Coordinated Care Initiative

Fiscal Year 2016-2017

Enrollment Status, Quality Measures,

and State Costs Report

Contents

Executive Summary

Welfare and Institutions Code Sections 14132.275(q)(1) and 14186.4(f)(1) require the Department of Health Care Services to submit written reports to the Legislature, beginning with the May Revision to the fiscal year 2013-14 Governor's Budget and annually thereafter, on the enrollment status, quality measures, and state costs related to the Coordinated Care Initiative (CCI). CCI includes a Duals Demonstration Project known as Cal MediConnect and the integration of Long-Term Services and Supports as a Medi-Cal managed care benefit. Implementation dates for enrollment into Cal MediConnect and mandatory enrollment into Medi-Cal managed care for Managed Long-Term Services and Supports were staggered throughout 2014 and early 2015 in the seven CCI counties of Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Implementation information can be found in the schedule titled, "CCI Enrollment Timeline by County and Population," on the CalDuals website at the following link: http://calduals.org/background/enrollment/.

Introduction

In January 2012, Governor Brown announced the CCI with the goals of enhancing health outcomes and beneficiary satisfaction for low-income seniors and persons with disabilities (SPDs), including dual eligible beneficiaries (individuals eligible for Medicare and Medicaid), while achieving substantial savings from rebalancing service delivery away from institutional care and into the patients' homes and communities. Working in partnership with the Legislature and stakeholders, the Governor enacted the CCI through Senate Bill (SB) 1008 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012), SB 1036 (Committee on Budget and Fiscal Review, Chapter 45, Statutes of 2012), and SB 94 (Committee on Budget and Fiscal Review, Chapter 37, Statutes of 2013).

CCI includes three major components:

- A three-year Duals Demonstration Project, called Cal MediConnect, for dual eligible beneficiaries that combines the full continuum of acute, primary, institutional, and home and community-based services (HCBS) into a single benefit package, delivered through an organized service delivery system.

- Mandatory Medi-Cal managed care enrollment for dual eligible beneficiaries.

- The inclusion of the Long-Term Services and Supports (LTSS) as a Medi-Cal managed care benefit for SPD beneficiaries who are eligible for Medi-Cal only or who are dual eligible.

The Department of Health Care Services (DHCS) executed a Memorandum of Understanding (MOU) with the Centers for Medicare & Medicaid Services (CMS) on March 27, 2013. The MOU provides federal authority and outlines the parameters for implementing Cal MediConnect.

Typically, this Legislative report contains activities, updates, and data relative to the applicable Fiscal Year reporting period. However, in an effort to provide the Legislature with a more accurate depiction of CCI enrollment and overall Cal MediConnect health plan performance, DHCS is including in this Fiscal Year 2016-2017 Enrollment Status, Quality Measures, and State Costs Report activities, updates, and data that fall outside of the Fiscal Year reporting period (through October 30, 2017).

CCI Demonstration Years are listed below:

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017
4	January 1, 2018 – December 31, 2018
5	January 1, 2019 – December 31, 2019

Enrollment

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

- Live in one of the following seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, or Santa Clara.

- Be age 21 or older.

- Have full benefits, meaning they have full Medicaid (Medi-Cal) coverage and are enrolled in Medicare Parts A and B (including those individuals who receive Parts A and B through a Medicare Advantage [MA] Plan) and are eligible for Part D.[1]

- Meet their monthly Medi-Cal share of cost (if they have any) by being in a Medi-Cal-funded nursing facility or receiving In-Home Supportive Services (IHSS).

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

- Beneficiaries enrolled in a Program of All-Inclusive Care for the Elderly (PACE).

- Beneficiaries enrolled in the AIDS Healthcare Foundation.

- Beneficiaries in certain rural zip codes in San Bernardino County (different than the excluded zip codes).

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

- Beneficiaries with other private or public health insurance.

- Beneficiaries with developmental disabilities receiving services through a Department of Developmental Services 1915(c) waiver; regional center; state developmental center; or intermediate care facility for the developmentally disabled, except in San Mateo County, beginning January 1, 2016.

- Beneficiaries enrolled in the following 1915(c) waivers: Nursing Facility/Acute Hospital, HIV/AIDS, Assisted Living, and In-Home Operations.

- Beneficiaries residing in designated rural zip codes in Los Angeles, Riverside, and San Bernardino Counties.

- Beneficiaries residing in a Veterans' Home of California.

- Beneficiaries with end stage renal disease (ESRD) in all counties except San Mateo and Orange. If a beneficiary develops ESRD after enrolling in a Cal

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

MediConnect health plan, he or she may stay enrolled in that plan.

- Beneficiaries in Los Angeles if enrollment in Los Angeles has met or exceeded its cap of 200,000 participants.

Cal MediConnect Enrollment Approach

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

In April 2014, DHCS began passive enrollment of dual eligible beneficiaries into Cal MediConnect in San Mateo County. Beneficiaries already enrolled in Medi-Cal managed care began to receive LTSS benefits in Los Angeles, Riverside, San Bernardino, San Diego, and San Mateo Counties.

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

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

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

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

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

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

As of October 1, 2017, approximately 116,351 beneficiaries were enrolled in Cal MediConnect. The Cal MediConnect Enrollment Dashboard, which provides monthly enrollment statistics by county and health plan, is available on the CalDuals website at the following link: http://calduals.org/background/enrollment/statistics/.

Cal MediConnect remains a voluntary choice for all dual eligible beneficiaries in CCI counties; however, these beneficiaries must still enroll in an MCP for their Medi-Cal benefits, including LTSS. Newly dual eligible beneficiaries are sent Welcome Packets that include the list of Cal MediConnect health plans and MCPs from which they can choose to enroll.

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

Mandatory Medi-Cal Managed Care Enrollment

DHCS mandatorily enrolled nearly all Medi-Cal beneficiaries into an MCP in CCI counties. The majority of Medi-Cal only beneficiaries were already enrolled in MCPs, but also received their LTSS through the same MCP. LTSS includes skilled nursing and HCBS, including IHSS, Community-Based Adult Services (CBAS), and Multipurpose Senior Services Program (MSSP) services.

For dual eligible beneficiaries who chose not to enroll in a Cal MediConnect health plan, the State required beneficiaries to enroll in an MCP to receive Medi-Cal services, including LTSS. For dual eligible beneficiaries, enrolling in an MCP did not change their Medicare benefits; they continue to receive health care services from their Medicare hospitals and providers.

Enrollment Notices and Education Materials

At least 90 days prior to passive enrollment, dual eligible beneficiaries received written notification on how and when their health care would change, and whom they could contact for assistance when choosing an MCP or Cal MediConnect health plan. Sixty days prior to a beneficiary's effective enrollment date, DHCS mailed an enrollment packet that included: (1) a letter describing the pending changes and actions required of the beneficiary; (2) a resource booklet describing what a health plan is and what it means to be enrolled in a health plan, particularly member rights and responsibilities; and (3) a choice book that included an enrollment choice form and a pre-stamped envelope, a detailed plan benefit comparison chart, and details for in-person presentations. For beneficiaries who did not actively make a health plan choice, DHCS mailed a reminder notice approximately 30 days prior to the enrollment effective date. All beneficiaries were sent a letter just prior to the enrollment effective date confirming their health plan choice or the DHCS assigned plan. DHCS, in accordance with CCI statutory requirements, verified enrollment notices were made available to the public at least 60 days prior to the first mailing of notices to beneficiaries.

DHCS developed the enrollment notices, choice book, and other materials for Cal MediConnect and mandatory Medi-Cal managed care enrollment after an extensive stakeholder review process. In February 2014, DHCS began working with a group of stakeholders to further revise and clarify the notices and choice form. These stakeholders met with DHCS senior leadership to discuss the notices and other issues on March 6, April 16, and May 6, 2014. Following this process, and in partnership with CMS, the choice form and 60-day notice went through beneficiary testing and a stakeholder review process. In response to this feedback, DHCS made changes and provided the revised 90-, 60-, and 30-day notices and choice form to the California Collaborative for another stakeholder comment period in June 2014. The California

Collaborative includes 37 statewide advocacy and stakeholder groups and is connected to local Collaborative coalitions of stakeholders in each of the CCI counties. Comments received from the California Collaborative stakeholders were incorporated into the final notices and choice form. As a result of these activities, DHCS revised the notices and materials for consistent messaging across different materials and to more clearly explain the following:

- Plan choices and instructions for opting out.

- Continuity of care provisions.

- How to determine which providers are part of each plan's network.

- Covered services and benefits.

- Whom to contact for assistance.

All CCI notices were written at a sixth-grade reading level and in the 13 Medi-Cal threshold languages used at that time, as well as in alternative formats that were culturally, linguistically, and physically appropriate. DHCS posted all final notices and related materials, including the choice book, choice form, and the Cal MediConnect and the Managed Long-Term Services and Supports (MLTSS) Guidebooks on the CalDuals website at: http://www.calduals.org/implementation/cci-documents/notices/.

These notices and materials are no longer actively used following the end of passive enrollment but are still available online. Note that San Mateo and Orange Counties are County Organized Health System (COHS) counties, and the COHS Cal MediConnect health plans were responsible for developing and mailing their own enrollment materials.

In addition to these materials, DHCS created a new MCP Guide and Choice Book that is mailed to two groups of dual eligible beneficiaries: (1) new dual eligible beneficiaries who have Medicare first and later gain Medi-Cal eligibility in CCI counties; and (2) existing dual eligible beneficiaries who move into a CCI county. These materials went through a stakeholder comment period and were released in summer 2016. They also underwent extensive user testing and revisions in partnership with Health Research for Action at UC Berkeley's School of Public Health and a series of literacy reviews to verify that they meet readability standards and are not above a sixth-grade reading level. The materials are available in Medi-Cal threshold languages and in accessible formats, as required. The materials are mailed to the aforementioned beneficiaries as a part of their regular enrollment process. These beneficiaries are already required to enroll into MCPs for LTSS in order to receive their Medi-Cal benefits. DHCS is now implementing the process required to inform these beneficiaries of their options and to mandatorily enroll them into MCPs. The new materials incorporate lessons DHCS has learned about how to communicate with dual eligible beneficiaries concerning the CCI, including lessons learned through stakeholder input and beneficiary testing of previous materials.

Additionally, DHCS has released a CCI Beneficiary Toolkit. This comprehensive toolkit contains stand-alone fact sheets that cover various topics and aspects of Cal

MediConnect and CCI in more depth. The fact sheets address questions that currently enrolled and eligible beneficiaries often have, including:

- Can I keep my current doctor?

- How do I keep seeing my current doctors?

- How does Cal MediConnect help me get the care I need?

- What is a Health Risk Assessment (HRA) and a Care Coordinator?

Another included fact sheet helps explain some of the particulars related to MCPs, such as the definition of a network. This toolkit helps eligible beneficiaries understand their options and how Cal MediConnect may benefit them. It also helps beneficiaries better understand how to navigate their MCPs if they choose to opt out of Cal MediConnect. The toolkit underwent stakeholder review and user testing in partnership with the Health Research for Action at UC Berkeley's School of Public Health. As with other materials, these documents were subject to a final literacy review process and were translated into the 13 Medi-Cal threshold languages. The toolkit is an easy-to-use resource for enrolled and eligible beneficiaries, caregivers, and stakeholders. It is available online at http://calduals.org/learn-more-resources/toolkits/beneficiary-toolkit/ as well as in hard copy, and is being distributed during outreach activities.

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

Beneficiary and Provider Outreach

DHCS developed a Beneficiary and Provider Outreach Plan (Appendix A). This outreach plan was shared with stakeholders and will be updated as needed throughout CCI implementation.

The primary goal of the outreach plan is to provide beneficiaries, including those in nursing care and their caregivers, providers, family members, conservators, and/or other authorized representatives, with the information they need about the CCI. Acknowledging the significant role providers play in informing and guiding beneficiaries, the outreach plan emphasizes providers and their staff as key outreach targets. The outreach plan recognizes the diversity of the CCI target population and the variety of languages spoken by the beneficiaries. Also, per statutory requirements, specific provisions have been made to educate beneficiaries on PACE options.

DHCS has been implementing the outreach plan since late 2013 in each CCI county. A technical advisor team on the project from July 2014 through July 2015 and an outreach coordinator team based across the seven CCI counties were at the heart of the local

outreach effort. The technical advisors and outreach coordinators build bridges between the local resources, community-based organizations (CBOs), stakeholders, providers, doctors, hospitals, health plans, and the individuals making decisions on how to participate. Activities included the following:

- Participating in local stakeholder coalitions, particularly as they relate to communications and outreach to the beneficiary and provider populations.

- Providing informational presentations to beneficiaries, providers, and advocates.

- Delivering "train the trainer" presentations to organizations who regularly interact with the beneficiary population and need support understanding and explaining the CCI.

- Providing monthly tele-town halls for beneficiaries receiving 60-day notices during passive enrollment periods.

- Hosting bi-monthly stakeholder update calls (meetings were monthly until November 2015).

- Hosting monthly webinars for providers and advocates in all CCI counties.

- Organizing community forums and local town halls.

- Creating and hosting health fairs and resource fairs for beneficiaries.

- Supporting effective information flow between the counties and the State, particularly to identify information and outreach needs in local communities.

- Developing and refining outreach materials and maintaining the website www.calduals.org.

- Maintaining an email inbox for stakeholders to email their CCI-related questions, concerns, and feedback.

DHCS works closely with other state entities serving this population as part of the outreach effort. DHCS is working with the California Department of Aging (CDA) to encourage effective communications between the State and the local HICAPs. During the beginning of the passive enrollment process, CDA sent out monthly surveys to the HICAPs and Area Agencies on Aging (AAA) asking them to identify issues and needs. Based on these monthly surveys and regular communications with the HICAPs, DHCS and CDA developed new and updated materials for the HICAPs and hosted regular webinars to provide updates and answer questions.

DHCS and the Department of Managed Health Care (DMHC) established an Ombudsman program to assist beneficiaries. The Ombudsman program managed by DMHC went live on April 1, 2014, and is operated by the Legal Aid Society of San Diego and several experienced subcontractors located in the CCI counties. The Legal Aid Society of San Diego and its subcontractors are highly experienced in providing consumer assistance services. The subcontractors report their concerns and issues directly to DMHC. In addition, DHCS held bi-monthly meetings with the Legal Aid

Society of San Diego to work on ongoing issues and to exchange information about Ombudsman work; these meetings continue as needed.

DHCS has worked extensively to increase outreach to health care providers, beneficiaries, and other stakeholders, including developing three educational toolkits, available at: http://calduals.org/learn-more-resources/toolkits/

- CCI Physician Toolkit—provides information on how providers can work with health plans and how they can participate in care coordination activities.

- CCI Beneficiary Toolkit—provides a cohesive story of the program and provides stand-alone fact sheets that cover various topics and aspects of Cal MediConnect and the CCI in more depth.

- Cal MediConnect Hospital Case Manager Toolkit—provides guidance, answers common questions, and relays important information about Cal MediConnect to hospital case managers and discharge planners. The goal of this toolkit is to facilitate beneficiary transitions out of the hospital and back into the community.

In January 2015, DHCS hosted the first of a series of Cal MediConnect provider summits to increase communication between providers, health plans, and health plan delegates. DHCS hosted a second Cal MediConnect provider summit in June 2015 and continues to look for opportunities for future summits.

Overall Performance

DHCS developed the Cal MediConnect Monthly Enrollment Dashboard, available at http://calduals.org/background/enrollment/statistics/, as an additional tool for communicating with advocates, beneficiaries, and other stakeholders. This dashboard contains enrollment and opt-out numbers by county. DHCS posted the first enrollment dashboard on the CalDuals website in April 2014 and continues to update it monthly. In addition to this dashboard, DHCS began releasing opt-out data broken down by language, ethnicity, and age in June 2015. DHCS also began sharing HRA data on an HRA dashboard, available at http://calduals.org/background/cci/evaluations/health-risk-assessment-hra-dashboards/, beginning in February 2015. As of March 2016, HRA data has been integrated into a more comprehensive Cal MediConnect Performance Dashboard http://calduals.org/background/cci/evaluations/cal-mediconnect-performance-dashboard/. The Performance Dashboard shares data on how Cal MediConnect health plans are performing in six areas related to care coordination, quality, and service utilization, including: (1) HRAs; (2) Appeals by Determination; (3) Hospital Discharge; (4) Emergency Utilization; (5) LTSS Utilization; and (6) Case Management.

DHCS will combine the enrollment and performance dashboards into a single dashboard in early 2018. The new dashboard may contain plan performance results on the National Opinion Research Center (NORC) quality measures that monitor HRAs, Individualized Care Plans (ICPs), reassessments and more. Below are highlights from the new dashboard. Data is displayed in calendar years, which corresponds to DYs. Data charts from 2014 - 2016 have been included in this report to provide a more

comprehensive view of performance trends than would be shown by data from a single year.

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

Chart 1A: HRA Completion – Completed*

Percent of members who were reached, were willing to participate, and had an HRA completed within 90 days

■ California ■ Totals Across All Demonstrations

	2014	2015	2016
California	82.2%	83.4%	90.3%
Totals Across All Demonstrations	69.2%	78.4%	89.6%
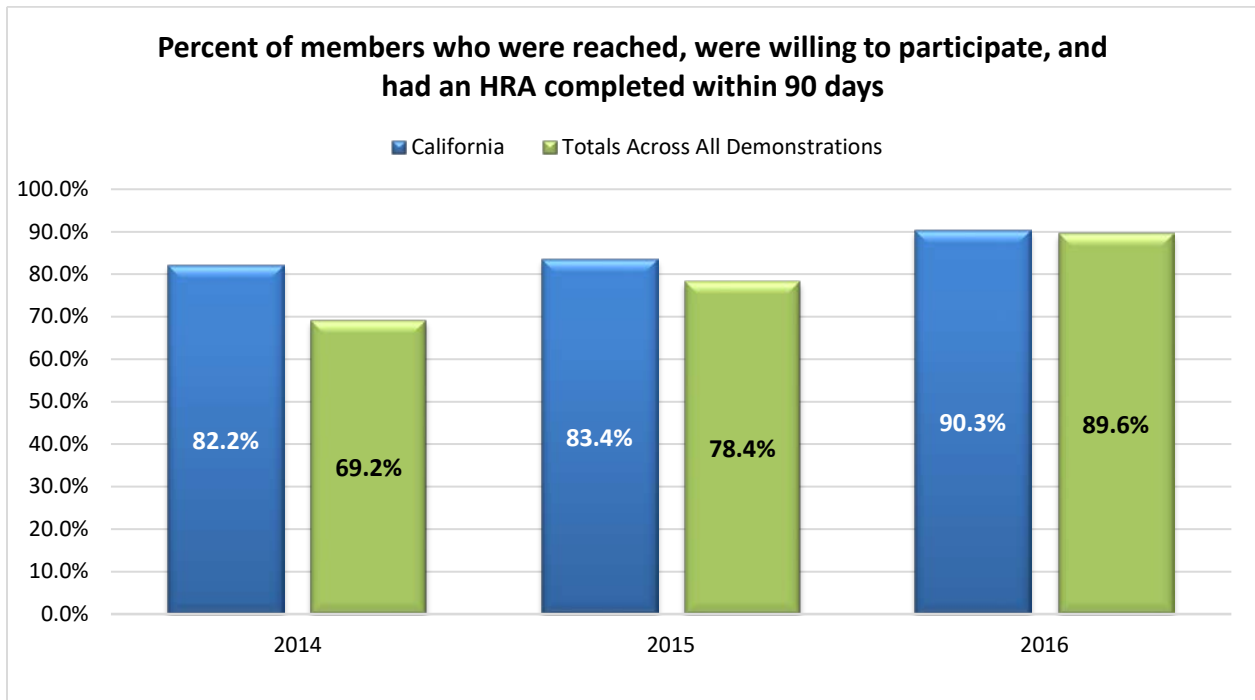
Chart 1B: HRA Completion – Unable to Reach*

Percent of members who the Cal MediConnect health plan was unable to reach within 90 days to complete an HRA

■ California ■ Totals Across All Demonstrations

	2014	2015	2016
California	43.3%	35.6%	27.1%
Totals Across All Demonstrations	33.9%	24.4%	23.8%
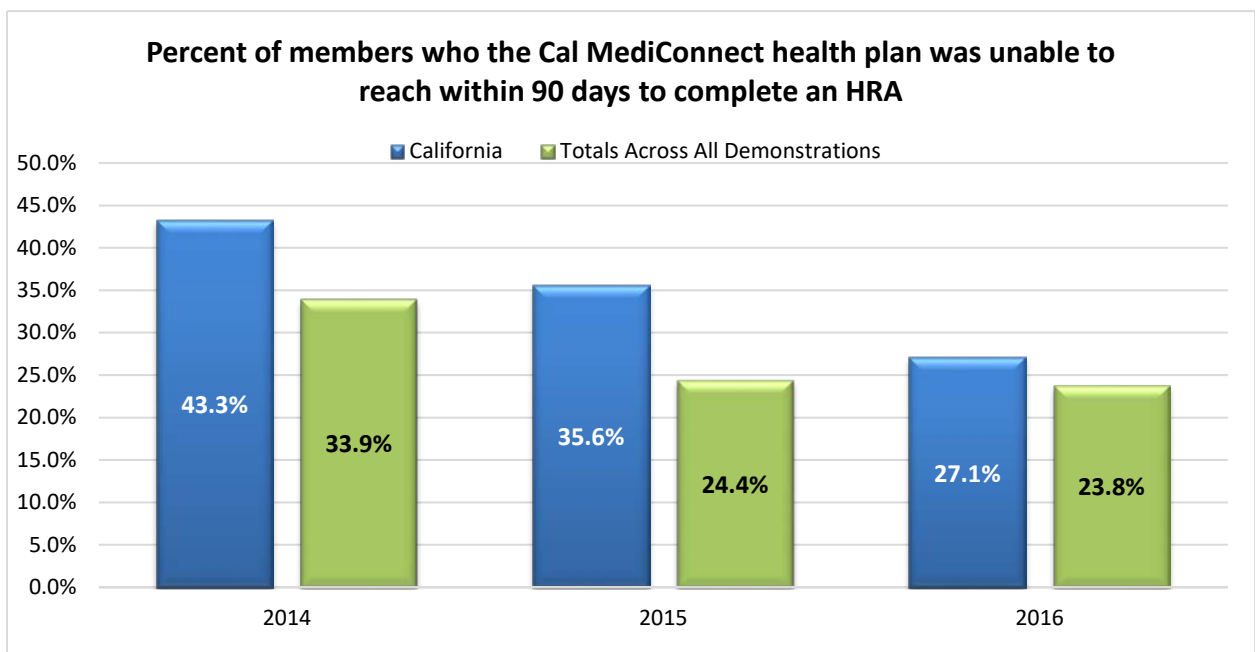
* The HRA measures on which Charts 1A and 1B are based were effective and in place starting in 2014, when CCI began. 2014 data comes only from the Cal MediConnect health plans that were fully operational that year.

Chart 1A shows that, in the first two years of the demonstration, California slightly outperformed the national average for HRAs completed within 90 days; in the third year of the demonstration, California's average was close to the national average. However, Chart 1B shows that, in each year of the demonstration, California's rate was higher than the national average for members that the Cal MediConnect health plan was unable to reach to complete the HRA within 90 days of enrollment.

After the HRA, the ICP is the next key component of a member's enhanced care coordination within Cal MediConnect. As shown in Chart 2A, California performed on par with the national average for ICP completion within the required number of days. California was more successful on average when attempting to reach members, as shown in Chart 2B.

Chart 2A: ICP Completion – Completed**

Percent of members who were reached, were willing to participate, and had a care plan completed within the required number of days

- Totals for CA
- Totals Across All Demonstrations

	2015	2016
Totals for CA	57.3%	65.2%
Totals Across All Demonstrations	57.3%	65.4%
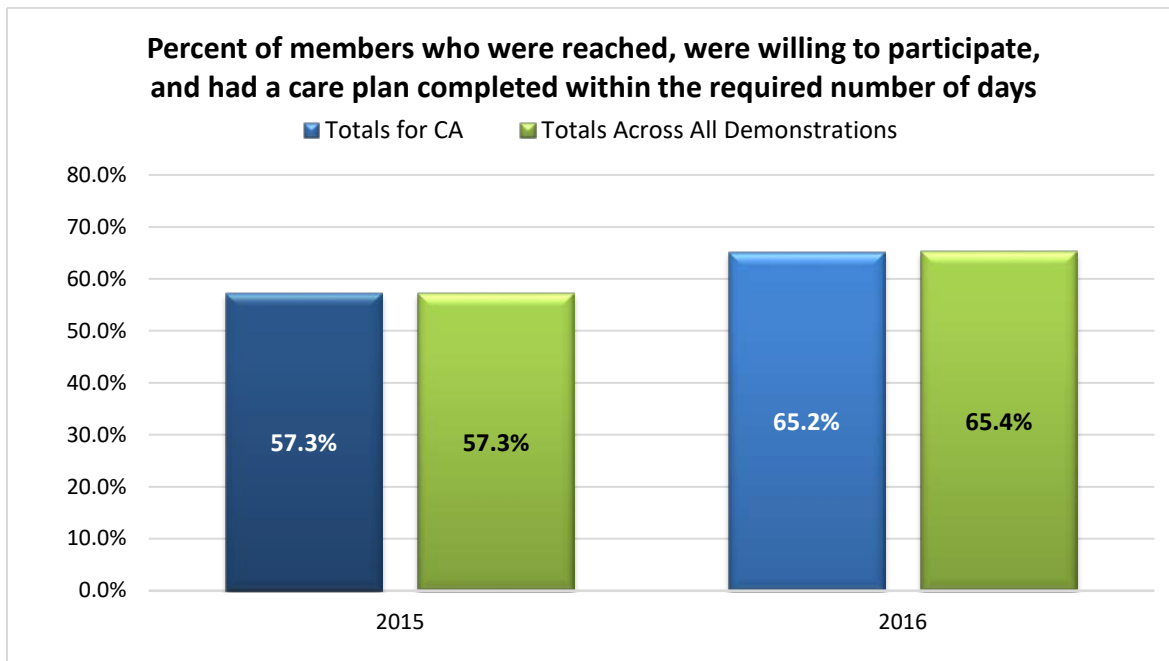
Chart 2B: ICP Completion – Unable to Reach**

Percent of members who the Cal MediConnect health plan was unable to reach within the required number of days to complete a care plan

- Totals for CA
- Totals Across All Demonstrations

2015: 7.8% | 14.7%
2016: 6.2% | 18.5%
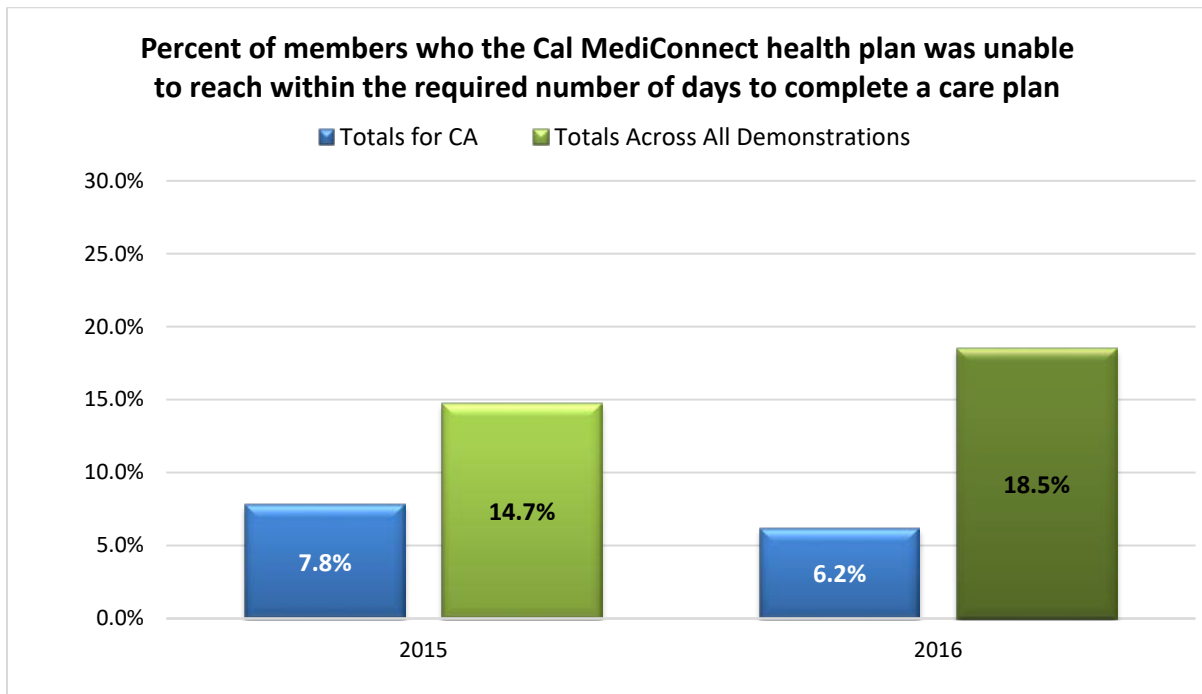
** The ICP measures on which the data in Chart 2B were based were effective in late 2014. Cal MediConnect health plans first began reporting on these measures with the 2015 data.

Cal MediConnect health plans help members determine what their most important health goals are and record them in the ICP. California aligned with the national average until 2016.

Chart 3A: Discussion of Care Goals – Initial ICPs*

Percent of initial care plans that included at least one documented discussion of care goals

- Totals for CA
- Totals Across All Demonstrations

2014: 73.6% | 72.1%
2015: 63.3%
2016: 51.4% | 72.6%
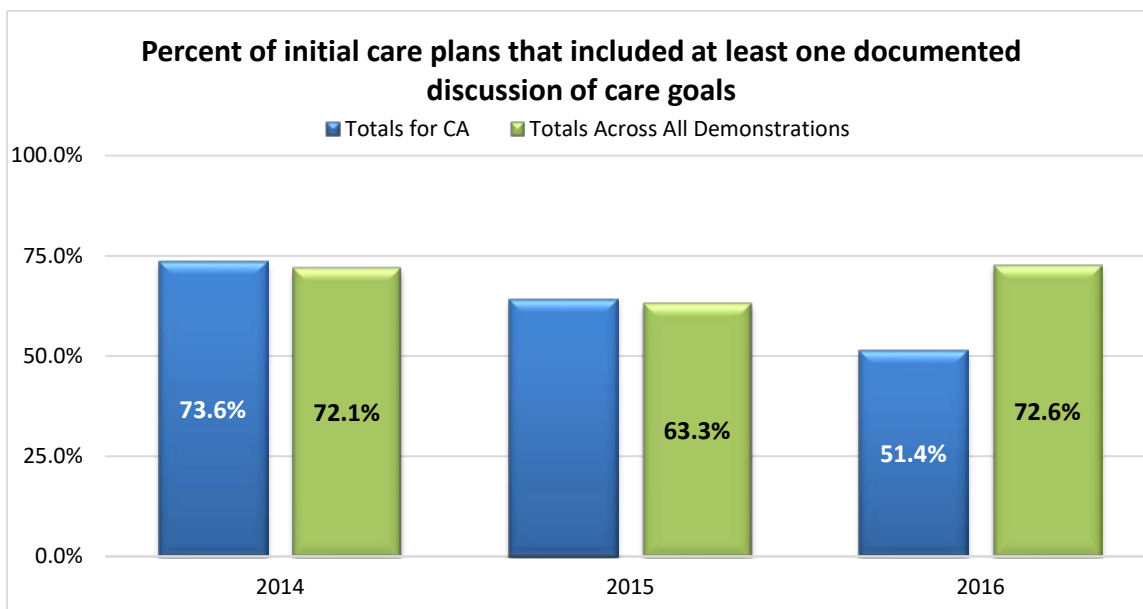
* Cal MediConnect health plans that were operational in 2014 reported this data for 2014. Cal MediConnect health plans that were operational in 2015 began reporting with 2015 data.

Goals were more difficult to document for revised ICPs, which began in 2015. At the end of 2016, the Contract Management Team (CMT), a joint CMS and DHCS team, met with each of the Cal MediConnect health plans to review sample ICPs (with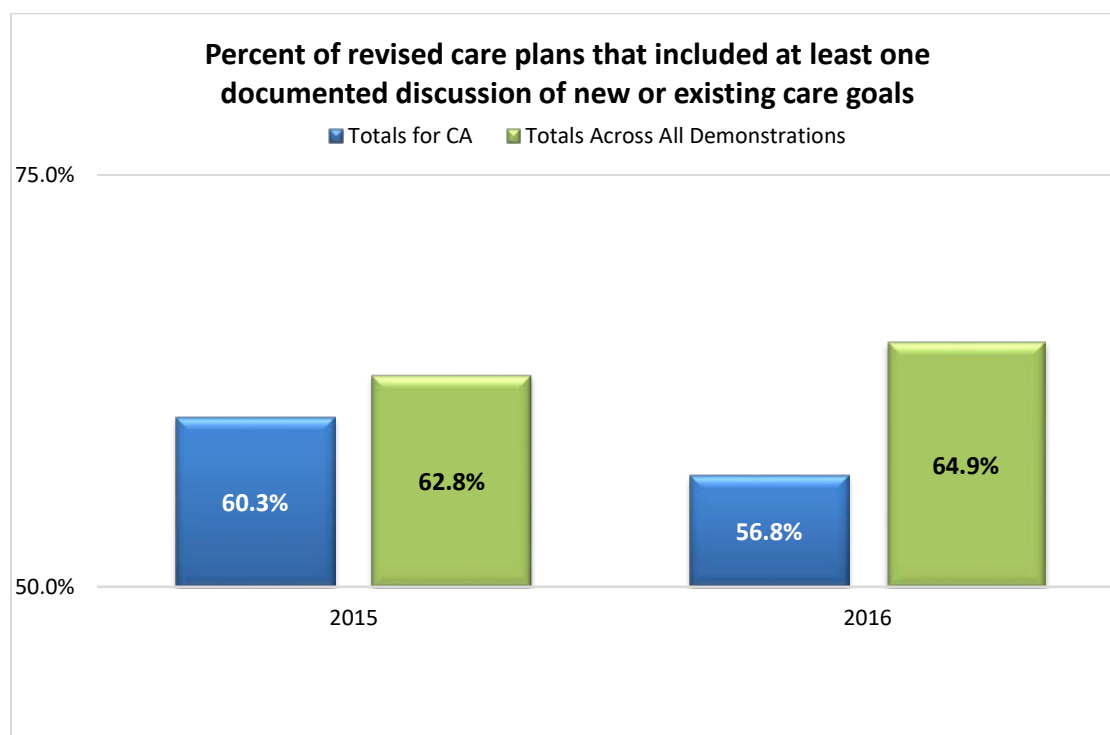 goals), ICP processes, and the systems used to document and update those ICPs and goals. The CMT developed a set of promising practices based on observations from the reviews, which the Cal MediConnect health plans were encouraged to use through the year. The CMT will also perform a new review of sample ICPs at the end of 2017, and into early 2018, to monitor progress.

Chart 3B: Discussion of Care Goals – Revised Care Plans

Percent of revised care plans that included at least one documented discussion of new or existing care goals

■ Totals for CA   ■ Totals Across All Demonstrations

	2015	2016
Totals for CA	60.3%	56.8%
Totals Across All Demonstrations	62.8%	64.9%

(Chart shows bars scaled between 50.0% and 75.0%)

* Cal MediConnect health plans that were operational in 2014 reported ICP data for 2014. Cal MediConnect health plans that were operational in 2015 began reporting with 2015 data. Care plans were based on the ICP data.

Reassessments help Cal MediConnect health plans update a member's overall health status to determine if additional course-correction is needed. Reassessments began in 2015, but continued to pose a challenge for Cal MediConnect health plans through 2016. In 2016, the CMT asked the Cal MediConnect health plans about their reassessment processes, successes, and challenges as the monthly topic discussion for July 2016. Based on the responses, the CMT developed and shared a survey summary with the Cal MediConnect health plans. The summary included observations, challenges and promising practices. Some of the challenges the Cal MediConnect health plans faced were:

- Difficulty in reaching members within regulatory timeframes
- Homeless population is difficult to contact and track
- Members are not incentivized to complete the HRA or do not recognize the benefits of completing the HRA
- Member has limited cell phone minutes or resources to complete the call
- Some HRA elements seems too complex for the population
- Primary care providers have low engagement
- Protections around mental health information create difficulties in engaging specialty mental health providers

The summary also proved some promising practices. When the CMT discusses reassessments again during the care plan review discussion at the end of 2017, the CMT will see if those practices were put into place, if any were successful, and if new solutions have been discovered. Promising practices included:

- Members without a completed HRA should have an alert in the medical system's database. If the member contacts the Cal MediConnect health plan for any reason, an alert is sent to the member services representative and the call is transferred to the appropriate department for HRA completion
- Conducting Internet research to locate members with outdated contact information
- Multiple quality review points throughout the outreach cycle
- Weekly peer-to-peer evaluations on reassessment strategies
- Pilot program launched in which staff make additional outreach calls after the vendor to complete the HRA
- Development and implementation of a monitoring tool to track and oversee annual reassessment needs and timelines
- Investment in hospital- and field- based transition of care staff
- Medical management system that alerts care management team members when there is a newly identified diagnosis of a particular disease

Chart 4: Reassessments

Reassessments of those who had an assessment in the previous year

- Percent of Currently Enrolled Members Who Had an Assessment Completed During the Previous Reporting Period Who Had a Reassessment Completed During the Current Reporting Period
- Percent of Currently Enrolled Members that Had a Reassessment Completed During the Current Reporting Period That Was Within 365 Days of the Most Recent Assessment Completed During the Previous Reporting Period
- Percent of Currently Enrolled Members Who Were Enrolled For at Least 90 Days During the Previous Reporting Period, Did Not Have an Assessment Completed During the Previous Reporting Period But Had an Assessment Completed During Current Reporting Period

	2015 California Averages	2016 California Averages
Blue	61.9%	60.4%
Red	49.9%	45.1%
Green	33.8%	26.5%

For charts 1-4, Source: Cal MediConnect health plan reported monitoring measure data. Full measure specifications can be found in the core and state-specific reporting requirements documents.[2]

Quality Measures

DHCS monitors Cal MediConnect health plans by using approximately 100 measures[3] relating to beneficiary overall experience, care coordination, and the fostering of and support of community living, among many other factors. These measures build on the required Healthcare Effectiveness Data and Information Set (HEDIS), Medicare Health Outcome Survey, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, which are already required to be reported under Medicare and Medicaid. These measures also include measures related to LTSS. CMS also collects all existing Medicare Parts C and D metrics.

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[2] Reporting requirements can be found at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html. Measure data are provided for informational purposes only and do not constitute official evaluation results.

[3] Current and past quality measures: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html

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

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

CMS and DHCS have developed the benchmarks that the Cal MediConnect health plans are required to meet. These benchmarks vary depending on the measure and the year.

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

Starting in Demonstration Year (DY) 2, Cal MediConnect health plans have two ways to pass a quality withhold measure: (1) If the Cal MediConnect health plan meets the established benchmark for the measure, or (2) If the Cal MediConnect health plan meets the established goal for closing the gap between its performance in the calendar year prior to the performance period and the established benchmark by a stipulated percentage (typically 10%). If the Cal MediConnect health plan meets the benchmark or the gap closure target, it will earn a "met" designation for that measure. If the Cal MediConnect health plan does not meet the benchmark or the gap closure target, it will receive a "not met" designation for that measure.

All Cal MediConnect health plans performed at 75% or higher for the quality withhold measures for Calendar Year 2014, which is the latest data available. DY 1 consists of Calendar Years 1 and 2, April 1, 2014 to December 31, 2015.[4]

Three of the eight plans with data to report performed at 100%.[5]

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[4] The complete details regarding the core quality withhold measures and methodology across all demonstrations for DY 1 can be found at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY1QualityWithholdGuidance060614.pdf

[5] CMS released information publically for Calendar Year 2014 quality withhold measures and may be reviewed here: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAQualityWithholdAnalysisResultsReport2014.pdf.

Table 1: CMC Quality Withhold Summary for Calendar Year 2014

	CW1 Assessments Core 2.1 Benchmark: 90%	CW2 Consumer Governance Board Core 5.3 Benchmark: 100%	CAW1 Documentation of Care Goals CA 1.6 Benchmark 90%	CAW2 Behavioral Health Shared Accountability: Policies and Procedures CA 2.2 Benchmark: 100%	CAW4 – Interaction with Care Team CA 1.12 Benchmark 90%	CAW5 – Ensuring Physical Access to Buildings, Services and Equipment CA3.1 Benchmark: 100%	# of Measures Met	# of Measures Not Met	% of Measures Met	% of Withhold Received
	Met/Not Met	Met/Not Met	Met/Not Met	Met/Not Met	Met/Not Met	Met/Not Met	Total	Total	Total	
Blue Cross	Not Met	Met	Not Met	Met	Met	Met	4	2	67%	75%
Molina	Not Met	Met	Not Met	Met	Met	Met	4	2	67%	75%
Care1st	Not Met	Met	Met	Met	Met	Met	5	1	83%	100%
CHG	Not Met	Met	Met	Met	Met	Met	5	1	83%	100%
Health Net	Met	Met	Not Met	Met	Not Met	Met	4	2	67%	75%
HPSM	Not Met	Met	Met	Met	Met	Met	5	1	83%	100%
LA Care	Met	Met	Not Met	Met	Not Met	Met	4	2	67%	75%
IEHP	Met	Met	Met	Not Met	Not Met	Met	4	2	67%	75%
California Averages							4.4	1.63	73%	84%

Notes
- CalOptima entered the program in mid-2015 and early 2016.
- Santa Clara entered the program in January 2015.
- CAW3 - Mental Health Parity was suspended while updated technical specifications were under development.
- CW4 - Encounter Data was removed due to delays in clarifying encounter submission requirements for California MMPs
- CW9 - Screening for Clinical Depression was removed since the measure is currently suspended
- CW 13 - Encounter Data analysis may be modified for California MMPs contingent upon the status of encounter submission

The quality withhold measures for DY 1 are associated with a withhold of the Cal MediConnect health plan's capitation payment annually. For DY 1, the withhold is one percent. Throughout mid-to-late 2016, CMS and DHCS worked collaboratively to analyze the quality withhold data to determine the percentage of the capitation payment that each Cal MediConnect health plan receives for having successfully met the associated threshold benchmarks.

DY 2 and DY 3 will be associated with a withhold of the Cal MediConnect health plan's capitation payment annually. The withhold is two percent in DY 2 and three percent in DY 3.

For DY 2 and DY 3, CMS and DHCS are working collaboratively to analyze the quality withhold data to determine the percentage of the capitation payment that each Cal MediConnect health plan will receive for having successfully met the associated threshold benchmarks.[6] Along with stakeholder feedback, CMS and DHCS are jointly refining and updating the quality measures in DY 2 and DY 3.

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

Table 2: Core Quality Withhold Measures

				Core Quality Withhold Measures		
Measure Name	Metric #	Measure Steward/ Data Source	Measure Name	Description	Quality Withhold Measure	Additional notes on the measure
CW1	2.1	CMS Defined	Assessments	Members with an assessment completed within 90 days of enrollment.	Year 1	
CW2	5.3	CMS Defined	Consumer Governance Board	Establishment of consumer advisory board or inclusion of consumers on a pre-existing governance board consistent with contractual requirements.	Year 1	
CW3		AHRQ/ CAHPS (Medicare CAHPS-CAHPS 4.0)	Customer Service	Percent of the best possible score the plan earned on how easy it is for members to get information and help from the plan when needed: · In the last 6 months, how often did your health plan's customer service give you the information or help you needed? · In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? · In the last 6 months how, often were the forms for your health plan easy to fill out?	Year 1	
CW5		AHRQ/ CAHPS (Medicare CAHPS—CAHPS 4.0)	Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly members get appointments and care:	Year 1	

				Core Quality Withhold Measures		
Measure Name	Metric #	Measure Steward/ Data Source	Measure Name	Description	Quality Withhold Measure	Additional notes on the measure
				· In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? · In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? · In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?		
CW6		NCQA/ HEDIS	Plan all-cause readmissions	Percent of plan members discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason.	Years 2 and 3	Lower rates are better
CW7		AHRQ/ CAHPS (Medicare CAHPS – Current Version)	Annual Flu Vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	Years 2 and 3	If a Cal MediConnect health plan's score for this measure has very low reliability (as defined by CMS and its contractor in the Cal

Measure Name	Metric #	Measure Steward/ Data Source	Measure Name	Description	Quality Withhold Measure	Additional notes on the measure
				Core Quality Withhold Measures		
						MediConnect health plan CAHPS report), this measure will be removed from the total number of withhold measures on which the Cal MediConnect health plan will be evaluated.
CW8		NCQA/ HEDIS	Follow-up after hospitalization for mental illness	Percentage of discharges for plan members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days of discharge.	Years 2 and 3	
CW10		NCQA/ HEDIS	Reducing the risk of falling	Percent of plan members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	Years 2 and 3	

				Core Quality Withhold Measures		
Measure Name	Metric #	Measure Steward/ Data Source	Measure Name	Description	Quality Withhold Measure	Additional notes on the measure
CW11		NCQA/ HEDIS	Controlling blood pressure	Percentage of plan members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) for members 18-59 years of age and 60-85 years of age with diagnosis of diabetes or (150/90) for members 60-85 without a diagnosis of diabetes during the measurement year.	Years 2 and 3	
CW12		CMS Prescription Drug Event (PDE) Data	Medication adherence for diabetes medications	Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	Years 2 and 3	

Core Quality Withhold Measures						
Measure Name	Metric #	Measure Steward/ Data Source	Measure Name	Description	Quality Withhold Measure	Additional notes on the measure
CW13		Cal MediConnect health plan Encounter Data	Encounter Data	Encounter data for all services covered under the demonstration, with the exception of Prescription Drug Event (PDE) data, submitted timely in compliance with demonstration requirements.	Years 2 and 3	To qualify for the quality withhold in CY 2015, the Cal MediConnect health plans in California must begin submitting encounters no later than Nov. 15, 2015. 80% of encounters are submitted according to the criteria identified above timely, unless otherwise specified in the three-way contract and state-specific attachment. CMS and the states will monitor progress and reserve the right to revisit the benchmark as appropriate. For DY 3, completeness of the encounter submissions may be factored into the analysis. Additional information regarding this update will be provided at a later date.

Core Quality Withhold Measures						
Measure Name	Metric #	Measure Steward/ Data Source	Measure Name	Description	Quality Withhold Measure	Additional notes on the measure
						Stakeholders will have the opportunity to comment on the new criteria and benchmark prior to finalization.
*CW4 - Encounter Data was removed due to delays in clarifying encounter submission requirements for California Cal MediConnect health plans						
*CW9 - Screening for Clinical Depression was removed since the measure is currently suspended.						
*CW 13 - Encounter Data analysis may be modified for California Cal MediConnect health plans contingent upon the status of encounter submission						

Table 3: State-Specific Quality Withhold Measures

Quality Withhold Measures – State Specific						
Measure Name	Metric #	Measure Steward/ Data Source	Measure Name	Description	Quality Withhold Measure	Additional notes on the measure
CAW1	CA1.6	State-defined process measure	Documentation of Care Goals	Members with documented discussions of care goals	Years 1	
CAW8					Years 2 and 3	
CAW6	CA1.7	State-defined process measure	Behavioral health shared accountability	Members receiving Medi-Cal specialty mental health services receiving coordinated care plans as indicated by having an Individualized Care Plan (ICP) with the	Year 3	

			Quality Withhold Measures – State Specific			
Measure Name	Metric #	Measure Steward/ Data Source	Measure Name	Description	Quality Withhold Measure	Additional notes on the measure
				primary mental health provider		
CAW4	CA1.12	State-defined process measure	Interaction with care team	Members who have a care coordinator and have at least one care team contact during the reporting period	Year 1	
CAW9				Percent of members who have a care coordinator and have at least one care team contact during the reporting period	Years 2 and 3	
CAW2	CA2.2	State-defined process measure	Behavioral Health Shared Accountability	Policies and procedures attached to the MOU with county behavioral health agency(ies) around assessments, referrals, coordinated care planning, and information sharing	Year 1	
CAW5	CA3.1	State-defined process measure	Ensuring Physical Access to Buildings, Services and Equipment	Cal MediConnect health plans with an established physical access compliance policy and identification of an individual who is responsible for physical access compliance	Year 1	
CAW7	CA4.1	State-defined process measure	Behavioral health shared accountability outcome measure	Reduction in emergency department (ED) use for seriously mentally ill and	Years 2 and 3	

			Quality Withhold Measures – State Specific			
Measure Name	Metric #	Measure Steward/ Data Source	Measure Name	Description	Quality Withhold Measure	Additional notes on the measure
				substance use disorder (SUD) members		

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

- DMHC and DHCS will submit an annual joint report to the Legislature on financial audits performed on Cal MediConnect health plans.

- DHCS continues to coordinate with DMHC, CDSS, CDA, and CMS to monitor Cal MediConnect health plans and will institute Corrective Action Plans (CAPs) when appropriate. The CMT oversees the performance of Cal MediConnect health plans. If the CMT determines that a Cal MediConnect health plan is not meeting a performance standard, the CMT sends a series of notices to the plan, with each subsequent notice increasing in severity. The Cal MediConnect health plan must respond with a detailed CAP explaining how and when the health plan will come into compliance with the performance standard. Failure to implement the agreed upon CAP may result in the CMT terminating the contract or issuing other sanctions. Once the health plan successfully completes the corrective actions, the CMT sends a formal letter detailing the health plan's compliance.

- DHCS continues to work with stakeholders and CMS to develop and refine ongoing quality measures for Cal MediConnect health plans that include primary and acute care, LTSS, and behavioral health services.

- DHCS will continue to contract with an External Quality Review Organization (EQRO) to support the activities of the Performance Improvement Project (PIP; formerly referred to as the Statewide Collaborative).

DHCS awarded the current EQRO contract to Health Services Advisory Group. As part of the contract, DHCS began collaborating with the EQRO to work with the Cal MediConnect health plans regarding the PIP process, which began in January 2016. The PIP is plan-specific and addresses improving care coordination with a focus on the integration of the LTSS programs.

The rapid-cycle PIPs that Cal MediConnect health plans initiated in January 2016 concluded as of June 30, 2017. All Cal MediConnect health plans submitted their PIP modules 4 and 5, the last two modules of the plan, by September 2017 for Health Services Advisory Group, Inc. (HSAG) validation. HSAG notified PIP validation results to eight Cal MediConnect health plans as of October 30, 2017 (two Cal MediConnect health plans' PIP validation results are currently pending).

As part of Module 5 validation, HSAG assesses the validity and reliability of the results based on CMS validation protocols and assigns the following final confidence levels for each PIP:

- High confidence – The PIP was methodologically sound; achieved the SMART (specific, measurable, achievable, relevant, and time-bound) Aim goal; and the demonstrated improvement was clearly linked to the quality improvement processes implemented.

- Confidence – The PIP was methodologically sound; achieved the SMART Aim goal; and some of the quality improvement processes were clearly linked to the demonstrated improvement; however, there was not a clear link between all quality improvement processes and the demonstrated improvement.

- Low confidence – Either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

- Not credible – The PIP methodology was not executed as approved.

Following are final confidence levels for Cal MediConnect health plan PIPs that HSAG validated as of October 30, 2017.

Table 4: PIP Confidence Levels – Outcomes

Cal MediConnect health plan	PIP Topic	Final Confidence Level
Anthem/CareMore	Improving Care Coordination by LTSS Programs with a Focus on CBAS	Low Confidence
CalOPTIMA	Improving In-Home Supportive Services Care Coordination	Pending
Care1st	Transitioning Cal MediConnect Members from Long-Term Care Facilities Safely Back to the Community	Low Confidence
CHG	Reducing Inappropriate Acute Hospitalization Admissions from a Nursing Facility	Confidence
Health Net	Electronic Communication of Care Plans to Providers for Members Who Are in CBAS and MSSP	Low Confidence

Cal MediConnect health plan	PIP Topic	Final Confidence Level
HPSM	Reducing Readmissions from Skilled Nursing Facilities	Low Confidence
IEHP	Health Risk Assessments	Confidence
L.A. Care	Managed Long-Term Support Services	Not Credible
Molina	Improving Care Coordination and Integration of LTSS for Members Receiving IHSS Services by Facilitating Their Enrollments in a CBAS Program	Confidence
SCFHP	Decreasing Potentially Preventable Readmissions LTSS	Pending

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

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

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

CMS provided a press release on this initiative at the beginning of January 2017. The press release can be found at: http://www.calduals.org/2017/01/05/new-initiative-announced-by-state-federal-agencies/.

In accordance with the requirements of SB 1008, as stated above, DHCS released the Cal MediConnect Performance Dashboard, which includes six metrics: (1) HRAs, (2)

Appeals by Determination, (3) Hospital Discharge, (4) Emergency Utilization, (5) LTSS Utilization, and (6) Case Management. All data included in this dashboard is reported to the CMS contractor, the National Opinion Research Center at the University of Chicago by the Cal MediConnect health plans. Currently, the dashboard is evolving and DHCS is considering revising the metrics based on stakeholder feedback and Cal MediConnect health plan performance.

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

Table 5: MLTSS Monitoring Items

Table 5 displays the MCP measures that are used to monitor plans' fulfillment of their obligation to provide covered MLTSS services to their members in CCI counties in accordance with State and federal law. The results are publicly reported in summary format by health plan and by county. DHCS works with CMS to publish details as they become available. CMS and DHCS may at any time agree to delete, modify, or add new metrics to improve reporting. There are several evaluation activities underway on the metrics. For example, the SCAN Foundation has funded two projects. One is a Rapid Cycle Polling Project, which is being conducted by the Field Research Group. The other is a three-year evaluation of Cal MediConnect, which is comprised of researchers from the University of San Francisco Institute for Health and Aging and the University of California, Berkeley School of Public Health. These evaluations, as well as other evaluation activities, are described in further detail in the annual CCI Evaluation Outcome Report. This legislative report can be accessed at the following link: http://www.dhcs.ca.gov/formsandpubs/Pages/Reports2thelegislature.aspx.

Criteria	Metric	Frequency	Data Source	Expected Outcome
Enrollment Status	MCP selection and mandatory enrollment numbers and percentages for beneficiaries eligible for MLTSS will be tracked in each MLTSS county	Monthly	MEDS Data	100 percent of beneficiaries eligible for MLTSS will either make an MCP selection, or be passively enrolled in each MLTSS county
MCP Changes	Number of beneficiaries who changed MCPs in Geographic Managed Care and Two-Plan model counties	Monthly	MEDS Data	Number of plan changes by MCP and county will be monitored. No more than 10 percent auto-assigned to an MCP will change plans due to access to care or

Criteria	Metric	Frequency	Data Source	Expected Outcome
				continuity of care concerns
Primary Care Provider (PCP) Assignment	Number of MLTSS beneficiaries assigned to a PCP	Monthly	Monitoring Report from MCPs	100 percent of Medi-Cal only and partial duals without Medicare Part B beneficiaries who are mandatorily enrolled or make a plan choice will be assigned a PCP within 30 days
Benefit Package	DHCS will monitor , through ongoing surveys and readiness and implementation monitoring, that MCPs provide for enrollees LTSS in care settings appropriate to their needs	Quarterly	DHCS	DHCS will assure compliance with the characteristics of home and community based settings, per Section 1915(c) and 1915(i) (Title 42, United States Code, Section 1396n) regulations and in accordance with implementation/effective dates published in the Federal Register
Plan Readiness – Initial and Ongoing	DHCS shall submit to CMS its plan for ongoing monitoring of MCPs	Quarterly, with assessment and reports on network adequacy submitted to CMS no later than 60 days after the close of each calendar quarter	DHCS	• Network adequacy will be verified on a quarterly basis for the first year • Plan readiness will be conducted similarly to Healthy Families and Geographic Expansion • Readiness assessments will be aligned with the Cal MediConnect reporting where possible; DHCS will complete a network certification for each county • DHCS will assess and monitor MCP capacity for the

Criteria	Metric	Frequency	Data Source	Expected Outcome
				MLTSS population
Participant Rights and Safeguards, Information, and Network Adequacy Requirements	For network adequacy, in addition to Title 42, Code of Federal Regulations, Section 438, DHCS must: • Require MCP to refer everyone eligible for IHSS to the county social services agency and support member transition • Require MCPs to refer all IHSS recipients to the Public Authorities network of IHSS workers/providers who will be providing services while the recipient waits for a county IHSS worker or the normal IHSS worker cannot provide services • Have MCPs submit Memoranda of Understanding (MOUs) between the plan, the counties and MSSP sites • Require MCP to offer a care coordinator to everyone on a MSSP waitlist when the MLTSS member is waiting for an MSSP slot with a contracted MSSP site • Require MCP to refer IHSS recipients who are awaiting a caregiver to other HCBS benefits (Community Based Adult Services [CBAS], MSSP) or work with CBOs and resources to help bridge the gap to meet their	Information is due to CMS prior to implementation and every six months afterward for the term of the demonstration.	DHCS	DHCS will monitor the following: • That MCPs maintain and provide the Public Authority contact information for the adequate network of IHSS workers/providers to support member transition • Adequate MOUs are in place to facilitate access to care between plan, county, and MSSP sites • That MCPs refer all those eligible for MSSP to all contracted MSSP sites • Availability of MCP care coordinators for members waiting for MSSP slot • That MCPs refer IHSS recipients awaiting a caregiver to other HCBS benefits (CBAS, MSSP) to help meet/bridge their needs • That MCPs will work with CBOs and resources to help IHSS recipients bridge the gap to meet their needs until they begin to receive IHSS

Criteria	Metric	Frequency	Data Source	Expected Outcome
	needs. •Require DHCS to identify all nursing facilities (NFs) that house MLTSS members • MCPs should demonstrate adequate capacity in their contracted nursing homes			DHCS will monitor NFs that house MLTSS members and show the percent that have been contracted by each MCP. MCPs will track and monitor all facilities that house MLTSS members including the number and percent of facilities contracted per MCP to ensure adequate capacity in contracted NFs
Quality Oversight and Monitoring – Measurement Activities	DHCS shall collaborate with CDSS to develop mandatory MCP reports related to the critical elements of MLTSS, including network adequacy, timeliness of assessments, MLTSS authorizations, service plans and service plan revisions, plan changes, utilization data, call monitoring, quality of care performance measures, fraud and abuse reporting, participant health and functional status, complaint and appeal actions. These reporting requirements must be specified in the MCP contract. DHCS must provide reports to CMS to demonstrate their	Annually	DHCS	DHCS will oversee ongoing monitoring of individual wellbeing and plan performance and use this information in ongoing monitoring and quality improvement efforts, in addition to quality reporting efforts DHCS will analyze MCP reports as part of its quality oversight and based on the results, take corrective action as needed to enforce compliance. DHCS will obtain, monitor, and evaluate key experience and life indicator information, including information on actions taken by DHCS. The

Criteria	Metric	Frequency	Data Source	Expected Outcome
	oversight of the key elements of the MLTSS program. DHCS shall collaborate with CDSS to measure key experience and quality of life indicators for MLTSS participants. The measures must be specific to the needs of MLTSS participants and data must be collected using best practices for reaching special populations (e.g., phone or in person). Survey results must be maintained by DHCS and reported to CMS, along with any action(s) taken or recommended based on the survey findings. The EQRO should validate the survey results. DHCS must analyze the results, discuss them with stakeholder advisory groups, post the results on its website, and provide the results in print upon request.			information will be made available to advisory groups and publically posted. DHCS will use performance measures Quality Strategy/reports to develop MCP report cards that are public, transparent, easily understandable and useful to participants in choosing an MCP.
Complaints/ Appeals	Number/percent of appeals or complaints	Monthly	MCPs	Complaints and grievances will be consistent with what was experienced by MLTSS members prior to transition. MCPs must resolve grievances within required timeframes
Provider Network Changes	Additions/deletions of participating providers by MCP	Quarterly	MCPs submit quarterly reports to DHCS	MCP's provider network will remain consistent with the network assessed during readiness.

Criteria	Metric	Frequency	Data Source	Expected Outcome
Continuity of Care	Number of continuity of care requests and outcomes for MLTSS members	Monthly	MCPs	MCPs will report all cases of transitioning MLTSS members receiving or requesting continuity of care
Consumer Satisfaction with MCP	MCP Call Center Report for MLTSS members by type of inquiry	Quarterly	MCPs submit quarterly reports to DHCS	MCPs will ensure the number of complaints and types of complaints related to access to care and continuity of care, with consideration to the transition, are taken into account. The expectation is that there will be a decrease each month following the transition.
Support and Retention of Community Placement	Members referred to the HCBS waivers are assessed for the HCBS waiver Members referred to IHSS are assessed by the county social services agency for IHSS. Members newly admitted to NFs without a discharge plan in place were first afforded supports and services in the community Number and proportion of beneficiaries who transitioned to the community from an institution and did not return to the institution, excluding post hospital rehabilitation, within a year. Number and proportion of beneficiaries receiving LTSS in the community	Quarterly	MCPs	MCPs will do the following: • Refer members to appropriate services that support retention of community placement • Track and monitor the number of referrals made to HCBS waivers and the number of completed assessments performed by the HCBS providers • Track and monitor the number of IHSS referrals made to the county social services agency and the number of completed assessments performed by the county social services agency. DHCS shall collaborate with CDSS

Criteria	Metric	Frequency	Data Source	Expected Outcome
	along with number and proportion of beneficiaries receiving LTSS in an institution.			to address outcomes regarding tracking and monitoring the number of referrals made and the number of completed assessments performed. • Track and monitor the number of referrals made to HCBS programs for newly admitted NF residents without discharge plans in place. If the evaluation indicates an increase in NF placement rather than community replacement, the rates will be adjusted to create an incentive to keep beneficiaries in community placement

State Costs

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

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

- Year Two (September 1, 2014 – August 31, 2015): CMS contributed 75 percent federal financial participation (FFP) and the State contributed 25 percent from the State General Fund. The unobligated funding from Year One was made available for Year Two and CMS paid 100 percent FFP.

- Year Three (September 1, 2015 – July 31, 2016): CMS contributed 50 percent

FFP and the State contributed 50 percent from the State General Fund.

- Year Four (August 1, 2016 – June 1, 2017): CMS contributed 50 percent FFP and the State contributed 50 percent from the State General Fund.

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

- Ongoing stakeholder engagement and communication that includes the development and execution of a communications plan to engage health plans, CBOs such as Centers for Independent Living or Aging and Disability Resource Centers, physician offices, hospitals and clinics, CBAS providers, county behavioral health agencies, public authorities, county IHSS workers, MSSP sites, and consumers.

- Beneficiary and provider outreach and education that includes the development and dissemination of fact sheets, enrollment notices, educational and informational materials, and choice packets.

- Rate development and actuarial analyses that include rate setting, risk adjustments, cost distributions, and the development of savings targets and outcome reporting.

- Medicare data analyses and reporting that include processes and systems to link historical Medicare and Medi-Cal data for dissemination to health plans to conduct HRAs, integration of data for use in determining health plan assignments, assessing acuity and risk stratification and reporting of outcomes and trends.

- Operational planning and transition management services that include strategic network management and integration of Cal MediConnect policies, coordinating and conducting health plan and State operational readiness activities, and assessments of post-implementation activities and operational training needs.

- Project management support that includes the development and maintenance of project plans, tasks, activities, programmatic roles and responsibilities, and timelines. It also includes the development and implementation of processes to identify, mitigate, and resolve project issues and risks, along with the preparation and dissemination of project progress and tracking reports for various State and federal agencies

- MLTSS program evaluation analyses based on data currently collected from the MLTSS population. This includes trend analyses and tracking/monitoring beneficiaries throughout the CCI counties before and during implementation of the CCI program.

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

Budget

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

- Hilary Haycock, Harbage Consulting, LLC: Ms. Haycock is President of Harbage Consulting and has more than 10 years of experience working to improve health policy at the federal, state, and local levels. Ms. Haycock has published extensively on health reform concepts with a focus on health care policy communications and stakeholder engagement.

- Carolyn Hubbert, PMP, Public Consulting Group, LLC: Ms. Hubbert is a Senior Information Technical and Project Management Consultant with PCG and has more than 20 years of experience in health care, business, and IT. Her extensive expertise includes large-scale implementation and management, all phases of the System Development Life Cycle from requirements to testing through project closure, Independent Verification and Validation, Project Oversight and Contract Turnover and Takeover.

- Tracy Meeker, PMP, Public Consulting Group, LLC: Ms. Meeker is a certified PMP and has 20 years of progressive responsibility in project management, business intelligence, and data integration in government health care consulting, including more than five years on Medi-Cal programs, and commercial health care consulting. Her most recent experience includes providing HIPAA and Health Information Exchange Consulting Support Services for the State of California, Office of Health Information Integrity eHealth branch.

- Ashley Wilborn, Public Consulting Group, LLC: Ms. Wilborn has nearly 10 years of progressive responsibility in business analysis, business intelligence, and data integration in state, federal, and private health care consulting. She primarily works with health care organizations to integrate standards and regulations for improved operations for all who serve or are served by the health care system. Affordable Care Act-related efforts and other state and federal regulations that affect California agencies have been her primary focus areas.

- Dr. Andrew Bindman, University of California, San Francisco: Dr. Bindman has practiced, taught, and performed health services research at San Francisco General Hospital for over 25 years. He has applied his research experience through scientific methods that best incorporate ideas and data analyses that assist in the policymaking process. He has also published extensively on evaluations of Medicaid health policies with a focus on access to care and health outcomes. His experience includes work at the internal level comparing health care systems across multiple countries.

Appendix A: Coordinated Care Initiative Beneficiary and Provider Outreach Plan

The federal Centers for Medicare & Medicaid Services (CMS) is working with the California Department of Health Care Services (DHCS) to implement a health reform project in seven California counties. The project, called Cal MediConnect, aims to promote coordinated care and enhance health outcomes and the quality of life for Medicare and Medi-Cal enrollees, also called dual eligible beneficiaries. In addition, most Medi-Cal beneficiaries in these counties will choose Medi-Cal managed care health plans (MCPs) for their Medi-Cal benefits, including long-term services and supports (LTSS). These two policy transitions make up the California Coordinated Care Initiative (CCI) and are taking place in: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

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

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

Updates to information in the last submitted Fiscal Year 2015-2016 Enrollment Status, Quality Measures, and State Costs Report, Appendix A, are in italics for ease of review.

Purpose and Scope of Outreach and Education Plan

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

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

will not advise beneficiaries on which plans to select but will provide resources to assist with these decisions.

Target Audiences and Clarity of Reference
The outreach approach recognizes that the CCI-eligible population receives their information from established and trusted routes of communication. The State is supporting and supplementing those existing pathways with accurate information and a focus on facilitation and coordination with other important stakeholders at the State and local levels.

Key Audiences

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

Implementation: DHCS Project Lead from Sacramento

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

- Beneficiary-friendly notices and other noticing materials
- Interagency coordination
- Support for local agencies
- Outreach toolkit development
- "Train the trainer" program
- HCO training and staffing

- User-friendly website
- Regular calls/meetings with key stakeholders
- Beneficiary outreach
- Provider outreach
- Population-specific outreach

Beneficiary-Friendly Notifications

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

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

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

Status: In Summer 2016, DHCS released a new Medi-Cal Managed Care Plan Guide and Choice Book to be sent to two groups of dual eligible beneficiaries: 1) new dual eligible beneficiaries who have Medicare first and later gain Medi-Cal eligibility in CCI counties; and 2) existing dual eligible beneficiaries who move into a CCI county. These

materials went through a stakeholder comment period in September 2015. They also underwent extensive user testing and revisions in partnership with the Health Research for Action at UC Berkeley's School of Public Health and a series of literacy reviews to verify that they meet readability standards and are not above a sixth-grade reading level. Further, the materials are available in Medi-Cal threshold languages and available in accessible formats, as required.

Interagency Coordination

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

Status:

- DHCS, CDA, CDSS, and DOR conducted weekly calls on policy and outreach items during initial implementation periods;

- DHCS and CDA worked closely on several outreach-related activities related to passive enrollment, including:
  - A call-triage strategy so that beneficiaries face "no wrong door" when contacting state and local agencies.
  - Verifying that HICAP staff have the proper materials to use in answering beneficiary questions.
  - Verifying that county-specific materials are available for beneficiaries on who to call with CCI and Cal MediConnect questions and when they need assistance.
  - Refining established feedback mechanisms so that beneficiary issues and questions arising in HICAPs or HCO are shared among agencies, allowing the agencies to work together on solutions.

- DHCS and DMHC worked together to develop a special Cal MediConnect Ombudsman program to help beneficiaries enrolled in Cal MediConnect with complaints about their health plans and to educate beneficiaries about their rights and responsibilities as plan members. The Cal MediConnect Ombudsman program has provided services since the program went live in April 2014.

Support for Local Agencies

Supporting and coordinating with local agencies, such as the local HICAPs and AAAs, in their efforts are key parts of this plan. Many local agencies serve as important sources of information for beneficiaries. For example, HICAPs already serve as trusted

sources of information for Medicare beneficiaries. In addition, other local agencies need materials, assistance with coordination of outreach efforts, support in their outreach efforts, and assistance in training their staffs.

Status:

- The State helped secure CMS grant funding to support HICAP capacity for the CCI. This grant funding requires quarterly data reporting on call volume and other selected indicators, which helps the State monitor beneficiary access of HICAP counseling.

- California Health Advocates delivered additional trainings to HICAPs;

- DHCS and CDA continue to partner to provide updated materials and other resources to HICAPs including up-to-date fact sheets and frequently asked question (FAQs) documents.

- DHCS partnered with private organizations, including the SCAN Foundation, to provide additional support to the HICAPs.

- DHCS and CDA continue to partner to provide updated materials and other resources to HICAPs including up-to-date fact sheets, frequently asked question documents, and other materials.

- Local outreach coordinators continue building and maintaining relationships with local organizations, coalitions, and workgroups to coordinate outreach efforts and to support outreach efforts already underway in the CCI counties.

Outreach Toolkit

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

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

- Presentation slide decks for beneficiaries, advocates, and providers.

- Beneficiary fact sheets on eligibility, continuity of care, plan member rights and responsibilities, IHSS services, and the PACE.

- Provider fact sheet on payment policies under the CCI.

- General brochure on the CCI.

DHCS released a companion physician toolkit to help providers understand continuity of care, contracting and billing processes, and other information they need to communicate with patients about the CCI. DHCS developed this toolkit in part to address misconceptions physicians ~~may~~ have about how their practices may change

under the CCI, and to help physicians continue to treat their patients whether they join or opt out of Cal MediConnect. The toolkit also includes information for physicians to share with their patients who are eligible for Cal MediConnect.

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

<u>"Train the Trainer" Program</u>

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

- This program includes assisting and developing a plan for outreach through Benefits Counselors and Legal Advocates.

- This program includes an effort to educate stakeholders on how the substance abuse/mental health benefits are administered.

- This program also supports CBOs and provider coordination. Support and help existing communication channels that are available through local AAAs and other CBOs. Examples include: Meals on Wheels Programs, Para-transit agencies, Senior Centers and Senior Centers without Walls.

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

<u>Health Care Options Training and Staffing</u>

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

Status:

- DHCS periodically refines the CCI-specific FAQ guide for HCO customer service representatives and provides daily, weekly, and as needed training for the representatives; and

- DHCS continues to secret shop the call center and use the feedback for training purposes, to improve beneficiary and stakeholder experience, and to inform FAQ guide updates.

User-Friendly Website

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

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

Regular Outreach to Key Stakeholders

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

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

- DHCS hosts bi-monthly stakeholder update calls

- DHCS participates, as invited, in weekly Sacramento-based and monthly local collaborative meetings of stakeholders to provide updates and solicit feedback

- DHCS hosts weekly calls with health plans on policy and outreach issues.

Beneficiary Outreach

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

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

Status: Existing methods of beneficiary outreach are ongoing. In addition, following is occurring:

- The first phase of passive enrollment has ended in each county.

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

- Outreach coordinators continue working with local groups to deliver presentations to beneficiaries where they are, such as senior centers, senior housing, various CBOs, and nursing homes for example.

- DHCS has developed a CCI beneficiary toolkit. This comprehensive toolkit tells a cohesive story of Cal MediConnect and contains stand-alone fact sheets that cover various topics and aspects of Cal MediConnect and the CCI in more depth. This toolkit helps eligible beneficiaries understand their options and how Cal MediConnect may benefit them. It also helps these beneficiaries better understand how to navigate their Medi-Cal MCPs when choosing not to participate in Cal MediConnect. The toolkit was released for stakeholder comment and underwent extensive user testing in partnership with Health Research for Action at UC Berkeley's School of Public Health. The toolkit is an easy-to-use resource for enrolled and eligible beneficiaries, caregivers, and stakeholders. It is available online and in hard copy in the 13 Medi-Cal threshold languages and is being distributed during outreach activities.

Provider Outreach

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

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

Population Specific-Outreach

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

- Ethnic/minority and limited English proficiency beneficiaries
- Ethnic/minority physicians
- Beneficiaries with disabilities

- Beneficiaries in nursing facilities and their authorized agents
- Beneficiaries who are homeless or are living in low-income housing
- Beneficiaries accessing nutritional programs and other social services and community based programs.
- Beneficiaries with mental and behavioral health needs
- Faith-based groups

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

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

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

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

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

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

- Participating in local stakeholder coalitions, particularly as they relate to communications and outreach to the beneficiary and provider populations.

- Providing informational presentations (in-person and via webinar) to beneficiaries, providers, and other stakeholders.

- Delivering "train the trainer" presentations to organizations who regularly interact with the beneficiary population and need support understanding and explaining the CCI.

- Facilitating good information flow between the counties and the State, particularly to identify information and outreach needs in local communities.

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

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

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

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

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

- Developed local, county-specific outreach plans. Using the overall outreach plan context, enrollment information for each county, and the landscape assessment, technical advisors and outreach coordinators developed a tailored county outreach plan, which operates in tandem with the overall State outreach plan.

- Support local groups and CBOs. Technical advisors and outreach coordinators support groups such as local health plans, HICAP agencies, AAAs, Independent Living Centers, Aging and Disability Resource Centers, Caregiver Resource

Centers, Public Authorities, and Health Consumer Centers, as well as local CBOs, advocates, senior centers, and county agencies. They are also familiar and work with referral/informational services such as 2-1-1 through the United Way.

- Work in cooperation with health plans and PACE programs. Outreach coordinators support these groups' beneficiary and provider outreach.

- Work with and inform provider groups. Outreach coordinators work with groups such as the CMA, CMA county affiliates, CAPGs, ethnic and specialty medical societies, local medical groups and independent practice associations, local hospital associations, durable medical equipment suppliers, pharmacies and pharmacists, and CBOs that act in a provider capacity (such as transportation support services).

- Conduct direct outreach employing various mechanisms. These activities include:

  o Discussions and presentations with key stakeholders, beneficiaries, and providers in their "home" settings, including places like senior centers, low-income housing complexes, churches, care centers, and nursing homes

  o Attendance at health fairs and other pre-organized events to offer presentations or materials

  o One-on-one listening sessions for relationship building purposes.

- Create a meeting structure for county leaders. In counties where it is needed and not duplicative around existing local initiatives, the team develops an infrastructure to support leadership meetings for representatives of all major areas of interest—including but not limited to hospitals, physicians, county health/mental/social services leaders, representatives from the health plans, PACE programs, and advocates. The goal is for each local group to become self-sustaining.

- Assist with media events as needed. There are efforts to reach people though the media.

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

Status: Since December 2014, a team of six outreach coordinators have been providing outreach to beneficiaries, providers, advocates, and other stakeholders across the CCI counties. Outreach coordinators are extensively trained and are very knowledgeable about the CCI. Coordinators provide outreach and education, deliver presentations, participate in local stakeholder events, and work on local communications workgroups. In addition, technical advisors were hired in each county through local stakeholder coalitions. The outreach team currently consists of a group of seven individuals with social work, community organizing, and provider engagement

backgrounds. Some members of the team also speak languages represented by the beneficiary audience: Korean, Spanish, and Tagalog.

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

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

Attachment 1: Coordinated Care Initiative Toolkit

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

The toolkit has tailored materials for different levels of audiences:

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

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

Basic Toolkit

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

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

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

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

Physician Toolkit

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

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

Beneficiary Toolkit

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

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

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

Cal MediConnect Case Manager Toolkit

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

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

Attachment 2: Landscape Assessment

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

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

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

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

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

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

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