



## **Coordinated Care Initiative**

Fiscal Year 2014-2015

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 *most* 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/ci-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 2014-2015 Enrollment Status, Quality Measures, and State Costs Report covers activities and information through March 1, 2015. Updates to information in the last submitted Fiscal Year 2013-2014 Enrollment Status, Quality Measures, and State Costs Report are in italics for ease of review.*

## Enrollment Status and Timelines

*In April 2014, DHCS began passively enrolling dual eligible beneficiaries into Cal MediConnect in San Mateo County, and those 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, the State began passive enrollment into Cal MediConnect and also began 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. Passive enrollment into Cal MediConnect began in Los Angeles County in July 2014 and in Santa Clara County in January 2015. Orange County has not yet implemented CCI, but*

*is scheduled to begin opt-in enrollment in July 2015 and passive enrollment in August 2015.*

Enrollment is being 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.”

*Note that Alameda County is no longer participating in CCI. In July 2014, a Superior Court judge ruled that the State may appoint a conservator to take over the finances of Alameda Alliance for Health (AAH), which would have been the Cal MediConnect plan for Alameda County. The conservatorship will operate for a year and is retroactive to May 5, 2014, which is the day that the Department of Managed Health Care (DMHC) took over the finances of AAH. In order for AAH to improve and focus on its financial and operational condition and transition back to local control, DMHC, DHCS, AAH and local providers agreed as of November 2014 that Alameda County should no longer participate in the CCI.*

*As of May 1, 2015, there were approximately 123,000 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

DHCS is using a passive enrollment process for individuals eligible for Cal MediConnect. This means that the State will enroll eligible dual *eligible beneficiaries* into Cal MediConnect health plans unless the individual actively chooses not to join (*opts out*) and *notifies* the State of this choice. The State *notifies beneficiaries* 90-days prior to the enrollment effective date, followed by a 60-day notice and enrollment packet, and a 30-day reminder notice. The 60 and 30-day notices include instructions on how to opt out of Cal MediConnect. 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 are 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;
- 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);
- 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 will not be 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 and beneficiaries transitioning from a Dual-Eligible Special Needs Plan to Cal MediConnect were included in the January 1, 2015, passive enrollment phase into Cal MediConnect.*

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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.

### Mandatory Medi-Cal Managed Care Enrollment

DHCS is mandatorily *enrolling* nearly all beneficiaries who are enrolled in Medi-Cal into an MCP in CCI counties. Most Medi-Cal only beneficiaries are 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.

For dual eligibles who choose 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 doctors, hospitals, and providers.

All Medi-Cal beneficiaries in the seven CCI counties will be 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 *has* approximately 60 days to decide if he or she wants to join Cal MediConnect. If a beneficiary does not notify *DHCS's contracted enrollment broker*, MAXIMUS, of his/her choice to opt out of Cal MediConnect, he or she will be 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 focuses on promoting continuity of care by evaluating a beneficiary's medical history and primary provider utilization history. The automatic assignment process uses 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 promotes continuity of care in a facility by determining if an individual is currently residing in a long-term care facility. The individual's providers will be matched to providers in a participating Cal MediConnect health plan's network. A Cal MediConnect health plan will be selected for each beneficiary that best matches the current medical

needs of the individual. If a beneficiary does not make an affirmative choice, and cannot be matched to a health plan through medical history and primary provider utilization history data, he/she will be 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 receive written notification on how and when *their health care* will change, and who they can contact for assistance when choosing an MCP or *Cal MediConnect plan*. Sixty days prior to a beneficiary's effective enrollment date, DHCS mails an enrollment packet that includes: 1) a letter describing the pending changes and actions required of the beneficiary; 2) a resource booklet that describes 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 mails 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, ensures that enrollment notices are 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.*

All CCI notices are 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 posts 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/>.

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 (HICAP).

### Beneficiary and Provider Outreach

DHCS developed a Beneficiary and Provider Outreach Plan (Appendix A). This outreach plan has been shared with stakeholders and will be updated as additional opportunities for education and training are identified throughout the CCI transition.

The primary goal of the outreach plan is to ensure that beneficiaries, including those in nursing and group homes, 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 and an outreach coordinator team, based across the seven CCI counties, are 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 population;
- 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 as well as monthly stakeholder update calls; and*
- Ensuring there is good information flow between the counties and the State, particularly to identify information and outreach needs in local communities.

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.

*DHCS works extensively to increase outreach to health care providers, including the development of a physician tool kit, including information on how providers can work with health plans and how they can participate in care coordination activities. In January 2015, DHCS hosted the first of a series of Cal MediConnect provider summits to increase communication between providers, health plans, and health plan delegates.*

DHCS developed the Cal MediConnect Monthly Enrollment Dashboard as an additional tool for communicating with advocates and beneficiaries. This dashboard contains the “notice mailing schedule” and enrollment and opt out numbers by county. DHCS posted the first dashboard on the CalDuals website in April 2014 and updates it monthly. DHCS also began sharing Health Risk Assessment (HRA) data on an HRA dashboard beginning in February 2015. The HRA dashboard provides information about Cal MediConnect HRA completion rates and is updated quarterly. The current enrollment and HRA dashboards, as well as archived dashboards, can be found at the following link: <http://www.calduals.org/enrollment-data/>.

## Quality Measures

DHCS *monitors* Cal MediConnect health plans by using approximately 100 measures that examine areas including access and availability, care coordination and transitions, health and well-being, mental and behavioral health, patient-caregiver experience, screening and prevention, and quality of life. These measures build on the required Healthcare Effectiveness Data and Information Set (HEDIS), Medicare Health Outcome Survey (HOS), 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 the State are currently developing the monitoring thresholds that the Cal MediConnect health plans will have to meet and the reporting frequency for each of the core quality measures. These additional details about the measures will be provided in guidance issued by CMS, *which is expected to be released later in 2015*. CMS and the State *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*). 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.

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	

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Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
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 medications with the current medication list in the medical record documented	NCQA/HEDIS	X	
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: [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000	IRE	X	

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Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
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: [(Number of cases upheld) / (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 as: [(Total number of complaints logged into the Medicare Complaints Tracking Module (CTM) for the drug plan regarding any issues) / (Average contract enrollment)] * 1,000 * 30 / (Number of days in period)	CMS CTM data	X	
Part D beneficiary access and performance problems	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  Medicare gives the drug plan a lower score (from 0 to 100) when it finds problems  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	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	

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Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
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 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 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	

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Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
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	
Care for older adults – Functional status assessment	Percent of plan members whose doctor has done a:  <ul style="list-style-type: none"> <li>• Functional status assessment to see how well they are doing</li> <li>• Activities of daily living (such as dressing, eating, and bathing)</li> </ul>	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	

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Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
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 (POA)	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 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	CMS  Beneficiary database	X	
Members choosing to leave health plan	Percent of health plan members who chose to leave health plan in current year	CMS	X	

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Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
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	<p>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</p> <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>	AHRQ/CAHPS	X	

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Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
Getting needed care	Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists  <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>	AHRO/CAHPS	X	
Getting appointments and care quickly	Percent of best possible score the plan earned on how quickly members get appointments and care  <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,</li> <li>• 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>	AHRO/CAHPS	X	
Overall rating of health care quality	Percent of best possible score the plan earned from plan members who rated the overall health care received  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?	AHRO/CAHPS	X	
Overall rating of health plan	Percent of best possible score the plan earned from plan members who rated the overall plan.  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?	AHRO/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	
Cardiovascular care – Cholesterol screening	Percent of plan members with heart disease who have had a test for –bad (LDL) cholesterol within the past year	NCQA/HEDIS	X	

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Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
Diabetes care – Cholesterol screening	Percent of plan members with diabetes who have had a test for bad (LDL) cholesterol within the past year	NCQA/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
<i>The number of critical incident and abuse reports for members receiving LTSS</i>	<i>Enrollee protections</i>	State defined measure		X
<i>Members with an individual care plan completed</i>	<i>Care coordination</i>	CMS/State defined measure	X	X

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Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
<i>Low risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the Health Risk Assessment (HRA)</i>	Care coordination	CMS/State defined measure	X	X
<i>High risk members with an ICP within 30 days after the completion of the HRA</i>	Care coordination	CMS/State defined measure	X	X
<i>Members with first follow-up visit within 30 days after hospital discharge</i>	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
<i>Readmissions of short-and long-stay nursing facility residents after hospitalization for diabetes, chronic obstructive pulmonary disease or any medical diagnosis</i>	Utilization measure	State defined measure		X
Unmet need in LTSS	Unmet need in ADLs/IADLs, and IHSS functional level	State defined measure		X
<i>IHSS Case manager contact with member</i>	Ability to identify case manager or contact case manager <i>DHCS will work with CMS and will publish details as they become available</i>	State defined measure		X
<i>Satisfaction with IHSS case manager, home workers, personal care</i>	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	AHRO/CAHPS	X	X
Access to care	Percent of respondents who always or usually were able to access care quickly when they needed it	AHRO/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.

**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		State defined measure		X
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			
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			
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 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

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Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
Access to care	Percent of respondents who always or usually were able to access care quickly when they needed it	AHRQ/CAHPS	X	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
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 will be 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 Quality (AHRQ)/ Consumer Assessment of	X	

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Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
		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 *is working* closely with the State to monitor other measures related to community integration. CMS and the State 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 working to* implement monitoring requirements by doing the following:

- DMHC and DHCS will submit an annual joint report to the Legislature on financial audits performed on Cal MediConnect health plans *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 *works with* stakeholders and CMS to develop 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 audit Cal MediConnect health plans for quality measures and to validate encounter data.

The functions and purpose of the EQRO are standard in all MCP and Cal MediConnect health plan quality and outcome reviews. DHCS is in the process of determining the EQRO vendor and negotiating the contract terms. The EQRO and state and federal funding will be determined later in 2015. As part of the contract, DHCS plans to have the EQRO work with the Cal MediConnect health plans to perform two Performance Improvement Projects (PIPs). The first PIP will be plan specific, and will address specific clinical and non-clinical areas of health care that would improve health outcomes for enrollees. The second PIP will be an all-Cal MediConnect plan PIP where all plans will work together on a certain topic. CMS will also be responsible for a PIP, where there will be one individual chronic care improvement project per plan that targets MA enrollees with multiple or severe chronic conditions. The EQRO will also collect and validate the performance measures for the beneficiaries enrolled in Cal MediConnect for each plan.

In conjunction with Cal MediConnect evaluation efforts, DHCS, CDSS, and CDA will monitor the utilization of medical services and LTSS (including IHSS), and will identify and share publicly on the dashboard any significant changes in aggregate or average utilization among beneficiaries enrolled in Cal MediConnect or the CCI.

For the Managed Long-Term Services and Supports 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 statewide collaborative Quality Improvement Project (QIP) that is currently geared towards decreasing avoidable hospital readmissions. In addition, DHCS conducts regular monitoring efforts of existing health plans that includes the provision of technical assistance, requirements to complete CAPs, requiring annual QIPs 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 will be 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 and 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. DHCS will begin to utilize the measures later in 2015. CMS and DHCS can mutually agree at any time to delete modify, or add new metrics, as deemed necessary to improve reporting going forward.

**Table 4: MLTSS Monitoring Items**

Criteria	Metric	Frequency	Data Source	Expected Outcome
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<i>Enrollment Status</i>	<i>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</i>	<i>Monthly</i>	<i>MEDS Data</i>	<i>100 percent of beneficiaries eligible for MLTSS will either make an MCP selection, or be passively enrolled in each MLTSS county</i>
<i>MCP Changes</i>	<i>Number of beneficiaries who changed MCPs in Geographic Managed Care and Two-Plan model counties</i>	<i>Monthly</i>	<i>MEDS Data</i>	<i>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</i>
<b><i>Criteria</i></b>	<b><i>Metric</i></b>	<b><i>Frequency</i></b>	<b><i>Data Source</i></b>	<b><i>Expected Outcome</i></b>
<i>Primary Care Provider (PCP) Assignment</i>	<i>Number of MLTSS beneficiaries assigned to a PCP</i>	<i>Monthly</i>	<i>Monitoring Report from MCPs</i>	<i>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</i>
<i>Benefit Package</i>	<i>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</i>	<i>Quarterly</i>	<i>DHCS</i>	<i>DHCS will assure compliance with the characteristics of home and community based settings, per Section 1915(c) and 1915(i) (Title 42, United States Code, Section 1396n) regulations and in accordance with implementation/effective dates published in the Federal Register</i>

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<p><i>Plan Readiness – Initial and Ongoing</i></p>	<p><i>DHCS shall submit to the federal Centers for Medicare and Medicaid Services (CMS) its plan for ongoing monitoring of MCPs</i></p>	<p><i>Quarterly, with assessment and reports on network adequacy submitted to CMS no later than 60 days after the close of each calendar quarter</i></p>	<p><i>DHCS</i></p>	<ul style="list-style-type: none"> <li><i>• Network adequacy will be verified on a quarterly basis for the first year</i></li> <li><i>• Plan readiness will be conducted similarly to Healthy Families and Geographic Expansion</i></li> <li><i>• Readiness assessments will be aligned with the Cal MediConnect reporting where possible; DHCS will complete a network certification for each county</i></li> <li><i>• DHCS will assess and monitor MCP capacity for the MLTSS population</i></li> </ul>
<p><i>Criteria</i></p>	<p><i>Metric</i></p>	<p><i>Frequency</i></p>	<p><i>Data Source</i></p>	<p><i>Expected Outcome</i></p>

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<p><i>Participant Rights and Safeguards, Information, and Network Adequacy Requirements</i></p>	<p><i>For network adequacy, in addition to Title 42, Code of Federal Regulations, Section 438, DHCS must:</i></p> <ul style="list-style-type: none"> <li>• <i>Require MCP to refer everyone eligible for in-home supportive services (IHSS) to the county social services agency and support member transition</i></li> <li>• <i>Require MCPs to refer all IHSS recipients to the Public Authorities network of IHSS workers/providers who will be providing services while the recipient waits for a county IHSS worker or the normal IHSS worker cannot provide services</i></li> <li>• <i>Have MCPs submit Memoranda of Understanding (MOUs) between the plan, the counties and Multipurpose Senior Services Program (MSSP) sites</i></li> <li>• <i>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</i></li> <li>• <i>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.</i></li> <li>• <i>Require DHCS to identify all nursing facilities (NFs) that house MLTSS members</i></li> <li>• <i>MCPs should demonstrate adequate capacity in their contracted nursing homes</i></li> </ul>	<p><i>Information is due to CMS prior to implementation and every six months afterward for the term of the demonstration.</i></p>	<p><i>DHCS</i></p>	<p><i>DHCS will ensure the following:</i></p> <ul style="list-style-type: none"> <li>• <i>That MCPs maintain and provide the Public Authority contact information for the adequate network of IHSS workers/providers to support member transition</i></li> <li>• <i>Adequate MOUs are in place to ensure access to care between plan, county, and MSSP sites</i></li> <li>• <i>That MCPs refer all those eligible for MSSP to all contracted MSSP sites</i></li> <li>• <i>Availability of MCP care coordinators for members waiting for MSSP slot</i></li> <li>• <i>That MCPs refer IHSS recipients awaiting a caregiver to other HCBS benefits (CBAS, MSSP) to help meet/bridge their needs</i></li> <li>• <i>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</i></li> </ul> <p><i>DHCS will monitor NFs that house MLTSS members and show the percent that have been contracted by each MCP.</i></p> <p><i>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</i></p>
<i>Criteria</i>	<i>Metric</i>	<i>Frequency</i>	<i>Data Source</i>	<i>Expected Outcome</i>

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<p><i>Quality Oversight and Monitoring – Measurement Activities</i></p>	<p><i>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.</i></p> <p><i>DHCS must provide reports to CMS to demonstrate their oversight of the key elements of the MLTSS program.</i></p> <p><i>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).</i></p> <p><i>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</i></p>	<p><i>Annually</i></p>	<p><i>DHCS</i></p>	<p><i>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</i></p> <p><i>DHCS will analyze MCP reports as part of its quality oversight and based on the results, take corrective action as needed to ensure compliance.</i></p> <p><i>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.</i></p> <p><i>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.</i></p>
<p><i>Complaints/Appeals</i></p>	<p><i>Number/percent of appeals or complaints</i></p>	<p><i>Monthly</i></p>	<p><i>MCPs</i></p>	<p><i>Complaints and grievances will be consistent with what was experienced by MLTSS members prior to transition. MCPs must resolve grievances within required timeframes</i></p>
<p><i>Provider Network Changes</i></p>	<p><i>Additions/deletions of participating providers by MCP</i></p>	<p><i>Quarterly</i></p>	<p><i>MCPs submit quarterly reports to DHCS</i></p>	<p><i>MCP's provider network will remain consistent with the network assessed during readiness.</i></p>
<p><b>Criteria</b></p>	<p><b>Metric</b></p>	<p><b>Frequency</b></p>	<p><b>Data Source</b></p>	<p><b>Expected Outcome</b></p>

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<i>Continuity of Care</i>	<i>Number of continuity of care requests and outcomes for MLTSS members</i>	<i>Monthly</i>	<i>MCPs</i>	<i>MCPs will report all cases of transitioning MLTSS members receiving or requesting continuity of care</i>
<i>Consumer Satisfaction with MCP</i>	<i>MCP Call Center Report for MLTSS members by type of inquiry</i>	<i>Quarterly</i>	<i>MCPs submit quarterly reports to DHCS</i>	<i>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.</i>
<i>Support and Retention of Community Placement</i>	<p><i>Members referred to the HCBS waivers are assessed for the HCBS waiver</i></p> <p><i>Members referred to IHSS are assessed by the county social services agency for IHSS.</i></p> <p><i>Members newly admitted to NFs without a discharge plan in place were first afforded supports and services in the community</i></p> <p><i>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.</i></p> <p><i>Number and proportion of beneficiaries receiving LTSS in the community along with number and proportion of beneficiaries receiving LTSS in an institution.</i></p>	<i>Quarterly</i>	<i>MCPs</i>	<p><i>MCPs will do the following:</i></p> <ul style="list-style-type: none"> <li><i>• Refer members to appropriate services that support retention of community placement</i></li> <li><i>• Track and monitor the number of referrals made to HCBS waivers and the number of completed assessments performed by the HCBS providers</i></li> <li><i>• 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.</i></li> <li><i>• 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</i></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, 2015), CMS pays 50 percent FFP and the State pays 50 percent from the State General Fund.

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

- Ongoing stakeholder engagement and communication that *includes* the development and execution of a communications plan to engage health plans, 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;
- Information technology system development and modification that include modifications to beneficiary enrollment systems, capitation payment systems, claims payment and encounter reporting systems, and data warehouse systems, as needed to support Cal MediConnect;
- 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: Peter J. Eells; Harbage Consulting, LLC; *Public Consulting Group, LLC (PCG)*; 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.

- Peter J. Eells: Mr. Eells has more than 35 years of information technology (IT) experience working in all phases of IT construction including but not limited to: cost/benefit analysis, business requirements, architecture, design, coding, implementation, and post production support. He has led teams of analysts and developers on small and large projects. He has also worked independently on self-directed, various platforms and languages. Prior to consulting with the State, he was the vice president for Citigroup's Citiwest IT development team. Prior to serving at Citigroup, he was vice president in charge of production support for California Federal Bank. For the past eight years, he has provided consultative services to DHCS and the Department of Motor Vehicles.
- 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 (PCG), 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, PCG, 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 (HIPPA) 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 Consultant 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 Health Insurance Portability and Accountability Act and Health Information Exchange Consulting Support Services for the State of California, Office of Health Information Integrity eHealth branch.
- Tyson Wright, PMP, Public Consultant Group, LLC: Mr. Wright, a certified PMP and has more than 12 years of public sector IT experience. He is skilled in data analysis, data mapping, and requirements development, and maintenance. He also has extensive experience in test planning, execution, and management and system development.
- 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 plans for their Medi-Cal benefits, including long-term supports and services (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 several years of policy and planning work, DHCS is mailing notices to beneficiaries and passive enrollment *is underway in most of the CCI counties*. As such, this seems an excellent time to provide an updated vision of the outreach and education work underway to support beneficiaries, their caregivers and providers during this transition.

*Updates to information in the last submitted Fiscal Year 2013-2014 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 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 population today receives their information from established 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 continuity of care for beneficiaries, these providers need information about what the CCI <i>means</i> 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 provide service to.
Local “Guides” and Stakeholders	<p>“Guides” are organizations already supporting the dual eligible population. <i>They</i> need access to information and other resources about the CCI to fulfill their missions. This <i>includes</i> 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 societies, Area Agencies on Aging (AAAs), HICAPs, legal aid societies, other local</p>

	advocacy organizations, legislative aides (all offices, including regional), insurance agents/brokers, county governments and agencies, and tribes and tribal leaders.
Leadership	Advocates, policymakers in the executive and legislative branches (in California and nationally) and opinion leaders. This group <i>needs</i> to understand the CCI as it continues to develop and will also need ongoing information about the status of 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
- 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 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.

### Interagency Coordination

A unique aspect of the CCI is *coordinating* 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 began providing services 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. For outreach around the CCI to be successful, HICAPs need additional funding and training to support 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; and
- Outreach coordinators are 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 Program of All-Inclusive Care for the Elderly (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 toolkit to support local organizations in

training their staffs to assist beneficiaries and providers. In some areas, plans are developing these efforts already, and DHCS can support those efforts as needed.

- This program *includes* assisting and developing a plan for outreach through Benefits Counselors and Legal Advocates;
- Note: this program *includes* an effort to educate these groups on how the substance abuse/mental health benefits will be 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. DHCS *continues to provide* “Train the Trainer” presentations in CCI counties.

#### Health Care Options Training and Staffing

HCO, run by DHCS with MAXIMUS as the contractor, *serves* as a primary contact for beneficiaries as they make their plan choices. DHCS must develop materials to train DHCS/MAXIMUS call center staff so they are familiar with choice packets and prepared to answer questions. It is critical that these materials are available in some permutation to all potential intake points for a provider and/or beneficiary.

#### **Status:**

- *In April 2014*, DHCS *established* a CCI-specific HCO call center where all customer service representatives will provide service only to CCI-eligible beneficiaries. There is a separate CCI-specific HCO phone number for CCI-eligible beneficiaries that routes them directly to that separate call center;
- DHCS has developed, *and periodically refines*, a CCI-specific FAQ *guide* for HCO customer service representatives and provides *daily, weekly, and as needed* training for the representatives; and
- DHCS coordinated with other agencies, particularly CDA, on *developing* those materials.

#### User-Friendly Website

DHCS will continue to update and refine CalDuals.org, a consumer-friendly website through which beneficiaries and their advocates can access relevant information.

**Status:** CalDuals.org is an important source of information for State-level 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*.

### 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 will 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 monthly stakeholder update calls;*
- DHCS hosts quarterly calls or meetings with stakeholders;
- 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 *is utilizing* existing methods of informing consumers of program changes and their choices. Beneficiaries who must choose a Cal MediConnect or Medi-Cal managed care plan 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, which *includes* information on their plan choices.

DHCS *is working* to expand on this outreach, always respecting privacy protections.

**Status:** Existing methods of beneficiary outreach are ongoing. In addition:

- DHCS *continues* to host monthly tele-town hall calls with beneficiaries who have received 60-day notices with their plan choices. During these calls, beneficiaries are able to ask questions of DHCS staff; and
- Outreach coordinators are working with local groups to deliver presentations to beneficiaries where they are, such as senior centers, *senior housing*, and nursing homes for example.

### Provider Outreach

Providers are a trusted source of information for beneficiaries, and their participation in CCI is key to ensuring long-term continuity of care. DHCS *is working* with provider associations to ensure that information flows in a timely manner for gatherings and publications, as well as work to assist with routine member inquiries and clarification.

**Status:** DHCS is in regular contact with provider associations, *medical groups*, *independent practice associations*, and *other providers* to share information and provide materials. The CalDuals.org website offers easy access to provider-specific information, *including a Physician Toolkit*. In addition, the State has partnered with

California Association of Physician Groups (CAPG) to deliver a series of physician group-oriented webinars to CAPG members on key Cal MediConnect topics, and would welcome similar partnerships with other provider associations. DHCS *also partnered* with the California Medical Association (CMA) Foundation to conduct focus groups with physicians to assess their understanding of the CCI and information needs, as well as to distribute physician-focused educational materials.

### 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 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 presented to the Network of Ethnic Physician Organizations and is looking for more opportunities to work with that group. In addition, DHCS is working with New America Media to host an ethnic media roundtable in each CCI county and roundtables in San Mateo, Riverside/San Bernardino, San Diego, Los Angeles, *and Santa Clara* counties have reached a number of ethnic media outlets including those serving the Chinese, Korean, Pilipino, and Spanish-speaking communities among others. In addition, outreach coordinators are delivering presentations in low-income housing complexes, developed materials for Meals on Wheels programs, *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. 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, CBOs, advocacy organizations, and social service agencies.

Coordinators also play a role in direct beneficiary and provider contact. 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 population;
- 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; 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 skills. Experience with health policy – on an advocate or personal level – is preferred but not required. Individuals with experience reaching out to an elderly, disabled, or provider population *are* also given preference. Outreach coordinators go through an intensive training program on the relevant policy and outreach principles.

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

Technical advisors have 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 participate 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*:

- Assist with an initial landscape assessment. This activity primarily consists of outreach coordinators meeting with local stakeholders to understand the unique needs of each county, and to best determine how DHCS outreach efforts can amplify and complement existing work (see Attachment 2 for more information).
- Develop a local, county-specific outreach plan. Using the overall outreach plan context, enrollment information for each county, and the landscape assessment, technical advisors and outreach coordinators develop 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 advocates, local senior centers, and county agencies. They *are* also familiar and work with services such as 2-1-1 through the United Way.
- Work in cooperation with health plans and PACE programs. Technical advisors and outreach coordinators support these groups' beneficiary and provider outreach.
- Work with and inform provider groups. Technical advisors and outreach coordinators work with groups such as the CMA, CMA county affiliates, CAPGs, ethnic and specialty medical societies, local hospital associations, durable medical equipment (DME) suppliers, 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;
  - Support of the HCO enrollment specialists who are stationed at the county eligibility offices to help them advertise their weekly enrollment sessions; and
  - One-on-one listening sessions for relationship building purposes.
- Create a meeting structure for county leaders. If needed and not duplicative around existing local initiatives, the team will develop an infrastructure to support leadership meetings in each CCI county 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. Efforts are made to hire coordinators with appropriate language capabilities throughout the regions.

**Status:** *Since December 2014, a team of five 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 meetings and 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. 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 the year.

## **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;
- General CCI brochure,
- *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 about enrollment, health plan options and problems with your plan, as well as fact sheets on a number of policy topics, available on CalDuals.org.

### 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.*

#### Potential Future Toolkit Components

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

*The first step in the Landscape Assessment is 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.*

The beneficiary audience assessment *then begins* with interviews with at least the following groups:

- 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 managed care plans;
- Leaders of key consumer advocacy organizations;
- Dual eligible beneficiaries; and
- Nursing homes.

The provider audience assessment *is composed of* interviews with at least 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 managed care plans and PACE programs.