Cal MediConnect

EVALUATION OUTCOME REPORT

January 2020

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Executive Summary

In 2014 the Department of Health Care Services (DHCS), in partnership with the Centers for Medicare & Medicaid Services (CMS) implemented Cal MediConnect, a managed care Financial Alignment Demonstration for individuals dually eligible for Medicare and Medicaid (Duals).

Welfare and Institutions Code section 14132.275(m) requires DHCS to conduct an evaluation, in partnership with CMS, to assess outcomes and the experience of Duals enrolled in Cal MediConnect. DHCS is required to provide a written report to the Legislature after the first full year of demonstration operation, and annually thereafter, and must consult with stakeholders regarding the scope and structure of the evaluation.

This report describes the ongoing monitoring activities and evaluations of Cal MediConnect in late calendar year 2018, and all of calendar year 2019, including an evaluation of the impact on the enrollee experience, quality, utilization, and cost; a rapid-cycle polling project; and an evaluation focusing on the coordination of medical health care, behavioral health care, and Long Term Services and Supports (LTSS).

This report includes two updates:

- In November 2018 the first evaluation report of California's demonstration prepared by Research Triangle Institute International was published, based on results up through calendar year 2016. This report included several successes and challenges for the initial years of the demonstration, although many of the challenges identified in the conclusions have been addressed by subsequent program changes.

- In May 2019 The SCAN Foundation released a partnered evaluation from the University of California, San Francisco and the Institute for Health and Aging regarding the findings from the Rapid Cycle Polling Project.[1] Although confidence in navigating health care was fairly high for all Cal MediConnect enrollees, there were significant differences by race, language, and disability.

DHCS and CMS are committed to addressing areas for improvement, and have ongoing efforts underway to monitor and improve enrollee satisfaction and health outcomes in Cal MediConnect.

[1] The entire report can be found at: https://www.thescanfoundation.org/the-buzz/cal-mediconnect-beneficiaries-continue-reporting-high-satisfaction/.

Background

The Financial Alignment Initiative – Partnerships to Provide Better Care

In July 2011, CMS announced the opportunity for states and CMS to better coordinate care for Duals under the Financial Alignment Initiative through two different demonstration models:

1. **Managed fee-for-service** in which a state and CMS 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 contract with health plans (three-way contract) that receive a prospective, blended payment to provide enrolled Duals with coordinated care.

California is testing the capitated model, under the Cal MediConnect program. 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 Initiative are evaluated to assess their impact on enrollee care experience, quality, coordination, and costs.

Coordinated Care Initiative

The Coordinated Care Initiative (CCI) is authorized by 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).[2]

The CCI initially included three major components, in seven counties[3]:

1. Cal MediConnect, a capitated model Financial Alignment Initiative;
2. Mandatory Medi-Cal managed care enrollment for all Duals for their Medi-Cal benefits, and
3. The integration of all 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; therefore, in accordance with state law, the program was discontinued.

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[2] California legislation authorizing the CCI is searchable here: http://leginfo.legislature.ca.gov/faces/billSearchClient.xhtml.

[3] The seven counties where CCI was implemented are: Los Angeles, Orange, San Diego, San Mateo, Riverside, San Bernardino and Santa Clara.

Resulting changes included:

- In-Home Supportive Services (IHSS) would no longer be included as a Medi-Cal managed care benefit in the CCI counties, but would continue to be available to eligible beneficiaries through local counties.
- The transition of the Multipurpose Senior Services Program (MSSP) from a fee-for-service benefit to a benefit fully supported in Medi-Cal managed care 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 following components of the CCI continued in the seven counties: Cal MediConnect; mandatory Medi-Cal managed care enrollment of Duals for their Medi-Cal benefits; and the integration of LTSS, including nursing facility care and Community Based Adult Services, but with the exception of IHSS, into managed care.

In September 2019, the Department of Health Care Services (DHCS) further announced the intention that MSSP would no longer be covered as a Medi-Cal managed care benefit in CCI counties and would instead operate as a fee-for-service benefit, as it did prior to the implementation of the CCI in 2014. The effective date for the MSSP transition to fee-for-service was anticipated to be January 1, 2021, but has been subsequently delayed. This transition requires an amendment to DHCS' Medi-Cal 2020 1115 waiver. Given the current COVID-19 public health emergency, it was determined that it was not feasible to amend the waiver at this time. DHCS is currently working with CMS to establish a new transition date.

Cal MediConnect

Through Cal MediConnect, enrollees have access to a wider scope of benefits than many traditional Medicare Advantage 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 the high level of care coordination. DHCS and CMS contract with Medicare-Medicaid Plans (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 enrollees' 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 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	January 1, 2020 – December 31, 2020
7	January 1, 2021 – December 21, 2021
8	January 1, 2022 – December 31, 2022

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 amongst 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 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 state and federal laws and requirements.[4]

[4] CMS updated the three-way boilerplate contract in 2019 and the updated version can be found here: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAContract.pdf.
A summary document of changes made to the three-way contract is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAContractSummaryOfChanges.pdf.

Evaluation Activities of Cal MediConnect

Annual Evaluation Report

CMS contracted with Research Triangle Institute International (RTI International) to evaluate and monitor the implementation of state demonstrations under the Financial Alignment Initiative for impacts on a range of outcomes including enrollee experience, quality, utilization, and cost for the eligible population as a whole, as well as to evaluate and monitor for impacts on specific subpopulations (enrollees 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.[5]

The goals of the evaluation are to monitor demonstration implementation, evaluate the impact of the demonstration on enrollee experience, monitor unintended consequences, and monitor and evaluate the demonstration's impact on a range of outcomes for the eligible population as a whole and for subpopulations (e.g. people with behavioral health and/or substance use disorders, LTSS recipients, etc.). To achieve these goals, RTI International is collecting qualitative and quantitative data from the state demonstration projects each quarter; analyzing Medicare and Medicaid enrollment and claims data; and conducting site visits, enrollee focus groups, and key informant interviews. RTI International is also incorporating relevant findings from any enrollee surveys provided by other entities. Information from monitoring and evaluation activities will be provided by RTI International to CMS and DHCS in annual reports, followed by a final evaluation report.[6]

The first evaluation report of California's demonstration, prepared by RTI International, was published in late 2018, based on results up through calendar year 2016. Key conclusions from that report include:

- Health plans, county agencies, stakeholders, and advocates support the fundamental principle that coordinated, integrated care will improve enrollees' lives and ultimately reduce health care costs. 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. Plans' three-way contracts provide flexibility, rather than a consistent statewide system. Consequently, each plan has forged its own approach to develop new systems and processes across multiple state, CMS, and county systems.

[5] 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.
[6] The first annual evaluation report, released in late 2018, is available to view at: https://innovation.cms.gov/Files/reports/fai-ca-firstevalrpt.pdf.

- In the nearly three years since the California demonstration began, plans 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 plans have made headway in transitioning beneficiaries from long term care facilities back to the community, which is a fundamental goal of the demonstration.

- 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.

Implementation and Ongoing Monitoring

CMS' contractor, the National Opinion Research Center (NORC) at the University of Chicago, receives data on behalf of CMS from all MMPs. NORC is responsible for ensuring that the data received from MMPs is submitted in accordance with federal and state-specific reporting requirements. NORC checks the data submitted based on edits and validation checks that were developed for each core and state-specific MMP quality reporting measure.

A subset of these quality reporting metrics are included in the Cal MediConnect Performance Dashboard, which shares data on MMPs' performance in six areas related to care coordination, quality, and service utilization including: (1) Health Risk Assessments (HRA); (2) appeals by determination; (3) hospital discharge; (4) emergency utilization; (5) LTSS utilization; and (6) case management.[7] CMS and DHCS collectively monitor this data and provide clarifying and technical guidance to MMPs, as necessary, to support them in maintaining correct and consistent interpretation of the reporting requirements.

DHCS' Cal MediConnect Performance Dashboard Metrics Summary contains enrollment and demographic information as well as MMP performance results on NORC quality measures that monitor HRAs, ICPs, and reassessments. DHCS releases dashboard updates one month following the completion of each quarter.[8] Additional measures, based on stakeholder feedback, will be added into the dashboard as data becomes available. Most recently, throughout 2019, LTSS data has been added into the dashboard.

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

[8] Dashboards are available at: https://www.dhcs.ca.gov/Pages/Cal_MediConnectDashboard.aspx.

The SCAN Foundation Funded Evaluations

The SCAN Foundation funded two evaluations of the Cal MediConnect program: a Rapid Cycle Polling Project and a longer-term University of California Evaluation, as described below. DHCS worked collaboratively with the SCAN Foundation and stakeholders to develop the content of both evaluations.

Rapid Cycle Polling Project

The SCAN Foundation contracted with Field Research Corporation (FRC) to conduct a Rapid Cycle Polling Project to quantify the impact of Cal MediConnect on California's Duals population in as close to real time as possible. The study compares the levels of confidence and satisfaction of Cal MediConnect enrollees to that of Duals who were eligible for Cal MediConnect, but have chosen not to participate (opt-outs), or who live in a non-Cal MediConnect county. The polling project has completed six waves. FRC completed the first four waves of the polling project, and the University of California, San Francisco, completed the fifth and sixth waves.

In June 2018, the University of California, San Francisco completed the sixth wave of the Cal MediConnect Rapid Cycle Polling Project. This survey included over 2,900 interviews with enrollees who were asked about their confidence and satisfaction with health care, as well as any problems encountered. Enrollees were also asked about their needs for and use of LTSS. The results of the sixth wave were released on October 3, 2018.[9]

A summary of the findings show that Cal MediConnect enrollees' confidence in navigating their health care continues to increase. This increase shows a large majority of enrollees who express confidence that they know how to manage their health conditions (82 percent), how to get questions about their health needs answered (84 percent), and who to call if they have a health need or question (89 percent). In alignment with the first finding, enrollee satisfaction with their health care continues to increase, similar to the results in previous waves. In addition, enrollees were asked about the length of time they had been seeing their current personal doctor. Having a shorter (one year or less) relationship with a personal doctor could be interpreted as a sign of problems with continuity of care. The results of the sixth wave reflected that Cal MediConnect enrollees are reporting longer relationships with their personal doctor, which is a key indicator of the care continuum that is especially important when transitioning to managed care. Lastly, only a small percentage, between 10 and 16 percent of Cal MediConnect enrollees, reported that they encountered problems with their health service (e.g. misunderstandings about their health care services or coverage, doctor they had been seeing was no longer available through their plan).

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[9] The full reports on the polling project findings for waves one through six can be accessed at: https://www.thescanfoundation.org/initiatives/advancing-integrated-care/evaluating-cal-mediconnect/.

University of California Evaluation of Cal MediConnect

In 2014, an evaluation team comprised of researchers from the University of San Francisco, Institute for Health and Aging and the University of California, Berkeley School of Public Health, designed and implemented a three-year research brief of Cal MediConnect. The evaluation team engaged stakeholder input and built upon the national evaluation, and developed, pilot tested, and finalized data collection instruments, and obtained approval from California's Committee for the Protection of Human Subjects. The following research briefs, which often include data from previous years, were conducted for calendar year 2018 and are outlined below.

In January 2018, the SCAN Foundation released a research brief conducted by researchers from the University of California, San Francisco and Berkeley on the provider perspectives of Cal MediConnect. [10] This research brief built upon a July 2016 evaluation of the early impact of Cal MediConnect on various health systems stakeholders, but primarily Cal MediConnect MMPs. Data collected for this research brief included 19 interviews with additional provider stakeholders, including physician providers, provider groups, MMP directors of provider networks, Federally Qualified Health Centers, hospitals, management services organizations, and Long-Term Care providers. Findings included the following general themes:

1. Providers perceived Cal MediConnect to be part of a general trend toward more integrated systems of care.
2. Cal MediConnect's additional benefits added value, though awareness of them could be improved, and access more consistent.
3. For some providers, Cal MediConnect introduced more complexity into their client population, presenting challenges with time and resource management.
4. Many providers experienced challenges navigating enrollee eligibility data, as well as the Cal MediConnect referral and authorization processes.
5. Providers struggled with care transitions without assistance from MMPs.
6. Data collection and reporting processes created challenges for some providers.
7. Low MMP reimbursement rates led some providers to decline participation.
8. Provider contracting arrangements with MMPs varied, sometimes including risk-sharing agreements.
9. Some barriers remained in aligning financial incentives between and across MMPs and providers.
10. Cal MediConnect has facilitated data sharing, though progress varies among MMPs and providers.

In May 2018, the SCAN Foundation released an evaluation conducted by researchers from the University of California, San Francisco and Berkeley on coordinating care for Duals through Cal MediConnect, including the progress made and challenges that

[10] The presentation for these findings and additional information can be found at: http://www.thescanfoundation.org/sites/default/files/provider_perspectives_final_010818.pdf.

remain in coordinating care for Duals.[11] Ninety-four key informant interviews were conducted with health system stakeholders, including Cal MediConnect MMPs, physicians, provider groups, hospitals, Long-Term Care facilities, and Home and Community Based Services providers. Key findings include:

1. State and federal policies recognize that care coordination is an essential part of integrating care for Duals.
2. There is great variation in how MMPs are organizing and delivering care coordination benefits.
3. The Cal MediConnect care coordination benefit encourages collaboration across health system stakeholders.
4. The Cal MediConnect care coordination requirement could improve care transitions across health care settings.
5. The Cal MediConnect care coordination benefit could improve access to HCBS.
6. The Cal MediConnect care coordination benefit has affected California's health care workforce.
7. Awareness about the Cal MediConnect care coordination benefit varies among MMPs, providers, and enrollees.
8. Data sharing barriers remain a significant challenge to successful, non-duplicative care coordination efforts.

In September 2018, the SCAN Foundation released a partnered evaluation from the University of California, San Francisco Community Living Policy Center and the Institute for Health and Aging to assess Cal MediConnect enrollees' experiences with care, including access, quality, and coordination over time.[12] A total of 2,100 Duals completed the first telephone survey in 2016. Of those, 1,291 Duals completed a second survey in both 2016 and 2017. Key findings included:

1. Very few people (less than half of one percent) changed MMPs or disenrolled from Cal MediConnect after one year in the program.
2. Cal MediConnect satisfaction overall was very high (94 percent) with enrollees reporting they were "very" or "somewhat" satisfied with their benefits. Satisfaction with benefits was highest among Cal MediConnect enrollees compared to Duals who opted out or those in non-CCI counties.
3. In both 2016 and 2017, one in five Cal MediConnect enrollees reported delays or disruptions in getting care or services. Those who experienced delays or disruptions in care were asked to describe the delays/disruptions they

[11] The presentation for these findings and additional information can be found at: http://www.thescanfoundation.org/sites/default/files/uc_coordinating_care_for_duals_through_cal_mediconnect_may_2018.pdf.

[12] The presentation for these findings and additional information can be found at: https://www.thescanfoundation.org/sites/default/files/assessing_the_experiences_of_dually_eligible_beneficiaries_in_cal_mediconnect_final_091018.pdf.

experienced. Reported delays/disruptions included, but are not limited to, delays in receiving medical equipment, medication, appointments, difficulty accessing specialists and primary care providers, and trouble finding a primary care provider. Of those who reported delays/disruptions, 61 percent reported the problems were unresolved. However, those using specialty care were more likely to see problems resolved.

4. Primary care visits decreased among Cal MediConnect enrollees between 2016 and 2017, from 3.5 visits down to 2.9 average visits in a six-month period.
5. Two-thirds of Cal MediConnect enrollees used specialty care.
6. Over 70 percent of Cal MediConnect enrollees reported the ability to go to their hospital of choice all the time, and almost 90 percent of those hospitalized reported being ready to go home when discharged.
7. One in five Cal MediConnect enrollees used behavioral health services, and a majority of those took medication for mental health conditions.
8. Cal MediConnect enrollees took an average of six prescription medications. About two-thirds reported having paid out-of-pocket for prescriptions; this is lower than the out-of-pocket expenses reported by non-Cal MediConnect enrollees, of whom three-quarters reporting paying out of pocket.
9. Less than one-third of Cal MediConnect enrollees reported having a care coordinator.
10. Over three-quarters of Cal MediConnect enrollees said their primary care provider seemed informed and up-to-date about their care from specialists; and about 54 percent said their providers usually or always share information with each other.
11. Compared to opt-outs, more Cal MediConnect enrollees reported getting a ride from their MMP to medical appointments.
12. Half of non-English speaking Cal MediConnect enrollees reported they could “never” get a medical interpreter when they needed one.
13. Among Cal MediConnect enrollees, those who need LTSS had lower satisfaction overall, and were almost four times more likely to rate their overall quality of care as fair or poor.
14. Approximately 37 percent of Cal MediConnect enrollees who needed help with routine needs (e.g., household chores, doing necessary business, shopping, getting around outside the home) reported they needed more help, or got no help at all with those activities.

In May 2019, the SCAN Foundation released a partnered evaluation from the University of California, San Francisco and the Institute for Health and Aging regarding the findings from the Rapid Cycle Polling Project.

Key findings include:[13]

1. Confidence navigating health care was fairly high for all Cal MediConnect enrollees, and seemed to increase between 2015 and 2018. While there were no significant differences in 2018 by county, there were some significant differences by race, language, and disability.
2. There were some significant differences across counties in satisfaction with choice of doctors and choice of hospitals by race, language, and disability.
3. There were few differences by county in problems encountered with health care, with the exception of a question only asked of non-English-speaking enrollees about access to interpreters. Those in Santa Clara and San Mateo Counties were the most likely to say they were not provided an interpreter when they needed one.
4. By 2018, Cal MediConnect enrollees in San Mateo County were the most likely to say they had a personal doctor. They were also the most likely to say that their personal doctor was the same doctor they had before they transitioned to Cal MediConnect.
5. There were few differences by county in those who reported having a single care manager, with the exception that Cal MediConnect enrollees in San Mateo County who did have a single care manager were the most likely to say their single care manager was from the plan.
6. There were significant differences by county in the percentage of Cal MediConnect enrollees getting assistance with care needs, getting IHSS, their monthly IHSS hours, and unmet needs for personal care.

As outlined above, many findings displayed positive trends in the measures observed, as well as high enrollee satisfaction ratings. In addition there are areas of dissatisfaction including instances of delays or disruptions in getting care or services, and lower satisfaction overall for enrollees requiring LTSS.

DHCS and CMS are addressing these areas for improvement in a number of ways. First, if an issue is identified for an individual including transportation and interpretation services, DHCS and CMS work directly with the MMP and the enrollee to solve the issue. Next, a key to minimizing delays and disruptions in care is for each enrollee to have a completed HRA, a completed ICP, and an engaged care team. Additionally, DHCS and CMS hold, at minimum, monthly conversations with MMPs to discuss topics of concern such as those above. DHCS and CMS pose questions to the MMPs before the calls about process and outcomes. In each call, best practices are discussed and opportunities for improvement are identified. Further, MMPs are required to do on-going Performance Improvement Projects (PIP) based on two California-specific reporting measures: Members with an ICP Completed; and Members with Documented

[13] The entire report can be found at: https://www.thescanfoundation.org/the-buzz/cal-mediconnect-beneficiaries-continue-reporting-high-satisfaction/.

Discussions of Care Goals. Many of the specific areas of delay and disruption in getting care and services outlined above are being addressed by a comprehensive ICP, more frequent care team interaction, and more active care coordination.

As mentioned above, the 2018 SCAN Foundation findings included lower satisfaction overall for enrollees requiring LTSS. DHCS and CMS are actively involved in initiatives to improve the delivery of LTSS in the area of skilled nursing facility services.

In 2017 and 2018, DHCS published Dual Plan Letters addressed to MMPs that provide guidance and clarification in areas that can decrease delay or disruption in care in areas including: non-emergency medical and non-medical transportation services; PIPs; care plan option services; and HRAs.

Based on the evaluation results outlined above, DHCS is working closely with MMPs and CMS to address the issues raised in the SCAN Foundation findings and through other sources, and improve coordination and integration of care for Duals.