Provision of Home- and Community-Based Services through Cal MediConnect Health Plans

Carrie Graham, PhD, MGS
Mel Neri
Brooke Hollister, PhD
Marian Liu, PhD
Stephen Kaye, PhD
Edward Bozwell Bueno
Winston Tseng, PhD
Charlene Harrington, RN, PhD

University of California, San Francisco and Berkeley

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EXECUTIVE SUMMARY

In 2014, California implemented a Dual Alignment Demonstration called the Coordinated Care Initiative (CCI).[1] This demonstration integrated Medicare and Medicaid benefits through a capitated managed care system. In California, Medicaid (Medi-Cal) managed care health plans in seven demonstration counties created a new product called "Cal MediConnect" (CMC).[2] Dually eligible beneficiaries in those counties were passively enrolled into CMC health plans, with the option to "opt out." Enrolled beneficiaries received all Medicare and Medi-Cal benefits, including medical care and managed long-term services and supports (LTSS), through one health plan. One goal of the program was to decrease expenditures through incentives to redirect care away from institutional settings and toward more home- and community-based services (HCBS). Some HCBS that were coordinated by CMC health plans included:

- **In-Home Supportive Services** (IHSS). California's Medicaid personal care program became a CMC benefit in 2014. Although CMC health plans did not have the authority to assess for IHSS eligibility, IHSS was paid as a "pass-through" payment from the state.

- **Community-Based Adult Services** (CBAS–formerly called Adult Day Health Care). CBAS had become a managed care benefit before the CMC demonstration in 2012.

- **Non-emergency transportation services**. CMC health plans were required to provide non-emergency transportation for their members, typically up to 30 rides per year.

- **Multipurpose Senior Services Program** (MSSP). MSSP is a care management program for community-dwelling older adults (aged 65+) on Medi-Cal who are at risk for nursing home placement. The MSSP program was originally slated to become a managed care benefit during the CCI demonstration, but transition was delayed until 2020.

- **Other non-Medi-Cal HCBS**. Programs such as Meals on Wheels, independent living centers (ILCs), senior service organizations, and other local HCBS providers offer a variety of support services to seniors and people with disabilities–services that are not typically covered by Medi-Cal. CMC health plans had the option to refer their members to these HCBS or pay for the services using flexible spending options.

Researchers from the University of California have conducted an ***evaluation*** of the impact of the CMC program on beneficiaries and health systems. The following research brief includes results from an in-depth examination of the efforts of CMC health plans to administer HCBS through their new managed LTSS programs. Data collected for this research brief built on the results of *Phase I* and included an online survey with CMC health plans as well as 20 in-depth interviews with representatives from HCBS agencies that served CMC beneficiaries. Key findings and recommendations are listed below and discussed more fully at the conclusion of the report.

KEY FINDINGS

1. **The CCI has improved coordination and collaboration between CMC health plans and agencies that provide Medi-Cal-reimbursed HCBS such as IHSS and CBAS, resulting in better access for many beneficiaries**. Both plans and HCBS providers reported that CMC health plans were successful in advocating for additional IHSS hours and other services to fill gaps in care for their members. Individualized care teams and joint care coordination units that worked across agencies were effective in increasing collaboration and access to services. The impact the "re-carve out" of IHSS will have on the progress that has been made is currently unclear and should be monitored closely.

2. **A lack of clarity about the scope of CMC health plans' responsibility for HCBS has led to unmet expectations around referral and payment for non-Medi-Cal HCBS**. Although some plans used flexible spending (i.e., Care Plan Options, or CPOs) to contract with non-Medi-Cal HCBS (e.g., homemaker services, check-in services, chore services, meal delivery, or home safety assessments), other plans did not. This created confusion and unmet expectations within some HCBS agencies that provide critical support services to community-dwelling CMC members who would prefer more collaboration with CMC health plans.

3. **Local HCBS providers offer critical support services to duals that are not covered by Medi-Cal, but some CMC health plans experience barriers to working with these agencies.** Local HCBS providers such as ILCs, senior service agencies, and meal programs play a critical role in serving the dual population, especially ethnic minorities or other niche groups that may be more difficult for CMC health plan staff to reach. Lack of awareness of these services and underestimation of their value by the health plans as well as varying levels of business acumen and information technology (IT) infrastructure on the part of the agencies may have prevented some potentially useful collaborations.

4. **The brokerage model, in which CMC health plans work with one large HCBS agency to coordinate an array of HCBS for their members, is a promising practice that has the potential to increase access to HCBS.** Working with one HCBS agency as the "middle man" to provide and coordinate HCBS effectively leveraged the experience of the agency and helped to overcome some of the contracting barriers that exist between CMC health plans and smaller agencies. This practice also transfers the responsibility of contracting and collaborating with the ever-changing landscape of local HCBS from the plan to an agency with more experience and flexibly in that area.

5. **MSSP staff have extensive expertise providing intensive care management for older adults at risk for nursing home placement, but CMC health plans varied in the extent to which they leveraged the program.** As a waiver program, MSSP has limited "slots," resulting in a waitlist. Some CMC health plans referred qualified members to MSSP programs and others contracted with MSSP to provide care management to their qualified members who were "waitlisted." Other CMC health plans, however, made few referrals. It remains to be seen whether the transition of MSSP to a managed care benefit in 2020 will increase referral and collaboration between plans and MSSP providers as it has with other Medi-Cal HCBS.

6. **Although there have been many improvements in HCBS agencies sharing data with CMC health plans, data sharing from CMC health plans to HCBS agencies still needs improvement.** Despite the many promising practices around data sharing between plans and HCBS agencies, IT infrastructure and Health Insurance Portability and Accountability Act (HIPAA) regulations still pose barriers.

RECOMMENDATIONS

1. **The state and CMC health plans should clearly articulate the objectives, measures of success, and scope of responsibility of the plans for HCBS, including for both Medicaid HCBS and non-Medicaid HCBS.**

2. **CMC health plans should use a person-centered approach to assess LTSS unmet needs regularly in their members.**

3. **The state should encourage CMC health plans to communicate and contract with community-based senior service agencies, ILCs, and other local non-Medi-Cal HCBS providers, especially those that are serving their CMC members.**

4. **The state should issue guidance around the transition of MSSP to managed care, stipulating that all members who meet eligibility requirements (over 65 and eligible for nursing home placement) should be referred to the new benefit.**

5. **The state should educate beneficiaries and providers about the variety of HCBS that they can expect to be covered by CMC health plans.**

6. **CMC health plans must work more closely with HCBS agencies to ensure that data sharing is executed efficiently in both directions.**

7. **The state should issue guidance encouraging plans to continue close collaboration with IHSS programs, despite the "re-carve out" and change in payment.**

INTRODUCTION AND BACKGROUND

In 2014, California became one of 13 states to implement a Dual Alignment Demonstration. In California, this demonstration was called the Coordinated Care Initiative (CCI).[1] The CCI was designed to test the integration of Medi-Cal (California's Medicaid program) and Medicare benefits through a capitated managed care system. To implement the program, existing Medi-Cal managed care (MMC) health plans in seven demonstration counties created new insurance products called "Cal MediConnect" (CMC).[2] Beginning in 2014, individuals eligible for both Medi-Cal and Medicare (called "dually eligible" or "duals") residing in the demonstration counties were passively enrolled into CMC health plans, with the ability to "opt out." Those who remained enrolled in CMC received all Medicare and Medi-Cal benefits, including medical services, behavioral health, managed long-term services and supports (LTSS), and care coordination through one health plan.[3, 4] Over the enrollment period, about half of eligible beneficiaries opted out, meaning they could keep their original Medicare but were still required to enroll in an MMC plan for their Medi-Cal benefits, including LTSS. Opt-out rates were higher among beneficiaries using LTSS and among certain language groups such as Russian, Armenian, Farsi, Korean, and Chinese.[5]

Managed LTSS in Cal MediConnect

A key feature of the CMC demonstration was the implementation of managed LTSS. The term "long-term services and supports" typically refers to non-acute services such as skilled nursing care, home health care, personal care assistance, homemaker services, and transportation. LTSS can be provided in both institutional settings like skilled nursing or rehabilitation facilities, as well as in community settings such as beneficiaries' homes or assisted living/residential care facilities. When these services are provided in a non-institutional setting, they are referred to as "home- and community-based services," or HCBS. Research shows that HCBS enable people to remain in their homes and communities, delaying or preventing more expensive institutional-based care.[6,7] Furthermore, rebalancing services toward HCBS and away from institutional care has the potential to reduce overall spending.[6,7]

> Home- and Community-Based Services are types of person-centered care delivered in the home and community. A variety of health and human services can be provided. HCBS programs address the needs of people with functional limitations who need assistance with everyday activities, like getting dressed or bathing. HCBS are often designed to enable people to stay in their homes, rather than moving to a facility for care.
>
> – *Centers for Medicare & Medicaid Services* [8]

CMC LTSS Benefits: CMC and MMC plans were directly responsible for coordinating (and in some cases administering) Medi-Cal HCBS benefits, including: In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), and transportation. CMC care coordinators were responsible for coordinating HCBS, including both referring to or in some cases paying for other non Medi-Cal services using flexible spending options.

In-Home Supportive Services: The IHSS program was established in California in 1973 and currently provides services to over 550,000 Medi-Cal beneficiaries with disabilities for help with their personal care needs, including bathing, toileting, and grooming, as well as housekeeping, grocery shopping, and meal preparation. Other IHSS services include transportation services and accompaniment to doctor's appointments, certain paramedical services, and protective supervision.[9] The IHSS program is unique in that it is "consumer directed," which means that consumers hire, fire, train, and supervise their own IHSS workers (although some consumers choose IHSS workers who are provided through agencies). Currently, 460,000 IHSS home care workers are employed by the program.[9]

Historically, the IHSS program was paid for by a state/county cost-sharing arrangement in which the counties paid for 35 percent of non-federal program costs and the state paid the remaining 65 percent.[10] With CCI, all counties' share of cost was held at 2011-2012 levels. CMC and MMC health plans were required to coordinate and pay for IHSS, but each county's Department of Social Services, not the CMC health plan, remained responsible for program administration, including conducting assessments, authorizing or increasing hours, and enrolling consumers (although the CMC health plans do have discretion to recommend a reassessment of IHSS worker hours).[10,11] The CCI also provided specific funding for IHSS social workers to participate in Interdisciplinary Care Team (ICT) meetings. The process evaluation data from Phase I of this evaluation revealed that CMC health plans noted improvements in communication and collaboration with IHSS workers soon after program implementation.[12] Overall collaboration between IHSS and managed care plans has also reportedly improved and led to increased coordination between sites.[10]

The California State budget for 2017-2018[13] continues CMC and Medi-Cal managed LTSS for two more years, with the exception that IHSS will be "re-carved" out. This means that IHSS will no longer be included as a benefit in either CMC or Medi-Cal managed LTSS plans and will instead revert back to a fee-for-service benefit as it was before the CCI.[14] Not only will this carve-out shift IHSS costs back to the counties, but it also means that care coordination between health plans and the IHSS program will no longer be required, but only encouraged.[10] It remains to be seen how the CCI counties will manage the fiscal challenges that result from this carve-out and if the increased collaboration between CMC health plans and IHSS social workers will continue.

Community-Based Adult Services: The CBAS program (formerly known as Adult Day Health Care, or ADHC) became a managed care benefit statewide in 2012, prior to the implementation of the CCI.[15,16] In 2012 (as part of amendments made to the 1115 Bridge to Reform Medicaid waiver), ADHC participants were transitioned into a new, initially smaller program, called CBAS[16,17,18] to be paid as a MMC benefit.[15] CBAS currently serves 31,000 Medi-Cal beneficiaries, providing nursing and mental health services; physical, occupational, and speech therapies; social services; personal care; meals and nutritional counseling; various therapeutic activities; and transportation to and from the CBAS center.[15,16] Under the CCI, CBAS continued to be a benefit provided through CMC and MMC plans.

Transportation through CMC: A new key benefit for CMC members was non-emergency, accessible transportation for medical appointments.[19] Although the number of rides was not specified in the Memorandum of Understanding between the Centers for Medicare & Medicaid Services (CMS) and the State of California[19], most CMC health plans offered 30 trips per year per member, paid for and coordinated by the CMC health plans.

Care Plan Options/Flexible Spending: During the negotiation of the three-way contract among California's Department of Health Care Services (DHCS), the health plans, and CMS, California negotiated a "flexible spending" option called Care Plan Options (CPO).[19, 20] Essentially, this allowed CMC health plans to purchase optional goods and services for beneficiaries that were not typical Medi-Cal or Medicare benefits. The rationale for this feature was that plans should be given the flexibility to purchase services that would increase their members' access to HCBS, improve their quality of life, improve health, and help prevent acute-care episodes, disruptions in care, or unwanted relocations/institutionalization.[21] Though purchased services through CPOs were not tracked nor reported by CMC health plans, key informant interviews with plans in Phase I of this evaluation found that some of the typical services purchased as CPOs included: minor home modifications, appliances, utilities, technology, cell phones and plans, housing advice and support, health education, and medical equipment and various home-based services not otherwise covered.[12]

LTSS Coordination and Assessment: The CCI required CMC health plans to develop care coordination programs that were responsible for coordinating both medical care and LTSS. To implement this process, CMC health plans were required to conduct a Health Risk Assessment (HRA) of all new members. DHCS recently updated guidelines that required plans to include specific questions to assess the need for LTSS in these ***health risk assessments***.[22]

In addition to coordinating services that are CMC LTSS benefits, some CMC care coordinators work to coordinate other community-based services that members may be getting elsewhere. Some examples of these other services are: Meals on Wheels, disability advocacy and support through independent living centers (ILCs), home health or personal care services through private home health agencies, care coordination through MSSP, or other various supports through community-based senior service agencies. CMC health plans sometimes pay for these services through CPO flexible spending while other times they simply refer to or communicate with the program.

Evaluation of Cal MediConnect

As part of the evaluation of Cal MediConnect, University of California researchers have examined how the demonstration impacted the health system as a whole[12] as well as how it has impacted beneficiaries' experiences with care.[23] As part of the second phase of this evaluation, researchers conducted in-depth case studies on topics of interest (see past ***Research Briefs***). This research brief describes an in-depth examination of: 1) the progress made by CMC and MMC health plans in providing managed LTSS and, in particular, HCBS to their dually eligible members; 2) their accomplishments in this area; and 3) continued challenges.

METHODS

Data collected for this research brief included an online survey of CMC health plans as well as key informant interviews with stakeholders from various community-based agencies and stakeholder organizations providing HCBS to CMC members.

Online survey with CMC health plans: In January 2017, CMC health plans were emailed a survey asking targeted questions about how they work with HCBS agencies and long-term care facilities to facilitate transitions from institutional to community-based care. CMC health plans were asked to describe: 1) any specific diversion programs they may have implemented; 2) existing collaborations with HCBS agencies; and 3) the greatest challenges or barriers they continue to face in providing HCBS. Six of 11 CMC health plans in four of the CCI counties completed the survey. Subsequent email and telephone follow-up interviews were conducted with selected plans to clarify responses.

Telephone interviews with key informants: Between the fall of 2016 and the summer of 2017, researchers conducted 20 in-depth telephone interviews with key informants from all seven CCI counties. Individuals represented ILCs; MSSP, CBAS, and IHSS agencies; housing providers; stakeholder associations; senior service agencies; and home-delivered meal providers. Interviews were conducted with various individuals within the organizations who had firsthand knowledge of and experience with the provision of their services to CMC beneficiaries. Interviews were transcribed and content analysis was conducted. Key themes emerged and are summarized below.

FINDINGS

The Impact of CMC Care Coordination on HCBS

CMC care coordination and ICTs facilitated access to HCBS: Care coordination, which was a new benefit provided by CMC health plans, played an important role in getting CMC beneficiaries needed HCBS. HCBS programs like CBAS, MSSP, and IHSS all reported that they were coordinating with the heath plans and with each other more effectively as a result of the care coordination provided by CMC health plans. Respondents reported that CMC care coordination helped various agencies better identify the HCBS needs of CMC beneficiaries and direct them to associated resources.

> *"Just out of [ICT] meetings, I'm getting quite a bit more information from the team that is then being coordinated among the team to meet those goals … We have actually worked with [CMC plan]. We worked with some care coordinators in terms of housing issues and things like that, so … it's nice to have a contact person within the managed care plan who we can kind of pop ideas at to see who can have the resources maybe to help."* – CBAS Program

Participation in ICT meetings by social workers from HCBS programs was mentioned as a primary driver of improved HCBS access for CMC members. Social workers from IHSS, CBAS, and MSSP all reported that attending the ICT meetings with the CMC plan allowed them to get to know the CMC beneficiaries better, have a better understanding of their unmet needs, and fill gaps in services in a more person-centered way.

> *"We're under the same mandate to include the participant or their authorized representative in what their desired wishes and goals are for the care plans that we do with them, which are every six months, so we have integrated that into our care plans now. I've actually found it really interesting from a administrative perspective because I'm seeing that my staff knows a little bit more about these people now that they're having to get more feedback because they're obligated to document it. It's been really helpful for us, in terms of the person-centered care planning at our center, that we have more information and more ideas of what these folks want and need, which might not have been as easily available in the past."* – CBAS Program

HCBS providers developed care coordination innovations in conjunction with CMC: The CMC program sparked some innovative care coordination approaches not just within the CMC health plans, but also within other HCBS programs. For example, some HCBS programs (such as IHSS) established specific Care Coordination Units to better work with CMC health plans to coordinate various HCBS.

> *"It [IHSS Care Coordination Unit] was primarily created for care coordination-related activities. There are times when we also assist with the coordination with MSSP. We have a designated call number that the plan will contact, and if it's related to MSSP, they will still call our [IHSS Care Coordination Unit] and then we will direct the information to wherever it needs to go. MSSP staff are also able to coordinate with [IHSS Care Coordination Unit] staff in case there is an inquiry with a Cal MediConnect member and they need to obtain additional information or participation in the ICT."* – IHSS Program Manager

Another innovative program was a partnership between MSSP programs and CMC health plans. In some counties, CMC health plans would contract with MSSP programs to provide intensive care management for their members who qualified for the service due to complex care needs and high risk for nursing home placement but were on the waiting list (see Box 1 below).

Box 1: MSSP-Light

"MSSP-Light" is an innovative program that was created in San Diego County to serve CMC beneficiaries who qualified for the service but were on the MSSP waitlist. Because MSSP is currently a waiver program with a limited number of clients they can serve, at least two of the CMC health plans in San Diego paid the program directly to provide the usual array of MSSP services (i.e., intensive case management to older adults who are at risk for nursing home placement) to their members on the waitlist. Although the estimated number of CMC clients who were receiving MSSP-Light was not large, it is a promising practice that has potential for expansion.

"MSSP sends them a weekly report of all the clients that are on the waitlist or enrolled and basically their status and where they're at within the program. And if they're on the waitlist or they're pending, the health plan can then look at offering services. They may refer them to MSSP–Light, and then once MSSP–Light provides services and their name comes up on the list, then they will be referred back to MSSP."
– MSSP Program Manager

MSSP: Intensive care management for older adults with complex care needs: In January 2020, the MSSP program is slated to transition to a managed care benefit.[13,14] During the CMC demonstration, there was variation among health plans as to how much they leveraged MSSP. For example, some CMC health plans referred their qualified members to MSSP for care management, while others reportedly bypassed MSSP and provided intensive care management to their institutionally at-risk members directly. The lack of referrals from CMC health plans in some counties was concerning for some respondents because of the at-risk nature of the population.

> *"We have received very few referrals directly from the health plan, which is disturbing. It should be very disturbing because MSSP criteria are institutionally frail, at-risk seniors … we get almost no referrals from the managed care plans."*
> – Area Agency on Aging

Some MSSP representatives reported that MSSP care coordinators were uniquely qualified to provide the intensive case management needed for institutionally at-risk seniors. They expressed concern that CMC care coordination programs do not have the same expertise with the duals population nor do they have the capacity to provide the high-contact, intensive services that they feel are required.

> *"Managed care plans have had a lot of experience in managing health for kids and younger adults, but when it comes to really frail folks, I think they have limited experience in [the MSSP population]."* – Area Agency on Aging

"I am very skeptical as to how the health plans would run MSSP if it were in their hands, because we've been working hand in hand with them for a long time. I can tell they have a problem really grasping the social model [of disability] … Our MSSP staff is contacting each client every month. And they go visit them every quarter, and they get a complete re-evaluation by a nurse and a social worker every year. That's a lot of intense case management." – County Agency

One respondent recommended that in preparation for MSSP to become a managed care benefit, health plans should invest in more training for their staff specifically around the scope and intensity of the care coordination services that are required for seniors at risk for nursing home placement. This could come in the form of shadowing MSSP workers or doing home visits.

"[Health plans] have a lot to learn before they take on MSSP. I think there should really be a lot more shadowing going on. You know, spending a couple weeks, at least every year, with the MSSP staff seeing what they do, who they call, and what resources they're hooking them up with. It's not just a matter of having an ICT from time to time. It's having your workers go out and visit these people, build a rapport with them, talk to them every month, and see them every quarter. Hooking people up with resources is just one aspect of it." – County Agency

Referrals to HCBS for CMC Members

A key part of CMC was the health plans' new responsibility for coordinating and referring members to HCBS. Referrals to HCBS fell into two broad categories: 1) referrals to HCBS that were CMC/managed care benefits (e.g., IHSS, CBAS, transportation) and 2) referrals to other non-Medi-Cal HCBS (e.g., MSSP, Meals on Wheels, senior services agencies, chore services, ILCs) that were either funded elsewhere and were thus without cost to the plans or were paid for by CMC health plans using CPO flexible spending.

CMC referral to HCBS managed care benefits: HCBS providers and CMC health plans reported their experiences working together to provide services to their members.

CMC involvement has facilitated access to IHSS: IHSS is the largest Medi-Cal LTSS program, and CMC has reportedly led to increased access for some beneficiaries.[10] Despite the fact that CMC health plans were only charged with coordinating IHSS and were not involved directly in determining eligibility, both CMC and HCBS providers reported that the plans often advocated for their members to be enrolled or reassessed for more hours. Some reported that IHSS hours were approved more quickly due to increased collaboration and coordination with CMC health plans. Representatives of IHSS programs confirmed that CMC health plans were indeed actively making referrals and that the demonstration resulted in these referrals being more streamlined and efficient.

"We streamlined our referral process for our close partners like [CMC] health plans. They don't have to fill out so many forms. They just have to do one page or a couple of notes, and then that will be okay. For the IHSS social worker, all they have to do is complete a very short paragraph for us, too, and then we'll take over." – IHSS Program Manager

Innovations such as joint care management programs between the plan and IHSS social workers also helped to improve coordination and increase access (see Box 2 below).

> *"I think that is a big benefit to the members that the IHSS services are approved quicker as well, because it doesn't take as long to gather that information. Health plan representatives know what we need. They're familiar with the required form. They're able to provide us with those forms right away. And with the other members who don't participate [in CMC], sometimes it's a little bit more challenging to get that documentation from the doctor and get the doctor to fill it out correctly."* – IHSS Program Manager

Box 2: IHSS Care Coordination Unit (CCU)

Coordination of HCBS was a new benefit provided by CMC health plans. To help address this new responsibility, at least four CCI counties created distinct IHSS Care Coordination Units (CCUs) that work to coordinate care for their CMC members. In some counties, this strategy included the co-location of IHSS and CMC plan staff. The creation of CCUs reportedly increased participation in the ICT meetings, improved communication between CMC health plans and IHSS staff, facilitated the use of standardized forms to streamline referrals, and encouraged the re-assessment of IHSS recipients to ensure adequate hours. It also made it easier for IHSS social workers to participate in urgent ICT meetings with less lag time.

> *"When implementing this, we decided to transition the tasks and inquiries of participation in the ICTs to a specialized unit, the Care Coordination Unit (CCU). Through the establishment of the CCU, we've cultivated a good relationship with the care coordinators. Before the participation of the CCU, the ICT occurred on a more haphazard basis. The CCU has afforded us the ability to standardize our process for participating in the ICTs. The CCU enabled our staff to be present at the ICTs by having the designated staff that can respond at a moment's notice."* – IHSS Program Manager

The CCI also allocated funds specifically for IHSS social workers to attend ICT meetings.[10] A survey conducted in one county showed that the majority of CMC IHSS recipients reported improved health and feeling more empowered to manage their health needs as a result of working with their IHSS social worker.[*] Despite the promising nature of this practice, the funding for IHSS social workers to participate in the ICT meetings will be eliminated at the end of the demonstration.[10] Regardless, many of the counties with CCUs have expressed a commitment to continued coordination of care for IHSS recipients even after the CMC demonstration ends.

[*] Personal communication with a county agency.

On the other hand, there is still room for improvement. Some IHSS representatives reported that CMC health plans could advocate more for their members and their advocacy could be improved if they were better educated about what the IHSS can and cannot provide to members.

> *"They [the plans] do advocate for their members, but it's not a lot, really. We kind of track all our calls and requests for reassessments and requests for increase in [IHSS] hours, and it's certainly not as much interaction or collaboration as I had initially expected."* – County Agency

CBAS through CMC: CBAS became a managed care benefit in 2012, approximately two years before the implementation of the CMC demonstration. In part because it was already an MMC benefit, both CMC health plans and CBAS programs had made substantial progress in collaborating to serve dually eligible beneficiaries. The CBAS centers that were interviewed reported it was fairly easy to make contracts with and collaborate with the CMC health plans because they had been working with managed care previously. One CBAS center reported an improvement in services to its clients because of the help of the CMC care coordinators.

> *"They are helpful. We have actually worked with [CMC health plans]. We worked with some care coordinators in terms of housing issues and things like that, so yeah … it's nice to have a contact person within the managed care plan who we can kind of pop ideas at to see who can have the resources maybe to help."* – CBAS Program

> *"CMC care coordinators make our life easier."* – CBAS Program

Provision of transportation through CMC was mixed: Additional transportation services to medical appointments were a key new benefit provided to CMC enrollees. When asked about the provision of transportation services for CMC beneficiaries, HCBS providers reported mixed experiences. For some, transportation through CMC was readily authorized and obtained when it was needed. Others noted that when CMC health plans were responsible for transportation, the variety of vendors they could use was reduced or services were delayed.

> *"We've had a lot of trouble with services that the health plans promote like transportation. That's one of the services that we routinely would provide, but the health plans now provide it. However, the delays make it almost impossible for MSSP clients to take advantage of it, because their doctor's appointments come and they need transportation. It's a really frail population and they're told 'Oh, we can get to you in a week, or two weeks.' It's not a demand response system … Before CCI … we were able to use multiple vendors for services. However, now we're restricted to using only those vendors that the health plans allow. They're not demand responsive. They're not responsive."*
> – Area Agency on Aging

Referral to non-Medi-Cal HCBS: Most CMC health plans reported making referrals to HCBS programs that were non-Medi-Cal services agencies like Meals on Wheels, ILCs, housing agencies, and home health service agencies. Some CMC health plans made great efforts to identify and develop relationships with hundreds of HCBS providers in their counties.

"We've got reps whose job is to go out into the community and find CBOs [community-based organizations] that provide services to seniors and persons with disabilities, develop relationships with them, and understand who they are, what they do, and who they serve. They find what the criteria is that they are looking for and make sure they understand what we as a health plan do to find ways to work in a mutual beneficial way. There are close to 1,000 different organizations that we have a relationship with." – CMC Health Plan

Despite the efforts of some CMC health plans, referrals to HCBS that were not Medi-Cal or Medicare benefits remained challenging in many counties.

Fewer than expected referrals: Some non-Medi-Cal HCBS providers (e.g., ILCs, community-based senior service agencies) in demonstration counties had originally anticipated that CMC health plans would make large numbers of referrals to their programs. Ultimately, many were surprised by the lower-than-anticipated referrals. Furthermore, some HCBS agencies reported very little communication or collaboration even when their clients were in CMC health plans. Some respondents attributed this to their local CMC health plans' lack of awareness about the availability of CBOs providing HCBS in their communities and the benefits those local agencies could bring to CMC members.

"We have definitely really tried to work more closely with the health plans … but we found it really difficult to get them to really understand [the impact] that community-based services have on the health and well-being of clients. We're the ones that are in the home all the time. We can report back. We haven't had a lot of success even working with [CMC] social workers and care teams with shared clients. I think that from our standpoint, it really just seems like they wanted to take everything on and create their own systems."
– Senior Services Agency

Some CMC health plans confirmed that there were barriers to working with non-Medi-Cal HCBS agencies in their county. Because HCBS agencies are often funded by short-term grants, their target populations, capacities, and services often change, making it difficult for CMC health plans to keep track and ensure appropriate referral. Furthermore, some CMC health plans noted that a major barrier to working with HCBS agencies involved difficulties reconciling their own needs for information technology (IT), regulatory requirements, billing procedures, oversight, and reporting with the HCBS agencies' business acumen capacities.

"CBOs need to restructure their services to support health plans' needs, including billing, service definitions, expanded business operations, and capabilities."
– CMC Health Plan

Lack of clarity about the scope of CMC health plans' responsibility for non-Medi-Cal HCBS: Lack of clarity about CMC health plans' responsibility for HCBS led to some unmet expectations around contracting and payment for services. Some HCBS providers had expectations that the plans would use flexible spending options to pay them to provide various HCBS (e.g., chore services, home safety assessment, check-in services) that were not otherwise covered by Medi-Cal or Medicare. For example, an agency that fundraised to provide free services to low-income clients reported that they expected the CMC health plans to pay them to provide these same services to CMC members.

"The plans have made it clear that they don't have to reimburse for community-based services, so they're not going to … they didn't have to pay us to do grocery shopping or check in on somebody. As a non-profit that works with volunteers, they really wanted to not pay us our costs. Our non-profit is volunteer based, and we can't fundraise to subsidize for a big insurance company."
– Senior Services Agency

Lack of clarity about CMC health plans' responsibility for HCBS also extended to beneficiaries and medical care providers. Some respondents noted that CMC beneficiaries and providers are both unaware that CMC health plans are responsible for HCBS, a barrier to self-advocacy and referral. Indeed, focus groups with CMC beneficiaries in the early stages of the demonstration showed low levels of awareness that HCBS was a covered benefit.[24] To help remedy this situation, HCBS providers recommended more education for CMC beneficiaries and providers about the LTSS services available through their plans.

"It is a foreign concept because I would never ask my health provider, my health plan, 'Can you help me with transportation?' … It is such a foreign concept."
– Area Agency on Aging

Brokerage model – partnering with one agency to help facilitate access to HCBS: A key strategy by some CMC health plans was to contract with one large HCBS provider to take over coordination of and referral to various HCBS for their members. The "brokerage partners" who worked with CMC health plans included a variety of both for-profit and non-profit agencies like ILCs, home health, housing, or community-based senior services agencies. Many of these HCBS partners have years of experience both providing HCBS directly and coordinating with large networks of community providers. Some had recent experiences working as lead agencies for the California Community Transitions Project,[25] the state's implementation of the Money Follows the Person demonstration. Because of their experience and knowledge of local systems, brokerage partner agencies were often able to work quickly to identify and fill gaps in care for CMC members.

"The health plans don't want to contract with many different providers. They want to contract with one. We are here. We've established a network division, and health plans contract with us. And they get access to all the other network of community-based organizations … We were always there for them whenever they needed a provider to do work that they've never done before. They're an insurance company. They're not a direct service provider. For [CMC members] who are LTSS-eligible, we and our network of partners are the experts in knowing what other services they are eligible for." – HCBS Provider (brokerage partner)

Using a brokerage model was identified as a promising practice for overcoming barriers around contracting with multiple, smaller HCBS providers because a larger agency may have more business acumen around contracting and reporting to managed care plans. Additionally, one respondent explained that larger HCBS agencies may have more financial flexibility to both advance funds and weather billing delays.

> *"There was a billing problem. Some [HCBS] agencies didn't get paid for six months, us included … We weathered the storm … we made it work … And a lot of the agencies didn't, [because] the [smaller HCBS providers] have restrictions on their funds. So, for example, whereas we will prepay to purchase that bath tub and shower conversion—we'll spend the $2,500 on it and get reimbursed, a [smaller HCBS provider] can't do that because they can't touch those restricted funds. So they have to have unrestricted funds to use in order to prepay for that work."*
> – Home Health Care Agency (brokerage partner)

Data Sharing

Data sharing is essential for effective coordination of HCBS, especially when services are coming from several sites. Data need to be shared in various directions, among the state, the health plans, and various HCBS providers (some with contracts with the plans, and some without). This has been an ongoing challenge due to a lack of both integrated IT systems and HIPAA regulations. Since the planning stages of CMC, plans and HCBS agencies have been gathering for periodic meetings and "collaboratives" to improve their working relationship, including improving procedures for sharing data across sites. Many HCBS providers reported that because of CMC, data sharing with health plans had become more efficient. Some of the solutions that have been implemented include creating electronic information sharing and increasing communication between HCBS providers and the health plan so that medical records do not need to be requested from the doctors' offices.

> *"I think one of the benefits of us being able to work directly with health plan representatives is the sharing of data so that it is easier to get information related to the medical condition. Sometimes it is challenging to coordinate, especially when we have an applicant and we're not able to get the required documentation from their doctor. [But] by participating in the Cal MediConnect program, we can reach out to that health plan and get that information a lot easier …"*
> – IHSS Program Manager

> *"When we do have joint conferencing on clients with [CMC plan] for example, they have access to our medical records. We've worked out an arrangement where they can electronically tap into our records, and they've been great. They want to keep themselves updated as to … what's going on."* – Area Agency on Aging

Data sharing remains a challenge: Although care coordination and communication across sites has become more routine due to CMC, data sharing continues to be a challenge. Although HCBS providers feel that they are more efficiently sharing their records with the CMC health plans, they sometimes reported that the health plans were not equally as efficient or willing to share information with them.

"Something that has been mentioned before in terms of improvement is data sharing. We wish we could have utilization data, and … it's really difficult for them to send it to us. The data sharing has been one-sided so far. I think that we could do some improvement there … They don't have a way of sharing the utilization data with us … They have utilization data, but they don't have a way of pulling the data specific to our MSSP client." – MSSP Program Manager

"The plans are very proactive in reaching out to obtain information but not so much to provide information. There have been cases ... in which our workers have reached out to the plans, maybe to inquire about durable medical equipment or maybe to obtain a health risk assessment that they might have performed. And it's not like they've been stonewalled or anything, but it's taken a while to get back."
– County Agency

Suggestions for improving data sharing: HCBS providers offered up a variety of approaches that they felt could continue to improve data sharing. Recommendations included standardized reporting procedures and forms for sharing data, designated liaisons for the various HCBS programs and CMC health plans so that there is one person to contact for data sharing, and initiating data sharing earlier in the process.

"So if you could have some standardization, … it would be nice if we had a contact person, like a CBAS contact person that everyone up front says this is where you send all these types of documents to … like discharge summaries and incident reporting … and a fax number or phone number that every center here in [county] knows to contact …" – CBAS Program

"I think the communication should start even prior to them making that IHSS referral—letting our unit know who they're making a referral on, what kinds of needs they have, and where we're going to obtain the information for a solid assessment." – County Agency

Box 3: What does the "Re-Carve Out" of IHSS Mean for the Program?

One goal of the CCI was to reduce costs. To that end, the legislation included a "poison pill" that forced dissolution of the CCI when cost savings were not demonstrated in the general fund.[4,10] A factor complicating the demonstration of cost savings was the change in funding responsibility for the IHSS program between county budgets and the state general fund.[10] Although the CCI will officially dismantle in January 2018, many of the elements of the CMC program will remain in place, including managed LTSS, with the exception that much of the funding for IHSS would revert back (or be "re-carved out") from the general fund back to county budgets, as it was before the demonstration. Representatives of county IHSS programs said it was too early to know for sure how this "re-carve out" would impact the IHSS program and the people who rely on it. Most hoped the impact of this would be minimal, considering it has been a "pass-through" payment system (i.e., managed care plans paid for the service but they did not administer it or conduct the assessments to determine eligibility).

> *"I think it was so new that I don't know if it will really impact anything too much because I don't know if [IHSS] really got a full foothold in the managed care."* – CBAS Provider

Financially, though, the counties may see barriers to continuing the program at its current level. In the last five years, program expenditures for IHSS have risen from $1.7 billion (2012-2013) to $3.5 billion (2016-2017), increasing at a rate of around 4 percent annually.[10] In order to reduce those costs, the IHSS program is reverting back to county budgets starting in 2018. Although this will transfer approximately $600 million back to the counties, this payment will not cover the financial costs. Some speculate that county funding pressures will cause increased caseloads, delays in care, or reductions in IHSS hours.

> *"The only thing that the client would probably notice would maybe be a little bit of a delay in processing their paperwork should we become short staffed at some point. There would be maybe some delays in services, but they probably wouldn't really feel the impact …"* – IHSS Program Manager

Finally, results of this evaluation found that CMC plan care coordination made a positive impact on beneficiary access to the program through advocacy for increased IHSS hours and the provision of "gap" care during IHSS enrollment delays.[12,26] Two funding mechanisms that helped to implement coordination—IHSS as a CMC benefit, and state funding for IHSS social workers to attend CMC ICTs—have been eliminated. Currently, CMC health plans and IHSS social workers are being encouraged to continue working together without the funding to do so.[10] Despite this encouragement, there is some concern that the involvement by CMC health plans in IHSS coordination may be undone by the "re-carve out" of IHSS.

> *"At least when [CMC health plans] were paying for [IHSS], they had some idea of what was going on. There was a little bit more incentive on the county and the worker to engage with the plan. There's a lot of concern that this [re-carve out] means it just goes back to being a completely separate system of care. That makes advocating for more hours difficult, because you don't really know what [beneficiaries are] getting."* – Health Plan Representative

KEY FINDINGS

1. **The CCI has improved coordination and collaboration between CMC health plans and agencies that provide Medi-Cal-reimbursed HCBS such as IHSS and CBAS, resulting in better access for many beneficiaries**. Both plans and HCBS providers reported that CMC health plans were successful in advocating for additional IHSS hours and other services to fill gaps in care for their members. Individualized care teams and joint care coordination units that worked across agencies were effective in increasing collaboration and access to services. The impact the "re-carve out" of IHSS will have on the progress that has been made is currently unclear and should be monitored closely.

2. **A lack of clarity about the scope of CMC health plans' responsibility for HCBS has led to unmet expectations around referral and payment for non-Medi-Cal HCBS**. Although some plans used flexible spending (i.e., CPOs) to contract with non-Medi-Cal HCBS (e.g., homemaker services, check-in services, chore services, meal delivery, or home safety assessments), other plans did not. This created confusion and unmet expectations within some HCBS agencies that provide critical support services to community-dwelling CMC members who would prefer more collaboration with CMC health plans.

3. **Local HCBS providers offer critical support services to duals that are not covered by Medi-Cal, but some CMC health plans experience barriers to working with these agencies.** Local HCBS providers such as ILCs, senior service agencies, and meal programs play a critical role in serving the dual population, especially ethnic minorities or other niche groups that may be more difficult for CMC health plan staff to reach. Lack of awareness of these services and underestimation of their value by the health plans as well as varying levels of business acumen and IT infrastructure on the part of the agencies may have prevented some potentially useful collaborations.

4. **The brokerage model, in which CMC health plans work with one large HCBS agency to coordinate an array of HCBS for their members, is a promising practice that has the potential to increase access to HCBS.** Working with one HCBS agency as the "middle man" to provide and coordinate HCBS effectively leveraged the experience of the agency and helped to overcome some of the contracting barriers that exist between CMC health plans and smaller agencies. This practice also transfers the responsibility of contracting and collaborating with the ever-changing landscape of local HCBS from the plan to an agency with more experience and flexibly in that area.

5. **MSSP staff have extensive expertise providing intensive care management for older adults at risk for nursing home placement, but CMC health plans varied in the extent to which they leveraged the program.** As a waiver program, MSSP has limited "slots," resulting in a waitlist. Some CMC health plans referred qualified members to MSSP programs and others contracted with MSSP to provide care management to their qualified members who were "waitlisted." Other CMC health plans, however, made few referrals. It remains to be seen whether the transition of MSSP to a managed care benefit in 2020 will increase referral and collaboration between plans and MSSP providers as it has with other Medi-Cal HCBS.

6. **Although there have been many improvements in HCBS agencies sharing data with CMC health plans, data sharing from CMC health plans to HCBS agencies still needs improvement**. Despite the many promising practices around data sharing between plans and HCBS agencies, IT infrastructure and HIPAA regulations still pose barriers.

RECOMMENDATIONS

1. **The state and CMC health plans should clearly articulate the objectives, measures of success, and scope of responsibility of the plans for HCBS, including for both Medicaid HCBS and non-Medicaid HCBS.** If needed, CMC health plans, providers, consumers, and other stakeholders should be brought together to develop consensus around the objectives and scope of the managed LTSS program, including how success is measured. A state plan that leverages lessons learned and accomplishments achieved during the CCI demonstration would be useful for informing ongoing or expanding managed LTSS models both statewide and nationally.

2. **CMC health plans should use a person-centered approach to assess LTSS unmet needs regularly in their members.** Due to the reported lack of awareness on the part of beneficiaries about their LTSS benefits, it is up to the CMC health plans to proactively assess for unmet needs, whether or not the beneficiary actively voices a concern. In HRAs and other assessments, CMC beneficiaries should be routinely asked about any impairment in activities of daily living and unmet needs for services. Ideally, LTSS assessment would use a person-centered approach that also queries the beneficiaries' goals and priorities for LTSS and leverages a variety of HCBS existing in the community to ensure that those needs are met.

3. **The state should encourage CMC health plans to communicate and contract with community-based senior service agencies, ILCs, and other local non-Medi-Cal HCBS providers, especially those that are serving their CMC members.** Smaller HCBS agencies, especially those who serve "niche" subgroups (e.g., ethnic minorities; lesbian, gay, bisexual, and transgender older adults; homeless), could act as a bridge for CMC health plans to connect with difficult-to-reach members. More training or boilerplate contract language to encourage CMC health plans to use flexible spending options to leverage the expertise of HCBS agencies would be helpful. Additionally, using a "brokerage model" to engage one larger HCBS partner who then contracts with (and facilitates referrals to) smaller agencies may be effective in expanding the scope of HCBS for CMC members.

4. **The state should issue guidance around the transition of MSSP to managed care, stipulating that all members who meet eligibility requirements (over 65 and eligible for nursing home placement) should be referred to the new benefit.** Until then, because the MSSP program still has limited waiver slots, innovations such as "MSSP–Light" (where CMC health plans pay for MSSP services for members on the wait list) is an example of a promising practice demonstrating how CMC health plans can work with MSSP waiver programs to ensure members get the care management they need.

5. **The state should educate beneficiaries and providers about the variety of HCBS that they can expect to be covered by CMC health plans.** When beneficiaries and providers are more aware of the services that are available, they will be more likely to ask for what they need, resulting in a more person-centered approach to care. A campaign to increase consumer awareness of HCBS benefits available through CMC could help increase access in the long term and potentially reduce opt-out rates among those using LTSS.

6. **CMC health plans must work more closely with HCBS agencies to ensure that data sharing is executed efficiently in both directions.** Some effective strategies that should be expanded include: naming liaisons at both agencies, creating paired care coordination units, and developing IT solutions.

7. **The state should issue guidance encouraging plans to continue close collaboration with IHSS programs, despite the "re-carve out" and change in payment.** Funding for IHSS social workers and CMC health plans to collaborate on care teams has been shown to be beneficial in encouraging partnership, collaboration, and likely increased access to IHSS services for members. The state should explore ways to support continued collaborative care planning across agencies.

ACRONYMS LIST

ADHC (Adult Day Health Care): Through February 2012, this was an optional benefit under the Medi-Cal program. It was replaced by Community-Based Adult Services starting in April 2012.

CBAS (Community-Based Adult Services): Replacing Adult Day Health Care in April 2012, this program offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent institutionalization.

CBO (Community-Based Organization): Organizations or non-profits that are based in the communities they serve, working with the community at the local level to achieve their mission.

CCI (Coordinated Care Initiative): California's 1115 waiver demonstration program launched in seven counties in 2014 to provide better coordinated care to dually-eligible beneficiaries, those with both Medicare and Medi-Cal.

CCU (Care Coordination Unit): Created by certain Coordinated Care Initiative health plans to help coordinate and facilitate care for their In-Home Supportive Services Cal MediConnect members.

CMC (Cal MediConnect): Under the Coordinated Care Initiative, a health plan that combines Medicare and Medi-Cal benefits for dually-eligible beneficiaries.

CMS (Centers for Medicare & Medicaid Services): A federal agency within the U.S. Department of Health and Human Services that administers the Medicare program and helps states administer their Medicaid and State Children's Health Insurance Programs.

CPO (Care Plan Options): A flexible spending option to purchase goods and services for Cal MediConnect beneficiaries that were not typical Medi-Cal or Medicare benefits.

DHCS (Department of Health Care Services): The department tasked with providing Californians with access to affordable, integrated, high-quality health care, including medical, dental, mental health, and substance use treatment services as well as long-term care.

HCBS (Home- and Community-Based Services): Medicaid-funded, person-centered services delivered in home- or community-based settings rather than in an institutional setting.

HIPAA (Health Insurance Portability and Accountability Act): Signed into law in 1996, this act established set of national standards for the protection of certain health information, called the "privacy rule." The privacy rule applies to health plans, health care clearinghouses, and to any health care provider who transmits health information in electronic form.

HRA (Health Risk Assessment): A survey tool required for all Cal MediConnect enrollee's that assesses current medical, psychosocial, cognitive, and functional risks as well as any needs for long-term services and supports.

ICT (Interdisciplinary Care Team): A team of care providers representing the different health services and supports received by a Cal MediConnect beneficiary who work together to coordinate the beneficiary's person-centered care, services, and supports.

IHSS (In-Home Supportive Services): A consumer-directed program for Medi-Cal beneficiaries with disabilities who need assistance with their personal care needs such as bathing, toileting, and grooming, as well as housekeeping, grocery shopping, and meal preparation.

ILC (Independent Living Center): A consumer-controlled, community-based, cross-disability, private, non-profit agency designed and operated within a local community by and for people with disabilities. The services provided help to maximize the ability of people with disabilities to live independently in the community of their choosing.

IT (Information Technology): The use of computing and/or telecommunication systems to study, store, manipulate, send, and retrieve electronic data or information.

LTSS (Long-Term Services and Supports): Non-acute care services (such as skilled nursing care, home health care, personal care assistance, homemaker services, transportation) provided in both institutional and community settings.

MMC (Medi-Cal Managed Care): A managed care health plan for Medi-Cal beneficiaries.

MSSP (Multipurpose Senior Services Program): A care management program for community-dwelling older adults (aged 65+) on Medi-Cal who are at risk for nursing home placement.

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