Cal MediConnect

HEALTH PLAN QUALITY AND COMPLIANCE REPORT

January 2019

Contents

Executive Summary

Updates since the release of the previous Health Plan Quality and Compliance report have been italicized for ease of review.

In January 2012, Governor Brown announced his intent to enhance health outcomes and enrollee satisfaction for low-income seniors and persons with disabilities 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] SB 75 (Chapter 18, Statutes of 2015*),[4] and SB 97 (Chapter 52, Statutes of 2017).*[5]

The CCI included three major components:

1. *A Duals Demonstration Project called* Cal MediConnect,
2. Mandatory Medi-Cal managed care enrollment for *Duals (individuals who are eligible for Medicare and Medicaid),* for their Medi-Cal benefits, and
3. The integration of Long-Term Services and Supports (LTSS) *into Medi-Cal managed care.*

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. Changes to the budget related to the discontinued CCI components included:

- In-Home Supportive Services would no longer be included as a health plan benefit, but would continue to be available to eligible beneficiaries as a fee-for-service benefit.
- The transition of the Multipurpose Senior Services Program from a fee-for-service benefit to a benefit fully supported under the managed care plans would be delayed for two years.
- The State would not proceed with the Universal Assessment Tool.

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

[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
[5] SB 97 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB97

following components of the CCI have been continued: Cal MediConnect; mandatory Medi-Cal managed care enrollment of *Duals* for their Medi-Cal benefits; and the integration of LTSS (with the exception of *In-Home Supportive Services*) 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 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 *will be* updated *in the first quarter of 2019. A* link to the updated contract will be *provided* in the next iteration of this legislative report. The current three-way contract template is available for reference.[6]

[6] 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 *Duals (individuals who are* eligible for Medicare and Medicaid) 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 *enrollee* care experience, quality, coordination, and costs. California is testing the capitated model*, referred to as Cal MediConnect*.

Coordinated Care Initiative

In January 2012, Governor Brown announced the Coordinated Care Initiative (CCI), which is designed to enhance health outcomes and *enrollee* 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 (Chapter 33, Statutes of 2012), SB 1036 (Chapter 45, Statutes of 2012), SB 94 (Chapter 37, Statutes of 2013), *SB 75 (Chapter 18, Statutes of 2015),* and SB 97 (Chapter 52, Statutes of 2017). This initiative was discontinued in January 2018.

Key discontinued components include:

- In-Home Supportive Services (IHSS) would no longer be included as a health plan benefit, but would continue to be available to eligible beneficiaries as a fee-for-service benefit, just as it was before implementation of the CCI:
  - Funding changes implemented under the CCI would end, and funding for IHSS would no longer be included in the capitation rates for plans.
  - Plans and counties would be encouraged to collaborate on care coordination.
- DHCS, in conjunction with the Department of Aging, delayed the transition of the Multipurpose Senior Services Program for two years from a fee-for-service benefit to a benefit fully supported by managed care plans.

- The State does not plan to proceed with the Universal Assessment Tool. However, the State recognizes that a number of the proposed items developed through this process cover important topics that could be useful if addressed during the IHSS in-home assessment and in plans to assess if and how they may be leveraged by the IHSS program.

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 *for their Medi-Cal benefits*; and
3. Integration of 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."[7]

Cal MediConnect

Through Cal MediConnect, *enrollees* 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 *it* 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 *enrollees* 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 *enrollees'* medical and behavioral health, LTSS, functional, and social needs, and for ensuring care coordination for *enrollees* based on these assessments.

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

[7] 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.

Cal MediConnect includes protections that verify enrollees receive high-quality care. CMS and DHCS established *several* 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

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 *enrollees*, including a contracting process that facilitates coordinated program operation, enforcement, monitoring, and oversight. The three-way *contract includes* 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.

Quality Monitoring and Quality Withholds

To verify that *enrollees* in Cal MediConnect receive high quality care and to encourage quality improvement, both Medicare and Medicaid withhold a percentage of the 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 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 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, MMPs could meet a quality withhold measure in two ways: (1) If the MMP met the established benchmark for the measure, or (2) If the MMP 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 CMS Core and State-Specific Quality Withhold 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. In addition, DHCS identified a selected set of metrics to evaluate LTSS quality.

Table 1: CMS Core Quality Withhold Measures[8]

CMS 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	

[8] *The Medicare-Medicaid capitated financial alignment model quality withhold technical notes (DY 2-5) can be found at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/QualityWithholdGuidanceDY2-503142018.pdf*

CMS 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)/ CAHPS (Medicare CAHPS-CAHPS 4.0)	Customer Service	Percent of the best possible score the plan earned on how easy it is for members to get information and help from the plan when needed: · In the last 6 months, how often did your health plan's customer service give you the information or help you needed? · In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? · In the last 6 months how, often were the forms for your health plan easy to fill out?	DY 1	

CMS Core Quality Withhold Measures						
Measure Name	**Metric #**	**Measure Steward/ Data Source**	**Measure Name**	**Description**	**Quality Withhold Measure**	**Additional notes on the measure**
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: · In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? · In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? · In the last 6 months, how often did you	DY 1	

CMS Core Quality Withhold Measures						
Measure Name	**Metric #**	**Measure Steward/ Data Source**	**Measure Name**	**Description**	**Quality Withhold Measure**	**Additional notes on the measure**
				see the person you came to see within 15 minutes of your appointment time?		
CW6	N/A	National Committee for Quality Assurance (NCQA)/ HEDIS	Plan all-cause readmissions	*The ratio of the plan's observed readmission rate to the plan's expected readmission rate. The readmission rate is based on the 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*s 2, 3, 4* and *5*	Lower measure rates mean that readmissions are occurring less often. Therefore reflect better quality of care. *This measure will be removed from the quality withhold analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will also be removed if the MMP's total number of index stays is 10 or fewer.*
CW7	N/A	AHRQ/ CAHPS (Medicare CAHPS –	Annual Flu Vaccine	Percent of plan members who got a vaccine	DYs 2, *3, 4* and *5*	If *an MMP's* score for this measure has very low

CMS Core Quality Withhold Measures						
Measure Name	**Metric #**	**Measure Steward/ Data Source**	**Measure Name**	**Description**	**Quality Withhold Measure**	**Additional notes on the measure**
		Current Version)		(flu shot) prior to flu season.		reliability (as defined by CMS and its contractor in the CAHPS report), this measure will be removed from the *quality withhold analysis*.
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*, 3, 4* and *5*	*This measure will be removed from the quality withhold analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will also be removed if the MMP's HEDIS audit designation is "NA," which indicates that the denominator is too small (<30) to report a valid rate.*

CMS Core Quality Withhold Measures						
Measure Name	**Metric #**	**Measure Steward/ Data Source**	**Measure Name**	**Description**	**Quality Withhold Measure**	**Additional notes on the measure**
CW10	N/A	NCQA/ HEDIS	Reducing the risk of falling	Percent of plan members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	DYs 2, *3, 4* and *5*	*As noted in the Calendar Year (CY) 2018 Medicare Advantage (MA) Call Letter, NCQA made changes to this measure that require revisions to the underlying survey questions in the HOS. As a result, this measure will not be included in the quality withhold analysis until further notice.*
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-	DYs 2, *3, 4* and *5*	*This measure will be removed from the quality withhold analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will*

CMS Core Quality Withhold Measures						
Measure Name	**Metric #**	**Measure Steward/ Data Source**	**Measure Name**	**Description**	**Quality Withhold Measure**	**Additional notes on the measure**
				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.		*also be removed if the MMP's HEDIS audit designation is "NA," which indicates that the denominator is too small (<30) to report a valid rate.*
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, *3, 4* and *5*	*This measure will be removed from the quality withhold analysis if the MMP has 30 or fewer enrolled member-years in the denominator.*
CW13	N/A	Cal Medi-Connect health plan Encounter Data	Encounter Data	Encounter data for all services covered under the demonstration, with the exception of PDE data, submitted in compliance with	DYs 2, *3, 4* and *5*	*If the submission standards cited in an MMP's three-way contract are more stringent than those described in the*

CMS Core Quality Withhold Measures						
Measure Name	**Metric #**	**Measure Steward/ Data Source**	**Measure Name**	**Description**	**Quality Withhold Measure**	**Additional notes on the measure**
				demonstration requirements.		*schedule/criteria above, MMPs will be required to adhere to their contract's standards. This will be noted in the state specific attachments, if applicable.*
*CW4 - Encounter Data was removed due to delays in clarifying encounter submission requirements for California Cal MediConnect health plans						
*CW9 - *This measure* was *retired, and therefore will not be included in* the *quality withhold analysis*.						
*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 1-5.

Table 2: Demonstration Years Two *through Five* State-Specific Quality Withhold Measures[9]

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	*Percent of members* with documented discussions of care goals	DY 1	
CAW8					DYs 2, 3, *4* and *5*	
CAW6	CA1.7	State-defined process measure	Behavioral health shared accountability *process measure*	*Percent of members* receiving Medi-Cal specialty mental health services *that received* care *coordination* 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	

[9] The Medicare-Medicaid capitated financial alignment model quality withhold technical notes (D Y2-5): California-specific-measures can be found at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/CAQualityWithholdGuidanceDY2-5_03162018.pdf

Quality Withhold Measures – State Specific						
Measure Name	**Metric #**	**Measure Steward/Data Source**	**Measure Name**	**Description**	**Quality Withhold Measure**	**Additional notes on the measure**
CAW9				Percent of members who have a care coordinator and have at least one care team contact during the reporting period	DYs 2, 3, *4* and *5*	
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 responsible for physical access compliance	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**
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, 3, *4* and *5*	*For DY 2 through 5, CY 2015 will serve as the baseline year, except for MMPs that began operating in CY 2015 or added a new service area in CY 2015. For those MMPs, this measure will apply as a quality withhold starting in DY 3, with CY 2016 serving as the baseline year for DY 3 through 5.*

As shown in Tables *3A and 3B* below, of the MMPs that reported data in CY *2016, four of the MMPs with data reported performed at a level that qualified them to receive 100 percent of their* quality withhold *payments.* [10]

Table 3A: Cal MediConnect Quality Withhold Summary for Calendar Year 2016 (1 of 2)

Cal MediConnect Quality Withhold Summary for Calendar Year 2016							
	CW 6 – Plan All-Cause Readmissions	CW 7 – Annual Flu Vaccine*	CW8 – Follow-Up After Hospitalization for Mental Illness*	CW11 – Controlling Blood Pressure*	CW12 – Medication Adherence for Diabetes	CW13 – Encounter Data	CAW7 – Behavioral Health Shared Accountability Outcome Measure*
Benchmark	1.00	69%	56%	56%	73%	80%	10% Decrease
Blue Cross	Met	Met	Not Met	Met	Met	Met	N/A
Care 1st	Not Met	Met	Met	Met	Met	Met	Not Met
Community Health Group (CHG)	Met	Met	Not Met	Met	Met	Met	Met
Health Net	Met	Not Met	Not Met	Met	Met	Met	Met
Inland Empire Health Plan (IEHP)	Met	Met	Met	Met	Met	Not Met	Met
LA Care	Met	Not Met	Met	Met	Met	Met	Met
Molina	Met	Met	Met	Met	Met	Met	Met
CalOptima	Met	N/A	Met	Met	Met	Not Met	N/A
Health Plan of San Mateo (HPSM)	Met	Met	Met	Met	Met	Met	Met
Santa Clara Family Health Plan (SCFHP)	Met	Met	Met	Met	Met	Not Met	N/A

[10] CMS released information publically for CY 2016 quality withhold measures and may be reviewed here: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/QualityWithholdResultsReport_CA_DY2_06192018.pdf.

Table 3B: Cal MediConnect Quality Withhold Summary for Calendar Year 2016 (2 of 2)

Cal MediConnect Quality Withhold Summary for Calendar Year 2016						
	CAW8 – Documentation of Care Goals*	CAW9 – Interaction with Care Team*	Total Number of Measures	Total Number of Measures Met	Measures Passed	Withhold MMP Receives
Benchmark	55%	78%	Total	Total	Percent	Percent
Blue Cross	Met	Met	8	7	88%	100%
Care 1st	Met	Met	9	7	78%	75%
Community Health Group (CHG)	Not Met	Met	9	7	78%	75%
Health Net	Met	Met	9	7	78%	75%
Inland Empire Health Plan (IEHP)	Met	Met	9	8	89%	100%
LA Care	Met	Not Met	9	7	78%	75%
Molina	Met	Met	9	9	100%	100%
CalOptima	Not Met	Not Met	7	4	57%	50%
Health Plan of San Mateo (HPSM)	Met	Met	9	9	100%	100%
Santa Clara Family Health Plan (SCFHP)	Met	Not Met	8	6	75%	75%

Notes:

1. *N/A items are not applicable due to low enrollment or inability to meet other reporting criteria.*
2. *A "Met" designation can be earned by meeting the benchmark or the gap closure target. The gap closure target measures closing the gap between the MMP's performance in the prior calendar year and the benchmark by a stipulated improvement percentage (typically 10%).*
3. *An "*" indicates measures that also utilize the gap closure target methodology.*

As shown in Table 4A and 4B below, of the MMPs that reported data in CY 2015, two of the ten MMPs with data reported performed at a level that qualified them to receive 100 percent of their quality withhold payments. [11]

Table 4A: Cal MediConnect Quality Withhold Summary for Calendar Year 2015 (1 of 2)

Cal MediConnect Quality Withhold Summary for Calendar Year 2015						
	CW 1 – Assessments Core 2.1	CW 2 – Consumer Governance Board Core 5.3	CW 3 – Customer Service CAHPS	CW 5 – Getting Appointments and Care Quickly CAHPS	CAW 1 – Documentation of Care Goals CA 1.6	CAW 2 – Behavioral Health Shared Accountability: Policies and Procedures Facilitating CA 2.2
Benchmark	88.2%	100%	86.0%	74.0%	90.0%	100%
Blue Cross	Not Met	Met	N/A	N/A	Met	Met
Care 1st	Met	Met	N/A	Not Met	Not Met	Met
CHG	Not Met	Met	Not Met	Not Met	Met	Met
Health Net	Not Met	Met	N/A	Not Met	Not Met	Met
IEHP	Met	Met	Not Met	Not Met	Not Met	Not Met
LA Care	Met	Met	Not Met	Not Met	Not Met	Met
Molina	Met	Met	N/A	Not Met	Met	Met
CalOptima	Met	Not Met	N/A	N/A	No Met	Met
HPSM	Not Met	Met	Not Met	Met	Not Met	Met
SCFHP	Not Met	Met	N/A	N/A	Not Met	Met

[11] CMS released information publically for Calendar Year 2015 quality withhold measures and may be reviewed here: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/QualityWithholdResultsReport_CA_DY1_06192018.pdf

Table 4B: Cal MediConnect Quality Withhold Summary for Calendar Year 2015 (2 of 2)

Cal MediConnect Quality Withhold Summary for Calendar Year 2015						
	CAW 4 – Interaction with Care Team CA 1.12	CAW 5 – Ensuring Physical Access to Buildings, Services and Equipment CA 3.1	Total Number of Measures	Total Number of Measures Met	Measures Passed	Withhold MMP Receives
Benchmark	90.0%	100%	Total	Total	Percent	Percent
Blue Cross	Met	Met	6	5	83.3%	100%
Care 1st	Met	Met	7	5	71.4%	75%
CHG	Met	Met	8	5	62.2	75%
Health Net	Not Met	Met	7	3	42.9%	50%
IEHP	Not Met	Met	8	3	37.5	25%
LA Care	Not Met	Met	8	4	50%	50%
Molina	Met	Met	7	6	85.7	100%
CalOptima	Met	Met	6	4	66.7%	75%
HPSM	Not Met	Met	8	4	50%	50%
SCFHP	Not Met	Met	6	3	50%	50%

Notes:

1. N/A items were removed from the total number of measures that the MMP was evaluated, due to MMP unable to report.
2. CW4: Due to delays in clarifying encounter submission requirements for California MMPs this was excluded from the quality withhold analysis for CY 2015.
3. CAW3: This measure was suspended for CY 2015 and is therefore excluded from the quality withhold analysis.

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 as 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.[12]

[12] 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

To achieve these goals, RTI International *collects* qualitative and quantitative data from *California* each quarter; analyz*es* Medicare and *Medicaid* enrollment, claims*, and encounter data*; conducts site visits, beneficiary focus groups, and key informant interviews; *and incorporates* relevant findings from any beneficiary surveys conducted by other entities.

RTI International published the Financial Alignment Initiative California Cal MediConnect: First Evaluation Report November 2018.[13] The Evaluation Report provides overviews, processes, successes, and *challenges* in the *areas of: Integration of Medicare and Medi-Cal; Eligibility and Enrollment; Care Coordination; Beneficiary Experience; Stakeholder Engagement; Financing and Payment; Quality of Care; and Medicare Savings Calculation. The following findings are summarized from the report:*

- *About a third of enrollees have received care coordination under Cal MediConnect, during the first two demonstration periods. Those receiving this benefit have responded with positive feedback in a number of surveys and focus groups to say their access to care and quality of life have improved.*
- *The demonstration calls for MMPs to pay for IHSS services; however, MMPs have had no authority to assess or authorize these important LTSS services. Estimates of charges were not provided in advance for planning purposes, charges occurred after the fact and were delayed, and MMPs were at full risk. All MMPs interviewed through 2016 stated this was challenging for their financial planning. In the nearly three years since the California demonstration began, MMPs and county agencies have been developing ways to work together and share information, and develop processes to provide integrated care to enrollees. Promising practices have been emerging, such as co-location of staff, targeted dementia training, and strategic use of data systems to support integration. Some MMPs have made headway in transitioning beneficiaries from long term care facilities back to the community, which is a fundamental goal of the demonstration.*
- *The varied county and MMP approaches and previous county and health plan experience within the California demonstration have led to varied successes and challenges. The evaluation of the demonstration is designed to be model-wide. However, the design of the California demonstration—with its varied types of counties, delivery systems, and MMPs—does not lend itself easily to one overall assessment.*
- *Communicating policies and educating delegated and out-of-network providers has been a struggle for the State, CMS, MMPs, and stakeholders. In counties with multiple MMPs, county LTSS and behavioral health agencies found that they must adapt their systems in order to work with each of the plans; this has not always worked easily. Because of their county and historical linkages, county-*

[13] The Financial Alignment Initiative California Cal MediConnect: First Evaluation Report November 2018 is available at: https://innovation.cms.gov/Files/reports/fai-ca-firstevalrpt.pdf

operated MMPs generally have made more progress towards integration with other county-based LTSS and behavioral health agencies than had commercial plans. Commercial plans that previously had extensive Dual Eligible Special Needs Plan experience also made progress at integrating LTSS because of their understanding of this population and these services. However, early stakeholder concerns of plan readiness have endured. Other MMPs, inexperienced with this population and with the provision of LTSS, have struggled to understand the needs of the dual eligible population and negotiate the complexities of LTSS and behavioral health systems.

- *The State and most MMPs have seen lower than expected enrollment as a problem and they have been working to increase enrollment through streamlining processes, improving continuity of care provisions, new deeming periods, and other program improvements. The demonstration's complex enrollment schedule generated multiple challenges and negative attention, including legal actions. Although many missteps were corrected in the first year of the demonstration, the negative effects lingered. Even in 2016, when explaining the low enrollment rate and the reluctance of providers to participate in the demonstration, interviewees pointed to systems inadequacies, general reluctance of providers to participate in managed care, and to concerns over the transfer of SPDs to managed care that took place prior to the demonstration.*
- *MMPs reported they were attracted to the demonstration by the potential of 456,000 beneficiaries estimated to be eligible for Cal MediConnect. While some opt-outs and disenrollments were expected, as of December 2016, enrollments numbered 113,600. MMPs noted that they had made considerable investments in staff and infrastructure with the expectation that high enrollments would allow them to recoup their upfront investments.*
- *The provision of flexible benefits and the rate structure that rewards MMPs for achieving lower institutional rates are designed to promote care in the community, rather than in institutional settings. Some MMPs have been using flexible Care Plan Options funds strategically to support enrollees at home and divert institutionalizations and to transition enrollees from long-term care facilities to the community. Other MMPs appeared to use these benefits ad hoc, or not at all. Without data showing institutionalization rates, it has not been possible to evaluate the overall effectiveness of these nursing facility diversions or transitions. RTI will analyze institutionalization rates and other measures in future reports as data become available.*
- *The demonstration continues to evolve in 2017 and beyond. The State has stepped up activities designed to improve Cal MediConnect and bolster enrollments. These actions have included fine-tuning enrollee supports, facilitating MMPs to share best practices to improve quality of care, strategic contact with providers linked to high opt-out rates, and reengineering enrollment methods. The state has also undertaken efforts to strengthen health assessment linkages to LTSS referrals by standardizing LTSS Health Risk Assessment (HRA) questions and monitoring the use of flexible benefits.*

In addition to RTI International's November 2018 Evaluation Report, monitoring and evaluation activities will also be reported in subsequent evaluation reports, and in an upcoming final aggregate evaluation report.

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 contain 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.[14]

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) HRAs; (2) Appeals by Determination; (3) Hospital Discharge; (4) Emergency Utilization; (5) LTSS Utilization; and (6) Case Management.[15] 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.

In the first quarter of 2018, DHCS *finalized the combination of* the enrollment and performance dashboards into a single dashboard. The new dashboard *contains* plan performance results on the National Opinion Research Center quality measures that monitor HRAs, ICPs, and reassessments. The dashboard *has been* released quarterly *with updates since*. Additional measures, based on stakeholder feedback, will be added into the dashboard as data becomes available.

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[14] *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/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes.html*

[15] The Cal MediConnect Dashboard is available at: *https://www.dhcs.ca.gov/Documents/CMCDashboard9.18.pdf*

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, 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 Medicare requirements for these efforts.

The Health Plan Management System CCIP Module serves as the means for MMPs to submit and report on their CCIPs and QIPs 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 *MMP* QIP was "*Reducing inpatient hospital readmissions within 30 days of discharging from a hospital."*

Per the QIP and CCIP Resource Document 2018/2019, the CCIP focus area is Promote Effective Management of Chronic Disease. [16]

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 CY, 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 MMPs to report on CCIPs. CMS and DHCS *reviewed* the QIP submissions and *DHCS* will conduct *another round of* reviews in early 2019. As of 2018, CMS is no longer formally reviewing QIPs; however, *per the three-way contract, MMPs are still required to submit their QIPs for review by the state. CMS will* retain the ability to audit the QIPs *as necessary.*

Performance Improvement Projects

2016 – 2017 Performance Improvement Project – Improving Care Coordination

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.

MMPs commenced a rapid-cycle PIP process in January 2016 that required the submission of five modules. DHCS' 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 provided feedback to MMPs, offering multiple opportunities to fine-tune Modules 1 through 3. Module 4, titled, "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 MMPs submitted their PIP modules 4 and 5 in September 2017 for HSAG validation. HSAG disseminated PIP validation results to eight MMPs as of October 30, 2017 (two MMPs' 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:

[16] *The CMS QIP and CCIP requirements are located in the 2018/2019 QIP and CCIP Resource Document, located on the MA Quality website at: https://www.cms.gov/Medicare/Health-Plans/Medicare-Advantage-Quality-Improvement-Program/Overview.html*

- High confidence – The PIP was methodologically sound, achieved the Specific, Measureable, Attainable, Relevant Time-Bound (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 MMP PIPs that HSAG validated as of October 30, 2017.

Table *5*: Performance Improvement Project 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

MMP	PIP Topic	Final Confidence Level
SCFHP	Decreasing Potentially Preventable Readmissions LTSS	Not Credible

The follow up to the 2016-2017 PIP on improving care coordination included DHCS and CMS providing technical assistance, and holding, at a minimum, monthly conversations with MMPs to discuss topics of concern that relate to the PIP such as care coordination and MMP performance against California and national health care measures. DHCS and CMS send questions to the MMPs before the calls about process and outcomes. In each call, best practices are discussed and opportunities for improvement are identified. Based on the efforts initiated in the 2016-2017 care coordination improvement PIP, it was determined that the follow-on 2017-2018 PIP would continue the focus on care coordination through the perspective of ICPs in order to improve the rates of both completed ICPs and ICPs with documented care goals.

When MMPs are not meeting performance targets and are not improving quality, there are financial consequences related to the quality withhold measures (discussed above in this report). For the 2016-2017 PIP, there are related quality withhold measures in the areas of care coordination and interaction with the care team. The 2017-2018 ICP PIP specifically relates to the quality withhold measures, and substandard quality and performance will negatively impact MMP financial compensation.

2017 – 2018 Performance Improvement Project – Individualized Care Plan

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.

DHCS' EQRO conducted specific trainings and technical assistance calls to guide MMPs through the process and CMS contracted with HSAG to validate the results.

Unlike the previous MMP PIPs, which used HSAG's rapid-cycle PIP approach, MMPs *are implementing* 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.

Key phases of the study include: study design; baseline measurement; implementation of quality improvement activities; and re-measurement and evaluation, summarized as: I) Design; II) Implementation and Evaluation; and III) Outcomes.

MMP PIP activities in 2018 included:

- *MMPs submitted the first annual PIP summary form.*
- *HSAG validated and scored the submitted PIPs and provided the completed tools.*
- *Selected MMPs resubmitted PIPs to correct any deficiencies and HSAG validated the resubmissions.*
- *MMPs completed and submitted their first and second progress updates, and HSAG reviewed the submissions, provided feedback and technical assistance as needed.*

The results of HSAG's review of the ICP PIP November 2018 Progress Update are summarized in the table below. In addition to the information provided, HSAG outlined feedback and recommendations in areas such as: being clear on when the initiative started for the applicable population; providing the evaluation data results and analysis for each intervention; ensuring goals are set to achieve statistically significant improvement from the baseline; revising the baseline, and reporting the revised baseline, in appropriate circumstances; and considering not implementing an intervention due to lack of quantitative data on effectiveness. MMPs were asked to address any applicable recommendations when submitting the March 2019 annual submission.

Table 6: ICP MMP PIP Progress Review Update Tool Summary – November 2018

Criteria	***Anthem***	***CalOptima***	***Care 1st***	***CHG***	***Health Net***	***HPSM***	***IEHP***	***Molina***	***SCFHP***
1. The MMP provided an overall progress summary for the PIP that was comprehensive and aligned with the topic.	*Yes*	*Yes*	*Inc*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*
2. The MMP provided an interim rate for all PIP study indicators.	*Yes*	*Yes*	*No*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*
3. The MMP provided an analysis of results that included whether there has been improvement as the PIP has progressed.	*Yes*	*Yes*	*No*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*

Criteria	Anthem	CalOptima	Care 1st	CHG	Health Net	HPSM	IEHP	Molina	SCFHP
4. The MMP provided an update on interventions for the PIP that were active, logically linked to a priority barrier, and can impact outcomes.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
5. The MMP specifically explained how it is evaluating each intervention.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6. The MMP included documentation regarding PDSA.	N/A	Yes	Yes	Yes	N/A	N/A	N/A	N/A	N/A
7. The MMP documented lessons learned.	Yes	Yes	Yes	Yes	N/A	Yes	Yes	Yes	Yes
8. The MMP reported next steps that encompassed identified needs and made sense for the PIP.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A
9. The MMP requested technical assistance.	No	No	No	No	No	No	No	No	No
10. HSAG recommends a technical assistance call with the MMP.	No	No	No	No	No	No	No	No	No

Key: Inc = Incomplete; N/A = Not Applicable / Not Assessed

Regarding the table above, HSAG granted an extension for CareMore and L.A. Care. Feedback from those MMPs will be provided in 2019 and available for the next legislative report.

A similar process to 2018 will take place in 2019 including MMPs submitting their second annual PIP Summary Form (which will include the first re-measurement), HSAG validating and scoring the submitted PIPs, and MMPs submitting progress updates in July and November 2019.

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.[17]

MMPs provide 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. *Reviews by CMS and DHCS of the 2018 third quarter reports are in progress and, as is the standard practice, feedback as appropriate will be provided to and discussed with MMPs. Within the quality improvement initiative, MMPs have the discretion to focus improvements in areas that make best sense for their member population. This approach has led to concentration in areas such as infectious disease prevention, fall prevention and post admission focus and education. In addition, MMPs have identified that, in some cases, a small number of members have accounted for multiple hospital admissions and readmissions in a single year, and have responded by directing resources and efforts to those members.*

Consumer Assessment of Healthcare Providers and Systems Results

2016 Survey 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 to assist with RTI International's independent evaluation of the Financial Alignment Initiative. These supplemental questions delve into areas of greater focus under the demonstrations, including care coordination, behavioral health, and *HCBS*.

[17] 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/

Highlights of the 2016 survey findings include these results:

- Overall, respondents had positive views of their MMP and the quality of their health care. When asked to rate their MMP 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 MMP 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.[18]

2017 Survey 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 MA-PD CAHPS survey. The MA-PD CAHPS survey is designed to measure important aspects of an individual's health care experience, including the access to and quality of services. MMPs are also required to include ten additional 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 further into areas of greater focus under the demonstrations including care coordination, behavioral health, and HCBS.

Highlights of the 2017 survey findings include these results:

- *Respondent characteristics indicated the capitated financial alignment models continue to serve individuals with a range of needs.*
- *For demonstrations with at least two years of measurement, overall views of MMPs and quality of health care improved over time, with respondents more likely to give high ratings (9 or 10) and less likely to give low ones (0 to 6). When asked to rate their MMP on a scale from 0 to 10 (with 0 being the worst possible and 10 being the best possible), 63% of all demonstration respondents rated*

[18] 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

their MMP a 9 or 10 in 2017, compared to 59% in 2016. When asked to rate their health care on the same 0 to 10 scale, 60% of demonstration respondents rated their health care a 9 or 10, compared to 59% in 2016. Close to 90% of respondents rated their MMP and health care a 7 or higher on a scale of 0 to 10 in 2017, compared to over 85% in 2016.

- *Respondents reported high levels of access to needed care and prescription drugs, but were less positive about getting appointments and care quickly.*
- *Respondents receiving care coordination support expressed satisfaction with the assistance they received.*

Survey results for 2017 *are available for review.*[19] *The 2018 survey results are pending and* will be included in the next legislative report.

[19] *The complete survey report is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FAICAHPSResultsDec2017.pdf*