

July | 2016

Cal MediConnect: How Have Health Systems Responded?

Brooke Hollister, PhD

Carrie Graham, MGS, PhD

Charlene Harrington, RN, PhD, FAAN

Alice Wong, MS

Luke O'Shea, MA

Elaine Kurtovich, MPH

Brenda Nussey

Pi-Ju Liu, PhD

Health Research for Action, UC Berkeley
Institute for Health and Aging, UC San Francisco
Community Living Policy Center, UC San Francisco



Table of Contents

INTRODUCTION.....	5
BACKGROUND.....	5
PURPOSE OF HEALTH SYSTEM RESPONSE STUDY.....	7
METHODOLOGY	8
PARTICIPANTS	8
INTERVIEW INSTRUMENTS	8
ANALYSIS.....	9
RESULTS	11
HEALTH PLAN RESPONSE TO CMC	11
The Value of CMC for Health Plans	12
Health Plan Preparation for CMC	13
Health Plan CMC Implementation Efforts.....	15
The Challenges of CMC for Health Plans.....	18
CMC Plan Delegation Models.....	25
CMC Plan Delegation Rationale.....	28
PROVIDER AND PPG RESPONSE TO CMC.....	30
The Value of CMC for Providers and PPGs.....	30
Provider and PPG Preparation for CMC.....	32
Provider and PPG CMC Implementation Efforts	33
The Challenges of CMC for Providers and PPGs.....	35
LTC FACILITY RESPONSE TO CMC.....	37
The Value of CMC for LTC Facilities	37
LTC Facility Preparation for CMC.....	38
LTC Facility CMC Implementation Efforts	39
The Challenges of CMC for LTC Facilities.....	40
IHSS RESPONSE TO CMC.....	43
The Value of CMC for IHSS	44
IHSS Preparation for CMC	45
IHSS CMC Implementation Efforts.....	45
The Challenges of CMC for IHSS.....	46
CBAS RESPONSE TO CMC.....	47
The Value of CMC for CBAS.....	47
CBAS Preparation for CMC.....	48
CBAS CMC Implementation Efforts.....	49
The Challenges of CMC for CBAS	50
MSSP RESPONSE TO CMC	51
The Value of CMC for MSSP.....	51
MSSP Preparation for CMC.....	52
MSSP CMC Implementation Efforts	52
The Challenges of CMC for MSSP.....	52

HEALTH SYSTEM RESPONSE: CARE COORDINATION	54
Care Coordination Workforce: Title, Qualifications, and Credentials	54
Beneficiary Assignment to Care Coordinators.....	55
HRAs and Other Assessments.....	56
Levels of Care Coordination	61
Care Coordination Activities	61
Individualized Care Plans (ICPs)	62
Interdisciplinary Care Teams (ICTs).....	63
Care Coordination Across Sites.....	65
Defining and Delivering Person-Centered Care	68
Challenges with Accessing Care Coordination Services.....	69
HEALTH SYSTEM RESPONSE: ANCILLARY SERVICES, SUPPLEMENTAL BENEFITS, AND CARE PLAN OPTIONS	70
Pharmacy.....	70
Durable Medical Equipment.....	71
Transportation.....	72
Vision	73
Dental.....	74
Care Plan Options.....	74
HEALTH SYSTEM RESPONSE: QUALITY	79
Quality Oversight	79
HEALTH SYSTEM RESPONSE: COST	82
Reducing Unnecessary Hospital Admissions, Readmissions, or LTC Placement	82
Improving Care Transitions	83
Transitioning Beneficiaries in LTC to the Community	85
HEALTH SYSTEM RESPONSE: CARING FOR CHALLENGING POPULATIONS.....	87
Addressing Homelessness and Housing.....	87
Treating Substance Use Disorders.....	88
Serving Beneficiaries with Mental Illness.....	89
Unknown and At-risk	90
KEY FINDINGS AND RECOMMENDATIONS	91
CONCLUSION AND DHCS RESPONSE.....	99
APPENDICES	102
APPENDIX A: EMAIL SCRIPTS.....	102
APPENDIX B: HEALTH PLAN KI PRE-INTERVIEW DATA REQUEST FORM.....	104
APPENDIX C: HEALTH PLAN KI INTERVIEW PROTOCOL.....	106
APPENDIX D: STAKEHOLDER KI INTERVIEW PROTOCOL	109
APPENDIX E: HEALTH SYSTEM RESPONSE CODEBOOK.....	113

Supported by a grant from The SCAN Foundation—advancing a coordinated and easily navigated system of high-quality services for older adults that preserves dignity and independence. For more information, visit www.TheSCANFoundation.org.

Additional funding provided by the National Institute on Disability, Independent Living, and Rehabilitation Research (grant 90RT5026) and the Administration for Community Living.

For a summary of key findings from this report, go to http://www.thescanfoundation.org/sites/default/files/cal_mediconnect_health_system_key_findings.pdf.

Suggested citation: Hollister, B., Graham, C., Harrington, C., Wong, A., O’Shea, L., Kurtovich, E., Nussey, B., Liu, P-J. (2016). *Cal MediConnect: How Have Health System Responded?* Long Beach, CA: The SCAN Foundation. Retrieved from http://www.theSCANFoundation.org/sites/default/files/cal_mediconnect_health_system_full_report.pdf.

Acronyms Used in This Report

AAA	Area Agency on Aging
CBAS	Community Based Adult Services
CBO	Community Based Organization
CCI	Coordinated Care Initiative
CMC	Cal MediConnect
CMS	Centers for Medicare and Medicaid Services
COHS	County Organized Health System
CPO	Care Plan Option
DHCS	California Department of Health Care Services
DME	Durable Medical Equipment
D-SNP	Dual Eligible Special Needs Plans
FFS	Fee-For-Service
FQHC	Federally Qualified Health Center
HCBS	Home- and Community-Based Services
HRA	Health Risk Assessment
HUD	Department of Housing and Urban Development
ICP	Individual Care Plan
ICT	Interdisciplinary Care Team
IHSS	In-Home Supportive Services
KI	Key Informant
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
MA	Medicare Advantage
MLTSS	Managed Long-Term Services and Supports
MMC	Medi-Cal Managed Care
MSSP	Multipurpose Senior Services Program
PCP	Primary Care Physician
PPG	Participating Provider Group
ROI	Return on Investment
SMI	Severe Mental Illness

INTRODUCTION

BACKGROUND

Over 9.6 million seniors and adults with significant disabilities in the United States (US) are dually eligible for Medicaid and Medicare.¹ They represent beneficiaries with the lowest incomes and, on average, the most complex care needs and the highest care utilization. Not surprisingly, they also account for a disproportionate share of spending in both programs. The *Patient Protection and Affordable Care Act* gave the Centers for Medicare and Medicaid Services (CMS) new demonstration authority to implement and test programs to align the financing and/or administration of Medicaid and Medicare for dually eligible beneficiaries. Twenty-six states submitted applications to implement a “dual financial alignment” demonstration, and CMS has finalized Memorandums of Understanding (MOUs) with 13 states.^{2,3} CMS estimated that as many as two million dually eligible beneficiaries in the US might be included in state alignment demonstrations.⁴ Enrollment in the first demonstration in Massachusetts became effective in October 2013, with more states following in early 2014.

California’s dual alignment demonstration, called Cal MediConnect (CMC), was designed as a capitated managed care model aligning Medicare and Medi-Cal (California’s Medicaid program) financing and administration. Existing Medi-Cal managed care (MMC) plans in seven selected demonstration counties created new CMC products. The first counties began passively enrolling eligible beneficiaries in CMC plans in April 2014, with passive enrollment ending in all counties except Orange by March 2016. CMC is part of a broader statewide initiative called the Coordinated Care Initiative (CCI), which includes CMC as well as Medi-Cal Managed LTSS in the seven demonstration counties.

Once enrolled, CMC beneficiaries have all Medicare and Medicaid services coordinated through one CMC plan and integrated under one payment system. Most strikingly, the CMC plan is financially responsible for all LTSS, including both institutional care (skilled nursing/rehabilitation) and

¹ Musumeci, M. (2012). Explaining the State Integrated Care and Financial Alignment Demonstrations for Dual Eligible Beneficiaries. The Henry J. Kaiser Family Foundation. Retrieved from <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8368.pdf>.

² As of December, 2015, CMS has finalized memoranda of understanding (MOUs) with 13 states to implement 14 demonstrations: Summer, L., & Hadley, J. (2015). Early Insights from Commonwealth Coordinated Care: Virginia’s Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries. The Henry J. Kaiser Family Foundation. Retrieved from <http://kff.org/medicaid/issue-brief/early-insights-from-commonwealth-coordinated-care-virginias-demonstration-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries/>.

³ Musumeci, M. (2015). Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda Of Understanding Approved by CMS. The Henry J. Kaiser Family Foundation. Retrieved from <http://kff.org/medicaid/issue-brief/financial-and-administrative-alignment-demonstrations-for-dual-eligible-beneficiaries-compared-states-with-memoranda-of-understanding-approved-by-cms/>.

⁴ The Kaiser Family Foundation (2015) State Demonstration Proposals to Integrate Care and Align Financing and/or Administration for Dual Eligible Beneficiaries. Retrieved from <http://kff.org/medicaid/fact-sheet/state-demonstration-proposals-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries/>.

INTRODUCTION: BACKGROUND

home- and community-based services (HCBS), creating an incentive that privileges less expensive home service over institutional care. Though county social services are still responsible for assessment of In-Home Supportive Services (IHSS) eligibility, the CMC plans pay for the service and have developed channels of communication to request additional home care hours. Three new benefits provided to CMC beneficiaries include: care coordination, vision care, and non-emergency transportation services. Some CMC plans provide increased dental benefits while others do not. Additionally, most CMC plans are offering Care Plan Options (CPOs), which is a term that describes plans' abilities to pay for a variety of services (respite care, home modification, etc.), intended to help beneficiaries prevent unnecessary utilization or institutionalization. If implemented well, CPOs may also play a key role in helping California rebalance services to privilege community living over institutionalization. Incentives to rebalance services away from more costly institutional care are one of the primary areas where costs savings are anticipated in CMC.

By May 2016, over 120,971 dually eligible beneficiaries were actively enrolled in CMC health plans (29% of eligible enrollees).⁵ Enrollment numbers varied by county, from 9,382 beneficiaries in San Mateo to 40,046 beneficiaries in Los Angeles.

Beneficiaries had the choice to “opt-out” of CMC before they were enrolled or to dis-enroll later. Those who didn't join CMC could keep their original Medicare, but they were still required to join the MMC plan through which their Medi-Cal services, including medical care, long-term services and supports (LTSS), and behavioral health services, were managed. The opt-out rate in California was higher than anticipated, with about half of those eligible opting out and another 7% dis-enrolling.⁵

The opt-out rate is variable in different counties and different populations. In San Mateo County (where Medi-Cal is part of a county organized health system [COHS] and most dual beneficiaries had already been members of the MMC special needs plans before the transition) the opt-out rate was very low, at 10%, with only 1% dis-enrolling. Conversely, almost 58% of eligible beneficiaries in Los Angeles County opted out and 8% dis-enrolled.⁵ Opt-out rates also differ by language. There were extremely high opt-out rates among Armenian and Russian beneficiaries (over 90% in some counties).⁶ The opt-out rate among Mandarin and Korean beneficiaries varied, but was higher than average in most counties. Farsi language speakers had an above average opt-out rate in Los Angeles, San Bernardino, San Diego, and Orange counties, but a below average opt-out rate in Santa Clara (44%) and Riverside (51%) counties. Spanish speakers had by far the lowest opt-out rate, though it varied by county (8%-43%). These ethnic variations by county suggest an “ethnic enclave” effect where certain providers serving specific ethnic groups may be giving different advice in different counties. Finally, over 61% of beneficiaries who used In-Home Supportive Services (a consumer-driven home care program) opted out of CMC. New research has provided more insight into the factors that influence beneficiaries to opt-out of CMC, including: providers

⁵ All counties, except Orange, have frozen reporting metrics due to the end of passive enrollment.). Numbers presented are March 2016 numbers for all counties except Orange County. DHCS (2016) CMC Monthly Enrollment Dashboard. Retrieved from <http://www.calduals.org/wp-content/uploads/2016/05/CMC-Enrollment-Dashboard-May-Final.pdf>.

⁶ DHCS (May 2016) Cal MediConnect Opt-out Breakdown by Language, Ethnicity and Age by County. Retrieved from <http://www.calduals.org/wp-content/uploads/2016/05/May-Detailed-Opt-Out-Final.pdf>.

INTRODUCTION: PURPOSE OF HEALTH SYSTEM RESPONSE STUDY

having a strong influence over decisions, proactive decision makers are risk averse, maintaining access to multiple providers is a challenge, and opting out is perceived to ensure freedom of choice.⁷ These findings correspond with what was learned through this health system response study, and this report will focus only on findings that are able to provide further information or clarification to previously released reports about opt-out rates.

PURPOSE OF HEALTH SYSTEM RESPONSE STUDY

Researchers at the University of California worked with a stakeholder advisory group to design an evaluation of CMC, California's dual financial alignment demonstration. It was decided that the evaluation should include qualitative interviews with stakeholders engaged in CMC to determine how the program has impacted the health system and how the system and stakeholders have responded to CMC. The aims of the health system response study are to: (1) examine organizational impacts and health system responses to the demonstration; and (2) identify challenges, promising practices and recommendations to improve the coordination of care across sites for dual beneficiaries. Additionally, results from the first phase of key informant (KI) interviews will also be used to identify topics for further inquiry and case studies in phase two of the health system response project (beginning in Winter 2017).

Efforts were made to interview participants from across the CMC counties and representing a variety of identified stakeholder groups, including: CMC plans, participating provider groups (PPGs), long-term care (LTC) facilities, IHSS, Multipurpose Senior Services Program (MSSP), Community Based Adult Services (CBAS), hospitals, state and federal government, and community-based organizations. However, this first phase of KI interviews relied more heavily on information from CMC plan KIs to provide a foundation of understanding of CMC and plan practices that could better guide a second phase of interviews beginning in 2017, which will engage a broader group of stakeholders. Efforts were also made to interview participants with expertise in serving various types of beneficiaries, including: seniors, people with disabilities, racially and ethnically diverse beneficiaries, non-English-speaking beneficiaries, and those accessing behavioral health services or substance use services.

⁷ Tanamor, M. (2015). Coordinated Care Initiative Evaluation Outcome Report: Dual Eligible Plan Choice Report. Retrieved from http://www.dhcs.ca.gov/formsandpubs/Documents/LegislativeReports/CCI_Outcomes-Evaluation_April2016.pdf.

METHODOLOGY

PARTICIPANTS

With input from the project advisory group, we identified health system stakeholder groups that were important to include in our KI interview sample. Within those stakeholder groups, and with input from the project stakeholder advisory group, potential KIs were identified based on their experience with CMC, regional representation, and representation of targeted stakeholder groups noted above. Additional KIs were identified through recommendations from KI interviews (purposive or snowball sampling). KIs were invited to participate by email (Appendix A).

KI interviews were conducted over the telephone between July 2015 and February 2016. Interviews lasted from 20-90 minutes. Many of the CMC plan KIs were broken up into two groups of expertise: 1) administrative, management, and finance; and 2) medical directors, LTSS directors, directors of care coordination, etc. Each interview included up to four participating KIs.

In the first phase of the health system response study, we completed a total of 36 interviews. Out of those 36 interviews, 15 interviews were with 37 CMC plan KIs representing nine CMC plans. CMC plan KIs included: executive directors, CEOs, LTSS administrators, medical directors, directors of care coordination, contract managers, and quality improvement managers. CMC plans from six of the seven CMC counties participated (Orange County was delayed in their implementation and were excluded from the first round of interviews). The remaining 21 interviews were completed with 21 KIs representing various health system stakeholder groups: government (3), advocates (4), community-based organizations (7), providers (6), and housing (1). Gaps in KI's representation of stakeholder groups will be identified and addressed in the second round of interviews in 2017.

INTERVIEW INSTRUMENTS

With input from the study's stakeholder advisory group, we developed two KI interview discussion guides. One was designed specifically for interviews with CMC plan KIs (Appendix: C) and another for interviews with medical care providers, ancillary service providers, LTC facilities, LTSS providers, and HCBS providers (Appendix: D).

The primary domains covered in the interview instruments include: general information, perception of CMC, readiness, financial impact, administrative impact, workforce, provider networks and delegation, opt-outs, care coordination, medical services, ancillary and supplemental benefits, LTSS, LTC facilities, collaborations, cultural competency, innovative and promising practices, challenges, and an overall assessment of CMC. Interview instruments were used loosely and few KIs were able or willing to answer all of the questions. If two interviews were conducted with a plan, the instrument was broken up as shown in Appendix C. CMC plan KIs were invited to respond to interview instrument questions prior to the interview in order to expedite the process or to provide input from a colleague who was unable to attend the interview. Three health plans returned the interview instrument with written responses prior to the interview, which were included in the data analysis.

METHODOLOGY: ANALYSIS

In addition to the CMC plan KI interview instrument, a data request form was developed, which included quantitative data requested from each health plan. The purpose of this data request form was to inform our analysis of concrete organizational factors such as: beneficiaries enrolled, provider delegation practices, care coordination workforce and delegation practices, Health Risk Assessment (HRA) completion, interdisciplinary care team (ICT) activities, and risk stratification (Appendix B). Plans were also asked to send copies of their HRA, additional assessment tools, a sample of an individual care plan (ICP), and a list of their LTSS providers. Seven health plans returned the data request form, 7 shared their HRAs, 3 shared other assessments, 6 shared a sample ICP, and 4 shared a list of their LTSS providers. These materials helped inform our interview process and analysis, and will be requested again in phase two of the health system response study.

ANALYSIS

Content analysis of the qualitative data was conducted by the research team using Dedoose software, a web-based application designed for qualitative data analysis.⁸ The research team created an initial codebook including codes representing themes that were expected to emerge from the data based on 1) research questions, 2) previous research, and 3) input from the advisory group. Two members of the research teams used the initial codebook to independently code several KI transcripts. A baseline inter-rater reliability test was created for the two primary coders, whose kappa scores were 0.63 and 0.56. The study team then met to review the coding and discuss areas where codes were in disagreement or overlapped. The codebook was iteratively revised to merge similar codes, create new codes, and refine all code definitions. Three new transcripts were chosen and inter-rater reliability tests were performed. After the first test, the kappa score was 0.76 and 0.63. The research team met to again refine the codebook and merge and expand definitions of codes. Subsequent tests of inter-rater reliability reached 0.90 and 0.92, indicating that agreement between the two primary coders was excellent. The final codebook was then used to code all of the other transcripts (Appendix E). Figure 1 is a code cloud, which shows codes and their relative frequency. Excerpts from each code were linked to memos and themes were summarized in each memo as they emerged.

⁸ Dedoose: About Us. Retrieved from <http://www.dedoose.com/about-us/>.

RESULTS

In the following sections, we present information about each health system stakeholder and how they responded to CMC, including: their perspective on the value of CMC, how they prepared for CMC, how they participated in implementation efforts, and what challenges they may have faced as a result of CMC. Following the health system stakeholder response, we present ways in which the health system responded as a whole to CMC, including: coordinating care; providing ancillary services, supplemental benefits and care plan options; improving quality; controlling cost; and caring for challenging populations. The report concludes with a summary of key findings and recommendations.

HEALTH PLAN RESPONSE TO CMC

There are a total of 10 CMC plans that provide both CMC and Medi-Cal managed care in the seven demonstration counties. Most counties have at least one “local initiative” health plan, which is a public, non-profit health plan, as well as one or more “commercial” plans.⁹ San Mateo and Orange counties differ from other demonstration counties in that they are county organized health systems (COHS) and only offer one, local community CMC plan. In both COHS counties, most dually eligible beneficiaries were receiving Medi-Cal through this health plan before the demonstration. Riverside and San Bernardino counties are “two-plan counties” with one commercial plan and one local community plan.¹⁰ San Diego and Los Angeles counties are both “geographic managed care” models and offer one local community plan and up to four additional commercial CMC plans.

The CMC plans vary widely by county in terms of size, enrollments, geography, number of beneficiaries, and their hospital and provider networks. The CMC plans also vary in how they are organized and the extent to which financial management and risk is delegated to physician groups. As expected, the size and scope of the CMC plans and their communities resulted in very different experiences reported by their health plans and other KIs. Before the CMC demonstration, health plans were experienced in providing and managing hospital care and medical services for the Medi-Cal managed care population. Several CMC plans also had experience with offering D-SNPs (Dual Eligible Special Needs Plans) where they provided Medi-Cal and Medicare to dually eligible beneficiaries. In the CMC demonstration, plans receive a prospective blended rate and are at full financial risk for all primary, acute, pharmacy, behavioral health, and long-term services and supports covered by Medicare and Medicaid.³

Health plan KIs provided insights about their response to CMC, particularly: 1) the value of CMC for health plans; 2) their preparation and readiness for the CMC transition; 3) their implementation

⁹ Wunsch, B. (2015). Medi-Cal managed care plans and safety-net clinics under ACA [PowerPoint slides]. Retrieved from <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20S/PDF%20Sacto12102015MediCalPlansSafetyNet.pdf>.

¹⁰ Reilly, T., Wunsch, B. and Krivit, S. (2010). California’s Local Community Health Plans: A Story of Cost Savings, Improvement, and Community Leadership. Retrieved from http://www.pachealth.org/docs/100054_cae_localcommunityhealthplans_7.pdf.

RESULTS: HEALTH PLAN RESPONSE TO CMC

efforts since the transition; and 4) the challenges of CMC for plans. This section also describes how and why CMC plans may be delegating medical service and care coordination.

The Value of CMC for Health Plans

Plans were better able to integrate and coordinate care in CMC: Several CMC plan KIs reported that they were able to coordinate the full spectrum of care for CMC beneficiaries better than they could for MMC beneficiaries.¹¹

In [MMC] we only have the Medi-Cal side of the equation. We don't have the financial risk for the Medicare side of the equation, so there's no ability to make those kinds of adjustments and reimbursements and different kinds of financial risk arrangements or incentives for physicians and hospitals. In Cal MediConnect where we have both the Medicare and the Medi-Cal side, we have much more flexibility and can create incentives for the physician delivery system to work with us on the MLTSS side. Those abilities are absent in just the MLTSS-only program.

Another CMC plan KI noted that the difference between care coordination in CMC and MMC was that in CMC the plans could now provide assistance to beneficiaries in accessing LTSS benefits and coordinating with all of their providers. With an MMC member, they could coordinate the person's IHSS services, but they had limited knowledge of the medical services provided through Medicare. CMC plan KIs reported that this made it very difficult to coordinate care and form an ICT for MMC members.

In [MMC] it is much more difficult to effectively manage these members because we don't have relationships with their physicians, and the physicians may be directing care in a manner that does not necessarily take advantage of the support available through a plan.

Several CMC plan KIs noted that it was easier to develop partnerships with PPGs and hospitals in CMC than it was in MMC because of the expanded scope of responsibility and flexibility in CMC.

CMC spurred better collaboration: Some CMC plan KIs also noted that they were working together more since CMC and that competitive walls between plans had come down.

The health plans have really been very collaborative across the board on all different initiatives. That is a best practice overall and I hope to see that continue. The competitive walls have come down and we really do share best practices across the board. It's not one health plan alone, it's all of us working together to provide better care for our members.

In one region, CMC plans developed a workgroup to get together and share their best practices in CMC.

¹¹ CMC beneficiaries are referred to using a variety of terms. CMC plans often refer to their “members,” while providers refer to their “patients,” and many LTSS KIs refer to their “consumers.” We retain the KIs original terminology where possible, but utilize the term “beneficiary” most consistently in this report.

RESULTS: HEALTH PLAN RESPONSE TO CMC

Additionally, many KIs described participating in county or statewide collaboratives to facilitate information sharing, education and training, and relationship building across health system stakeholders. While some of these regional collaboratives existed prior to CMC, health plans were often not involved. In contrast, many CMC plans have utilized stakeholder groups or their advisory committees to form collaboratives with CBOs, LTSS providers, advocacy organizations, and other stakeholders. One county government KI reported that preparedness for CMC required many collaborations and efforts to build relationships across the health system.

Preparedness involved evaluating readiness for the transition; supporting advocacy for CCI; engaging with health plans, the state, and stakeholders; and creating planning structures with the health plan [such as co-located staff]. The AAA [Area Agency on Aging] was also part of this planning table and that's unique in our county. This was an outgrowth of our coalition, a stakeholder group that included members from the Commission on Disability, Commission on Aging, IHSS Advisory Committee, and all of our non-profit providers.

Other KIs described how CMC plans were using health fairs or other community events to bring together key stakeholders.

The plans are actually the ones facilitating these community-based meetings. It's a two-way street. The plans are learning more about the resources available in the community, and the community resources are learning more about what the plan can do.

Plans were committed to CMC and hope it will continue: CMC plan KIs often reported that although challenges existed in CMC, they were committed to the program and hoped it would continue, as it helped their beneficiaries.

We are committed to the success of the program. We think that the patients that we see are benefiting from the coordinated care. It's the right thing to do. It's been tough, it's been challenging, but changing health care is tough. At the end of the day, for the person that has stayed with the program, they are receiving a higher level of care, and we want to continue to provide that for this population.

We really have found that the program enables us to work with the member, the physician, the community, the family, and the caregiver. We believe that the program is good and that it really has allowed us to better serve the member and their needs, not just the medical, but psychosocial, and service needs. I think that everyone's definitely committed to the program to try to make it work, to get the outcomes that were really the goals of the program.

CMC plan KIs also reported an interest in learning about promising practices and efforts to continue to align the financial and economic incentives of the entire health system to meet the goals of CMC.

Health Plan Preparation for CMC

Plan history influenced CMC transition: CMC plan KIs noted that their history and experience with MMC products, Medicare Advantage (MA) products, and Medicaid Waiver programs mattered in how well they were able to adapt to CMC.

RESULTS: HEALTH PLAN RESPONSE TO CMC

We felt that the goals of the demonstration very much aligned with our [MA] model of care, our mission and philosophy on health care. We're fortunate, because we felt that our model of care was aligned with the goals of the demonstration, we had our same investments in readiness that we really felt was the foundation of [CMC].

Many CMC plan KIs also cited their pre-existing relationships with LTSS providers and CBOs as either an asset or a challenge to the plan in their transition to CMC. Another CMC plan KI noted that the keys to a smooth transition to CMC included plan history and experience with managed care and managed LTSS, having structures in place to facilitate collaboration (contracts, shared data systems, collaboratives, shared resources), and leaders that valued and encouraged collaboration. Another CMC plan KI noted that they entered CMC with strong support in their community.

We are blessed in that we have good relationships with our county and with our community. We have a lot of community support. Local advocates are very familiar with the health plan naïve and have been very supportive. People push for this program as opposed to fighting it.

CMC required an expansion of provider networks: Some CMC plan KIs reported struggling with a lack of specialty providers in their networks, especially if they had not previously developed their networks under Medicare Advantage, MMC, or D-SNP products prior to CMC. While CMS looked at the network requirements for both Medicare and Medicaid and chose the most stringent of the two for CMC, this still left inadequate networks around unique specialties that duals beneficiaries utilize more than others beneficiaries (such as podiatrists and endocrinologists). Specialties that were noted as a particular challenge by CMC plan KIs were: behavioral health and substance abuse providers, podiatrists, and opticians. Occasionally, CMC plan KIs noted that a gap in their network sometimes required them to delegate to PPGs or county behavioral health. However, some KIs questioned whether CMS and California Department of Health Care Services (DHCS) were able to verify the adequacy of CMC plans' delegated provider networks, especially if the plans didn't yet have contracts with the PPGs at the time of the readiness review.

There were conversations with the plan and some of the provider groups, but it was often earlier in the process so the plans hadn't necessarily completed all of their contractual arrangements with these groups. [CMS and DHCS] relied a lot on plans attesting that all of the requirements they were meeting at the plan level were also being met downstream. I don't know that that was always the case.

CMC required plans to expand their legal and contracting capacity: CMC plan KIs described how they developed each contract according to the capacity of the PPG to accept risk in each area of care or service. One CMC plan KI established an entire Division of Financial Responsibility to help manage and individualize their contracts.

[We] tailor the arrangement to both the population being served and the capacity of the group, and then evolve the group [to accept more responsibility and risk over time].

While some plans, like that above, had centralized contract procedures, other plans required their PPGs to assume financial risk for LTSS and to establish contracts with LTSS providers and LTC facilities.

Health Plan CMC Implementation Efforts

In looking back, CMC plan KIs noted what a big change and challenge it was to implement CMC. They reported that CMC required organizational changes in almost every department and level of the health plan.

Considering the controversy around CMC, and what it took to get it through, I give everybody kudos for being where we are now. [It is] very difficult to launch a program like this.

Additionally, several KIs noted that CMC was implemented at the same time as a lot of other changes in health care, which added to the complication of implementation. When asked what they did to help implement CMC, some plan KIs had a hard time remembering which policy implementations resulted in specific efforts.

It happened at the same time as the Medi-Cal expansion. It happened at the same time as we got the mandate to assume responsibility for mild to moderate mental health. We had to set up a lot of new programs at the same time.

CMC plans hosted meetings and educational sessions with other stakeholders: To develop their relationships other health system stakeholders; such as physician providers, LTSS providers, LTC facilities, and CBOs; CMC plan KIs reported hosting meetings and educational events. One CMC plan KI noted their extensive efforts to educate and reeducate providers about CMC, the plan's role, and additional services and supports.

I think we tend to do so much education from the provider perspective. I don't think they really knew what this is all about. For instance, in the beginning, we were faxing care plans and emailing the providers. [They were asking] why are you sending all of this stuff and why do you want us to participate in these ICT meetings?

Many CMC plan KIs described efforts to hold educational sessions with LTC facilities, IHSS, MSSP, CBAS, and CBOs about CMC and how to best coordinate with the plan.

We've done some training with [IHSS] and we're starting to meet on a regular basis with them. Prior to that, we did come up with a coordination guide. We met for several weeks with the IHSS folks and put together a kind of formal written document that spelled out how we would work together.

The plans have advisory committees, but different plans have put different community resources on the agenda, so they meet monthly. One meeting, they'll talk about transportation and the local Para transit, and other transportation vendors will talk about all of the services that they provide. Then the next agenda topic will be housing and the local and city and county housing authorities will come and talk about the vouchers they have for special populations, or the programs that are available.

CMC plan KIs also reported working with professional associations and unions to understand their perspective, organize educational sessions, and to improve their relationships. One CMC plan KI noted their efforts to collaborate with county agencies through CMC:

RESULTS: HEALTH PLAN RESPONSE TO CMC

We have collaborated with the County Department of Social Services, the Department of Mental Health, the Department of Public Health and the Long-Term Care Ombudsman to leverage one another's capabilities and better meet the needs of our members.

CMC plans sought to develop relationships with county behavioral health departments:

Although a portion of behavioral health services, for those with severe mental illness (SMI), was carved out of the CMC benefits package, CMS and DHCS attempted to integrate plans with county behavioral health departments as much as possible to facilitate collaboration. This was a challenge though as county behavioral health departments varied in their interpretation of the definition of SMI, their ability to share data with CMC plans, and their willingness to participate in ICTs. Plans in some CMC counties reported struggling more than others to develop relationships with county behavioral health departments. Many CMC plan KIs noted that CMC has facilitated closer relationships with county behavioral health departments, but implementation has been challenging.

One plan described their efforts to create a large behavioral health collaborative, engaging over 34 sites to improve access to behavioral health and substance use disorder services for their members. A foundation funded this behavioral health integration initiative with \$20 million over two years. This CMC plan also chose to provide specialty mental health to their beneficiaries through their own provider network, unless the member had an existing relationship with a county behavioral health provider.

CMC plans attempted to improve access to behavioral health care: One plan KI reported using financial incentives to make sure that their beneficiaries had access to outpatient mental health services.

[The plan paid] a little bit more than average for the initial visit...it ensures ready access, because providers will put our Medicaid beneficiaries to the front of the line and we don't struggle with getting access to out-patient services.

Another CMC plan KI described how CMC allowed them to leverage resources and improve access to behavioral health providers in a rural region, in a way that they wouldn't have been able to before.

We have counties that are extremely rural with very few resources. We have always struggled with access in more rural settings, but in reality, when the health plan takes full responsibility for a population, they do a pretty good job, and I think we're able to reach the needs of the population and spread access, because we can keep our fingers on it. [In one region] there are a lot of private practice providers, behavioral health providers, but they don't work with HMOs, let alone Medicaid. We had to come up with a different strategy for that area which meant importing behavioral health clinicians, psychiatrists, psychologists, Spanish speaking providers, into FQHCs that were also embedded in that same region. Then they became our anchors for delivering care because really, we didn't have a private practice base like we have in other areas of our counties that really was willing to contract and take care of the Medicaid population. By having responsibility and leveraging at a lot of levels,

RESULTS: HEALTH PLAN RESPONSE TO CMC

you can get creative about how you embed behavioral health providers where you need them in order to create access in areas that otherwise would be very difficult.

CMC plans encouraged LTSS referrals and advocated for expanded services: Several CMC plan KIs noted efforts to encourage their providers to refer beneficiaries to IHSS, MSSP, or CBAS.

We're encouraging the providers to maximally use IHSS. In fact, we've done work with the union and with IHSS workers to increase the scope of service they provide because we think it's such a critical element of it.

With usage of LTSS factoring into the capitated blended rate that CMC plans were paid per member, the incentive for this is clear, but CMC plan KIs also noted the value of IHSS services in ensuring their beneficiaries' needs were met. Some CMC plan KIs described how they were able to advocate for additional hours for a beneficiary with IHSS if they determined there was a need for it.

We try to connect with them, keep them informed, see what information they can share with us, share what we can. Especially if we know that there's a change in the member's condition and they need a change in their IHSS hours, and we call them and we ask them to consider additional hours - just to go out and do a reassessment. That's their call whether they do that or not, but they're just much more accessible now.

However, some CMC plan KIs reported that IHSS' independence prevented them from expanding access to services for their beneficiaries:

IHSS, it's completely neutral and finance independent of the health plan in the demo. Its benefits are not controlled by the health plan. It technically sits on the health plan books, but the health plan has no control over it.

CMC plans encouraged informal caregivers to become IHSS workers: Several CMC plan KIs mentioned efforts to convert informal caregivers into IHSS workers so that they can get paid for the work. IHSS is also much more willing to do in-hospital assessments to help the caregiver get started with IHSS before the patient is discharged. This is an important development, but may also mean that their beneficiary is placed in a higher risk category, which is triggered by the delivery of IHSS hours but not by the delivery of informal caregiving hours.

CMC plans assisted beneficiaries with identifying care workers: One CMC plan KI described how IHSS has evolved from *"a program that was primarily put in place for people with a disability."* Beneficiaries were involved in their own care and could manage the process of contacting a list of providers, interviewing them, and choosing a provider that they were comfortable working with. Now, IHSS is *"a much larger percentage of folks that are elderly with dementia that are challenged in doing [this]."* They noted that public authorities were sometimes able to assist beneficiaries with this process, but that the plans have also stepped into this role.

CMC plans attempted to prevent gaps in care: A collaboration between a county's IHSS program and a CMC plan resulted in the creation of a back-up system for providing personal assistance services when the scheduled IHSS worker didn't show up. This IHSS KI reported that they worked

RESULTS: HEALTH PLAN RESPONSE TO CMC

with the plan to make sure that there were providers available in case of an emergency, which meant that beneficiaries weren't caught without a caregiver during a critical time. An IHSS KI also reported being much more willing to do in-hospital assessments to help the caregiver get started with IHSS before the patient was discharged. These types of collaborations have the potential to lead to higher quality of care for CMC beneficiaries as well as lower costs and unnecessary utilization of higher cost services for CMC plans.

The Challenges of CMC for Health Plans

CMC plans found beneficiary data files challenging to work with: One of the more common critiques of CMC was that the data files they received from the state were incomplete and unhelpful in their efforts to reach beneficiaries. *"There were problems with the data sets compiled by CMS and the state and transmitted to the plans."* Data files from the state were often delayed or inaccurate. One CMC plan KI mentioned that they spent a lot of effort just trying to figure out who opted out.

We would think a member had not opted out one day, go through the process of finding the member the next, only to find out they had opted out the day before.

CMC plan KIs noted that a bit more time at the front end could have solved some of these problems: *"Some things could have been anticipated better, but some couldn't have been anticipated."* Some CMC plan KIs described innovative efforts to locate beneficiaries who they weren't able to locate from state beneficiary data files.

[We are] mining claims data that we've been given on the Medicare side, so if they've got no prescription or gone to the ER, [we've] been calling the pharmacist or the hospital and trying to figure out last address or information to find them. I think [we've] also been partnering with homeless shelters or other types of community providers.

[When patients are hospitalized], we can identify the location and the address of people who are elusive, who move around and we may not know their address or their contact information until they hit the hospital and we find out they're there via the census.

CMC plan KIs also reported reaching out to their Medicare Advantage or MMC beneficiaries who opted out of CMC to explain the benefits of enrollment. Another CMC plan hosted informational sessions at LTC facilities prior to their residents' membership enrollment period.

CMC plans found that dually eligible beneficiaries were hard to reach: Many KIs noted that the dually eligible population didn't read the letters sent to them nor did they typically reach out for assistance. Many CBAS centers and other CBOs ended up deciphering and translating CMC letters for their beneficiaries individually, taking up considerable staff time and resources. One CMC plan KI reported that their population moved around so much that receiving mail and phone calls was difficult. Another KI noted that the health plans often posted things on their website, but *"poverty is a major issue in our county and many people do not have access to computers and cannot understand what is posted."* Due to the difficulty with outreach and notification, several KIs noted that it was difficult to know how many people made informed decisions regarding CMC. There was some

RESULTS: HEALTH PLAN RESPONSE TO CMC

concern among KIs about whether beneficiaries actually understood their options, the benefits of the program, and the consequences of opting out.

The volume of CMC notifications was overwhelming for some beneficiaries: A CBAS center noted that there were so many notifications and letters from DHCS about CMC during the early phases of CMC implementation that their clients panicked. They claimed that their beneficiaries' stress levels were heightened every time they received a letter and that by the time DHCS sent them important forms, "they were desensitized" and had stopped reading and caring about them. "There was a CCI fatigue by the time those changes took place." Some beneficiaries received more than 20 letters. One CMC plan KI said many beneficiaries did not know that they were enrolled until they were contacted to complete their HRA. This meant that the CMC plan often spent time helping beneficiaries opt-out.

I think it's going to take us years to recover the trust of individuals who felt that, whether it was a good program or not, they didn't understand it, they dis-enrolled, and it's going to take them a while to feel that they want to trust us to take a chance and dip their toe back in the water and try.

The amount of materials received about CMC may have been too daunting and the content too dense and technical, further perpetuating confusion or lack of clarity of benefits offered.

CMC notification materials were inaccessible for some beneficiaries: Many KIs reported that CMC materials were not understandable. One federally qualified health center (FQHC) KI worried that beneficiaries with limited literacy could easily fall through the cracks in CMC. "A health literacy translation was needed, not just a language translation."

Many KIs reported that it was incorrectly assumed that beneficiaries could have been effectively informed by mail about CMC. Several CMC plan KIs noted that more diverse types of outreach to beneficiaries were needed. In particular, several KIs argued that CMC really required person-to-person explanation and assistance. Some CMC plan KIs reported wanting more information for the general public through the media. To improve beneficiary access to information, an FQHC KI reported that they were installing a kiosk in their lobby so beneficiaries could log in to their patient account on the health plan website and print documents.

CMC notification and outreach efforts were ineffective: Notification to beneficiaries and subsequent outreach was a major concern for many CMC plans. They had many insights into the challenges of communicating with this population and suggestions for how notification and outreach could be improved.

Notification and outreach was not effective in teaching beneficiaries about the benefits of CMC. Despite notification letters and additional community outreach from both DHCS and the CMC plans, beneficiaries still were typically not aware of the benefits they could get through CMC. One CMC plan KI discussed focus groups that were held with beneficiaries who opted out, and their dismay when they realized that despite all of their efforts to inform prospective beneficiaries about the benefits of CMC, the participants were largely unaware. However, the CMC plan KI reported that after learning about the benefits at the focus group, beneficiaries seemed more open to enrolling.

RESULTS: HEALTH PLAN RESPONSE TO CMC

It was a little concerning to us that our own members that were part of the focus groups really didn't know about our benefits, the supplemental benefits. You can imagine how much we sent and how much we called them. They just don't know. That was a little baffling as you would imagine. When the focus group facilitator would say, "Well, you know there's dental, vision, transportation." "Oh, no, I didn't really realize that. I didn't really read the material. I have gotten so many materials and so many letters that none of them really made sense to me."

CMC plan KIs described how the early notification letters sent out by DHCS did not include any information about the new supplemental benefits that CMC plans could provide. They argued that because DHCS was required to remain "neutral," they were prohibited from giving beneficiaries even a list of the new benefits they might receive from CMC. Letters mentioned the name "Cal MediConnect" and not much else.

There was not a good articulation of what the benefits were. There wasn't a good outreach plan or communication plan. The enrollment materials were very confusing both for Medi-Cal Managed Care and Cal MediConnect.

CMC plan KIs noted that the wording of the notification letters from the DHCS read as a "warning" rather than a welcome.

The message of the letters from the state was, "This thing is going to happen to you unless you do something." Since beneficiaries didn't know what that "thing" was, or what they might get from it, they were scared into opting out. It was like, you keep sending me these letters telling me to get out. OK, I'll make the call.

CMC plan KIs reported that rules and limitations around CMC marketing were also difficult. One CMC plan KI noted the challenge of preparing for implementation and educating providers and collaborators:

...[when there were] some pretty strong limitations on how we could be out there talking about that, because the marketing and enrollment were controlled by Health Care Options, by the state's third party.

The CMC plan KIs reported finding it difficult to make sure that "both members and providers were clear about our participation in the dual program." One CMC plan KI noted that Medicare Advantage plans were marketing at the same time that they were trying to notify beneficiaries about CMC and that their use of brokers gave them an edge. "Medicare Advantage can use brokers, we can't."

If some other state was launching on this now, I would tell them to take advantage of the fact that you have health plans with a lot of experience in marketing and in enrollment activities. Don't let those sit on the sidelines. One thing that I feel like we are dealing with now is, we had a lot of [negative] voices in the public sphere when it came to opinions about CMC because all the ones who could've spoken positively about them were not allowed to speak about them. You had health plans who were trying to make CMC work and really couldn't promote the program very much because we were so afraid that we would get

RESULTS: HEALTH PLAN RESPONSE TO CMC

caught up in being accused of illegal marketing practices. We had some ability to do general community education, but really even that felt like we were pushing it when we would ask to be able to do things like that. And I do feel like as a state, we were very skittish on this idea that we had to maximize member protection that we really lost an opportunity to even promote the program.

However, another KI noted that unlike other CMC plans, one COHS CMC plan was allowed to directly reach out to beneficiaries in their county. However, this KI worried that the CMC plan may have been incentivized to give incorrect information about CMC. This KI reported that they knew someone who called the CMC plan and was told “*that she had to enroll or she wouldn’t have drug coverage.*”

CMC plans struggled with workforce planning, investment, and turnover: CMC plan KIs reported having a difficult time determining how many care coordinators they needed to hire during implementation. In regions with high opt-out rates, many CMC plan KIs found they had over-hired. This led at least one CMC plan to keep more care coordination services in-house rather than let go of the care coordinators they had hired. Some CMC plans relied on a temporary workforce to ensure that they could meet the completion requirements of HRAs. One CMC plan KI described hiring for CMC as “*a hill climb,*” meaning that they started with a lower number of staff, and attempted to hire as quickly as possible when needed.

It was, from an administrative side, a real steep hill to climb to be able to get enough folks. I had to submit very detailed staffing plans to CMS and to the state when we started the program, and first with developing what you needed and then going out and actually executing to get it done. It was quite a climb.

One CMC plan KI reported needing to hire almost 200 new staff, which was not counting the staffing increases in their delegated PPGs or vendors.

It is not an understatement that all areas of health plan operations have needed modification and/or augmentation to administer this program.

CMC plans operating in counties with broad geographical distribution found it challenging to reach all of their beneficiaries, with some setting up satellite offices for staff to improve access.

We realized that we really needed to put them closer to the members they were serving because so many of this population are homebound or just disconnected from the health care system and we have to go where they are. We can’t just take care of them over the telephone.

Unfortunately, some CMC plans in competitive environments and regions reported that there wasn’t an adequate workforce to meet their needs, which required them to “*...reconsider traditional or preferred staffing models.*”

We had to hire so many staff. It was a parallel effort, Affordable Care Act expansion with Medicaid expansion, and [our plan was] getting into the marketplace at the same time as we were staffing up and getting ready for the enrollment in the Cal MediConnect program. Our

RESULTS: HEALTH PLAN RESPONSE TO CMC

biggest challenge was hiring enough staff quickly enough that were qualified, and we could get them in and trained prior to start-up of the programs, and that was in a very competitive marketplace. We're really drawing talent from a number of competitors, from commercial health plans, Medicaid plans, Medi-Cal plans, Medicare plans, so the limited number of qualified staff, that was very tough.

One CMC plan KI stated that hiring registered nurses (RNs) into care coordination positions was particularly challenging as they could find higher-paying jobs elsewhere. This CMC plan KI noted, however, that they had an easier time hiring licensed vocational nurses (LVNs) and licensed clinical social workers (LCSWs) into care coordination positions. Some CMC plan KIs also noted that having non-clinical staff located in diverse communities improved their access to and trust amongst those communities (see [Care Coordination Workforce](#) section).

Several CMC plan KIs described efforts to hire “new care management staff, more social workers, more people skilled in LTSS.” Several CMC plan KIs noted how CMC required them to adapt their models of care significantly to serve duals beneficiaries and to account for the shift toward LTSS. Many CMC plans described investing in intensive training programs for their staff.

We realized we needed a much wider range of not only experience, but training, to be able to meet the diverse needs of the staff in the new program. [It was] expensive. Some of it is general programmatic. We had general training on: What is the CMC program? What do these folks look like? What are their needs? And then very specific trainings for care managers, for utilization management staff, and for contracting staff. We realized it just wasn't another line of business; it was a dramatically different line of business.

Even for a plan that had been doing D-SNPs for several years, we realized this population was different and the fact that we have their long-term services and support responsibility. It just was so different that we really needed to have education. We do a lot of online training, but there are a lot [of] face-to-face classes too. There's a lot of general education on this program, which was done across the whole organization.

With the intensity of staff training that was required in the transition to CMC, plan KIs were understandably concerned with staff turnover. KIs noted that there was a lot of movement and turnover of care managers in CMC plans, and a “poaching” of staff from other health system stakeholders.

We had to set up a lot of new programs at the same time. That has led to a lot of staff turnover—people are extremely tired. We've had a lot of turnover in our leadership and our staff in the health services area. It was extremely hard. Internally the impact on the organization has been difficult.

Several KIs noted though that turnover within plans did not necessarily equate to turnover within CMC. Some staff left to work for other CMC plans.

RESULTS: HEALTH PLAN RESPONSE TO CMC

CMC plans found it difficult to adjust to ongoing policy changes: KIs noted that DHCS was developing policies while the CMC plans were trying to implement the program. CMC plan KIs reported having a hard time keeping up with the policy changes and DHCS's dual plan letters.

I think the state was developing policy as we were implementing the program, which is hard at the health plan level because a health plan is a big ship and it's hard to turn things on a dime. That's been tough.

One KI thought that if there were more resources at DHCS in the beginning of CMC, some of the dual plan letter demands could have been incorporated into the process earlier. However, they also noted that not all issues or needs addressed in dual plan letters could have been predicted.

CMC data requirements and reporting were unnecessarily burdensome: Although CMS tried to create core CMC reporting requirements and state specific reporting requirements from what was already being collected through Medicare and Medicaid (with some additional state-specific reporting requirements), several CMC plan KIs expressed frustration with what they considered to be CMC's additive or duplicative data collection and reporting requirements. One CMC plan KI claimed:

Neither Medicare nor Medicaid were willing to give in on any of their data collection requirements, so there was no effort to consolidate data collection and reporting.

There's no administrative simplification in this program whatsoever. In fact, there is more administrative burden. There is 45 years of programs here that the federal government hasn't figured out how to put together, that are being put together in these demonstrations with all the 45 years' worth of rules associated with those programs.

Another CMC plan KI speculated that without such intense reporting requirements, they may have been better able to focus on beneficiary needs.

There are times when we are doing what we are doing and some of our requirements and then we get to that almost existential question of how is this really helpful to the beneficiaries? Because of how things are so prescribed, one can't help but to question this from time to time. If we are given that flexibility, we can easily then just throw that out and not have so much work or waste in this whole process.

One plan KI reported that CMC was such a large adjustment for the health system that evaluating the program in the first year was unlikely to show meaningful results.

Year 1 is not where the state should assess CMC. Extend the program for a couple more years, then the benefits of the program will be clear.

CMC savings targets and timelines were unrealistic: Some CMC plan KIs argued that the "State is expecting cost-savings too soon—[they have] unrealistic expectations." Another KI agreed that a return on investment (ROI) so soon in a program was not likely.

RESULTS: HEALTH PLAN RESPONSE TO CMC

Frankly, the program should've been invested with the fee-for-service equivalent dollars for the first couple of years before any assumed savings would take place. The biggest savings are going to be in avoided hospitalizations and delayed admissions to custodial care, which are real, but I don't think you can see those until probably even the third year.

One KI reported that while the savings rates in California were high, there was also a risk corridor that offered some protection for the CMC plans. CMC plan KIs often claimed that the savings from CMC were largely being amassed by the state rather than the plans, which they claimed was unfair given that CMC didn't allow them to adjust provider payment rates.

From a common sense perspective, we're paying the same rates that the state was paying, so it's difficult to have savings if we're being required to do everything they were and they were going broke. We have to have time.

One of the most common financial challenges expressed by CMC plan KIs was that they were expected to produce savings in the same time period that they were offering a new product, developing new relationships, and attempting to implement innovative programs.

CMC is designed to take savings on the front end as reductions in health plan reimbursements; it is leaving little opportunity for plans to realize additional savings to share with members, providers and agencies.

Another CMC plan KI noted that CMC required "significant investments to stand up to the program and we are working to recoup those investments through operating income." Some CMC plan KIs asserted that the high savings targets were driven by a desire to rein in Medi-Cal spending.

There were either actuaries that convinced policy makers this was a great idea or there was a budget goal that was trying to be achieved.

CMC quality withholds were too punitive: To incentivize high quality care in CMC, a portion of the capitated rate paid to plans was withheld each year of the demonstration. If the CMC plan met the established quality benchmarks, the withheld amount was to be repaid to plan retrospectively.

The number one problem with demo financially is that the demo takes the savings off the top before you've gotten a nickel. This idea of an assumed savings of 1% the first year, 3%, and 4% is difficult because the savings don't occur that fast.

CMC plan KIs claimed that the CMC quality withholds were punitive rather than incentivizing:

Under the D-SNP and Medicare advantage program, you get a star rating and you get a bonus of about 5%. That's a very important opportunity for plans to enhance their revenue by doing a good job. In the demo, it's treated as a penalty. On top of the assumed savings, which are taken out of the premium all together, there is now a withhold for quality. You have to meet certain quality indicators and earn it back to get even. I think there's a fundamental flaw in the demo in that regard. The fact you have to earn it back is making the whole quality thing a penalty exercise as opposed to an improvement opportunity.

RESULTS: HEALTH PLAN RESPONSE TO CMC

Additionally, one KI noted that CMS and DHCS tried to select quality measures that were already developed, vetted, and tested, but some noted that they were too focused on process rather than outcomes and that there was a lack of appropriate LTSS quality measures.

CMC plans struggled with beneficiary retention: Although not unique to CMC, some plan KIs expressed concern about investing in beneficiaries who may not be beneficiaries for very long because they are allowed to dis-enroll at any time.

This is a traditional Medicare advantage dual concern, that you have them one month and then they're gone the next. You put a lot of time and energy into developing a care plan for somebody who isn't there for long, going into the home and maybe remodeling, or cleaning it up, or making their conditions more livable, removing items in their living conditions that could expose them to unhealthy conditions. [If] you do that, and the member dis-enrolls...it's not the money that matters but it can be a little challenging and a little disheartening to go to all that effort and then the member is gone.

Plans were uncertain about the future of CMC: Many CMC plan KIs reported feeling uncertain about the future of the CMC. They reported that the state's delay in committing to an extension of the program sent mixed signals around how much they should invest in the program.

I think the state of California has to commit to this program for the longer term...I think California should be raising their hands high and saying, "Yeah, we're in." That would send a signal to the plans that we can make investments now so that we would have at least 3 more years for us to measure our returns. I think that would be very, very helpful to the plan in terms of their commitment and planning to this program and use of resources. If we think it's going to end in a year and a half, it's like, "Why should we invest more in it?"

CMC plan KIs also reported that continuing with passive enrollment was essential to CMC's future. Many CMC plan KIs were worried that, due to the demonstrated challenges of effectively communicating the benefits of CMC to potential beneficiaries, passive enrollment (where beneficiaries are assigned to a plan with the option to dis-enroll) was especially important to ensure participation in the program. They were concerned that a reliance on voluntary enrollment may not be effective at keeping the program financially viable.

CMC Plan Delegation Models

CMC plan KIs reported relying on a variety of delegation models to deliver services to their beneficiaries. NCQA defined delegation as "A formal process by which the organization gives another entity the authority to perform certain functions on its behalf. Although the organization may delegate the authority to perform a function, it may not delegate responsibility for ensuring that the function is performed appropriately." As with other health insurance products in California, CMC plans could delegate a variety of activities, such as: utilization management, claims processing, credentialing and re-credentialing processes, complex case management, special needs population model of care, disease management, member connections, and/or customer service. A delegate is paid a capitated rate and takes on responsibility and risk for delivering all services in a contract.

RESULTS: HEALTH PLAN RESPONSE TO CMC

While CMC plans contracted with a variety of entities to provide services, they rarely created delegation arrangements outside of PPGs.

Delegation practices can be described as non-delegated (where all responsibility and financial risk remains in-house at the plan), mixed (where plans retain some of the responsibility and the risk, and delegate others), or fully delegated models (where plans delegate all services and risk). Delegation models in CMC differed greatly both within and across plans.

Depending on which county, we [CMC plan] have counties that are fully delegated and we have counties that are mixed model, some counties only take PCP risk. There is a pretty big variance.

Examples of CMC plan delegation models: One CMC plan KI noted the complexity of efforts to summarize plan delegation practices:

Folks were trying to make all these assumptions like, "Well, tell me what they delegate." I was like, "Well, it really depends. It depends on the plan, it depends on the group, and it's changing all the time."

Unfortunately, the interviews with CMC plans provided little clarity on how to summarize the delegation practices within CMC. The complexity of these models was evident in the ways that CMC plan KIs described them using various terminology and detailing the types of services that are delegated and to whom. One CMC plan KI reported that they do not delegate any services, although they contract out for HRA completion and complex case management.

There are no delegated entities and no risk sharing. We do have a small care management program in-house. We contract out the HRA work for the high and low-risk. The case management and care coordination part comes back to us in-house and our team takes it from there. We also work with two external complex case management programs that assist us with the members that are high touch and high need.

Another CMC plan KI noted that although they don't delegate out medical services, they do offer a "capitated" (risk sharing) vision plan.

For medical services, we really don't delegate. Unlike many of the other health plans, we have direct contracts for Cal MediConnect with our primary care doctors and our specialty groups. We do have capitated vision service plans, our pharmacy network is through [vendor], and DME I believe is through one vendor.

Several CMC plan KIs noted much more complexity in their delegation within the plan and across services and delegates.

We delegate outpatient care to the medical group. The physician services that are provided outside the hospital are delegated to the group. Some of our groups are full risk, who also delegate to the management of patients in the inpatient for our Cal MediConnect program. However the complex case management and ICT and MLTSS, those functions are managed at a plan level. They are not delegated. We work in collaboration with the medical groups

RESULTS: HEALTH PLAN RESPONSE TO CMC

and the physicians to make sure that the members have access to the MLTSS services and long-term care. We manage that process internally. They refer to us when they identify members who have those needs.

Often CMC plan KIs differentiated between the delegation of provider services and care coordination. With the appropriate management of care expected to be one of the major cost-savers in the CMC program, some plans were hesitant to relinquish control over care management even when they delegated provider services. Other plans noted that for PPGs to be adequately incentivized to accept risk, they needed to hold both the risk and potential savings of provider services and care management.

If we have a risk arrangement with the IPA, and many of the Medicare risk arrangements are global, then they provide the care management. In that case the IPA's offices. Some of the bigger groups do have care management on site.

The withhold will get passed through, whatever we end up getting or losing, they'll feel the same thing. From that standpoint, they're motivated.

CMC plan KIs reported developing financial risk sharing arrangements with PPGs that share savings from reduced hospitalizations with the providers.

We capitate professional services to what we call PPGs, or you might think of them as IPAs. They coordinate primary care, specialty care, ancillary services like laboratory radiology. We hold the pharmaceutical risk and we hold the hospitalization risk. There are shared risk pools between the medical group and health plan over hospitalization.

Sharing savings with providers could facilitate the alignment of incentives between the plans and PPGs and may also draw more fee-for-service (FFS) providers into the CMC program. LTSS and CBOs often reported an interest in developing shared savings arrangements with plans, as they felt the services they provided could have an impact on overall costs. However, any evidence of these shared savings arrangements beyond delegated PPGs were in early stages of discussion.

With such variability in delegation models, one KI noted that CMC was a perfect natural experiment. Decisions about delegation were likely to impact CMC plan finances and administration, other health system stakeholders, and beneficiary experiences. One KI reported that a common assumption was that plans that do everything in-house are better, but argued that sometimes the PPGs were able to offer more specialized services. This KI argued that there were likely to be a lot of positive outcomes and innovations that come out of the delegated, non-delegated, and mixed models. However, this would require adequate data collection on the complexities of delegation models and practices to be able to assess their impact. One KI noted that CMS' Health Plan Management System required CMC plans to report any functions that they delegate out; however:

It was never built to capture the complexity of what's happening in California. There's no way for the plans to communicate in the system just how much is being delegated and how those relationships work.

CMC Plan Delegation Rationale

CMC plan KIs cited several factors influencing their decision to delegate or not, mainly related to plan history, systems factors, skills or expertise, implementation pressure, or desire for control over quality and savings.

Systems level factors: PPGs in particular regions of California have a much larger presence in health care systems, making it hard for plans to start from scratch and rebuild something that was already there. For example, if a majority of providers in a region practice through PPGs, plans may have found it necessary to delegate services to those PPGs in order to meet the network adequacy requirement in their CMC readiness review. A few CMC plan KIs reported that they chose to delegate out the HRA process in order to meet the tight timeline for plans to complete assessments.

Assessment of experience and skill: CMC plans with a history of delegating care or coordination through other MA or D-SNP products were much more likely to continue that practice in CMC. One KI argued that, in some regions, the PPGs were more capable than the CMC plans at providing certain services. *“They know better how to serve their population and they have more experience doing it.”* This same KI also noted:

There’s also just so many incredibly smart, educated providers that are looking for really innovative ways of delivering care and always seem to be on the forefront.

Many CMC plan KIs reported that the decision to create risk and savings sharing arrangements with delegated entities depended on their perceived experience and ability to take on risk. One CMC plan KI described how they tailored their delegation model to the capacity of the PPG:

That’s really important because you have some groups who have hospitalists that manage hospital care well; others are just learning how to do that. Some are good at managing social services because it’s been an integrated part of their history.

One CMC plan KI argued that most of the “sophisticated” groups that were prepared to take on more risk may not actually have had much experience in serving lower-income Medi-Cal populations. They concluded that CMC could actually expand access for dually eligible beneficiaries to the more sophisticated, value-based systems of care.

Desire for control over services, quality, and finances: CMC plan KIs noted that not all plans were comfortable with the lack of control in highly delegated models.

With IPAs we have less control, obviously. It’s one step removed from the plan. Most of the challenges are working through another entity to make sure that the care is delivered in the way that the plan wants the care to be delivered.

In delegated models, CMC plan KIs discussed strategies about how they provided oversight over their providers to ensure the quality of services provided (see [Quality](#) section). Many CMC plan KIs also cited a desire to have more control over the authorization of services or areas of service delivery that have the most potential to result in savings for the plan. For example, many CMC plan KIs reported keeping care coordination in-house for their most complex and high-cost beneficiaries.

RESULTS: HEALTH PLAN RESPONSE TO CMC

Need to fully integrate behavioral health services: One CMC plan KI described the challenge that CMC plans face in attempting to fully integrate mental health services in a delegated model. This CMC plan KI noted that several plans now have behavioral health directors, and more plans *"hold on to the behavioral health population and do it themselves."*

If you take a fully delegated model, and you carve out the behavioral health along with the medical to an IPA or a medical group, they may be sophisticated on the medical side, but every one of those groups sub-carve out to a behavioral health provider outside of the group.

This CMC plan KI argued that there was only one medical group in California that had truly made a commitment to behavioral health integration. *"Until they do, all [the plan is] doing is wasting those behavioral health dollars by running through a middle man."* However, the KI acknowledged that this type of true integration required a behavioral health provider population that was willing to work with managed care plans and PPGs that were willing to give up the capitation for behavioral health. Even with these challenges, however, the KI argued that California was arriving at a tipping point, which would necessitate this kind of integration.

It's going to reach a tipping point, and what's going to happen is if you look at all the initiatives coming down right now from CMS, including PRIME, Whole Person Care, 1115 waiver, Health Homes; at the center, you'll see that they are all really requiring behavioral health integration at the provider's site. If health plans haven't integrated, how are they going to really create that integration at the point of delivery? I think it's really going to be challenging in the next couple of years to meet these requirements.

Some CMC plan KIs reported choosing to delegate all of their behavioral health services to the county behavioral health departments for their non-SMI population as well as their SMI population. They claimed that this has been helpful to allow beneficiaries to continue to see their providers if they tend to shift in and out of eligibility for a SMI designation.

The way that the counties and the health plans interact are slightly different based on the county. Each of those counties do their coordination slightly differently. They do their communications slightly differently. The scope of what their providers do is slightly different. For example, in [one duals county], the county chose not only to be a partner with us on the Medi-Cal benefits they provide, but they also wanted to take on the Medicare benefits for a member who was already accessing the specialty mental services, so there's no having to move a member from provider to provider. They can just stay with that county system.

PROVIDER AND PPG RESPONSE TO CMC

Independent physicians, hospitals, participating provider groups (PPGs), and sometimes LTSS agencies can provide medical care. For the purposes of this report, we use the term providers to mean physician providers, other health care providers such as nurse practitioners, and hospitals. LTSS providers are discussed separately as IHSS, CBAS, or MSSP. PPGs are managed care organizations of medical doctors, hospitals, and other health care providers who have agreed to provide health care service on either an FFS or capitated basis.

Regional differences in provider competition and markets are dramatic across CMC counties. In northern California, there is less competition because there are few independent providers, and many hospitals and PPGs are linked into a few large systems. In the southern California health system, there are many more plans, hospitals, PPGs, and independent providers that are competitive and not linked to larger systems. Prior to CMC, many of the plans already had physician networks, hospital networks, and/or relationships with PPGs, but the increased number of beneficiaries from CMC placed pressure on plans to expand their own networks and/or to contract with PPGs to access their networks.

KIs provided insights about provider responses to CMC, particularly: 1) the value of CMC for providers and PPGs; 2) their preparation and readiness for the CMC transition; 3) their implementation efforts since the transition; and 4) the challenges of CMC for providers and PPGs.

The Value of CMC for Providers and PPGs

CMC improved communication between providers, PPGs, and plans: Several KIs, not just provider KIs, noted how they have appreciated CMC plans' willingness to open up lines of communication, making it easier to reach someone at the plan when needed. One CMC plan KI claimed that providers appreciated their member services department.

Our member services department is manned 24 hours, 7 days a week by our staff and we tend to answer 90% of our calls within 10 seconds. Our customer service for the member and for the physician is a big help.

CMC could improve billing: When asked what administrative value providers experienced in working with CMC plans, several KIs noted improvements in billing and claims processes:

With the fact that we are both the Medicaid and the Medi-Cal plan, we require one claim, they send it to one place, and we process it both as primary and secondary. While that may not seem like the largest of victories, when you look at the scale, both the large number of duals and the large number of services that they incur, that's measurable.

[Providers appreciate the CMC plan's] loyalty, volume of referrals, easy claims payment, rapid claims payment. You just need to understand what a private practitioner needs.

RESULTS: PROVIDER AND PPG RESPONSE TO CMC

CMC could reduce the burden of care coordination: Many CMC plan KIs noted that care coordination was one of the greatest potential benefits of CMC, especially for providers with constraints on the amount of time they had available to spend with each patient.

When I have a 15-minute session with a complicated member like this, and I'm already behind schedule and there's calls coming in from the pharmacy, from the health plan, etc. I open up the chart and there's 20 medications that need to be refilled. Then they have these forms that need to be signed. Then I see that their diabetes is not well controlled, their blood pressure is not controlled, they didn't take their last meds that I prescribed. All of a sudden 14 minutes have gone by, and you have one minute extra and they have all these questions.

Physicians in their offices have a certain amount of time to see complicated patients. When they have the ability to lean on a care coordinator or care manager to support some of what needs to get arranged, facilitated, and coordinated. That's a benefit for them.

Some of these members are going to be very, very complex and are going to stretch [the provider's] ability, not only from a medical standpoint, but for all of the other needs that they have. [With the plan] doing the care management, [providers] get to focus and practice at the top of their license, which is to provide the medical services, and the plan takes care of all the other stuff. We find that it works well and they appreciate it.

CMC plan KIs reported that providers, especially those in smaller practices, would have difficulty providing the kind of care management that CMC requires. One CMC plan KI noted that providers can learn valuable information about their beneficiaries from the care coordinator that they couldn't get from their own exam of the beneficiary, such as: feedback from the assessment, home visits, and audits of the prescription history of the beneficiary.

CMC encouraged the adoption of integrated data systems: Many provider KIs described ways that CMC allowed them to systematize their ability to coordinate care with other physicians, specialists, behavioral health services, or LTSS. Through the integration of data systems, some providers were benefiting from easy access to information about their patient from various sources. For example, a provider could check to see: if their patient was taking any medication that could interfere with a particular treatment; what the care coordinator was already doing to address a particular issue; what a beneficiary's health goals were; or identify the beneficiary's care coordinator so that they could propose an ICT meeting (see [Coordinating Care Across Sites](#) section).

CMC could facilitate beneficiary referral, activation, and engagement: While CMC plan KIs argued that providers benefited from the increase in referrals from the plan, one FQHC KI noted that the referral of beneficiaries to their center was still pretty low. A couple of CMC plan KIs reported that providers also benefited from declines in “no show” rates because:

[...the plan] had facilitated getting the appointment in the first place, may have arranged the transportation, probably made a reminder call to the person, and in some cases, may have had to accompany the person.

RESULTS: PROVIDER AND PPG RESPONSE TO CMC

Another CMC plan KI reported that providers benefited from the intensive health education the plan provided, increasing the health literacy and engagement of their beneficiaries.

We are helping them actually understand their chronic condition. We've encountered many people with chronic conditions that don't understand their condition. No one has stopped to really educate them about the condition, so why [would they] take another pill when [they're] already taking so many? When we can really help people understand how to best provide care for themselves and understand their condition, we can really be a partner with them. A lot of our clinicians have been very excited to be able to really spend the time explaining what it is and what someone needs to do, and directing them to disease management programs so that they can provide more information and more support. Our care center staff [are] always excited when they can make that kind of win because until the person understands the condition, why would they comply with their medication? Why would they make changes, and why would they stop eating certain things if they don't understand how it impacts their condition?

Providers and PPG could share in CMC savings: One potential value of CMC for some PPGs was the opportunity to receive a share of CMC plans' savings.

Our groups are paid under a capitated system, not a fee-for-service system, and they are delegated by health plans for downstream claims payments of other providers. They sit right in the middle in between health plans and independent providers, because they act as providers but they also act as payers.

When PPGs hold the financial risk for CMC beneficiaries, they also have the ability to provide care coordination or alter care in a way that could lead to savings in delayed institutionalization or a decrease in unnecessary utilization.

Provider and PPG Preparation for CMC

Provider history influenced CMC transition: A provider KI noted that some PPGs had a long history of serving the dually eligible population.

[They] didn't need to do much to prepare. They already had an infrastructure in place because they were already serving duals for several years through Medicare Advantage. They know duals very well, with some exceptions. As you probably know not all duals are alike.

However, many KIs noted regional differences in physician and PPG readiness for CMC.

[In northern California], they've got their network, they've got their plan. There is very tight alignment there with all the providers. There is far less competition in the north. The north is coalesced into these large provider systems that have gobbled up a lot of remaining independents. It's really quite different from the Southern California market.

CMC readiness review required enhancement of PPG care coordination: PPGs that were delegated responsibility for medical care and care coordination of CMC beneficiaries, were expected

RESULTS: PROVIDER AND PPG RESPONSE TO CMC

to meet readiness review criteria prior to implementation. This required many providers and PPGs to prove to CMC plans, DHCS, and CMS that they could adequately serve CMC beneficiaries. However, one provider KI felt that some of the CMC plans were held to unnecessary internal care coordination readiness standards given the capacity of their delegated PPGs.

You have very high-functioning Medicare Advantage plans with duals, but they weren't providing all of the care that the demonstration requires. The readiness review process was ruthless with some of these plans, forcing them to spend millions to develop care management infrastructure internally within the plan when [PPGs] had care management infrastructure and were using it daily in the Medicare Advantage and the D-SNP population.

Provider and PPG CMC Implementation Efforts

Many physician were reluctant to participate in CMC: Many KIs noted that one of the main issues in implementation of CMC was the reluctance on the part of physicians to join the CMC plans' networks. CMC plan KIs reported that community-based Medicare FFS physicians were the most challenging for plans to recruit into their networks. Additionally, they believe that these Medicare physicians actively encouraged their beneficiaries to opt-out of CMC. This allowed FFS physicians to continue seeing beneficiaries at a higher rate. CMC plan KIs and LTSS provider KIs often described the role of physicians in encouraging beneficiaries to opt-out.

It's a tough provider crowd to convince that these programs are good for members. Certainly members make their own decision, but they're heavily influenced by their physicians. It's still a work in progress to get them to see the benefits.

One KI said that physician reluctance was not exclusive to CMC, but that many FFS physicians were suspicious of most programs that DHCS implements and have long-standing aversions to managed care.

[There is a] historical cynicism on the part of physicians around anything DHCS does. Even if DHCS came out with something that was hugely beneficial to physicians, physicians would have been really skeptical about that because of the historical relationship particularly around Medi-Cal rates, problems with provider enrollment, and a whole panoply of problems that physicians typically had with the department.

However, a provider KI noted that in the case of CMC, there was opposition even among physicians who have historically participated in managed care models. This opposition appeared to be closely related to CMC plan KIs' perspective of CMC rates and the demand for physicians to practice in higher paying Medicare Advantage networks.

A lot of our higher-performing MA groups have shied away from the demonstration because of the rates. It's not a compelling business proposition to them to do more work for less money when the enrollment rates for Medicare Advantage in California are skyrocketing. It used to be at 10% opt-in by 65-year-olds into MA in California. Over the span of two years it increased to over 51% as the boomers started to move in. [Boomers] like HMOs, they are moving into Medicare HMOs. [PPGs] have their hands full with MA right now and so there

RESULTS: PROVIDER AND PPG RESPONSE TO CMC

are a lot of top performing 4 ½ and 5 star physician groups in California in the MA system who are just not playing in the duals demonstration.

KIs reported that some physicians in particular ethnic communities (enclaves) were more hesitant than others to participate in CMC.

Russian providers have all stated clearly to their patients that they have no intention of joining a CMC health plan network. There have been articles in the Russian language newspaper by doctors with those statements, telling patients that they have a choice, showing them the forms they would receive in the mail, and that Russian dual eligibles need to be aware of the consequences of that choice. They were careful not to violate any anti-trust laws.

KIs claimed that physicians serving ethnic enclaves often had strong relationships with their beneficiaries, who relied on their language access and cultural understanding. KIs noted that many beneficiaries placed a lot of authority and respect with their doctors and did not want to lose their connection with their physicians. *“They are the unquestioned voice of authority.”*

Efforts were made to educate providers about CMC: One KI described efforts that DHCS made to improve education and outreach to providers who didn’t join the program, especially those who had high numbers of beneficiaries who opted out. One Provider KI discussed working with DHCS to hold focus groups to better understand provider needs around the CCI program. They used those focus groups to develop a Physician’s Toolkit.¹² They also claimed that providers were skeptical about CMC information from DHCS and plans. Consequently, they worked with The SCAN Foundation to provide opportunities for providers to hear unbiased information about CMC and whether or not it made sense for them and their beneficiaries to participate.

A provider KI reported that there were some efforts by DHCS and Harbage Consulting to enhance participation of diverse physicians in CMC. They reported working with the Ethnic Physician Organizations (Korean, Chinese, Indian, etc.), to partner on events that would allow physicians to learn more about CMC. The goal of these events was to provide details about CMC, dispel myths, and allow opportunities to ask questions. KIs reported this partnership increased Ethnic Physician Organization’s investment in ensuring their physicians were educated about the program. Some of the events included physicians who had been very vocally opposed to the CCI.

I was really impressed, because it’s a very feisty group of physicians who have been really vocally opposed to CCI. There was someone from The SCAN Foundation there, and I said “okay, brace yourself as this may get ugly,” and it wasn’t. It was a very civil discussion. I saw a lot more sort of open mindedness about listening. There were complaints and gripes about DHCS and other things, but I felt it was very effective, and achieved the goal that we had been trying to achieve, which was really just to be able to have physicians hear about what CCI is and isn’t, and to make their own decisions about what’s in the best interest of their practice and their patients. That was the goal.

¹² CalDuals.org: Physician Toolkit. Retrieved from <http://www.calduals.org/providers/physician-toolkit/>.

RESULTS: PROVIDER AND PPG RESPONSE TO CMC

However, the KI noted skepticism about whether or not these types of sessions could change the minds of providers who were “vehemently opposed.”

Realistically, I don't think that's going to happen. At this point, what I think is important is to at least soften the folks who are screaming about how horrible CCI is, to let other physicians have a chance to hear about the program and make a decision for themselves, and let some of those other voices through so that physicians can make unbiased, informed decisions.

CMC plans attempted to incentivize provider participation: In response to push-back from providers, some CMC plan KIs described offering adjusted rates to incentivize their participation. However, one provider KI disagreed that this was happening systematically, and another questioned whether these efforts would be successful.

[One CMC plan] spent millions trying to build a directly contracted network with all the managed care holdout doctors and has thrown money at that physician population to try to organize it into a coherent model. They are doing the care coordination at the plan level and trying to organize all of these formerly fee-for-service doctors. We'll see how they do.

One CMC plan KI reported efforts to incentivize the participation of physicians providing outpatient mental health services.

[The plan] paid a little bit more than average for the initial visit...it ensures ready access, because providers will put our Medicaid beneficiaries to the front of the line and we don't struggle with getting access to out-patient services.

The Challenges of CMC for Providers and PPGs

One provider KI noted that, on paper, CMC was phenomenal, but they were still working through some of the challenges.

The blueprint on paper for Cal MediConnect is phenomenal, it's beautiful. It's not there in practice yet. It takes a long time to really develop the links, to break down the silos and to build the capacity. I think that's happening, I'm not hearing negative things about Cal MediConnect, I'm hearing positive things. There are a lot of problems, people are addressing the problems, and they're making slow, incremental progress with the population. Overall I think my sense of it from my perspective is that it's grabbing hold, it's working slowly.

Providers reported delays in access to information about CMC: One provider KI claimed that they were not getting complete information about CMC from DHCS. They said they needed more information on all aspects of CMC, from an overall description of the program to more specific things such as opt-out forms. While some said that the information they received from DHCS has improved, this did not happen until very late in the implementation. One KI reported that DHCS had made a greater effort to reach out to providers, but it would have been better if it had happened earlier in the implementation.

CMC may increase administrative burden on some providers: Some provider KIs, especially those representing the perspective of PPGs, noted an increase in administrative burden caused by

RESULTS: PROVIDER AND PPG RESPONSE TO CMC

CMC, such as: increased data collection and reporting requirements; contracting requirements; and challenges with billing and claims procedures. Several KIs reported increased data collection and reporting burden as a result of CMC, but one provider KI didn't feel the increased data collection was due to CMC alone, but was magnified by reporting requirements in Medicare Advantage as well.

[Providers and PPGs are] dealing with a lot of those compliance issues on the MA side. Everybody understands [since] they've been doing quality and performance measurement reporting through the Integrated Health Care Association and through MA Five Star system for years. They have a whole infrastructure in the groups to accumulate data from the physicians and to pass it on up to clearing houses for compliance purposes.... Everybody has to adjust to the new standards, there were some new standards imposed in the demonstration that were in addition to the baseline that existed in MA; that everybody just adjusts to, that's not a big problem.

Many provider KIs spoke of difficulty in contracting with CMC plans. One FQHC KI reported that they were not informed about what CMC was or that they needed to have a contract to be able to serve the population they had already been serving. As a FQHC, they reported feeling like they were caught in between the state and federal governments because they were not allowed to bill for services rendered, even though they were mandated to provide services. For two years, they reportedly provided services without reimbursement.

We had a hard time believing the state wasn't going to pay us but the law changed in 2013. We received a rash of patient complaints because we weren't able to serve them.

This FQHC KI claimed that neither CMS nor DHCS provided guidance in this process, but was unsure if other FQHCs or providers had the same problem. There were only a few FQHCs in their region, but some counties had many more. They suspected that some FQHCs had a closer relationship with DHCS than they did, which could have led to more guidance and assistance.

Once a contract was established with the CMC plan, an FQHC KI claimed that as a contractor with a CMC plan, "We had to figure it out ourselves." There was no training on using the plan's online portals and how to bill claims. They were as confused as the beneficiaries were about how to process their eligibility information.

The CMC plan was not able to provide the guidance that was needed for the first 3-4 months of our contract. When you're in a county with such a small number of FQHCs, you're not a priority to the plan compared to other private providers. The main advice we received was, "Go to the website and download the application." We only recently received CMC manuals after getting the contract.

LTC FACILITY RESPONSE TO CMC

The number of LTC facilities in CMC counties varied greatly. In San Mateo County, their one CMC plan may contract with up to 17 LTC facilities in a relatively small geographical area. In contrast, Los Angeles County's five CMC plans (and many PPGs) may contract with the 391 LTC facilities located across a large geographical area. Although some CMC plans had previous referral relationships with LTC facilities for short-term post-acute services, most plans did not have contracts with LTC facilities and had not provided long-term custodial services to beneficiaries prior to CMC.

KIs provided insights about LTC facilities' responses to CMC, particularly: 1) the value of CMC for LTC facilities; 2) their preparation and readiness for the CMC transition; 3) their implementation efforts since the transition; and 4) the challenges of CMC for LTC facilities.

The Value of CMC for LTC Facilities

LTC facilities faced a significant adjustment through the implementation of CMC. Thus, it is not surprising that LTC facility KIs were the least likely of respondents to report positive outcomes or perceived value of CMC. However, LTC facility KIs reported that they were resigned to the trend toward managed care health systems that CMC represents and they understand the political and economic forces behind the trend.

LTC resident referrals and transfers may be less restricted under CMC: Some KIs reported that one potential benefit of CMC for LTC facilities was that plans could admit people from the community without requiring a hospitalization. For individuals needing intensive supervision rather than intervention, a short-term stay in an LTC facility could be seen as a less costly alternative to hospitalization, but was not an option before CMC. Another CMC plan KI believed that LTC facilities realized that CMC plans were a good referral source. For LTC facilities that struggled to build relationships with multiple hospitals or PPGs to ensure resident referrals, having a central health plan to work with could improve the flow of residents into their facility. Additionally, KIs noted that LTC facilities who worked with CMC plans to transition residents back into the community with additional services and supports, had opportunities to fill their beds with higher-paying residents, such as post-acute or rehab residents (see [LTC Transitions](#) section).¹³

CMC encouraged alliances with new stakeholders: LTC facilities have also built new alliances that wouldn't have been likely prior to CMC. KIs reported that collaborations and relationship building between CMC plans and LTC facilities during CMC was challenging from both perspectives. However, after efforts to cross-educate CMC plans and LTC facilities about each other's capacities and needs, some KIs reported that those relationships were stronger.

Although challenging in the beginning, the relationship between LTC providers and the health plan is improving. We are actively engaging the California Association of Health

¹³ Ensslin, B., & Brodsky, D. (2016). *Housing Options for High-Need Dually Eligible Individuals: Health Plan of San Mateo Pilot*. Retrieved from <http://www.chcs.org/resource/housing-options-for-high-need-dually-eligible-individuals-health-plan-of-san-mateo-pilot/>.

RESULTS: LTC FACILITY RESPONSE TO CMC

Facilities (CAHF) and the Ombudsman in the process. We have worked hard to help all involved to understand that our goal is to minimize disruption to care, improve care coordination and health outcomes, and reduce the anxiety that necessarily comes with change.

An LTC KI noted that they have also built stronger collaborations with other health system stakeholders as a result of their efforts to oppose CMC.

We work with many different groups and form relationships with them...Our Board of Governors now has members from the California Medical Directors Association, Directors of Nursing Association, and others. It's important to have allies.

We have monthly calls from a managed care advisory network, we have 100 people that are invited to those calls. They tell us what's going on at the local level. It's our neighborhood watch program for managed care.

CMC could facilitate billing and encourage alternative reimbursement models: Some CMC plan KIs reported creating blended reimbursement rates for both Medicare and Medi-Cal, which they believed would simplify billing for LTC facilities by preventing the need to sort through each resident's insurance benefits. However, LTC facility KIs cited more challenges with billing than simplification, especially early in CMC implementation. Another CMC plan KIs reported being open to discussions about alternative reimbursement models.

We did these huge meetings with literally 100 to 120 skilled nursing facility administrators and staff, because I went to them and we really spent time saying, "Tell us how to make it work? How can we pay you in ways that work for you?"

Reimbursement is the combination of post-acute rate and custodial rate. The goal is to simplify the payment process with less administration.

I have been having conversations with a couple of nursing homes chains about the idea of having a different relationship with them where we would try out some alternative reimbursement models with them, and they are certainly receptive to it.

However, LTC facility noted that the blended rates plans offered were lower than the Medicare rate (see [Challenges of CMC for LTC Facilities](#) section).

LTC Facility Preparation for CMC

Efforts to educate LTC facilities about CMC were needed: One KI noted that because LTC facilities needed more information and basic education about how to work with CMC plans, an LTC facility association provided webinars, face-to-face trainings, and legal assistance and guidance. Additionally, a LTC facility association KI reported educating their members about the metrics they would be responsible for in CMC, and preparing them to collect and report data on those metrics. They also provided webinar trainings on billing processes and how to work with CMC plans.

RESULTS: LTC FACILITY RESPONSE TO CMC

LTC facility KIs cited several trusted sources of information that helped them prepare for and implement CMC, including their national and regional trade associations, the American Health Care Association (AHCA), and the California Association of Health Plans (CAHP). One LTC facility KI noted monitoring the CMS and State websites frequently for news or developments related to CMC.

CMC required some LTC facilities to expand their contractual and legal workforce: In order to meet the contractual requirements of working with CMC plans, one LTC facility KI reported hiring staff that specialized in managed care. Additionally, LTC facility KIs reported needing to expand their contract departments in preparation for CMC, especially in highly delegated regions where facilities were often required to establish contracts with each PPG, which requires extensive work and expertise. Some LTC facility KIs reported hiring specialists to manage the various billing and reporting demands of CMC.

LTC Facility CMC Implementation Efforts

CMC education continued with LTC facilities after implementation: LTC facility KIs reported the need for ongoing education and training as challenges arose in CMC implementation.

Much of the initial work done to transition Cal MediConnect members in LTC Nursing Facilities occurred between the health plan and the LTC provider. Since LTC is a service new to the health plan—and working with a health plan is new to LTC providers—it has been a journey of learning. There has also been some member and family confusion, frustration and mistrust. Adjustment, communication and training have occurred and are ongoing.

An LTC association KI described a summit they were planning for their members, health plans, and other stakeholders in Southern California, with organized panels on best practices, continuity of care, reimbursement, and other issues.

[The association] re-directed funds to cover a dedicated staff member on managed care, opened an office, paid for meetings and costs of organizing the summit, up to \$500,000.

They reported that this effort would be worthwhile as it would result in curricula that could be a resource for their association members. The LTC facility association KI also reported educating their members about what to look for in contracts and how to negotiate with health plans, while “being careful to avoid anti-trust issues.” They created a toolkit that showed their members how to make sure they were properly reimbursed by plans.

LTC facilities were engaged in the stakeholder process: An LTC facility association KI noted that they served on a state-wide CCI and CMC advisory committees with CMC plans that focused on reimbursements, regulatory issues, and continuity of care. They identified problems that might be happening at the state level and communicated those issues to their members to keep them informed. They reported that it was invaluable for them to be on this committee, because they could “stop train wrecks before they happen.”

LTC resident enrollment in CMC was low: Many informants believed that some LTC facilities advised their residents to opt-out of CMC, at least in the initial part of the demonstration. This

RESULTS: LTC FACILITY RESPONSE TO CMC

suspicion coincided with previously released notices from CMC and DHCS barring this activity¹⁴ and clarifying who can serve as an LTC resident's enrollment assistant.¹⁵ One KI questioned the cognitive capacity of some LTC residents to make the decision to opt-out of CMC and speculated that it was very easy in these circumstances for facilities to make the decision for them.

CMC plan KIs described efforts to reduce LTC beneficiary opt-outs by building good relationships with facilities or offering payment models or incentives so that LTC facilities would stop advising their residents to opt-out. One CMC plan KI mentioned that although they had not analyzed their data yet, they believed that they were not getting high opt-out rates from LTC facilities because they were paying high rates to LTC facilities.

The Challenges of CMC for LTC Facilities

LTC facilities faced challenges in contracting with CMC plans and PPGs: As mentioned earlier, LTC facility KIs reported many contracting challenges with CMC plans. There was some confusion when the program was first implemented because some plans believed that the current contracts they had with LTC facilities for Medi-Cal or D-SNP would cover CMC. Some KIs reported that it wasn't until the demonstration was implemented that some CMC plans realized these existing contracts would have to be revised.

Initially, contracts between CMC plans and LTC facilities were largely determined by where the CMC plans' beneficiaries were discharged or were already residents. Some CMC plan KIs reported developing contracts with all LTC facilities in their area, while another plan reported developing contracts with some facility chains for purposes of convenience. Although contracting with larger chains may decrease the administrative burden of CMC plans, this is likely to disadvantage smaller facilities as well as decrease access for CMC beneficiaries who may prefer smaller facilities.

Unlike the comprehensive Medi-Cal fee-for-service rate, LTC facility KIs reported that they had to "negotiate the rates for everything from dental care, pharmacy, physical therapy, custodial, everything." One LTC facility KI noted that smaller facilities often don't have the bandwidth to allocate to the contracting work needed to participate in CMC.

When you get into the skill level of care, it's easy for Medi-Cal because they pay Medi-Cal rates. If you get into the Medicare side of the house, the plans have, and the IPAs, since they didn't have the RUGs rates, they have a level of care, and their level of the care can differ facility by facility or health plan by health plan. They can have five different types of level of care and what's included, what's not. Are they giving an extra money for bariatric? Are they not? From a facility point of view, before you admit somebody, you have to open the contract

¹⁴ CMS (2015) Memo to Long Term Care Facilities on Disenrollment Issues. Retrieved from <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/LTCFDisenrollmentMemo052615.pdf>.

¹⁵ DHCS (2015) Designating an "Enrollment Assistant" to Represent Medi-Cal Beneficiaries with their Enrollment Decisions. Retrieved from http://www.calduals.org/wp-content/uploads/2015/09/Cal-MediConnect-Enrollment-Assistants_REVISED-VERSION.pdf.

RESULTS: LTC FACILITY RESPONSE TO CMC

and say, 'If this is a level three, what does that really mean?' Because it'll be different from [plan to plan]. It's an administrative nightmare.

By the end of the first year, some KIs claimed that many of the initial problems with contracting had been reduced. One CMC plan KI acknowledged having to reform their referral process, authorization process, and claims payment process to facilitate the relationship with LTC facilities, saying: “Once these processes were fixed, the relationship was smoother.”

LTC facilities had difficulty with variable reimbursement arrangements: LTC facility KIs that worked with different CMC plans reported that it was challenging to understand and adjust to each plan’s payment methods and procedures. In highly delegated models, LTC facilities had a difficult time knowing who was responsible for paying for a resident's care. One KI argued that a resident could come in to a facility with a CMC plan card, but that didn’t ensure the plan was the responsible party, since the plan could delegate the authorization process and risk to a PPG.

In some cases, we'd call and get an authorization and then discover that the authorization wasn't valid because the risk really belonged to a third party.

If I had a contract, it would have been nice to have some clear explanation of how do you process payment. What happens when somebody is enrolled in one plan, decides to dis-enroll, enroll in another, dis-enroll in that, and go back to the first one, which happens routinely. We spend literally hours, if not days, on hold trying to chase down patient-by-patient, payer-by-payer, who has specific contract responsibility.

Some CMC plan KIs acknowledged that LTC facilities housing predominantly Medi-Cal residents had more challenges with CMC, since those facilities needed to work with up to 5 different health plans and many PPGs with different rates and billing codes than Medi-Cal fee-for-service. LTC facility KIs reported not knowing how to contact the plans or the PPGs and who to call about contracts and billing. An LTC facility KI reported learning about the responsibility of plans in this situation, but claims that there are still problems:

[The plans] have a legal responsibility, we have been told by our lawyers, to move that claim to the responsible payer. And those claims haven't been moved.

While many KIs reported improvements since the initial challenges in implementing CMC, some KIs noted that issues remained. Since CMC’s launch, CMS instructed plans to give LTC facilities contact information for a person at the plan who was knowledgeable and fully authorized to approve payments or answer questions about billing and claims.

LTC facilities were impacted by delayed billing and denied claims in CMC: Some LTC facility KIs reported that CMC had a negative financial impact on LTC facilities.

We have gone from less than 2% of our accounts receivable over 90 days to over 60% of our accounts receivable over 90 days in these categories. We're looking at, literally right now, millions of dollars of claims. Now I will tell you even though we're told, “We're not going to pay it because it's not timely,” we are seeing that they know they've got a problem because in

RESULTS: LTC FACILITY RESPONSE TO CMC

some of those old claims, they are paying them. We have brought in outside consultants—we are paying for outside billers to help us.

Facility KIs reported that CMC plans have 45 days to pay a claim (rather than the 15 days under Medi-Cal fee-for-service billing), which delayed the payments and had a negative impact on facility cash flow. LTC facility KIs reported that sometimes CMC plans would wait until the 44th day to deny their claim, starting the clock over again, and requiring the facilities to correct the claim, re-submit, and possibly wait another 45 days for payment or denial. KIs reported that this was a significant challenge for smaller LTC facilities that had to make payroll if they relied on funds from CMC plans and if they didn't have other lines of credit.

Larger providers have deeper pockets and can survive delays in payments and the shift in reimbursement schedules. It is harder on smaller, family-owned facilities.

Another KI said that about four or five smaller family-run LTC facilities were bought out after CMC because they struggled with an inability to sustain cash flow during long delays in reimbursement.

CMC plan knowledge about LTC reimbursements was limited: Some KIs reported that prior to CMC, many plans did not understand LTSS and what LTC facilities do in particular. One LTC facility KI claimed that this lack of knowledge was reflected in their contracts.

When they started out they didn't understand the difference between what I'll call custodial and skilled care. They didn't understand what was in the rate and what wasn't in the rate. They didn't understand bed holds, share-of-cost, but they're all different.

LTC facility KIs reported that the lack of CMC plan knowledge about LTC reimbursement resulted in delays in establishing reimbursement methods and contracts.

CMC health plans were completely unprepared on LTC reimbursement...they were unfamiliar with the needs of very ill people who needed extended stays in facilities and how to reimburse those services. HMOs typically don't have to deal with such a frail elderly population and they didn't understand the depth and magnitude of what facilities do and how to work with SNFs and ICFs, aka "LTC custodial care," including patients with complex medical needs. Billing staffs of these health plans are not up to speed.

Another concern by LTC facility KIs was CMC plan's lack of knowledge about Medi-Cal LTC facility requirements, especially the Medi-Cal bed-hold rule that requires nursing homes to hold open a bed for hospitalized Medi-Cal residents.

It was really interesting, because not one of the health plans in the room, and they were all there, knew that everyone who is on Medi-Cal has a right to a seven-day bed hold that is paid for by Medi-Cal and then the right to the next available bed.

IHSS RESPONSE TO CMC

Established in 1973, IHSS is a state program offered through the Department of Social Services and administered by each county in California for the provision of home care workers that are hired, trained, and managed by low-income blind, aged or disabled individuals. To qualify for IHSS, one has to live in their own home, be a U.S. citizen, qualify for SSI/SSP or Medi-Cal, and demonstrate a need for assistance with activities of daily living. IHSS is paid for through a combination of federal, state, and county funds; certain benefits such as Worker's Compensation Insurance and State Disability Insurance; and a share of cost depending on a beneficiary's income level.¹⁶

IHSS pays for a wide variety of home-based services performed by IHSS workers,¹⁷ including: personal care, household tasks, transportation, protective supervision, paramedical, and other services. Services may be provided through agencies depending on the counties or through independent workers including family members. Beneficiaries may hire, train, change workers, and manage their own workers.

Each county handles the enrollment of IHSS workers (including orientations and background checks), negotiates and establishes wages, and oversees the handling of timesheets and payment for services. County social workers have responsibility for assessing beneficiary eligibility, authorizing services, conducting annual assessments of beneficiaries, and carrying out quality assurance and improvement. Most counties have established public authorities, quasi-government agencies, to provide assistance and education to recipients and providers, investigate background of providers, establish and maintain a registry of providers, provide on-call services, and act as the employer of record for IHSS independent providers. The Public Authority negotiates with the local labor unions to set wages, benefits and working conditions. There have been significant changes to IHSS prior to CMC.¹⁸ Recently, an IHSS Statewide Authority was created to serve as the employer of record for the seven counties in the CCI duals demonstration.¹⁹

In the CMC program, health plans now pay for and "manage" IHSS. However, beneficiaries can still hire, change, and manage their IHSS providers, and county IHSS social workers are still responsible for assessing beneficiary needs and approving IHSS hours. CMC plans are required to establish MOUs with county social services agencies to coordinate IHSS and they may request changes in IHSS services for beneficiaries. IHSS is the only LTSS program that is responsible for the management of services in CMC, but is unable to control the assessment or provision of services.

¹⁶ CDSS: In-Home Supportive Services (IHSS) Program: Share-of-Cost. Retrieved from http://www.cdss.ca.gov/agedblinddisabled/res/FactSheets/IHSS_Share_of_Cost_Color.pdf.

¹⁷ Barnes, C., Logsdon, V., Sutherland, S., & Gonzales, E. (2006). Provider Handbook: The In-Home Supportive Services (IHSS) Program. Retrieved from <http://www.cdss.ca.gov/agedblinddisabled/res/pdf/ProviderHandbook.pdf>.

¹⁸ For more on a timeline of changes to IHSS (starting pg. 43): CDSS (2015) Local Assistance 2015-16 Governor's Budget: Reference Documents. Retrieved from <http://www.cdss.ca.gov/cdssweb/entres/localassistanceest/Jan15/ReferenceDocuments.pdf>.

¹⁹ California In-Home Supportive Services Authority (IHSS Statewide Authority). Retrieved from <http://www.ihsstatewideauthority.ca.gov>.

RESULTS: IHSS RESPONSE TO CMC

KIs provided insights about IHSS' responses to CMC, particularly: 1) the value of CMC for the IHSS program, social workers, and care workers; 2) their preparation and readiness for the CMC transition; 3) their implementation efforts since the transition; and 4) the challenges of CMC for the IHSS program, social workers, and care workers.

The Value of CMC for IHSS

CMC inspired better collaboration and communication between IHSS and plans: Several KIs claimed that communication and collaboration between IHSS and plans have improved due to the CMC demonstration. A CMC plan KI described how hard it was, prior to CMC, to reach IHSS social workers as they had high caseloads and were often in the field. One KI noted that it was not uncommon for plans to "have no idea who the IHSS representatives were" at the beginning of the CMC stakeholder process. Though the level of communication and collaboration differed across counties, a majority of KIs reported improvements in this area. IHSS KIs often noted county collaboratives, stakeholder workgroups, and participation in CMC plan advisory committees as important facilitators of communication and collaboration across health system stakeholders.

The SCAN Foundation regional networks are getting people together to talk. These efforts have been very timely and helpful in facilitating these conversations.

Several additional strategies for improving communication between IHSS and CMC plans were described by KIs. One CMC plan KI discussed a pilot to strengthen the IHSS-plan relationship, help clarify the role of IHSS and the plan, and to improve the ability of the plan to receive information about their beneficiaries from IHSS workers. To further facilitate collaborations, several CMC plans and IHSS agencies have established liaisons that work with the other entity to ensure better communication. For example, one CMC plan KI reported having an internal IHSS liaison who was dedicated to collaborating with IHSS and PPGs to manage the care of IHSS beneficiaries. Another IHSS KI noted that being in a COHS allowed them to better integrate and coordinate care.

The health plan made space for our [IHSS] staff. They have meetings with nurses, physicians, health plan staff and they meet once a week with health plan to identify potential beneficiaries that are high-risk, high-utilizers.

CMC could be beneficial to the IHSS workforce: One IHSS KI believed that CMC was going to be "beneficial for a lot of people, including the IHSS workforce." They saw the ability of IHSS workers to participate on their beneficiary's ICT as an important workforce development. They also believed that care coordination and better medical care could help IHSS workers care for beneficiaries with complex medical needs in the home. One KI claimed that the biggest value of CMC for IHSS workers was the potential for plan incentives that would ensure that the number of IHSS hours authorized would be better aligned with the needs of IHSS beneficiaries.

The promise with IHSS was that, being part of Cal MediConnect, there would be an opportunity for a closer alignment of need with hours. If people needed more hours, it would be in everyone's best interest to provide that since the plan bears all the risk and wants to avoid higher levels of care and cost.

RESULTS: IHSS RESPONSE TO CMC

Several CMC plan KIs described how they had advocated for increased IHSS hours for beneficiaries who need them. Though CMC plans could not authorize hours themselves, they were able to request a reassessment with IHSS social workers. Additionally, some CMC plans opted to pay for additional IHSS hours beyond what is authorized in order to prevent more costly utilization of care.

IHSS Preparation for CMC

As IHSS benefits and autonomy remained largely intact through CMC, IHSS KIs reported less need than other LTSS health system stakeholders to prepare for the transition to CMC.

History of IHSS relationships with plans facilitated CMC transition: CMC plans that had worked closely with IHSS and with their unions prior to CMC often reported having stronger relationships. Collaborations with IHSS varied by region as some regions have less exposure to managed care or MLTSS. IHSS providers with a history of collaborating with managed care organizations reported having a more seamless transition to CMC. One KI reported that COHS CMC plans have stronger relationships with county-run programs, like IHSS. KIs also reported that IHSS agencies varied in their capacity to work within managed care settings.

IHSS was engaged in the CMC legislative process: IHSSs KI reported being involved throughout the drafting of legislation for CCI along with various other stakeholders. IHSS KIs reported that they commented on issues important to their beneficiaries, social workers, and care workers. One IHSS KI reported that these efforts enhanced their relationship with other CCI stakeholders and helped them learn about other stakeholders' priorities.

IHSS CMC Implementation Efforts

CMC education and outreach to IHSS were helpful: An IHSS KI reported that informational sessions about CMC were held for IHSS workers and beneficiaries, often in partnership with DHCS or plans. One IHSS KI described their efforts to work with DHCS to host tele-town halls with IHSS workers and beneficiaries. They made thousands of calls and played a recording announcing the event. IHSS workers and beneficiaries were then called back at the appointed time and could decide whether or not they wanted to join the call. The tele-town halls gave IHSS workers and beneficiaries an opportunity to learn more about CMC and ask questions. One KI noted that the tone was positive on the calls and it was an effective way to provide factual information and dispel myths about CMC.

IHSS recipients were more likely to opt-out of CMC: KIs noted many reasons for the high opt-out rate of IHSS beneficiaries. Some KIs believed that IHSS beneficiaries had been encouraged to opt-out through their strong advocacy network and organization. Misinformation also seemed to play a role in the high number of opt-outs among IHSS beneficiaries, with many KIs noting a pervasive rumor that CMC plans would automatically cut IHSS hours of beneficiaries who enrolled. However, one KI believed that some IHSS workers and beneficiaries had a poor opinion about managed care prior to CMC, explaining their tendency to opt-out.

There's a fierce loyalty to the IHSS program and everything it represents, and the decades and decades of development. There was just an overwhelming fear that managed care was going to take away the rights of individuals to manage their own care.

RESULTS: IHSS RESPONSE TO CMC

Some KIs pointed to the unique features and needs of this population that may have encouraged IHSS beneficiaries to opt-out of CMC. Because many IHSS workers are family members, several KIs noted a hesitancy and fear of any disruption to the services and supports that they themselves had been able to “cobble together.”

Many frail elderly rely on their family members to help make decisions. Many of these family caregivers are IHSS providers and they fear changes in their income as IHSS workers under CMC and changes to their loved ones’ doctors and prescriptions. People who opt-out do not have the confidence that their doctors and prescriptions will remain the same, and they are afraid of the unknown.

One KI speculated that IHSS beneficiaries could also be more involved in their own care, and therefore less enticed by the appeal of CMC care coordination benefits. Some CMC plan KIs reported efforts to overcome IHSS worker and beneficiary skepticism of CMC, as IHSS workers could be a valuable resource for the plan.

We would love to convince people that there won’t be any oversight so that they can be confident they won’t lose hours. We think that we could expand their scope and pay them more. It’s incredible to think that you have someone in the home who has training and could be [the plan’s] medical eyes and ears. It really is kind of a leap of faith [for IHSS workers to believe] that as the government [and the CMC plan] looks at you more, they’re not going to take something away.

The Challenges of CMC for IHSS

Concerns from consumer advocates were raised throughout the creation and implementation of CMC, including that CMC could impact: 1) the authorization of IHSS hours, 2) the consumer-directed nature of IHSS, and 3) the relationship between an IHSS beneficiary and their care worker (see [Interdisciplinary Care Team](#) section).

More outreach to IHSS workers about CMC was needed: Some KIs believed that IHSS workers could have benefited from more and earlier outreach from CMC plans. Though there was some effort to create relationships between the plans, DHCS, and IHSS administrators, they did not believe this trickled down to IHSS social workers, care workers, or beneficiaries.

Everyone felt that relationships were being put in place between IHSS and the plans, but it was really surprising to see data on the number of IHSS beneficiaries that were opting out and dis-enrolling. Leadership might have facilitated and built those relationships, but it was clear that it did not translate down to IHSS workers or social workers.

Barriers remained to increasing IHSS hours: One KI reported that in early CMC discussions, there was some interest in developing a way for plans to pay existing IHSS workers to provide additional hours, but efforts stalled. Consequently, if plans wanted to expand home care hours beyond those authorized by IHSS, they must identify and pay an external care worker to provide those hours rather than the existing IHSS worker(s). One KI noted that efforts on this issue continue through proposed state legislation.

CBAS RESPONSE TO CMC

CBAS centers (California's Adult Day Health Centers [ADHCs]) are licensed community-based day health programs that provide services to older persons and adults with chronic medical, cognitive, or mental health conditions and/or disabilities who are at risk of needing institutional care. Each CBAS program is multidisciplinary, person-centered, and involves families and/or caregivers as well as beneficiaries. The programs may provide: professional nursing; caregiver support; art, physical, occupational and speech therapies; mental health services; therapeutic and social activities; social services; crisis intervention; case management; advocacy; personal care; meals and nutritional counseling; and transportation.

In California, the CBAS program is administered by DHCS, but the California Department of Public Health (CDPH) licenses the CBAS centers and the California Department of Aging (CDA) certifies them for participation in Medi-Cal.

California's ADHC program was an optional Medi-Cal State Plan benefit until April 1, 2012, when it transitioned to an MMC benefit under California's Bridge to Reform 1115 Medicaid Demonstration Waiver.²⁰ Consequently, CBAS entered CMC having already transitioned to a managed care model, with some of the program's requirements being met by, or in collaboration with, MMC plans (e.g., person-centered planning, informing beneficiaries of service options, coordination of care). In CMC, plans work with CBAS centers to help beneficiaries access CBAS services.

CBAS services remained the same as those provided through ADHCs, but eligibility for CBAS was restricted to beneficiaries enrolled in a MMC plan or county-organized health system. CBAS is also available for a small number of Medi-Cal FFS beneficiaries who are exempt from MMC.²¹ Compared to IHSS and MSSP, CBAS stakeholders and beneficiaries had a smoother transition to CMC.

KIs provided insights about CBAS' responses to CMC, particularly: 1) the value of CMC for the CBAS program; 2) their preparation and readiness for the CMC transition; 3) their implementation efforts since the transition; and 4) the challenges of CMC for the CBAS program.

The Value of CMC for CBAS

Because CBAS entered CMC having already transitioned to a program service authorized by managed care plans, they had the benefit of experience, but this also made it difficult for them to differentiate CMC from CCI or MMC.

I couldn't tell you how CCI and CMC are different. They're all smushed together. It's hard to pinpoint what changes were due to what.

²⁰ California Department of Health Care Services and California Department of Aging (2015) DRAFT Home and Community-Based Settings Transition Plan. Retrieved from https://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/HCB_Settings_Stakeholder_Activities/Key_Documents/Docs/2015_0519_CBAS_Draft_HCB_Settings_Transition_Plan_With_Attachments.pdf.

²¹ California Department of Aging: Community-Based Adult Services (CBAS) Program Information. Retrieved from http://www.aging.ca.gov/programsproviders/adhc-cbas/Program_Overview.aspx.

RESULTS: CBAS RESPONSE TO CMC

Some CBAS KIs were able to point to specific CMC value, such as: stronger collaborations across health system stakeholders, better alignment, and potential for shared savings.

CMC spurred greater collaborations: One CBAS KI noted that CMC is “fantastic from a systems point of view.” They were part of SCAN CA LTSS collaborative, which they reported being effective in promoting communication across agencies and identifying problems.

This has been a really positive outcome of CCI and CMC, maybe more so with CCI. CMS's Medicare side of the demonstration has been involved more than they ever have been before, better than I've seen after 30 years in the field.

Enrollment of beneficiaries in CMC could benefit CBAS centers: A CBAS KI noted that, although they were not counseling their clients about whether to join the program, they did recognize the advantage if their clients enrolled in CMC. One CBAS KI reported that CMC better aligned plan's financial incentives with theirs.

The plans with CMC are 100% at risk for everything from the Medicare benefit, hospitalizations, physicians, and emergency department visits, all the way through the Medicaid benefits, which include CBAS, IHSS, and MSSP. To the extent that the centers are a preventive service, and are helping the plans avoid costs and unnecessary utilization, those savings accrue back to the plan and maybe they will reward CBAS centers for helping them avoid costs and support their members.

The CBAS KI said that although they did not yet have risk sharing or shared savings arrangements with CMC plans, they were exploring this with some of their plan partners throughout the state.

Savings could filter down, but it is not required. Some of the plans see the value of supporting CBAS. Some are thinking ahead, and can justify paying a differential rate to the centers because we are all in the same risk pool. When the individual is only in Medicare FFS, all of the savings that the centers can generate are going to Medicare, not to the plans. So CMS benefits from what CBAS does, not the plans. With CMC, it is to the center's financial advantage to have those savings go to the plans because they can discuss shared savings with the plans in a way that they can't with CMS.

The CBAS KI noted that not all of their centers were clear about this opportunity yet. They were teaching their centers more about how managed care works and how capitation works. They were planning a 2-day intensive managed care academy. “It's all part of the process of learning how to work in a new environment, it's challenging, but also presents opportunities.” Another CBAS KI described opportunities that they were pursuing with a CMC plan to provide additional services to CMC beneficiaries for a fee, such as “home assessments, support group/interventions, diabetes education, diabetes testing, nutrition, gait training, and exercise classes.”

CBAS Preparation for CMC

CBAS shared potential CMC challenges with DHCS prior to implementation: One CBAS KI claimed that because they entered the managed care environment prior to CMC, there really haven't been

RESULTS: CBAS RESPONSE TO CMC

any changes in CBAS provision with CMC to prepare for. In fact, they reported that, because of their experience, they were actually able to help DHCS and plans understand some potential challenges with CMC.

CBAS sought trusted sources of information about CMC: Sources of information about CMC by various CBAS KIs included the Center for Health Care Rights and the CDA (in the form of in-person trainings). One CBAS KI claimed that they tried to educate themselves about CMC to help their beneficiaries, but they *"had to work on the fly with so many moving parts."*

CBAS CMC Implementation Efforts

CBAS involved in the development of CMC quality measurements: A CBAS KI reported that they were planning a workgroup conversation with the state health and aging departments, plans, and providers around quality measurements. There is a CBAS quality evaluation workgroup that has hosted CDA staff and discussed measures with DHCS staff. The KI noted that the goal of these conversations is *"to align what outcomes CBAS can impact that the plans need to pay attention to."*

CBAS beneficiary enrollment in CMC was low: One CBAS center with a majority of clients who were Russian speaking reported that they did not have a single client that was in CMC; they all opted out. One CBAS center reported establishing contracts with four CMC plans, though none of their existing clients became CMC beneficiaries. One CBAS KI speculated that CBAS beneficiaries' high opt-out rates may have been a byproduct of the challenges that the program and CBAS beneficiaries faced in 2011/2012.

Beneficiaries in CBAS went through a difficult transition in 2011/2012. The benefit was eliminated; centers were preparing to close down. Then there was the settlement. There were all the other transitions with strangers coming into the centers conducting face-to-face interviews. It was a traumatic experience for these older adults and their families to go through that tremendous upheaval. People who lived through that experience are very skeptical of the state automatically enrolling them into a huge change with a lot of uncertainty and unanswered questions.

This KI believed that to improve enrollment in CMC, it would take time and peer-to-peer communication about the benefits of the program.

CMC could increase referrals to CBAS: Some CMC plan KIs reported that they were surprised at the low utilization rate of CBAS among their beneficiaries. They noted that this could be an area where they expand referrals in the future. One CBAS KI noted that, *"It's funny how few health care providers, doctors and health plans know about CBAS."* A CBAS KIs hoped that CMC could shift health system thinking toward understanding the valuable role that CBAS centers could play in improving quality, expanding access, and controlling costs.

There should be more incentives in CMC to refer to CBAS. In any big systems change it is a challenge to change thought processes and referral patterns. It may be a lack of understanding of CBAS, maybe they think it is day care and don't understand the medical component?

The Challenges of CMC for CBAS

CBAS beneficiaries were confused about CMC: One CBAS KI reported that, due to fear and misinformation, 40% of their clients dropped out of their center thinking that the center was part of CMC. The California Department of Aging gave two in-person presentations to their clients assuring them that they could still receive CBAS services. Some returned to the center after they were assigned to an MMC plan.

Data sharing with CMC plans was limited: CBAS KIs noted that they were sharing many types of beneficiary data with CMC plans, including: CBAS eligibility assessment data and data about admissions, discharges, and incidents involving Adult Protective Services (APS).

We know their members better than they do since we see them more often. We know their families, their vital signs, diet, bowel habits, everything.

Because CMC plans paid for CBAS services, KIs noted that they had a right to look at CBAS data. However, CBAS KIs reported that they didn't have the same access to CMC plan data, which would be beneficial to them. Some CBAS KIs noted that they could benefit from access to health plan data on outcomes related to their services, such as HRA data. One noted that having access to service utilization data would allow them to measure utilization rates pre- and post-CBAS usage.

CBAS struggled with CMC billing, claims, and authorizations: A CBAS association KI reported that 36% of CBAS centers surveyed said there was a significant change in their billing and claims processes, and about 25% said there was a significant change in the authorization process. One KI noted how some plans were easier to work with than others. *"I dread working with [plan]—there's a lot of turnover and it's impossible to get through."* This KI noted that other CMC plans were easier, especially if they had a specific contact within the plan.

CBAS centers were unable to establish contracts for expanded services with CMC plans: One CBAS KI reported that they had hoped to expand additional services to CMC beneficiaries that would be paid for by the plan. They hoped they could be an additional resource for the plan's beneficiaries. Some of the additional services they proposed to the CMC plan included: home assessments, support group/interventions, diabetes education, diabetes testing, nutrition, gait training, and exercise classes. They also noted that they would be a great resource for plans to improve communication with beneficiaries. The CMC plan has so far not contracted with them for these services.

We're only 5-10 miles away from them; we could work more closely with them. There's been no interest from the CMC plan. We could be an additional resource to them but we're not seen that way.

MSSP RESPONSE TO CMC

The Multipurpose Senior Services Program is a state program that offers care management (both social and medical) for adults over 65 on Medi-Cal. The program is administered by the California Department of Aging, with 41 local agencies statewide under contract to provide social and health care management for frail elderly clients who wish to remain in the community. The goal of the MSSP is to arrange for and monitor the use of community services to prevent or delay premature institutional placement of these frail clients. Clients eligible for the program must be 65 years of age or older, live within an MSSP site service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, be currently eligible for Medi-Cal, and be certified or certifiable for placement in a nursing facility. Services provided by MSSP include: adult day care/support center, housing assistance, personal care assistance, protective supervision, care management, respite, transportation, meal services, social services, and communication services.²²

Originally, under the CCI program, MSSP would continue to operate as a waiver program in CCI counties for a period of 19 months following the implementation of CMC. At the end of the 19-month period, which varies by county, MSSP would transition from a waiver benefit to a Medi-Cal managed care benefit. As part of this transition, the MSSP payment structure for CCI participating plans will change from a carved-out FFS payment to a managed care capitated payment, whereby CCI participating plans that serve MSSP waiver participants will be capitated and responsible for payment to MSSP sites and will be fully at-risk for the cost of MSSP services provided to their members. During the transition period, plans participating in CCI are required to reimburse MSSP provider(s) operating in the CMC counties.²³ However, when the CMC demonstration began, plans were unfamiliar with MSSP and the population they served and in 2015, Budget Trailer Bill Language provided an extension until the end of 2017 before CMC plans assume full responsibility for MSSP.²⁴

KIs provided insights about MSSP's response to CMC, particularly: 1) the value of CMC for MSSP; 2) their preparation and readiness for the CMC transition; 3) their implementation efforts since the transition; and 4) the challenges of CMC for MSSP.

The Value of CMC for MSSP

CMC enabled better collaborations with MSSP: An MSSP KI reported that because of CMC, they were able to form new relationships with health plans that they didn't have previously. They reported that the awareness among CMC plans about the MSSP program and population had expanded due to their collaborations.

²² DHCS: Multipurpose Senior Services Program (MSSP). Retrieved from <http://www.dhcs.ca.gov/services/ltc/Pages/MSSP.aspx>.

²³ DHCS (2015). All Plan Letter 15-002 dated January 22, 2015 to all Medi-Cal Managed Care Health Plans and Medicare-Medicaid Plans Operating in Coordinated Care Initiative Counties. Retrieved from <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPsandPolicyLetters/APL2015/APL15-002.pdf>.

²⁴ Gorn, D. (2015). State Responds to Concerns, Resets Timeline for Senior Program Transition. Retrieved from <http://californiahealthline.org/news/state-responds-to-concerns-resets-timeline-for-senior-program-transition/>.

MSSP Preparation for CMC

MSSP sought trusted sources of information about CMC: MSSP KIs cited several trusted sources of information that helped them prepare for and implement CMC, including: their MSSP Association, Justice in Aging, HICAP, and the LTC Ombudsman. They also noted the value of participating in inter-organizational collaborations and working with providers and advocates.

MSSP CMC Implementation Efforts

MSSP provided training to CMC plans: MSSP KIs reported providing significant amounts of training to CMC plans about MSSP and available resources in the community for their beneficiaries.

They're learning from the sites about opportunities and all kinds of other resources available at the community level, that isn't directly funded by Medicaid. They're learning about Older Americans Act, they're learning about independent living centers, they're learning about the triple A's, all of these other local resources available to the beneficiaries and their plans.

MSSP beneficiary enrollment was low: Some MSSP KIs said that there was a great deal of confusion among their clients during the CMC implementation. For example, some of their clients were not assigned to a CMC plan, some did not know if they were assigned to one or not, and they could not find out why the clients were not enrolled.

The population served by MSSP tended to be more medically fragile and needed more assistance with enrollment. Limited literacy was prevalent in the MSSP client population, and there tended to be a need for more individual counseling as well as materials written at a lower literacy level.

[CMC] materials were not understandable; the literacy level was too high. This reform really required a person-to-person presentation, which we didn't have the resources to provide.

One MSSP KI reported that nearly all of their beneficiaries opted out of CMC because they wanted to keep their current doctors.

Almost everyone we serve dis-enrolled or opted out of CMC. Out of 371 clients, 21 are in CMC. We didn't encourage them to opt-out.

Physicians were the major factor in opting out. MSSP clients are usually nursing-home certifiable and have complex medical conditions, and they are very concerned with keeping their PCP and specialists. Many of these doctors would do home visits and they didn't want to lose that relationship. Plus, they didn't want to lose doctors that spoke their language.

The Challenges of CMC for MSSP

CMC may have excluded MSSP in the planning process: One MSSP KI reported that MSSP should have been more involved in CMC planning.

MSSP is an existing, long-standing program, but the state gave all the power to the health plans. MSSP wasn't a partner at the table. We were treated and viewed as vendors, which makes it difficult to transition MSSP into CMC successfully.

RESULTS: MSSP RESPONSE TO CMC

MSSP lacked information about CMC: One MSSP KI reported that, while they did participate in the stakeholder process and engaged with many health plans, they had a lot of unanswered questions during implementation. Another MSSP KI reported that preparing for CMC was difficult because the timelines kept changing.

We had a different notion of when the roll-out would happen and we had different phases of training and education due to shifting timelines. There were vague reporting requirements and timeframes from the state. We knew we had to be flexible with all the unknowns.

CMC plans lacked knowledge about MSSP and their beneficiaries: MSSP KIs reported that most plans seem to understand IHSS and CBAS, but not MSSP. They reported that CMC plans were unaware of MSSP services and eligibility requirements and unprepared to serve CMC beneficiaries.

Health plans just don't understand this population. They understand nursing homes, but not people who are frail and eligible for nursing homes but able to live in the community. This is a niche population and their system isn't set up to serve them.

One MSSP KI reported that the CMC plan's lack of knowledge about MSSP led to limited or inappropriate referrals.

We've gone to great lengths on explaining what [MSSP] is to health plans. We occasionally get referrals from health plans for people who aren't even eligible for MSSP.

However, one CMC plan KI reported that their referrals were denied because MSSP disagreed with their assessment of eligibility. An MSSP KI reported that CMC plan training was still needed about the role of MSSP and how it differs from, rather than duplicates, that of the plan's care coordinators.

MSSP found contracting with CMC plans difficult: Among MSSP KIs, there was the sense that CMC increased their financial and administrative burden. One MSSP program reported that the contracts process with CMC plans and PPGs was challenging. MSSP agencies needed more time to engage in the negotiation process. Even with only 21 of their clients enrolled in CMC, one MSSP established contracts with 5 CMC plans, which required a lot of time, energy, and attorney fees.

[Contracting was] fast and furious with tight deadlines and expectations from payers that we could approve contracts within days. There was a presumption by the provider networks that we'll just sign the contracts and there's no room to negotiate. It's taken a lot of attorney time for our organization to make sure we have the correct risk language and services.

HEALTH SYSTEM RESPONSE: CARE COORDINATION

Care Coordination Workforce: Title, Qualifications, and Credentials

Care coordinator titles: Terms for the workforce conducting care coordination were often used interchangeably and inconsistently across and sometimes even within CMC plans. Terms included: care coordinator, care manager, case manager, care navigator, personal care coordinator, and community connector. For the purposes of this report, we utilized the term “care coordinator” to refer to any employee or delegated subcontractor of the duals demonstration health plan who coordinates the care of beneficiaries, conducts HRAs, develops person-centered care plans, convenes ICTs, and ensures that beneficiaries receive necessary services.

Care coordinator credentials and training: CMC plan KIs reported that most of their care coordinators were nurses or social workers. CMC plan KIs mentioned that, prior to CMC, nurse care coordinators often didn't recognize the value of social work care coordinators, treating them as a lower level of skill and delegating menial tasks to them. Some plan KIs noted that CMC forced a culture change within care coordination departments with social worker skills being more in demand and recognized as providing significant value for the coordination of non-medical care for LTSS beneficiaries. CMC plan KIs reported seeing nurse care coordinators and social work care coordinators working more closely together, acknowledging the skills that both disciplines bring to the task.

I've seen cases where a nurse might not think that CBAS or something of that nature is needed, but the care coordinators from the MLTSS are present and they address these issues in a very smooth and therefore apparently effortlessly, old-fashioned way.

One CMC plan KI called this shift “*the evolution of the nurse,*” but noted that this culture shift also went in the other direction, with some social worker care coordinators becoming more proficient in recognizing medical needs.

The evolution of the social worker for us is that the traditional social worker is usually field-based and so focused on the psychosocial issues, yet sometimes forgets about the physical health issues. [Since CMC], they have really stepped up to learn about the physical health conditions and see the interactions between it all. We really moved from looking at parts of the person to the whole person, to put it distinctly.

CMC plan KIs reported a need to enhance the training of their care coordinators in several areas as a result of CMC. One CMC plan KI described their efforts to train their care coordinators in person-centered care.

I guess the way that we approached it in a nutshell is we're trying to do as much training as we can to make sure that our case managers and provider groups' case managers are sensitive to what person-centered care means from the patient or the member's perspective as opposed to from our perspective.

RESULTS: HEALTH SYSTEM RESPONSE: CARE COORDINATION

Several KIs reported a need to provide training on care coordination for particularly challenging and high-risk populations, such as people with SMI or cognitive impairment. Several KIs mentioned a collaboration between Alzheimer's organizations and CMC plans, called The CMC Dementia Project. The project aimed to train CMC care coordinators in dementia-capable care coordination and offered education classes, support groups, respite, and other services to beneficiaries with dementia and their caregivers.²⁵ Additionally, to meet the requirement in California's 3-way contract to provide a "dementia care specialist" care coordinator, several CMC plans contracted with Alzheimer's organizations to provide training for these specially designated staff.

We also collaborated with Alzheimer's organizations to train our case managers to better connect with members and caregivers dealing with dementia and Alzheimer's disease as well as to leverage resources available to caregivers through the organization and its partners.

Non-clinical care coordinators: Some CMC plan KIs reported utilizing non-clinical care coordinators to provide services for lower risk beneficiaries, or provide services that didn't require clinical skills. These coordinators were often referred to by a different name, such as "community connector," "care navigator," or "personal care coordinator."

I think the biggest innovative practice is our community connectors program. These are non-clinical staff who are trained just to help be supplements to our care management staff, to help find members, to help them access services, go visit them in their home, be a face-to-face connection for the health plan.

We supplement the work that's going on with our clinicians with personal care coordinators, who are non-clinical staff who assist. It's a team of individuals that work together on an established caseload. It's usually one nurse to 2-3 personal care coordinators.

Non-clinical coordinators were also used to facilitate access to difficult-to-reach and diverse populations. In this case, the non-clinical care coordinators were often bilingual and sometimes worked in satellite offices, closer to more rural CMC beneficiaries.

If a member is discharged from the hospital, the community connector can make sure that they understood their discharge instructions, make sure they pick up their prescriptions, take them sometimes to their appointments, or accompany them if there is a language issue. The community connectors are typically paired with members of the same language so there's no misinterpretation, or misunderstanding, or confusion of some of the doctor's instructions, or vice versa, what the members are trying to convey to the doctor.

Beneficiary Assignment to Care Coordinators

CMC plan KIs discussed a variety of ways that they and their PPGs assigned care coordinators to their beneficiaries, with the recognition that although beneficial for care coordinators to develop a

²⁵ Hollister, B., & Chapman, S. (2015). *Dementia Care Coordination Workforce and Practices in Seven Duals Demonstration States*. Retrieved from http://healthworkforce.ucsf.edu/sites/healthworkforce.ucsf.edu/files/Research_Brief-Dementia_Care_Coordination_Workforce_and_Practices_Seven_Duals_Demonstration_States.pdf.

RESULTS: HEALTH SYSTEM RESPONSE: CARE COORDINATION

one-on-one relationship with beneficiaries, this was not always feasible. CMC plans sometimes assigned care coordinators based on existing relationships (e.g., IHSS beneficiaries will continue to receive care coordination from their IHSS care coordinator).

We contracted with CBAS facilities and MSSP providers to have them complete health risk assessments to maximize the time they have directly interfacing with our members.

Some CMC plans assigned care coordinators to beneficiaries based on the care coordinator's workload, so that they would have beneficiaries with a variety of risk levels and needs. Other plans assigned care coordination caseload based on risk level, with lower caseloads for care coordinators who serve high risk/high needs beneficiaries. Another CMC plan KI described assigning care coordinators to beneficiaries based on their area of expertise regarding the beneficiary's needs (LTSS) or particular disease (breast cancer survivor providing care coordination to beneficiaries with cancer). Some CMC plans assigned beneficiaries to care coordinators using a rotating cycle or by alphabet. Some CMC plan KIs reported that their care coordinators served both beneficiaries in CMC and those in other products within their plan, which may be particularly valuable when beneficiaries transition in and out of Medi-Cal eligibility.

Other CMC plan KIs reported developing teams of care coordinators and case managers. CMC plan KIs also reported using a team-based approach to ensure that specialized care coordinators could consult with care teams to serve a larger number of beneficiaries (e.g., behavioral health or pharmacy care coordinators). When utilizing a team approach to care coordination, KIs reported the need to select a primary care coordinator who was basically the point person to engage with the beneficiary and the rest of the team. This model also helped to facilitate care coordination across sites.

[The case manager's] role is to make sure we are sharing information. It would be the same thing, for example, in the world of aging and adult services. If someone was connected to MSSP and had a dedicated social worker, that person is the primary case manager for that particular member. Our staff may know certain other pieces of information to funnel through that case manager who can then use that to make appropriate decisions.

Many CMC plan KIs reported having internal care coordination programs or departments targeting particular populations. A common example of this was their efforts to hire care coordinators with specialties in behavioral health or substance use disorders. One CMC plan KI described a complex care management department that served high-risk beneficiaries with multiple medical conditions or LTSS care management programs specifically for beneficiaries receiving LTSS. A couple of CMC plan KIs described care coordinators who specialized in coordinating the care of beneficiaries in hospitals or LTC facilities; who helped beneficiaries transition back to the community or a lower level of care (see [Health System Response: Cost](#) section).

HRAs and Other Assessments

CMC plan KIs reported that the health risk assessments were their first opportunity to learn more about their beneficiaries than they could from utilization data.

RESULTS: HEALTH SYSTEM RESPONSE: CARE COORDINATION

What we've seen in the data is that, an overwhelming majority of the time, it's not until you conduct the health risk assessment that you fully understand the social service and other non-medical, non-behavioral health needs of the members that are so important for us to be able to identify unmet LTSS and home and community-based service linkages.

Each plan's HRA must include certain requirements set by DHCS and CMS, but the plans had some flexibility. For example, HRAs are required to include questions about cognitive impairment, but plans could choose what those questions could be. DHCS reviewed HRAs and approved them prior to CMC implementation.

Beyond the HRA, CMC plans could also utilize additional assessments. For example, if a beneficiary was determined to have a cognitive impairment based upon the HRA, this could prompt the CMC plan to schedule an additional assessment to assist with coordinating the care of that beneficiary. CMC plan KIs described their triggers for these additional assessments, which were plan specific, but could include: discharge assessments, fall risk assessments, mental health assessments, LTC transition assessments, dementia assessments, caregiver assessments, etc.

What happens is that the health risk assessment is the initial indicator of risk, but then when the case managers connect with the member, on the behavioral health side for example, there is another tool that gets layered on to the health risk assessment for them to really dig deeper on the behavioral health side.

Some CMC plan KIs also described how they supplemented their own assessments with assessments conducted by PPGs, IHSS, MSSP, or CBAS.

Beneficiary risk assignment: CMC beneficiary risk was assessed in a variety of ways. First, utilization data from DHCS and CMS were used to assign risk level. Factors taken into consideration included: beneficiary utilization of CBAS, MSSP, or IHSS; specific beneficiary diagnoses; or beneficiary utilization of services. CMC plans were then required to reach out to all beneficiaries to conduct an HRA, targeting high-risk beneficiaries first. Based on information collected through the HRA, the member's risk category could be updated at the state level, which would help determine the blended capitated rate the CMC plan was paid for each beneficiary. In addition to the state's risk assignment, CMC plans could have their own internal risk assignment for beneficiaries. This wouldn't change reimbursement levels, but could impact the beneficiary's care plan and access to care coordination or other services.

We stratify using the criteria created by the state. These are evidence-based criteria. At the same time, we target vulnerable populations such as in-patient, homeless, LTSS, high utilizers and behavioral health members.

The final risk ends up being determined when we had the clinical review by the nurse or by the team. That's when we make our own determination on the risk level. It's really based on needs. If a member has a lot of conditions and they're truly connected to their specialist, they're seeing their primary care regularly, there are no issues on the medications, they have appropriate support, the need there is actually low. We actually deemed that as a low risk. However, if someone is very much disconnected, at risk for institutionalization or in an

RESULTS: HEALTH SYSTEM RESPONSE: CARE COORDINATION

institution, having a lot of acute care visits or episodes, we're going to deem that person as high risk and consider the various interventions available to us.

HRA completion procedures: CMC plan KIs sometimes reported that specially trained non-clinical staff members completed the HRA, but that the HRA data was later reviewed and analyzed by clinical care coordination staff. Some CMC plans contracted with outside agencies to expedite the completion of HRAs.

We hired a company that actually used multiple plans. They do the initial HRA outreach and their people are not licensed individuals, they're just going through the questions. Then our HRA comes back to the health plan and is reviewed by a nurse who goes through the HRA, reaches out to the member, and develops the Individualized Care Plan.

HRAs were mostly completed over the phone, but some plans or contracted entities conducted HRAs in beneficiaries' homes, in LTC facilities, hospitals, emergency rooms, or even in their provider's office. Beneficiaries in CMC plans that delegate care management functions to PPGs may be more likely to complete HRAs in their doctor's office with the PPG's care coordinator. One CMC plan KI described how in-home assessments could identify social factors influencing health (aka "social determinants"), especially for people living in poverty. In-home HRAs allowed CMC plans to assess living conditions, meet a beneficiary's caregiver, assess for safety, and factor those social determinants into their plan of care.

There's a lot that they can get over the phone, and have health interventions put into place immediately. Sometimes it is best to do a face-to-face after you've already stratified the population using your data, or just because you know from the diagnosis or the medical history of the beneficiary that you should do a second face-to-face assessment. Then, at that point, we also do the environmental assessment. You don't want to just assess the members' medical needs; you want to assess the whole person, taking into account their social needs, their caregiver support, and their environment. There are a lot of things that the plan can do to mitigate the next medical crisis just by showing up in the home.

CMC plan KIs also reported many barriers to completing in-home HRAs. For example, a good number of beneficiaries refused in-home assessments. Occasionally CMC plan KIs reported that in-home assessments could put their care coordinators at risk if they were required to enter unsafe neighborhoods or the homes of beneficiaries with an unstable mental illness or substance abuse problems.

While many CMC plans targeted in-home assessments to high-risk beneficiaries, one CMC plan KI described an intensive assessment process for all of their beneficiaries, which included an initial visit regardless of risk level. This home visit included both a medical assessment as well as the HRA.

Our first visit with our members, particularly dual members, could be two hours, because they're here now, let's get blood tests, let's get X-rays, let's get this person on the right track and get needed medication, medication changes. We are always validated by hearing things from our patients that they're receiving a level of care that they haven't received before.

RESULTS: HEALTH SYSTEM RESPONSE: CARE COORDINATION

Another CMC plan KI described a two-tiered assessment process: the first tier being the standard HRA conducted within 10 days of enrollment, and the second tier, which they attempted to complete within 45 days of enrollment.

That's our initial health assessment, and that's where we have contracted with doctors to go into the home and do a physical and basic lab pull, just to complete a full health assessment of the individual.

Although the KI reported that they attempt to do initial health assessments with all of their CMC beneficiaries, they admitted that it has been difficult to talk beneficiaries into setting up an appointment for an in-home visit by a doctor.

Assessing person-centered care goals: The process for a beneficiary to identify specific problems and related care goals and priorities was expected to be part of the HRA process. When asked how they ensured that care plans were person centered, one KI described how the care plans started out as "opportunities" that were identified through the HRA. *"Later, the ICPs are reviewed and augmented with the member."* One CMC plan KI believed that person-centered care started with the HRA. *"In the very beginning of the relationship if you can get that person to sit down and talk to you, it's a tool. It's like interviewing somebody with a checklist in front of you."* One KI described how their care coordinators were trained in motivational interviewing, to listen for the issues that were not being spoken, and to ensure that the goals that were included in the care plan were centered around the areas the beneficiary had agreed to address.

Based on the answers from the HRA, we create a care plan with specific items; we call them PGIs: Problems, Goals, and Interventions; which are generated based on those answers.

We always are guided by, and our first part of our conversation always starts out with, what do you know about your health situation and what is your biggest concern for your health?

We start that discussion at our earliest engagement with our patients, what's their care goals, we talk about advanced directives. If you start the conversation very early, when those situations come, you lay the path to continue the conversation. We start it very early.

Some people usually can tell you what they're concerned about, and we try to start there and see if we can't intervene in a way that makes them feel like we can be useful and helpful.

Some CMC plan KIs acknowledged that by contracting with a vendor to complete HRAs, they missed an opportunity to get to know their member. *"The vendor never sees the person. They never talk to them again. So it really is just a piece of paper, you know what I mean?"* In this situation, one CMC plan KI explained that, once they received the HRA, they called the beneficiary to review the HRA and then conduct any follow up assessments that were needed (see [Defining and Delivering Person-Centered Care](#) section). Other KIs reported concern that the roots of person-centered care may be lost if not elicited from the beneficiary during the HRA, documented thoroughly in the ICP, or upheld by the beneficiary's ICT.

RESULTS: HEALTH SYSTEM RESPONSE: CARE COORDINATION

Assessments with challenging populations: CMC plan KIs reported creative methods of obtaining information about beneficiaries with dementia or other challenging populations, including: asking LTC facility staff, asking caregivers, conducting an assessment at the home when other family or caregivers were present, or getting more information from the physician or their authorized representative.

For the patients that have dementia in a nursing home, our nurse practitioner is on site. They would do an assessment, but they would typically also engage with the clinical staff at the nursing home to obtain that information. If the person is living in the community and there's information about a family member, authorized representative, or durable power of attorney, we would reach out to that member through their appropriate representative. If we call a member and they have dementia and the staff person feels that this person is having difficulties completing the survey, we typically will end the call. If the person can't self-identify someone that we should follow up with, we typically will go back and follow up with the physician that they've been going to, to get more information from the physician.

Assessing informal caregivers: As noted by many KIs, informal or family caregivers could be a valuable resource for CMC plans, as long as the beneficiary consents to their involvement. Many KIs noted the challenges posed by the beneficiary consent requirements.

Health plans and the state have struggled figuring out the legal issues around talking with family caregivers on behalf of the member.

When asked if and how plans assessed or involved informal caregivers, one CMC plan KI reported that caregiver needs and capacities were indirectly assessed through functional assessment questions in the member's HRA. Another CMC plan KI reported that they asked caregivers about their activities as a caregiver, in order to assess what other support the caregiver needed.

We have caregivers come to the ICT. We ask them specific questions about how much time they are spending, do they have time to do other things. We ask them those questions. Then we make a determination as a team to say let's look at our CPO services, what can we offer them?

We definitely offer caregiver support and training. If there are medical needs that need to be attended to, the caregiver is going to have to do them, if the person is diabetic and needs to take insulin, those types of things. We also offer community resources for the caregiver.

Another CMC plan KI reported consulting with an Alzheimer's organization about tools that could help the plan make decisions regarding CPOs for caregivers, such as a caregiver strain instrument to monitor caregiver "burn out." A CBO KI reported that,

...[CMC plans] are starting to realize that they can't just pay attention to the member who needs LTSS, but must also pay attention to their support network, because if the family caregiver burns out or otherwise withdraws, then the whole thing falls apart.

RESULTS: HEALTH SYSTEM RESPONSE: CARE COORDINATION

One KI noted that CMC plans may have a financial incentive to allow the caregiver to do as much of the caretaking as possible.²⁶ However, this also poses a high risk for CMC plans, which would have to bear the cost of utilization or institutionalization that may result if a caregiver is unsupported. Additional CMC plan training to recognize caregiver strain and offer available services and support could improve beneficiary quality of life, avoid unnecessary utilization and institutionalization, and support caregivers.

Levels of Care Coordination

CMC plan KIs reported providing various levels of care coordination services based on a member's risk level or particular needs.

Low Risk: For a low-risk member, care coordination could be as simple as: completing an HRA over the phone or by mail; reviewing the HRA and developing a care plan; mailing the ICP to a beneficiary with a request to contact the plan if there are any discrepancies or concerns; and an "on-the-books" ICT consisting of the member, their primary care physician, and a care coordinator. The ICT may never meet or communicate over the phone and the provider and care coordinator may never actually see the ICP.

Moderate Risk: Care coordination for beneficiaries who were at a moderate risk level could include more in-depth assessments, more complex ICPs, more frequent contact with their care manager, and ICTs with additional members, such as specialty providers and care coordinators or IHSS workers.

High Risk: Higher risk beneficiaries' care coordination could be as extensive as: an in-person, in-home HRA followed by comprehensive assessments including in-depth conversations about individual goals of care; the creation of an ICP which was shared with the beneficiary, their caregiver, and all providers; the formation of an ICT attended monthly by all relevant providers, the plan's medical director, the member, their caregiver, and a team of care coordinators; referrals to specialists and LTSS services conducted and scheduled by the care coordinator; transportation to appointments; and identification and provision of available community based services and CPOs as needed.

Care Coordination Activities

As with HRAs, CMC plan KIs reported that other elements of care coordination were conducted in a variety of settings, including: over the phone, in the beneficiary's home, at the LTC facility, at the hospital, at the doctor's office, at the health plan, at CBAS centers, and even on the street corner.

Common care coordination tasks: When asked about the most common services CMC care coordinators performed, plan KIs responded: finding beneficiaries and completing HRAs, developing individualized care plans, facilitating access to care and services, sharing information

²⁶ Cohens, K. (2016). Voluntary Means Voluntary: Coordinating Medicaid HCBS with Family Assistance. Retrieved from <http://www.justiceinaging.org/voluntary-means-voluntary-coordinating-medicaid-hcbs-with-family-assistance-2/>.

RESULTS: HEALTH SYSTEM RESPONSE: CARE COORDINATION

between providers to better coordinate care, developing and monitoring care plan goals with beneficiaries and providers, and conducting inter-disciplinary care teams.

[Care coordinators provide] assistance with physician appointments or community resources like: food assistance, housing, mental health support, and health coaching.

Care coordinator trouble shooting may include: helping someone get their DMEs delivered, helping them if they've lost access to a service, and helping them complete paperwork. The state has issued a new policy to let the member have an enrollment assistant, which will be a huge help. Care coordinators help with transportation, making sure that someone is getting to an appointment, getting information from PCP or hospital.

Individualized Care Plans (ICPs)

At the most basic level, the ICP was created from the HRA and included the beneficiary's primary diagnoses, medications, current treatments, and personal goals. If the beneficiary is low risk, and there was no need for follow up or further assessment, one CMC plan KI reported mailing the ICP to the member, their provider(s), and their care coordinator(s). Another CMC plan KI noted that the ICP was sent to the beneficiary with instructions to contact the plan if they wished to review or revise their care plan.

Once we generate it, we mail it out to the member for them to review. Then after that, we'll give them a call to engage them and talk about the care plan, and refine it as needed.

One CMC plan KI clarified that nurses or physicians finalized the ICPs, depending on how complex the case was. Another CMC plan KI described a process where non-clinical care coordinators could create care plans for low-risk beneficiaries that were then reviewed and approved by clinical staff. Non-clinical care coordinators could then be tasked with carrying out or facilitating tasks that met the goals of the care plan.

The nurse could say to the care coordinator, "Here's one of the issues. We need to get this member signed up for a health education class. Can you please do the outreach and get that person signed up for a diabetes class," for example. Or, "I've talked to the person [and] they're really having trouble getting an appointment with the specialist that they're authorized to see, can you call and facilitate getting that appointment?"

Care plans could be updated after assessments, after ICT meetings, or as deemed necessary by the care coordinator, ICT member, or beneficiary.

Who controls the ICP? PPGs may control the ICPs and care coordination for low-risk beneficiaries, but if plans preferred to keep care coordination in-house for complex beneficiaries or beneficiaries with behavioral health issues, the plan care coordinator would usually control the ICP. In this case, CMC plan KIs reported having internal ICPs, but noted that PPGs or county behavioral health departments may also have ICPs for that beneficiary. The beneficiary and approved family caregiver(s) have control over ICPs to the extent that they participated in the HRA process, communicated wishes to their care coordinator or providers, and participated in ICTs.

Sharing ICPs: CMC plan KIs with effective data management systems reported being better able to share HRAs, ICPs, and clinical records with relevant parties. CMC plan KIs with less advanced data management systems reported sharing ICPs and other data by fax or mail. The beneficiary and approved family members received copies of the ICP in the mail. If the providers or ICT members were not HIPAA-covered entities, CMC plan KIs reported that they required them to get a release of information from the beneficiary or their representative to allow them to share the ICP or other beneficiary data.

Interdisciplinary Care Teams (ICTs)

ICTs included, at a minimum, the beneficiary, any beneficiary- approved caregiver, the PCP, and the care coordinator. The task of an ICT is to ensure that all relevant parties have an opportunity to share information, clarify care priorities, and troubleshoot issues impacting a beneficiary's health. While these ICTs may have existed on paper, CMC plan KIs reported that not all beneficiaries had active ICTs that participated in telephone or in-person case conferences. They argued that many CMC beneficiaries did not require this level of care coordination. Some CMC plan KIs reported that only about 10% of their CMC beneficiaries had active ICTs, though all beneficiaries who completed an HRA had one "on paper." One CMC plan KI reported that they conducted ICTs for 100% of their CMC beneficiaries, regardless of need. When asked what an ICT looked like for a low-risk beneficiary, the CMC plan KI responded:

It looks exactly the same as a high risk. We're presenting the medical history, we present all the UM data, we present anything that we found during home visit. We invite the member and their PCP to the meeting, and we discuss what their goals are going to be for their care plan. For an individual that is low risk, no utilization, no prescriptions, no chronic illnesses, they usually are going to have a care plan that is focused on prevention and wellness.

ICT participation: CMC plan KIs provided many anecdotes about how easily care could be coordinated if they had everyone at the table. One CMC plan KI described how difficult it was to convene an ICT for non-CMC beneficiaries since they don't have the information or participants that they need to fully coordinate the beneficiary's care. Even with the integration and alignment under CMC, many CMC plan KIs noted that ICTs were a challenge to schedule and convene.

It's hard to get doctors to make time to participate. The members generally don't want to participate. It's really a fine idea that everybody would come to a room and spend about an hour talking about the case, and everyone would have a chance to talk. The reality is, there are just too many people, and too much going on. You have to be smart and selective about who you do an extensive ICT for.

By participating in ICTs, one CMC plan KI noted that they could reduce an overwhelming list of ailments by contributing what their care goals were or what could help improve their quality of life at the ICT. One CMC plan KI described how some beneficiaries found it difficult to participate in these meetings with everyone talking about their health care and needs. It could also be a challenge with many people on the call. "It can be very intimidating and people get really nervous." Beneficiary

RESULTS: HEALTH SYSTEM RESPONSE: CARE COORDINATION

participation could also delay the ICT process, since it could take more time to solicit beneficiary engagement or to ensure that beneficiaries maintain trust in the other ICT members.

Informal caregivers are allowed to participate in ICTs with the member's approval. One plan described a caregiver engagement program that is being piloted by some of their more sophisticated PPGs.

[Caregivers are asked] to participate in the interdisciplinary care team process, report changes in condition to us so that we can better manage the patient.

Some CMC plan KIs reported having difficulty in getting providers to participate in ICTs. Plans with strong relationships with their PPGs may have found this easier. Some CMC plan KIs said that participation was part of their PPG's per member per month (PMPM) rate. To overcome physician aversion to participating in ICTs, one CMC plan KI described how they used community connectors to attend office visits with beneficiaries and used a cell phone to connect the physician with the nurse care coordinator at the plan.

Most CMC plan KIs described special efforts to integrate county behavioral health providers into ICTs. Another CMC plan KI described efforts to attend various ICT meetings held by county behavioral health clinics, since they share many cases.

We've been challenged to get county behavioral health representation at the meetings just due to staffing limitations.

Several CMC plan KIs also described various efforts to encourage the involvement of the IHSS worker in their care planning, especially through their participation in ICTs. According to the person-centered care requirements of CMC, plans are required to get the permission of the beneficiary before an IHSS worker can participate in an ICT or give information about the beneficiary to the plan. To facilitate IHSS participation, some CMC plan KIs described efforts to schedule ICTs during the IHSS workers' hours with their beneficiary.

I've heard that IHSS workers have been asked to participate in ICTs, but maybe it's during their hours while they're there with the member, so they are compensated in a way. I don't know that there's any consistency with that.

Another CMC plan KI reported an incentive program to encourage IHSS worker's participation:

We're encouraging [the IHSS workers'] involvement in the care management of their consumer. We're asking them to participate in the interdisciplinary care team process and report changes in condition to us so that we can better manage the patient, so that we're able to help them with what's needed, which may be very basic such as "my DME supplies didn't come in" to, "there's a change here." Short of making a 911 call, we're able to help them through either their provider or case manager at the provider level. The incentive for being involved with this and making those reports to us is an additional \$40 stipend a month. Their hours are not impacted so it's an incentive, for us to know how that member is

RESULTS: HEALTH SYSTEM RESPONSE: CARE COORDINATION

doing, connecting them with their provider as necessary, but also keeping that caregiver engaged as part of the team that helps coordinate care.

Consumer advocates often oppose this sort of approach, as it poses a risk that IHSS workers may circumvent the privacy or autonomy of beneficiaries or otherwise weaken the consumer- directed nature of the program.

Conducting ICTs: Many CMC plan KIs described the immense amount of preparatory work that goes into a well-run ICT.

[ICTs] could take an hour and a half, with many people on the phone. Sometimes, it's been difficult to get the technology to cooperate to make sure everyone can join the call. Other ICTs can take 5-10 minutes.

Another CMC plan KI noted that if they only had the physician's attention for 10 minutes, the care coordinators needed to do a lot of background work and preparation to make the best use of the ICT's time.

There is an art in the science to it, to be able to do the three to five minutes and decide what is relevant to be presented and what can be suppressed for the moment and so forth. [You need an] efficient process when a provider is going to be calling in so you're not bumbling around. It really makes the experience so much better and hopefully will encourage them to call in again.

One CMC plan KI described having both external and internal ICTs.

Our external meetings are with community service reps in many areas of health care, and our internal meetings are with the internal team to discuss and problem-solve. We are still learning how to do this and changing and adapting as we need to, to make these meetings highly productive.

Another CMC plan KI described how ad-hoc ICT meetings were sometimes needed to address challenges as they developed.

When there's a really hot case where there's a lot going on, or something just pops up on the radar screen and we find out about somebody through a phone call, or through the utilization department, we will call an ICT and we'll bring everybody to the table that we think is relevant and who can help solve the problems. Those are ad hoc, and they happen a lot here. Sometimes in a week you can have three or four ad hoc ICTs on an individual as the case starts to evolve. Sometimes you start with the people you can get ahold of, then you've got to try to get the 10 minutes of the physician's time to get on the phone with you. You just really try to roll with it.

Care Coordination Across Sites

The tendency for CMC plans to delegate care coordination (as well as provider services) varied by region, with southern California plans more likely to delegate all services. In all integrated health

RESULTS: HEALTH SYSTEM RESPONSE: CARE COORDINATION

systems, but especially those that were highly delegated, there was a risk of duplicating care coordination efforts. In delegated models, both the CMC plans and the PPGs could have their own assessment processes, care coordinators, ICPs, and ICTs. KIs described strategies to facilitate care coordination across sites and to prevent duplication.

Coordinating the coordinators: Many CMC plan KIs reported struggling with ensuring that they were not duplicating services within their own care coordination departments as well as across collaborating partners. One CBAS KI believed that there was confusion around who does care coordination. *“There are so many care coordinators, but no one is coordinating the coordinators.”* One CMC plan KI even noted that they had to reorganize internally within the plan to prevent duplication and confusion.

I'll give you an example of how it used to be prior to us reorganizing. You could have been called by our disease management team, by our care management team, by our health education team, and by our triage team. I got a handwritten note from a member to tell me about all the people they had talked to and I said, “we need to change this.” We've consolidated most of these things within care management. We had to do internal consolidation so that they weren't getting multiple people from the plan calling them. I haven't seen it be a big issue with people outside us, but it is a legitimate point.

CMC plan KIs noted several ways they were attempting to prevent the duplication of services, including: using electronic health records (EHRs) or data management systems to ensure access to medical records by all coordinating partners, identifying one primary care coordinator either at the plan or another partnering entity, identifying liaisons to partner with coordinating entities, or delegating roles among partnering coordinators.

To really provide the best care to the member, everyone needs to understand their role in care coordination, from the PCP, to the specialist, to any of the ancillary providers that might be engaged, to coordinators providing care management in the hospital setting.

I think what we are realizing, and what our ground level staff are definitely realizing is, we have all these case management services. They are really good at what they do and sometimes don't necessarily think outside of what they do. For the CBAS folks, sometimes they may miss coordination related to a specialist. Or if there was a hospitalization they may not know what is going on but we do. We're also that conduit for information and making sure they are aware of these things.

If care coordination was already being conducted well by a PPG, CMC plan KIs reported not wanting to duplicate their work or disrupt existing processes. Occasionally, CMC plans would still ask PPG care coordinators to collaborate with the plan's internal care coordinator.

[If a PPG has] processes already in place with integrated care teams, care assessments, in-home visits and all that. They're already doing it and they don't want to disrupt their existing processes with another complicated process.

RESULTS: HEALTH SYSTEM RESPONSE: CARE COORDINATION

Data sharing and IT systems can facilitate collaboration across sites: As care coordination and collaboration across the health system are vital components of CMC's model of care, data systems were noted by KIs as either a valuable resource or crucial flaw in establishing successful collaborations. Data sharing was an often-noted challenge to coordinating care across sites, but especially between CMC plans and county departments of behavioral health. This challenge was sometimes the result of HIPAA restrictions. Another barrier to data sharing between CMC plans and county behavioral health departments was that they all used different data systems and had different preferences for how to interact and communicate. *"It's about meeting the counties where they're able to meet us."* One CMC plan KI described their approach of training nurses in their care coordination unit to access the county behavioral health EHR system so that they could pull case management and progress notes on their beneficiaries. Another CMC plan KI reported creating their own shared care plan platform to facilitate data sharing with county behavioral health providers.

Our plan developed a shared care plan platform to facilitate care planning between medical, LTSS, and behavioral health providers that enables the promise of full integration.

Another plan KI claimed that sharing data with the county department of behavioral health had improved with CMC, because they had access to their beneficiary's data as a payer.

You can't do basic coordination of care, let alone integration, if you can't share health care data with the counties. Having the duals was critical, because as the payer we can overcome that because the county councils don't have an issue as long as we're paying the bill. That funding stream created in the duals really helped create a platform for integration, even with county mental health.

One CMC plan KI described how they have utilized incentives to encourage information sharing among behavioral health providers. The CMC plan would only pay their primary behavioral health providers for their initial visit with a beneficiary if they submitted their treatment plan and made an effort to collect a release of information from the beneficiary, so they could share information with the beneficiary's PCP.

When I pay a little bit more for that initial visit, I'm also paying for them to go online and submit their treatment plan, not only to me but to capture in ROI so I can put it in the mailbox of the primary care doctor securely.

The plan could then facilitate the connectivity of the behavioral health provider and primary care provider's treatment plans. In turn, this plan gave their providers access to beneficiary's data.

When you're evaluating a member and you're a behavioral health provider, suddenly you have access to all the medical services that person has received over the last six months, right there on their portal. It really speeds up their assessment and allows them to do a better job clinically.

This plan noted that this bi-directional communication is now standard as opposed to the exception.

RESULTS: HEALTH SYSTEM RESPONSE: CARE COORDINATION

When you automate it as the plan by making it part and parcel of the way that they do their work every day, then you can actually get meaningful routine coordination of care for providers that otherwise wouldn't even know the other one existed.

Another CMC plan KI described how they had attempted to improve coordination of care and information sharing with IHSS. This CMC plan KI described how IHSS had access to their quality management system, which facilitated access to information about a beneficiary's care between IHSS, the CMC plan, and providers. However, the CMC plan KI admitted that they sometimes needed to remind partners that they had access to this system to learn about their beneficiary's care.

Defining and Delivering Person-Centered Care

Delivering person-centered care was one of the requirements in CMC's 3-way contract between the plans, DHCS, and CMS. However, there was little definition about what person-centered care looks like. Consequently, each CMC plan had to define person-centered care for themselves.

We don't really take a step without really engaging the member. I mean, the member has to be completely into it. It's not something we're doing to the member. We're doing it with the member. So that's number one. It's an attitude and a philosophy, which really is important because there's plenty of programs out there where, I guess they could call themselves case management but they're really not engaging the member. This is all again back to what I was saying before about spending the time to invest in a relationship with the member on the front end, which may take some time. They've got their own idea of what they've got to work on. Well, guess what, that's what person-centered care is about, not what we think they need to work on.

One CMC plan KI described how one of the biggest benefits for beneficiaries of CMC is the person-centered care coordination:

It's the addition of a more patient-centric approach. Bringing in the case management, bringing in care coordination. It's kind of wrapping the services around the members as opposed to having the member piecemeal and patchwork their services together.

One CMC plan KI noted how traditional health systems in the US are based in an economic structure, which reinforces the belief that *"if you have a health problem, it's someone else's fault. If you have a social problem, you're a loser."* This KI asserted that CMC could contribute to a significant cultural shift in US health systems, toward more equal emphasis and spending on medical and social services. Another KI noted that CMC required an "evolution" of social workers and nurse care coordinators. *"We really moved from looking at parts of the person to the whole person, to put it distinctly."* One CMC plan described how participating in ICTs allowed a beneficiary to prioritize his conditions, and contribute to a plan of care that worked within his personal limitations.

The member had some activity in the ER and some discomfort. During this meeting he came out and said that the most important burden was his constipation. Then the provider said, "well, come in and I'll write you a prescription." The member said, "it's difficult for me to go in. Even if you write a prescription it's difficult for me to go to the pharmacy because it's far

RESULTS: HEALTH SYSTEM RESPONSE: CARE COORDINATION

away and it's hard for me to get out of the apartment." In this meeting we were able to have the provider not only write the prescription, but send the medication to the member's house, all during this 15-minute call.

However, another CMC plan KI described how the restrictions around accessing certain services limit their ability to take a person-centered approach to their member's care.

[CMC] is a program-centered model. It's not really person-centered when you look at the way that it's structured. We have to get people in certain programs to receive reimbursement. MSSP doesn't accept younger people, IHSS won't serve the homeless, members with behavioral health issues aren't going to go to CBAS centers. HUD won't authorize section 8 for their homeless members.

Another CMC plan KI argued that their internal data systems were not conducive to a person-centered approach to care, that the fillable forms can't capture a discussion about care goals.

These fillable fields aren't talking to [the beneficiary]. We're talking about how much pain he's in and how that affects his sleep and how that affects his relationship and his ability to go out and look for work or to go to the store and get stuff for his family. Our goal is to have those conversations be reflected in the care plan. From claims and utilization data [the plan] can say to the member, "You're a diabetic and you're really non-compliant," but what member is going to say, "I'd like to work on my non-compliance?" The person's care goals are more likely, "I just want to feel better. I feel like crap all the time. I'm really sad. I'm really depressed. I'm feeling hopeless." The diabetes is very important, but I guarantee the diabetes is going to get taken care of if we can address the underlying hopelessness. What is that really about? "Well, I haven't had a job in three years." Ah, okay, there you go. "I'm in pain all the time." Oh, bingo, okay. "Well, I'm depressed. My wife left me." Okay, how about a mental health visit? "I can't even put the food on the table. I'm caregiving for my granddaughter and I don't feel good myself." Oh, bingo. You see? Before you know it, you've built something there and after you do that, maybe a couple months later you can start working on the diabetes.

Challenges with Accessing Care Coordination Services

Some KIs from IHSS, MSSP and CBAS were unsure about the extent to which care coordination was being provided to beneficiaries. *"I expected to see more care coordination."*

Care coordination among our clients in CMC has been inconsistent. Our clients in CMC are unaware that it's available from their plan, but they are receiving care coordination from us.

Another KI reported that when care coordination was happening, it was done well. *"Where it's happening it seems to be positive, but it's not happening everywhere."*

Additionally, several KIs noted that language barriers also exist in the provision of non-medical services through CMC, such as care coordination, LTSS, LTC facilities, ancillary and supplemental services, and services provided by CBOs. As one KI noted, added benefits in CMC are appealing, but *"...if there isn't adequate language access, how can they access those additional benefits?"*

HEALTH SYSTEM RESPONSE: ANCILLARY SERVICES, SUPPLEMENTAL BENEFITS, AND CARE PLAN OPTIONS

CMC plans provided ancillary services, and were allowed to offer supplemental benefits like dental and vision. Additionally, CMC allowed plans to provide care plan options (CPOs), services or goods not covered by Medicare or Medicaid, but necessary to allow beneficiaries to remain in the community.

Pharmacy

CMC plans educated beneficiaries about prescription adherence: CMC plan KIs reported that care coordinators educated beneficiaries about their medications and actively monitored adherence. One CMC plan KI described how health education from care coordinators has encouraged their beneficiaries to participate in their own medication management. Another CMC plan KI described how a beneficiary expressed appreciation for receiving health education about his medications. He claimed that no one had ever explained why he was taking so many medications. *“Until the person understands the condition, why would they comply with their medication?”* Another CMC plan KI described efforts to include pharmacists on the ICTs of beneficiaries that have many prescriptions or take complicated medications.

CMC plans monitored prescription medication to reduce polypharmacy: One of the KIs noted that CMC plans have made a large effort to remediate issues of polypharmacy and reduce interactions; which is important for their beneficiaries, especially if multiple providers are prescribing their medication.

One of the things that our physicians are constantly looking at is the number of meds that they're on. We have people who are taking 2 meds all the way up to 40 meds, and so it starts the conversation about medication reconciliation and what that looks like and how we do that. Sometimes we've gone from like 42 meds to 20 meds, which is huge and prevents a lot of falls and other bad outcomes.

CMC plan KIs also reported efforts to reduce drug interactions. One plan described how they found that they could educate physicians if they determined that a beneficiary was prescribed a contraindicated drug. They claimed the providers responded favorably to that feedback, and that they were able to *“make some improvements in pharmacy, either in terms of the number of prescriptions or so forth, or the pricing that was done.”*

One CMC plan KI described how, even if a beneficiary was being served by one of their delegated PPGs, they assigned an in-house pharmacist to oversee the beneficiary's medications and to consult with the physician about prescription practices if needed. Another CMC plan KI described their efforts to examine the use of psychotropic medications by their LTC residents. If a facility had a high rate of psychotropic medication use, the plan could contact the doctor or facility to learn more. Doing so allowed them to keep *“an eye on the quality and the outcomes perspective.”*

RESULTS: HEALTH SYSTEM RESPONSE: ANCILLARY SERVICES, SUPPLEMENTAL BENEFITS, AND CARE PLAN OPTIONS

One CMC plan KI also noted that their medical information technology system helped facilitate pharmacy's ability to stay informed of patient's care and medications, and to communicate with other providers.

Continuity of medication was a challenge, especially early in CMC implementation: KIs reported that a common disruption experienced by beneficiaries after the transition to CMC was regarding access to their medications. One LTC facility representative noted that many of their residents had their medications changed several times due to plan formulary changes. Coverage for more expensive drugs was sometimes more difficult to acquire. Though these issues were resolved, it took time to reconcile medication for each beneficiary who was impacted.

We've had, in about a year and a half, three different times where drugs were changed, the amounts were changed, or, in one case, a very expensive drug wasn't paid for some period of time, but they all have been resolved on an individual basis. When it's a problem, it's a big problem, but I think overall the plans have been pretty responsive to the issues we've had. I think it's just initially a learning curve. No long-term huge issues with that, but there's always an opportunity with the more expensive drugs.

Durable Medical Equipment

CMC plans ensured access to DME and medical supplies: CMC plan KIs acknowledged that being able to access appropriate durable medical equipment (DME) and supplies was an important component of enabling their beneficiaries to stay in their home for as long as possible or to transition back to their home from the hospital or LTC facility. One CMC plan KI noted that getting proper DME to beneficiaries had been a key focus of the health plan care coordinators.

We have worked with several members participating in the CCT program to help ensure that these members have the appropriate DME and transportation services to remain in the community. We have worked closely with their PCPs and ancillary providers to help members obtain required DME and other resources to ensure safety in the home.

Another way CMC plans ensured access to specific DME that was needed, but not covered by Medicare or Medi-Cal, was to pay for it directly. One KI from a care coordination contracting agency said the plan would allow them to purchase certain DME for their beneficiary under the care plan option provision.

Our occupational therapists are great with durable medical equipment, so if Medi-Cal or Medicare won't cover something like a hand-held shower head or one of those kinds of things that really helps a client to be more independent, we have the flexibility with the plan to make that call and purchase the equipment.

One CMC plan KI described how their DME provider hand-delivered DME instead of shipping it, so when they arrived at the residence, they could do a kind of non-clinical assessment. For example, if the DME provider was delivering a wheelchair, and the member's home did not have a ramp, they would feed that information back to the plan. One KI described delivering a continuous positive airway pressure (CPAP) machine to a beneficiary who didn't have electricity.

RESULTS: HEALTH SYSTEM RESPONSE: ANCILLARY SERVICES, SUPPLEMENTAL BENEFITS, AND CARE PLAN OPTIONS

[The DME provider] was like, it's not going to do any good for this member to have this piece of equipment and never be able to turn it on, or turn it on sporadically because their electricity is off. It's interesting the evolution of health care today is such that people are starting to recognize that it's not just about giving the member a service or providing a product. There's a much more holistic approach.

Another CMC plan KI described how the plan care coordinator worked with the utilization department and medical director to address the issue of getting a specialized wheelchair for a beneficiary.

We had a member with a complex wheelchair issue. A power wheelchair is a big deal in managed care because they're expensive and there are a whole bunch of regulations around standards, utilization rules and all this stuff. Anyway, this doesn't always serve the person who is utilizing the wheelchair, unfortunately. Because we're two steps away from the Utilization Department and actually in the Utilization Department, we're able to work directly with the medical director and our wheelchair vendors to find something that's going to work with the member better, he was a very large guy and just could not get the right wheelchair for his body size and also for the needs that he had. But, the only way he could get out of his house to go get food was in his wheelchair. If he didn't have this wheelchair functioning, it would've really changed his quality of life substantially to the point where probably he'd have to be hospitalized.

Some disruption to DME access occurred: Despite the focus on DME access, KIs reported that disruptions in DME access could be a problem after transition. One CBAS KI reported minor hiccups with accessing DME for beneficiaries after switching to CMC, but reported that those problems have been resolved. Another KI expressed concern about plans contracting with providers that offer the cheapest rates, because the quality of the beneficiaries' supplies suffers. However, she noted that this problem may not be "related to Cal MediConnect per se."

Transportation

Transportation was a highly valued benefit for CMC beneficiaries: Many CMC plan KIs noted that transportation was one of the most important benefits the plan provided to beneficiaries. One CMC plan KI noted that transportation was particularly important to their beneficiaries because of their county's geography.

The transportation benefit is used very heavily, because you know our geography out here is a problem. The transportation benefit, in my mind, is probably one of the best benefits.

Transportation is important in getting beneficiaries to care. Without transportation, beneficiaries delay care, which leads to ER usage or other complex care issues.

To keep people at home as long as possible, plans need to get people to medical services.

Transportation is a big part of care coordination. All services are connected once transportation services are in place.

RESULTS: HEALTH SYSTEM RESPONSE: ANCILLARY SERVICES, SUPPLEMENTAL BENEFITS, AND CARE PLAN OPTIONS

One MSSP KI reported that although they see a lot of beneficiaries using transportation services, they didn't see a major difference in access to transportation between those in CMC and those enrolled in MMC who opted out.

CMC plans offered expanded transportation services: Several CMC plan KIs reported that they cover non-medical transportation services such as taxi rides. One KI noted that *"it is unreasonable to expect members to make reservations 7-10 days in advance."* For CBAS centers who reported that getting Para transit services set up for their clients required a lot of logistics, plan-funded transportation services may expedite access to CBAS services. One CMC plan KI described how they offered *"40 one-way visits, which is very helpful obviously for this population, which can assist with getting to medical appointments and other things that they might need."* The flexibility of this approach to funding transportation services for CMC beneficiaries may also address some of the challenges Para transit has with providing door-to-door rather than curb-to-curb service to beneficiaries who may need it (e.g., beneficiaries with dementia).

Authorization processes may create barriers to accessing transportation services: One CBAS center said that transportation services were more difficult to access since the transition to CMC, because each plan had different timelines and requirements. *"One plan's authorization for transportation expires every 90 days."* This required the CBAS social worker to contact the plan every 90 days to get the service reauthorized.

Vision

Several CMC plan KIs reported that vision benefits were a highlight of CMC and attractive to beneficiaries, with more extensive benefits than previously offered:

We have a slightly more robust vision benefit, supplemental benefit, than the other plans, in that we offer \$175 in eye wear over a 2-year period. Then we're also offering some chiropractic visits which we find are helpful for the population here in LA County. That seems to be an attractive benefit as well.

However, a few CMC plan KIs reported that utilization of improved vision benefits was low, with one predicting an increase in utilization in the future.

We haven't had a lot of utilization for our vision services through VSP, but I think our members are still getting used to understanding the additional benefits they have and don't have. I'm sure that that utilization will increase over time.

Some CMC plan KIs reported challenges in finding specialists to provide these vision benefits, and optometrists were one example:

We had some problems at one point because we were challenged to find services where the optometrist could come in to the facility and provide eye exams for residents. We found a service, and I've got to say it's probably not a high priority thing but it's another one of those things where the continuity, perhaps, isn't there because it's like setting up ambulance services throughout LA County. That's a big ask. Finding optometrists who will go to your

RESULTS: HEALTH SYSTEM RESPONSE: ANCILLARY SERVICES, SUPPLEMENTAL BENEFITS, AND CARE PLAN OPTIONS

skilled facility and take care of a resident or two; that's a big ask financially. That was another issue.

Dental

Beneficiaries received dental benefits, either through Denti-Cal or through the plan. CMC plans varied in their provision of dental benefits—some provided dental, some did not, and some provided wrap-around dental services in addition to Denti-Cal.²⁷ Plans that had a D-SNP plan before CMC noted that their ability to offer dental was really valuable after Denti-Cal was cut back.

As a result of CMC, some plans offered supplemental dental services in addition to what was provided by the state Denti-Cal program:

Dental is a unique benefit here in California. You might hear this from the other plans and that the state carved out Denti-Cal for adults a couple of years ago. We're offering supplemental benefits that provide some additional dental services to our members. I think that's helpful, although it's not ideal, the way it's constructed with the carve-out.

CMC plans that chose to offer additional dental benefits reported that they were a selling point for their CMC product. However, some CMC plan KIs reported that they made sure their beneficiaries knew about Denti-Cal benefits, but didn't see a point to offering additional supplemental dental benefits. Some plans that did not provide additional dental benefits cited financial reasons.

Care Plan Options

Care Plan Options (CPOs) are optional services provided by most CMC plans. This supplemental benefit allows plans to pay for and provide additional goods or services, which are not covered by Medi-Cal or Medicare, to beneficiaries if it will prevent or delay more costly levels of care. Most CMC plan KIs reported providing some form of CPOs, though not very broadly. One CMC plan KI decided against offering CPOs, though they reported considering it later in the demonstration. CMC plan KIs reported providing a variety of CPO services:

- Minor home modifications – grab bars, levered door knobs, handrails
- Structural modifications – ramps, shower, widened door frames
- Appliances – refrigerator, washer/dryer, heaters
- Utilities – gas or water services
- Technology- telehealth, medic-alert, and safe-return systems
- Cell phones and plans
- Cleaning/chores/meals/shopping/personal care not otherwise covered
- Medical equipment not otherwise covered – shower head, blood pressure monitors, orthopedic shoes
- Housing advice and support
- Health education courses – home counseling for diabetics on how to cook healthy meals to help them control their diabetes

²⁷ Cohens, K. (2015). Give Your Advocacy Teeth. Justice in Aging. Retrieved from <http://www.justiceinaging.org/give-your-advocacy-teeth/>.

RESULTS: HEALTH SYSTEM RESPONSE: ANCILLARY SERVICES, SUPPLEMENTAL BENEFITS, AND CARE PLAN OPTIONS

- Caregiver support groups and respite
- Financial services – money management, assistance in accessing SSI
- Recuperative care for homeless members
- Socialization – friendly visitor programs, social interaction, education on being a good tenant/neighbor

Low-cost home modifications, such as grab bars, were most often reported as a CPO provided by CMC plans.

We have care plan options available now which are not official benefits, but health plans are now allowed to spend additional dollars to provide additional services that help people stay at home, and independent, and out of hospitals. [We are] able to pay for things like water heaters in homes, ramps in and out of the person's home, small appliances, small air conditioners, emergency response systems, things like that. We couldn't provide those things before.

Two CMC plan KIs reported offering cell phones to high-risk beneficiaries who were difficult to find, homeless, or did not otherwise have access to a phone. One plan offered a \$150 CPO stipend per beneficiary deemed eligible.

What we said to our delegated groups is, "If you've got a member who needs some kind of an assessment, you don't know what's going on inside the home," we will deploy a resource, typically social worker resource, to go into the home and check what's going on. Is there food in the refrigerator? Are the medications organized appropriately? Are there dangerous items in the house that are going to cause falls? That's what that \$150 is for.

CPOs also allowed CMC plans to “top up” services and supports, particularly personal care services, beyond the IHSS approved number of hours. They could also fill in the gap between when the services needed were determined, evaluations were conducted, and authorization was given, which was especially valuable after hospital discharge. As one KI reported:

We have primarily seen additional personal care beyond in-home support of services. That benefit is actually capped at 283 hours per month. In cases where the county may not authorize additional IHSS hours, the plan has actually been layering on additional personal care that's purchased through the plan as a care plan option.

Some CMC plan KIs described how they used CPOs to help support informal caregivers as well as the beneficiary.

It's leveraging those existing dollars that are available for the caregivers, because we understand that you cannot begin to move people back to the community if there isn't someone who is their primary caregiver or if they're not supported.

CMC plan KIs reported using a range of vendors to deliver CPOs, including MSSP or other LTSS providers, though plans often retained control over CPO authorization. As providing CPOs was fairly new to most CMC plans, several KIs reported consulting with MSSP or Independent Living Centers (ILCs) to identify appropriate CPOs and vendors.

RESULTS: HEALTH SYSTEM RESPONSE: ANCILLARY SERVICES, SUPPLEMENTAL BENEFITS, AND CARE PLAN OPTIONS

We literally went down the list of the purchase waiver services and MSSP and contracted for all of those services.

CMC plans were selective about who received CPOs: CPOs were typically offered to those beneficiaries determined to be high risk or in needs of services to help them transition home from a hospital or LTC facility. To determine what CPOs should be offered to whom, most plans were using a combination of utilization data, HRA data, predictive risk tools, and professional assessments to identify individuals with “actionable needs.” One of the CMC plan KIs with a more developed protocol for CPO provision reported:

The person has to be a Cal MediConnect member. They have to have completed an HRA. They have to have a care plan in place to support the need for these additional services. They have to have the additional face-to-face assessment from our care plan options contracted vendor.

One CMC plan KI reported developing a special CPO assessment, which they claimed identified more detailed needs and risks than the standard HRA. Some CMC plan KIs reported targeting CPOs to particularly challenging or costly populations, such as homeless beneficiaries or those residing in an LTC facility. One CMC plan KI reported consulting with an Alzheimer's organization about assessment tools that could help the plan identify high levels of caregiver burden so that they could target CPOs to that beneficiary and their caregiver.

CMC plans connected beneficiaries to community resources: Most CMC plans sought to identify available community resources prior to providing a service as a plan-funded CPO. For example, one CMC plan KI mentioned referring their beneficiaries to an Alzheimer's organization for education classes and support groups.²⁸ Another CMC plan KI mentioned working with an organization that paid for and installed ramps through grant funding.

It was amazing, the number of services available either through government agencies or through community-based organizations. This one organization built ramps for folks who needed access after being wheelchair bound and it's all free. It's important for our staff to understand and be able to tap into those resources. Our staff ends up being able to connect those services with the needs of the patients.

However, several KIs noted that there had been some criticisms over what the plans could and would pay for and what community organizations would provide without payment from the plan.

The community agencies only have so much funding. They would like us to spend [our plan] dollars on whatever we can. When Cal MediConnect started, we got the impression from the state that it was expected that the health plan would look outside and figure out if the services were available in a particular way, and use those community resources. Our approach is, make it happen quickly for the member. If it's not obvious or readily available, or we're not aware of an existing resource, we just go ahead and take care of it ourselves.

²⁸ Lindberg, B.W. (2016). Dementia Care Network Sharing Formula for Success. Retrieved from https://www.geron.org/images/gsa/gerontologynews/March_2016.pdf.

RESULTS: HEALTH SYSTEM RESPONSE: ANCILLARY SERVICES, SUPPLEMENTAL BENEFITS, AND CARE PLAN OPTIONS

One KI reported a concern over how this practice could lead to the allocation of scarce resources to CMC plan beneficiaries who have an advocate connecting them to those resources.

CMC plans struggled to track and report CPOs: One CMC plan KI noted that, because CPOs were not tracked through claims, they needed to develop a process in their case management system to track the invoices for CPOs.

There are no codes for a ramp. For those things, they are done completely off of that system. Right now, we track them manually on a spreadsheet, and those are paid as invoices, not as claims.

One KI reported that this was a particular challenge for CMC plans that delegated services to PPGs.

Care teams across our delegated provider groups may have provided CPOs. However, this activity is not being actively tracked or reported.

Another KI noted that tracking free services provided would be especially difficult:

It would be hard for them to track a service that they weren't funding. Even the MSSP sites have a very difficult time tracking how much other services and resources they're leveraging for their clients. They probably spend 25% of a beneficiary's annual budget on purchased services, and they get the other 75% of services funded through another mechanism or community-based resource. I would assume it's even more difficult at the plan level.

Another KI reported concern with the lack of effort to track free services and their ROI as it poses a challenge for CBOs, which might otherwise be able to make the argument that their services impact outcomes. For example, a CMC plan may collect data that could show how providing a washer and dryer to someone with no access to a laundromat can improve a member's hygiene and health; but they are not collecting data that could show how free support groups, education classes, and respite services from an Alzheimer's organization can delay institutionalization, or how utilizing agencies funded by the Older American's Act (OAA), such as the LTC Ombudsman Program, can improve quality and decrease fraud.

CMC plans interested in determining CPO return on investment: KIs reported that the ability to track CPO data was necessary so that they could determine any ROI.

I think we'll have more data six months down the road in terms of what we actually purchased and cost involved. I think that's part of our process just in terms of making the case for the service, is what's the cost if we don't do it.

One CMC plan KI mentioned that the "limited profitability" in CMC made the ROI of CPOs an important issue. There were a range of views about how likely CPOs were to produce a financial return. Most CMC plan KIs agreed that there were significant savings to be made if they kept someone out of an LTC facility, but seeing those savings could take time.

RESULTS:

I think to start to deploy [CPOs], and see the fruits of them, isn't going to happen overnight. There'll be a time period between your investment and when you'll be able to measure it. The measurement, to me, would be reduced utilization of emergency room services, excessive prescription drug use, or admissions to custodial care or skilled nursing centers.

One CMC plan KI noted that several PPGs were piloting post-acute transition programs using CPOs. They were tracking the outcomes of these pilots and planned to disseminate them as best practices to other PPGs if they were successful.

There's a large sample of post-acute transition experiments going on, from meals to in-home visits to medically organized social events to community-wide social events; the last two both being preventive and retrospective. Whether it's a movie or a social event or something of this sort, [it's] an ability to touch them on an ongoing basis, both to retain the membership but also to be able to basically look at the people and involve them and see if, by involving them, they actually diminish the number of health care problems they have going forward. What we're trying to do in the process of the demo is separate those that are successful and then pollinate them to all of the groups.

One KI was particularly excited about “experiments” that looked at socialization CPOs as a potential preventative intervention.

The theory is that it provides the social infrastructure that more wealthy people have as a regular part of their life.

CMC plans questioned the impact of CPOs on their future rates: Offering CPOs was new for most CMC plans and required plans to establish a process to target high-risk beneficiaries, determine what CPO could be effective, define authorization procedures, contract with vendors, and ensure timely delivery. Several KIs noted that, as there were no billing codes for CPOs, these services are not taken into account in future rate-setting processes with DHCS and CMS. If, by providing CPOs, beneficiaries improve in their health and decrease in their acuity, CMC plan's capitated rates could drop because their acuity rate is less.

[There are] numerous barriers [to providing CPOs], including the fact that they are not benefits, so we do not get reimbursed for these costs and cannot include costs in our medical loss ratio [MLR]. Also, with no established guidelines for CPOs, there is a concern about liability.

Although the beneficiary's risk level impacts the plan's capitated payment, another KI noted that the risk adjustment process for the Medi-Cal portion of the capitated rate incentivizes plans to keep beneficiaries at lower risk levels. Additionally, the Medicare capitation rates are prospective, making it unlikely that a CMC plan would choose marginally higher capitation payments in the next year rather than the opportunity to avoid large and immediate costs through the provision of CPOs.

HEALTH SYSTEM RESPONSE: QUALITY

CMC policy included several incentives to improve quality of care, including: increased collection and reporting of quality metrics, quality withholds, and person-centered care requirements. KIs reported a possibly less intentional result of CMC, the incentive for CMC plans to conduct quality oversight of services provided.

Quality Oversight

CMC plans monitored collaboration and integration across stakeholders: One CMC plan KI described how they have tied submission of an online treatment plan with reimbursement for initial visits with behavioral health providers.

I get 100% of treatment plans from behavioral health providers after the first visit, because that's their way to get paid for that first visit. I don't have to do pay for performance and I don't have to struggle with them because I basically tie submission to us as a pre-requisite to getting paid.

The CMC plan KI also asked providers to attest to obtaining a release of information from the beneficiary, allowing them to share the treatment plan with their ICT. The CMC plan KI asserted that 80% of their beneficiaries approved such a release of information. The plan then targeted outreach to providers with low completion rates of release of information forms. Additionally, the plan determined which primary care providers were least likely to view their patient's behavioral health treatment plans to target education and in-services toward those providers.

CMC plans were interested in oversight of LTSS and CBO services: As with LTC facilities, one CMC plan KI mentioned the need to have oversight of CBAS programs to ensure that their beneficiaries were being well cared for. One CBAS center described how a CMC plan conducted assessments with beneficiaries at their center, which also allowed them to assess the CBAS environment, review medical records, and extract data from CBAS records.

Another CBO KI noted how, since CMC implementation, it was important for them to prepare for a higher level of scrutiny and oversight from the CMC plans, DHCS, and CMS.

I would say they have higher scrutiny because they're delegating their case management, occupational therapy, a bunch of services to us so they have higher scrutiny on us as a result of it. We've already been audited by [CMC health plan]. We plan to have an audit by them again next year. We are a first-tiered downstream entity of theirs, so we could get audited by CMS. There's a higher-level of scrutiny, but there's also a higher potential for really great success in starting new, innovative programs.

CMC plans conducted quality oversight in LTC facilities: Some CMC plan KIs noted the difficulty of addressing poor quality of care in LTC facilities. One CMC plan KI described how they had to move some of their beneficiaries out of an LTC facility that had been decertified by the state regulatory agency. The quality deficiencies at some LTC facilities seemed to provoke the CMC plans into an oversight and regulatory role that they had not undertaken before. Because CMC plans were

RESULTS: HEALTH SYSTEM RESPONSE: QUALITY

responsible for the full continuum of their member's care, they reported being interested in ensuring that their beneficiaries residing in LTC facilities: 1) needed and wanted to be there, 2) were receiving high quality of care, and 3) were being cared for in a cost-effective manner.

While CMC plans were required to contract with any facility housing their beneficiaries, they had considerable control over where they placed their beneficiaries who were in need of LTC. Several CMC plan KIs reported being selective regarding which LTC facilities they contracted with by conducting research on facility credentials, complaints, ratings, and other factors.

Any time we contract with any facility, we have to run a credentialing on them. One of the things that we look at, of course, is their licensing and any accreditations that they might have. We also look at their CMS rating. Are there any sanctions against them, what's their safety rating, do they have a lot of falls? There had been facilities that we've chosen not to contract with, then there's been facilities that we didn't have a choice but to contract with because a Cal MediConnect member was in there when we took over the program.

I think the idea now is, as you build relationships and people become institutionalized, you need institutionalization. You can direct now. Now we can pick the ones that we have a better relationship with that have demonstrated better quality indicators and things of that nature, but it really wasn't an option in that first cycle of enrollment for these members.

Some CMC plan KIs reported looking into ways to monitor LTC facilities with high hospital admission rates, to determine if those admissions were medically necessary.

CMC plans collaborated with local LTC Ombudsman Programs: One innovative practice in quality oversight reported by some CMC plan KIs was to work with their local LTC Ombudsman Program. The LTC Ombudsman Program helped them navigate LTC facility regulations, residents' rights, and regulatory, licensing and certification systems. CMC plan KIs reported that the LTC Ombudsman Program was a valuable source of information about LTC facility quality, operational practices, and any history of deficiencies. One CMC plan KI reported having an Ombudsman accompany them on facility visits. During these visits, the Ombudsman educated the plan about the history of deficiencies in the facility, introduced them to facility staff, advised them on how to review charts to identify poor quality of care or fraudulent activity, and explained how the plan could address deficiencies or complaints.

We go in jointly unannounced and [the ombudsmen] are looking at something a little bit different than [the CMC plan]. One facility, it was so filthy, there were pills on the floor. The residents, none of them had shoes on. It looked like they had been living in their clothes. The Long-Term Care Ombudsman can address those concerns and kick it up to the state. If there are issues, we want to resolve them right then instead of having to go back and forth. So the Long-Term Care Ombudsman has been great in filling us in on what's really going on, some of the prior issues the facility has had, if there are pending investigations with the Department of Justice and the Office of the Inspector General because of Medicare fraud and Medi-Cal fraud. They really do a great job because they know the facilities and they know the residents. We are looking to try to get more visibility about the Ombudsman because we

RESULTS: HEALTH SYSTEM RESPONSE: QUALITY

know they're doing great work. They're underfunded and we've got to work together as a team with some of these facilities because there are a lot of issues.

From the LTC Ombudsman's perspective, visiting facilities with the CMC plan was like walking into a facility with "the checkbook." For example, when a resident was being told by the LTC facility that he was getting a ration of diapers, the LTC Ombudsman was able to intervene based on the requirements in the CMC plan's contract with the facility.²⁹ When a facility was rationing a resident's supplies:

[The CMC plan] was able to point out to them, "You need to provide this." That really streamlines that complaint process for us. The plan is essentially the checkbook. If we're coming in with the checkbook, we're able to get the needs met of those clients more quickly. Then we can keep an eye on it for them. If it comes up again, then we know exactly who to go to at the plan. The plan gives [the facility] a little write-up of the things that they need to correct or that are out of compliance with their contract.

These new partnerships could exemplify how CMC realignment can encourage collaborations that lead to higher quality of care for beneficiaries.

²⁹ Hollister, B., Davies, M., Mokler, P.M. & Graham, C. (2016). Yes, Collaboration Can Happen—and Means Better Quality of Life for LTC Residents. Retrieved from <http://asaging.org/blog/yes-collaboration-can-happen-and-means-better-quality-life-ltc-residents>.

HEALTH SYSTEM RESPONSE: COST

KIs discussed many ways that the health system was responding to CMC in ways that could better control costs. CMC is incentivizing partnerships and innovations that can avoid hospitalization and institutional placement, improve care transitions home from the hospital, and facilitate the transition of LTC residents back to the community.

Reducing Unnecessary Hospital Admissions, Readmissions, or LTC Placement

Within the capitated model of CMC, plan and PPG KIs noted their strong incentive to prevent unnecessary hospital admissions.

That's the low-hanging fruit for cost savings for this population. It's tremendous. If you look at the Medicare Advantaged figures, the average bed days per thousand for the traditional Medicare population is about, I think, 1,778 bed-days per year. For the higher-performing Medicare Advantage groups in California, it can be 500-700 bed-days per year.

Another CMC plan KI was able to succinctly describe how CMC changed their incentive to avoid LTC placement:

Prior to Cal MediConnect, the health plan only had financial responsibility for the month of admission to a long-term care facility and the month after. Then they were dis-enrolled from the health plan. They stayed in the long-term care facility, but they became fee-for-service Medi-Cal. We just didn't do much. I mean I probably should have done more than we did, but we just didn't do much because we knew they were going to be dis-enrolled. Now that we've got full responsibility, of course it's a completely different scenario.

CMC plans expanded assessments and care coordination for high utilizers: CMC plan KIs regularly described efforts to identify and contact high utilizers of hospitals for more intensive care coordination.³⁰

It's just a matter of patient-centered care interventions to keep these folks out of the hospital. If you're managing their meds with them, they are not going to have adverse medication reactions and end up in an ER. You're doing the toenail cutting, all of these different interventions. Even when it comes down to sending in somebody to the home to eliminate the trip-and-fall hazards, the torn carpet, the lose cords, putting in grab bars and anything you can do to decrease risk of hospitalization. That's going to pay off tremendously.

Many CMC plan KIs also reported trying to make sure that their beneficiaries knew how to contact their care coordinator who could help them access care in non-emergency situations.

³⁰ Health Care Transformation Task Force (2016). White Paper: Developing Care Management Programs to Serve High-Need, High-Cost Populations. Retrieved from <http://www.hcttf.org/releases/2016/2/22/health-care-transformation-task-force-releases-best-practices-for-care-management-programs-for-high-need-high-cost-patients>.

RESULTS: HEALTH SYSTEM RESPONSE: COST

CMC plans attempted to dis-incentivize LTC resident's hospital readmissions: Some CMC plan KIs reported attempts to address perverse financial incentives that may result in unnecessary hospital admissions from LTC facilities. The CMC plan KI reported that LTC facilities sometimes readmitted residents to hospitals in order to re-establish their resident's post-acute payment rate. To address this issue, some CMC plan KIs reported paying the same rate for post-acute care as they did for custodial care. However, as noted previously, not all LTC facility KIs appreciated the blended rates offered by CMC plans, as they were lower than what Medicare paid. Other CMC plan KIs reported that they did not require a three-day hospital stay for LTC facility admissions in order to avoid unnecessary acute care costs.

We don't require an inpatient admission of three days for a skilled level of care. We have taken away that perverse incentive, and we pay the long-term care facilities based on the status of the member.

With the increased incentives for CMC plans to place their members in high-quality, cooperative facilities and for hospitals to avoid readmissions, one LTC facility KI noted the importance of maintaining referral sources.

If the hospital [or plan] is punished because [the LTC facility] is readmitting patients, [their] referral source will dry up real quick.

CMC plans provided additional primary care services in LTC facilities: CMC plan KIs reported efforts to strengthen primary care for LTC residents by having physicians, nurse practitioners, and physician assistants in LTC facilities. CMC plan KIs believed that this practice served as a resource to facilities, lightening their workload and ensuring quality care for residents.

We're trying to strengthen the role of the primary care provider for beneficiaries who are long term in a facility, involving them more in managing the member's care. I don't want to characterize it as something new because there are doctors out there who do this, but we're making it more of a coordinated system where the doctor checks in once every 30 days.

One CMC plan KI reported contracting with physicians in each facility, which has "gone a long way in having a consistent stream of communication and building relationships." Another CMC plan KI reported assigning geriatricians or geriatric specialist nurse practitioners to LTC facility residents if they didn't already have a primary care provider. CMC plan KIs reported that, by improving access to primary care in LTC facilities, they could improve the quality of care, facilitate early discharge, and prevent hospital readmissions.

Improving Care Transitions

CMC plans expanded efforts to identify and reach beneficiaries during transitions: CMC plan KIs reported not always being aware of when their beneficiaries were hospitalized or in need of assistance with transitions in care. CMC plan KIs reported that they sometimes had to review the hospital admission records to identify their beneficiaries who were hospitalized.

RESULTS: HEALTH SYSTEM RESPONSE: COST

[Plans are] really trying to incentivize providers to put the claims in sooner rather than later. They're cutting back a lot on the number of retroactive claims that they're willing to authorize. They're giving much stricter timelines.

If hospitalized beneficiaries were not identified while they were in the hospital, CMC plan KIs expressed concern that their beneficiaries' follow-up care could be jeopardized.

CMC plans utilized specialized care transition staff: CMC plan KIs reported using their own nurses in some hospitals to support care transitions, though this approach seemed to be limited to hospitals where the plan had a high concentration of beneficiaries. One CMC plan KI discussed how their inpatient discharge nurse used a transition assessment that's specific to the discharge and transition process. Another CMC plan KI reported that they have designated care managers who start the discharge planning process as soon as someone is admitted to the hospital.

Concurrent Review Care Managers follow our members at the point of the acute care admission throughout the care continuum. Discharge planning begins from day 1 of the admission to identify and support the transitional health care needs of the member. It is this transitional care planning that minimizes fragmentation of care from the inpatient to outpatient setting.

One CMC plan KI described establishing acute care hospitalists who could divert their beneficiaries to the community rather than a post-acute or LTC setting post-hospitalization. These hospitalists could divert CMC plan beneficiaries to the community rather than a post-acute or LTC setting after hospitalization. In addition, by improving the care provided, hospitalists could play a role in reducing readmissions. While this approach worked for one CMC plan, another KI reported difficulty in working within some hospitals, requiring them to enter the hospital as a visitor in order to access their beneficiaries.

Our transition of care has evolved to the point now where we are trying to send some of our staff into the hospital as a visitor, if we're not in there as a provider. It's hard to get into hospitals and get credentials to go in. If we can't go in as the credentialed provider, we go in as a visitor and make a connection with the member, talk to them briefly about their discharge, give them a business card, and tell them we'll talk to them when they get home.

Another CMC plan KIs reported contracting with a CBO to transition services through an LTC nurse specialist.

When a member is slated for long-term nursing facility placement (even while a member is still receiving care in an acute or skilled setting) the LTC nurse specialist will evaluate the potential for community placement. The LTC nurse specialist will recommend a plan to return home and work with the member and their family to offer the opportunity to coordinate services, including MLTSS and HCBS waiver programs.

Interestingly, another CMC plan KI described using well-trained lay people to assist with care transitions. Because of the plans' large geographical area, the plan used "community connectors" to visit beneficiaries in the hospital.

RESULTS: HEALTH SYSTEM RESPONSE: COST

They are part of our in-patient discharge and care transition team. They're unlicensed staff located at 2 of our hospitals. For our members being discharged to home, they try to engage with them while they're still in the hospital and meet with them, pre-discharge, to go over things like understanding medications, following up with the primary care, and just introduce themselves in the model. After discharge, they'll either engage them by phone or, if possible, be able to do a home visit to ensure that they're actually able to follow up with primary care and address any sort of needs, equipment, etc., post-discharge.

Care transition coordinators in CMC plans provided a variety of services: In order to facilitate beneficiaries' transitions back to the community safely without readmission, CMC plan KIs reported that care transitions coordinators provided:

...referrals to member resources, where appropriate, such as mental health care, case management/disease management, home and community based services, including referrals to state waiver services that are outside the scope of the plan.

CMC plan KIs also reported “ensuring services are accessed in a timely manner to minimize delay in services or discharges” and facilitating “expeditious authorizations of services to post-acute care service,” even if the plan had to pay for the services as a CPO.

Many CMC plan KIs noted that beneficiary education around medications was especially important after a hospital transition. One KI noted that it was very important to have a post-discharge meeting with their beneficiaries to ensure that they understood their new medications and would not end up right back in the hospital.

When folks come out of the hospital in the post-discharge meeting, you have to have two or three interventions with them to go through their medications. You've got to have a care management nurse literally with a pill dispenser, going through the medication, showing them the colors, explaining what the pills do, and checking to make sure they understand.

Transitioning Beneficiaries in LTC to the Community

By assuming financial risk for LTC under CMC, if a beneficiary required LTC, most CMC plan KIs described efforts to reduce the length of stay in LTC facilities and to transition the beneficiary back to the community. One CMC plan estimated that 10-30% of their beneficiaries residing in LTC facilities did not need to be there. CMC plan KIs reported exploring innovative ways to transition willing beneficiaries back into the community. One KI notes that a shortage of LTC beds required them to think more creatively about how to provide institutional levels of care in the community.

I think what drove us also is that nursing home beds are really hard to find for Medicaid. We've seen, in [this community], several nursing homes close over the last several years. Others are at threat of closure. It's an older community. We have to get ahead of this. We have to have other options for people. I think that really motivated us in a way that [it would not have in counties] where there are more nursing home beds available.

RESULTS: HEALTH SYSTEM RESPONSE: COST

Another KI noted that LTC facility relationships with CMC plans appeared to vary by region and market demand for LTC beds. Where there were more beds available, LTC facility KIs saw CMC plan efforts to move their members back to the community as a threat to their occupancy and bottom line. In regions with a shortage of LTC beds, facilities were more likely to work with the CMC plans to identify beneficiaries who were interested in and able to be transitioned into the community.

CMC plans identified residents to transition back to the community: Some CMC plan KIs reported identifying residents that could transition out of LTC facilities using utilization data and HRAs. Other CMC plan KIs reviewed the resident's minimum data set assessment forms to find those residents who reported wanting to return to the community. Other plans sent out "LTC care managers" to visit beneficiaries in the facility to make further determination about their desire to move back into the community. One CMC plan KI noted that they assessed whether the member: had or could access safe housing; was eligible for personal care or IHSS; was cognitively intact and able to make decisions or had a caregiver or authorized representative that could do so; and did not wander. One CBO KI explained that a majority of the referrals to their care transition program came directly from LTC facilities.

We have a wait list of over 100 people, and 80% of our referrals come from skilled nursing facilities. One administrator told me, "we're sending you our 10 most challenging clients that take up 90% of our time. By getting these people out, that opens us up, but it also opens up our staff time." Most of our caseload is from the skilled nursing facilities, and I think they see it as a great thing because they're getting some of their long-term care folks out.

CMC plans had limited success in transitions: Although most CMC plan KIs reported only limited success with transitioning custodial care residents back to the community, one CMC plan KI reported transitioning 40 beneficiaries, each of which they estimated would have cost them up to \$150,000 if they had remained in the facility.

They have a significant amount of other revenue that is being invested in that program which is why they can do it. That revenue source is not available to us here in the county. So for us to get into the housing business, trust me, we have really looked at this in our county and we're still going to. We're still very involved in where the money is flowing in our county around housing and how we get streamlined services and supports in the housing arena for our members. But it's challenging. A lot of the money in our county is going to the chronically homeless. We don't always know if our members are chronically homeless. We're not going to have the resources to purchase housing. CPOs are not going to solve that or even get us closing to addressing that issue.

Successful transitions back to the community were facilitated by good relationships with LTSS and CBOs, provision of CPOs, and availability of free services in the community to help the plan support the transition.³¹

³¹ Ensslin, B. & Brodsky, B. (2016). Housing Options for High-Need Dually Eligible Individuals: Health Plan of San Mateo Pilot. Retrieved from <http://www.chcs.org/resource/housing-options-for-high-need-dually-eligible-individuals-health-plan-of-san-mateo-pilot/>.

HEALTH SYSTEM RESPONSE: CARING FOR CHALLENGING POPULATIONS

When asked who were their most challenging beneficiaries, which populations were the most difficult to serve, or what beneficiaries were most at risk of falling through the cracks of CMC, KIs noted several populations: 1) beneficiaries who are experiencing homelessness or those with unstable housing; 2) beneficiaries with SMI and/or substance use disorders; and 3) “unknown” beneficiaries (those the plan has failed to make contact with) who are at risk. Many beneficiaries fall under one or more of these categories, further compounding the challenge of serving them.

I don't think anybody has a handle on how to deal with these tougher populations yet. The warm handoffs aren't there, the infrastructures aren't there, the silos are still in place.

Addressing Homelessness and Housing

CMC plan KIs were almost unanimous in citing beneficiaries who are experiencing homelessness as the most challenging population for them to serve, especially if they were not able to locate or support housing for them.

This will not be successful if we can't house some of these homeless [individuals] and keep them out of the emergency room.

For the amount of money we pay for one high utilizer, we could have bought them a house.

One CMC plan KI reported having 800 homeless beneficiaries who were high risk and had high levels of need. However, the plan was getting the low rate for these beneficiaries because they lack a home in which to receive LTSS services.

Restrictions limited CMC plan solutions to housing problems: To get around barriers to spending Medicare or Medicaid dollars on housing, CMC plan KIs reported several strategies, including paying a per-beneficiary, per-month case rate to CBOs which were combined with separate funding streams that did not have restrictions around supporting housing costs.

With the homeless organizations, we can pay for the external intensive case management part of it, but we can't pay for the housing.

[The CBO] developed a subsidy pool, a flexible subsidy pool where there are multiple funding streams coming into the flexible subsidy pool from multiple payer sources. That's what the plan leverages to fill the gap from what the beneficiary can pay to what the market rent is.

We're very careful about the restriction on Medicaid dollars not being used for housing, so our approach has been more to really be the coordinating entity that makes sure all the possible resources that could be available to augment somebody's income for housing [are accessed]. For example, we incorporate any resources through the “Money Follows the Person Program,” a community transitions program, and the assisted living waiver, which has a whole range of options that are available to use.

RESULTS: HEALTH SYSTEM RESPONSE: CARING FOR CHALLENGING POPULATIONS

Some CMC plan KIs reported that there were resources in the community that they were able to tap into or pay for as a CPO to ensure that their beneficiaries did not lose their housing, or that housing could be secured after discharge from an acute or LTC facility. These community partners often worked with landlords to preserve existing housing resources or with various other partners to secure housing for their beneficiaries. Other CMC plans have attempted to partner local city and county housing authorities to expedite or expand housing services for their beneficiaries.

We really encourage partnerships with the local city and county housing authorities. They have vouchers from federal HUD that can be used for special populations. We're seeing that a lot of the agendas of the city and county housing authorities are to house the homeless. HUD will cover housing vouchers, and so the plans are really starting to create those partnerships with the housing authorities.

One KI also described how CMC plans could utilize dollars set aside for housing through the Substance Abuse and Mental Health Services Administration (SAMHSA).

[SAMHSA] actually set aside a number of dollars to build capital specifically for people with mental health and substance abuse issues. The plans are working closely with each county mental health office to facilitate referrals to those SAMHSA dollars for housing.

While some CMC plan KIs reported efforts to address housing challenges for their beneficiaries, many CMC plans didn't have similar resources in their communities, but continued to strategize about ways they could address the problem in the future.

Maybe we could have our own properties where we could put homeless people or people who are repatriating back to the community from [LTC facilities]. Right now we don't have good options or enough options.

Treating Substance Use Disorders

Launching a pain management health home: One CMC plan KI described their efforts to address the high-dose opioid population "that really plagues most health plans." The CMC plan KI described the tendency for beneficiaries with back pain to be driven to high dose opioids when nothing else works. The plan first mined their data to identify their beneficiaries:

...[with] a pattern of going into the ED, a pattern of going to multiple sources for narcotics, and other utilization patterns that really spell a pain patient that is not well controlled and relying on just opioid treatment, which is a large number of patients that are costing the health system a great deal of money because they are not really treated effectively.

The CMC plan KI described their efforts to engage beneficiaries' existing pain doctors, retain the beneficiaries' site of service, and to avoid stigmatized terminology, which could prevent participation. In response, the plan designed a pain management health home with a:

...complex treatment plan that includes the pain doctor at the center that still has access to the opioids and the interventions that you would find with a pain specialist, but now we've

RESULTS: HEALTH SYSTEM RESPONSE: CARING FOR CHALLENGING POPULATIONS

added psychiatry, psychologists, naturopathic, chiropractic, physical therapy, all the supportive services that need to be part of one health home around this population.

In the first month, beneficiaries were seen multiple times a week and a wellness program was established to help the beneficiary *"proactively replace narcotics with healthy behaviors and effective treatments."* The KI reported high levels of engagement in the program and efforts to examine outcomes that are tied, not only to reduction of their pain and better functioning, but also reduction in prescription cost, emergency department utilization, and hospital costs.

Serving Beneficiaries with Mental Illness

Developing fully integrated behavioral health systems: One CMC plan KI reported developing an innovative program targeted to individuals with SMI. While the program started prior to CMC, they were looking to expand it among their CMC beneficiaries. The CMC plan KI developed an integrated program for their *"very complex population that had been going in and out of the psychiatric hospital."* The program ensured that beneficiaries received:

...whatever they need while they are in the psychiatric hospital to prepare for transition, to leave the hospital, and to be supported out-patient. If they are homeless, we would arrange and coordinate housing. If they have substance abuse issues, it's getting them into co-occurring substance abuse treatment on discharge.

While they noted that this population of beneficiaries was similar to the Medi-Cal SMI population in the county mental health system, under CMC, *"these happen to be our responsibility."*

Our counties don't want to take more Duals because of their capacity with MediCal. Our Duals are served predominantly in our own directly contracted network, not in the county mental health system. There are a smattering of embedded Duals in both counties that have been there historically, but we are the payer, and so the difference is we've contracted with all of the county providers that are serving those members

The CMC plan KI reported positive outcomes from this program, such as:

...a reduction in emergency department visits by about 80% and almost that much in terms of psychiatric bed days. All in all, after paying for all the services, we had a return on investment in the pilot of about 25% reduction in cost for that very severe population.

The CMC plan KI attributed these positive outcomes to the ability of the pilot to link behavioral health services with physical health services and with primary care, a task that they didn't think would be possible in a delegated model.

Providing recuperative care: One CMC plan KI described exploring innovative models of care to address many of the overlapping issues faced by beneficiaries who are homeless, have substance use disorders, and/or have an SMI. The CMC plan KI reported partnering with a community-based organization to provide recuperative care to beneficiaries so they could return to shelters, qualify for housing, and reconnect with behavioral health or substance use disorder services.

RESULTS: HEALTH SYSTEM RESPONSE: CARING FOR CHALLENGING POPULATIONS

We're out there working very, very hard to locate people and assist them in making connections with providers, helping them understand the benefits of becoming known to a provider as opposed to an emergency room, trying to help people figure out where to go. Some of them live in really hideous makeshift situations. It's really difficult. It's really hard to help those folks. If you can get some of these people with severe behavioral health issues who've been homeless into these recuperative care programs where they can recover from their health issues, then often, you can do some really intensive case management to help the person get sober and connect them with an income resource like SSI. Help them get stable enough so that when they do leave, they're on housing lists or they go into housing. They're in much better condition physically, emotionally, and mentally than when they came in.

Unknown and At-risk

Some CMC plan KIs noted that one of the most challenging populations for them to serve were their “unknown” beneficiaries who were high risk, but not connected to the plan or to LTSS.

I worry the most about the people who are isolated, who are not connected to a CBAS center, not connected to our partners, they aren't visiting the doctor, they may have a lot of chronic conditions, they may be very fragile in the community, and they're difficult to engage. That's who I think is our biggest challenge.

There's that whole bucket of people who we're not touching, that are not answering our HRAs, those are the hidden costs that we just don't know.

One CMC plan KI described a best-case scenario of a previously unknown and at-risk member, who was able to complete an HRA, which triggered follow up by the care coordinator.

The member had very little knowledge of having access to any benefits at all. He hadn't seen a doctor in 9 years. He had chronic illnesses that weren't being managed in any way. He was marginally housed and depressed. The care coordinator was able to get him in to see a provider, access to behavioral health, housing, etc.

CMC plan KIs struggled with how to identify and reach these populations. One PPG KI described how they used predictive modeling to identify unknown and at-risk members using their own data and potential trigger points that could precede declines in health status or increases in utilization.³²

A lot of groups with larger patient populations are using predictive analytical software now to look for trends in claims data and in counter data to predict who might be at risk and to provide warnings, so that you can intervene clinically. You can do that at a plan level as well.

For example, CMC plans could include caregiver, elder abuse, or social isolation measures in their assessments, which could trigger further assessment and preventative services. ¹

³² Health Foundation for Western & Central New York (2015). Triggers of Decline Chart. Retrieved from <http://www.hfwcn.org/Tools/Broadcaster/frontend/itemcontent.asp?reset=1&ItemID=547>.

KEY FINDINGS AND RECOMMENDATIONS

Health System Response Varied by Region and Plan

Health systems across California vary greatly by county in terms of their history of managed care; the capacity of their provider groups; the availability of a qualified workforce; the volume of beneficiaries they serve; the geographic spread of their beneficiaries; and the integration of their medical, behavioral, LTSS, and social care services. These variations were notably apparent in how CMC plans built their network of providers, how they delegated services, how contracts and payments were structured, and how health system stakeholders collaborated. There was a broad recognition among KIs that what worked well for one CMC plan may not have worked well for another plan in the same region (or even the same plan in another region). For example, County Organized Health Systems (COHS) experienced a more seamless transition to CMC due to the fact that they were the single Medi-Cal plan in their county, their plan networks were already well developed, and most beneficiaries were already part of their Medicaid Managed Care (MMC) plan or Dual Eligible Special Needs Plan (D-SNP). Conversely, in southern California there was a very high level of delegation of medical care, authorization of services, and care coordination to PPGs. While this allowed plans to serve larger numbers of beneficiaries, it also reduced the extent to which the plans had control over the services provided. There was also a great deal of variation around how care coordination programs were implemented, with many plans creating innovative programs unique to their county and the needs of their beneficiaries. The integration of behavioral health varied, too, including one CMC health plan that was fully integrating behavioral health by building behavioral health capacity directly into the plan. KIs noted that current data reporting systems are challenged to capture the variability and complexity of practices across regions and plans.

Recommendation: DHCS or CMS should develop reporting systems that capture the regional and CMC plan variation in delegation and care coordination practices in order to assess their relative strengths and challenges.

CMC Education and Outreach Was a Challenge

Many KIs were critical of outreach efforts and educational materials provided to beneficiaries and other stakeholders. Notification materials especially could have used more detailed descriptions outlining the potential benefits of the program for beneficiaries and the providers who serve them. While some efforts have been made to improve CMC materials for beneficiaries, several KIs noted that many providers were still not well informed about the potential benefits of CMC. As beneficiaries' decisions about enrollment are strongly influenced by their providers, educating providers is imperative to sustaining adequate beneficiary participation in CMC.

Recommendations: Education and outreach efforts should continue with both beneficiaries and providers along with clear dissemination plans developed by DHCS. Special efforts should be made with physicians serving diverse communities, providers with high proportions of opt-outs, and IHSS social workers and care workers. Moving

KEY FINDINGS AND RECOMMENDATIONS

forward, outreach and education tools should be updated to include outcome data and examples of CMC success.

CMC Impacted the Health System Workforce

One common theme across KI interviews was that CMC required an adjustment to the health system workforce. Major adjustments to workforce infrastructure occurred in areas such as enhanced specialty provider networks; recruiting and training of adequate and qualified care coordinators; and expanded contractual, legal, and administrative staff. Though expanding the workforce can be a challenge, many of the changes have led to positive results. For example, the “evolution” of nurse and social work care coordinators often had a positive impact on care. As the health system workforce expands and diversifies, the importance of adequate data systems becomes more essential, especially in their ability to collect, report, and share data both within and across organizations; convene interdisciplinary care teams (ICTs); monitor services provided; and facilitate administrative processes.

Recommendations: Shifting health system workforce needs and challenges should be closely monitored, predicted, and addressed by CMC Plans and DHCS to meet the evolving needs of health systems and beneficiaries. DHCS should also encourage the adoption of adequate data systems that enable data sharing and foster collaboration both within and across stakeholder organizations.

CMC Strained the Financial and Administrative Capacity of Some Stakeholders

The administrative burden on health system stakeholders reportedly increased substantially as a result of CMC’s data collection and reporting requirements. Although some CMC plan KIs reported simplified billing as a potential benefit of CMC, provider and LTSS KIs often reported challenges early in implementation with establishing and/or managing contracts, navigating variable processes across plans, adjusting to provider payment rates, and adapting to lags in cash-flow that were a result of denied claims. These challenges may have been especially burdensome on smaller PPGs or LTC facilities that were less able to adapt to these changes or withstand any disruptions in cash-flow.

Recommendations: DHCS should continue to monitor CMC’s financial and administrative impacts, especially on independent providers, and small PPGs or LTC facilities. DHCS could also encourage plans to standardize processes in order to alleviate administrative burden on stakeholders that work with multiple plans.

KEY FINDINGS AND RECOMMENDATIONS

Health Systems Reported Challenges with Competing Pressures to Invest and Save

Most health plan KIs were positive about CMC and committed to its continuation. They were, however, concerned about the pressure to cut costs while simultaneously investing significantly in new systems of care, an expanded workforce, and innovative programs. Health plan KIs reported that the savings targets in CMC were ambitious and that additional time would be needed for cost savings to be realized. Similarly, most CMC plan KIs felt rates were too low and that quality withholds (i.e., the portion of the CMC rate that is withheld from the plan until quality benchmarks are met) were more punitive than incentivizing. Plan KIs also reported that they were not given the flexibility in determining CMC payment structures that they would need to succeed.

Recommendation: Evaluations of CMC effectiveness, particularly around cost savings, should take into account likely lag times between investment and savings.

CMC Encouraged Collaboration Across Health System Stakeholders

CMC led to increased levels of collaboration between health plans and multiple stakeholders and providers serving dually eligible beneficiaries. Statewide and regional meetings (called “collaboratives”) that were formed as part of the CMC implementation process were a key factor in successfully promoting shared learning, enhanced communication, and collaboration across health system stakeholders. This was especially true in large counties where the multiple plans and high numbers of CBOs have historically made collaboration and communication more difficult. Collaborations between health plans and IHSS, a key requirement of the demonstration, were strengthened using strategies such as co-locating staff and developing portals to share data and were reported as effective in improving services for beneficiaries. In an effort to address beneficiaries’ non-medical needs, several CMC plans developed promising partnerships with CBOs.³³ There were also many challenges due to lack of, or ineffective collaborations in CMC counties. Challenges arose when health system stakeholders were not adequately informed about each other’s roles, limitations, and capacities. Collaborating and communicating across the health system, especially between health plans, LTSS and behavioral health is a mandate of the CCI legislation. Though a great deal of progress has been made, additional investment in communication systems and collaboration across stakeholders will be essential over time for advances to be maintained and improved.

Promising Practices: Some CMC plans reported building new collaborative relationships, such as with Alzheimer’s disease organizations to train their care coordinators, improve identification and diagnosis of their beneficiaries with Alzheimer’s disease or related dementias, and expand access to services and supports for beneficiaries with dementia and their caregivers.

³³ The SCAN Foundation: Linkage Lab Initiative. Retrieved from <http://www.thescanfoundation.org/linkage-lab-initiative>.

KEY FINDINGS AND RECOMMENDATIONS

Recommendation: CMC plans should continue to invest in communications and collaboration across health system stakeholders to meet the needs of their beneficiaries and share promising practices.

HRAs and Other Assessments Were Challenging but Valuable

CMC health plans were required to conduct a health risk assessment (HRA) for all new members, but many experienced serious challenges due to the difficulty of reaching beneficiaries with outdated contact information from DHCS. Many beneficiaries were also reportedly reluctant to participate in an assessment. As of March 2016, only 88 percent of CMC beneficiaries have completed an HRA overall, with the percentage of completion varying by plan from 56 percent to 100 percent.³⁴ CMC health plans conducted HRAs in a variety of ways, with many KIs noting the value of CMC plans conducting in-home assessments, especially with complex or high-risk beneficiaries. Although HRAs were expected to meet certain criteria established by CMS and DHCS, each CMC health plan's assessment form was proprietary and unique. Due to this, there was concern that HRAs were not adequately assessing non-medical or social needs, and were therefore not triggering referral to appropriate care coordination or LTSS. CMC health plans felt that HRAs were important because they were a first step in providing person-centered care to beneficiaries, a mandate of the demonstration. However, some KIs expressed concern that HRAs may not do enough to identify the care goals and priorities of beneficiaries.

Promising Practices: CMC plan KIs described developing additional assessment protocols that were triggered as a result of HRA or utilization data. For example, one CMC plan used a caregiver strain question in their assessment if a caregiver was identified in the HRA.

Recommendation: DHCS should more clearly define person-centered care for CMC health plans, and ensure that beneficiaries' goals are elicited in the HRA process.³⁵ The development, piloting, and adoption of a universal screening assessment tool and procedures by DHCS, with guidance from plans, could address this challenge.

CMC Plans Varied in How They Implemented ICPs and ICTs

As part of the assessment and care coordination processes in CMC, plan KIs reported completion of, or intention to complete, individualized care plans (ICPs) for all CMC beneficiaries. However, there was a great deal of variation across plans in how ICPs were implemented, ranging from ICPs that were created solely from utilization data to ICPs that were "living documents" created and adjusted through interdisciplinary care teams (ICTs) and shared with all relevant parties. Similarly, the

³⁴ DHCS (2016). Cal MediConnect Performance Dashboard. Retrieved from <http://www.calduals.org/enrollment-information/enrollment-data/cal-mediconnect-performance-dashboard/>.

³⁵ The SCAN Foundation: Person-Centered Care. Retrieved from <http://www.thescanfoundation.org/our-goals/person-centered-care>.

KEY FINDINGS AND RECOMMENDATIONS

implementation of ICTs varied, from ICTs that existed solely on paper with no formal meeting to ICTs that included multiple members meeting weekly. CMC plan KIs noted the importance of organization and expediency in arranging and holding ICTs to make the best use of, and encourage the participation of, all ICT members. While, many KIs pointed out that not all CMC beneficiaries needed an intensive ICP and ICT, more information is needed from plans about their ICP and ICT implementation.

Recommendations: DHCS should establish a reporting process on ICP and ICT implementation. Best practices in organizing and conducting ICTs should be identified, replicated across CMC plans, and integrated into future CMC plan requirements.³⁶

Care Coordination Holds Promise

CMC required health plans to develop and expand care coordination programs. CMC plan KIs reported significant investments in care coordination workforce, specialized trainings, expanded collaborations, and sometimes even an evolution in their internal culture of care. Several KIs reported innovative approaches to care coordination in CMC, such as specialized complex care departments or care coordinators specially trained in care transitions or to serve LTSS beneficiaries. Some plans also reported different levels of care coordination, with more extensive support for higher-risk beneficiaries. Most CMC plans employed a variety of credentialed care coordinators including registered nurses and social workers, who were sometimes supported by non-credentialed “care navigators” or “community connectors.” Most CMC plan KIs were able to provide numerous anecdotes of successful care coordination, expanding upon existing literature on the promise of care coordination.³⁷ While all plans reported conducting care coordination activities, they varied greatly in the volume of beneficiaries receiving these services from 100 percent in one plan to only 10 percent in another. This variation suggests CMC plans may define care coordination differently, with some equating basic utilization review or completion of an HRA as care coordination.

Recommendations: DHCS should work with CMC plans to more clearly define levels of care coordination and improve data collection and reporting on care coordination practices in order to better assess their impact. DHCS should also make efforts to ensure that beneficiaries understand care coordination and its potential benefits.

CMC Encouraged Efforts to Avoid Unnecessary Utilization and Cost

The CMC demonstration is designed with many pathways and potential strategies to control costs. CMC plans reported efforts to avoid unnecessary utilization of medical services including: intensive

³⁶ Philip, A., & Herman Soper, M. (2016). Interdisciplinary Care Teams for Medicare-Medicaid Enrollees: Considerations for States. Retrieved from http://www.thescanfoundation.org/sites/default/files/chcs_icts_for_medicare-medicaid_enrollees_012216.pdf.

³⁷ The SCAN Foundation: The Promise of Coordinated Care. Retrieved from <http://www.thescanfoundation.org/promise-coordinated-care>.

KEY FINDINGS AND RECOMMENDATIONS

care coordination for at-risk members, enhanced support for members and caregivers, improved transitions across sites of care, and attempts to mitigate financial incentives that encourage LTC facilities to re-hospitalize residents. A key area where CMC health plans might achieve cost reductions is in the transition of beneficiaries from institutional care to lower cost home and community-based services. Though most CMC plans were interested in facilitating the transition of willing LTC residents back to the community, only a couple plans reported success in doing so. Efficacy of these efforts may depend on adequate community resources, including the availability of accessible and affordable housing options; the effective provision of home- and community-based services; and cooperation of LTC facilities and LTSS providers.

Recommendation: Best practices in avoiding unnecessary utilization of medical services should be identified, replicated, and integrated into future CMC policy reform efforts.

Better Tracking of CPOs and Referrals to Community-Based Organizations Is Needed to Document Their Return on Investment

CMC allows plans to provide optional services, beyond plan benefits and supplemental services, to beneficiaries, called care plan options (CPOs). These CPOs are intended to give CMC plans the flexibility to provide services not otherwise covered to beneficiaries to help them avoid higher levels of care. CMC plan KIs reported providing a variety of CPOs including: cell phones, home modifications, home appliances, socialization programs, personal care services, and housing support. Once an “actionable need” was identified, CMC plans either identified available resources and services through community organizations, or they provided the resource or service as a CPO. The documentation of CPOs provided to beneficiaries is inconsistent across plans, with only a few plans reporting efforts to track their return on investment. The CMC plans that were tracking CPOs reported tracking only the services they paid for, excluding the services that were provided through community organizations’ existing services. The lack of consistency in the tracking of CPOs makes it difficult to assess their return on investment. Furthermore, community organizations that provide free services to CMC beneficiaries want to make sure that their role in the demonstration, their contribution to cost savings, and the positive impact they are having on CMC beneficiaries are captured and taken into account as policymakers decide how the program may be structured in the future.

Recommendations: CMC plans should enhance efforts to track the provision of CPOs as well as resources or services provided by community organizations in order to determine their return on investment. Such data should be used to identify promising practices for expanded replication.

CMC Could Improve Access to LTSS

Several CMC plan KIs reported efforts to improve access to LTSS for CMC beneficiaries, especially in the area of referral to IHSS, CBAS and MSSP, or advocating for re-assessments of current IHSS

KEY FINDINGS AND RECOMMENDATIONS

recipients to increase their hours. Despite this, some organizations that provide home and community-based services raised concerns about the lack of referrals from CMC plans, and some were disappointed in the extent to which the CMC health plans were contracting for their services. They expressed skepticism about the capacity of CMC plans to adequately provide LTSS without leveraging the expertise of stakeholders that have a long history of providing these services to dually eligible beneficiaries. The duplication of care coordination services was especially concerning, especially in situations where the CMC plan and the LTSS provider had not developed a collaborative relationship.

Promising Practices: CMC plan KIs reported efforts to 1) increase referrals to IHSS, CBAS, and MSSP; 2) enroll informal caregivers as IHSS workers; 3) request re-assessments and additional services; and 4) pay for certain LTSS services as care plan options to avoid delays in access or gaps in care.

Recommendations: CMC plans should share promising practices in expanding access to LTSS. DHCS should continue to encourage CMC plans to collaborate with LTSS providers, especially around the provision of care coordination.

CMC Has Impacted Coordination Between IHSS and Plans

While the county Social Services Department retained control over the assessment and authorization of IHSS hours for CMC beneficiaries, CMC plans paid for and coordinated services. Though this limited the ability of CMC plans to directly influence the provision of IHSS to their beneficiaries, KIs did report that the level of communication and coordination between IHSS and plans had improved tremendously. CMC health plans worked to communicate more effectively with IHSS social workers, sometimes co-locating staff or creating data systems to enhance communication. IHSS and CMC plan KIs also reported arranging education and outreach sessions with IHSS social workers, care workers, and beneficiaries. Many CMC plan KIs expressed an interest in IHSS care worker's involvement in their beneficiary's care planning and ICTs. However, some KIs were concerned that this could happen without the beneficiaries consent, risking the consumer-directed nature of IHSS.

Recommendations: DHCS should monitor CMC plans' efforts to engage IHSS care workers in care planning and ICTs, and ensure that the consumer-directed foundation of IHSS is upheld.

Plans Responded to the Challenge of Serving Some Populations

While not unique to CMC, KIs noted challenges in serving particular CMC beneficiaries, especially homeless beneficiaries, those with severe mental illness or substance use disorders, and those that are "unknown" and at risk. A large number of beneficiaries fall under one or more of these categories, further compounding the challenge of serving them. However, with CMC's additional

KEY FINDINGS AND RECOMMENDATIONS

benefits and flexibility, some plans were developing innovative approaches to address the challenge. While some CMC plans were able to patch together community resources or multiple funding streams to meet the needs of these challenging populations, other plans reported that they didn't have the same resources in their communities. This disparity in community-based resources to supplement the benefits and services provided by the CMC plan could lead to variable CMC outcomes regarding the ability to serve challenging populations.

Promising Practices: CMC plan KIs described efforts to integrate behavioral health care into primary care, develop innovative pain management health homes, utilize recuperative care services, and identify housing resources.

Recommendations: CMC plans should share promising practices in serving challenging populations to be shared by DHCS. DHCS should also monitor disparities in serving challenging populations across CMC plans and counties, and seek to address these challenges in future reform efforts.

CMC Encouraged Quality Oversight

CMC policy included several incentives to improve quality of care, such as increased collection and reporting of quality metrics, quality withholds, and person-centered care requirements. However, KIs also reported an incentive for CMC plans to conduct quality oversight. This interest in ensuring quality of the care provided to their beneficiaries seemed to be especially important in newer areas of plan responsibility – LTC and LTSS.

Promising Practices: CMC plan KIs reported efforts to: 1) tie payments and shared savings arrangements to quality outcomes, 2) assess the quality of LTC facilities and LTSS using rating systems,³⁸ and 3) enforce quality through partnerships with oversight agencies, such as the LTC Ombudsman Program.³⁹

³⁸ CalQualityCare.org-Your Guide to Quality Health Care in California. Retrieved from <http://www.calqualitycare.org/>.

³⁹ Hollister, B., Davies, M., Mokler, P.M. & Graham, C. (2016). Yes, Collaboration Can Happen—and Means Better Quality of Life for LTC Residents. Retrieved from <http://asaging.org/blog/yes-collaboration-can-happen-and-means-better-quality-life-ltc-residents>.

CONCLUSION

The aims of this health system response study are to: (1) examine organizational impacts and health system responses to CMC; and (2) identify challenges, promising practices and recommendations to improve the coordination of care across sites for dual beneficiaries. Although the demonstration is still in progress, these early reports from KIs have shown how CMC has impacted individual health system stakeholders, such as: health plans, providers and PPGs, LTC facilities, IHSS, CBAS, and MSSP. Additionally, KIs reported ways in which the health system has responded as a whole to CMC's efforts to enhance care coordination; provide ancillary services, supplemental benefits and care plan options; improve quality; and control costs. To further assess the impact of CMC, a second phase of the health system response evaluation will be conducted in 2017 with a broader representation of health system stakeholders. The second phase of the evaluation will build upon the findings in this report, explore new areas of inquiry, and develop case studies to further exemplify health system responses to CMC.

California Department of Health Care Services (DHCS) Response

California's Coordinated Care Initiative (CCI) is a historic undertaking to help improve the lives of low-income seniors and people with disabilities. DHCS appreciates the various evaluation efforts supported by The SCAN Foundation, and is encouraged by early evaluation data^a that shows beneficiaries in Cal MediConnect (CMC) health plans are confident in and satisfied with their care. DHCS also recognizes the challenges that come with trying to integrate different health care systems in a way that provides improved and coordinated care to beneficiaries. Throughout the history of the CCI, DHCS has worked with CMC plans and other stakeholders to address issues and improve and strengthen the program. DHCS is implementing program improvement strategies^b developed to target the areas identified in the evaluations to date, and will continue to use data-driven quality improvement strategies as program implementation continues.

DHCS is currently working on a number of projects within the CCI to continue improving collaboration across health system stakeholders. For example:

- DHCS is working with the California Hospital Association and the CMC plans on a hospital case manager toolkit^c that will help facilitate smoother care transitions for CMC members during hospital admissions and discharges. DHCS is working with the plans and CCI counties around a similar toolkit or best practices white paper on how the plans, their delegates and the county behavioral health agencies and providers can continue to strengthen care coordination for CMC members.
- DHCS has begun convening best practices meetings with CMC plans to target specific topics for quality improvement, such as strengthening data collection and reporting or care coordination for patients with dementia.

Continued...

CONCLUSION AND DHCS RESPONSE

- DHCS has worked closely with the plans and providers to improve communication and resolve billing, authorization and contract challenges, particularly during the initial transition period in implementation. DHCS facilitated a number of meetings between plans and specific provider groups to resolve these issues, as well as hosting several large provider summits designed to strengthen communication within CMC networks.
- The DHCS-CMS contract management teams continue to work closely one-on-one with the CMC plans to resolve challenges as they are identified.

DHCS is also taking several steps to encourage broader use of LTSS services. DHCS is working with stakeholders to standardize the HRA questions designed to prompt referrals for non-medical or long term services and supports (LTSS) needs.^d These new questions will reflect best practices developed by plans with high rates of LTSS referrals. Additionally, DHCS is strengthening data collection around LTSS referrals to better track how effectively plans are linking beneficiaries to needed services. This will enable a better understanding of how and why CMC plans are identifying a need for LTSS and services to which they are providing referrals. DHCS has also recently proposed that CMC plans clarify the extent to which ICPs and ICTs are being completed, utilized, and executed.

DHCS is also working to ensure that eligible beneficiaries and their providers understand the promise of CMC. DHCS has also developed new materials for beneficiaries; the Cal MediConnect Beneficiary Toolkit^e has been developed to support beneficiaries, their key supports, and options counselors in choosing the best option for the beneficiary, in addition to the formal notices and guidebooks. DHCS has also created a Guidebook^f for new dual eligibles. The Beneficiary Toolkit and new Guidebook have undergone stakeholder review and beneficiary user testing with Health Research for Action at the UC Berkeley School of Public Health. They will be finalized by the end of July and then shared broadly.

As the evaluation efforts have shown, written materials are not always sufficient to effectively educate beneficiaries about the program and its potential benefits. DHCS is continuing to work on-the-ground in CCI counties with other stakeholders and partners to reach and educate dual eligibles about the program, including targeted and culturally competent outreach in diverse communities. DHCS is also working with the CMC plans to encourage appropriate education and marketing efforts towards duals who may benefit from the program.

As the evaluation notes, providers are a key source of information for dual eligibles. DHCS has conducted a detailed analysis of beneficiaries who have opted out of the program and their most frequently used providers in an effort to more effectively focus provider education and outreach activities, in partnership with the health plans. This work will include language-specific outreach and activities focused at physicians who serve diverse communities.

DHCS will continue to work with CMC plan partners and stakeholders to identify areas to improve the program and ensure that more eligible beneficiaries know how Cal MediConnect can improve their health and quality of life.

Continued...

CONCLUSION AND DHCS RESPONSE

REFERENCES

- ^a DHCS (2016). Latest Survey Results Finds Cal MediConnect Enrollees Are Expressing Increased Satisfaction. Retrieved from <http://www.calduals.org/2016/06/16/latest-survey-results-finds-cal-mediconnect-enrollees-are-expressing-increased-satisfaction/>.
- ^b DHCS (2016). Cal MediConnect Voluntary Enrollment Strategy. Retrieved from <http://www.calduals.org/wp-content/uploads/2016/06/DRAFT-Cal-MediConnect-Voluntary-Enrollment-Strategy-2016-06-30-16.pdf>.
- ^c DHCS (2016). Cal MediConnect Hospital Case Manager Toolkit. Retrieved from www.calduals.org/wp-content/uploads/2016/03/Case-Manager-Toolkit_-3-3-16.pdf.
- ^d DHCS (2016). Standardized Health Risk Assessment (HRA) Long-term Services and Supports (LTSS) Referral Questions. Retrieved from <http://www.calduals.org/wp-content/uploads/2016/05/HRA-LTSS-Questions-5.5.16.pdf>.
- ^e DHCS (2016). Beneficiary Toolkit. Retrieved from <http://www.calduals.org/2015/11/24/for-review-new-toolkit-for-dual-eligible-beneficiaries/>.
- ^f DHCS (2015). Revised Managed Care Guide and Choice Book for New Dual Eligible Beneficiaries in CCI Counties. Retrieved from <http://www.calduals.org/2015/09/21/for-review-revised-managed-care-guide-and-choice-book-for-new-dual-eligible-beneficiaries-in-cci-counties/>.

Supported by a grant from The SCAN Foundation – advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. For more information, visit www.TheSCANFoundation.org.

APPENDICES

APPENDIX A: EMAIL SCRIPTS

Health Plan KI Email Script

Subject line: Invitation to participate in key informant interview about Cal MediConnect

Hello,

We are contacting you because our University of California research team, lead by Dr. Carrie Graham, was recently funded by The SCAN Foundation to conduct an evaluation of the Cal MediConnect Program. I have attached a description of our evaluation efforts to this email. As part of this evaluation, we will be conducting interviews with key stakeholders (including plans, providers, advocates, and other community based organizations who work with the duals population). Our primary aim is to learn about how Cal MediConnect has been implemented from the point of view of various stakeholders.

As a first step, we would like to begin by interviewing representatives from each of the Cal MediConnect health plans. We would like to learn from you, how Cal MediConnect is being implemented through your plan, your assessment of how it is going, and what the impact has been on your plan and system of care.

If you are willing to participate, we will send our interview questions for you to review ahead of time. We are interested in interviewing you as well as anyone else from your plan that you think might be able to answer our questions. Each interview will be conducted over the phone and will take about one hour. We will also send a data request form that we hope you can complete and return to us prior to the interview.

As a participant, your name will be kept confidential, and we will not report the name of any health plan when reporting findings, but given the limited plan's participating in Cal MediConnect, we can't guarantee that your plan won't be identifiable. Being in this study is optional, and you can tell us if you want to stop being in the study at any time. You will not be charged for or receive compensation for participating in the interview.

If you, or someone from your organization, agree to participate, please reply to this email or contact Brooke Hollister (Phone or Email) or Carrie Graham (Phone or Email).

We are excited about this project and hope you can join us!

Best,

APPENDICES

Stakeholder KI Email Script

Subject line: Invitation to Participate in key informant interview about Cal MediConnect

Hello,

We are contacting you because our University of California research team, lead by Dr. Carrie Graham, was recently funded by The SCAN Foundation to conduct an evaluation of the Cal MediConnect Program. I have attached a description of our evaluation efforts to this email. As part of this evaluation, we will be conducting interviews with key stakeholders (including plans, providers, advocates, and other community based organizations who work with the duals population). Our primary aim is to learn about how Cal MediConnect has been implemented from the point of view of various stakeholders.

We are particularly interested to speak with you, or someone from your organization because of your experience with Cal MediConnect and/or working with dually-eligible beneficiaries.

If you or someone else at your organization is willing to participate, we will send our interview questions for you to review ahead of time.

The interview will be conducted over the phone and will take about 30-60 minutes.

We will keep all of your information confidential. Being in this study is optional, and you can tell us if you want to stop being in the study at any time. You will not be charged for or receive compensation for participating in the interview.

If you, or someone from your organization, are interested in participating in this study, please reply to this email or contact me at (Phone)

If you have any questions about the study please feel free to contact Dr. Brooke Hollister (Phone or Email) or Dr. Carrie Graham (Phone or Email).

We are excited about this project and hope you can join us!

Best,

APPENDIX B: HEALTH PLAN KI PRE-INTERVIEW DATA REQUEST FORM

Prior to your interview with the Cal MediConnect Evaluation team, please provide the following information about your health plan. This information will be valuable to interviewers and will ensure that your interview will be as efficient as possible. If possible, please email this form and additional requested documents back to (Email) prior to your scheduled interview. Thank you for your participation in the Cal MediConnect Evaluation Project!

Name of person completing form:

Email address:

Health plan:

Name of Cal MediConnect Product:

- 1) Can you estimate how many total Cal MediConnect members your plan currently has? (include total number of duals)
- 2) Can you estimate what percent of these beneficiaries were members of your plan through Medi-Cal managed care before the transition to Cal MediConnect?
- 3) Can you estimate the total number of duals who have opted out of Cal MediConnect, but are members of your plan's Medi-Cal Managed Care product?
- 4) Can you tell us the names of the Independent Practice Associations (IPAs) or Participating Provider groups (PPGs) your plan is delegating to?
 - a) How many MDs, NPs, are in the IPA panels?
- 5) What proportion of your members are delegated to these agencies?
- 6) What is the total number of care coordinators/managers in your health plan (or delegated agency) that provide Cal MediConnect care coordination/management?
 - a) What % are RNs?
 - b) What % are MSWs?
 - c) What % are other credentialed staff? Please detail the credential types:
 - d) What % are non-credentialed staff?
- 7) What percent of your Cal MediConnect beneficiaries have completed a health risk assessment (HRA)?
- 8) What percent of your Cal MediConnect beneficiaries get care coordination/ management?
- 9) What percent of your Cal MediConnect beneficiaries are assigned an Interdisciplinary Care Team?

APPENDICES

- a) Who participates on the interdisciplinary care teams?
- b) How often do interdisciplinary care teams meet?
- c) Do they meet in person?
- d) On average, how long do the meetings last?
- e) On average, how many participants are on an interdisciplinary care team?

10) What percent of your members are considered high risk?

11) How does your health plan determine if a beneficiary is high risk?

12) If we need more information, is there someone else from your health plan that we can speak with?

- a) Name
- b) Position
- c) Contact information

13) Prior to the interview, please send us the following:

- a) A copy of your plan's HRA form(s)
- b) A copy of any additional assessment tools used by your health plan
- c) A sample of an individualized care plan
- d) Network list of LTSS providers

APPENDIX C: HEALTH PLAN KI INTERVIEW PROTOCOL

* Interviewers will use this interview guide loosely during your interview. Interviews may not address all topics or questions and additional questions may be asked. You are welcome to write in responses to our questions and return them to (Email) prior to your scheduled interview if you would like to expedite the interview process. If you choose to do this, the interview will focus on clarifying responses or addressing any unanswered questions. Your input is very valuable to this study and the future of Cal MediConnect, thank you for your time!

General Information (all participants)

- 1) Can you describe your professional position and your role and involvement with Cal MediConnect?
- 2) Can you tell us about how your health plan delegates members to Independent Practice Associations (IPAs) or Participating Provider groups (PPGs)

Benefits (all participants)

- 3) What would you say are the major changes in benefits for Cal MediConnect members?
- 4) Why did your plan elect/not elect to offer a supplemental dental plan?
- 5) From your plan's perspective, what are the greatest (most useful) benefits for Cal MediConnect members?
- 6) From your plan's perspective, what are the greatest (most useful) advantages of Cal MediConnect for providers?
- 7) Is your plan providing members with additional (optional) services above and beyond core Cal MediConnect benefits?

Financial impact (CEO/Management)

- 8) What impact has Cal MediConnect had on the financial status of your health plan?
- 9) How are savings being shared with delegated agencies?
- 10) Are savings being shared with members through expanded benefits or optional services?

Administrative impact (CEO/Management)

- 11) How has your plan responded to the different data collection or reporting requirements of Cal MediConnect?
- 12) Has Cal MediConnect impacted your health plan's workforce?

Provider Networks (CEO/Management)

- 13) What has your health plan done to ensure that provider networks are adequate for the Cal MediConnect population?

APPENDICES

14) What are some areas where you still need to expand provider networks?

Opt-out (CEO/Management)

15) Who is opting out of Cal MediConnect and why?

16) Are community outreach strategies working to notify/inform dual eligibles?

17) How has care changed for people who opted out but are still members of your plan's Medi-Cal Managed Care plan or MLTSS?

Care Coordination / Management (Directors of Medical Care, Care Coordination, and/or LTSS)

18) What do you call the care coordination/management service in your health plan?

19) Is care coordination/management being provided internally through your health plan or are you contracting out or collaborating with other agencies to provide this benefit?

20) Who provides care coordination/management?

21) How does your plan decide what conditions lead to a member qualifying as high risk?

22) Describe the different levels of care coordination/management and what each consists of?

23) What are the most common services care coordinators/ managers are performing for members?

24) How are members assessed for care coordination/management?

a) Who conducts the needs assessment/health risk assessment?

b) What is done with the data from assessments after they are completed?

c) Are caregivers or family members invited to participate in the assessment process?

d) After the initial assessment, how often do care coordinators interact with members?

25) What does your health plan call a member's individualized care plan? Does it have a specific name other than "individualized Care Plan?"

26) Under what circumstances is an interdisciplinary team called together to consult on a member's care?

27) Who usually participates on the interdisciplinary care team?

28) What efforts are made to ensure that the care plan is person-centered? Do you ask members about their personal goals and priorities?

29) Overall, how effective would you say the Interdisciplinary Care Teams have been from the health plan's perspective?

30) How is your health plan currently collaborating with other providers/agencies to coordinate care for Cal MediConnect members?

31) How well is care coordination/management working? What are the benefits, promising practices, and lesson learned?

32) What have been the main challenges to implementing and providing care coordination/management for your Cal MediConnect members?

Long-Term Services and Supports (Directors of Medical Care, Care Coordination, and/or LTSS)

33) Please describe how your health plan has been managing long-term services and supports for Cal MediConnect members?

APPENDICES

- 34) How are members' experiences different now that they have managed LTSS?
- 35) What role does your health plan play in helping members transition from a hospital or a LTC facility to the community?

Skilled Nursing/Rehab Care through Cal MediConnect (Directors of Medical Care, Care Coordination, and/or LTSS)

- 36) From your health plan's perspective, how has it been to work with Cal MediConnect members who are living in SNFs or in rehab facilities?
- 37) How is Cal MediConnect changing members' experiences of care in SNFs or in rehab facilities?
- 38) We understand that many SNF residents have opted out. Is that true? If yes, why?
- 39) We understand there were initially some issues with contracting between the health plans and facilities. Has that been resolved? How?

Concluding Assessment of Cal MediConnect (all participants)

- 40) What has been the most challenging aspect of implementing Cal MediConnect?
- 41) What Cal MediConnect populations are the most challenging for your health plan to serve?
- 42) Are there any ways in which your Health Plan is different or exceptional in its implementation of Cal MediConnect compared to the other plans in California?
- 43) Was there anything we didn't discuss today that you think is important for us to know?

APPENDIX D: STAKEHOLDER KI INTERVIEW PROTOCOL

KI Name:

Title:

Organization:

Contact information:

Introduction

Thank you for agreeing to speak with me today. We were awarded a grant from the SCAN Foundation to evaluate Cal MediConnect using telephone surveys, focus groups, and key informant interviews. You were identified as a key informant because of your experience with Cal MediConnect and/or working with dually-eligible beneficiaries. While the telephone surveys and focus groups will collect data on beneficiary experiences, in this interview we are interested in the impact Cal MediConnect has had on providers, organizations, and systems that serve dually eligible beneficiaries. I'm going to ask you about several different topic areas, if you feel that you are unable to provide feedback on a particular topic, we can proceed to the next topic.

- 1) First of all, could you describe your professional position and your role and involvement with the California duals demonstration, known as Cal MediConnect?
 - a. What is your organizational affiliation?
 - b. What is your area of expertise?
 - c. Do you work directly with beneficiaries? If yes, in what capacities?

We would like to know what current or anticipated effects the CCI has had on you, your organization, or systems of care in the following domains:

Readiness:

- 2) What did your organization do to prepare for the transition into Cal MediConnect?
- 3) Were your preparations sufficient? What other preparations would have helped? What would you do differently?
- 4) Were individuals in your organization adequately trained/ prepared for Cal MediConnect?
- 5) What, if any, were your sources of accurate information and technical assistance for the transition to Cal MediConnect?
- 6) How could the state and/or federal governments helped you better prepare for Cal MediConnect?

Financial impact:

- 7) What impact has Cal MediConnect had on the financial status or administration of your health system organizations?
- 8) How has Cal MediConnect impacted income, billing, staffing, and other resources of the organization or health system?

APPENDICES

Administrative impact

- 9) Have there been changes to reporting, data collection, or paperwork related to Cal MediConnect?
- 10) Has Cal MediConnect led to any changes in how your organization evaluates its operational or financial goals in the short term? In the long-term?
- 11) Have there been changes to how you evaluate and report on effectiveness or quality of care since the transition to Cal MediConnect?

Workforce impact

- 12) How has the transition to Cal MediConnect impacted the availability, recruitment, and/or training of the health systems workforce?
- 13) How has the transition to Cal MediConnect impacted the availability, recruitment, and/or training of the long-term care and social services and supports workforce?

Impact on Beneficiaries

- 14) How do you think beneficiaries in CalMediConnect that you work with are faring? Are things better, the same, worse?
- 15) Have you seen any major changes in the quality of services for beneficiaries in CalMediConnect?
- 16) Have you seen any major changes in access to services for for beneficiaries in CalMediConnect?

Cultural competency

- 17) Are Cal MediConnect services appropriate/ adequate for people:
- 18) Are materials and services provided appropriate to their preferred language, literacy level, and disability?
- 19) Have you seen changes in physical accessibility in Cal MediConnect providers in your area for people with disabilities as a result of Cal MediConnect?
- 20) Have you seen changes in the way Cal MediConnect health providers in your area evaluate or administer requests for disability accommodations and/or cultural needs of individual members as a result of Cal MediConnect?
- 21) What populations are the most at risk for falling through the cracks in Cal MediConnect?

Inter-organizational Collaboration

- 22) Has your organization expanded its collaborations as a result of Cal MediConnect?
- 23) Have you experienced any resistance to collaboration or participation in Cal MediConnect from providers, organizations, or others?
- 24) What have been the benefits, challenges, best practices, or lessons learned from any collaboration efforts as a result of Cal MediConnect?

Innovations, Promising Practices, and Challenges

- 25) What are some of the innovations or promising practices in implementation or service delivery due to Cal MediConnect that you have observed so far?

APPENDICES

- 26) Have there been opportunity to learn from promising practices or challenges that have been faced in other duals demonstration projects or MLTSS transitions?

General Services and Supports

- 27) How have services (medical services, behavioral health and substance use disorder services, LTSS) changed since Cal MediConnect began?
- 28) Has the transition to Cal MediConnect led to new, modified or expanded programs, policies or procedures?
- 29) Have there been changes to the effectiveness or quality of care provided since the transition to Cal MediConnect?
- 30) Have there been changes to the population(s) served by your organization since the transition to Cal MediConnect?
- 31) Have beneficiaries experienced delays or disruptions in accessing services?
- 32) How has the transition to Cal MediConnect impacted your organizations' ability to effectively serve Cal MediConnect clients/ patients?
- 33) Are services provided with consumer direction? Are there sufficient opportunities for beneficiaries and their caregivers to participate in care planning? How much control do beneficiaries have on their health care decisions and care planning?
- 34) Are beneficiaries receiving optional benefits or services above and beyond core medical and behavioral health care and LTSS?
- 35) What have been the biggest challenges to service delivery? Were they expected?
- 36) Are you seeing any savings that can be put into additional services?
- 37) Are provider networks adequate to serve new enrollees?
- 38) How are providers coordinating services across settings (medical, behavioral health/ substance use disorder, or long-term services and supports)?
- 39) How are referrals being across settings (medical, behavioral health/ substance use disorder, or long-term services and supports)?
- 40) How are health plans coordinating with medical, BH/SUD, or LTSS providers?
- 41) Are any medical, behavioral health/ substance use disorder , or long-term services and supports services or benefits being denied?
- 42) What service needs remain unmet?
- a. Medical providers
 - b. Behavioral health/ substance use disorder providers
 - c. Long-term services and supports providers

Long-Term Services and Supports

- 43) Who is providing LTSS? (health plans, IHSS, MSSP, C-BAS)
- 44) Are people living in the least restrictive setting possible?

Home and Community based Social Services and Supports

- 45) Are services such as home and community based services such as transportation, home modifications, meals on wheels being provided?
- 46) Are plans collaborating with HCBS providers or the aging services network when appropriate?
- 47) Are beneficiaries and caregivers referred to HCBS when appropriate?

APPENDICES

Prescription drugs and durable medical equipment

- 48) How have ancillary benefits (prescription drugs, durable medical equipment) changed under Cal MediConnect?
- 49) Have beneficiaries had disruptions in their medication regimens or had to change prescriptions?
- 50) Are pharmacies familiar with accommodations and alternate formats for prescriptions for people with disabilities?
- 51) Are there barriers to accessing necessary DMEs?

Care Coordination / Care Management

- 52) How has care been coordinated/managed across organizations or settings (medical, behavior health, LTSS)?
- 53) Who provides care coordination/management to Cal MediConnect beneficiaries?
- 54) Is care coordination/management being provided by health plans or by delegated agencies?
- 55) How well is care coordination/management working to the best of your knowledge? (benefits, challenges, promising practices)
- 56) How are beneficiaries assessed for care coordination/ management needs?
- 57) How often do care coordinators/ managers interact with beneficiaries?
- 58) What are some examples of care coordination services provided?
- 59) Who participates on the beneficiaries care team? Why or why not?
- 60) How often do care teams meet?
- 61) Is there duplication in the care coordination/ management provided by different organizations or across settings?

Other

- 62) Do you have any additional comments about the Cal MediConnect Health System Response that you would like to share with us?

APPENDIX E: HEALTH SYSTEM RESPONSE CODEBOOK

Parent Code	Description
Child Code	
Access	Has access to services or supports changed under CMC?
Agencies	How are KIs collaborating w/ local agencies and other governmental entities?
Authorization of services	Who is allowed to authorize services? What procedures are required? What factors influence authorization decisions?
BH/SUDS	How have behavioral health or substance use disorder services (BH/SUDS) changed under CMC?
CBOs	What role do community based organizations (CBOs) play in CMC? How are plans collaborating with CBOs?
CMC vs. MMC, D-SNP	What are the differences or similarities between Cal MediConnect, Medicaid Managed Care, Duals Special Needs Plans (D-SNPs) or waiver programs? What has changed since CMC?
CMS	What is the role of Centers for Medicare and Medicaid Services (CMS)? What are their requirements? What is their perspective? How are they perceived?
CPOs	Are plans offering care plan options (CPOs)? What CPOs are being provided? Who qualifies for CPOs? How do they track and record CPOs? Who provides the CPOs? Do they pay these entities to provide them?
Other	Other CPOs not included in child codes (e.g., housekeeping, safety, training, life skills)
Home modifications	Ramps, grab bars, lifts, etc.
Meals	Meals, groceries, nutrition programs, etc.
Other	Other CPOs not included in child codes (e.g., housekeeping, safety, training, life skills)
Respite	Respite services
Socialization	Socialization activities
Utilities and Technology	Member utilities, electricity, gas, cell phones, medic alert devices, or other technologies.
Care Coordination	What is care coordination (CC)? What does it include? How is it delivered?
CC Mode	How is CC being provided? Over the phone? In person or face-to-face? In provider's office? In LTC facility?
CC Delegation	Do plans delegate out for CC services?
CC Activities	What does CC include? Are there levels of CC provided?
CC Across Sites	How is care being coordinated across sites and with different entities? How are providers working with care coordinators?
CC Referrals	What types of referrals do CCs make to outside agencies or CBOs?

APPENDICES

Parent Code	Description
Child Code	
CC Workforce	What are CC's qualifications, experience, education, training? What are plan CC hiring practices? Is there high turnover of CCs?
Care Transitions	How do care managers transition members from one level of care to another?
Caregivers	Are caregivers identified, assessed, and involved?
Collaborations	How are KIs collaborating and with whom? What incentivizes, encourage, or discourages collaboration? Are there county collaboratives or advisory committees?
Contracts	What is in the 3-way contract? How prescriptive are the contracts between plans and provider groups? How are plans contracting with LTC or LTSS providers, and CBOs?
DME	Has access, cost or quality of durable medical equipment (DME) changed since CMC? How are DMEs authorized? What types of DMEs are provided?
Data, Data Analysis and Data Systems	How is data collected, reported, shared, and analyzed?
Data Sharing and Systems	How is data shared across partnering entities? What technologies are used to facilitate data sharing? How are information portals, IT systems, or EHRs being used? Who can access data?
Data Collection and Reporting	How is data being collected and reported to State/CMS? How are plans collecting their own data such as through focus groups or member surveys?
Data Analysis and Evaluation	How is data being analyzed or evaluated by the KIs, plans, CMS, other stakeholders, or the state?
Decision Making	Are members encouraged to establish legal document regarding health care decisions? Do they have a DPA for Health Care? Is their decision making capacity assessed? Do they have a conservator who can make decisions for them?
Dental	Are supplemental dental benefits provided by the plan? Why or why not?
Finances	What has been the financial impact of CMC on KIs?
Financial Risk	Are risk calculations accurate? How are plans sharing risk and/or savings with provider groups, IHSS, etc, and why?
Financial Incentives	Are plans using innovative payment models to incentivize better practices among providers?
Billing and Claims	What are the billing and claims processing, procedures, and challenges?
Payment, Rates, and Reimbursement	How are payments made? How are rates negotiated? What are plan or other KI perspectives of rates?
Savings and ROI	Are savings being realized? What is the return on investment in CMC?

APPENDICES

Parent Code	Description
Child Code	
HRAs and assessments	What do health risk assessments (HRA) look like? What additional assessments are conducted and why? Have all members completed an HRA?
Assessment mode	How are assessments conducted? Over the phone? In person or face-to-face? In provider's office? In LTC facility?
HRA Delegation	Are plans delegating the HRA process? Do they use an HRA vendor?
Member Risk Assignment and Stratification	How is member risk determined? How many levels of risk are there? Are there triggers that put someone at a higher risk level? What does risk level mean for access to care coordination?
Hospice/ Palliative Care	Have hospice or palliative care services changed since CMC?
Hospital	What is the role of hospitals in CMC? What is their perspective? How are they collaborating?
ICT/ICP	How are Individualized Care Plans (ICPs) and Interdisciplinary Care Teams (ICTs) being executed in CMC?
Individualized Care Plan	What is an ICP? Who gets one? Who has access to them? What do they include?
Interdisciplinary Care Teams	What is an ICT? Who gets an ICT? Who participates in the ICT? How often do they meet?
Implementation	Have there been any issues with implementing CMC? What has the process of implementation been like? What went well? What were the challenges?
Information, Education, and Training	How was information provided to KIs, plans, providers, and members? What materials were used? What trainings were provided and by whom?
Future of CMC	What are the KIs predictions of CMC in the future? What do they hope to see? What are they hoping will change?
Enrollment	How are KIs conducting outreach and enrollment to access current and potential members? How has enrollment gone? How are eligible members identified and contacted?
Readiness and Preparation	How have KIs prepared for CMC?
LTSS	How has access, quality and costs of LTSS services changed since CMC?
LTC Facilities	What are LTC facilities perspectives of CMC? How have LTC facilities prepared for CMC? How was CMC implementation for LTC facilities? Have LTC facility collaborations changed because of CMC?
IHSS	What is In-Home Supportive Services' (IHSS') perspective of CMC? How has IHSS prepared for CMC? How was CMC implementation for IHSS? Have IHSS collaborations changed because of CMC?
CBAS	What is Community Based Adult Services' (CBAS') perspective of CMC? How has CBAS prepared for CMC? How was CMC implementation for CBAS? Have CBAS collaborations changed because of CMC?

APPENDICES

Parent Code	Description
Child Code	
MSSP	What is Multipurpose Senior Services Programs' (MSSP) perspective of CMC? How has MSSP prepared for CMC? How was CMC implementation for MSSP? Have MSSP collaborations changed because of CMC?
Language and literacy	Are non-English speaking members having trouble with CMC? What is the literacy level of materials provided? How is health literacy assumed?
Members	How have members been impacted by CMC?
Challenging populations	What are the most challenging members to serve from the KI's perspectives? Which beneficiaries may fall through the cracks?
Homeless	How is CMC impacting homeless beneficiaries or transient populations?
Dementia	How is CMC impacting beneficiaries with dementia and their caregivers?
Disability	How is CMC impacting beneficiaries with a disability?
Diversity	How is CMC impacting diverse beneficiaries? How has the diversity of their members (race, ethnicity, sexual orientation) impacted the plan's ability to provide adequate and appropriate services? How are providers serving diverse populations?
Member Education	How has education been provided to members about their own health, or disease management?
Member Outreach	How have KIs attempted to provide outreach to members? How are KIs communicating with members in CMC?
Member Perspective	What are the added benefits for members in CMC? How do members understand their benefits?
Opt-Outs	Who has opted out? Who is asking them to opt-out? Why are they opting out?
Oversight	Who provides oversight of plan activities or delegated entity activities? How is oversight conducted? Why is oversight needed? Is there a need to conduct oversight in CMC to prevent fraud?
Person Centered Care	How involved is the member in their care? How are their wishes and preferences captured? Is whole person care being provided?
Pharmacy/ Medications	Has access, quality or cost of pharmacy services changed as a result of CMC?
Physician Providers	How have physician providers been impacted as a result of CMC?
Provider Delegation	How are plans delegating physician provider services?
Physician Perspective	What are the benefits to physician providers of participating in CMC? What are provider perspectives about CMC?
Physician Referral	How are referrals made to specialists in CMC? Who authorizes referrals?
Network Adequacy	How adequate are provider networks?

APPENDICES

Parent Code	Description
Child Code	
Provider Groups	How have independent provider associations (IPAs) or preferred provider groups (PPGs) been impacted by CMC?
Provider Workforce	What are the physician provider workforce issues? What are their training needs?
Plan	How are plans involved with and executing CMC?
Plan History	What was the plan's history or experience coming in to CMC? Do they have experience with MLTSS? This code may overlap with CMC vs. MMC vs. D-SNP, though not all the time.
Plan Perspective	What is the plan's perspective of CMC?
Quality	How has CMC impacted the quality of services and care?
Stakeholders	What is the role of stakeholder groups in the plan/ state/ region/ community? How have advocates or professional groups been involved in CMC?
State	What is the role of the state agencies in CMC?
Supplemental Codes	These supplemental codes should be applied along with other codes (eg. What are the "challenges" related to "sharing data" with "IHSS"? What can I "quote" related to "care coordination"?)
Advocacy	Use when participants are describing advocacy, or advocating on behalf of members.
Anecdote	Use to highlight anecdotes or stories told by KIs
Challenge	Use when challenges are mentioned.
Delegation Rationale	Why are plans delegating or not? This code will always be paired with provider delegation, CC delegation, or HRA delegation codes.
Geography	Use this supplemental code when geography or regions are described, especially when differences are highlighted.
Innovative and Promising Practices	This code should be used to capture all innovative programs and promising practices described by KIs.
Participant	Use this code to capture title of KI.
Quotable	This code should be used to highlight quotes that can exemplify a code.
Transportation	How has access, quality, and cost of transportation been impacted by CMC? How are transportation benefits being utilized?
Vision	How has access, quality, and cost of vision services been impacted by CMC?