# Cal MediConnect

# HEALTH PLAN QUALITY AND COMPLIANCE REPORT

**January 2018**

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## Executive Summary

In January 2012, Governor Brown announced his intent to enhance health outcomes and enrollee satisfaction for low-income seniors and persons with disabilities (SPDs) through shifting service delivery away from institutional care to home and community-based settings. Governor Brown enacted the Coordinated Care Initiative (CCI) by signing Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012),[1] SB 1036 (Chapter 45, Statutes of 2012),[2] SB 94 (Chapter 37, Statutes of 2013),[3] and SB 75 (Chapter 18, Statutes of 2015).[4]

[1] SB 1008 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB1008
[2] SB 1036 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB1036
[3] SB 94 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB94
[4] SB 75 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB75

The CCI included three major components:

1. Cal MediConnect,
2. Mandatory Medi-Cal managed care enrollment for dual-eligibles for their Medi-Cal benefits, and
3. The integration of Long-Term Services and Supports (LTSS).

The CCI-enabling legislation included a provision to discontinue the CCI should the Director of Finance determine it was not cost-effective. It was determined during the 2017-18 Governor's budget that the CCI was no longer cost-effective, and; therefore, in accordance with state law, the program was discontinued. Although CCI was not cost-effective during the initial demonstration period, the Administration determined that certain aspects of the CCI, such as Cal MediConnect, provided the potential to reduce the cost of health care for affected individuals and improve health outcomes. Therefore, based on the lessons learned from CCI, the following components of the CCI have been continued: Cal MediConnect; mandatory Medi-Cal managed care enrollment of dual-eligibles for their Medi-Cal benefits; and the integration of LTSS (with the exception of IHSS) into managed care. Although CCI was discontinued as a program, for ease of reference DHCS will continue to use the term CCI in this document as it pertains to the continuing components.

Welfare and Institutions Code (WIC) Section 14182.17(e)(1)(C) requires the Department of Health Care Services (DHCS) to report to the Legislature, effective January 10, 2014, and for each subsequent year of Cal MediConnect, on the degree to which Medicare-Medicaid Plans (MMPs) in counties participating in Cal MediConnect have fulfilled their quality requirements.

This report describes the degree to which MMPs in counties participating in Cal MediConnect have fulfilled quality requirements as set forth in the MMP contract (three-way contract). The three-way contract was recently updated, and a link to the updated contract will be updated in the next iteration of this legislative report. The current three-way contract template is available for reference.[5]

[5] The current three-way contract template can be found at: http://calduals.org/wp-content/uploads/2018/05/CA-3-Way-contract-FINAL_010918.pdf

# Background

## The Financial Alignment Initiative – Partnerships to Provide Better Care

In July 2011, the Centers for Medicare and Medicaid Services (CMS) announced the opportunity for states and CMS to better coordinate care for beneficiaries eligible for Medicare and Medicaid (Duals) under the Financial Alignment Initiative through two different demonstration models:

1. **Managed fee-for-service** in which a state and CMS can enter into an agreement by which the state would be eligible to benefit from savings resulting from initiatives to improve quality and reduce costs for both Medicare and Medicaid.

2. **Capitated model** in which a state and CMS can contract with health plans (three-way contract) that receive a prospective, blended payment to provide enrolled Duals with coordinated care.

The Financial Alignment Initiative is designed to align the financial incentives of Medicare and Medicaid to provide Duals with a better health care experience. All state demonstrations under the Financial Alignment Incentive are evaluated to assess their impact on the beneficiary's care experience, quality, coordination, and costs. California chose and is testing the capitated model.

## Coordinated Care Initiative

In January 2012, Governor Brown announced the Coordinated Care Initiative (CCI), which is designed to enhance health outcomes and beneficiary satisfaction for low-income seniors and persons with disabilities (SPDs) while shifting service delivery away from institutional care to home- and community-based settings. To implement the CCI, the Legislature passed, and Governor Brown signed, 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), SB 94 (Committee on Budget and Fiscal Review, Chapter 37, Statutes of 2013), and SB 97 (Committee on Budget and Fiscal Review, Chapter 52, Statutes of 2017). This initiative was discontinued in January 2018.

These three major components of the CCI are continuing:

1. A Duals Demonstration Project called Cal MediConnect (California's Financial Alignment Demonstration) that combines the full continuum of acute, primary, institutional, and behavioral health, along with home- and community-based services (HCBS), into a single benefit package, delivered through an organized service delivery system comprised of Medicare-Medicaid plans (MMPs);

2. Mandatory Medi-Cal managed care enrollment for Duals; and
3. Integration of Medi-Cal funded Long Term Services and Supports (LTSS) into Medi-Cal managed care (MLTSS).

Enrollment in the CCI began on April 1, 2014, as described in the implementation schedule titled, "CCI Enrollment Timeline by Population and County."[6]

## Cal MediConnect

Through Cal MediConnect, Duals have access to a wider scope of benefits than many traditional health plans. For example, Cal MediConnect covers dental, vision, non-medical transportation services, and non-emergency medical transportation services.

Access to care and utilization of benefits under Cal MediConnect is convenient due to Cal MediConnect utilizing a high level of care coordination. The Department of Health Care Services (DHCS) and CMS contract with MMPs that oversee and are accountable for the delivery of covered Medicare and Medicaid services for Duals in seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. MMPs are responsible for providing a comprehensive assessment of Duals' medical and behavioral health, LTSS, functional, and social needs, and for ensuring care coordination for enrolled Duals based on these assessments.

Cal MediConnect is designed to offer opportunities for enrollees to self-direct services, to be involved in care planning, and to live independently in the community. Enrollees and their caregivers work with interdisciplinary care teams to develop person-centered, individualized care plans (ICPs).

Cal MediConnect includes enrollee protections that verify enrollees receive high-quality care. CMS and DHCS established a number of quality measures that evaluate overall enrollee experience, care coordination, and support of community living, among many other factors.

Cal MediConnect Demonstration Years (DYs) are listed below:

| Cal MediConnect DY | Calendar Dates |
|---|---|
| 1 | April 1, 2014 – December 31, 2015 |
| 2 | January 1, 2016 – December 31, 2016 |
| 3 | January 1, 2017 – December 31, 2017 |
| 4 | January 1, 2018 – December 31, 2018 |
| 5 | January 1, 2019 – December 31, 2019 |

[6] The CCI Enrollment Timeline by County and Population is available at: http://www.calduals.org/wp-content/uploads/2014/11/CCI-enrollment-by-County-11.20.14.pdf.

## Memorandum of Understanding and the Three-Way Contract

DHCS executed a Memorandum of Understanding (MOU) with CMS on March 27, 2013. The MOU provides federal authority and outlines the parameters for implementing Cal MediConnect.

Specific requirements are outlined in the three-way contracts between the state, CMS, and the MMP(s). These three-way contracts require MMPs to offer quality, accessible care as well as improved care coordination among medical care, behavioral health, and LTSS for enrolled Duals, including a contracting process that facilitates coordinated program operation, enforcement, monitoring, and oversight. The three-way contracts include provisions requiring CMS and DHCS to evaluate the performance of primary-contracted MMPs and their subcontractors. MMPs are held accountable for ensuring that their subcontractors meet all applicable laws and requirements.

The three-way contract template was recently updated and is available on the CMS website.[7]

## Quality Monitoring and Quality Withholds

To verify that Duals enrolled in Cal MediConnect receive high quality care and to encourage quality improvement, both Medicare and Medicaid withhold a percentage of their respective components of the capitation rate paid to each MMP participating in Cal MediConnect. MMPs are eligible for repayment of the withheld amount subject to their performance on a combination of CMS Core and State-Specific quality withhold measures. All of the metrics selected for the quality withhold are part of the larger set of quality metrics used for ongoing health plan monitoring. The quality measures are discussed later in this report.

CMS and DHCS developed the benchmarks that the MMPs are required to meet, which vary depending on the measure and the year. For each measure, MMPs earn a “met” or “not met” designation. MMPs receive the quality withhold payment according to a tiered scale based on the total number of measures met. For example, MMPs that meet 80-100% of measures receive 100% of the withheld amount, and MMPs that meet 60-79% of measures receive 75% of the withheld amount.

In Demonstration Year (DY) 1, the quality withhold was equal to one percentage point based on ten performance measures. These measures focused on key structure and process improvements, including the proportion of initial health assessments completed within the specified timeframe, evidence of the establishment of an enrollee governance board, and evidence of appropriate access to services. The quality withholds increased to two percentage points in DY 2 and three percentage points in DY 3 based on

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[7] The three way contract can be found at the following link: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/California.html

different quality measures focused on clinical processes and outcomes. The three-way contract includes more details about the quality withhold measures, including performance standards.

Starting in DY 2, Cal MediConnect health plans could meet a quality withhold measure in two ways: (1) If the Cal MediConnect health plan met the established benchmark for the measure, or (2) If the Cal MediConnect health plan met the established goal for closing the gap between its performance in the DY prior to the performance period and the established benchmark by a stipulated percentage (typically 10%).

The Core Quality Withhold Measures and State-specific Core Quality Measures are listed in Tables 1 and 2 below along with results that are presently available. Future years' quality withhold measures, benchmarks, and standards are currently in review with CMS and DHCS.

Each MMP is required to report data for quality metrics selected by CMS and DHCS for ongoing monitoring during the demonstration period. There are 85 metrics listed in the MOU that form the quality monitoring efforts of Cal MediConnect. These metrics are similar to those for other states that have approved MOUs for Dual integration efforts. The quality metrics selected are derived largely from standard measurement sets including the Healthcare Effectiveness Data and Information Set (HEDIS), the Health Outcomes Survey (HOS), and the Consumer Assessment of Healthcare Providers and Systems (CAHPS), as well as measurement sets used to evaluate quality in Special Needs Plans (SNPs). In addition, DHCS identified a selected set of metrics to evaluate LTSS quality.

Table 1: Core Quality Withhold Measures

| Core Quality Withhold Measures | | | | | | |
|---|---|---|---|---|---|---|
| Measure Name | Metric # | Measure Steward/ Data Source | Measure Name | Description | Quality Withhold Measure | Additional notes on the measure |
| CW1 | 2.1 | CMS Defined | Assessments | Members with an assessment completed within 90 days of enrollment. | DY 1 | - |
| CW2 | 5.3 | CMS Defined | Consumer Governance Board | Establishment of consumer advisory board or inclusion of consumers on a pre-existing governance board consistent with | DY 1 | - |

| Core Quality Withhold Measures | | | | | | |
|---|---|---|---|---|---|---|
| Measure Name | Metric # | Measure Steward/ Data Source | Measure Name | Description | Quality Withhold Measure | Additional notes on the measure |
| | | | | contractual requirements. | | |
| CW3 | N/A | Agency for Health Research and Quality (AHRQ)/ Consumer Assessment of Healthcare Providers and Systems (CAHPS) (Medicare CAHPS-CAHPS 4.0) | Customer Service | Percent of the best possible score the plan earned on how easy it is for members to get information and help from the plan when needed:<br>· In the last 6 months, how often did your health plan's customer service give you the information or help you needed?<br>· In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect?<br>· In the last 6 months how, often were the forms for your health plan easy to fill out? | DY 1 | - |
| CW5 | N/A | AHRQ/ CAHPS (Medicare CAHPS — CAHPS 4.0) | Getting Appointments and Care Quickly | Percent of best possible score the plan earned on how quickly members get appointments and care:<br>· In the last 6 months, when you needed care right away, how | DY 1 | - |

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

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

| Core Quality Withhold Measures | | | | | | |
|---|---|---|---|---|---|---|
| Measure Name | Metric # | Measure Steward/ Data Source | Measure Name | Description | Quality Withhold Measure | Additional notes on the measure |
| | | | | who discussed it with their doctor and got treatment for it during the year. | | |
| CW11 | N/A | NCQA/ HEDIS | Controlling blood pressure | Percentage of plan members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) for members 18-59 years of age and 60-85 years of age with diagnosis of diabetes or (150/90) for members 60-85 without a diagnosis of diabetes during the measurement year. | DYs 2 and 3 | - |
| CW12 | N/A | CMS Prescription Drug Event (PDE) Data | Medication adherence for diabetes medications | Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. | DYs 2 and 3 | - |
| CW13 | N/A | | | | | |

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

| Core Quality Withhold Measures | | | | | | |
|---|---|---|---|---|---|---|
| Measure Name | Metric # | Measure Steward/ Data Source | Measure Name | Description | Quality Withhold Measure | Additional notes on the measure |
| | | | | | | information regarding this update will be provided at a later date. Stakeholders will have the opportunity to comment on the new criteria and benchmark prior to finalization. |
| *CW4 - Encounter Data was removed due to delays in clarifying encounter submission requirements for California Cal MediConnect health plans | | | | | | |
| *CW9 - Screening for Clinical Depression was removed since the measure is currently suspended. | | | | | | |
| *CW 13 - Encounter Data analysis may be modified for California Cal MediConnect health plans contingent upon the status of encounter submission | | | | | | |
| *Measures with N/A in the Metric # column are based on CAHP, AHRQ, or other national data standards. | | | | | | |

The table below includes data for DYs 1-3. The table will be updated with data for additional DYs in the next report.

Table 2: Demonstration Years Two and Three State-Specific Quality Withhold Measures

| Quality Withhold Measures – State Specific | | | | | | |
|---|---|---|---|---|---|---|
| Measure Name | Metric # | Measure Steward/ Data Source | Measure Name | Description | Quality Withhold Measure | Additional notes on the measure |
| CAW1 | CA1.6 | State-defined process measure | Documentation of Care Goals | Members with documented discussions of care goals | DY 1 | |
| CAW8 | | | | | DYs 2 and 3 | |

| Quality Withhold Measures – State Specific | | | | | | |
|---|---|---|---|---|---|---|
| Measure Name | Metric # | Measure Steward/ Data Source | Measure Name | Description | Quality Withhold Measure | Additional notes on the measure |
| CAW6 | CA1.7 | State-defined process measure | Behavioral health shared accountability | Members receiving Medi-Cal specialty mental health services receiving coordinated care plans as indicated by having an ICP with the primary mental health provider | DY 3 | |
| CAW4 | CA1.12 | State-defined process measure | Interaction with care team | Members who have a care coordinator and have at least one care team contact during the reporting period | DY 1 | |
| CAW9 | | | | Percent of members who have a care coordinator and have at least one care team contact during the reporting period | DYs 2 and 3 | |
| CAW2 | CA2.2 | State-defined process measure | Behavioral Health Shared Accountability | Policies and procedures attached to the MOU with county behavioral health agency(ies) around assessments, referrals, coordinated care planning, and information sharing | DY 1 | |
| CAW5 | CA3.1 | State-defined process measure | Ensuring Physical Access to Buildings, Services and Equipment | Cal MediConnect health plans with an established physical access compliance policy and identification of an individual who is | DY 1 | |

| Quality Withhold Measures – State Specific | | | | | | |
|---|---|---|---|---|---|---|
| Measure Name | Metric # | Measure Steward/ Data Source | Measure Name | Description | Quality Withhold Measure | Additional notes on the measure |
| | | | | responsible for physical access compliance | | |
| CAW7 | CA4.1 | State-defined process measure | Behavioral health shared accountability outcome measure | Reduction in emergency department (ED) use for seriously mentally ill and substance use disorder members | DYs 2 and 3 | |

As shown in Table 3 below, all of the Cal MediConnect health plans that reported data in CY 2014 received 75% or higher of their withhold amount based on quality withhold measures, and three plans received 100% of their withhold amount for the quality withhold measures.[8]

[8] Data on 2014 quality withhold measures is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAQualityWithholdAnalysisResultsReport2014.pdf.

Table 3: Cal MediConnect Quality Withhold Summary for Calendar Year 2014

| CMC Quality Withhold Summary – CY 2014 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | CW1 Assessments Core 2.1 Benchmark: 90% | CW2 Consumer Governance Board Core 5.3 | CAW1 Documentation of Care Goals CA 1.6 Benchmark 90% | CAW2 Behavioral Health Shared Accountability: Policies and Procedures CA 2.2 | CAW4 – Interaction with Care Team CA 1.12 Benchmark 90% | CAW5 – Ensuring Physical Access to Buildings, Services and Equipment CA3.1 | # of Measures Met | # of Measures Not Met | % of Measures Met | % of Withhold Received |
| | Met/Not Met | Met/Not Met | Met/Not Met | Met/Not Met | Met/Not Met | Met/Not Met | Total | Total | Total | |
| Blue Cross | Not Met | Met | Not Met | Met | Met | Met | 4 | 2 | 67% | 75% |
| Molina | Not Met | Met | Not Met | Met | Met | Met | 4 | 2 | 67% | 75% |
| Care1st | Not Met | Met | Met | Met | Met | Met | 5 | 1 | 83% | 100% |
| CHG | Not Met | Met | Met | Met | Met | Met | 5 | 1 | 83% | 100% |
| Health Net | Met | Met | Not Met | Met | Not Met | Met | 4 | 2 | 67% | 75% |
| HPSM | Not Met | Met | Met | Met | Met | Met | 5 | 1 | 83% | 100% |
| LA Care | Met | Met | Not Met | Met | Not Met | Met | 4 | 2 | 67% | 75% |
| IEHP | Met | Met | Met | Not Met | Not Met | Met | 4 | 2 | 67% | 75% |
| **California Averages** | | | | | | | **4.4** | **1.63** | **73%** | **84%** |

Notes

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

## California Evaluation Design Plan

CMS contracted with Research Triangle Institute (RTI) International to evaluate and monitor the implementation of demonstrations under the Financial Alignment Initiative for impacts on a range of outcomes including beneficiary experience, quality, utilization, and cost for the eligible population as a whole, as well to evaluate and monitor for impacts on specific subpopulations (beneficiaries with mental illness and/or substance use disorders, LTSS recipients, etc.). This includes an aggregate evaluation and state-specific evaluations. California's state-specific evaluation is outlined in the California Evaluation Design Plan.[9]

To achieve these goals, RTI International is collecting qualitative and quantitative data from the State each quarter; analyzing Medicare and Medi-Cal enrollment and claims data; conducting site visits, beneficiary focus groups, and key informant interviews. RTI is also incorporating relevant findings from any beneficiary surveys conducted by other entities. Information from monitoring and evaluation activities will be provided to CMS and DHCS in annual reports, followed by a final evaluation report. As of the date of this Legislative report, RTI International is creating an annual report, which will be updated in the next version of this Legislative report.

[9] The California Evaluation Design Plan is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAEvalPlan.pdf.

## Cal MediConnect Reporting Requirements

### Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements and California Specific Reporting Requirements

In November 2013, CMS published the "Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements," which contains the quality evaluation measures that all states participating in the Financial Alignment Initiative are required to report. These core measures address the full range of services and benefits for Cal MediConnect, including medical, pharmacy, LTSS, and behavioral health, as well as care coordination and consumer satisfaction.

In addition to these core reporting requirements, there is a separate reporting appendix for state-specific measures that have been developed with stakeholder input over the course of the planning and implementation phases of Cal MediConnect.[10]

A subset of these quality reporting metrics are included in the Cal MediConnect Performance Dashboard, which shares data on Cal MediConnect MMPs' performance in six areas related to care coordination, quality, and service utilization including: (1) Health Risk Assessments (HRAs); (2) Appeals by Determination; (3) Hospital Discharge; (4) Emergency Utilization; (5) LTSS Utilization; and (6) Case Management.[11] CMS and DHCS collectively monitor this data and provide clarifying and technical guidance to MMPs, as necessary, to support MMPs in maintaining correct and consistent interpretation of the reporting requirements.

DHCS is currently combining the enrollment and performance dashboards into a single dashboard with an expected completion time of early 2018. The new dashboard may contain plan performance results on the National Opinion Research Center quality measures that monitor HRAs, ICPs, and reassessments. The dashboard will be released quarterly. Additional measures, based on stakeholder feedback, will be added into the dashboard as data becomes available.

In addition to the quality measures, per the three-way contract, MMPs are also required to submit all HEDIS, HOS, and CAHPS data, as well as all other measures. HEDIS,

[10] Core measures and state-specific measures are available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2015CoreReportingRequirements121415.pdf.

[11] The Cal MediConnect Dashboard is available at: http://calduals.org/background/cci/evaluations/cal-mediconnect-performance-dashboard/

HOS and CAHPS data must be reported consistent with Medicare requirements. CMS also collects existing Medicare Part D metrics.

## Quality Improvement Project Requirements and Activities

The three-way contract specifies that MMPs are required to conduct a "Chronic Care Improvement Program" (CCIP) as well as a Quality Improvement Program (QIP) following the Plan-Do-Study-Act (PDSA) methodology. MMPs are following all of the Medicare requirements for both of these efforts.

The Health Plan Management System CCIP Module serves as the means for MMPs to submit and report on their CCIPs to CMS and the State. The CCIP and QIP modules allow MMPs to report on the CCIP and QIP throughout the entire life cycle of the CCIP and QIP as defined below:

- **Plan**: Describes the processes, specifications, and outcome objectives used to establish the CCIP. The Plan section of the CCIP is only submitted once (in the fall of the MMP's first operational year). Once approved by both CMS and the State, MMPs begin implementation of the CCIP, including collecting data that will subsequently be used in the Annual Update, which includes the "Do, Study, and Act" sections.

- **Annual Update:** This consists of the "Do," "Study," and "Act" sections and is completed annually, beginning the first year of CCIP implementation and each year thereafter for the duration of the project:

    - **Do**: Describes how the CCIP is conducted, the progress of the implementation, and the data collection plan.

    - **Study**: Describes and analyzes findings against the benchmark(s) or goal(s), as determined by the MMP, and identifies trends over several PDSA cycles that can be considered for the "Act" stage.

    - **Act**: Summarizes the action plan(s) based on findings and describes the differences between the established benchmarks and the actual outcomes, providing information regarding any changes based on actions performed to improve processes and outcomes, including a short description of actions performed.

The topic for the CCIP was "Decreasing Cardiovascular Disease" and the topic for the QIP was "Reducing All-Cause Hospital Readmissions."[12]

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[12] The CCIP and QIP requirements can be found here: http://www.thescanfoundation.org/sites/default/files/field_research_medicare_medi-cal_polling_results_2_12-7-15.pdf.

Since the planning documents were submitted in early 2015, MMPs conducted the Do-Study-Act portions of the methodology by testing their interventions, studying the results, and making changes to interventions, when appropriate, to better achieve their expected outcomes. At the end of each calendar year, MMPs submitted their annual updates to their initial planning documents, describing the actions taken throughout the year and what modifications, if any, were implemented to meet their expected outcomes.

Since the last report, CMS discontinued requiring plans to report on CCIPs. CMS and DHCS have begun to review the current QIP submissions and will conduct final reviews in early 2018. As of 2018, CMS is no longer formally reviewing QIPs; however, they retain the ability to audit the QIPs.

## Performance Improvement Projects

In addition to the CCIP and QIP, in 2016, DHCS began Performance Improvement Projects (PIP) on the topic of improving care coordination with a focus on the integration of the LTSS programs, as required by the three-way contract requirements. This was formerly referred to as the statewide collaborative.

MediConnect health plans commenced a rapid-cycle PIP process in January 2016 that required the submission of five modules. DHCS's External Quality Review Organization (EQRO) conducted module-specific trainings and technical assistance calls to guide MMPs through the process and CMS contracted with Health Services Advisory Group, Inc. (HSAG) to validate the results. MMPs were required to submit and pass Module 1 (PIP initiation) and Module 2 (SMART Aim Data Collection) prior to submitting Module 3 (Intervention Determination). The EQRO reviewed module submissions and provide feedback to MMPs, offering multiple opportunities to fine-tune Modules 1 through 3. Module 4, entitled, "Intervention Testing," utilized PDSA cycles and was the longest phase of the five modules. Module 5 concluded the PIP process by summarizing the project.

This rapid-cycle PIP concluded as of June 30, 2017. All Cal MediConnect health plans submitted their PIP modules 4 and 5 by September 2017 for HSAG validation. HSAG disseminated PIP validation results to eight Cal MediConnect health plans as of October 30, 2017 (two Cal MediConnect health plans' PIP validation results are currently pending). As part of Module 5 validation, HSAG assessed the validity and reliability of the results based on CMS validation protocols and assigned the following final confidence levels for each PIP:

- High confidence – The PIP was methodologically sound, achieved the SMART Aim goal, and the demonstrated improvement was clearly linked to the quality improvement processes implemented.

- Confidence – The PIP was methodologically sound, achieved the SMART Aim

goal, and some of the quality improvement processes were clearly linked to the demonstrated improvement; however, there was not a clear link between all quality improvement processes and the demonstrated improvement.

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

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

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

Table 4: PIP Confidence Levels

| MMP | PIP Topic | Final Confidence Level |
|---|---|---|
| Anthem/CareMore | *Improving Care Coordination by LTSS Programs with a Focus on Community-Based Adult Services (CBAS)* | Low Confidence |
| CalOptima | *Improving In-Home Supportive Services Care Coordination* | Low Confidence |
| Care1st | *Transitioning Cal MediConnect Members from Long-Term Care Facilities Safely Back to the Community* | Low Confidence |
| CHG | *Reducing Inappropriate Acute Hospitalization Admissions from a Nursing Facility* | Confidence |
| Health Net | *Electronic Communication of Care Plans to Providers for Members Who Are in CBAS and MSSP* | Low Confidence |
| HPSM | *Reducing Readmissions from Skilled Nursing Facilities* | Low Confidence |
| IEHP | *Health Risk Assessments* | Confidence |
| L.A. Care | *MLTSS* | Not Credible |
| Molina | *Improving Care Coordination and Integration of LTSS for Members Receiving IHSS Services by Facilitating Their Enrollments in a CBAS Program* | Confidence |
| SCFHP | *Decreasing Potentially Preventable Readmissions LTSS* | Not Credible |

Beginning in November 2017, all MMPs engaged in a new PIP based on two California-specific reporting measures: (1) CA1.5 Members with an ICP Completed, and (2) CA1.6 Members with Documented Discussions of Care Goals.

Unlike the previous MMP PIPs which used HSAG's rapid-cycle PIP approach, MMPs will conduct the new PIPs using HSAG's outcome-focused PIP methodology. The outcome-focused methodology places emphasis on study indicator outcomes and targets for statistically significant improvement over baseline on an annual basis. This PIP methodology is in alignment with CMS PIP Protocols.

## Quality Improvement Strategy – Los Angeles and Orange Counties

MMPs in Los Angeles and Orange counties have also begun a quality improvement strategy, as of April 2017, aimed at reducing hospital admissions for nursing home residents. Through this CMS-led initiative, participating MMPs must develop and implement interventions to reduce avoidable hospitalizations and other adverse events for nursing facility residents.[13]

As of December 2017, MMPs have provided two quarterly reports to CMS and DHCS. Since interventions are different for each MMP, comparisons across plan reports are not practical. However, CMS and DHCS regularly monitor the MMPs in these counties to help them determine if the quality of care has improved and resulted in reductions in overall hospitalizations within the scope of each of the plans' interventions. Results of this quality improvement strategy will be provided in future Legislative reports as the results become available.

## 2016 Consumer Assessment of Healthcare Providers and Systems Results

CMS is committed to measuring and reporting consumer experience and satisfaction. Under the Medicare-Medicaid Financial Alignment initiative, CMS measures consumer experience in multiple ways, including through beneficiary surveys such as the CAHPS survey.

Under the capitated Financial Alignment Model, MMPs are required to annually conduct a Medicare Advantage - Prescription Drug (MA-PD) CAHPS survey. The MA-PD CAHPS survey is designed to measure important aspects of an individual's health care experience, including the accessibility to and quality of services. MMPs are also required to include supplemental questions as part of their annual survey in order to assist with RTI International's independent evaluation of the Financial Alignment Initiative. These supplemental questions delve into areas of greater focus under the

[13] CMS provided a press release on this initiative at the beginning of January 2017. The press release is available at: http://www.calduals.org/2017/01/05/new-initiative-announced-by-state-federal-agencies/

demonstrations, including care coordination, behavioral health, and home and community-based services.

Highlights of the 2016 survey findings include these results:

- Overall, respondents had positive views of their health plan and the quality of their health care. When asked to rate their health plan and their health care on a scale from 0 to 10 (with 0 being the worst possible and 10 being the best possible), 59% of respondents rated their MMP and their health care a 9 or 10 and over 85% of respondents rated their health plan and health care a 7 or higher.

- Respondents reported high levels of access to needed care and prescription drugs, but were less positive about getting appointments and care quickly.

- The majority of respondents reported their doctor communicated well and they found customer service helpful.

Respondents receiving care coordination support expressed satisfaction with the assistance they received.

Survey results for 2016 are available for review.[14] At the time of this report, the 2017 CAHPS survey has been completed, but the results have only recently been provided. Updates for 2017 will be included in the next legislative report.

[14] The complete survey report is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FAICAHPSResultsAug2017.pdf