California Coordinated Care Initiative Evaluation Strategy

Background

Persons who qualify for benefits under both the Medicare and Medicaid programs, commonly known as dual eligible beneficiaries or simply "dual eligibles," disproportionately have multiple chronic medical conditions and/or cognitive or behavioral health conditions. Because the Medicare and Medicaid programs have different rules and coverage provisions, care for dual eligibles is often fragmented and otherwise poorly managed.

The Affordable Care Act created a new Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare and Medicaid Services (CMS) that, in coordination with the Center for Medicare and Medicaid Innovation, is attempting to develop new approaches to improving care for dual eligible persons. The MMCO has several initiatives underway to find ways to make the two programs work together more effectively. One of these initiatives has provided grants to 15 states to design new models for coordinating care for dual eligible beneficiaries. California is one of these demonstration states.

California Coordinated Care Initiative Core Aims

Much work has been done by multiple groups to prepare for and help design the California Coordinated Care Initiative (CCCI), California's demonstration project for coordinating care for dual eligible beneficiaries. These efforts have led to a number of documents articulating underlying principles, strategic and operational aims, and priorities for the CCCI. The various reports have not yet been fully harmonized, but in the aggregate, they highlight six core aims.

1. Streamlining and simplifying service delivery
2. Reducing fragmentation of care
3. Improving beneficiaries' quality of life
4. Improving beneficiaries' satisfaction with service delivery
5. Improving health outcomes
6. Slowing the growth of health care expenditures

CCCI Evaluation

To assist in interpreting the results of the 15 state dual eligible demonstration programs, CMS has contracted with the Research Triangle Institute (RTI) to conduct a national evaluation of the overall coordinating care initiative. RTI's national evaluation strategy and template is still being developed.

The California Department of Health Care Services (DHCS) has proposed to also conduct a state evaluation to provide more granular and state-specific data than will likely derive from the

RTI national evaluation. To assist in this regard, the DHCS has been discussing an evaluation strategy with the Institute for Population Health Improvement (IPHI) in the University of California Davis Health System.

For a number of pragmatic reasons, the state evaluation will need to align with RTI's national evaluation, and in so far as possible the state will need to use national evaluation metrics so that "apples to apples" comparisons can be made. Since the national evaluation strategy is still evolving, the state evaluation is similarly evolving.

Preliminarily, several evaluation "target areas* have been identified for state-specific evaluation. In focusing on these target areas, IPHI has been mindful that the number of things that would be nice to know about exceeds the number of things for which information can be reasonably and reliably obtained and tracked. Therefore, in considering a state-specific evaluation strategy, IPHI has tried to be both practical and parsimonious in selecting target areas for consideration. The six evaluation target areas highlighted below align with the CCCI's core aims and have at least some validated performance metrics that could be used for evaluation purposes.

1. Beneficiary satisfaction with services across the continuum of care (i.e., per setting) and with care transitions and continuity of care;
2. Health-related quality of life (physical and mental health), including functionality or functional status and relief of pain or comfort in cases of advanced illness;
3. Coordination of care, focusing especially on communication between patient and caregiver post-discharge and in care transitions;
4. Utilization of services (e.g., infrastructure, screening and assessments, facility bed day rates and length of stay), focusing especially on services related to:
    a. potentially avoidable hospitalizations (both admissions and readmissions)
    b. emergency services
    c. medication management
    d. health care associated conditions
    e. mental/behavioral health services
    f. home and community-based services
    g. long term s services and support
5. Expenditures, focusing especially on total or aggregate expenditures per setting of care and risk-adjusted per capita costs; and
6. Outcomes, including
    a. risk-adjusted mortality rates
    b. hospital and other care setting-specific mortality rates
    c. high impact condition-specific morbidity and mortality rates
    d. health care associated condition occurrence rates