring certain CPOs, such as home modifications; and including durable medical equipment providers in continuity of care provisions. As one stakeholder put it, “enrollees using wheel chairs often have a closer relationship with the person who does their wheelchair adjustments, than they do with their [primary care provider].” In 2015, stakeholders reemphasized that they recognize the value of the demonstration when it is executed as intended. After DHCS had made policy modifications stakeholders had flagged, many stakeholders appeared to be more supportive of the demonstration than in the beginning, and they reported working with the State and MMPs to improve the implementation process and to educate all sides involved, including beneficiaries and providers.

To address a particular demonstration challenge—a lack of knowledge about Cal MediConnect rules among beneficiaries and providers—Justice in Aging, which provided technical assistance to Cal MediConnect Ombudsman Program, played a vital role. Justice in Aging has conducted multiple webinars and trainings (e.g., on MMP and provider choice and beneficiary rights for beneficiaries, and, more recently, on incorrect billing for providers) to other, smaller community organizations. Additionally, Justice in Aging produces a Cal MediConnect Advocacy guide that explains demonstration policies to all participating stakeholders. This guide has been updated annually as policies change.

In summary, such meaningful and productive stakeholder involvement resulted in significant improvements in the demonstration design and implementation. In response to specific stakeholder comments, the State made several changes and policy adjustments. For example, stakeholders worked with the State on revising enrollment materials and notification letters to improve the language and make these materials more user friendly and accessible. Stakeholder involvement also affected some implementation timelines, for example, delaying MSSP transition into Cal MediConnect to accommodate the needs of the frailest Cal MediConnect enrollees. DHCS issued multiple dual plan letters (DPLs) in response to issues such as continuity of care disruptions and incorrect billing, raised by stakeholders. Similarly, the access to care issues resulting from nursing facility discharges were brought to DHCS’ attention

by the California Collaborative, leading to DHCS issuing a DPL on discharge planning. Another example of improved cooperation with stakeholders was the State's 2016 strategy to improve enrollment. DHCS withdrew its proposal to renew passive enrollment after receiving negative stakeholder input, even though this change to the current enrollment policy was supported by the MMPs (please see *Section 3.3.5* for a full description of enrollment policies).

6.3 Successes

- **California has an active and participatory stakeholder community.** This community was vigorously involved in both the demonstration and the broader CCI move toward managed care, and was focused on protecting beneficiary rights and improving care and access to services.
- **Increased State collaboration with providers and stakeholders in the last year was productive; this increase followed feedback from providers and stakeholders who perceived the early outreach as not sufficient.** In 2016, DHCS, working with Harbage Consulting, significantly increased outreach activities on all fronts. By engaging stakeholders in more meaningful ways and recognizing the value of their contributions, stakeholder opposition has turned into productive involvement.
- **Stakeholders' attitudes towards Cal MediConnect evolved over time.** Stakeholders have become significant partners with the State in shaping Cal MediConnect policies to ensure that the promises of care coordination and person-centered care come to fruition for this vulnerable population.

6.4 Challenges

- **Despite early efforts by the State to engage providers, provider buy-in was low throughout the start-up and early implementation stages of the demonstration.** Some providers, provider organizations, and stakeholders were resistant to managed care in general; others cited insufficient outreach and education as a contributing factor to broad opposition to the demonstration among health care providers. Variation among counties, competition from established Medicare Advantage plans, and the sheer volume of providers, including those practicing in hard-to-reach minority ethnic neighborhoods, presented additional barriers to engaging the provider community.
- **Lack of understanding of the demonstration and low buy-in among providers and stakeholders may have contributed to substantial opt-outs and disenrollments.** During early implementation, some providers actively discouraged their patients from participating in Cal MediConnect.
- **Institutional providers, particularly nursing facilities, did not feel adequately involved in early stakeholder engagement efforts.** Nursing facility stakeholders reported low awareness and understanding of long-term care services among some MMPs. To address this challenge, members of the California Collaborative provided education to MMPs on nursing facility services, billing and payment practices, and MMP responsibilities for covering long-term care services.

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7. Financing and Payment

Highlights

- During the implementation period, financing and payment have been sources of frustration for health plans. While some of these frustrations have been resolved, there has been lingering uncertainty whether the rate structure is sustainable for the plans.
- Central to the plans' concerns has been low enrollment relative to expectations. Without increased volume, most Cal MediConnect plans reported they are unlikely to recover the fixed investment costs necessary to launch and manage the product.
- Plans felt the State and CMS were overly optimistic in the assumptions that plans could divert members with LTSS needs away from institutional nursing facility care and provide the necessary services in a community setting for substantially lower rates.
- Other major sources of uncertainty for plans have been the delay in updating Medicaid rates over the course of the demonstration, the delay in accounting for IHSS costs, and the delay in establishing the Medicaid risk profiles of each plan's enrollee population.

7.1 Rate Methodology

All covered Medicare and Medicaid services are paid on a capitated basis. Cal MediConnect plans receive three monthly capitation payments from the Centers for Medicare and Medicaid Services (CMS) and the California Department of Health Care Services (DHCS). CMS makes a monthly payment reflecting coverage of Medicare Parts A and B services and a separate amount reflecting Part D services. DHCS makes a monthly payment reflecting coverage of Medi-Cal services, using a single blended rate that takes into account the relative risk of the population actually enrolled in each contracted plan (three-way contract, p. 136).

State officials reported that they were pleased with the cooperation of participating Cal MediConnect plans during demonstration payment policy development. Before finalizing the methodology and developing the Medicaid component of the demonstration capitation rates, State officials and plan Chief Financial Officers participated in rate-setting workshops. The resulting rates are blended and are adjusted and weighted based on population characteristics. The timing of the rate adjustment was also discussed with the plans. Actuaries on both sides reviewed the final methodology and the data to ensure the State's assumptions were correct before the final rates were set. State officials reported the rates went through three iterations before being finalized.

This section describes the rate methodology of the demonstration and findings relevant to implementation.

7.1.1 Rating Categories and Risk Adjustments

The Medicare Parts A and B component of the rate is risk adjusted based on the risk profile of each enrollee using the existing Medicare Advantage CMS-Hierarchical Condition Categories (HCCs) and CMS-HCC end-stage renal disease risk adjustment methodology. Beginning in 2015, CMS was to calculate and apply a coding intensity adjustment in proportion to enrollees with prior Medicare Advantage experience (three-way contract, pp. 154–5; 2014 rate report, pp. 4–5).

The Medicare Part D component includes the Medicare Part D direct subsidy set at the Part D national average monthly bid amount for the calendar year. The Medicare Part D component is adjusted using the existing Part D prescription drug RxHCC risk score methodology. The prospective payment also includes an amount for the low-income cost-sharing subsidy and Federal reinsurance (three-way contract, pp. 142–3). All of these payments are reconciled after the end of each payment year.

The Medi-Cal component is paid as a single rate, weighted by the share of each plan’s enrollees classified into four risk adjustment categories: *Institutionalized* enrollees are those residing in long term care facilities for ninety or more days; home and community based services (*HCBS*) *High* enrollees are those receiving Community-Based Adult Services, those who are clients of Multipurpose Senior Service Program sites, or those receiving In-Home Supportive Services (IHSS) and classified as “severely impaired”; *HCBS Low* enrollees are IHSS recipients classified as “not severely impaired”; and *Community Well* enrollees are the remainder. These risk groups are similar to those discussed in **Section 4** relating to the health risk assessment (HRA) conducted by care coordinators. If plans cannot reach enrollees to conduct a HRA, these enrollees are considered HCBS High, as are enrollees without any historical health care data (California Department of Health Care Services, 2015c).

Relative cost factors for each group are based on actuarial calculations. At the start of the demonstration, except for the plan in San Mateo County, the risk adjustment methodology was to be applied monthly and retroactively match plans’ actual enrollment by category. In all counties other than San Mateo, beginning after 12–14 months, depending on when the fiscal quarter ends, rates are calculated prospectively for a single fiscal quarter based on the distribution of risk categories before that quarter began. In San Mateo County, this risk adjustment regime was in effect for two quarters starting in April 2014. In the final phase, beginning in October 2014 for San Mateo County, and after a single fiscal quarter of the previous phase in the other counties, rates will be based on a targeted relative mix of the population and will not be adjusted during the fiscal year. The targeted mix will assume shifts in populations away from the *institutionalized* category over the course of the year.

Savings Percentage

Aggregate savings percentages are to be applied, by county, to the baseline spending amounts for both the Medicare Parts A and B and Medi-Cal components of the capitated rate. **Table 17** shows that in the first demonstration year (April 2014–December 2015), the savings adjustments range from 1 percent in Los Angeles County to 1.47 percent in San Mateo County. The adjustments are to increase in each demonstration year and, by demonstration year 3 (CY 2017), will range from 4 percent in San Mateo County to 5.5 percent in Los Angeles, San

Bernardino, and Orange counties. Savings percentages have not been applied to the Part D component. CMS monitors Part D costs on an ongoing basis, and material changes may be factored into future year savings percentages (California three-way contract, 2014, p. 143).

Table 17
County-specific interim savings percentages:
Minimum savings percentages and the county-specific addition as of February 14, 2014

County	Year 1 1.00%	Year 2 2.00%	Year 3 4.00%
Los Angeles	+ 0.00	+ 1.50	+ 1.50
Orange	+ 0.42	+ 1.50	+ 1.50
Riverside	+ 0.22	+ 1.50	+ 1.14
San Bernardino	+ 0.44	+ 1.50	+ 1.50
San Diego	+ 0.23	+ 1.50	+ 1.10
San Mateo	+ 0.47	+ 0.33	+ 0.00
Santa Clara	+ 0.23	+ 1.45	+ 0.95

SOURCE: California three-way contract, 2014, Savings Percentages, Section 4.2.3.1.

7.1.2 Performance Incentives

In the first demonstration year, CMS and DHCS withheld 1 percent of their respective components of the capitation rates (not including the Part D component). Performance incentive (withhold) measures are identified in *Appendix B*. The withhold is repaid to Cal MediConnect plans subject to their performance on established quality thresholds. Each Cal MediConnect plan will receive a “pass” or “fail” score for each withhold measure. If the plan meets the determined benchmark, it will receive a “pass” for that measure. If the plan does not meet the benchmark, it will receive a “fail” for that measure. The higher the aggregate score, the higher the returned portion of the withhold. Year 1 measures are more structure and process oriented; in contrast, Year 2 and 3 measures are more related to health outcomes and coordination of care. As of the time of report production, DHCS intended to post on its website information showing Cal MediConnect plans’ progress toward meeting the quality requirements (Centers for Medicare & Medicaid Services, 2014b). Accountability for achieving quality is shared between Cal MediConnect plans and their county-based behavioral health agencies. This shared accountability is achieved by including withhold measures specific to behavioral health (two in Year 1 and one in Years 2 and 3) (California three-way contract, 2014, p. 22). Determinations of plan performance for 2014 were made available in June 2017. Future reports will discuss this information in greater detail. In January 2017 CMS announced the amounts of the withheld portion of the Medicare rate that each of the eight plans operating in 2014 would receive, and in addition, CMS announced in October 2017 the quality withhold amount for 2015. As of report production, DHCS has not yet announced the Medi-Cal portions of its performance payment. Details about this will be discussed in a future report.

Risk Corridors

The three-way contract established limited up-side and down-side risk corridors for each demonstration year and sets forth the method for calculating the percentage of the gain or loss

that will be shared by the plan, CMS, and DHCS. If plan costs exceed the interim capitation rates (excluding the Part D payments and costs), CMS and DHCS will pay the plan 67 percent of the excess cost, split in proportion to their respective contribution to the total capitation rate. If plan costs are less than initial capitation rates by more than the county-specific savings percentage but by less than twice the savings percentage, the plan will pay 50 percent of the “excess” savings to CMS and DHCS, in proportion to their respective contribution to the capitation rate. Any savings that exceed twice the county savings percentage are retained by the plan (three-way contract, 2014, pp. 144–54).

7.1.3 IHSS Payments

Cal MediConnect plans have a memorandum of understanding in place with IHSS agencies in each county, defining the county’s responsibilities as an employer of record for IHSS personnel, and defining the scope of services provided to IHSS recipients (California three-way contract, 2014, p. 67). One important aspect of the Cal MediConnect payment policy has been the payment arrangement for IHSS (please refer to *Section 2.2.6, Integrated LTSS* for more on IHSS). IHSS hours have been determined through assessments conducted by the county social services office, but Cal MediConnect plans have been at full risk for IHSS provider payments. Historically, counties and the State have always been responsible for setting wages for IHSS workers, about 70 percent of whom are family members of personal care recipients; for Cal MediConnect, a statewide public authority responsible for setting rates. Cal MediConnect plans have not been responsible for setting wages for IHSS workers. On an annual basis, DHCS is to reconcile actual IHSS expenditures with interim payments and either pay the excess of interim over actual expenditures to the plan or collect the excess of actual over interim expenditures from the plan (three-way contract, pp. 162–3). During each site visit plans reported this has been troublesome because, while they are at full risk for IHSS payments, plans have had no input into the assessment or the determination of hours for these personal care services. Although plans received a monthly file with all IHSS payments made for active enrollees, they were required to wait until reconciliation takes place, a process that has been greatly delayed.

7.2 Financial Impact

7.2.1 Early Implementation Experience

At the very early stages of implementation, while plans expressed commitment to the goals of the demonstration, they also expressed considerable uncertainty about the financial viability of the model given what they understood about the rate structure. In particular, they expressed concern about the overall adequacy of capitation rates for beneficiaries with LTSS needs, and that the difference between Medicaid institutional and HCBS rates would create disincentives to transitioning their members from facilities to the community. As the demonstration matured, in 2016, plans noted that this uncertainty continued, especially in areas where affordable community housing options are limited. On the Medicare capitation rate, initial uncertainty among plans about the adequacy of the rates has largely evaporated, and there was little worry expressed by plans about their ability to cover the traditional acute medical care needs of their members.

The primary sources of plans’ financial uncertainty at the time of the 2016 interviews were the lack of updates in rates since calendar year 2014, and the lack of timely reconciliation

of blended Medi-Cal rates and IHSS payments. Calendar year 2014 rates were adjusted in 2016, but Medi-Cal rates for subsequent years have not been updated at all; IHSS reconciliation had not been made since 2014, and several plans reported that they were unable to reconcile their population composition with State data used to assign members to the four Medi-Cal risk categories. Plans were not convinced that the State was using the right data to assess population risk, and at least one plan had spent substantial effort to reconcile its own data with DHCS staff, but it was never able to get its own population mix to match that of the State. Whatever the source of the delays in reconciling financial data, including any issues plans had submitting timely data, plans were reluctant to say that the model was sustainable into the future. Future reports will continue to explore this topic.

7.2.2 Rate Methodology Design Implications

The primary concern that plans expressed about rate methodology, as opposed to the actual implementation of the rates, was the assumption about plans' abilities to transition members with LTSS needs from institutional to community settings. To some extent, this concern may be driven by the fact that this is an unfamiliar task for most managed care plans. One plan official stated the following:

This whole program is moving us into what I consider nonclinical spaces of health care delivery. We don't have those challenges in the traditional health care settings. The challenge is that we have members who end up in an institutional setting and need to be there. It's the baseline assumption both the State and CMS agencies have made in this new space, which is really addressing the nonclinical side of care delivery." At least one plan has embraced this diversion activity, although it had had limited success and was unsure that the loss in revenue would be matched by reduction in cost of LTSS for diverted members.

7.2.3 Cost Experience

Through 2016, none of the plans were willing or able to say whether they were making or losing money on their Cal MediConnect lines of business because they did not yet know what their revenue would be once rates were set and their population mixes were determined, and IHSS payments reconciled. Many plans said that lower than expected volume of enrollment meant that they were losing money on certain fixed costs they were required to incur to support the demonstration, including bringing on and training staff for care coordination who were underutilized. In addition, plans stated that the cost of reaching and assessing newly assigned members, many of whom had outdated contact information, was larger than expected and yet not something that is included in either the Medicare or Medi-Cal rates.

7.3 Successes and Challenges

Plans expressed commitment to the goals and broad outlines of the demonstration, but they have been disappointed by low enrollment. This low enrollment has been viewed as a threat to financial viability, as revenue may be insufficient to cover the up-front investments made to launch the new product. Although plans were disappointed that passive enrollment for newly eligible beneficiaries was not approved by the State in 2016, they were hopeful that streamlined enrollment would bolster enrollments.

State officials noted that setting correct rates was one of the biggest challenges in designing the demonstration, and plans have continued to express significant uncertainty about whether these rates have been sufficient to cover their costs. From the beginning of the demonstration, plans have expressed frustration with the length of time it has taken for the State to complete the tasks necessary to establish how much plans will be paid for the care they have provided their members. Sources of this delay have included turnover in State staff, and uncertainty at DHCS over the near-term status of the demonstration, which was renewed from year to year between 2014–2016 after the State determined Medi-Cal cost savings from the demonstration. This provision was dropped in the Governor’s 2017 budget, which falls outside the scope of this specific report. Future reports on Cal MediConnect will explore the implications of this change.

There were also delays in the reconciliation of IHSS payments. Although Cal MediConnect was implemented in April 2014, as of the time this report was written, reconciliation of IHSS expenditures had only been completed through the third quarter of 2014. This concern had been exacerbated by the fact that Cal MediConnect plans, by design, do not determine the amount of IHSS services for each beneficiary enrolled, even though the plans were at risk for the IHSS payments. The beneficiaries were assessed and the service amount was determined by the county IHSS agencies.

Cal MediConnect plans had originally understood that Medicare and Medi-Cal administrative and financial processes would be more integrated in the demonstration than they have been in existing models. Plan interviewees reported that they had “expected a consistent set of regulations like in Medicare Advantage plans.” Given that they have one capitated rate, several plan representatives were surprised at the need for separate processes for Medicare and for Medi-Cal claims and multiple claims adjudications. Appeals processes, encounters, and quality measures have all been in parallel systems. They explained that it was necessary to reprogram processes they had thought would be integrated; thus, they characterized the demonstration as coordinated, rather than integrated administratively (i.e., from the plans’ internal, administrative point of view).

Demonstration plans reported that payment incentives to promote transitions from institutions to the community may not be adequate beyond the actual calendar year of transition, and that the assumptions about their success in promoting transitions were overly optimistic yet locked into the rate methodology. These incentives were based on the difference between the per member per month (PMPM) payments the plans receive for nursing facility residents (the institutional rate) versus community residing members (the HCBS High rate) and on assumptions about a shift in case mix toward fewer enrollees residing in nursing facilities over time. For transitions that occurred during the first calendar year of the demonstration, plans continued to receive the higher institutional rate for a limited time after the enrollee had returned to the community. In later years of the demonstration, the rate methodology assumes the share of the plan’s enrollees garnering the higher institutional payment rates will decline during a plan year, whether or not plans are successful in making these transitions. Plans have contended that not only are start-up costs high for returning an enrollee to the community, but that maintaining these frail enrollees in the community with supports in the subsequent years will continue to be costly when the plans will be paid a community-based rate for those enrollees. Therefore, the degree of savings to the plans for enrollees who have transitioned to the community may not materialize as expected.

8. Quality of Care

Highlights

- CMS and DHCS designed a set of robust core reporting measures to ensure quality of care for all enrollees. MMPs have found the reporting burdensome, and reporting takes time away from care provision.
- CMS and the State have developed multiple safeguards to ensure quality of care in the three-way contract and oversight of the demonstration. These protections have included oversight of downstream entities in delegated counties. Some plans have also replicated quality controls, such as withholds, for their downstream entities. However, enrollees and stakeholders reported that enrollees have difficulty navigating the delegated environment and that quality reporting was not occurring with all downstream providers.
- In June of 2017, CMS publicly announced results of the quality withhold repayment analysis for the Medicare and Medicaid portions of the capitation rates. Each plan operating in 2014 performed well enough to receive at least some repayment, and some would receive the full amount withheld.
- DHCS contracted evaluators to conduct extensive focus groups and surveys of the demonstration population. Upon receiving results, DHCS responded by instituting multiple new initiatives designed to improve quality of care to enrollees.

8.1 Quality Measures

The Cal MediConnect demonstration requires that Cal MediConnect plans report standardized quality measures. These measures include:

- A set of core measures specific to all capitated Financial Alignment Initiative demonstrations that address domains of access, assessment, care coordination, enrollee protection, organization structure and staffing, performance and quality improvement, provider network, and systems and service utilization (CMS, 2016).
- A set of State-specific measures that were selected by California Department of Health Care Services (DHCS) staff in consultation with CMS after considering feedback from stakeholders. These include a variety of structure, process and outcome measures spanning a range of service areas including long-term services and supports (LTSS) and behavioral health.

The demonstration economizes on reporting burden by using some of the measures already required of Medicare Advantage plans, including applicable measures from the Part C and Part D Reporting Requirements such as appeals and grievances, pharmacy access, payment structures, and medication therapy management. Reporting and performance on several of these

measures are used as to determine what portion of the capitation rates retained by the state as a “quality withhold” will be repaid to the plan.

Cal MediConnect plans are required to submit three additional measure sets as part of the Medicare Advantage requirement:

- A modified version of the Medicare Advantage Prescription Drug Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey that, in addition to the core survey used by Medicare Advantage plans, includes 10 supplemental questions proposed by the RTI Evaluation Team to capture beneficiary experience specific to integration, behavioral health and LTSS (see *Section 5* for CAHPS findings);
- The subset of Medicare Healthcare Effectiveness Data and Information Set (HEDIS) measures, a standard measurement set used extensively by managed care plans, that are required of all Medicare Advantage plans; and
- Selected Health Outcomes Survey (HOS) measures based on a recurring survey of a random sample of Medicare beneficiaries to assess physical and mental health outcomes (three-way contract, 2014).

Appendix B includes a list of core and State-specific measures used for quality withhold repayment calculations. Data related to these measures are reported in relevant sections of this report.

In addition, the RTI Aggregate Evaluation Plan identified a set of quality measures that have been calculated by the RTI Team using encounter and fee-for-service (FFS) data. Many of these measures are part of the HEDIS measurement set and are largely clinical in nature (e.g., preventive screens, follow-up care) or related to service use (e.g., avoidable hospitalizations, emergency department use) (Walsh et al., 2013, pp. 77–85).

While many of the reporting requirements for Cal MediConnect plans were the same as requirements for other lines of business operated by the plans under either Medicare Advantage or Medi-Cal managed care, the Cal MediConnect demonstration introduced new requirements for monitoring and evaluation that included both entirely new metrics and variants on existing metrics. During each site visit, plans reported the new infrastructure required to collect new information and produce new reports was often a source of frustration. Several plan administrators felt that this new investment diverted resources away from patient care and was of limited value. Some of these difficulties were seen as implementation problems that had been resolved as measure specifications were clarified and data collection systems built, although others continued to be a challenge.

The new requirement for a timely health risk assessment was the metric most commonly mentioned by plans during site visits as difficult and costly to meet. In part, the poor quality of contact information meant extra time reaching new members, but even once contacted, some members were unwilling to spend the time to complete the assessment. Several plans using a delegated model of care reported that getting necessary encounter and clinical data for these

reports from downstream providers was difficult. One example given was the inconsistency between CMS and DHCS reporting requirements and HRSA requirements that determine how data are collected in Federally Qualified Health Centers (FQHC), which serve as primary care providers for some of the plans' Cal MediConnect members. Also singled out were difficulties in generating metrics for measures on members using behavioral health services. This problem was viewed as partially a legal problem concerning data sharing between the plan and behavioral health providers (please see *Section 4* for more on this topic), but also a problem of simply reaching these members.

8.2 Quality Management Structures and Activities

This section examines the components of the Cal MediConnect quality management system, including its interface with CMS, Cal MediConnect plans, and other independent entities, and describes how well the quality management system is working from various perspectives.

8.2.1 Assigned Roles, Structures and Processes at the State, Plan and Provider Levels

Most quality oversight happens at the plan level; the impact on individual providers and provider groups depends on their contractual arrangement with the primary plans, but the State's quality management and protection activities in Cal MediConnect take place at several key points: (1) demonstration-specific reporting requirements, (2) quality withholds, (3) external quality reviews, and (4) plan oversight by the contract management team (CMT) (please see *Section 2* for more on the CMT).

The three-way contract states that an increasing portion of the per member per month capitation payment will be withheld from plans each year of the demonstration, and also establishes quality requirements that plans must meet to earn back the withheld amount (see *Section 7*). In the first year of operation, plans can earn back the withheld portion by meeting a set of quality thresholds on several process measures. In the second and third years, plans will have to both report on their metrics and meet benchmarks on several specific clinical outcomes. According to some MMP officials, their plans incorporated quality withholds into their contracts with delegated provider groups, holding them to the same or similar performance standards to which the plan is held. Specific approaches to provider incentives varied from plan to plan, but while most plans had used quality incentives with their providers prior to Cal MediConnect, the quality withhold arrangement was new. In June 2017, CMS publicly announced results of the quality withhold repayment analysis for the Medicare and Medicaid portions of the capitation rates for Year 1 quality metrics. Every plan that was in operation during 2014 would receive at least 75 percent of the quality withhold, and three plans met or exceeded all the quality thresholds and would receive the full withhold payment.

In addition to core measure reporting that CMS requires of capitated model demonstrations under the Financial Alignment Initiative, the State developed a quality improvement system with monthly and quarterly reports to monitor enrollment, implementation, and utilization of services. Three dashboard reports have been publicly displayed. During the period covered by this report, the enrollment dashboard has been produced monthly since the beginning of the demonstration; the health risk assessment (HRA) dashboard has been produced

twice (for the period April 2014 to March 2015 and April 2014 to June 2015), and the Cal MediConnect performance dashboard has been produced once in March 2016, twice in 2018, and covers various metrics over different time periods (CalDuals.org, 2017). The performance dashboard shows hospital discharge, LTSS utilization, and case management data in addition to HRA and appeals data. RTI analysis of access to care and other outcome measures will be provided in future reports as data become available (RTI International, 2014).

CMS and California require that external quality reviews of the 10 participating Cal MediConnect plans be conducted by the Quality Improvement Organization (QIO) and External Quality Review Organization (EQRO). In addition, California and/or CMS may conduct periodic audits of the participating Cal MediConnect plans that may include annual site visits. For plans that fail to meet quality or other standards, the CMT has several levers, which include plan-specific limits on enrollment (three-way contract, 2014, p. 26).

CMS requires plans to engage in quality improvement projects (QIPs) throughout the duration of the contract (three-way contract, pp. 106–10). The State also requires similar improvement projects; in 2016, the State issued a DPL outlining requirements and timelines for these projects—which it calls Performance Improvement Projects (PIPs) (California Department of Health Care Services, 2016g). PIPs may last between 12 and 18 months and include trainings, assistance, and reviews by DHCS’ EQRO. The interventions began by October 2016 and were completed by July 2017. These PIPs were under way in 2016 during our site visit; one plan had identified performance issues related to coordination of care transitions for members using LTSS as a topic for its PIP. The plan was developing new interventions to address those challenges.

The delegation feature of California’s managed care environment, described in **Section 2**, has direct implications on how quality is monitored under the demonstration and which quality improvement activities are monitored. Regardless of the type of services and functions that are delegated to first tier, downstream, and other entities by Cal MediConnect plans, Cal MediConnect plans remain responsible and accountable for all quality improvement functions and responsibilities. State officials reported that other functions such as utilization management, credentialing, and on-site reviews can be delegated to other entities, but quality improvement reporting and quality metrics reporting may not be delegated. Plans are obligated to maintain a system to ensure accountability for delegated quality improvement activities (California three-way contract, 2014, p. 104). State officials also reported that DHCS requires that the Cal MediConnect plans be responsible for reviewing and ensuring that subcontractor organizations such as independent practice associations (IPAs) or other entities have adequate policies and procedures in place for quality monitoring; however, only the Cal MediConnect plans are audited and monitored. Spot checks and periodic site visits are part of the strategy employed by DHCS for monitoring plan performance. The State also reported that it is starting to implement corrective action for some delegated entities for not submitting data on a timely basis.

State officials also described delegation oversight as a very important component of the CMT’s work with Cal MediConnect plans to ensure that quality measurement requirements are passed along to subcontractors. Contract managers also ensure that subcontractor entities, including nursing facilities, are aware of the availability of technical assistance to help them in incorporating quality requirements into their organizational processes and in complying with data submissions.

As part of delegation arrangements, some plan representatives reported developing a quality monitoring program that extended the same metrics to delegated entities (mostly IPAs), where the delegated entities report appropriate customer service, document care goals, describe encounters, etc.; some of the delegated entities' payments and incentives are also tied to quality goal achievement. Some plans contracted with organizations that were willing to comply with these requirements. One plan reported that it selected providers for participation only after auditing their performance (i.e., selected IPAs capable of delivering quality care and providing appropriate quality monitoring). However, other plans explained that they needed to contract with multiple organizations and that some did not have the capacity to provide quality data. The evaluation team heard mixed responses with regard to plan selection of nursing facilities. Some plans did not select nursing facilities based on quality ratings.

Although CMS and the State have taken steps to ensure the quality of downstream entities in delegated counties, as noted earlier in this report (see *Section 2*), stakeholders and enrollees reported difficulties navigating the delegated entities and obtaining care.

8.2.2 External Evaluation Activities

As cited earlier in this report, the State authorized UC Berkeley and colleagues to conduct a series of qualitative studies. In summer 2014, with preliminary funding, the group conducted multiple stakeholder interviews and piloted two beneficiary focus groups. The group later conducted 12 focus groups with Cal MediConnect enrollees and two focus groups with Cal MediConnect-eligible beneficiaries who had disenrolled or opted out of the demonstration, as well as some phone interviews with hard-to-reach populations, including enrollees receiving behavioral health services. Groups were recruited from a sample of Medicare-Medicaid enrollees in six of the seven demonstration counties, and discussions were conducted between May and November of 2015. Researchers worked closely with senior staff at DHCS to design this research; the results were released in September 2016 (Graham et al., 2016a). The same researchers also analyzed data from a telephone survey of Cal MediConnect beneficiaries (Graham, Liu, and Kaye, 2016). Analysis of both focus group discussions and survey results found general satisfaction with Cal MediConnect among enrollees and improved access to a variety of health services. Those who used care coordination benefits found those benefits to be useful. However, State evaluator surveys revealed that only a small subset of enrollees were actually receiving care coordination, and about one-third of enrollees were unaware of the care coordination benefit; focus groups also revealed some shortcomings in communication materials about enrollment and the integration of LTSS services. Lack of continuity of care was identified as a key factor in decisions to opt out of enrollment. These results are discussed in more detail in *Sections 4* and *5* of this report. DHCS also contracted with Field Research Corporation to conduct a series of rapid cycle polling at regular intervals beginning June 2015. Its fourth set of results were disseminated in December 2016 and are consistent with UC Berkeley's findings (Field Research Corporation, 2016a).

Prompted by early results from these evaluation activities, DHCS solicited stakeholder feedback and instituted several initiatives to improve the performance of Cal MediConnect (California Department of Health Care Services, 2016a). The efforts focused on strengthening continuity of care, and improving care coordination and access to LTSS (please see *Sections 2* and *4* for more on these topics).

8.3 Results for Selected Quality Measures

8.3.1 HEDIS Quality Measures Reported for Cal MediConnect Plans

Fourteen Medicare HEDIS measures for MMP enrollees are reported in *Table 18*. RTI identified these measures for reporting in this Evaluation Report after reviewing the list of measures we previously identified in our Aggregate Design Report as well as the available HEDIS data on these measures for completeness, reasonability, and sample size; 2015 calendar year data were available for 9 of the 10 Cal MediConnect plans. These measures are:

- adult BMI assessment (the percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year)
- adults' access to preventive/ambulatory health services (the percentage of members age 21 and older who had an ambulatory or preventive care visit in the measurement year)
- ambulatory care (this measure summarizes utilization of ambulatory care in outpatient and emergency department visits)
- annual monitoring for patients on persistent medications (the percentage of members age 21 and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year)
- antidepressant medication management (the percentage of members 21 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment)
- blood pressure control (the percentage of members 21–65 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year)
- breast cancer screening (the percentage of women 50–74 years of age who had a mammogram to screen for breast cancer)
- care for older adults (percentage of adults 66 years and older who had each of the following during the measurement year: advance care planning, medication review, functional status assessment, and pain assessment)
- colorectal cancer screening (the percentage of members 50–75 years of age who had appropriate screening for colorectal cancer)
- comprehensive diabetes care (the percentage of members 18–65 years of age with diabetes (type 1 and type 2) who had each of the following in the measurement year: hemoglobin A1c (HbA1c) testing, HbA1c poor control (>9.0 percent), HbA1c control

(<8.0 percent), eye exam (retinal) performed, medical attention for nephropathy, blood pressure control (<140/90 mm Hg)

- disease modifying anti-rheumatic drug therapy in rheumatoid arthritis (the percentage of members who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug)
- follow-up after hospitalization for mental illness (the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner)
- initiation and engagement of alcohol and other drug dependence treatment (the percentage of adolescent and adult members with a new episode of alcohol or other drug dependence who received initiation of, and separately, engagement in alcohol and other drug treatment in the measurement year)
- plan all-cause readmissions (for members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission)

Results were reported for measures where sample size was greater than 30 beneficiaries. In addition to reporting the results for each MMP, the mean value for Medicare Advantage plans for each measure is provided for comparison. Four measures relating to care for older adults were not available in the Medicare Advantage national benchmark data.

We provide national benchmarks from Medicare Advantage plans where available, understanding that Medicare Advantage enrollees and demonstration enrollees may have different health and sociodemographic characteristics which would affect the results. Previous studies on health plan performance reveal poorer quality ratings for plans serving a higher proportion of dual eligible beneficiaries and beneficiaries with disabilities. HEDIS measure performance, in particular, is slightly worse among plans active in areas with lower income and populations with a higher proportion of minorities (Office of the Assistant Secretary for Planning and Evaluation, 2016). Benchmarks should be considered with that limitation in mind. These findings on California MMP HEDIS measure performance represent the early experience in the demonstration, and are likely to change over time as MMPs gain more experience in working with enrollees. Monitoring trends over time in MMP performance may be more important than the comparison to the National Medicare Advantage plans, given the population differences. Several years of HEDIS results are likely needed to know how well MMPs perform relative to each other and whether they perform above or below any potential benchmark.

Table 18
Selected HEDIS measures for Cal MediConnect Plans, 2015

Measure	National Medicare Advantage Plan Mean	Anthem BlueCross (%)	Care1st (%)	CHG (%)	Health Net (%)	IEHP (%)	LA Care (%)	Molina (%)	HPSM (%)	SCFHP (%)
Adult BMI assessment	93.0	87.5	91.0	88.8	92.9	96.8	87.1	95.1	87.1	5.5
Adults' access to preventive/ambulatory health services	94.7	71.1	78.1	87.0	73.7	89.6	75.4	73.4	94.4	88.2
Annual monitoring for patients on persistent medications										
Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)	92.6	89.5	88.6	92.5	90.6	91.3	85.0	88.2	92.1	90.3
Annual monitoring for members on digoxin	57.4	50.0	55.1	38.5	52.6	48.3	43.8	61.9	54.1	54.8
Annual monitoring for members on diuretics	92.9	89.0	87.2	93.7	91.1	90.9	83.8	88.4	93.1	90.6
Total rate of members on persistent medications receiving annual monitoring	91.9	88.8	87.7	92.5	90.1	90.5	84.2	88.0	92.0	89.9
Antidepressant medication management										
Effective acute phase treatment ¹	69.6	60.7	62.8	68.1	55.1	65.0	48.3	63.0	70.2	75.2
Effective continuation phase treatment ²	55.6	46.0	52.8	54.0	37.4	49.2	34.6	48.4	56.2	70.3
Blood pressure control³	67.6	62.9	58.6	54.0	63.0	62.3	56.2	49.5	70.3	N/A
Breast cancer screening	72.3	69.1	65.7	72.2	65.1	65.4	61.2	61.3	69.7	33.9

(continued)

Table 18 (continued)
Selected HEDIS measures for Cal MediConnect Plans, 2015

Measure	National Medicare Advantage Plan Mean (%)	Anthem BlueCross (%)	Care1st (%)	CHG (%)	Health Net (%)	IEHP (%)	LA Care (%)	Molina (%)	HPSM (%)	SCFHP (%)
Care of older adults										
Advance care planning	N/A	53.0	22.9	52.6	39.2	54.6	33.6	23.8	26.3	0.0
Medication review	N/A	47.2	69.8	70.6	99.4	81.5	58.4	45.4	75.2	0.4
Functional status assessment	N/A	55.6	38.5	54.0	73.2	63.0	38.4	31.7	44.0	0.0
Pain assessment	N/A	58.5	62.0	56.9	70.1	78.9	57.9	43.9	71.8	0.0
Colorectal cancer screening	66.7	74.1	53.3	64.2	64.0	57.4	45.3	64.0	61.8	41.9
Comprehensive diabetes care										
Received hemoglobin A1c (HbA1c) testing	93.1	92.3	90.3	92.7	87.4	90.7	85.2	87.6	90.0	88.6
Poor control of HbA1c level (>9.0%) (higher is worse)	28.4	26.2	42.6	34.8	31.1	28.4	46.9	41.1	48.9	77.2
Good control of HbA1c level (<8.0%)	61.8	65.1	48.7	55.2	56.9	58.3	42.3	51.2	46.2	20.0
Received eye exam (retinal)	68.3	63.7	59.6	54.0	60.3	65.3	64.6	53.2	72.5	47.4
Received medical attention for nephropathy	95.5	93.8	96.8	95.9	94.4	97.0	95.1	96.5	94.7	91.5
Blood pressure control (<140/90 mm Hg)	60.9	64.2	54.7	59.4	61.6	66.4	54.9	47.9	65.5	0.1
Disease modifying anti-rheumatic drug therapy in rheumatoid arthritis	76.7	73.4	76.2	85.5	66.2	73.1	71.0	71.4	80.9	93.9
Follow-up after hospitalization for mental illness	51.0	4.2	28.6	40.3	28.1	49.8	11.9	37.8	39.2	26.3

(continued)

Table 18 (continued)
Selected HEDIS measures for Cal MediConnect Plans, 2015

Measure	National Medicare Advantage Plan Mean (%)	Anthem BlueCross (%)	Care1st (%)	CHG (%)	Health Net (%)	IEHP (%)	LA Care (%)	Molina (%)	HPSM (%)	SCFHP (%)
Initiation and engagement of alcohol and other drug (AOD) dependence treatment										
Initiation of AOD treatment ⁴	32.3	12.8	47.4	35.5	27.1	30.4	33.9	47.0	34.7	34.6
Engagement of AOD treatment ⁵	3.2	1.4	3.6	2.3	2.8	3.4	2.5	4.3	6.6	0.0
Plan all-cause readmissions (Average adjusted probability total)	17.3	21.4	22.7	24.0	22.2	22.1	20.8	24.7	21.9	17.2
Ambulatory care (per 1,000 members)										
Outpatient visits	9,161.2	4,839.6	9,447.4	7,415.1	4,758.6	7,603.0	5,484.7	5,490.9	12,108.8	7,510.9
Emergency department visits	607.8	534.7	552.3	622.2	479.5	825.8	533.8	575.4	701.4	509.4

CHG = Community Health Group; HPSM = Health Plan of San Mateo; IEHP = Inland Empire Health Plan; N/A = not applicable; SCFHP = Santa Clara Family Health Plan.

NOTES: Data are not available for Cal Optima in Orange County, which began implementation in July 2015. Data for the Santa Clara Family Health Plan may be limited due to its January 2015 start date. Data for fall risk management, physical activity in older adults, and management of urinary incontinence in older adults are not available for CY 2015. Medicare HMO benchmark values were not available for all measures (e.g., care of older adults measures). Data for which the final sample size was <30 were determined too small to present; in cases where the final sample size was unavailable, RTI used the eligible population to make this determination. Detailed descriptions of HEDIS measures presented can be found in the RTI Aggregate Evaluation Plan:

<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/EvalPlanFullReport.pdf>.

¹ Represents the percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).

² Represents the percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

³ The following criteria were used to determine adequate blood pressure control: less than 140/90 mm Hg for members 18–59 years of age; diagnosis of diabetes and <140/90 mm Hg for members 60–85 years of age; no diagnosis of diabetes and <150/90 mm Hg for members 60–85 years of age.

⁴ Represents percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

⁵ Represents the percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

SOURCE: RTI analysis of 2015 HEDIS measures.

For each measure, results across MMPs have varied, and there has not been a consistent trend across measures for one MMP versus other MMPs. For one measure reported (initiation of alcohol and other drug dependence treatment), the majority of plans performed better than the national Medicare Advantage benchmark value (32.3 percent). For the remaining measures, the majority of plans performed below the benchmark values. This included measures related to adult BMI assessment, adults' access to preventive/ambulatory health services, annual monitoring for patients on persistent medications, antidepressant medication management, blood pressure control, breast cancer screening, colorectal cancer screening, comprehensive diabetes care, follow-up after hospitalization for mental illness, initiation and engagement of alcohol and other drug dependence treatment, plan all-cause readmissions, and ambulatory care. Related to comprehensive diabetes care, however, four out of nine plans performed better than the benchmark value for providing medical attention for nephropathy (95.5 percent) and blood pressure control (60.9 percent). Four plans also performed better than the benchmark value for providing disease modifying anti-rheumatic drug therapy in rheumatoid arthritis (76.7 percent). For all other measures, three or fewer plans performed better than the national Medicare HMO benchmark value.

8.4 Successes and Challenges

In June 2017, CMS publicly announced results of the quality withhold repayment analysis for the Medicare and Medicaid portions of the capitation rates that each plan would receive for 2014. These amounts had been withheld from the Medicare and Medicaid portions of the capitation rate. On the basis of their performance, every plan operating in that year would receive at least some of the amount withheld.

CMS and the State designed extensive quality monitoring to ensure enrollee quality of care; however, all plans stated that this data reporting effort was burdensome. New reporting metrics for the demonstration placed an additional burden on Cal MediConnect plans, according to MMP officials. They felt that it took time away from implementation and diverted resources away from patient care. The HRA reporting was particularly difficult due to the additional, unplanned effort needed to reach enrollees in order to conduct the HRA.

The delegation model has presented challenges for quality oversight. Several demonstration counties in southern California use extensive delegated models. Some plans reported that they provide rigorous oversight, while others admitted that small providers cannot provide quality reporting. Previous sections of this report note enrollees' and stakeholders' concerns about access and quality of care from downstream providers in delegated counties.

The State has designed extensive qualitative evaluations with its evaluators. California engaged evaluators to provide feedback from enrollees and also to compare those results to experiences of non-enrollees. DHCS then acted on those findings with improvements to improve plan performance and quality of care.

DHCS has attempted to make demonstration data transparent to the public. The enrollment and opt-out dashboards have been produced monthly from the start of the demonstration. As of the time when this report was produced, data on other measures (HRA, hospitalizations, and LTSS utilization) have not been produced regularly. As data become available and are refined, future reports are expected.

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9. Cost Savings Calculation

Highlights

- RTI conducted a preliminary estimate of Medicare savings using a difference-in-differences analysis examining beneficiaries eligible for the demonstration in the California demonstration area and comparison areas.
- The results of the preliminary multivariate analyses presented here do not indicate Medicare savings or losses as a result of the first 33 months of the California demonstration in aggregate at the 0.05 level.
- The low rate of enrollment in the demonstration is one reason for the finding of no statistically significant savings among beneficiaries eligible for the demonstration. For example, limited enrollment may have limited the potential impact on costs. It is also possible that there was some favorable selection in enrollment where lower risk beneficiaries may have been more likely to enroll. It is also worth noting that MMP rates were updated and increased during demonstration period 2.

As part of the California capitated model demonstration under the Financial Alignment Initiative, California, CMS, and health plans have entered into a three-way contract to provide services to Medicare-Medicaid enrollees (Centers for Medicare & Medicaid Services and Medicare-Medicaid Coordination Office staff, 2013). Participating health plans receive prospective blended capitation payment to provide both Medicare and Medicaid services for enrollees. CMS and California developed risk adjusted capitation rates for Medicare Parts A, B, and D, and Medicaid services to reflect the characteristics of enrollees. The Medicare component of the payment is risk-adjusted using CMS' hierarchical risk-adjustment model. The rate development process is described in greater detail in the Memorandum of Understanding and the three-way contract, and a description of the risk adjusted Medicare and Medicaid components of the rate are described in the Final Rate Reports (Centers for Medicare & Medicaid Services and State of California, 2013).

The capitation payment incorporates savings assumptions over the course of the demonstration. The same savings percentage is prospectively applied to both the Medicare and Medicaid components of the capitation payment, so that both payers can recognize proportional savings from this integrated payment approach, regardless of whether the savings is driven disproportionately by changes in utilization of services typically covered by Medicare or Medicaid. The goal of this methodology is to minimize cost shifting, to align incentives between Medicare and Medicaid, and to support the best possible outcomes for enrollees.

This chapter presents preliminary Medicare Parts A and B savings calculations for the first 33 months of the demonstration period using an intent-to-treat (ITT) analytic framework that includes beneficiaries eligible for the demonstration rather than only those who enrolled. Approximately 475,552 Medicare-Medicaid beneficiaries in California were eligible for and over 113,601 enrolled in the demonstration as of December 2016.

The Medicare calculation presented here uses the capitation rate that CMS pays to Cal MediConnect plans for beneficiaries enrolled in the demonstration, and not the actual payments that plans made to providers for services, so the savings are calculated from the perspective of the Medicare program. A similar approach will be applied to the Medicaid savings calculation when data is available. Part D costs are not included in the savings analysis.

The results shown here reflect quality withhold repayments for 2014 and 2015. The results will be recalculated as information on 2016 quality withhold repayments and 2014–2016 risk corridor payments and recoupments become available. Note that Medicare and Medicaid savings calculations will be conducted by RTI for each year of the demonstration as data are available.

The following sections discuss the analytic approach and results of these analyses.

9.1 Evaluation Design

To assess the impact of the demonstration on Medicare costs for Medicare-Medicaid enrollees, RTI used an ITT approach comparing the population eligible for the California demonstration with a comparison group not affected by the demonstration. An ITT approach diminishes the potential for selection bias and highlights the effect of the demonstration on all beneficiaries in the demonstration eligible population. All Medicare-Medicaid enrollees eligible for the demonstration constitute the evaluation sample, regardless of whether they enrolled in the demonstration or actively participated in the demonstration care model. Therefore, the analyses presented here include demonstration eligible beneficiaries including those who opted out, or participated but subsequently disenrolled; were eligible but were not contacted by the State or participating plans; and those who enrolled but did not seek services.

Beneficiaries eligible for the demonstration were identified using quarterly files submitted by the State of California. These files include information on all beneficiaries eligible for the demonstration, as well as indicators for whether each beneficiary was enrolled. Demonstration-eligible beneficiaries enrolled in Medicare Advantage were removed from the evaluation cost analysis because at the time when the evaluation determined who would be included in quantitative analysis for the Cal MediConnect demonstration, it was not known what proportion of the demonstration eligible or enrolled population they would represent. Only one passive crosswalk wave included Medicare Advantage beneficiaries, representing a one-time uptick in Medicare Advantage enrollment in January 2015. Given that this very large group of beneficiaries did not receive opt-in notices and was not included in passive enrollment closer to the beginning of the demonstration, RTI considered them as too different from the remaining beneficiaries to be included in the evaluation, and they were removed from both the demonstration and comparison groups. Managed care penetration in California is significant, and Medicare Advantage beneficiaries comprise a meaningful portion of demonstration enrollment in some counties, so it is important to consider the results in this context. That said, the majority of eligible beneficiaries were not enrolled in a Cal MediConnect plan and therefore were receiving usual FFS Medicare.

A comparison group was identified in two steps. First, RTI identified comparison areas that are most similar to California with regard to area-level measures of health care market

characteristics such as Medicare and Medicaid spending and State policy affecting Medicaid-Medicare enrollees. Second, beneficiaries were selected using a propensity score model (described in further detail below).

The California demonstration area consists of seven counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara), in five Metropolitan Statistical Areas (MSAs) (Los Angeles-Long Beach-Anaheim, Riverside-San Bernardino-Ontario, San Diego-Carlsbad, San Francisco-Oakland-Hayward, and San Jose-Sunnyvale-Santa Clara). The comparison area is comprised of 168 counties in 33 MSAs from 10 States and 40 non-metropolitan counties in Michigan. The pool of States was limited to those with timely submission of Medicaid data to CMS. All comparison areas are listed in *Figure 1*.

Figure 1
Metropolitan statistical areas in 10 comparison states

California MSAs (# counties if part)	Michigan MSAs	North Carolina MSAs
Bakersfield	Detroit-Warren-Dearborn (4)	Burlington
Fresno	Flint	Charlotte-Concord-Gastonia
Madera	Grand Rapids-Wyoming (3)	Fayetteville
Modesto	Lansing-East Lansing	Greensboro-High Point
Napa	Midland	Hickory-Lenoir-Morganton
Oxnard-Thousand Oaks-Ventura	Muskegon	Raleigh
Sacramento--Roseville--Arden-Arcade	Saginaw	Winston-Salem
San Francisco-Oakland-Hayward (4)	Rest of State (40)	
Stockton-Lodi		
Vallejo-Fairfield		
Georgia MSA	Missouri MSAs	Pennsylvania MSAs
Atlanta-Sandy Springs-Roswell	St. Louis	Philadelphia-Camden-Wilmington
	Springfield	Pittsburgh
Massachusetts MSA	New Jersey MSA	Texas MSA
Providence-Warwick	New York-Newark-Jersey City	Corpus Christi
		Wisconsin MSA
		Milwaukee-Waukesha-West Allis

Once comparison areas were selected, all Medicare-Medicaid enrollees in those areas meeting the demonstration’s eligibility criteria were pooled to estimate a propensity score model based on beneficiary and area characteristics. A propensity score is the predicted probability that a beneficiary is a member of the demonstration group conditional on a set of observed variables. Our propensity score models include a combination of beneficiary-level and region-level characteristics measured at the ZIP code (ZIP Code Tabulation Area) level. Beneficiary-level characteristics include age, gender, race, disability status, number of months of full-benefit dual Medicare-Medicaid eligibility, residence in urban area, and Hierarchical Condition Category (HCC) risk score where the risk score value was “frozen” to the value at the start of the demonstration period. Diagnoses codes are the basis for risk score calculations, and by freezing the score prior to any potential impact of the demonstration, we are able to control for baseline

health status. Region-level covariates were drawn from a factor analysis of ZIP code-based variables for the adult population. These covariates capture features of the age, employment, marital, and family status of households in each region. Measures of the distance to hospitals and nursing facilities were also included. Note that beneficiaries with ESRD were excluded from the demonstration group and the comparison group due to differences in eligibility criteria for ESRD beneficiaries across demonstration counties that cannot be replicated in the comparison group identification.

Propensity score weighting was used to increase the equivalence between the demonstration and comparison groups. Inverse probability of treatment weighting pulled the distribution of weighted comparison group propensity scores closer to that of the demonstration group, increasing the comparability of the demonstration and comparison groups.

Separate comparison group analyses were conducted for time periods: baseline year 1 (April 1, 2012–March 31, 2013), baseline year 2 (April 1, 2013– March 31, 2014), the first demonstration period (seven quarters from April 1, 2014–December 31, 2015), and the second demonstration period (January 1, 2016–December 31, 2016). Analyses were conducted for each period because eligible beneficiaries are identified separately for each time period.

RTI used a difference-in-differences (DID) approach to evaluate the impact of the demonstration on Medicare costs. DID refers to an analytic strategy whereby two groups—one affected by the policy intervention and one not affected by it—are compared on an outcome of interest before and after the policy intervention. The predemonstration period included 2 years prior to the start of the California demonstration (April 1, 2012–March 31, 2014), the first demonstration period (demonstration year 1) included the first 21 months of the demonstration (April 1, 2014–December 31, 2015) and the second demonstration period (demonstration year 2) included calendar year 2016 (January 1, 2016–December 31, 2016).

To estimate the average treatment effect on the demonstration eligible population for monthly Medicare expenditures, RTI ran generalized linear models (GLMs) with a gamma distribution and a log link. This is a commonly used approach in analysis of skewed data or in cases where a high proportion of observations may have values equal to zero. The model also employed propensity score weighting and adjusted for clustering of observations at the county level.

The GLM model included indicators for demonstration period, an indicator for assignment to the demonstration group versus the comparison group, and an interaction term for demonstration period and demonstration assignment. The model also included demographic variables and area level variables. The interaction term represents the combined effect of being part of the demonstration eligible group during the demonstration periods and is the key policy variable of interest. The interaction term is a way to measure the impact of both time and demonstration group status. Separate models were run to distinguish between overall savings (pre- versus postdemonstration) as well as savings for each demonstration period. Because the difference-in-difference variable was estimated using a non-linear model, RTI employed a post-estimation procedure to obtain the marginal effects of demonstration impact. The marginal effects of the demonstration impact are reported below.

Demographic variables included in the model were gender, and race. Area level variables included in the savings model were Medicare spending per Medicare-Medicaid enrollee age 19 or older, Medicare Advantage penetration rate, Medicaid-to-Medicare fee-for-service (FFS) fee index for all services, Medicaid spending per Medicare-Medicaid enrollee age 19 or older, fraction of Medicare-Medicaid enrollees using nursing facilities age 65 or older, fraction of Medicare-Medicaid enrollees using home and community-based services (HCBS) age 65 or older, fraction of Medicare-Medicaid enrollees using personal care age 65 or older, fraction of Medicare-Medicaid enrollees with Medicaid managed care age 19 or older, population per square mile, and physicians per 1,000 population. Additional area-based variables—such as the percent of adults with a college degree and proximity to hospitals or nursing facilities—were used as proxies for sociodemographic indicators and local area characteristics. Note that these variables were also used in the comparison group selection process. Individual beneficiary demographic characteristics are controlled for in the models and are also accounted for in the propensity score weights used in the analysis.

In addition to the variables noted here, the propensity score weights used in the cost savings analyses also include Hierarchical Condition Categories (HCC) risk score. HCC risk score is not included as an independent variable in the regression models predicting costs because HCC risk score is directly related to capitated payments. Due to the potential for differences in diagnoses coding for enrollees compared to beneficiaries in FFS after the start of the demonstration, the HCC risk score used to calculate the weights was “frozen” to the value at the start of the demonstration period. Diagnoses codes are the basis for risk score calculations, and by freezing the score prior to any potential impact of the demonstration, we are able to control for baseline health status.

9.2 Medicare Expenditures: Constructing the Dependent Variable

RTI gathered predemonstration and demonstration monthly Medicare expenditure data for both the demonstration and comparison groups from two data sources. Capitation payments paid to Cal MediConnect plans during the demonstration period were obtained for all demonstration enrollees from CMS Medicare Advantage and Part D Inquiry System (MARX) data. The capitation payments were the final reconciled payments paid by the Medicare program after taking into account risk score reconciliation and any associated retroactive adjustments in the system at the time of the data pull (March 2018). FFS Medicare claims were used to calculate expenditures for all comparison group beneficiaries, demonstration beneficiaries in the predemonstration period, and demonstration eligible beneficiaries who were not enrolled during the demonstration period as summarized in *Table 19*. FFS claims included all Medicare Parts A and B services.

Table 19
Data sources for monthly Medicare expenditures

Group	Predemonstration April 1, 2012–March 31, 2014	Demonstration period April 1, 2014–December 31, 2016
Demonstration group	Medicare FFS	Capitation rate for enrollees Medicare FFS for non-enrollees
Comparison group	Medicare FFS	Medicare FFS

FFS = fee for service.

Several adjustments were made to the monthly Medicare expenditures to ensure that observed expenditures variations are not due to differences in Medicare payment policies in different areas of the country or the construction of the capitation rates. **Table 20** summarizes each adjustment and the application of the adjustments to FFS expenditures or to the capitation rate.

The capitation payments reflect the savings assumptions applied to the Cal MediConnect and Medicare components of the rate, but do not reflect the risk corridor payments or the quality withhold amounts (withhold of 1 percent in the first demonstration period and 2 percent in the second demonstration period). The results shown here reflect quality withhold repayments for 2014 and 2015. The results will be recalculated as information on 2016 quality withhold repayments and 2014–2016 risk corridor payments become available.

Table 20
Adjustments to Medicare expenditures variable

Data source	Adjustment description	Reason for adjustment	Adjustment detail
FFS	Indirect Medical Education (IME)	MMP capitation rates do not include IME	Do not include IME amount from FFS payments.
FFS	Disproportionate Share Hospital (DSH) Payments and Uncompensated Care Payments (UCP)	The capitation rates reflect DSH and UCP adjustments	Include DSH and UCP payments in total FFS payment amounts.
FFS	Medicare Sequestration Payment Reductions	Under sequestration Medicare payments were reduced by 2% starting April 1, 2013. Because the predemonstration period includes months prior to April 1, 2013 it is necessary to apply the adjustment to these months of data.	Reduced FFS claim payments incurred before April 2013 by 2%.
Capitation rate	Medicare Sequestration Payment Reductions	Under sequestration Medicare payments were reduced by 2% starting April 1, 2013. Sequestration is not reflected in the capitation rates.	Reduced capitation rate by 2%.

(continued)

Table 20 (continued)
Adjustments to Medicare expenditures variable

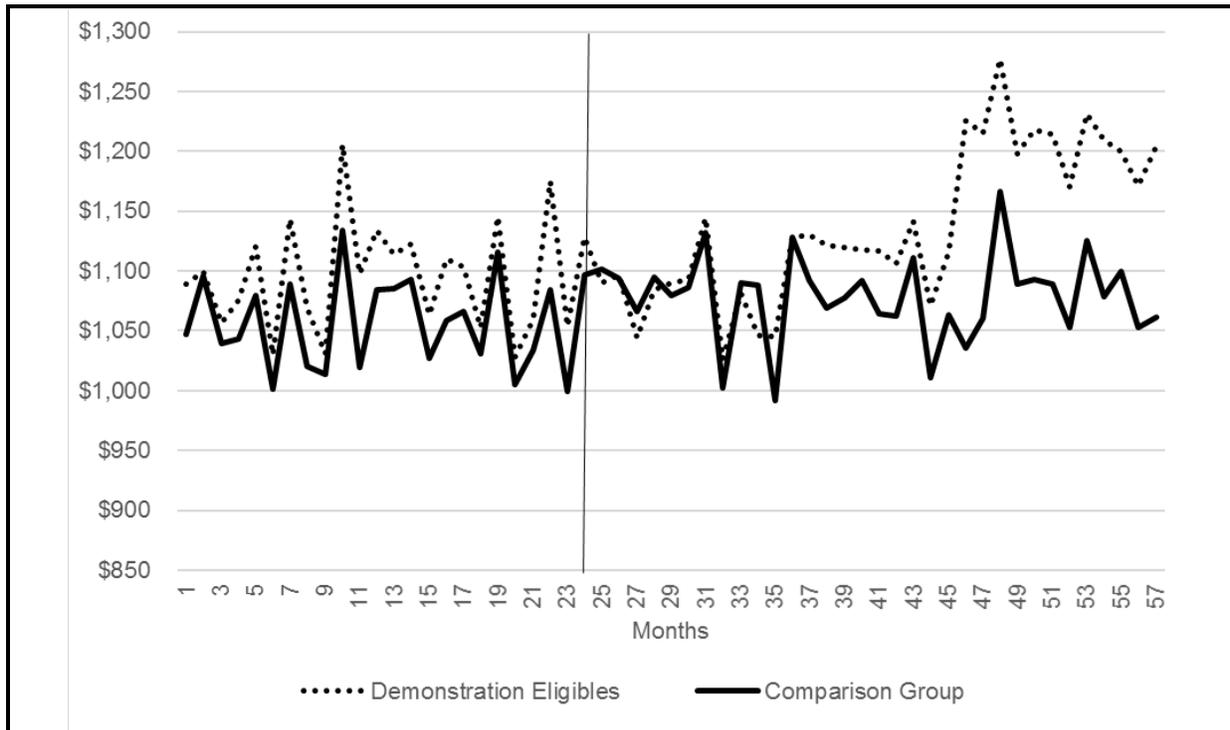
Data source	Adjustment description	Reason for adjustment	Adjustment detail
Capitation rate	Bad debt	The Medicare portion of the capitation rate includes an upward adjustment to account for bad debt. Bad debt is included in the FFS claim payments and therefore needs to be removed from the capitation rate for the savings analysis. (Note, “bad debt” is reflected in the hospital “pass through” payment)	Reduced blended capitation rate to account for bad debt load (historical bad debt baseline percentage). This is 0.87 for CY 2013, 0.88 for CY 2014, 0.89 for CY 2015, and 0.94 for CY 2016. Reduced the FFS portion of the capitation rate by an additional 1.89% for CY 2014, by an additional 1.71% for CY 2015, and by an additional 1.84% for CY 2016 to account for the disproportional share of bad debt attributable to Medicare-Medicaid enrollees in Medicare FFS.
FFS and capitation rate	Average Geographic Adjustments (AGA)	The Medicare portion of the capitation rate reflects the most current hospital wage index and physician geographic practice cost index by county. FFS claims also reflect geographic payment adjustments. In order to ensure that change over time is not related to differential change in geographic payment adjustments, both the FFS and the capitation rates were “unadjusted” using the appropriate county-specific AGA factor.	Medicare expenditures were divided by the appropriate county-specific AGA factor for each year. Note that for 2014 and 2015, a single year-specific AGA factor based on claims paid in the year, rather than the AGA factor used in Medicare Advantage (based on 5 years of data and lagged 3 years) was used to account for year specific policies. Note also that the AGA factor applied to the capitated rates for 2014 reflected the 50/50 blend that was applicable to the payment year.
Capitation rate	Education user fee	No adjustment.	Capitation rates in the MARX database do not reflect the education user fee adjustment (this adjustment is applied retrospectively). Education user fees are not applicable in the FFS context and do not cover specific Part A and Part B services. While they result in a small reduction in the capitation payment received by MMPs, we did not account for this reduction in the capitated rate.
Capitation rate	Quality withhold	A 1% quality withhold was applied in the first demonstration year and a 2% quality withhold was applied in the second demonstration year but the quality withholds were not reflected in the capitation rate used in the analysis.	Final quality withhold repayments for 2014 and 2015 were incorporated into the dependent variable construction. 2016 repayments will be incorporated as it becomes available.
Capitation rate	Risk corridor	Risk corridor payments or recoupments are based on reconciliation after application risk adjustment methodologies.	Information on risk corridor payments or recoupments will be incorporated as it becomes available.

CY = calendar year; FFS = fee for service; MMP = Medicare-Medicaid Plan.

9.3 Results

The first step in the analysis was to plot the unweighted mean monthly Medicare expenditures for both the demonstration group and the comparison group. *Figure 2* indicates that the demonstration group and the comparison group had parallel trends in mean monthly expenditures during the 24-month predemonstration period, which is an important assumption to the DID analysis.

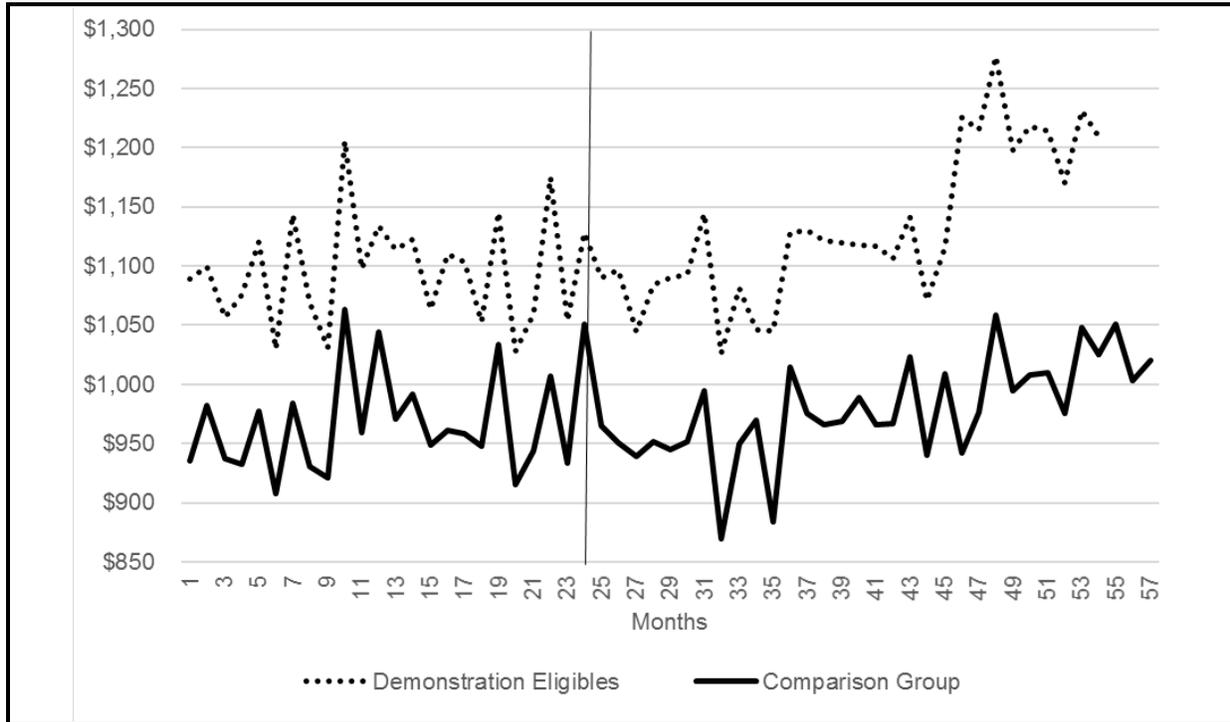
Figure 2
Mean monthly Medicare expenditures, predemonstration and demonstration period,
Cal MediConnect eligibles and comparison group,
April 2012–December 2016



SOURCE: RTI Analysis of California demonstration eligible and comparison group Medicare data (program: Cap Savings Calculation\ California\ca_qc_Final_rep_20181010_0304PM.xlsx).

Figure 3 demonstrates the same plot of mean monthly Medicare expenditures for both the demonstration group and the comparison group, after applying the propensity weights.

Figure 3
Mean monthly Medicare expenditures (weighted), predemonstration and demonstration period, Cal MediConnect eligibles and comparison group, April 2012–December 2016



SOURCE: RTI Analysis of California demonstration eligible and comparison group Medicare data (program: Cap Savings Calculation\ California\ca_qc_Final_rep_20181010_0304PM.xlsx).

Table 21 and *Table 22* show the mean monthly Medicare expenditures for the demonstration group and comparison group in the predemonstration and each demonstration period, unweighted. The weighted results for each demonstration period are shown in *Table 23* and *Table 24*. The weighted tables show an increase in mean monthly Medicare expenditures for the demonstration group and a decrease in mean monthly Medicare expenditures for the comparison group for demonstration period 1 and an increase in mean monthly expenditure for both groups in demonstration period 2. The weighted mean increase was \$21.92 for the demonstration group and the weighted mean decrease for the comparison group was \$6.38 per member per month (PMPM) in demonstration period 1. The weighted mean increase in demonstration period 2 was \$110.50 PMPM for demonstration eligible beneficiaries and \$41.20 PMPM for the comparison group. The DID values in each table represent the overall impact on savings using descriptive statistics. The change in the demonstration group minus the change in the comparison group is the descriptive DID value. This value would be equal to zero if the differences between predemonstration and the demonstration period were the same for both the demonstration group and the comparison group. A negative value would indicate savings for the demonstration group, and a positive value would indicate that there were no savings for the

demonstration group. The descriptive results using weights shown in both *Table 23* and *Table 24* do not indicate savings in either demonstration period.

Table 21
Mean monthly Medicare expenditures for the California demonstration, predemonstration period and demonstration period 1, unweighted

Group	Predemonstration period Apr 2012–Mar 2014	Demonstration period 1 Apr 2014–Dec 2015	Difference
Demonstration group	\$1,096.04 (\$1,055.80, \$1,136.28)	\$1,117.96 (\$1,090.18, \$1,145.73)	\$21.92 (\$5.79, \$38.05)
Comparison group	\$1,057 (\$1,024.71, \$1,088.90)	\$1,076 (\$1,044.62, \$1,107.30)	\$19.16 (\$11.34, \$26.97)
Difference-in-difference	—	—	-\$2.76 (-\$15.00, \$20.53)

— = data not available.

SOURCE: RTI Analysis of California demonstration eligible and comparison group Medicare data (program: CA AR2 output/ lgs_cacs511_noesrd_i2).

Table 22
Mean monthly Medicare expenditures for the California demonstration, predemonstration period and demonstration period 2, unweighted

Group	Predemonstration period Apr 2012–Mar 2014	Demonstration period 2 Jan 2016–Dec 2016	Difference
Demonstration group	\$1,096.04 (\$1,055.80, \$1,136.28)	\$1,206.54 (\$1,110.86, \$1,302.22)	\$110.50 (\$11.97, \$209.03)
Comparison group	\$1,057 (\$1,024.71, \$1,088.90)	\$1,084 (\$1,050.5, \$1,117.00)	\$26.93 (\$9.05, \$44.81)
Difference-in-difference	—	—	\$83.57 (-\$15.48, \$182.62)

— = data not available.

SOURCE: RTI Analysis of California demonstration eligible and comparison group Medicare data (program: CA AR2 output/ lgs_cacs511_noesrd_i2).

Table 23
Mean monthly Medicare expenditures for the California demonstration, predemonstration period and demonstration period 1, weighted

Group	Predemonstration period Apr 2012–Mar 2014	Demonstration period 1 Apr 2014–Dec 2015	Difference
Demonstration group	\$1,096.04 (\$1,055.80, \$1,136.28)	\$1,117.96 (\$1,090.18, \$1,145.73)	\$21.92 (\$5.79, \$38.05)
Comparison group	\$968.38 (\$929.63, \$1,007.12)	\$962.00 (\$924.0, \$1,000.0)	-\$6.38 (-\$17.82; \$5.07)
Difference-in-difference	—	—	\$28.29 (-\$8.70, \$1,007.12)

— = data not available.

SOURCE: RTI Analysis of California demonstration eligible and comparison group Medicare data (program: CA AR2 output/ lgs_cacs511_noesrd_i2).

Table 24
Mean monthly Medicare expenditures for the California demonstration, predemonstration period and demonstration period 2, weighted

Group	Predemonstration period Apr 2012–Mar 2014	Demonstration period 2 Jan 2016–Dec 2016	Difference
Demonstration group	\$1,096.04 (\$1,055.80, \$1,136.28)	\$1,206.54 (\$1,110.86, \$1,302.22)	\$110.50 (\$11.97, \$209.03)
Comparison group	\$968.38 (\$929.63, \$1,007.12)	\$1,009.57 (\$962.37, \$1,056.78)	\$41.20 (\$21.58, \$60.82)
Difference-in-difference	—	—	\$69.30 (−\$30.13, \$168.73)

— = data not available.

SOURCE: RTI Analysis of California demonstration eligible and comparison group Medicare data (program CA AR2 output/ lgs_cacs511_noesrd_i2 1).

While the descriptive statistics are informative, to get a more accurate estimate of savings, RTI conducted a multivariate regression analysis to estimate savings controlling for beneficiary and area level characteristics. Given the structure of the data, RTI used the GLM procedure in Stata with a gamma distribution and a log link, and adjusted for clustering at the county level.

In addition to controlling for beneficiary and market area characteristics, the model included a time trend variable (coded as months 1–57), a dichotomous variable for whether the observation was from the predemonstration or demonstration period (“Post”), a variable to indicate whether the observation was from a beneficiary in the comparison group or the demonstration group (“Intervention”), and an interaction term (“Intervention*Post”) which is the difference-in-differences estimate in the multivariate model for the net effect of demonstration eligibility. We also ran a model specific to the year of the demonstration and for this we included a dummy variable for each year of the demonstration (“DemoYear1” and “DemoYear2”) and two interaction terms (“Intervention*DemoYear1” and “Intervention*DemoYear2”).

Table 25 shows the main results from the DID analysis for demonstration years 1 and 2, and for the entire demonstration period, controlling for beneficiary demographics and market characteristics. To obtain the effect of the demonstration from the non-linear model we calculated the marginal effect of coefficient of the interaction term. The marginal effect of the demonstration for the intervention group over the two demonstration periods was positive but not statistically significant, indicating that there were no significant savings or losses to Medicare as a result of the demonstration using the ITT analysis framework. The estimate of the effect in demonstration period 1 indicated \$10.58 in losses, but this finding was not statistically significant. The estimate of the effect in demonstration period 2 indicated losses of \$81.27 and this finding was not statistically significant at the 0.05 level. The demonstration year 2 results in part reflect a risk adjustment-related change that increased the 2016 capitation payments for full benefit dually eligible individuals enrolled in MMPs. The impact of this change is found in the demonstration group but not the comparison group, which did not experience the same rate increase.

Table 25
Demonstration effects on Medicare savings for eligible beneficiaries—Difference-in-difference regression results, California demonstration

Covariate	Adjusted coefficient DID	<i>p</i> -value	95% confidence interval	90% confidence interval	80% confidence interval ¹
Intervention *Demo Year1 (April 2014–December 2015)	\$10.58	0.2610	−\$7.87, \$29.02	−\$4.90, \$26.06	−\$1.48, \$22.64
Intervention *Demo Year2 (January 2016–December 2016)	\$81.27	0.0871	−\$11.82, \$174.35	\$3.15, \$159.39	20.40, 142.13
Intervention*Demo Period (April 2014–December 2016)	\$36.36	0.0608	−\$1.65, \$74.37	\$4.46, \$68.26	\$11.50, \$61.21

¹ 80 percent confidence intervals are provided for comparison purposes only.

SOURCE: RTI Analysis of California demonstration eligible and comparison group Medicare data (program CA AR2 output/lgs_cacs493_noesrd_I2).

Table 26 shows the magnitude of the DID estimate relative to the adjusted mean outcome value in each period. The second and third columns represent the post-regression, mean predicted savings or loss for each group and period, based on the composition of a reference population (the comparison group in the demonstration period). These values show how different the two groups were in each period, and the relative direction of any potential effect in each group over time. The remaining columns show the difference-in-differences estimate (the coefficient on Intervention*Post), the *p*-value demonstrating significance, and the relative percent change of the difference-in-differences estimate compared to the mean monthly Medicare expenditures for the comparison group in the entire demonstration period.

The adjusted mean for monthly expenditures decreased between the predemonstration and demonstration period for the demonstration and the comparison group. The DID estimate (the coefficient on Intervention*Post) is positive but not statistically significant, indicating that there were no significant savings or losses in Medicare Parts A and B from across demonstration 1 and demonstration period 2 at the 0.05 level, using the ITT analysis framework. Looking at **Table 26**, the adjusted coefficient on the DID estimate for the demonstration overall (\$36.36 PMPM) is between the marginal effect of the DID estimate from demonstration year 1 (\$10.58 PMPM in **Table 25**) and the marginal effect of the DID estimate from demonstration year 2 (\$81.27 PMPM in **Table 25**). As noted in **Table 26**, the DID estimate reflects an annual relative increase of 3.7 percent, but this was not statistically significant.

Table 26
Adjusted means and overall impact estimate for eligible beneficiaries in the demonstration and comparison groups, California demonstration

Group	Adjusted mean for predemonstration period	Adjusted mean for demonstration period	Relative difference (%)	Adjusted coefficient DID	p-value
Demonstration group	\$1,194.54 (\$1,104.29, \$1,284.79)	\$1,145.00 (\$1,068.22, \$1,221.77)	3.7%	36.36 95% CI (-1.65, 74.37)	0.0608
Comparison group	\$1,056.50 (\$1,003.67, \$1,109.33)	\$980.85 (\$939.23, \$1,022.46)		90% CI (4.46, 68.26)	

CI = confidence interval; DID = difference-in-differences.

SOURCE: RTI Analysis of California demonstration eligible and comparison group Medicare data (program Programming Specifications\Cap Savings Calculation\California\gana\test\lgs_cacs500T3_noesrd and CA AR2 output/lgs_cacs493_noesrd_i2_log).

In addition to the cost savings analysis on all eligible beneficiaries (ITT approach), RTI conducted several sensitivity analyses to provide additional information on potential savings or losses associated with the demonstration overall and for the subset of beneficiaries enrolled in the demonstration. These sensitivity analyses included (1) simulating capitated rates for eligible enrollees not enrolled in the demonstration and comparing these rates to actual FFS expenditures; (2) predicting FFS expenditures for beneficiaries enrolled in the demonstration and comparing to the actual capitated rates; and (3) calculating a DID estimate based on a subgroup of beneficiaries enrolled in the demonstration with at least 3 months of eligibility in the baseline period. The results of these analyses are presented in *Appendix C*.

The findings of the sensitivity analyses indicate that the predicted capitated rates are lower than actual FFS expenditures for non-enrollees, and that predicted FFS expenditures are higher than actual capitated rates for enrollees. The enrollee subgroup DID analysis indicates additional costs compared to a comparison group, and this finding is statistically significant. Though the predicted capitated rate and predicted FFS sensitivity analyses suggest that the capitated rates were lower than FFS, these analyses are focused on non-enrollees and do not control for unobservable characteristics that may be related to the decision to enroll in the demonstration. The enrollee subgroup DID analysis was conducted to learn more about the potential impact of the demonstration on the subset of beneficiaries touched by the demonstration for at least 3 months. Note that similar 3-month eligibility criteria were applied to the comparison group for the baseline and demonstration periods for this analysis and weights were recalculated. The enrollee subgroup analysis is limited by the absence of person-level data on characteristics that potentially would lead an individual in a comparison area to enroll in a similar demonstration, and thus the results should be considered in the context of this limitation. For further discussion of these results see *Appendix C*.

9.4 Discussion

The results of the preliminary multivariate analyses presented here do not indicate Medicare savings or losses as a result of the first 33 months of the California demonstration in

aggregate at the 0.05 level.. The cost analyses provided here are with reference to the capitation rates paid for enrollees and the FFS expenditures for eligible beneficiaries that did not enroll in the demonstration. The estimates do not take into account actual payments for services incurred by enrollees and paid by the Cal MediConnect plans.

One potential reason that savings were not identified in these analyses is that there was not sufficient time for the program to demonstrate impact. For example, limited enrollment could limit the potential impact on costs. It is also important to note that given the ITT framework used to calculate savings, all eligible beneficiaries, regardless of their enrollment status were included in the calculation. However, enrollment in California was modest during the first 33 months of the demonstration. Approximately 475,552 Medicare-Medicaid beneficiaries in California were eligible for and over 113,601 enrolled in the demonstration as of December 2016. It is possible that there was some favorable selection in enrollment where lower risk beneficiaries may have been more likely to enroll. The large majority of the eligible beneficiaries were not enrolled in a Cal MediConnect plan, and were therefore receiving usual FFS Medicare. While the ITT framework helps mitigate selection bias in evaluating the impact of an intervention, it may be more challenging to detect savings in an ITT framework where enrollment penetration is low. As noted in **Section 9.1**, it is also important to note that demonstration-eligible beneficiaries enrolled in Medicare Advantage were removed from the evaluation cost analysis. Managed care penetration in California is significant so it is important to consider the results in this context.

RTI will continue to examine these results and will rerun the analyses when complete information on quality withhold repayments and risk corridors payments become available. Risk corridor calculations may result in additional payments to plans or in recoupments by CMS and DHCS. Once Medicaid data become available a similar calculation can be conducted on the Medicaid costs and it will be possible to have a more complete understanding of potential savings from the first 2 years of the California Cal MediConnect plan demonstration. Additional Medicare and Medicaid savings calculations will be conducted by the evaluation contractor for each year of the demonstration as data are available and future reports will show updated results for the first two years of the demonstration based on data reflecting additional claims runout, risk score reconciliation, and any retroactive adjustments.

10. Conclusion

The State of California, with CMS, has created an ambitious and complex demonstration under the Financial Alignment Initiative. Health plans, county agencies, stakeholders, and advocates support the fundamental principle that coordinated, integrated care will improve enrollees' lives and ultimately reduce health care costs. About a third of enrollees have received care coordination under Cal MediConnect during the first two demonstration periods. Those receiving this benefit have responded with positive feedback in a number of surveys and focus groups to say their access to care and quality of life have improved. LTSS, behavioral health, and primary care, each with its own language, systems, and priorities, have long existed in separate silos. Bringing them together, under one structure, in a relatively short period, has been a huge undertaking and challenging for all concerned. Plans' three-way contracts provide flexibility, rather than a consistent statewide system. Consequently, each plan has forged its own approach to develop new systems and processes across multiple State, CMS, and county systems.

In the nearly 3 years since the California demonstration began, plans and county agencies have been developing ways to work together and share information, and develop processes to provide integrated care to enrollees. Promising practices have been emerging, such as co-location of staff, targeted dementia training, and strategic use of data systems to support integration. Some plans have made headway in transitioning beneficiaries from long term care facilities back to the community, which is a fundamental goal of the demonstration.

The varied county and MMP approaches and previous county and health plan experience within the California demonstration have led to varied successes and challenges. The evaluation of the demonstration is designed to be model-wide. However, the design of the California demonstration—with its varied types of counties, delivery systems, and plans—does not lend itself easily to one overall assessment. Counties chosen for the demonstration are diverse in size, population, and delivery models. Two counties have one plan each, one in which provider delegation is a factor. Two counties with highly delegated models have only two plans; another has four. Additional plans were added to Los Angeles County to accommodate its large, highly diverse population and highly delegated model. Communicating policies and educating delegated and out-of-network providers has been a struggle for the State, CMS, plans, and stakeholders and has had a deleterious effect on enrollees subjected to incorrect billing. In counties with multiple plans, county LTSS and behavioral health agencies found that they must adapt their systems in order to work with each of the plans; this has not always worked easily. Because of their county and historical linkages, county-operated plans generally have made more progress towards integration with other county-based LTSS and behavioral health agencies than have commercial plans. Commercial plans that previously had extensive D-SNP experience also made progress at integrating LTSS because of their understanding of this population and these services. However, early stakeholder concerns of plan readiness have endured. Other plans, which were inexperienced with this population and with the provision of LTSS, struggled to understand the needs of the dual eligible population and negotiate the complexities of LTSS and behavioral health systems.

The State and most MMPs have seen lower than expected enrollment as a problem, and they have been working to increase enrollment through streamlining processes, improving

continuity of care provisions, new deeming periods, and other program improvements. The demonstration's complex enrollment schedule generated multiple challenges and negative attention, including legal actions. Although many missteps were corrected in the first year of the demonstration, the negative effects lingered. Even in 2016, when explaining the low enrollment rate and the reluctance of providers to participate in the demonstration, interviewees pointed to systems inadequacies, general reluctance of providers to participate in managed care, and to concerns over the transfer of seniors and persons with disabilities to managed care that took place prior to the demonstration,

Plans reported they were attracted to the demonstration by the potential of 456,000 beneficiaries estimated to be eligible for Cal MediConnect. While some opt-outs and disenrollments were expected, as of December 2016, enrollments numbered 113,600. Plans made considerable investments in staff and infrastructure with the expectation that high enrollments would allow them to recoup their upfront investments. State staff contended they were transparent with their enrollment assumptions; however, continuously declining enrollments in many counties have made some plans doubt their financial viability. Moreover, since the demonstration began, the State has not provided final Medicaid rates beyond calendar year 2014. Without those finalized rates, the state has been unable to provide Medicaid reconciliations for 2014 and beyond for the quality withhold and risk corridor. Whether commercial or non-profit, plans need to understand their financial position and determine the sustainability of their products to prepare for the future.

Together, the provision of flexible benefits and the rate structure that rewards plans for achieving lower institutional rates, are designed to promote care in the community, rather than in institutional settings. Some plans have been using the flexible Care Plan Options funds strategically to support enrollees at home and divert institutionalizations and also to transition enrollees from long term care facilities to the community. Other plans appeared to use these benefits ad hoc, or not at all. Without data showing institutionalization rates, it has not been possible to evaluate the overall effectiveness of these nursing facility diversions or transitions. RTI will analyze institutionalization rates and other measures in future reports as data become available.

The results of the preliminary multivariate analyses presented here do not indicate statistically significant Medicare savings or losses during the first 33 months of the California demonstration in aggregate. These results should be considered preliminary without Medicaid, final risk corridor and quality withhold data. Future reports will include final results for this period of performance. The Medicare savings calculated here are based on capitation rates paid for enrollees and the FFS expenditures for eligible beneficiaries that did not enroll in the demonstration. The estimates do not take into account actual payments for services incurred by enrollees and paid by the Cal MediConnect plans. RTI will continue to examine these results and will rerun the analyses when more data become available. Once Medicaid data become available for the first demonstration period and a similar calculation can be conducted on the Medicaid costs, it will be possible to have a more complete understanding of potential savings from the California MediConnect demonstration. Additional Medicare and Medicaid savings calculations will be conducted by the evaluation contractor for each year of the demonstration as data are available.

The demonstration continues to evolve in 2017 and beyond. The State has stepped up activities designed to improve Cal MediConnect and bolster enrollments. These actions have included fine-tuning enrollee supports, encouraging plans to share best practices to improve quality of care, strategic contact with providers linked to high opt-out rates, and reengineering enrollment methods. The State has also undertaken efforts to strengthen health assessment linkages to LTSS referrals by standardizing LTSS HRA questions and monitoring the use of flexible benefits. A little more than one-third of enrollees have received care coordination, which is vital to the integration of services; State and MMP efforts to extend the reach of this benefit to all enrollees who need it have not yet begun as of the time of this report.

California legislation authorizing the demonstration as part of the CCI called for an annual review by the California Department of Finance to determine the CCI's viability for the following year. The uncertainty of whether Cal MediConnect would continue from year to year caused those involved in the demonstration to be cautious in moving forward. The State's announcement on January 10, 2017, to continue Cal MediConnect even while terminating the CCI, provided an opportunity for the State, plans, and providers to strengthen their engagement in the demonstration.

10.1 Next Steps

The RTI evaluation team will continue to collect information on a quarterly basis from California officials through the online State Data Reporting System, covering enrollment statistics and updates on key aspects of implementation. The RTI evaluation team will continue conducting quarterly calls with the California State and CMS staff and will request the results of any evaluation activities conducted by the State or other entities, such as results from the Consumer Assessment of Healthcare Providers and Systems and State-specific demonstration measures the plans are required to report to CMS. RTI will conduct additional site visits and focus groups during the course of the demonstration.

As noted previously, CMS and DHCS have extended the California demonstration through 2019, which will provide further opportunities to evaluate the demonstration's performance. As data become available, future reports will include descriptive and regression-based analyses of quality and utilization measures for those eligible for the demonstration and for an out-of-State comparison group and implementation updates.

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Appendix A: Demonstration Design Features

Key features	Predemonstration	Demonstration
Summary of covered benefits		
Medicare	Medicare Parts A, B, and D.	Medicare Parts A, B, and D.
Medicaid	Medi-Cal covered services (including IHSS, CBAS, MSSP, provided via FFS).	Medi-Cal covered services, including institutional care, IHSS, CBAS, MSSP, and additional benefits in lieu of institutionalization.
Payment method (capitated/FFS/MFFS)		
Medicare	Mostly FFS. (Capitated for Medicare-Medicaid enrollees in PACE and D-SNPs.)	Capitated
Medicaid (capitated or FFS)		
Primary/medical	FFS and transitioning to capitated through the CCI.	Capitated
Behavioral health	FFS and transitioning to capitated through the CCI for Medicare and Medi-Cal behavioral health services. FFS for specialty MH and SU services provided by county-administered Medi-Cal Mental Health services (1915[b] waiver services) and Drug Medi-Cal benefits.	Specialty MH and SU services, financed and provided by county-administered Medi-Cal Mental Health services (1915[b] waiver services) and Drug Medi-Cal services, are excluded from the capitated rate. However, Cal MediConnect plans coordinate MH and SU services with county-administered agencies per each plan's BH-MOU.
LTSS (excluding HCBS waiver services)	FFS and transitioning to capitated through the CCI: IHSS, skilled nursing facility services, and subacute care services.	Capitated. The demonstration includes the following services: IHSS, skilled nursing facility services, and subacute care services.
HCBS waiver services	FFS and transitioning to capitated through the CCI: CBAS (1115[a] waiver), MSSP, Assisted Living, HIV/AIDS, In Home Operations, and the Nursing Facility/Acute Hospital 1915(c) waivers.	Capitated and includes CBAS, MSSP, and additional benefits in lieu of institutionalization. Other 1915(c) waiver services are not included in Cal MediConnect.

(continued)

Key features	Predemonstration	Demonstration
Care coordination/case management		
Care coordination for medical, behavioral health, or LTSS and by whom	Available only for PACE enrollees and some services in San Mateo and Orange counties. IHSS coordination is provided by the counties.	All enrollees have access to Cal MediConnect Plan care coordinators who are responsible for coordinating all services.
Care coordination/case management for HCBS waivers and by whom	Available only for the MSSP waiver (nursing facility certifiable population) enrollees.	Cal MediConnect Plan care coordinators coordinate care for enrollees, including MSSP and CBAS waiver populations. Other waivers are excluded from the demonstration.
TCM	Provided by county-administered agencies to certain individuals with mental illness under the Section 1915(b) “freedom of choice” waiver.	These services are excluded from the capitated rate and continue to be provided by county-administered agencies. However, Cal MediConnect plans coordinate these services with county-administered agencies per each plan’s BH-MOU.
Rehabilitation Option services	Same as above (for TCM).	Same as above (for TCM).
Clinical, integrated, or intensive care management	Only for those in PACE.	Cal MediConnect plans provide these services to beneficiaries identified as high risk.

BH-MOU = Behavioral Health Memorandum of Understanding; CBAS = Community-Based Adult Services; CCI = Coordinated Care Initiative; COHS = County Organized Health System (counties with one plan that provide Medi-Cal managed care services); D-SNPs = Dual Eligible Special Needs Plans; FFS = fee for service; HCBS = home and community-based services; HPSM = Health Plan of San Mateo; IHSS = In-Home Supportive Services; LIS: low-income subsidy; LTSS = long-term services and supports; MFFS = managed fee for service; MH = mental health; MLTSS = managed long-term services and supports; MOU = memorandum of understanding; MSSP = Multipurpose Senior Services Program; N/A = not applicable; PACE = Program of All-Inclusive Care for the Elderly; SU = substance use.

SOURCES: Information related to the demonstration in this table is from the Memorandum of Understanding (MOU, 2013).

Appendix B: Quality Withhold Measures

Demonstration year 1

Domain	Measure	Source
Encounter data	Encounter data submitted in compliance with contract requirements.	CMS/State-defined process measure
Assessments	Percent of enrollees with initial health assessments completed within 90 days of enrollment.	CMS/State-defined process measure
Beneficiary governance board	Establishment of beneficiary advisory board or inclusion of beneficiaries on governance board consistent with contract requirements.	CMS/State-defined process measure
Getting appointments and care quickly	Percent of best possible score the plan earned on how quickly enrollees get appointments and care <ul style="list-style-type: none"> • In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? • 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? 	AHRQ/CAHPS
Customer (enrollee) service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. <ul style="list-style-type: none"> • 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? 	AHRQ/CAHPS
Behavioral Health shared accountability process measure	Policies and procedures attached to an MOU with county Behavioral Health agency(ies) around assessments, referrals, coordinated care planning and information sharing.	CMS/State-defined process measure
Behavioral Health shared accountability process measure:	Percent of demonstration enrollees receiving Medi-Cal specialty mental health and/or drug Medi-Cal services receiving coordinated care plan as indicated by having an individual care plan that includes evidence of collaboration with the primary Behavioral Health provider.	CMS/State-defined process measure
Documentation of care goals	Percent of enrollees with documented discussions of care goals.	CMS/State-defined process measure

(continued)

Demonstration year 1 (continued)

Domain	Measure	Source
Ensuring physical access to buildings, services and equipment	The health plan has an established work plan and identified an individual who is responsible for physical access compliance.	CMS/State-defined process measure
Case manager contact with Enrollees	Percent of enrollees who have a case manager and have at least one case manager contact during the measurement year.	State-defined process measure

Source: Centers for Medicare & Medicaid Services (CMS) and State of California: Cal MediConnect contract, p. 158–9. 2014. <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAContractwithoutSub.pdf>. As obtained on January 13, 2017.

Demonstration year 2

Domain	Measure	Source
Plan all-cause readmissions	Percent of 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.	NCQA/HEDIS
Annual flu vaccine	Percent of plan enrollees who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS
Follow-up after hospitalization for mental illness	Percentage of discharges for 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.	NCQA/HEDIS
Screening for clinical depression and follow-up care	Percentage of enrollees ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS
Reducing the risk of falling	Percent of enrollees with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HOS
Controlling blood pressure	Percentage of enrollees 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) for members 18–59 years of age and 60–85 years of age with diagnosis of diabetes or (150/90) for members 60–85 without a diagnosis of diabetes during the measurement year.	NCQA/HEDIS
Part D medication adherence for diabetes medications	Percent of 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.	CMS
Behavioral Health shared accountability outcome measure	Reduction in emergency department use for seriously mentally ill and substance use disorder Enrollees.	State-defined measure

(continued)

Demonstration year 2 (continued)

Domain	Measure	Source
Documentation of care goals	Percent of enrollees with documented discussions of care goals.	CMS/State-defined process measure
Case manager contact with enrollee	Percent of enrollees who have a case manager and have at least one case manager contact during the measurement year.	State-defined process measure

Source: Centers for Medicare & Medicaid Services (CMS) and State of California: Cal MediConnect contract, p. 158–9. 2014. <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAContractwithoutSub.pdf>. As obtained on January 13, 2017.

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Appendix C: Sensitivity Analysis Tables

Tables in *Appendix C* present results from sensitivity analyses focusing on the California demonstration cost saving models.

C.1 Predicting Capitated Rates for Non-Enrollees

The goal of this analysis was to identify beneficiaries eligible for the California demonstration in the first demonstration period (April 2014–December 2015) and to look at what the capitation rate would have been (had they enrolled) compared to their actual fee-for-service (FFS) expenditures in the demonstration period.

C.1.1 Sample Identification

- Eligible but non-enrolled California beneficiaries in demonstration period 1 (April 1, 2014–December 31, 2015). Predicted Medicare capitated rates were calculated using the beneficiary risk score and the county of residence.

C.1.2 Calculating the Capitated Rate for Eligible but Non-Enrolled Beneficiaries

- Predicted capitated rates were calculated using the monthly beneficiary risk score (final resolved) and the base rate associated with the beneficiary’s county of residence. Differences in end-stage renal disease (ESRD), non-ESRD, and dialysis risk scores and base rates were taken into account.
- Mean predicted capitated rates were compared to mean FFS expenditures (non-Winsorized). Note that bad debt was removed from the capitated rate as this is not reflected in FFS payments. Sequestration was reflected in both the FFS payments and the capitated payment. Disproportionate share hospital payments and uncompensated care payment amounts were included in the FFS expenditures, as these amounts are reflected in the capitated rates.
- The predicted capitated rate for eligible but non-enrollees was \$1,237 compared to actual FFS expenditures of \$1,462 suggesting potential gross Medicare savings for the non-enrolled beneficiary population had this population been enrolled during demonstration period 1.

Table C-1
Observed FFS and predicted capitated rates for eligible but not enrolled beneficiaries

Variable	Observed	Mean	Standard error	Standard deviation	[95% confidence interval]	
Predicted cap	4,060,407	\$1,236.6	\$0.5	\$1,041.7	\$1,235.6	\$1,237.6
Observed FFS	4,060,407	\$1,462.1	\$3.6	\$7,266.1	\$1,455.0	\$1,469.1
Difference	4,060,407	-\$225.5	\$3.5	\$7,142.5	-\$232.4	-\$218.5

FFS = fee for service.

NOTES: RTI also tested the accuracy of the predicted capitated rate by generating a predicted capitated rate for enrollees and comparing it to the actual capitated rate from the plan payment files. RTI’s mean predicted capitated rate for enrollees was \$997.8 compared to an actual capitated rate of \$964.4 (difference of -\$13.3). Observed FFS and predicted capitated values reflect parallel adjustments.

C.2 Predicting FFS Expenditures for Enrollees

The goal of this analysis is the converse of what is presented in Analysis C.1. Here, we look at predicted FFS expenditures for enrollees based on a model predicting FFS expenditures for non-enrollees.

C.2.1 Methods

A data set with observations from base year 2 and from demonstration year 1 was created from the full data set to allow us to look at expenditures between the two periods. Beneficiary expenditures were summed across all months of each period and then “annualized” to represent the full 12 months of base year 2 (or 21 months of demonstration year 1).

The estimation process involved two steps. First, using non-enrollees, we regressed demonstration year 1 expenditures on base year 2 expenditures, base year 2 Hierarchical Condition Category (HCC) score, and a set of base year 2 demographic and area level variables. We used an unlogged dependent variable and ran ordinary least squares (OLS) models with and without propensity score weights (using the frozen HCC scores in the composition of the weights). The data were clustered by Federal Information Processing Standards (FIPS) code. This model explained 21.7 percent of the variation in expenditures for non-enrollees.

In the second step, we used the covariate values for demonstration enrollees estimated in the OLS non-enrollee model (from step 1) to calculate predicted expenditures for enrollees. We compared the predicted expenditure values for enrollees to the actual capitated payments made under the demonstration.

C.2.2 Results

Enrollees had lower predicted FFS expenditures in base year 2 (\$816 for enrollees vs. \$1,095 for non-enrollees) and a lower mean HCC score (1.20 for enrollees vs. 1.39 for non-enrollees).

Actual capitated payments for enrollees were, on average, \$280 per month lower than the predicted mean expenditures for enrollees in demonstration year 1 suggesting gross Medicare savings under the capitated Medicare rates for the enrolled population compared to the predicted FFS expenditures for this same population had they not been enrolled during demonstration period 1. Mean predicted expenditures for enrollees were \$252 per month lower than actual expenditures for non-enrollees.

Table C-2
Mean values of model covariates by group

Covariate	Eligible but not enrolled (N= 250,217)	Enrolled (N = 156,157)
Average monthly FFS expenditures in base year 2	\$1,095	\$816
Average monthly FFS expenditures in demo year 1	\$1,501	N/A
Average monthly capitated payment demo year 1	N/A	\$955
HCC score	1.39	1.20
Age	69.62	66.51
Also in another CMS demonstration	49%	33%
Female	60%	55%
Black	9%	12%
Asian	28%	18%
Other	5%	4%
Hispanic	14%	23%
Disabled	25%	32%
Patient care physicians per 1,000 population	74%	74%
% of households w/ member >= 60 yrs.	33.17	32.32
% of households w/ member < 18 yrs.	38.58	41.20
% of those aged <65 years with college education	25.79	22.75
% of those aged <65 years unemployed	11.24	11.93
% of those aged <65 years with self-care limitation	3.43	3.25
Fraction of duals with Medicaid managed care, ages 19+	1.00	1.00
Medicare Advantage penetration rate, all enr	0.47	0.47
% of pop. living in married household	67.73	66.69
Population per square mile, all ages	2,084.91	1,736.67
Medicaid spending per dual, ages 19+	12,789.38	12,593.04
Medicare spending per dual, ages 19+	8,940.26	8,914.98
Fraction of duals using nursing facilities, ages 65+	0.08	0.08
Fraction of duals using personal care, ages 65+	0.37	0.34
Distance to nearest hospital (miles)	3.37	3.80
Distance to nearest nursing home (miles)	2.71	3.03

ESRD = end-stage renal disease; HCC = Hierarchical Condition Category; FFS = fee for service.

SOURCE: RTI Program predictingFFS_CA_noESRD: Summary statistics: mean by categories of: enrollee

Table C-3
Expenditure prediction results from an unweighted OLS model

Enrollee observations = 156,157	Mean expenditures over the first year of the demonstration (21 months)		95% confidence interval	
	Predicted FFS for enrollees	\$26,223	\$26,059	\$26,387
Actual PMPM for enrollees	\$20,061	\$19,970	\$20,153	
Difference	\$6,162 (\$280 per month)	P = 0.0000		

FFS = fee for service; OLS = ordinary least squares; PMPM = per member per month.

SOURCE: RTI program: predictingFFS_CA_noESRD unweighted FFS3a.

C.3 Enrollee-Subgroup Analyses

The enrollee-subgroup analyses focused on a subgroup of beneficiaries identified as enrolled for at least 3 months in the demonstration period and with at least 3 months of baseline eligibility. Note that a subset of the comparison group developed for the ITT analysis was used in the enrollee subgroup analyses. Comparison group beneficiaries used in the enrollee subgroup analyses were required to have at least 3 months of eligibility in the demonstration period (April 1, 2014–December 31, 2016) and at least 3 months of eligibility in the predemonstration period (April 1, 2012–March 31, 2014), analogous to the criteria for identifying enrollees. The results indicate additional costs associated with enrollees. This enrollee sub-group analysis is limited by the absence of person-level data on characteristics that potentially would lead an individual in a comparison area to enroll in a similar demonstration, and thus the results should be considered in the context of this limitation.

Table C-4
California demonstration, mean monthly Medicare expenditures, enrollee subgroup analysis, predemonstration period and demonstration period 1, weighted

Group	Predemonstration period April 2012–March 2014	Demonstration period 1 April 2014–Dec 2015	Difference
Demonstration group	650.55 (595.39, 705.71)	826.59 (764.99, 888.19)	176.05 (161.65, 190.44)
Comparison group	699.97 (676.88, 723.06)	784.40 (758.98, 809.83)	84.44 (72.66, 96.22)
Difference-in-difference	N/A	N/A	91.61 (73.51, 109.71)

N/A = not applicable.

SOURCE: RTI Analysis of California demonstration eligible and comparison group Medicare data (program: PredictingFFS// lgs_cacs521_noesrd_i2_log).

Table C-5
California demonstration, mean monthly Medicare expenditures, enrollee subgroup analysis, predemonstration period and demonstration period 2, weighted

Group	Predemonstration period April 2012–March 2014	Demonstration period 2 Jan 2016–Dec 2016	Difference
Demonstration group	650.55 (595.39, 705.71)	1,009.94 (974.88, 1,044.99)	359.39 (281.45, 437.33)
Comparison group	699.97 (676.88, 723.06)	868.79 (839.73, 897.84)	168.82 (153.36, 184.28)
Difference-in-difference	N/A	N/A	190.57 (114.57, 266.57)

N/A = not applicable.

SOURCE: RTI Analysis of California demonstration eligible and comparison group Medicare data (program: PredictingFFS/ lgs_cacs521_noesrd_i2_log).

Table C-6
Demonstration effects on Medicare savings, enrollee subgroup analysis, difference-in-difference (DID) regression results, California demonstration (weighted)

Covariate	Adjusted coefficient DID	p-value	95% confidence interval	90% confidence interval	80% confidence interval¹
Intervention *DemoYear1 (April 2014– December 2015)	107.42	0.0000	87.70, 127.15	90.87, 123.97	94.53, 120.32
Intervention *DemoYear2 (January 2016– December 2016)	229.19	0.0000	142.46, 315.92	156.41, 301.98	172.48, 285.90
Intervention*Demo Period (April 2014– December 2016)	143.99	0.0000	108.00, 179.98	113.78, 174.19	120.45, 167.52

¹ 80 percent confidence intervals are provided for comparison purposes only.

NOTE: Adjusted coefficient greater than zero are not indicative of Medicare savings.

SOURCE: RTI Analysis of California demonstration eligible and comparison group Medicare data (program: PredictingFFS/ lgs_cacs521_noesrd_i2_log).