

Evaluation of Cal MediConnect

The SCAN Foundation

LTSS Summit 2017

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The Coordinated Care Initiative:

California's Dual Financial Alignment Demonstration

- California is one of 12 states implementing CMS dual financial alignment demonstrations: www.calduals.org
- By August 2017, over 116,000 dually eligible beneficiaries enrolled in “Cal MediConnect” Health Plans in 7 demonstration counties
- About half of eligible beneficiaries “opted out” of the program
- Enrolled beneficiaries have all Medicare and Medi-Cal services through one plan, one card, one number to call

Features of Cal MediConnect

- **Integrated Medicare and Medi-Cal benefits**
- **Care coordination:**
 - Health Risk Assessments
 - Individualized Care Plans
 - Interdisciplinary Care Teams
 - Care Plan Options (flexible spending for non-Medi-Cal services)
 - Coordination of Behavioral Health (still carved out)
- **Managed long-term services and supports:**
 - Skilled nursing & rehabilitation
 - In-Home Supportive Services (IHSS) paid through CMC plans, but managed by county Social Services
 - Transportation (30 rides)
 - CBAS

Evaluation Methodology

- **AIM 1: Participatory Evaluation Approach**

- Engagement with stakeholders and policy makers at all phases (Design -> interpretation of results)

- **AIM 2: Health System Response Study**

- Conduct key informant interviews to examine organizational impacts and health system responses to the demonstration and identify challenges, promising practices and recommendations to improve the coordination of care across sites for dual beneficiaries

- **AIM 3: Assess Beneficiaries' Experiences with Cal MediConnect**

- Identify the impact that the transition to Cal MediConnect has had on experiences with access to, quality of and coordination of care for dual beneficiaries

Assessing Beneficiaries' Experiences

- 14 focus groups with CMC and opt out beneficiaries (N=120)
- Longitudinal telephone survey with dually eligible beneficiaries in CMC, opt out and non-CCI counties

	Time 1 (2016)	Time 2 (2017)	Retention rate
CMC	744 (35%)	488 (38%)	66%
Opt-out	659 (31%)	330 (26%)	50%
Non-CCI	736 (34%)	473 (37%)	64%
Total	2,139 (100%)	1,291 (100%)	60%

* 78 beneficiaries re-enrolled in CMC after opting out

* 17 beneficiaries dis-enrolled from CMC

CMC Evaluation Topics Presented Today

1. Overall Satisfaction and Quality
2. Access to Care in CMC
3. Care Coordination
4. Managed Long-Term Services
and Supports

Beneficiary Ratings of Satisfaction and Quality of Care

- Overall satisfaction with benefits in CMC increased from 89% at T1 to 94% at T2
 - More people in CMC/Opt out increased ratings of quality since T1 than decreased
- Ratings of “excellent or good” quality of care increased for CMC members from 84% to 87% at T2
 - More people in CMC increased ratings of quality than decreased

Access to Care in CMC

- About a quarter of beneficiaries said that their access to various services was *better* at T1 after switching to CMC
- 79% in CMC said it was *always or usually* easy to get prescription medication at T2
 - Ratings of ease of getting prescription Rx increased at T2 for those in CCI counties
- Emergency Department visits decreased for CMC beneficiaries between T1 and T2
 - Younger adults (compared to age 65+)
 - People who visited PCP less
 - People who used specialty care more

Access to Care in CMC

- Specialty Care
 - Slightly fewer CMC beneficiaries reported using specialty care at T2 (no difference in # of visits)
 - 74% said it was *always or usually* easy to get specialty care appointments; and only 9% said they had trouble w. authorization
- Behavioral Health
 - BH visits in the last 6 months decreased for CMC (3.72 at T1 vs. 1.98 at T2, $p=.014$), but increased for non-CCI
 - 62% of CMC members said getting BH appts is “never easy” (compared to 50% of non-CCI and 71% of opt out)
 - 29% said that CMC plan assisted them with BH services
- Durable Medical Equipment
 - 48% of DME users reported unmet needs

Disruptions in Care

- 1 in 5 continue to report delays or disruptions in care at T2
 - At T2, fewer CMC members said all or some of their disruptions were resolved (56% at T1 down to 39% in T2)
 - At T2, who was more likely to report having disruptions? Those:
 - who used specialty care (compared to non users),
 - with functional impairment,
 - with LTSS needs,
 - who had no care coordination (compared with CMC care coordination)

Innovations in CMC Care Coordination

- Great deal of innovation and variation across counties and CMC plans...
 - Satellite offices to make care coordination more local
 - One “prime contact” vs. team approach
 - Transitional Care programs: hospital or SNF to community
 - Specialized care coordinators (IHSS, Behavioral health, LTC residents, people with dementia)
 - Non-credentialed care coordinators as “extender” of RN or SW, often bilingual
- Providers and CMC plans agreed that Interdisciplinary Care Teams were very effective in coordinating across agencies

T2 CMC Care Coordination

- About 31% of CMC members said they had a care coordinator from the plan
 - 96% are very or somewhat satisfied with their CC
 - 91% say their CC is somewhat or very well informed about their conditions and service needs
 - 85% say their CC usually or always takes into account their wishes
- No significant predictors of getting CMC care coordination

Plan Involvement in Care at T2

- 25% said CMC plan helped them find a primary care doctor
- 27% said CMC helped them get medications/answered questions about Rx
- 30% said CMC plan helped them find a specialist
- 64% of those who had been hospitalized said the CMC plan followed up to make sure they had services and supports after discharge
 - 89% said they felt ready to be discharged from the hospital
 - 85% said they had all the help they needed after discharge

Care Coordination Unmet Need

- Overall, 23% of CMC beneficiaries said they could use more care coordination
- 78% of CMC members said “*definitely or somewhat*” got all the help they needed to manage care between providers and services.
 - Significantly less than opt out (88%) or non-CCI (86%)
- Who is more likely to have an unmet need for care coordination?
 - Males
 - Those using specialty care
 - Those with fair or poor health
 - Those with disabilities and LTSS needs
 - Those with no care coordinator (compared with having CMC coordinator)

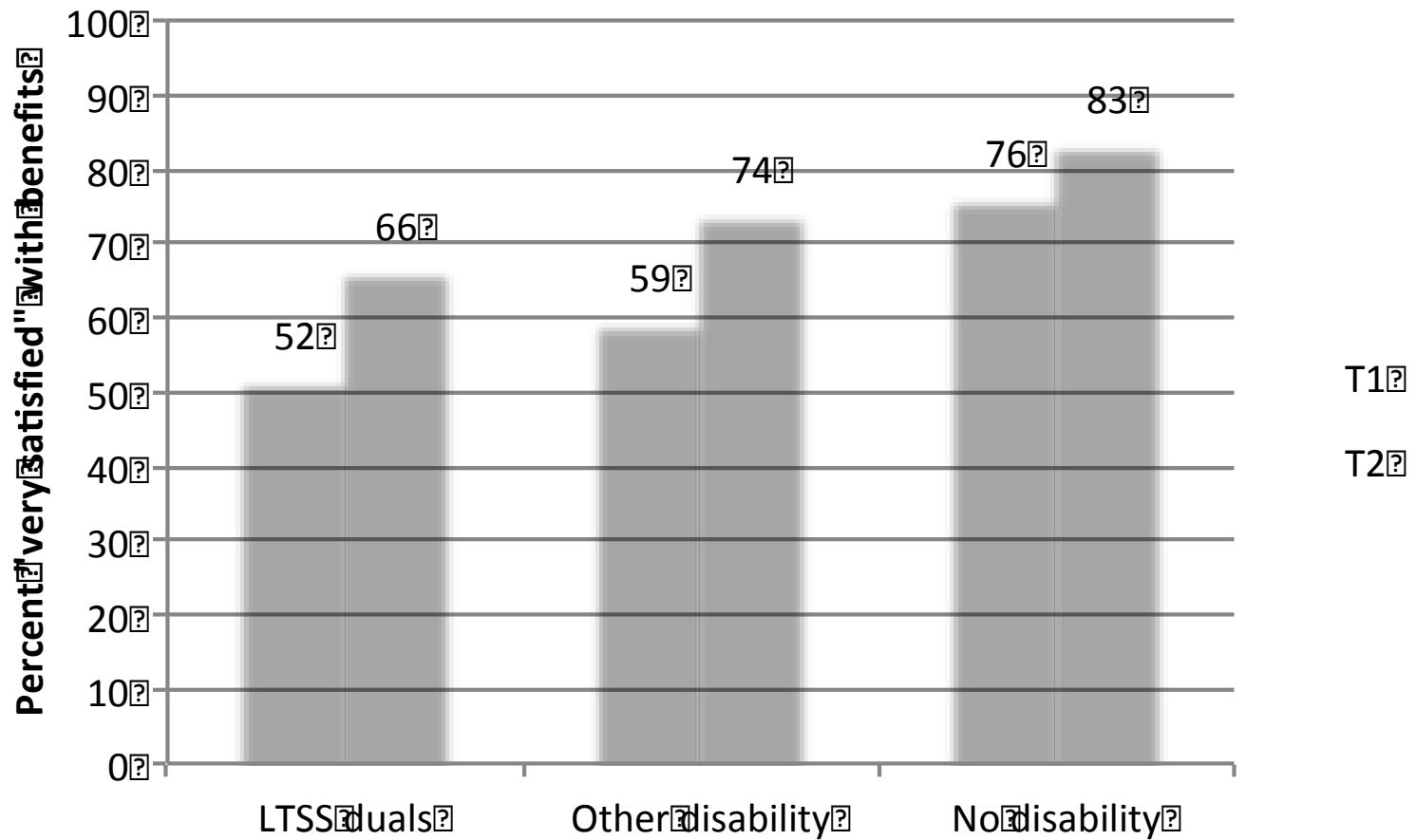
Cal MediConnect Progress toward Managed LTSS

- Collaborative meetings for shared learning across plans and LTSS providers
- Progress in CMC health plans working with nursing homes and other institutional facilities
 - Motivation to relocate members out of institutions
 - Focus on preventing cycle of hospitalizations
 - Variable success in relocating members to community settings
- Plans are advocating for increased IHSS
- Plans report using CPOs to purchase services to fill gaps in care
- Progress collaborating with some larger HCBS providers (brokerage model)
- Some HCBS providers (MSSP, community-based social services) report fewer referrals and less collaboration than they expected

Beneficiary Survey Findings on LTSS

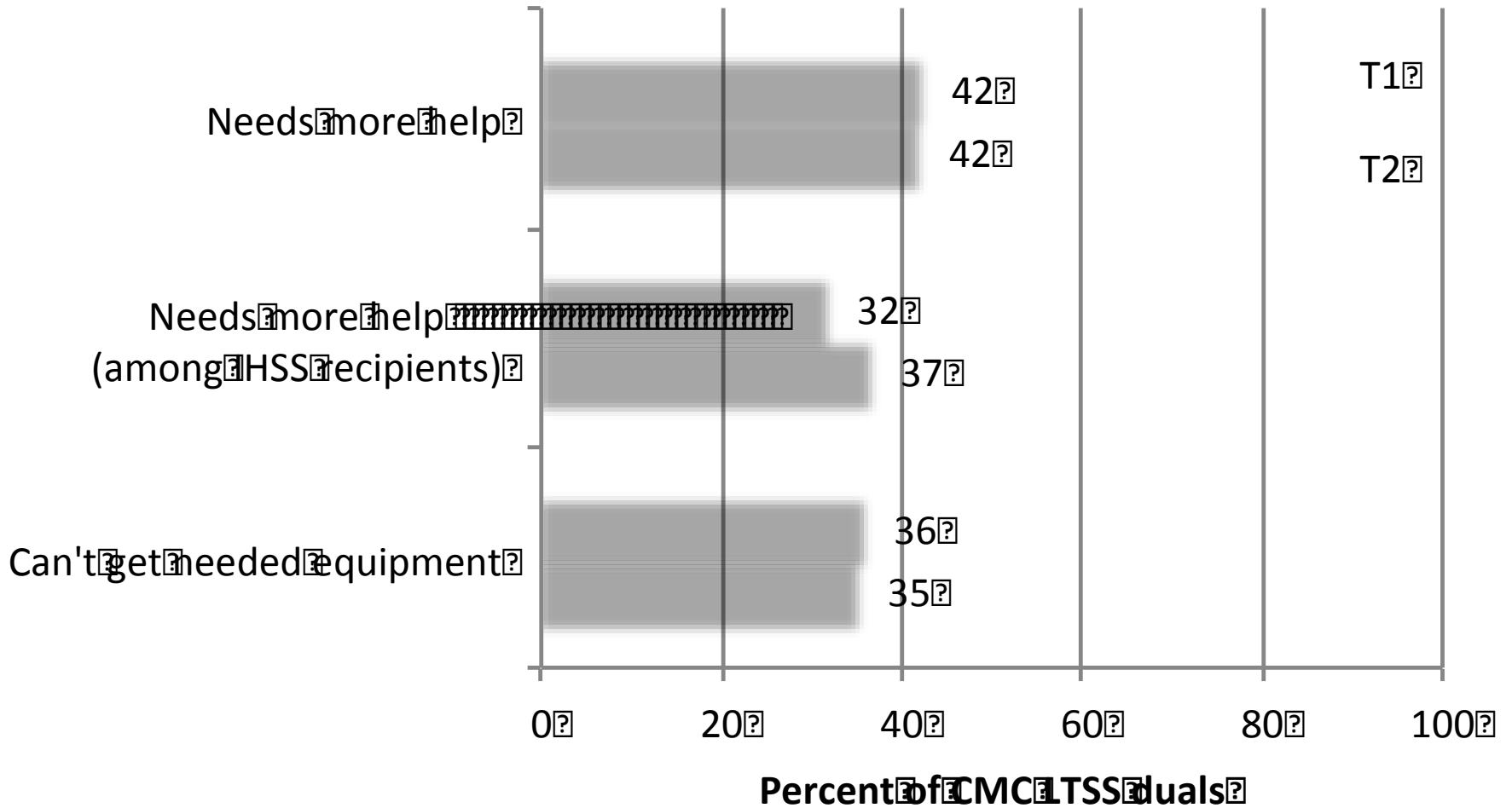
- We refer to beneficiaries who need help with daily activities as “LTSS Duals”
 - LTSS Duals may or may not be receiving paid HCBS
- By “daily activities,” we mean:
 - ADL (Activities of Daily Living), such as bathing, dressing, and getting out of a bed or chair
 - IADL (Instrumental Activities of Daily Living), such as preparing meals, shopping, or managing medications

LTSS duals remain less satisfied with CMC benefits

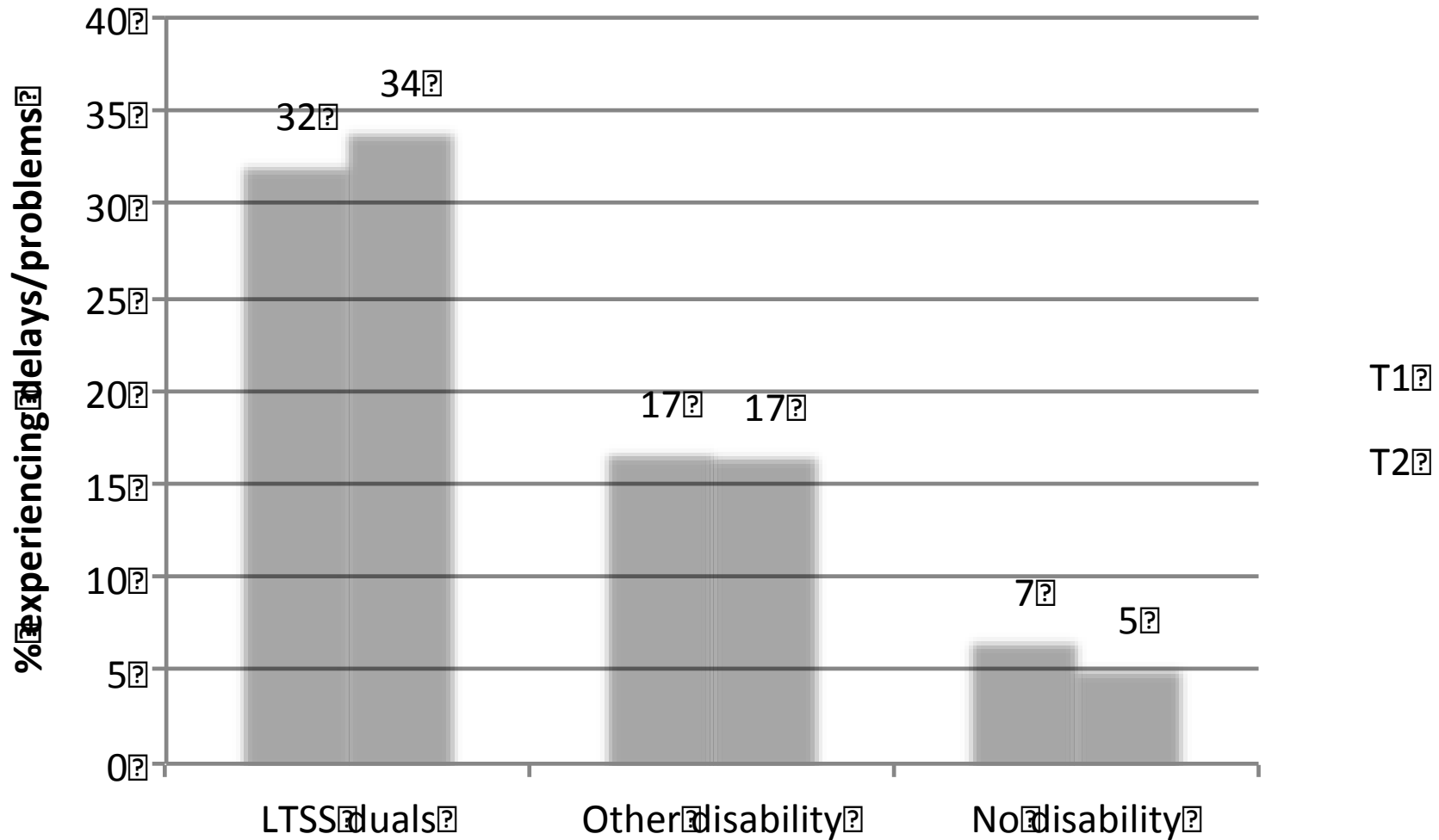


* In fact, unmet LTSS need was the primary predictor of lower satisfaction with benefits at T2

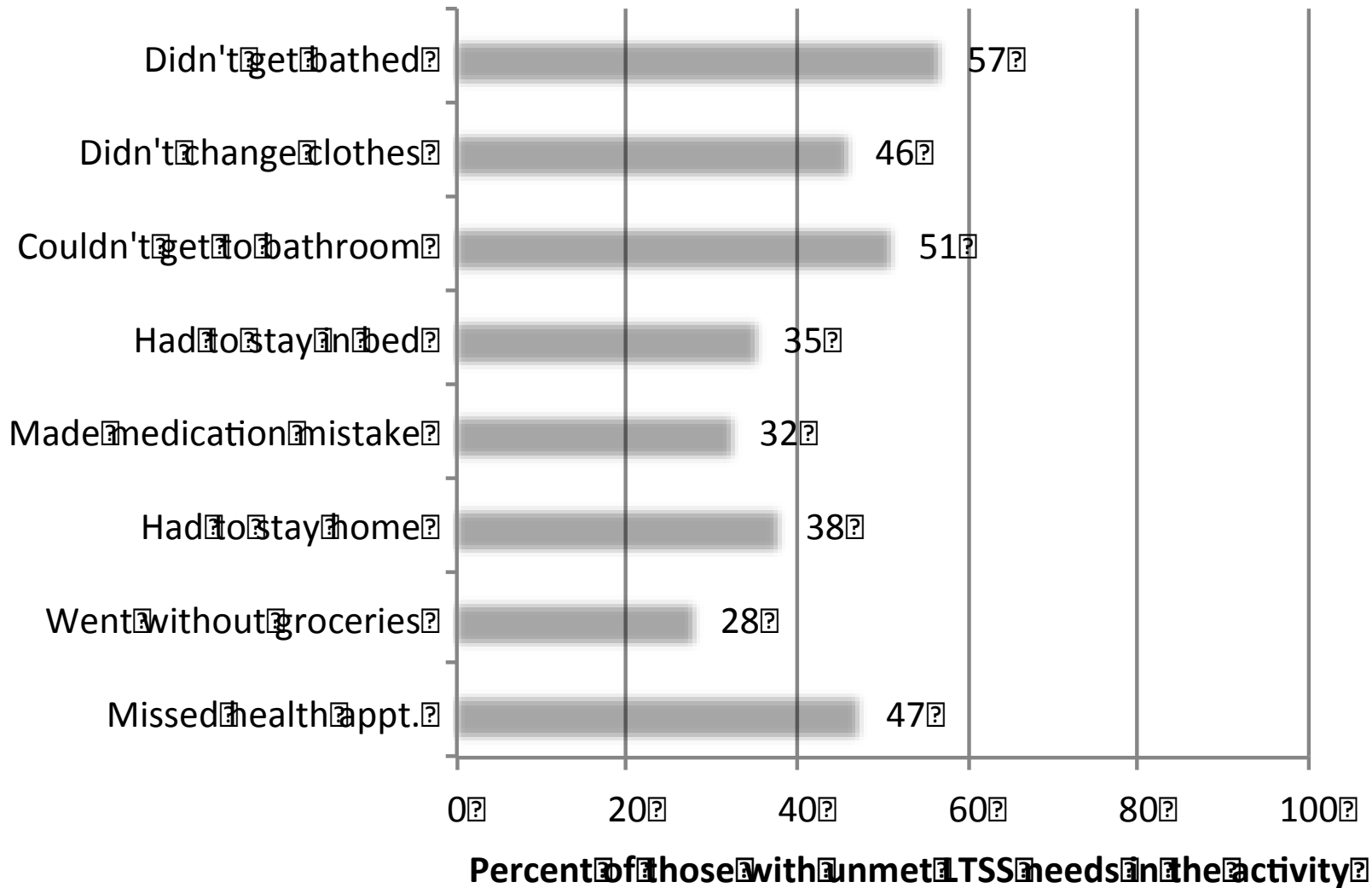
Unmet needs remain high among LTSS Duals



More healthcare delays/problems for CMC LTSS duals

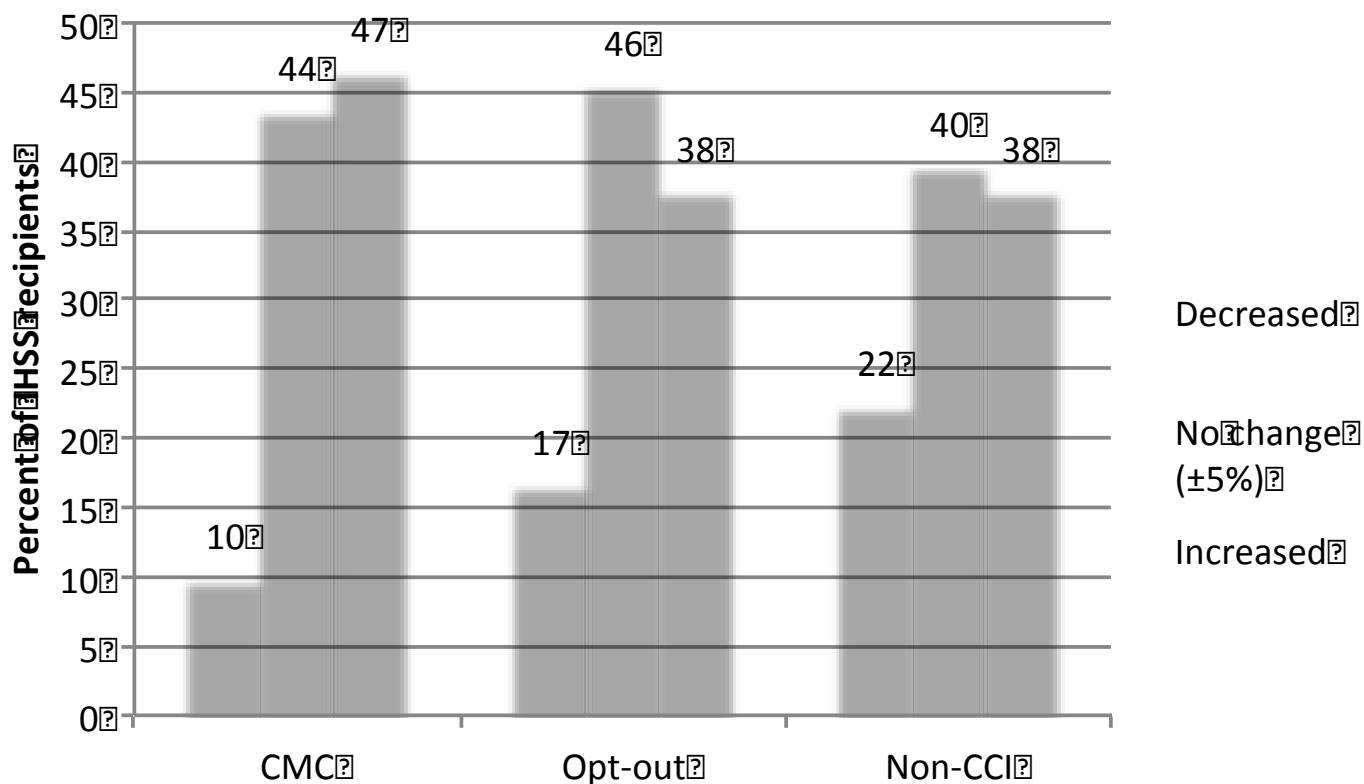


Unmet LTSS need often leads to adverse outcomes

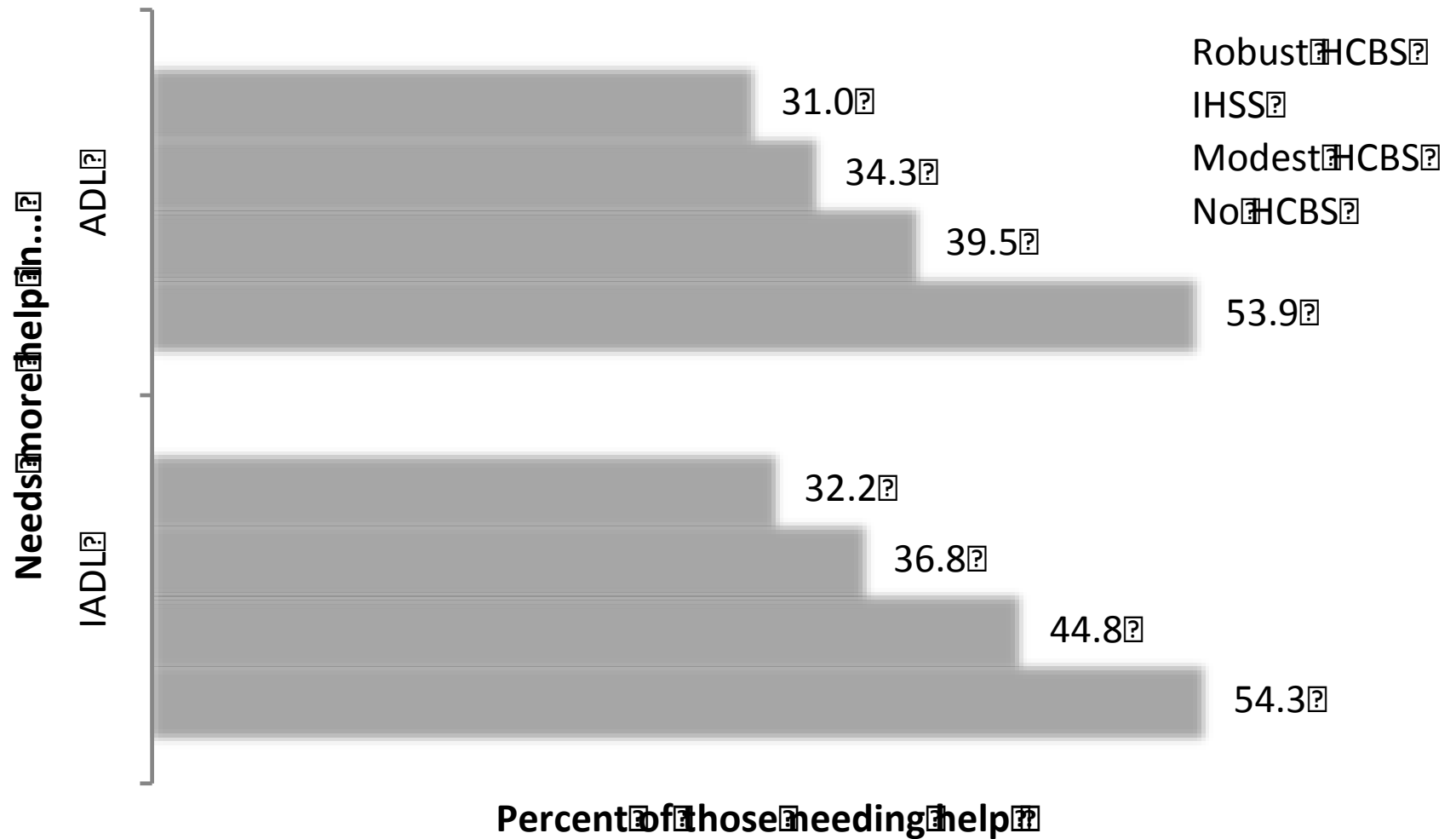


Are CMC plans helping members get IHSS or increase their hours?

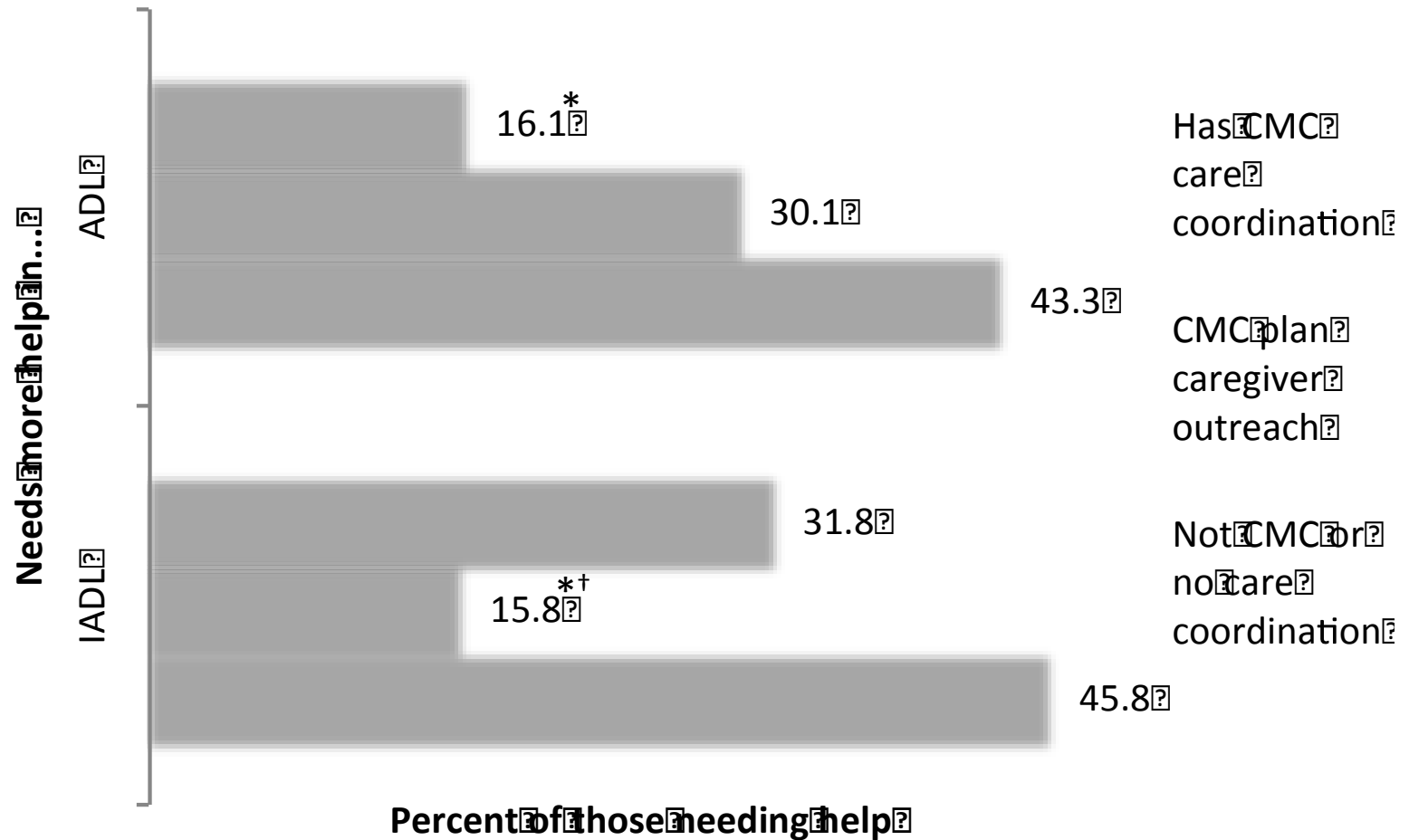
- 52% getting IHSS at T1 vs. 55% at T2 (not significant)
- IHSS hours increased significantly for CMC members only: Median 74 hours at T1 up to 89 hours at T2



Robust HCBS reduces unmet need for ADL/IADL among “LTSS Duals”



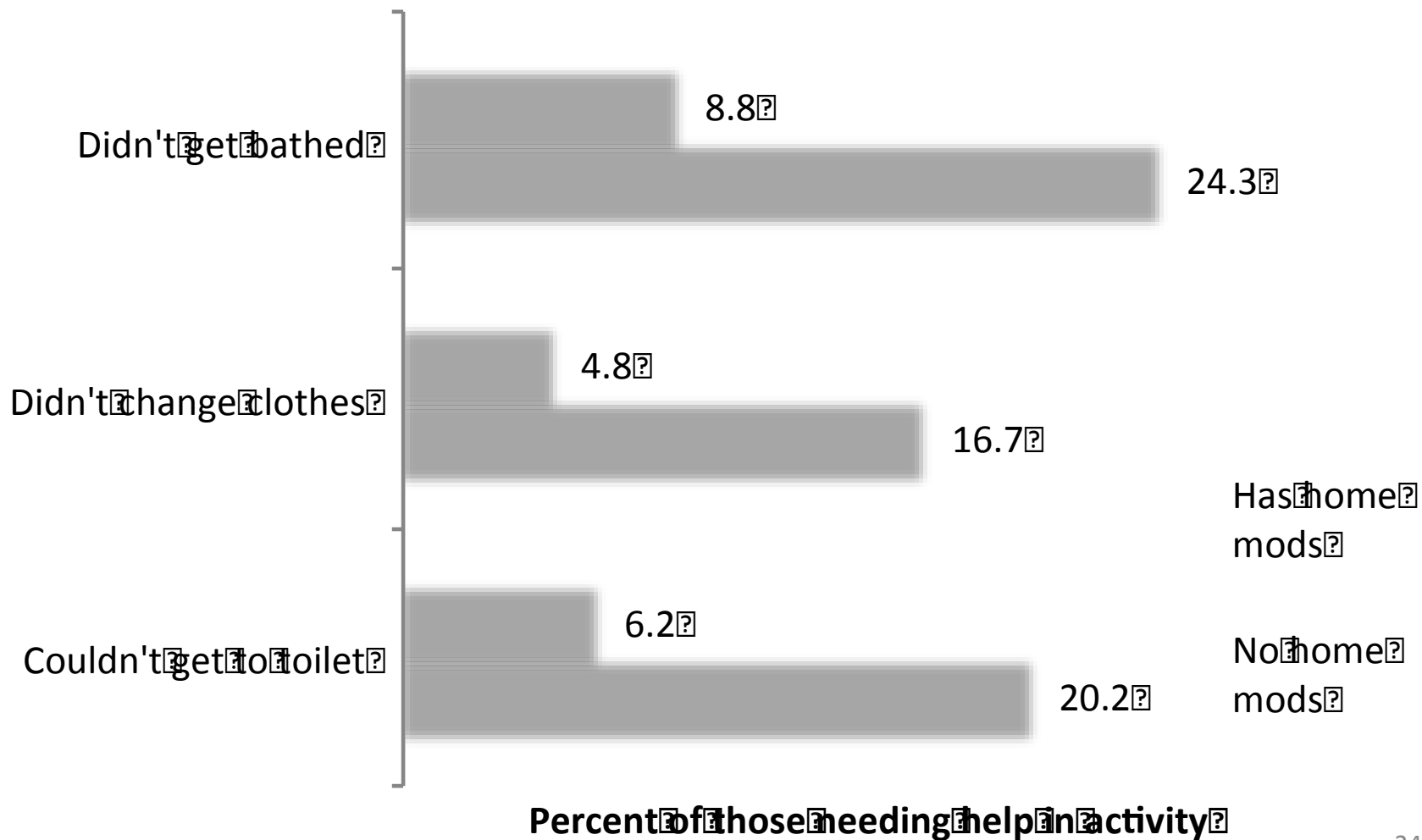
CMC care coordination & outreach to caregivers reduces unmet LTSS need



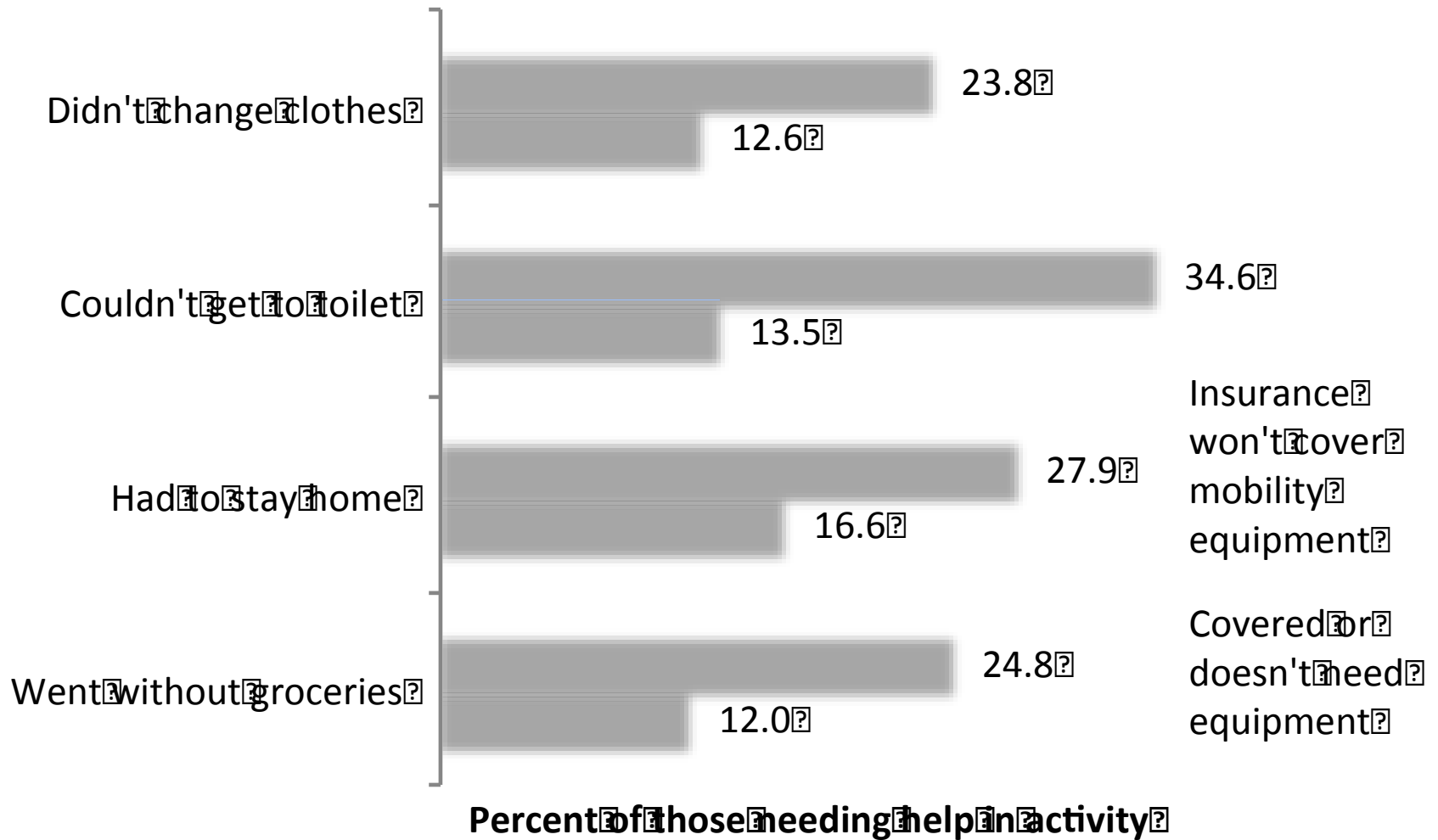
*Reduction is statistically significant

†Estimate has high uncertainty due to small sample size

Home modifications reduce adverse ADL outcomes



Lack of needed mobility equipment increases adverse outcomes



Key Findings (1)

1. Satisfaction with CMC continues to increase over time, except for people with unmet LTSS needs
2. Some areas of increased access:
 - Prescription medication access is “easier” at T2
 - Fewer ER visits for CMC members at T2
3. Some areas where access should be looked at more closely
 - Specialty Care
 - Behavioral Health

Key Findings (2)

4. CMC Care Coordination is working well for those who receive it, and is reducing some negative outcomes... but there is still work to be done to identify the beneficiaries who need it most.
5. Those with unmet need for LTSS (personal care, routine care & DME) should be targeted by health plans for additional assistance.
6. Robust IHSS is protective against adverse outcomes, and CMC involvement/advocacy has been effective in getting members increased hours.
7. CMC involvement (care coordination, outreach to helpers and home modification) are promising practices that reduce unmet needs and adverse outcomes.

Thank you for your attention!

For CMC evaluation summaries, go to
<http://www.thescanfoundation.org/our-goals/medicare-medicaid-integration>

For questions, please contact:

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