



## **Coordinated Care Initiative**

Fiscal Year 2015-2016

Enrollment Status, Quality Measures,  
and State Costs Report

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## **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 on the enrollment status, quality measures, and state costs, beginning with the May Revision to the fiscal year 2013-14 Governor's Budget, and annually thereafter, related to the Duals Demonstration Project, known as Cal MediConnect, and the integration of Long-Term Services and Supports as a Medi-Cal managed care benefit. As of the date of this report, enrollment into Cal MediConnect and the implementation of mandatory enrollment into Medi-Cal managed care for Managed Long-Term Services and Supports has commenced in *the* Coordinated Care Initiative (CCI) counties. Implementation information can be found in the schedule titled, "CCI Enrollment Timeline by Population and County," on the CalDuals website under the heading Enrollment Chart at the following link: <http://www.calduals.org/implementation/cci-documents/enrollment-charts-timelines/>.

## Introduction

In January 2012, Governor Brown announced the Coordinated Care Initiative (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 home and community. 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).

The three major components of the CCI are:

1. 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;
2. Mandatory Medi-Cal managed care enrollment for dual eligible beneficiaries; and
3. 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, and for SPD beneficiaries 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.

This Fiscal Year *2015-2016* Enrollment Status, Quality Measures, and State Costs Report covers activities and information through March 1, *2016*. Updates to information in the last submitted Fiscal Year *2014-2015* Enrollment Status, Quality Measures, and State Costs Report are in italics for ease of review.

## Enrollment Status and Timelines

*The first phase of passive enrollment into Cal MediConnect is largely complete.* In April 2014, DHCS *began passively enrolling* 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* into Cal MediConnect and also *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. *DHCS passively enrolled dual eligible beneficiaries* into Cal MediConnect in Los Angeles County in July 2014 and in Santa Clara County in January 2015. *Opt-in enrollment occurred in* Orange County in July 2015 and *passive enrollment began in* August 2015.

Enrollment was phased in on a monthly basis according to the implementation schedule titled, “CCI Enrollment Timeline by Population and County”, that can be found at the following link: <http://www.calduals.org/implementation/cci-documents/enrollment-charts-timelines/> under the heading “Enrollment Chart.”

As of *March 1, 2016*, there were approximately *123,500* beneficiaries 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://www.calduals.org/enrollment-data/>.

### 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. The State notified beneficiaries 90-days prior to the enrollment effective date, followed by a 60-day notice and enrollment choice packet, and a 30-day reminder notice. The 60 and 30-day notices included instructions on how to opt out of Cal MediConnect or choose a different Cal MediConnect health plan. Beneficiaries who enroll in a Cal MediConnect health plan may opt out or change health plans at any time. The opt out process only applies to Medicare benefits and participation in Cal MediConnect. Eligible beneficiaries were still required to choose a Medi-Cal managed care health plan (MCP) for their Medi-Cal benefits, including LTSS.*

Beneficiaries eligible for Cal MediConnect must:

- 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 who receive Parts A and B through a Medicare Advantage [MA] Plan) and eligible for Part D;<sup>1</sup> and
- 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).

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;

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<sup>1</sup> 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.

- Beneficiaries with developmental disabilities receiving services through a Department of Developmental Services 1915(c) waiver; regional center; state developmental center; or intermediate care facilities for the developmentally disabled (ICF/DD), *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 for San Mateo and Orange. If a beneficiary develops ESRD after enrolling in a Cal MediConnect health plan, he or she may stay enrolled in that plan; and/or
- Enrollment in Los Angeles has met and/or exceeded its cap of 200,000 participants.

The following groups of beneficiaries may voluntarily enroll in Cal MediConnect, but *were* not part of the passive enrollment process:

- Beneficiaries enrolled in a Program of All-Inclusive Care for the Elderly (PACE);
- Beneficiaries enrolled in the AIDS Healthcare Foundation; and
- Beneficiaries in certain rural zip codes in San Bernardino County (different than the excluded zip codes).

Beneficiaries included in the Medicare reassignment to a different Medicare Prescription Drug Plan, *Low Income Subsidy beneficiaries, and certain Dual-Eligible Special Needs Plan beneficiaries* were included in the January 1, 2015, passive enrollment phase into Cal MediConnect.

#### Mandatory Medi-Cal Managed Care Enrollment

DHCS mandatorily *enrolled* nearly all beneficiaries who are enrolled in Medi-Cal into an MCP in CCI counties. Most Medi-Cal only beneficiaries *were* already enrolled in MCPs, but now they receive 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. *By the end of 2015, all counties, except for Orange County, completed the passive enrollment process.*

For dual eligibles who *chose* not to enroll in a Cal MediConnect health plan, the State requires enrollment in an MCP for all Medi-Cal services, including LTSS. For dual eligible beneficiaries, enrolling in an MCP does not change their Medicare benefits. They can still receive health care services from their Medicare hospitals and providers. All Medi-Cal beneficiaries in the seven CCI counties *were* required to enroll in an MCP except for the following groups:

- Beneficiaries younger than age 21;
- Beneficiaries with developmental disabilities residing in an ICF/DD, except in Orange and San Mateo Counties;
- Beneficiaries residing in a Veterans' Home of California;
- Beneficiaries with other health insurance, except in Orange and San Mateo Counties;
- Beneficiaries enrolled in PACE;
- Beneficiaries enrolled in the AIDS Healthcare Foundation;
- Beneficiaries in certain rural zip codes; and
- Medi-Cal-only beneficiaries excluded due to an approved Medical Exemption Request.

### Health Plan Auto-Assignment Process

DHCS developed a process to assign beneficiaries to a Cal MediConnect health plan, should a beneficiary not make an affirmative health plan choice within the prescribed timeframe. A beneficiary *had* approximately 60 days to decide if he or she *wanted* to join Cal MediConnect. If a beneficiary *did* not notify DHCS's contracted enrollment broker, MAXIMUS, of his/her choice to opt out of Cal MediConnect, he or she *was* automatically enrolled into a Cal MediConnect health plan. Cal MediConnect health plan contract provisions allow a beneficiary to disenroll at any time.

The assignment process *focused* on promoting continuity of care by evaluating a beneficiary's medical history and primary provider utilization history. The automatic assignment process *used* the most recent 12 months of Medicare and Medi-Cal claims history data to identify an individual's most frequently utilized providers. The providers may be individual physicians, medical groups, and/or clinics. The process also *promoted* continuity of care in a facility by determining if an individual *was* residing in a long-term care facility. The individual's providers *were* matched to providers in a participating Cal MediConnect health plan's network. A Cal MediConnect health plan *was* selected for each beneficiary that best *matched* the current medical needs of the individual. If a beneficiary *did* not make an affirmative choice, and *could* be matched to a health plan through medical history and primary provider utilization history data, he/she *was* assigned to a health plan through an equitable distribution process.

### 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 who they *could* contact for assistance when choosing an MCP or Cal MediConnect 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 includes an enrollment choice form and pre-stamped envelope, detailed plan benefit comparison charts, and details for in-person presentations. For beneficiaries who do not actively make a health plan choice, DHCS *mailed* a reminder

notice approximately 30 days prior to the enrollment effective date. All beneficiaries *receive* a letter just prior to the enrollment effective date confirming their health plan choice or the DHCS assigned plan. DHCS, in accordance with the CCI statutory requirements, *has ensured* that 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 stakeholder period were incorporated into the final notices and choice form. As a result of these activities, DHCS revised the notices and materials to ensure consistent messaging across different materials and to more clearly explain the following:

- Plan choices and instructions for opt out;
- Continuity of care provisions;
- How to determine which providers are part of each plan's network;
- Covered services and benefits; and
- Who to contact for assistance.

These revised notices and materials continue to be used today. *Note that San Mateo and Orange Counties are County Organized Health System (COHS) counties, and the COHS Cal MediConnect plans were responsible for developing and mailing enrollment materials.*

All CCI notices *were* written at a sixth-grade reading level and in the 13 Medi-Cal threshold languages, as well as in alternative formats that are 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 Guidebooks on the CalDuals website at: <http://www.calduals.org/implementation/cci-documents/notices/>.

*In addition to these existing materials, DHCS released for stakeholder comment a new draft Medi-Cal Managed Care Plan Guide and Choice Book that, when finalized, will be 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. DHCS anticipates that the materials will be finalized and released in summer 2016. 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 mandatorily enroll them into MCPs. These new materials incorporate some of the lessons DHCS has learned to date about how to communicate with dual eligible beneficiaries about the CCI, including lessons learned from stakeholder input and beneficiary testing of previous materials. These materials are currently undergoing user testing and revisions in partnership with Health Research for Action at UC Berkeley's School of Public Health. Before being mailed out, these materials will undergo a final literacy review to ensure that they meet readability standards and are not above a sixth-grade reading level. All final materials will also be translated into threshold languages and available in accessible formats, as required. Finalized materials will be mailed to the aforementioned beneficiaries as a part of their regular enrollment process.*

*DHCS also released a draft Cal MediConnect beneficiary toolkit for stakeholder comment. DHCS anticipates the toolkit will be finalized and released in summer 2016. This comprehensive toolkit 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 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 and a Care Coordinator?*

*Another fact sheet included helps explain some of the particulars related to MCPs, such as the definition of a network. This toolkit will help eligible beneficiaries understand their options and how Cal MediConnect may benefit them. It will also help these beneficiaries better understand how to navigate their MCPs if they choose to opt out of Cal MediConnect. This toolkit is currently undergoing user testing in partnership with the Health Research for Action at UC Berkeley's School of Public Health. As with other materials, these documents will undergo a final literacy review and will be translated into all threshold languages. Once finalized, this toolkit will be an easy-to-use resource for enrolled and eligible beneficiaries, caregivers, and stakeholders. This toolkit is expected to be finalized by summer 2016 and will be available online and used in outreach activities.*

As part of the enrollment notice development process, DHCS developed materials to train MAXIMUS call center staff, to help ensure that they are familiar with choice packets and are prepared 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 identifying opportunities for improvement. Lastly, DHCS has made these training materials available in some permutation 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 ensure that beneficiaries, including those in nursing care and their caregivers, providers, family members, conservators, and/or other authorized representatives have the information they need about the CCI. Recognizing the significant role that providers play in informing and guiding beneficiaries, the outreach plan emphasizes the importance of that role to providers. The outreach plan also recognizes the diversity of the CCI target population and that the majority of the population in many counties does not speak English as their first language. 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, *which was on the project 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, various stakeholders, providers, doctors, hospitals, health plans, and the individuals making decisions on how to participate. Activities include:

- Participating in local stakeholder coalitions, particularly as they relate to communications and outreach to the beneficiary *and provider populations*;
- Providing informational presentations to beneficiaries and providers;
- Delivering “train the trainer” presentations to organizations who regularly interact with the beneficiary population and need support understanding and explaining the CCI;
- Hosting monthly tele-town halls for beneficiaries receiving 60-day notices *during passive enrollment periods*;
- *Hosting bi-monthly stakeholder update calls (these meetings were monthly until November 2015)*;
- Ensuring there is good 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](http://www.calduals.org), as needed; and*
- *Maintaining an 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 ensure effective communications between the State and the local HICAP. 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 DMHC established an Ombudsman program to assist beneficiaries. The Ombudsman program that is managed by DMHC went live on April 1, 2014, and is operated by the Legal Aid Society of San Diego and a number of experienced subcontractors located in the CCI counties. The Legal Aid Society of San Diego and all its subcontractors are highly experienced in providing consumer assistance services. The subcontractors report their concerns and issues directly to DMHC. *In addition, DHCS continues to have bi-monthly meetings with the Legal Aid Society of San Diego to work on ongoing issues and to exchange information about Ombudsman work.*

DHCS works extensively to increase outreach to health care providers, *beneficiaries, and other stakeholders*, including *developing three educational 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; and*
- *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. *In addition, DHCS hosted a second Cal MediConnect provider summit in June 2015 and continues to look for opportunities for future summits.*

DHCS developed the Cal MediConnect Monthly Enrollment Dashboard 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 dashboard on the CalDuals website in April 2014 and updates 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 Health Risk Assessment (HRA) data on an HRA dashboard beginning in February 2015, *which as of March 2016, has been integrated into a more comprehensive Cal MediConnect Performance Dashboard. The quarterly Performance Dashboard shares new data on how Cal MediConnect health plans are performing in six areas related to care coordination, quality, and service utilization. The metrics in this new dashboard are: 1) Health Risk Assessments; 2) Appeals by Determination; 3) Hospital Discharge; 4) Emergency Utilization, 5) LTSS Utilization; and 6) Case Management. All current and archived dashboards can be found at: <http://www.calduals.org/enrollment-data/>.*

## **Quality Measures**

DHCS monitors Cal MediConnect health plans by using approximately 100 measures relating to beneficiary overall experience, care coordination, and fostering and

supporting community living, among many others. 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.

The core quality measures are described in Table 1 below. CMS and DHCS are utilizing the reported measures in the combined set of core quality measures for various purposes, including implementation and ongoing monitoring, assessing plan performance and outcomes, and allowing quality to be evaluated and compared with other Cal MediConnect health plans.

Approximately ten quality measures have been identified annually as “quality withhold measures.” These measures will be associated with a withhold of the Cal MediConnect health plan’s capitation payment annually (one percent in year one; two percent in year two; and three percent in year three) (Tables 2 and 3 below). CMS and DHCS *have developed* the monitoring thresholds that the Cal MediConnect health plans are required to meet. *The complete details regarding the core quality withhold measures across all demonstrations for Demonstration Year 1 can be found at:*

*<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY1QualityWithholdGuidance060614.pdf>*

*The complete details regarding the California-specific quality withhold measures for Demonstration Year 1, which was the period April 1, 2014 through December 31, 2015, can be found at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY1QualityWithholdGuidanceCA.pdf>.*

Should a Cal MediConnect health plan not meet the required threshold for these measures during the measurement year, the plan will not earn back the capitation withhold for the given year.

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The specific measurement definitions for the State-specific measures denoted in Table 1 below are currently under development between CMS and the State.

**Table 1: Core Quality Measures under Cal MediConnect**

Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
Antidepressant medication management	Percent of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment	National Committee for Quality Assurance (NCQA)/ Healthcare Effectiveness Information Set (HEDIS)	X	
Initiation and engagement of alcohol and other drug (AOD) dependence treatment	Percent of adolescent and adult members with a new episode of AOD dependence who received the following: <ul style="list-style-type: none"> <li>• Initiation of AOD treatment: Percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis</li> <li>• Engagement of AOD treatment: Percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit</li> </ul>	NCQA/HEDIS	X	
Follow-up after hospitalization for mental illness	Percent of discharges for members six years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner	NCQA/HEDIS	X	
Screening for clinical depression and follow-up	Percent of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented	Centers for Medicare & Medicaid Services (CMS)	X	
Care transition record transmitted to health care professional	Percent of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	American Medical Association (AMA)-Physician Consortium for Performance Improvement (PCPI)	X	
Medication reconciliation after discharge from inpatient facility	Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care who had a reconciliation of the discharge	NCQA/HEDIS	X	

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Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
	medications with the current medication list in the medical record documented			
Consumers Assessment of Healthcare Providers and Systems (CAHPS), various settings including health plan plus supplemental items/questions, including:  <ul style="list-style-type: none"> <li>• Experience of Care and Health Outcomes for Behavioral Health (ECHO)</li> <li>• Home health</li> <li>• Nursing home</li> <li>• People with mobility impairments</li> <li>• Cultural competence</li> <li>• Patient centered medical home</li> </ul>	Depends on survey	Agency for Healthcare Research and Quality (AHRQ)/CAHPS	X	
Part D call center – Pharmacy hold time	Average time spent on hold when pharmacists call the drug plan's pharmacy help desk	CMS Call Center data	X	
Part D call center – Foreign language interpreter and TTY/TDD availability	Percent of the time that TTY/TDD services and foreign language interpretation were available when needed by members who called the drug plan's customer service phone number	CMS Call Center data	X	
Part D appeals auto-forward	How often the drug plan did not meet Medicare's deadlines for timely appeals decisions  This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the drug plan. This is calculated as: $[(\text{Total number of cases auto-forwarded to the IRE}) / (\text{Average Medicare Part D enrollment})] * 10,000$	IRE	X	
Part D appeals upheld	How often an independent reviewer agrees with the drug plan's decision to deny or say no to a member's appeal This measure is defined as the percent of IRE confirmations of upholding the drug plans' decisions. This is calculated as: $[(\text{Number of cases upheld}) / (\text{Total number of cases reviewed})] * 100$	IRE	X	
Part D complaints about the drug plan	How many complaints Medicare received about the drug plan  For each contract, this rate is calculated	CMS CTM data	X	

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Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
	as: $[(\text{Total number of complaints logged into the Medicare Complaints Tracking Module (CTM) for the drug plan regarding any issues}) / (\text{Average contract enrollment})] * 1,000 * 30 / (\text{Number of days in period})$			
Part D beneficiary access and performance problems	<p>To check on whether members are having problems getting access to care and to be sure that drug plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews</p> <p>Medicare gives the drug plan a lower score (from 0 to 100) when it finds problems</p> <p>The score combines how severe the problems were, how many there were, and how much they affect drug plan members directly. A higher score is better, as it means Medicare found fewer problems</p>	CMS Administrative data	X	
Part D Medicare Plan Finder (MPF) accuracy	Accuracy of how the MPF data match the Prescription Drug Event (PDE) data	CMS PDE data, MPF Pricing Files, Health Plan Management System-approved formulary extracts, and data from First DataBank and Medispan	X	
Part D high risk medication	Percent of the drug plan members who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices	CMS PDE data	X	
Part D diabetes treatment	Percentage of Medicare Part D beneficiaries who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes	CMS PDE data	X	
Part D medication adherence for oral diabetes medications	Percent of drug plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication	CMS PDE data	X	
Part D medication adherence for hypertension (ACEI or ARB)	Percent of drug plan members with a prescription for a blood pressure medication who fill their prescription often	CMS PDE data	X	

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	enough to cover 80 percent or more of the time they are supposed to be taking the medication			
Part D medication adherence for cholesterol (statins)	Percent of drug plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication	CMS PDE data	X	
Health plan makes timely decisions about appeals	Percent of health plan members who got a timely response when they made a written appeal to the health plan about a decision to refuse payment or coverage	Independent Review Entity (IRE)	X	
Reviewing appeals decisions	How often an independent reviewer agrees with the health plan's decision to deny or say no to a member's appeal	IRE	X	
Call center – Foreign language interpreter and TTY/TDD availability	Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by members who called the health plan's customer service phone number	CMS call center data	X	
High risk residents with pressure ulcers (long-stay)	Percent of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (three-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s)	National Quality Forum (NQF) endorsed	X	
Risk assessments	Percent of members with initial assessments completed within 90 days of enrollment	CMS/State defined process measure	X	
Individualized care plans	Percent of members with care plans by specified timeframe	CMS/State defined process measure	X	
Risk stratification based on long-term services and supports (LTSS) or other factors	Percent of risk stratifications using behavioral health/LTSS data/indicators	CMS/State defined process measure	X	
Discharge follow-up	Percent of members with specified timeframe between discharge to first follow-up visit	CMS/State defined process measure	X	
Self-direction	Percent of care coordinators that have undergone State-based training for supporting self-direction under the Demonstration	CMS/State defined process measure	X	
Care for older adults – Medication review	Percent of plan members whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year	NCQA/ HEDIS	X	

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Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
Care for older adults – Functional status assessment	Percent of plan members whose doctor has done a:  • Functional status assessment to see how well they are doing • Activities of daily living (such as dressing, eating, and bathing)	NCQA/HEDIS	X	
Care for older adults – Pain screening	Percent of plan members who had a pain screening or pain management plan at least once during the year	NCQA/HEDIS	X	
Diabetes care – Eye exam	Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year	NCQA/HEDIS	X	
Diabetes care – Kidney disease monitoring	Percent of plan members with diabetes who had a kidney function test during the year	NCQA/HEDIS	X	
Diabetes care – Blood sugar controlled	Percent of plan members with diabetes who had an A-1-C lab test during the year that showed their average blood sugar is under control	NCQA/HEDIS	X	
Rheumatoid arthritis management	Percent of plan members with rheumatoid arthritis who got one or more prescription(s) for an anti-rheumatic drug	NCQA/HEDIS	X	
Reducing the risk of falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year	NCQA/HEDIS Health Outcomes Survey (HOS)	X	
Plan all-cause readmissions	Percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason	NCQA/HEDIS	X	
Controlling blood pressure	Percent of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year	NCQA/HEDIS	X	
Comprehensive medication review (CMR)	Percent of beneficiaries who received a CMR out of those who were offered a CMR	Pharmacy Quality Alliance (PQA)	X	
Complaints about the health plan	How many complaints Medicare received about the health plan  Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the CTM) / (average contract enrollment)] * 1,000 * 30 / (number of days in period)	CMS  CTM data	X	
Beneficiary access and performance problems	To check on whether members are having problems getting access to care and to be	CMS	X	

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Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
	<p>sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from zero to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems</p>	Beneficiary database		
Members choosing to leave health plan	Percent of health plan members who chose to leave health plan in current year	CMS	X	
Getting information from drug plan	<p>Percent of the best possible score that the plan earned on how easy it is for members to get information from their drug plan about prescription drug coverage and cost:</p> <ul style="list-style-type: none"> <li>• In the last six months, how often did your health plan's customer service give you the information or help you needed about prescription drugs?</li> <li>• In the last six months, how often did your plan's customer service staff treat you with courtesy and respect when you asked for information or help about prescription drugs?</li> <li>• In the last six months, how often did your health plan give you all the information you needed about the prescription medications are covered?</li> <li>• In the last six months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine?</li> </ul>	AHRQ/CAHPS	X	
Rating of drug plan	<p>Percent of the best possible score that the drug plan earned from members who rated the drug plan for its coverage of prescription drugs</p> <ul style="list-style-type: none"> <li>• Using any number from zero to ten, where zero is the worst prescription drug plan possible and ten is the best prescription drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs?</li> </ul>	AHRQ/CAHPS	X	
Getting needed prescription drugs	Percent of best possible score that the plan earned on how easy it is for members to get the prescription drugs they need using the plan	AHRQ/CAHPS	X	

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Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
	<ul style="list-style-type: none"> <li>In the last six months, how often was it easy to use your health plan to get the medicines your doctor prescribed?</li> <li>In the last six months, how often was it easy to use your health plan to fill a prescription at a local pharmacy?</li> </ul>			
Getting needed care	<p>Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists</p> <ul style="list-style-type: none"> <li>In the last six months, how often was it easy to get appointments with specialists?</li> <li>In the last six months, how often was it easy to get the care, tests, or treatment you needed through your health plan?</li> </ul>	AHRQ/CAHPS	X	
Getting appointments and care quickly	<p>Percent of best possible score the plan earned on how quickly members get appointments and care</p> <ul style="list-style-type: none"> <li>In the last six months, when you needed care right away, how often did you get care as soon as you thought you needed?</li> <li>In the last six 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?</li> </ul>	AHRQ/CAHPS	X	
Overall rating of health care quality	<p>Percent of best possible score the plan earned from plan members who rated the overall health care received</p> <p>Using any number from zero to ten, where zero is the worst health care possible and ten is the best health care possible, what number would you use to rate all your health care in the last six months?</p>	AHRQ/CAHPS	X	
Overall rating of health plan	<p>Percent of best possible score the plan earned from plan members who rated the overall plan.</p> <p>Using any number from zero to ten, where zero is the worst health plan possible and ten is the best health plan possible, what number would you use to rate your health plan?</p>	AHRQ/CAHPS	X	
Breast cancer screening	Percent of female plan members aged 40-69 who had a mammogram during the past two years	NCQA/ HEDIS	X	
Colorectal cancer screening	Percent of plan members aged 50-75 who had appropriate screening for colon cancer	NCQA/HEDIS	X	

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Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
Cardiovascular care – Cholesterol screening	Percent of plan members with heart disease who have had a test for –bad (LDL) cholesterol within the past year	NCOA/HEDIS	X	
Diabetes care – Cholesterol screening	Percent of plan members with diabetes who have had a test for bad (LDL) cholesterol within the past year	NCOA/HEDIS	X	
Annual flu vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season	AHRO/CAHPS Survey data	X	
Improving or maintaining mental health	Percent of all plan members whose mental health was the same or better than expected after two years	CMS HOS	X	
Monitoring physical activity	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year	HEDIS / HOS	X	
Access to primary care doctor visits	Percent of all plan members who saw their primary care doctor during the year	HEDIS	X	
Access to specialists	Proportion of respondents who report that it is always easy to get appointment with specialists	AHRO/CAHPS	X	
Getting care quickly	Composite of access to urgent care	AHRO/CAHPS	X	
Being examined on the examination table	Percent of respondents who report always being examined on the examination table	AHRO/CAHPS	X	
Help with transportation	Composite of getting needed help with transportation	AHRO/CAHPS	X	
Health status/function status	Percent of members who report their health as excellent	AHRO/CAHPS	X	
Behavioral health shared accountability process measure Phase A (9/1/13 – 12/31/13) Phase B (1/1/14 – 12/31/14)	Phase A: Policies and procedures attached to a memorandum of understanding (MOU) with county behavioral health department(s) around assessments, referrals, coordinated care planning and information sharing  Phase B: Percent of demonstration enrollees receiving Medi-Cal specialty mental health and/or Drug Medi-Cal services receiving a coordinated care plan as indicated by having an individual care plan that includes the evidence of collaboration with the primary behavioral health provider	State defined measures		X
Behavioral health shared accountability outcome measure	Reduction in emergency room (ER) use for seriously mentally ill and substance use disorder enrollees (greater reduction in Demonstration Year Three)	State defined measure		X
The number of critical incident and abuse reports for members receiving LTSS	Enrollee protections	State defined measure		X
Members with an individual care plan completed	Care coordination	CMS/State defined measure	X	X

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Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
Low risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the Health Risk Assessment (HRA)	Care coordination	CMS/State defined measure	X	X
High risk members with an ICP within 30 days after the completion of the HRA	Care coordination	CMS/State defined measure	X	X
Members with first follow-up visit within 30 days after hospital discharge	Care coordination	CMS/State defined measure	X	X
ER utilization rates	Utilization measure, potentially revised to reflect avoidable ER visits	State defined measure		X
In-Home Supportive Services (IHSS) utilization	Utilization measure	State defined measure		X
Readmissions of short-and long-stay nursing facility residents after hospitalization for diabetes, chronic obstructive pulmonary disease or any medical diagnosis	Utilization measure	State defined measure		X
Unmet need in LTSS	Unmet need in ADLs/IADLs, and IHSS functional level	State defined measure		X
IHSS Case manager contact with member	Ability to identify case manager or contact case manager DHCS will work with CMS and will publish details as they become available	State defined measure		X
Satisfaction with IHSS case manager, home workers, personal care	Satisfaction with case manager, home workers, personal care	State defined measure		X
Encounter data	Encounter data submitted accurately and completely in compliance with contract requirements	CMS/State defined measure	X	X
Consumer governance board	Establishment of consumer advisory board or inclusion of consumers on governance board consistent with contract requirements	CMS/State defined measure	X	X
Customer service	Percent of best possible score the plan earned on how easy it is to get information and help when needed	AHRQ/CAHPS	X	X
Access to care	Percent of respondents who always or usually were able to access care quickly when they needed it	AHRQ/CAHPS	X	X

Table 2 displays the quality withhold measures for Year One. As stated above, these measures are associated with a withhold of the Cal MediConnect health plan's capitation payment annually. For Year One, the withhold is one percent. *Throughout mid to end of 2016, CMS and DHCS will be 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.*

**Table 2: Year One Quality Withhold Measures**

Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
Risk assessments	Percent of members with initial assessments completed within 90 days of enrollment	Centers for Medicare & Medicaid Services (CMS)/State defined process measure	X	
Behavioral health shared accountability process measure	<p>Phase A (9/1/13 – 12/31/13) Phase A: Policies and procedures attached to a memorandum of understanding (MOU) with county behavioral health department(s) around assessments, referrals, coordinated care planning and information sharing</p> <p>Phase B (1/1/14 – 12/31/14) Phase B: Percent of demonstration enrollees receiving Medi-Cal specialty mental health and/or Drug Medi-Cal services receiving coordinated care plan as indicated by having an individual care plan that includes the signature of the primary behavioral health provider</p>	State defined measure		X
Encounter data	Encounter data submitted accurately and completely in compliance with contract requirements	CMS/State defined measure	X	X
Consumer governance board	Establishment of consumer advisory board or inclusion of consumers on governance board consistent with contract requirements	CMS/State defined measure	X	X

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Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
Customer service	Percent of best possible score the health plan earned on how easy it is to get information and help when needed	Agency for Healthcare Research and Quality (AHRQ) /Consumer Assessment of Healthcare Providers and Systems (CAHPS)	X	X
Access to care	Percent of respondents who always or usually were able to access care quickly when they needed it	AHRQ/CAHPS	X	X
Interaction with care team	Percentage of members who have a care coordinator and at least one care team contact	State defined measure		X
Ensuring physical access to buildings, services and equipment	Documentation of an established work plan and identification of the individual responsible for physical access compliance	State defined measure		X
Documentation of care goals	Number of members with at least one documented discussion of care goals in the individualized care plan	State defined measure		X

Table 3 displays the quality withhold measures for Years Two and Three. As stated above, these measures will be associated with a withhold of the Cal MediConnect health plan’s capitation payment annually. The withhold is two percent in Year Two and three percent in Year Three.

**Table 3: Years Two and Three Quality Withhold Measures**

Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
Follow-up after hospitalization for mental illness	Percent of discharges for members six 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	National Committee for Quality Assurance (NCQA)/ Healthcare Effectiveness Data and Information Set (HEDIS)	X	
Screening for clinical depression and follow-up	Percent of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented	Centers for Medicare & Medicaid Services (CMS)	X	
Part D medication adherence for oral diabetes medications	Percent of health plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication	CMS  Prescription Drug Event (PDE) data	X	
Reducing the risk of falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year	NCQA/HEDIS  Health Outcomes Survey (HOS)	X	
Plan all-cause readmissions	Percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason	NCQA/HEDIS	X	
Controlling blood pressure	Percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year	NCQA/HEDIS	X	
Annual flu vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season	Agency for Healthcare Research and	X	

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Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
		Quality (AHRQ)/ Consumer Assessment of Healthcare Providers and Systems (CAHPS)  Survey data		
Behavioral health shared accountability outcome measure	Reduction in emergency room use for seriously mentally ill and substance use disorder enrollees (greater reduction in Demonstration Year Three)	State defined measure		X
<i>Interaction with care team</i>	<i>Percentage of members who have a care coordinator and at least one care team contact</i>	State defined measure		X
Documentation of care goals	Number of members with at least one documented discussion of care goals in the individualized care plan	State defined measure		X

CMS *continues to work* closely with DHCS to monitor other measures related to community integration. CMS and DHCS will also jointly refine and update the aforementioned quality measures in years two and three of Cal MediConnect.

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

- DMHC and DHCS *were scheduled to* submit an annual joint report to the Legislature on financial audits performed on Cal MediConnect health plans on January 1, 2016;
- DHCS will continue to coordinate with DMHC, CDSS, CDA, and CMS to monitor Cal MediConnect health plans and will institute Corrective Action Plans (CAPs), when appropriate. The Contract Management Team (CMT), a joint CMS and DHCS team, 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 will send a series of notices to the plan, with each subsequent notice increasing in severity. The Cal MediConnect 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; and
- 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 has begun collaborating with the EQRO to work with the Cal MediConnect health plans regarding the PIP process, which began in February 2016. The PIP will be plan specific, and will address *improving care coordination with a focus on the integration of the LTSS programs*.

*In addition to the DHCS PIP, each Cal MediConnect health plan is also required to undertake one CMS-required chronic care improvement project (CCIP) which is focused on reducing the incidence and severity of cardiovascular disease and one CMS-led quality improvement program (QIP) which is focused on reducing hospital readmissions. Both the CCIP and QIP are underway, with a planning phase occurring in 2015 and the actual implementation of each beginning in 2016.*

*In accordance with the requirements of SB 1008, DHCS recently released the Cal MediConnect Performance Dashboard which includes six metrics: 1) Health Risk Assessments, 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. A new Cal MediConnect Performance Dashboard will be released quarterly. The dashboard will evolve and DHCS may revise the metrics in future dashboards based on stakeholder feedback and MCP performance.*

For the Managed Long-Term Services and Supports (MLTSS) transition, the Cal MediConnect health plans in the seven counties will follow the existing Medi-Cal managed care reporting requirements which include reporting of 15 HEDIS measures annually, CAHPS currently on a tri-annual basis, and participation in a *PIP*. In addition, DHCS conducts regular monitoring efforts of existing health plans that includes the provision of technical assistance, requirements to complete CAPs, requiring annual *PIPs* and Improvement Plans be completed, for any HEDIS rate for which a health plan does not meet the minimum threshold.

Table 4 displays the MCP measures that *are being* used to ensure plans are fulfilling their obligation to provide covered MLTSS services to their members in CCI counties in accordance with State and federal law. The results will be publicly reported in summary format by health plan and by county. DHCS will work with CMS and will publish details as they become available. CMS and DHCS can mutually agree at any time to delete, modify, or add new metrics, as deemed necessary to improve reporting going forward. *There are several evaluation activities on the metrics underway. 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 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.*

**Table 4: MLTSS Monitoring Items**

Criteria	Metric	Frequency	Data Source	Expected Outcome
Enrollment Status	Medi-Cal managed care health plan (MCP) selection and mandatory enrollment numbers and percentages for beneficiaries eligible for Managed Long Term Services and Supports (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 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	Department of Health Care Services (DHCS) will ensure, through ongoing surveys and readiness and implementation monitoring, that MCPs provide for enrollees long-term services and supports 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

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Criteria	Metric	Frequency	Data Source	Expected Outcome
				with implementation/effective dates published in the Federal Register
Plan Readiness – Initial and Ongoing	DHCS shall submit to the federal Centers for Medicare and Medicaid Services (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	<ul style="list-style-type: none"> <li>• Network adequacy will be verified on a quarterly basis for the first year</li> <li>• Plan readiness will be conducted similarly to Healthy Families and Geographic Expansion</li> <li>• Readiness assessments will be aligned with the Cal MediConnect reporting where possible; DHCS will complete a network certification for each county</li> <li>• DHCS will assess and monitor MCP capacity for the MLTSS population</li> </ul>
Participant Rights and Safeguards, Information, and Network Adequacy Requirements	<p>For network adequacy, in addition to Title 42, Code of Federal Regulations, Section 438, DHCS must:</p> <ul style="list-style-type: none"> <li>• Require MCP to refer everyone eligible for in-home supportive services (IHSS) to the county social services agency and support member transition</li> <li>• 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</li> </ul>	Information is due to CMS prior to implementation and every six months afterward for the term of the demonstration.	DHCS	<p>DHCS will ensure the following:</p> <ul style="list-style-type: none"> <li>• That MCPs maintain and provide the Public Authority contact information for the adequate network of IHSS workers/providers to support member transition</li> <li>• Adequate MOUs are in place to ensure access to care between plan, county, and MSSP sites</li> <li>• That MCPs refer all those eligible for MSSP to all contracted MSSP sites</li> <li>• Availability of MCP care</li> </ul>

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Criteria	Metric	Frequency	Data Source	Expected Outcome
	<p>services</p> <ul style="list-style-type: none"> <li>• Have MCPs submit Memoranda of Understanding (MOUs) between the plan, the counties and Multipurpose Senior Services Program (MSSP) sites</li> <li>• 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</li> <li>• Require MCP to refer IHSS recipients who are awaiting a caregiver to other Home and Community-Based Services (HCBS) benefits (Community Based Adult Services [CBAS], MSSP) or work with community-based organizations and resources to help bridge the gap to meet their needs.</li> <li>• Require DHCS to identify all nursing facilities (NFs) that house MLTSS members</li> <li>• MCPs should demonstrate adequate capacity in their contracted nursing homes</li> </ul>			<p>coordinators for members waiting for MSSP slot</p> <ul style="list-style-type: none"> <li>• That MCPs refer IHSS recipients awaiting a caregiver to other HCBS benefits (CBAS, MSSP) to help meet/bridge their needs</li> <li>• That MCPs will work with community-based organizations and resources to help IHSS recipients bridge the gap to meet their needs until they begin to receive IHSS</li> </ul> <p>DHCS will monitor NFs that house MLTSS members and show the percent that have been contracted by each MCP.</p> <p>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</p>

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Criteria	Metric	Frequency	Data Source	Expected Outcome
Quality Oversight and Monitoring – Measurement Activities	<p>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.</p> <p>DHCS must provide reports to CMS to demonstrate their oversight of the key elements of the MLTSS program.</p> <p>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).</p> <p>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 External Quality Review Organization should validate the survey results. DHCS must analyze the results, discuss them with stakeholder</p>	Annually	DHCS	<p>DHCS will ensure 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</p> <p>DHCS will analyze MCP reports as part of its quality oversight and based on the results, take corrective action as needed to ensure compliance.</p> <p>DHCS will obtain, monitor, and evaluate key experience and life indicator information, including information on actions taken by DHCS. The information will be made available to advisory groups and publically posted.</p> <p>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.</p>
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.

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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	<p>Members referred to the HCBS waivers are assessed for the HCBS waiver</p> <p>Members referred to IHSS are assessed by the county social services agency for IHSS.</p> <p>Members newly admitted to NFs without a discharge plan in place were first afforded supports and services in the community</p> <p>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.</p> <p>Number and proportion of beneficiaries receiving LTSS in the community along with number and proportion of beneficiaries receiving LTSS in an institution.</p>	Quarterly	MCPs	<p>MCPs will do the following:</p> <ul style="list-style-type: none"> <li>• Refer members to appropriate services that support retention of community placement</li> <li>• Track and monitor the number of referrals made to HCBS waivers and the number of completed assessments performed by the HCBS providers</li> <li>• 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 to address outcomes regarding tracking and monitoring the number of referrals made and the number of completed assessments performed.</li> <li>• 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</li> </ul>

### 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 was from a fixed price contract, which was 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. Under this grant, the State received CMS approval for the following:

- Year Two (September 1, 2014 – August 31, 2015), CMS pays 75 percent federal financial participation (FFP) and the State pays 25 percent from the State General Fund. The unobligated funding from Year One was made available for Year Two and CMS pays 100 percent FFP; and
- Year Three (September 1, 2015 – July 31, 2016), CMS pays 50 percent FFP and the State pays 50 percent from the State General Fund.
- *Year Four: DHCS submitted revisions to the grant to CMS for review. Pending acceptance of the proposed revisions, DHCS will continue to allocate funds as outlined above in “Year Three.”*

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, community-based organizations, 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 others;
- Beneficiary and provider outreach and education that include the development and dissemination of fact sheets, enrollment notices, educational and informational materials and choice packets;
- Rate development and actuarial analysis that include rate setting, risk adjustments, cost distributions and the development of savings targets and outcome reporting;
- Medicare data analysis 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 that include strategic network management and integration of Cal MediConnect policies, coordinating and conducting health plan and State operational readiness activities, assessment of post-implementation activities and operational training needs; and
- 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.

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

### Budget

Below is background information on the various contract managers working on the CCI. The number of staff ranges from three to 23 employees spending 30 to 100 percent of their time on the CCI and about 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 (IV&V), Project Oversight and Contract Turnover and Takeover.
- Sara Rivera, PMP, Public Consulting Group, LLC: Ms. Rivera is a Project Management Institute (PMI) and certified Project Management Professional (PMP) with extensive large-scale integration experience in the public and commercial health care domain. Her experience includes project management, IV&V management, and business process re-engineering. Ms. Rivera has gained extensive knowledge of California's public health care delivery system, including Medi-Cal, through her work in managing complex, enterprise-wide Health Insurance Portability and Accountability Act (HIPAA) compliance projects. She has proven communication, facilitation, and team building skills and the ability to work with all levels of executive management, policy, business, and technical staff.
- 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.

- Branch McNeal, CPA, Mercer Health and Benefits, LLC: Mr. McNeal is a Senior Partner at Mercer, and has been accountable for multiple Medicaid/Children's Health Insurance Program (CHIP) and Medicare engagements. His work with the State transformed Medi-Cal managed care rate development processes and reimbursement structures. Branch was with Arizona's Medicaid/CHIP program for more than ten years and was a senior auditor with KPMG. He also was responsible for capitation rate and fee-for-service rate development, including financial analysis of encounter and financial statement data used in capitation rate development, clinical policy development, quality management activities, member eligibility and program integrity, including fraud and abuse.

## **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 coordination of care and enhance the quality of life among 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 ensures eligible beneficiaries have accurate, actionable information for their own decision-making processes. 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 the second version of that plan, which is intended to be iterative and 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 except for Orange County, which ends the first phase of passive enrollment in July 2016.*

*Updates to information in the last submitted Fiscal Year 2014-2015 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 help them have a good understanding of their options. At the same time, this plan acknowledges that there is an existing infrastructure for reaching these 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.

This plan is an outreach and education plan designed specifically for the CCI. It integrates aspects of what may be characterized as communications or marketing strategies including tools such as earned media and targeting, but it is not a marketing strategy, as its goal is to increase awareness among specific populations about their options under the program. However, part of ensuring that these populations have action-oriented information about their decision points and options, will involve 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 and its employees and consultants will not advise beneficiaries on which plans to select, but it will relay these details when appropriate.

## I. 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, <i>are</i> 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 ensure they have the information they need, whether they receive that information from Health Care Options (HCO), a Health Insurance Counseling and Advocacy Program (HICAP), a CBO, or a CCI outreach coordinator.
Providers	The CCI also 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 ensure <i>positive transitions</i> for beneficiaries, these providers need information about what the CCI means to their practice. 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 <i>serve</i> .
Local “Guides” and Stakeholders	<p>“Guides” are organizations already supporting the dual eligible population. They need <i>continued</i> 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.</p> <p>These organizations include CBOs, unions, medical <i>groups</i>, and <i>associations</i>, Area Agencies on Aging (AAAs), HICAPs, legal aid societies, local advocacy organizations, legislative aides (all offices,</p>

	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 <i>needs</i> to understand the CCI as it continues <i>through</i> implementation.
Health Plans	Health plans are as much an audience as they are a key partner in this outreach and education effort.

## II. Implementation: DHCS Project Lead from Sacramento

DHCS is executing the following tasks at a leadership level to ensure 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

Ensuring 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.

*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 September 2015, DHCS released for stakeholder comment a new draft Medi-Cal Managed Care Plan Guide and Choice Book that, when finalized, would be 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 are currently undergoing user testing and revisions in partnership with the Health Research for Action at UC Berkeley's School of Public Health. Finalized materials will be mailed to the aforementioned beneficiaries as a part of their regular enrollment process. It is expected that DHCS will finalize the materials in summer 2016. Materials will undergo readability testing and be translated into 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 conduct weekly calls on policy and outreach items;
- DHCS and CDA are working closely on a number of ongoing outreach-related activities, including:
  - A call-triage strategy so that beneficiaries face “no wrong door” when contacting state and local agencies;
  - Ensuring that HICAP staff have the proper materials to use in answering beneficiary questions;
  - Ensuring that county-specific materials are available for beneficiaries on who to call with CCI and Cal MediConnect questions and when they need assistance; and
  - 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; and
- *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; and
- 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 threshold languages and in county-specific formats as appropriate. DHCS will develop additional and county-specific toolkit materials, as needed.

### “Train the Trainer” Program

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; and
- 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 are working directly with CBOs to provide materials and support *as needed and requested*. DHCS continues to provide “Train the Trainer” presentations in CCI counties.

### Health Care Options Training and Staffing

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 threshold languages is available on the website as well. *The website is continually updated with relevant information and data.*

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 will continue 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; and
- 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:

- *The first phase of passive enrollment has ended in each county except for Orange County, where passive enrollment ends in July 2016, and the health plan in Orange County is responsible for noticing and enrollment for beneficiaries.*
- *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; and*
- *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 is developing a Cal MediConnect beneficiary toolkit. This 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. This toolkit will help eligible beneficiaries understand their options and how Cal MediConnect may benefit them. It will also help these beneficiaries better understand how to navigate their Medi-Cal MCPs if they choose not to participate in Cal MediConnect. The draft toolkit was released for stakeholder comment and is currently going under user testing in partnership with Health Research for Action at UC Berkeley's School of Public Health. Once finalized, this toolkit will be an easy-to-use resource for enrolled and eligible beneficiaries, caregivers, and stakeholders. It is expected to be finalized by summer 2016 and will be available online in the threshold languages and used in 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 ensuring long-term *success of the program and positive transitions for beneficiaries*. DHCS is working with *provider groups, provider associations, and various other providers* to ensure 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, 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 the 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; and
- Faith-based groups.

The goal is to ensure 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, *senior centers, to CBOs that serve beneficiaries, have developed materials for Meals on Wheels programs, are engaging IHSS beneficiaries and caregivers through working with unions, public authorities, and local counties,* and are engaging in other targeted outreach on a daily basis.

### **III. 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 ensure 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, ensure 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 so as 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; and
- Ensuring there is 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 Seniors and Persons with Disabilities 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:
  - 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;
  - Attendance at health fairs and other pre-organized events to offer presentations or materials;
  - 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 through 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.

#### **IV. 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; and
- 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:
  - Eligibility;
  - Continuity of care;
  - Member rights and responsibilities;
  - Benefits of CCI;
  - IHSS services; and
  - PACE programs;
- Provider fact sheet on payment under the CCI;
- County specific fact sheets;
- Language specific fact sheets in Medi-Cal threshold languages; and
- 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 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; and
- Physician fact sheets on:
  - Care coordination;
  - Payments;
  - Working with dual eligibles in Medi-Cal plans;
  - Contracting with Cal MediConnect plans; and
  - Continuity of care.

### CCI Beneficiary Toolkit

*DHCS is currently developing and user testing a CCI Beneficiary Toolkit. This 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 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. This toolkit will help eligible beneficiaries understand their options and how Cal MediConnect may benefit them. It will also help 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; and
- Nursing homes.

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

- Physicians
  - Groups,
  - Specialty physician societies,
  - County medical societies,
  - Ethnic medical societies, and
  - Any other opportunities to speak with independent physicians;
- Hospitals
  - Private,
  - County public hospitals, and
  - Community clinic associations;
- DME suppliers;
- CBOs who act in provider capacity at times (transportation);
- Pharmacies;
- Nursing homes/skilled nursing facilities;
- 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; and
- 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 to ensure that effective outreach is meeting the needs of beneficiaries, providers, and other stakeholders.*