FINANCIAL ALIGNMENT INITIATIVE

California Cal MediConnect Preliminary Second Evaluation Report

Summer 2021

Prepared for
Nancy Chiles Shaffer
Lanlan Xu
Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation
Mail Stop WB-06-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted by
Angela M. Greene and Zhanlian Feng
RTI International
3040 East Cornwallis Road
P.O. Box 12194
Research Triangle Park, NC 27707-2194

RTI Project Number
0214448.001.007.000.000.006

RTI INTERNATIONAL

FINANCIAL ALIGNMENT INITIATIVE
CALIFORNIA CAL MEDICONNECT
PRELIMINARY SECOND EVALUATION REPORT

By

RTI International

Galina Khatutsky, MS
Denise Tyler, PhD
Amarilys Bernacet, MA
Natalie Mulmule, BS
Deanna Okrent, MPA, MA
Emily Costilow, MA
Cleanthe (Cleo) Kordomenos, BA
Giuseppina Chiri, PhD
Hannah Cohen, BS
Allison Dorneo, BA
Nolan Sroczynski, MSPH
Matthew Toth, MSW, PhD
Joyce Wang, MPH
Edith G. Walsh, PhD
Wayne Anderson, PhD

Urban Institute
Timothy Waidmann, PhD

Project Directors: Angela M. Greene, MS, MBA, and Zhanlian Feng, PhD

Federal Project Officers: Nancy Chiles Shaffer, PhD, and Lanlan Xu, PhD

RTI International

CMS Contract No. HHSM-500-2014-00037i TO#7

Summer 2021

This project was funded by the Centers for Medicare & Medicaid Services under contract no. HHSM-500-2014-00037i TO #7. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. RTI assumes responsibility for the accuracy and completeness of the information contained in this report.

Acknowledgments

We would like to thank the State officials who contributed information reflected in this Preliminary Second Evaluation Report through interviews during site visits and quarterly telephone calls. We also thank the Medicare-Medicaid enrollees, managed care plan staff, consumer advocates, and other stakeholders who also answered our questions about their experience and perspectives on the demonstrations. We gratefully acknowledge the many contributions of CMS staff, especially our project officers, Nancy Chiles Shaffer and Lanlan Xu, and our former project officer, Sai Ma. We thank Amy Chepaitis for her careful review of and feedback on this report. Christopher Klotschkow, Catherine Boykin, Roxanne Snaauw, Valerie Garner, and Shari Lambert provided excellent editing, document preparation, and graphic design.

Contents

List of Tables

List of Figures

Glossary of Acronyms

AGA	Average geographic adjustment
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBAS	Community-Based Adult Services
CMS	Centers for Medicare & Medicaid Services
CMT	Contract Management Team
CPO	Care Plan Options; also referred to as MMP flexible benefits
CTM	Complaint Tracking Module
DHCS	Department of Health Care Services
DinD	Difference-in-differences
DME	Durable Medical Equipment
D-SNP	Dual Eligible Special Needs Plan
HCC	Hierarchical condition category
HEDIS	Healthcare Effectiveness Data and Information Set
HRA	Health risk assessment
ICP	Individualized care plan
ICT	Interdisciplinary Care Team
IHSS	In-Home Supportive Services
IME	Indirect medical education
IRE	Medicare Independent Review Entity
ITT	Intent-to-treat
LTSS	Long-term services and supports
MA	Medicare Advantage
MARx	Medicare Advantage Prescription Drug System
MMCO	Medicare-Medicaid Coordination Office

MMP	Medicare-Medicaid Plan
MSSP	Multipurpose Senior Services Program
MOU	Memorandum of Understanding
PS	Propensity score
SDRS	State Data Reporting System
UCP	Uncompensated care payment

Executive Summary

The Medicare-Medicaid Coordination Office and the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) created the Medicare-Medicaid Financial Alignment Initiative to test, in partnerships with States, integrated care models for Medicare-Medicaid enrollees. California and CMS launched the Cal MediConnect demonstration in April 2014 to integrate care for Medicare-Medicaid beneficiaries age 21 years and older. Ten health plans were competitively selected by the State and CMS to operate Medicare-Medicaid Plans (MMPs) in seven counties. MMPs receive capitated payments from CMS and the State to finance all Medicare and Medicaid services. MMPs also provide care coordination and flexible benefits that vary from plan to plan.

The Department of Health Care Services (DHCS) administers Cal MediConnect. The demonstration was implemented in the following seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Individuals eligible for Cal MediConnect include full-benefit Medicare-Medicaid beneficiaries age 21 or older who are enrolled in Medicare Parts A and B and eligible for Medicare Part D and have no other comprehensive private or public health insurance. Individuals participating in the following programs are not eligible to enroll in the demonstration but may do so after disenrolling from their current program: Program of All-Inclusive Care for the Elderly (PACE), the AIDS Healthcare Foundation, or 1915(c) waivers for Home and Community-Based Alternatives (HCBA), HIV/AIDS, or Assisted Living.

CMS contracted with RTI International to monitor demonstration implementation and to evaluate its impact on beneficiary experience, quality, utilization, and cost. The evaluation

includes individual State-specific reports. This Preliminary Second Evaluation Report for the California demonstration describes implementation of the Cal MediConnect demonstration and early analysis of the demonstration's impact. The report includes findings from qualitative data for calendar years 2017, 2018, and 2019 and Medicare cost savings analyses through calendar year 2017. The cost savings results presented are preliminary as risk corridor payments have not yet been included in the calculations.

This report does not contain the results of impact analyses based on service utilization data. Such analyses require enrollee encounter data from MMPs during the demonstration year (2017) as well as fee-for-service utilization data for the eligible but not enrolled and comparison group beneficiaries. It was not possible to conduct the utilization analysis for this report because RTI was unable to deem all encounter data complete. Future evaluation reports will contain utilization impact analyses if all MMP encounter data are deemed complete by RTI. Such analyses will include results for prior demonstration years if encounter data for those years are complete. Future analyses will also include Medicaid claims and encounters as those data become available.

Highlights

In September 2019, Cal MediConnect was extended for 3 more years, through December 31, 2022. Concurrently, the State announced its intent to transition Cal MediConnect into a new integrated delivery system, requiring Medi-Cal managed care plans to offer Dual Eligible Special Needs Plans (D-SNPs) as the integrated care option, beginning in 2023. As Cal MediConnect has matured, general satisfaction among enrollees has remained high, and both RTI and CMS focus group participants reported feeling that enrollment in the demonstration has had a positive impact on their lives. MMPs have received their quality withholds and have invested in creative efforts to better engage beneficiaries and maintain enrollment. For the period covered in this report (2017–2019), overall demonstration enrollment decreased, in part because of significant competition from D-SNP look-alike plans. Enrollment among plans was mixed, with one-half of the MMPs maintaining or growing enrollment and one-half having decreased enrollment. Other challenges reported in site visit interviews with stakeholders during the period for this report included insufficient reach and scope of care coordination, low long-term services and supports (LTSS) referral rates, and some barriers to LTSS access.

Policy Environment	CMS and California extended the demonstration through December 2019. CMS and the State later extended the demonstration for 3 more years through December 31, 2022.
	In 2023 California is planning to transition to California Advancing and Innovating Medi-Cal (CalAIM). CalAIM will implement a broad delivery system, program and payment reform across the State's Medicaid program, Medi-Cal, and includes requiring Medi-Cal plans to offer D-SNPs as the integrated care option statewide.

Integration of Medicare and Medicaid	The State made several changes to LTSS programs in relation to the demonstration. Two major home and community-based services are reverting to fee-for-service waiver programs.
Eligibility and Enrollment	Maintaining enrollment was noted as a challenge by MMPs during this reporting period. By June 2019, overall enrollment declined to 106,933 beneficiaries (DHCS, 2019e) from a high of 124,239 in March 2015 (DHCS, 2015).
	Competition from D-SNP look-alike plans and expanded benefits available in other Medicare Advantage products contributed to decreasing enrollment. Involuntary disenrollment due to interruptions in Medicaid eligibility was also reported as playing a role.
	Several MMPs undertook innovative and targeted approaches to bolster enrollee engagement and education, such as implementing enrollee location teams, conducting outreach to enrollees at risk of disenrollment, and providing benefits education where enrollees receive services.
	CMS and DHCS took multiple steps that might bolster enrollment: (1) an enrollment broker pilot with one MMP that began in mid-2019; and (2) a retrospective financial penalty to be applied as of January 1, 2019, to the Medicare portion of the capitation rate for plans with high voluntary disenrollment rates. This penalty is intended to address selection bias that may be impacting Medicare costs for the demonstration, and to align incentives for MMPs to improve quality for all enrollees.
Care Coordination	State evaluation findings pointed to high satisfaction among those who used care coordination. The State and MMPs took steps to improve care coordination and LTSS access and the rate of individuals receiving LTSS improved by about 10 percent between 2018 and 2019.

Care Coordination (continued)	During 2018–2019, MMPs took plan-specific actions to improve care coordination and completion of health risk assessments (HRAs). These actions included conducting care coordination and administering HRAs themselves, as opposed to having delegated entities perform the activities.
	In 2019, the re-executed three-way contract implemented requirements for additional education about the care coordination benefit and coordination with dental services provided by the Denti-Cal program not affiliated with the MMP.
	In response to previously reported language barriers, the new three-way contract specified that the individualized care plan must be made available in alternative formats and in an enrollee's preferred language.
Beneficiary Experience	Overall, beneficiary satisfaction with the demonstration has remained high, and RTI and CMS focus group participants reported feeling that enrollment in Cal MediConnect has had a positive impact on their lives.
	Plans continued to provide minimal additional flexible benefits, referred to as care plan options (CPOs).
	In 2018 and 2019, stakeholders and plans noted one of the biggest challenges to member engagement was the inability to reach homeless enrollees; several MMPs found creative ways to address this challenge.
	The demonstration's ombudsman reported that enrollees continued to resolve most issues through their MMP or providers without having to seek assistance from the State or the ombudsman. Grievances reported to the ombudsman in 2018 and 2019 primarily related to ride-sharing services and dental service payment and access.
Quality of Care	All MMPs except one received 100 percent of their calendar year 2017 quality withhold payment. This reflects an upward adjustment due to extreme and uncontrollable circumstances for four plans. One MMP received 75 percent. Withhold payments were similar in 2018 and plans we spoke to expected to meet benchmarks in 2019.

Quality of Care (continued)	The new three-way contract increased MMP quality withholds from 3 percent to 4 percent beginning in 2020.
Financing and Payment	MMPs continued to support and invest in the demonstration, despite some plans questioning financial sustainability. Plans raised concerns about the lack of transparency in results of blended Medi-Cal rates and risk corridor calculations, and about significant delays in Medi-Cal rate-setting, reconciliation, and payments. These issues have caused uncertainty about future revenue and made it difficult to manage care to a specific dollar target.
	The new three-way contract instituted a one-sided profit-sharing risk corridor beginning in 2020 that requires MMPs to share gains above a certain threshold with CMS and DHCS.
Demonstration Impact on Cost Savings	***Table ES-1*** summarizes the preliminary regression-based cost savings analyses and indicates significant gross Medicare Parts A and B additional costs among all eligible beneficiaries in the California demonstration (i.e., the intent-to-treat population), compared to those in the comparison group (see appendix ***Table D-8*** for detailed results).[1] A separate analysis, based on MMP enrollees only, shows a consistent pattern of cost increases, compared to their comparison group counterparts (see appendix ***Table D-9*** for detailed results).
	The costs calculated are based on Medicare Parts A and B expenditures either through fee-for-service (FFS) or Medicare Advantage and MMP capitated rates. The estimates do not include Medicare Part D or Medicaid expenditures, nor do they consider the actual payments for services incurred by enrollees and paid by the MMPs.

Table ES-1 summarizes the demonstration effects on total Medicare Parts A and B expenditures. Limited enrollment in the demonstration and the health characteristics of the eligible but not enrolled population contributed to these findings. MMP enrollees accounted for approximately 11 percent of total beneficiary months in our analytic sample. Thus, our findings

[1] The cost savings analysis results presented in this report reflect revised estimates, which are different from those shown in the First Evaluation Report (posted on November 29, 2018). This difference is due to methodological changes to include beneficiaries enrolled in Medicare Advantage as eligible for the demonstration, as well as corrections made to our analytic sample. These changes are described in ***Appendix D***.

are in large part driven by the cost and health profiles of the eligible but not enrolled beneficiaries. Interviews and the State's early disenrollment data analysis found that eligible beneficiaries with higher levels of functional impairment, such as LTSS recipients, and elderly non-English speakers have disenrolled/opted out of the demonstration at a significantly higher rate than other Cal MediConnect eligible beneficiaries. The State also used additional exclusion criteria that RTI was not able to replicate in the comparison group or for the demonstration group in the baseline period (see ***Appendix C*** for details). Further analysis shows that average risk scores and payments for the eligible but not enrolled population were higher compared to the eligible and enrolled population, suggesting greater medical needs in the eligible but not enrolled population (see ***Table D-10*** for details). Together, these factors contributed to the increases in Medicare Parts A and B costs among all demonstration eligible beneficiaries, relative to the comparison group.

Table ES-1
Summary of California demonstration effects on total Medicare expenditures among all eligible beneficiaries

Measure	Measurement period	Demonstration effect
Medicare Parts A and B cost	Cumulative (demonstration years 1–3)	Increase [R]
	Demonstration year 1	Increase [R]
	Demonstration year 2	Increase [R]
	Demonstration year 3	Increase [R]

NOTES: Statistical significance is defined at the α = 0.05 level. Red color-coded shading indicates where the direction of the difference-in-differences (DinD) regression estimate was unfavorable. To ensure accessibility for text readers and individuals with sight disabilities, cells shaded red receive a superscript "R." In the column for "Demonstration effect," an *Increase* or *Decrease* refers to the *relative* change in the outcome for the demonstration group compared to the comparison group, based on the DinD regression estimate of the demonstration effect during the specified demonstration period. For complete cumulative and annual DinD regression estimates, please see appendix ***Table D–8***.
SOURCE: RTI analysis of Medicare claims (program: ca_dy3_1482_reg.log).

SECTION 1

Demonstration and Evaluation Overview

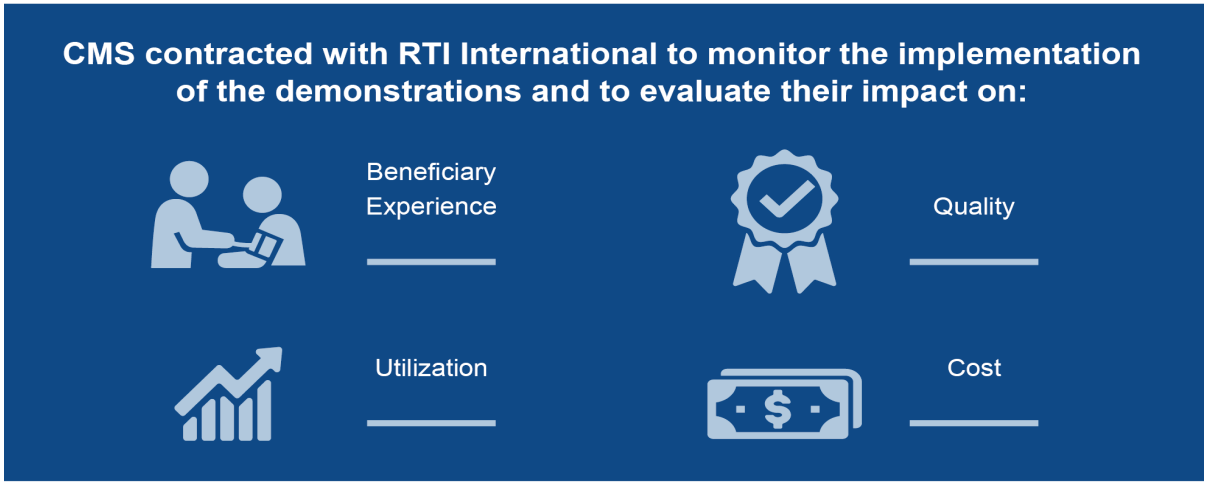
1.1 Demonstration Description

The Medicare-Medicaid Coordination Office (MMCO) and the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) have created the Medicare-Medicaid Financial Alignment Initiative to test, in partnerships with States, integrated care models for Medicare-Medicaid enrollees. California and CMS launched the Cal MediConnect demonstration in April 2014 to integrate care for Medicare-Medicaid beneficiaries age 21 years and older. Ten health plans were competitively selected by the State and CMS to operate Medicare-Medicaid Plans (MMPs) in seven counties. MMPs receive capitated payments from CMS and the State to finance all Medicare and Medicaid services. MMPs also provide care coordination and flexible benefits that vary by plan.

The demonstration was implemented in the following seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Individuals eligible for Cal MediConnect include full-benefit Medicare-Medicaid beneficiaries age 21 or older who are enrolled in Medicare Parts A and B and eligible for Medicare Part D and have no other comprehensive private or public health insurance. Individuals participating in the following programs are not eligible to enroll in the demonstration but may do so after disenrolling from their current program: Program of All-Inclusive Care for the Elderly (PACE), the AIDS Healthcare Foundation, or any of the following 1915(c) waivers: Nursing Facility/Acute Hospital, HIV/AIDS, Assisted Living, and In-Home Operations.

The First Evaluation Report includes extensive background information about the demonstration.

1.2 Purpose of this Report



This report includes qualitative evaluation information for the third, fourth, and fifth demonstration years (calendar years 2017, 2018, and 2019, respectively) with some reference to findings in 2016. This report provides updates in key areas including enrollment, care coordination, beneficiary experience, and stakeholder engagement activities, and discusses the challenges, successes, and emerging issues identified during the reporting period. We also present results on Medicare Parts A & B cost savings through calendar year 2017, the third demonstration year.

1.3 Data Sources

We used a variety of data sources to prepare this report (see below). See ***Appendix A*** for additional detail on data sources.

[This page intentionally left blank.]

SECTION 2

Demonstration Design and State Context

2.1 Changes in Demonstration Design

Cal MediConnect began in April 2014 as a 3-year demonstration that integrated and coordinated acute care with long-term services and supports (LTSS), and non-specialty behavioral health services. LTSS included the State's major LTSS programs: the In-Home Supportive Services (IHSS) program and two waiver programs—the Multipurpose Senior Services Program (MSSP) and Community-Based Adult Services (CBAS).

In January 2017, the California Department of Finance announced the continuation of Cal MediConnect through December 2019, but without IHSS. IHSS would continue to be available to enrollees on an FFS basis but would not be included as an MMP covered service. Thus, associated costs would no longer be in the MMPs' capitated rate after December 31, 2017. CBAS and MSSP continued to be included in the MMPs' capitation rate.

No major changes in the demonstration design occurred during 2018–2019. However, the California Department of Health Care Services (DHCS) made a series of important announcements. In April of 2019, DHCS announced the CMS-approved extension of the Cal MediConnect demonstration to December 31, 2022. The three-way contracts were amended accordingly. The demonstration extension will be accompanied by several other changes going forward; we discuss these changes in more detail in ***Section 3.5, Financing and Payment***:

- An increase from 3 percent to 4 percent in quality withholds for MMP plans, beginning in 2020 to further incentivize quality improvements;
- A new retrospective financial penalty for high disenrollment rates to incentivize better enrollment retention (DHCS, 2019a); and
- A new one-sided profit-sharing risk corridor was implemented beginning in 2020 that requires MMPs to share gains above a certain threshold with CMS and DHCS.

Due to the COVID-19 pandemic in 2020, DHCS extended its 1115(a) waiver for another year, and postponed the managed care carve-out of MSSP until 2022. Effective in 2022, DHCS intends to carve out the MSSP benefit and return the benefit to Medi-Cal FFS in the demonstration counties (DHCS, 2019b).

In October 2019, DHCS announced the California Advancing and Innovating Medi-Cal (CalAIM) Initiative, which includes the transition of Cal MediConnect to a new D-SNP aligned enrollment approach to integrated managed care for dually eligible beneficiaries in 2023 (DHCS, 2019c). (See more information in ***Section 3.1, Integration of Medicare and Medicaid***.)

2.2 Overview of State Context

Cal MediConnect began in 2014 as part of California's larger Coordinated Care Initiative (CCI), under the Bridge to Reform 1115(a) Medicaid Demonstration, which also included mandatory enrollment into managed long-term services and supports (MLTSS) (CMS, 2014). Several major features of the State policy and market environment shaped Cal MediConnect implementation:

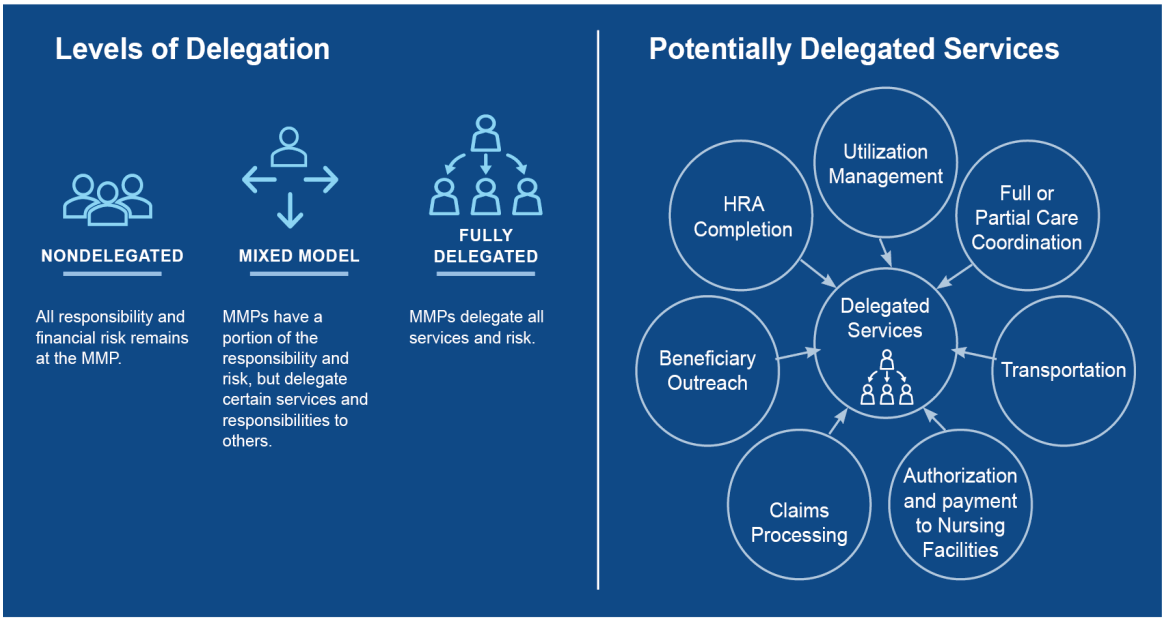
1. The county system administers IHSS, specialty mental health, and substance use services. Coordinating these services in the demonstration requires memorandums of understanding (MOUs) or other alternative arrangements, as well as significant cooperation. In 2017, the carve-out of IHSS reduced resources, modified existing MMP arrangements for coordinating IHSS services and required new processes and procedures; as a result, some county agencies reprioritized their work and reduced their participation in MMP care coordination activities such as interdisciplinary care team meetings.

2. In some counties, "D-SNP look-alike plans," sometimes operated by the same managed care companies as MMPs, have emerged as major competitors to Cal MediConnect, gaining significant enrollment and potentially reducing demonstration enrollment.

3. MMPs and stakeholders reported that the multi-layered delegation of managed care activities to providers (see **Figure 1)** often created confusion for beneficiaries, and was a reporting and quality monitoring challenge.

4. Widespread language and ethnic diversity in the demonstration counties continued to present a unique challenge for delivering language and culturally concordant care and providing beneficiary education.

Figure 1
Variation in MMP delegation arrangements among Cal MediConnect MMPs



Federal funding for the demonstration. Federal funding from CMS and the Administration for Community Living supports the Cal MediConnect Ombudsman program, which is operated by the Health Consumer Alliance. CMS provided DHCS $1.37 million in 2017, and $1.49 million in annual awards in 2018 and 2019, to support this network of ombudsman offices, located in each demonstration county. CMS also made a separate award to the California Department of Aging for State Health Insurance Program/Aging & Disability Resource Center (SHIP/ADRC) work in December 2017 for $500,000 per year to support enrollment counseling. In August 2020, the State received a $1.49 million to support the ombudsman offices from August 2020 through July 2021.

[This page intentionally left blank.]

SECTION 3

Update on Demonstration Implementation

In this section, we provide updates on important aspects of the demonstration that have occurred since the First Evaluation Report. This includes updates on integration efforts, enrollment, care coordination activities, stakeholder engagement activities, financing and payment, and quality management strategies.

3.1 Integration of Medicare and Medicaid

In 2017 through 2019, the CMT held monthly calls with the MMPs. Calls focused on best practices across a variety of topics, such as coordination of behavioral health and LTSS services, data reporting improvements, and improving access to durable medical equipment (DME).

MMPs continued to express difficulty coordinating with local agencies for IHSS absent the formal relationship that existed when IHSS were included in MMP capitation.

The State believed that administrative and operational challenges for MMPs to meet both Medicare and Medi-Cal rules and regulations made it hard to achieve true integration.

In this section we discuss the joint management of the demonstration, as well as updates to the successes and challenges of developing an integrated delivery system at the plan and provider level. We also describe State plans for the future integration of Medicare and Medicaid in California.

Cal MediConnect's early successes included the State and CMS' joint management of the demonstration, the relationships that the 10 MMPs[2] forged with community-based organizations and county-based agencies to provide the full range of Medicare and Medicaid services. In 2017 the CMT covered an array of programmatic improvements such as assisting MMPs to refine and improve assessments and care plans. In 2018 and 2019, the CMT continued to hold monthly calls with the MMPs; each call covered included a focused topic geared toward best practices. This allowed MMPs to learn from one another about a variety of topics, such as better coordination of behavioral health and LTSS services, data reporting improvements, and improving access to DME.

MMPs expressed difficulty coordinating with IHSS agencies after the Governor's 2017–2018 budget carved out IHSS and thereby dissolved previously established formal relationships. DHCS reported that after these services were carved out from Medi-Cal managed care, including Cal MediConnect plans, only one plan successfully put in place an MOU with their county IHSS agency.

In October 2019, DHCS announced the California Advancing and Innovating Medi-Cal (CalAIM) Initiative, which included the transition of Cal MediConnect to a new D-SNP aligned

[2] Effective January 1, 2019, Care 1St Health Plan's name changed to Blue Shield of California Promise Health Plan, and CareMore's name changed to Anthem Blue Cross Partnership of California (or simply Anthem).

enrollment approach to integrated managed care for duals in 2023. This reform will include statewide standardized managed care enrollment and benefits as well as coordination of statewide managed LTSS. Under this proposal, Medi-Cal managed care organizations with existing managed LTSS (MLTSS) plans will be expected to establish a matching Medicare D-SNP. The State hopes that this will enable plans to expand integrated care options without the administrative complexities of operating Cal MediConnect MMPs. The State believes that the administrative and operational challenges for plans to meet both Medicare and Medi-Cal rules and regulations made it hard to achieve true integration via MMPs. As a State representative shared:

> *There have been a lot of administrative challenges in operating those plans, particularly when you're trying to play by both the Medicare and Medi-Cal rules. [… This new model is] going to provide that integration because it will be the same plan owning both of the benefits without some of those administrative complexities that the demonstration was offering.*
>
> – State Official (2019)

3.2 Eligibility and Enrollment

Maintaining enrollment was one of the biggest challenges reported by the MMPs we spoke to. These MMPs pointed to changing market forces as the main reasons for enrollment challenges.

Overall demonstration enrollment declined during this time period. Enrollment among plans was mixed, with one-half of the MMPs maintaining or growing enrollment and one-half having decreased enrollment.

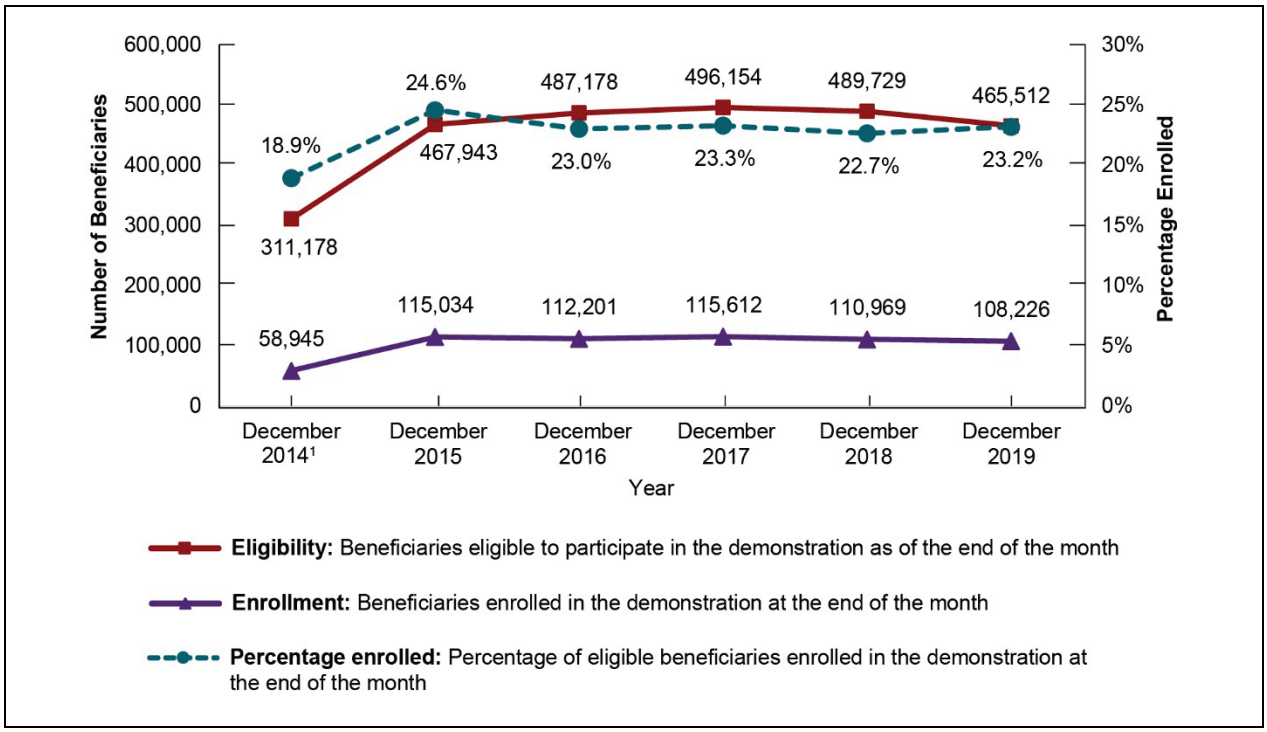
Several MMPs took innovative approaches to bolster member engagement and education, such as implementing member location teams, conducting outreach campaigns to target enrollees at risk of disenrollment, and providing benefits education where enrollees receive services.

In this section we provide updates on eligibility and enrollment processes, including integration of eligibility systems, enrollment methods, and outreach. We also outline significant events affecting enrollment patterns during the report timeframe.

Streamlined enrollment and 2016 changes to continuity of care and deeming—which considers a beneficiary eligible for a period of time pending re-establishing eligibility—initially led to enrollment growth, from 112,201 in December 2016 to 115,612 in December 2017. This growth did not continue; enrollment declined through 2018 and 2019, to 108,226 in December

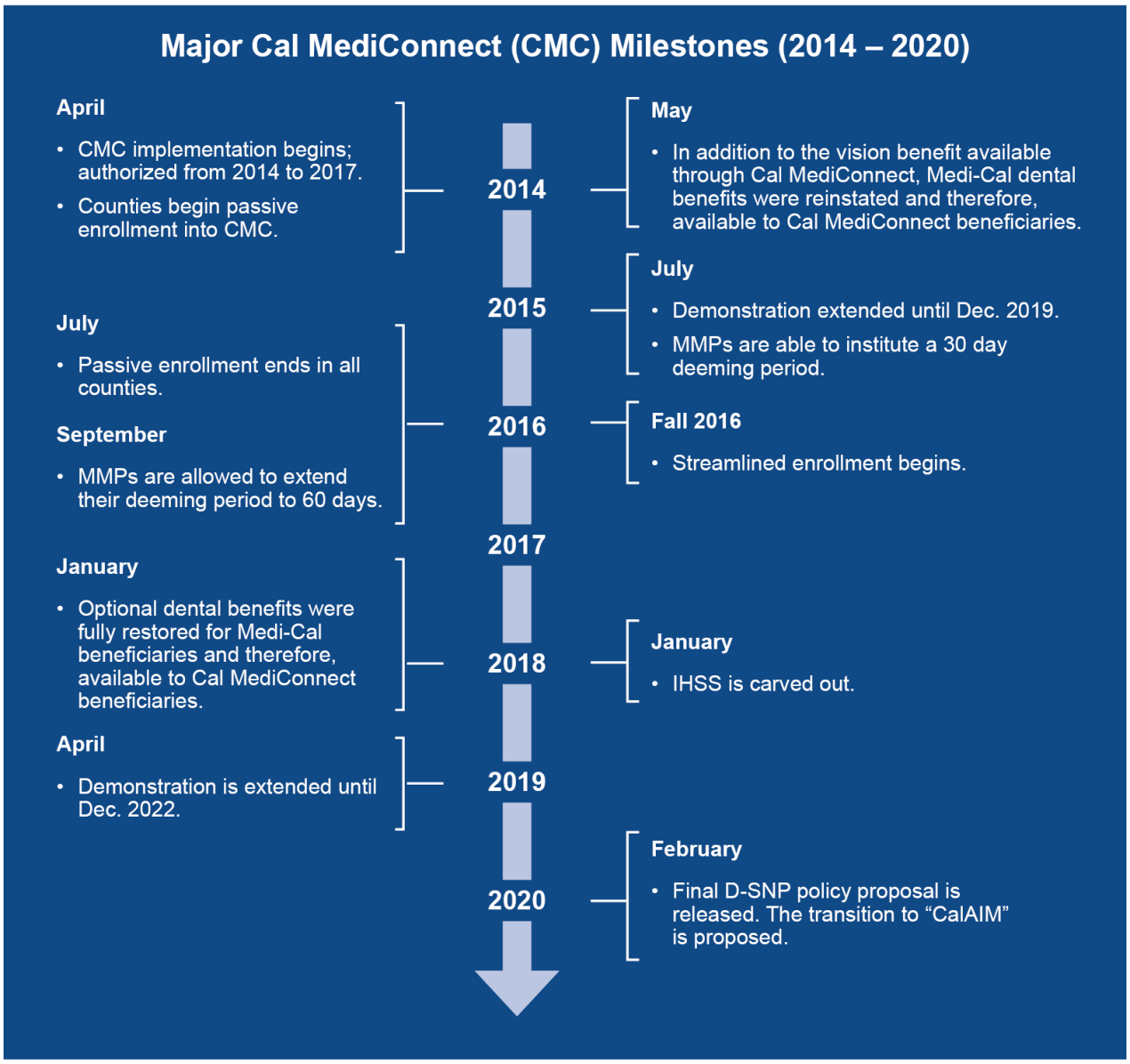
2019. However, enrollment among plans was mixed with half of the MMPs maintaining or growing enrollment and half having decreased enrollment during this time. Some MMPs reported focused and creative efforts to enroll and retain beneficiaries, as we discuss later in this section. ***Figure 2*** shows demonstration enrollment in California for the demonstration period 2014–2019. Although DHCS never planned or expected full enrollment into the demonstration, as indicated in ***Figure 2***, even at the peak of enrollment (2015), Cal MediConnect has never enrolled more than one-quarter of all eligible beneficiaries. ***Figure 3*** shows the enrollment timeline with major milestones.

Figure 2
Demonstration eligibility and enrollment, 2014–2019



[1] Cal MediConnect began operating in April 2014. Enrollment indicators are for the operating period of April to December 2014.

Figure 3
Major Cal MediConnect Milestones (2014–2020)



CMC = Cal MediConnect; D-SNP = Dual Eligible Special Needs Plan; IHSS = In-Home Supportive Services; MMP = Medicare-Medicaid Plan.

According to the new three-way contract finalized in September 2019, to further incentivize enrollment retention of Cal MediConnect enrollees, in 2020 CMS implemented a retrospective financial penalty in the Medicare A/B portion of the capitation rate for MMPs with high disenrollment rates. This penalty is intended to address selection bias that may be impacting Medicare costs for the demonstration (see ***Section 5.2, Demonstration Impact on Cost)***, and to align incentives for MMPs to improve quality for all enrollees. The penalty does not include enrollees who were involuntarily disenrolled due to loss of Medi-Cal eligibility.

In 2018, the State announced a pilot program that would allow MMPs to compensate brokers when a beneficiary chooses to enroll and stay in a plan, as is commonly done by MA plans but was prohibited of Cal MediConnect MMPs. This pilot began in mid-2019 and L.A. Care was the only MMP currently participating. Due to the recent implementation of this pilot, its effect on enrollment is not yet known. However, in 2019 another MMP spoke enthusiastically about the pilot:

We are excited about the potential from the broker pilot that was launched earlier this year with L.A. Care participating. That could offer an opportunity to grow the program at a rate that will allow for net positive enrollment month after month. Checking the State's reports over the last three months, L.A. Care has seen net positives which most plans haven't seen in a while, so hopefully that will support robust growth in the program moving forward.

– MMP Official (2019)

Some stakeholders, however, reported being opposed to the broker pilot. In 2018, one stakeholder said that "brokers bring more confusion and opportunity for disruption," primarily because they misinform beneficiaries about the benefits of the demonstration compared to other products.

3.2.1 Disenrollment Experience

Although two of the eight plans we spoke to in 2018 and 2019 reported net gains in enrollment, most plans continued to experience greater disenrollment than enrollment, resulting in net enrollment losses through mid-2019. For example, one MMP said:

...[W]e enroll close to 300 and we get disenrollment of close to 350, so every month instead of growing we lose little by little.

– MMP Official (2019)

Plans pointed to changing market forces such as competition from D-SNP look-alike plans and expansion of supplemental benefits in other MA products, different marketing regulations from the commercial side, and lack of awareness and misinformation about Cal MediConnect as the main reasons for enrollment challenges.

MMPs and stakeholders also described eligibility issues as a major contributor to disenrollment. Beneficiaries often lose their Medicaid eligibility due to delays in submitting their recertification paperwork or State delays in processing their recertification. California and CMS instituted "deeming," which considers a beneficiary eligible for a period of time pending re-establishing their Medi-Cal eligibility, and hence their eligibility for the demonstration.

In 2016, the State increased the deeming period during which beneficiaries can re-establish their Medi-Cal eligibility from 30 to 60 days. In 2019, one MMP reported that it built a best practice outreach effort around this extension:

…[T]he deeming helps because [the State] does give [beneficiaries] two months…. we also have an established outreach campaign to reach to those members, to let them know they're in this status and kind of guide them through the process of working with the county to get recertified.

– MMP Official (2019)

3.2.2 Enrollment Outreach

Some MMPs undertook innovative and targeted approaches to bolster enrollee engagement and education, such as implementing enrollee location teams, conducting outreach campaigns targeting enrollees at risk of disenrollment, and conducting benefits education where enrollees receive services.

Another MMP reported having a special work group to examine reasons for disenrollment and develop methods for improvement:

We also have a work group where we look at the disenrollment reasons and we do see where the member sometimes says, 'well, my specialist does not accept [Cal MediConnect] or my doctor told me to disenroll.' So, we identify issues or opportunities during that work group, and then we try to address those specifically.

– MMP Official (2019)

Additionally, an advocate reported that some MMPs have been administering HRAs in person to better engage with enrollees, which was not happening early in the demonstration, given the initial high volume of enrollees. One MMP reported extending customer service hours, including adding service hours on Saturday, to better serve enrollees. Another MMP reported conducting outreach at several points in the year to see how enrollees are doing, identify issues or concerns, and remind enrollees of their annual physical. This same plan also structured its call center so that the same customer service representative addresses a member's issue from beginning to end, to better build rapport and ensure a resolution.

Although the plans were unable to reach about one-fifth of their enrollees in 2019, ***Table 1*** shows some success in plan outreach efforts: the percentage of enrollees that plans were unable to reach has steadily decreased over the course of the demonstration.

Table 1
Percentage of members that Cal MediConnect plans were unable to reach following three attempts, within 90 days of enrollment, 2014–2019

Quarter	Calendar year 2014	Calendar year 2015	Calendar year 2016	Calendar year 2017	Calendar year 2018	Calendar year 2019
Q1	N/A	34.6	23.2	25.9	28.2	18.7
Q2	15.0	37.2	32.5	25.3	30.4	20.2
Q3	43.5	38.5	34.5	24.4	25.5	22.3
Q4	47.8	37.1	26.2	32.2	23.5	25.0

MMP = Medicare-Medicaid Plan; N/A = not applicable; Q = quarter.
NOTES: Because the California demonstration began in March 2014, data are not applicable for quarter 1 of 2014.The California demonstration began in quarter 2 of 2014 with opt-in enrollment in San Mateo County; therefore data for that quarter are limited. Data presented for quarter 2 of 2014 represent six plans (Care1st, Community Health Group, HealthNet, Inland Empire Health Plan, Molina Healthcare, and Health Plan of San Mateo). In quarter 3 of 2014, Anthem Blue Cross and L.A. Care began reporting data; in quarter 1 of 2015, Santa Clara Family Health Plan began reporting data; in Q3 2015, Cal Optima began reporting data. From 2016 forward, all 10 plans were reporting data for the measure. As of January 1, 2019, the ten plans reporting are: Anthem, Blue Shield (formerly Care 1st), CalOptima, Community Health Group, HealthNet, Inland Empire Health Plan, L.A. Care, Molina Healthcare, and Santa Clara Family Health Plan.
SOURCE: RTI analysis of MMP-reported data for Core Measure 2.1 as of July 2020. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

3.3 Care Coordination

During the period of this report, the State and MMPs took steps to improve care coordination and LTSS access. The rate of individuals receiving LTSS improved by approximately 10 percent between 2018 and 2019, reflecting specific efforts to increase LTSS referrals.

Two county-based MMPs demonstrated success in creatively allocating funds for transitioning institutionalized beneficiaries back to community.

Meeting the needs of linguistic minorities remained challenging. Despite concerted efforts by MMPs, stakeholders reported that enrollees do not appear to have clear information about how to access interpreter and other legally-mandated language access services.

In response to earlier challenges in coordinating with behavioral health providers, by 2018, several MMPs and stakeholders reported significant progress using various approaches, such as co-locating MMP and county behavioral health staff to improve cooperation.

In this section, we provide a summary of the Cal MediConnect care coordination model. We highlight the status of and progress in key care coordination components and processes: assessment, care planning, LTSS coordination, and information exchange. We also discuss beneficiary experience with care coordination in ***Section 4, Beneficiary Experience***.

Some stakeholders continued to report care coordination delivery to be a challenge during the period covered by this report. Some of these challenges centered on LTSS services. Among surveyed Cal MediConnect enrollees who reported needing LTSS, 37 percent reported having an unmet need for routine needs (e.g., household chores, shopping, getting around outside the home) and 25 percent reported an unmet need for personal care (e.g., assistance with bathing, toileting) (Graham et. al., 2018). According to beneficiary advocates, coordination with and use of LTSS remained low. As discussed in ***Section 3.1, Integration of Medicare and Medicaid***, some challenges stemmed from the IHSS carve-out, because only a small number of MMPs retained productive working relationships with the county agencies. One MMP official stated:

We're still working in partnership with the county agency that operates and manages the IHSS program, so one of the benefits of it was that we still have a strong relationship with [the county] counterpart on that.

– MMP Official (2019)

By contrast, MMPs who did not have strong, previously established relationships with counties noted collaborating and coordinating IHSS became more challenging after the carve-out. As a DHCS contractor shared:

Some of the challenges that the plans reported are in referrals. [Before the carve-out] a lot of them had developed streamlined processes for getting IHSS referrals over to the county and helping walk members through the process. They reduced wait times from months to weeks. And now [after the carve-out], the waiting process is creeping up again because coordination isn't happening in the same way, and it continues to challenge the demonstration.

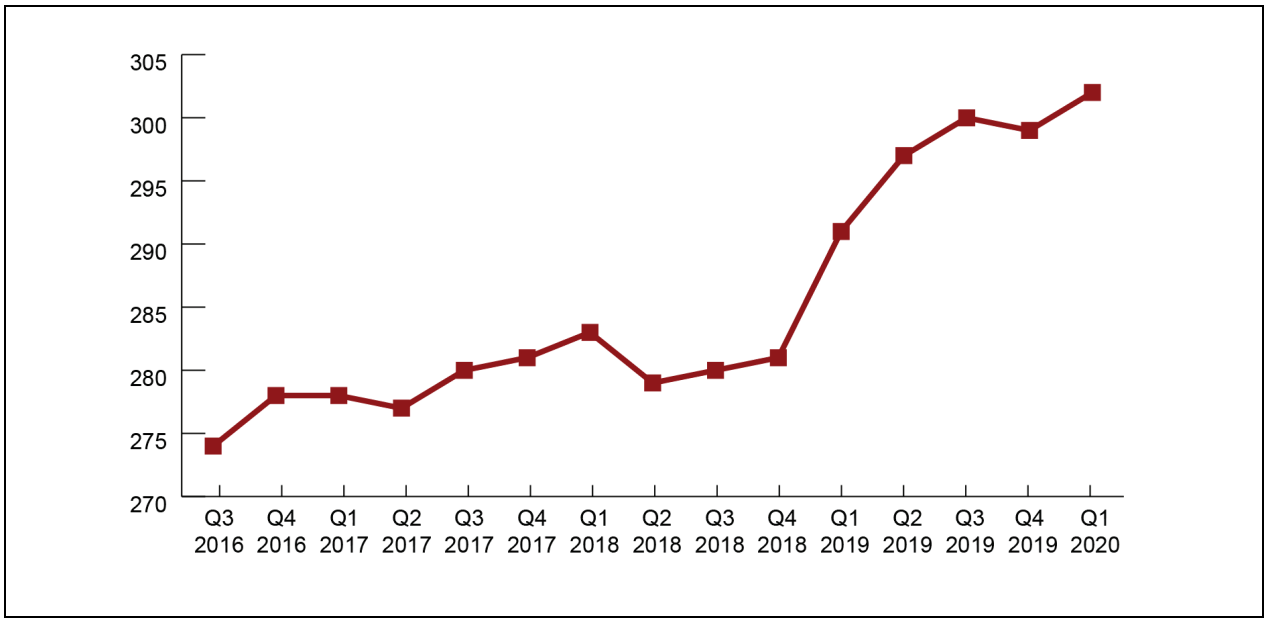
– DHCS Contractor (2019)

The State took steps to improve MMP care coordination. In 2017, the State provided technical assistance and learning collaborative support on the topics of "Targeting Care Coordination for High Utilizers," Outreach to Communities with Diverse Backgrounds" and "Care Transitions" in an MMP learning collaborative. In July 2017, the State released a policy change (effective January 2018) that required MMPs to include 10 new standardized LTSS referral questions in new enrollees' HRAs, with the goal of increasing LTSS referrals. To further improve LTSS care access and coordination, in 2018 and 2019 the State enhanced data reporting requirements by adding metrics on CPO services, Community-Based Adult Services (CBAS), MSSP, and IHSS referrals and utilization (DHCS, 2018).

There is evidence to suggest that State and MMP efforts to improve care coordination and LTSS access have been fruitful. A State evaluation funded by the SCAN Foundation found that

beneficiaries who are receiving care coordination are happy with the support they receive and MMPs reported that the Interdisciplinary Care Teams (ICTs) have been helpful in the care coordination process (Graham, Chapman, & Cohen, 2019). Additionally, the rate of individuals reported to be receiving LTSS continued to increase over the course of the demonstration, with an increase of approximately 10 percent taking place between the end of 2018 and the end of 2019 (please ***Figure 4*** below).

Figure 4
Members receiving LTSS per 1,000 members



LTSS = long-term services and supports; Q = quarter.
SOURCE: Data compiled from Cal MediConnect Performance Dashboard for the illustrated quarters of data. Available at https://www.dhcs.ca.gov/Pages/Cal_MediConnectDashboard.aspx (Accessed on April 12, 2021).

In 2018–2019, CMS shared that MMPs were taking their own actions to improve care coordination and HRA completion, including reducing the involvement of delegated entities or contractors and conducting these activities internally. One MMP also reduced the number of questions in their HRA to increase the assessment tool's utility and completion rates.

The CMT has provided ongoing implementation support to MMPs by regularly bringing them together to discuss how to address recurring issues and identify and share best practices. As part of improvement efforts across all FAI demonstrations in 2018, the California CMT surveyed all 10 MMPs about the identification of member language preferences and the provision of care coordination in the beneficiary's preferred language. This activity underscored the importance of language access and led to the clarification in the new three-way contract to ensure beneficiaries receive plan materials in their preferred language.

Other MMP best practices identified during a May 2018 State-led meeting that focused on care coordination and LTSS access included:

- developing or enhancing internal and external referral infrastructures;

- increasing in-person contacts;
- integrating HRA responses directly into electronic health records, care management software systems, or provider portals so that care team members all have access to the information; and
- implementing more thorough follow-up procedures to address identified member needs (DHCS, 2018).

Other best practices focused on care transitions, housing, and coordination with behavioral health services. Two county-based plans provide notable examples:

- One MMP used its own resources to find housing for and transition 181 enrollees back to a home, independent living facility, or assisted living facility in 2018, and get them supportive services.
- Another plan transitioned a total of 289 people across their managed care products, including their MMP, from skilled and long-term care back to the community as of September 2019 through implementation of a transition management program that targets specific individuals.[3] This plan also implemented a special program to address social isolation among frail enrollees.

Many MMPs reported in 2017 that they had limited success in working with counties to coordinate behavioral health services or to involve county behavioral health staff in Interdisciplinary Care Teams (ICTs) or Individualized Care Plans (ICPs). Most MMPs cited the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other Federal restrictions as barriers to data sharing necessary for coordination. However, in 2018, several MMPs and stakeholders reported significant progress in coordinating with behavioral health providers and co-locating plan staff at the counties to help with arranging behavioral health services and making sure enrollees are getting their needs met. Important improvements expected to increase access to care coordination included:

- increased data sharing with some counties; and
- MOUs with county behavioral health agencies.

Some MMPs also made progress in including primary care providers (PCPs) in the care coordination process. For example, one MMP reported in 2019 that it developed a sophisticated tool to assess polypharmacy and drug interactions and adverse events; the results of these medication reviews were routinely shared with Cal MediConnect enrollees' PCPs.

[3] The plan's Community Care Settings Program focused transition efforts on:
- institutionalized dual eligible members who could be receiving services in the community instead;
- dual eligible members in rehab facilities at risk of being institutionalized long term; and
- Medicaid-only plan members who are either institutionalized or living in the community and at risk of being institutionalized.

Cal MediConnect maturation also led to improvements in the care coordination workforce. For example, some MMPs reported that with time, care coordinators became more experienced and knowledgeable, and were providing higher quality service.

Despite steps to improve care coordination challenges, some stakeholders continued to report concerns about the need for MMPs to improve consumer education on Cal MediConnect services and benefits, particularly care coordination. Beneficiary advocates and industry stakeholders reported that plans were not adequately explaining the care coordination benefit consistently to beneficiaries, and were having difficulties reaching some of the enrollee population to sufficiently engage them in the care coordination process. Additionally, survey findings reported by SCAN and UCSF corroborated shortcomings in care coordination understanding and reach (Graham et al., 2018). They consistently noted that roughly one-third of beneficiaries reported receiving or being aware of the benefit.

Some MMPs attributed their limited ability to educate beneficiaries to the marketing restrictions on brokers (see ***Section 3.2, Eligibility and Enrollment*** for discussion about the broker pilot).

In response to these concerns, the three-way contract re-executed in September 2019 required MMPs to:

- coordinate across MMP contractors and other dental providers due to a reinstated Medi-Cal dental benefit;
- train network providers on the care coordination benefit; and
- clarify the composition of the ICT and its description in new member packets.

In addition, in response to the language access barriers previously reported in State-sponsored evaluations and the CMS focus groups, the renewed contract stipulated that ICPs must be made available in alternative formats (such as braille, audiotape, ASL video clips, or other formats as requested), and in an enrollee's preferred written or spoken language (CMS, 2019).

Another care coordination challenge that arose during the reporting period was inappropriate billing of dental services. According to a beneficiary advocate, due to a reinstatement of Medi-Cal dental benefits in 2018, there was some provider confusion during the period immediately following reinstatement, resulting in inappropriate billing of dental services for Cal MediConnect enrollees.

Overall, MMPs made progress on some care coordination measures. Modest improvements in assessment completion rates can be seen in ***Table 2***. Over the course of the demonstration (2014–2019), there was an overall positive trend in the percentage of all enrollees with an assessment completed within 90 days of enrollment. The percentage of enrollees willing to participate and reachable to complete an assessment within 90 days of enrollment also showed an overall upward trend over the course of the demonstration.

Table 2
Members whose assessments were completed within 90 days of enrollment, 2014–2019

Quarter	Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period	Percentage of assessments completed within 90 days of enrollment	
		All members	All members willing to participate and who could be reached
2014			
Q1	N/A	N/A	N/A
Q2	3,027	48.0	76.8
Q3	25,122	37.2	81.3
Q4	17,107	32.0	85.2
2015			
Q1	70,378	46.9	83.1
Q2	18,621	47.8	86.6
Q3	10,713	45.7	81.6
Q4	6,342	44.0	81.5
2016			
Q1	17,574	60.9	91.7
Q2	5,424	48.8	89.1
Q3	5,562	46.5	88.2
Q4	3,768	53.8	87.5
2017			
Q1	7,045	51.9	84.8
Q2	7,524	55.2	85.2
Q3	6,499	51.8	82.9
Q4	6,009	48.2	90.0
2018			
Q1	5,480	53.7	83.2
Q2	5,287	55.3	88.7
Q3	5,638	59.4	90.1
Q4	5,640	62.8	92.2
2019			
Q1	5,227	67.7	92.9
Q2	5,700	64.7	89.5
Q3	6,014	65.2	92.2
Q4	6,295	63.4	93.3

MMP = Medicare-Medicaid Plan; N/A = not applicable; Q = quarter

NOTES: Because the California demonstration began in March 2014, data are not applicable for quarter 1 of 2014.The California demonstration began in quarter 2 of 2014 with opt-in enrollment in San Mateo County; therefore data for that quarter are limited. Data presented for quarter 2 of 2014 represent six plans (Care1st, Community Health Group, HealthNet, Inland Empire Health Plan, Molina Healthcare, and Health Plan of San Mateo). In quarter 3 of 2014, Anthem Blue Cross and L.A. Care began reporting data. In quarter 1 of 2015, Santa Clara Family Health Plan began reporting data. In quarter 3 of 2015, Cal Optima began reporting data. From 2016 forward, all 10 plans were reporting data for the measure. As of January 1, 2019, the 10 plans reporting are: Anthem, Blue Shield (formerly Care 1st), CalOptima, Community Health Group, HealthNet, Inland Empire Health Plan, L.A. Care, Molina Healthcare, and Santa Clara Family Health Plan.

SOURCE: RTI analysis of MMP-reported data for Core Measure 2.1 as of July 2020. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

Table 3 shows that the percentage of high- and low-risk enrollees that completed an ICP within 30 days after the HRA varied over the course of the demonstration. For high-risk members willing to participate and who could be reached, completion rates fluctuated from a low of 47 percent to a high of 72 percent. For low-risk members willing to participate and who could be reached, completion rates fluctuated from a low of 52 percent to a high of 77 percent.

Table 3
Members with an ICP within 30 days of completing the HRA, 2015–2017

Quarter	High-risk members			Low-risk members		
	Total number with an HRA completed during the reporting period	Percentage completing an ICP within 30 days of HRA completion		Total number with an HRA completed during the reporting period	Percentage completing an ICP within 30 days of HRA completion	
		All members	All members willing to participate and who could be reached		All members	All members willing to participate and who could be reached
2015						
Q1	14,854	42.3	47.2	22,133	58.6	63.9
Q2	4,534	54.6	64.1	9,525	50.7	62.0
Q3	2,579	49.9	56.5	6,056	43.2	53.2
Q4	3,520	45.7	51.4	5,502	42.5	51.7
2016						
Q1	6,099	39.9	53.3	7,269	59.3	70.7
Q2	2,230	58.2	62.3	2,729	54.2	61.6
Q3	1,811	67.9	72.1	2,189	61.2	68.3
Q4	2,114	64.0	69.2	2,106	65.2	70.9
2017						
Q1	3,641	60.6	67.8	2,462	61.9	68.6
Q2	3,273	48.6	57.9	2,139	67.5	72.5
Q3	2,399	50.4	60.5	2,057	71.7	77.2
Q4	2,543	59.3	70.9	2,257	68.3	76.1

HRA = health risk assessment; ICP = Individualized Care Plan; MMP = Medicare-Medicaid Plan; Q = quarter.
NOTES: MMPs did not report data for these measures for 2014. In quarter 1 of 2015, Santa Clara Family Health Plan began reporting data. In quarter 3 of 2015, Cal Optima began reporting data. From 2016 through 2017, all 10 plans were reporting data for the measure. High-risk members are members who are at increased risk for having an adverse health outcome or worsening of his or her health status if he or she does not receive initial contact within 45 calendar days after their effective enrollment date. Low-risk members are members who do not meet the minimum requirements of a high-risk member. The State-specific measures CA 1.2 [High-risk members with an ICP within 30 days of completing the HRA]and CA 1.4 [Low-risk members with an ICP within 30 days of completing the HRA] were retired in quarter 1 of 2018; Individualized Care Plan data for 2018 and 2019 are presented in Table 5 using Core Measure 3.2.
SOURCE: RTI analysis of MMP-reported data for State-specific measures CA 1.2 and CA 1.4 as of July 2020. The technical specifications for these measures are in the Medicare-Medicaid Capitated Financial Alignment Model California-Specific Reporting Requirements document.

As shown in ***Table 4***, the percentage of all members, and all members not documented as unwilling to complete a care plan or unreachable, with a care plan completed within 90 days of enrollment, generally increased over the course of the demonstration, with minimal variation among the quarters. The percentage of care plans completed within 90 days of enrollment for members who were reachable and willing to complete a care plan reached its highest point (55.7 percent) in the fourth quarter of 2019.

Table 4
Members with care plans completed within 90 days of enrollment, 2018–2019

Quarter	Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period	Percentage of care plans completed within 90 days of enrollment	
		All members	All members willing to participate and who could be reached
2018			
Q1	5,482	29.4	37.8
Q2	5,282	29.1	38.7
Q3	5,636	30.7	40.2
Q4	5,640	29.6	40.0
2019			
Q1	5,227	29.3	40.5
Q2	5,700	29.8	41.3
Q3	6,014	37.5	53.7
Q4	6,295	38.4	55.7

MMP = Medicare-Medicaid Plan; Q=quarter
SOURCE: RTI analysis of MMP-reported data for Core Measure 3.2 as of January 2021. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

As shown in ***Table 5***, the percentage of enrollees with at least one documented discussion of care goals in their initial ICP varied over the course of the demonstration (2014–2019) with a low of 51.1 percent in 2016 and a high of 87.3 percent in 2019. Across all demonstration years, the percentage of enrollees with a revised ICP and at least one documented discussion of new or existing care goals also fluctuated, reaching a high of 74.6 percent in 2018.

Table 5
Members with an ICP developed with documented discussions of care goals, 2014–2019

Calendar year	Total number of members with an initial ICP developed	Total number of members with a revised ICP developed	Percentage of members with at least one documented discussion of care goals in the initial ICP	Percentage of members with at least one documented discussion of care goals in the revised ICP
2014	19,020	N/A	82.6	N/A
2015	59,077	24,344	64.3	60.3
2016	32,894	77,196	51.1	56.7
2017	24,233	91,137	61.0	47.1
2018	13,671	55,148	80.3	74.6
2019	15,319	53,525	87.3	70.3

ICP = Individualized Care Plan; MMP = Medicare-Medicaid Plan; N/A = not applicable; Q = quarter.
NOTES: MMPs did not report data on documented discussions of care goals in revised ICPs for 2014. Data presented for 2014 represent the eight plans that were active in calendar year 2014 (Care1st, Community Health Group, HealthNet, Inland Empire Health Plan, L.A. Care, Molina Healthcare, Health Plan of San Mateo, and Anthem Blue Cross). In 2015, Santa Clara Family Health Plan and Cal Optima began reporting data. From 2015 forward, all 10 plans were reporting data for this measure.
SOURCE: RTI analysis of MMP-reported data for State-specific measure CA 1.6 as of January 2021. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model California-Specific Reporting Requirements document.

As shown in ***Table 6***, MMPs have invested in increased care coordination capacity and the data suggest slight improvements. The number of care coordinators steadily increased over the course of the demonstration (2014–2019), while the turnover rate fluctuated. Average caseloads decreased from a demonstration-to-date high of 113.1 in 2015 to a low of 69.8 in 2019.

Data presented in ***Tables 2–6*** should be examined together with the Cal MediConnect Performance Dashboard data[4] in ***Figures 15–18*** for a full picture of care coordination trends. While the tables in this section show relatively high averages for the State, the Performance Dashboard data are more granular and show wide variation at the MMP level across care coordination metrics such as completed HRAs, having ICPs in place, and having a care coordinator.

[4] See the Cal MediConnect Performance Dashboard Metrics Summary for December 2020.

Table 6
Care coordination staffing, 2014–2019

Calendar year	Total number of care coordinators (FTE)	Percentage of care coordinators assigned to care management and conducting assessments	Member load per care coordinator assigned to care management and conducting assessments	Turnover rate (%)
2014	708	75.4	111.1	7.6
2015	1,342	76.9	113.1	16.2
2016	1,563	74.2	99.4	12.8
2017	1,687	72.8	95.7	12.9
2018	1,916	79.4	75.7	9.3
2019	2,072	78.0	69.8	11.6

FTE = full time equivalent; MMP = Medicare-Medicaid Plan.
NOTES: Data presented for 2014 represent the eight plans that were active in calendar year 2014 (Care1st, Community Health Group, Health Net, Inland Empire Health Plan, L.A. Care, Molina Healthcare, Health Plan of San Mateo, and Anthem Blue Cross). In 2015, Santa Clara Family Health Plan and Cal Optima began reporting data. From 2015 forward, all 10 plans were reporting data for this measure. As of July 2020, the 10 plans reporting are: Anthem, Blue Shield (formerly Care 1st), CalOptima, Community Health Group, HealthNet, Inland Empire Health Plan, L.A. Care, Molina Healthcare, and Santa Clara Family Health Plan.
SOURCE: RTI analysis of MMP-reported data for Core Measure 5.1 as of July 2020. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

3.4 Stakeholder Engagement

Although stakeholders felt much more engaged in demonstration decision-making in 2017, by the end of 2019 they reported that engagement was waning once again as the State prepared to transition to CalAIM. [5]

As the demonstration matured, stakeholder concerns shifted from enrollment issues to concerns about the adequacy of care coordination and access to certain services including DME, physical therapy, prescription medication, and transportation.

In this section we describe stakeholder engagement activities during the period of this report and the impact of those efforts on the demonstration. In the First Evaluation Report, we discussed increased collaborative efforts across stakeholders, improved communication and engagement between stakeholders and DHCS, and decreased provider resistance against the demonstration.

In 2017, some stakeholders reported that DHCS and Harbage Consulting had become more responsive than in past years, delivered better quality information, and pulled stakeholders

[5] The State released information for stakeholder review and feedback in late 2019, after the RTI 2019 site visit took place.

in for "substantive involvement" and evaluating the utility of implementation tools. Examples of substantive stakeholder participation included developing new LTSS referral questions for the HRAs and contributing to the Cal MediConnect Performance Dashboard development and review. DHCS requested that stakeholders rank and select the top five dashboard measures for inclusion in the quarterly dashboard that was released in 2018.

DHCS reported undertaking a major effort in 2017 to bring MMPs together in regular phone or webinar meetings, to share best practices and discuss areas for improvement. Advocacy organizations also reported increased involvement in the demonstration in 2017, and regular engagement with MMPs, consumer advocates, and other stakeholders. Although overall provider buy-in and support for Cal MediConnect had improved from previous years, providers continued to report challenges, such as payment delays, which made some providers reluctant to serve the Medi-Cal population, including Cal MediConnect enrollees.

Since 2017, providers (including ethnic minority provider associations and safety net providers) have expressed a better understanding and acceptance of the demonstration. They appreciated major improvements in marketing materials and information provided on the Cal MediConnect website, including a physician toolkit developed to educate providers about the CCI (California's larger Coordinated Care Initiative) and Cal MediConnect.

Soliciting Stakeholder Feedback

In 2017–2019, DHCS and Harbage continued to bring together stakeholders—such as MMP representatives and members of the California Collaborative for LTSS—in regular phone and webinar meetings to share best practices and discuss ongoing or new challenges. They held an in-person meeting in April 2018 to discuss best practices in care coordination for enrollees receiving LTSS and a summary report was released in September 2018 (DHCS, 2018). They conducted a similar effort that focused on best practices in behavioral health care integration between late 2018 and 2019, and released a summary report of findings to the public in May 2019 (DHCS, 2019d). Stakeholders also continued to focus on DME access issues. Harbage distributed a survey to all MMPs in the late summer of 2019 that informed the formation of a DME-focused work group tasked with developing recommendations to the State and to MMPs. Harbage also solicited stakeholder feedback for improvements to the data sharing process between MMPs[6] to enhance continuity of care. The connection between housing access and health care was another major focus area during this reporting period. Relationship building across stakeholder groups helped to increase awareness around this issue.

Ongoing Concerns: D-SNP Look-alike Plans

In 2018–2019, the growth of D-SNP look-alike plans remained a major concern for advocates, the State, and CMS. The State and MMCO discussed how to address concerns regarding the potential impact of look-alike plans on implementation of the demonstration. According to Harbage, moving forward with the broker pilot (discussed earlier in this section) was one response to the growth of these plans, and DHCS has discouraged MMPs from operating D-SNP look-alike plans. Advocacy organizations have released educational materials

[6] As of 2018, the three-way contract calls for MMPs to share information with each other when an enrollee moves from one MMP to another to ensure continuity of care.

on the matter to the public. The Medicare Advantage and Part D Final Rule for calendar year 2021 included a provision that CMS would not enter into contracts with new look-alike plans for 2022 or renew look-alike plans for 2023.

Decreasing Opportunity for Stakeholder Input

Several stakeholders reported a disinvestment by the State in the stakeholder engagement process starting in early 2018. They gave several examples:

- The State decided to move forward with the broker pilot, despite major stakeholder opposition.
- The State provided very short turnaround times for public comment periods related to other policy changes.
- Stakeholders were not sufficiently included in the development of the CalAIM proposal that was announced on October 29, 2019. For example, a Cal MediConnect ombudsman was not included in the CalAIM workgroup focusing on care coordination, and very few aging advocacy organizations were included in preliminary planning and decision-making for the initiative.

One stakeholder also pointed out that the State could better tailor and invest in education and outreach to generate buy-in from providers who primarily serve culturally and linguistically distinct communities. Citing the Chaldean community in San Diego as an example, the stakeholder explained:

> *"[I]f you don't go to those locally trusted social service agencies that are embedded in the community, speak the language, know the culture, whose staff are comprised of community members from those distinct communities, then you are not going to engage those communities."*
>
> – Stakeholder (2019)

3.5 Financing and Payment

In 2017–2019, although CMS and the State made favorable changes to payment rates and MMPs continued to support and invest in the demonstration, not all plans have found the demonstration to be financially sustainable.

While plans understood the blended rate methodology in theory, their own estimates of the proportions of their members in each rate cell produced a different final rate than what DHCS determined. There was an apparent lack of clarity at these plans about rules for assignment of Medi-Cal beneficiaries to rate cells.

The three-way contract finalized in September 2019 included three substantial changes to the rate structure:

- Retroactive to January 2018, IHSS payments were carved out from the MMP capitation payments, relieving the plans of the role of paying for those services and then reconciling payments made with DHCS at a later date.
- There was no risk corridor in place in 2018 and 2019, though a one-sided arrangement was introduced (with recoupment possibility for CMS and DHCS) effective January 2020. The calculations were modified, effectively capping net profit at 8.25 percent, where no such cap existed previously.
- Beginning in 2019, MMPs with high disenrollment rates are subject to a retroactive penalty in the Medicare Parts A and B portion of their capitation rate.

As they have from the beginning of the demonstration, plans continued to express concern with the Cal MediConnect payment methodologies. These concerns differed across plans, ranging from inadequacy of the Medicare Part A and B rate for a dually eligible population, to the practice of withholding a portion of the rate to be eventually repaid in part or in full if the plan met defined quality targets, to the unpredictability of the Medi-Cal blended rate calculation relative to plans' perceptions of their rate-cell mix.

On the Medicare side, there was some concern that the standard Medicare Advantage risk adjustment methodology was not sufficient for this high-cost population. CMS and DHCS acknowledged this problem and, in 2017, modified the rate structure to include Medicare outlier payments for new Cal MediConnect enrollees residing in nursing facilities in Los Angeles and Orange Counties.

On the Medi-Cal side, the extended length of time before DHCS announces plans' blended rates (the single rate for each plan calculated based on the characteristics of all beneficiaries enrolled in the plan) made it difficult for plans to manage costs relative to a revenue target. The removal of IHSS from capitation did reduce some uncertainty, which plans mostly viewed favorably.

During the timeframe of this report, retrospective risk corridor accounting for the early years of Cal MediConnect affecting both Medicare and Medi-Cal financing had not yet been completed and plans did not yet know their results. The disenrollment penalties were also new, and plans did not yet know their likely effect. However, one MMP described the higher relative profitability of their D-SNP look-alike product as a potential incentive to transition a member to the D-SNP look-alike, which the penalty is designed to discourage.

3.6 Quality of Care

All but one MMP received 100 percent of their quality withhold payment for calendar year 2017. This reflects an upward adjustment due to extreme and uncontrollable circumstances for four plans. Results for 2018 were similar and the MMPs we spoke to expected to meet benchmarks for 2019.

The amount of the quality withhold from capitation payments to Cal MediConnect plans increased from 3 percent to 4 percent in 2020.

Results of Healthcare Effectiveness Data and Information Set (HEDIS) measures varied across the 10 MMPs, but the majority of MMPs outperformed MA benchmarks in three measures (30-day follow-up after hospitalization for mental illness. medical attention for nephropathy [within measures of diabetes care], and emergency department visits per 1,000 members).

MMPs are taking targeted steps to improve specific HEDIS measures with CMT support.

Quality withhold results for calendar year 2017 were published in August 2019. All MMPs received 100 percent of their withhold payments except for one, and that MMP received 75 percent. Results were similar for calendar year 2018, with all but two MMPs receiving 100 percent of their withhold payments and two receiving 75 percent. In both 2017 and 2018, four MMPs received 100 percent of their withhold payment because they qualified for an upward adjustment due to extreme and uncontrollable circumstances (these MMPs qualified for the adjustment due to the wildfires in California in 2017 and 2018). In demonstration year 2 (2016), four MMPs received the full withhold payment, five received 75 percent and one received 50 percent (CMS, 2018d). Several MMPs the RTI evaluation team interviewed in 2017 had no financial incentives for providers tied to quality of care, and simply paid on an FFS basis. Plans that pass down quality withhold payments received as part of the demonstration to their delegated provider organizations reported that these payments had no real effect on provider behavior, since they were related to care delivered in the distant past. The principal benefit of the Cal MediConnect quality withhold program was to inform providers of what was being prioritized by CMS, DHCS, and the MMPs.

In discussing their expectations for 2018 and 2019, the MMPs we interviewed in 2019 expected to meet benchmarks, though one mentioned struggling with meeting the benchmark for

the follow-up after hospitalization for mental illness quality measure. Another noted it had enhanced monitoring and had taken steps to become more disciplined and structured when examining its metrics, such as creating workgroups that identify issues through data analysis and develop action plans for improvement. Another MMP reported that it was encouraging compliance with HEDIS measures during case management contact with their enrollees.

The new three-way contract increased the financial incentive for MMPs to focus on quality improvements. The amount of the quality withhold from capitation payments to plans increased from 3 percent to 4 percent starting in 2020.

3.6.1 Quality Management Structures and Activities

In 2019, DHCS discussed several efforts taken to improve data reporting. First, after realizing that plans were interpreting CPO services differently, DHCS clarified policy language describing "what counts [as a CPO] and what doesn't count" and made related changes to the data reporting process to facilitate more consistent reporting.

DHCS also discussed changes to the dashboard related LTSS service reporting. Previously, these were reported at a global level that included all LTSS. As of the time of this report, nursing facility, MSSP and IHSS services are reported separately. A stakeholder expressed appreciation for these changes:

I felt that [the State] actually took a lot of our concerns and comments into consideration. Not all of them, but I give them a lot of credit for further developing that dashboard.

– Stakeholder (2019)

3.6.2 MMP Quality Improvement Efforts

MMPs described their internal quality improvement efforts and the use of data to inform those efforts. For example, one MMP reported:

So over the past couple of years we really tried to add some additional structure to how we look at all of our key metrics and how we're performing, and not just looking at how we're [doing], but also how we make sure that we're getting any needed improvements. So with that we've established a core work group that manages this overall process and looking at everything that we're doing.

– MMP Official (2019)

As noted above, a few MMPs incentivized their provider networks by passing down demonstration quality withhold payments. One MMP described the approach it took in this area:

...[W]e enhance our pay for performance programs with [PCPs] every year. We reflect on the prior year and look for new opportunities to improve. In 2018 and 2019, this program has gained traction, we educate and engage with our providers, focus on patient experiences and clinical quality measures.

– MMP Official (2019)

This MMP also started a new hospital pay for performance program in 2018, which included "some great partnerships and focus on improving the area of readmissions, follow-up care after discharge, and also improving data sharing between hospitals and the plan." In 2018, another MMP reported launching a text message campaign for enrollees to improve medical adherence for blood pressure medication and to remind enrollees to get an annual flu shot.

Beyond determining bonus payments, MMPs also used quality monitoring and audits to determine whether a provider or provider group is allowed to continue under contract with the plan.

3.6.3 Selected HEDIS Quality Measures Reported for Cal MediConnect MMPs

MMPs are required to report HEDIS data to CMS and the States. HEDIS is a measure set developed and maintained by the National Committee for Quality Assurance. It is used by the vast majority of commercial, Medicare, and Medicaid health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality. In the FAI, MMPs report data on a subset of HEDIS measures that are required of all Medicare Advantage (MA) plans.

Five of the 13 Medicare HEDIS measures for MMP enrollees that RTI analyzes are reported in ***Figures 5–10***, with results on all 13 measures appearing in ***Tables B-1a, B-1b,*** and ***B-1c*** in ***Appendix B***. RTI identified these measures in RTI's Aggregate Evaluation Plan based on their completeness, reasonability, and sample size. Calendar year data for 2015 were available for 9 of the 10 Cal MediConnect MMPs, while calendar year data for 2016–2018 were available for all 10 Cal MediConnect MMPs.[7] In response to the COVID-19 Public Health Emergency, CMS did not require Medicare plans (including MMPs) to submit HEDIS 2020 data covering the 2019 measurement year. Medicare plans (including MMPs) resumed normal reporting for measurement year 2020, with that data becoming available later in 2021.

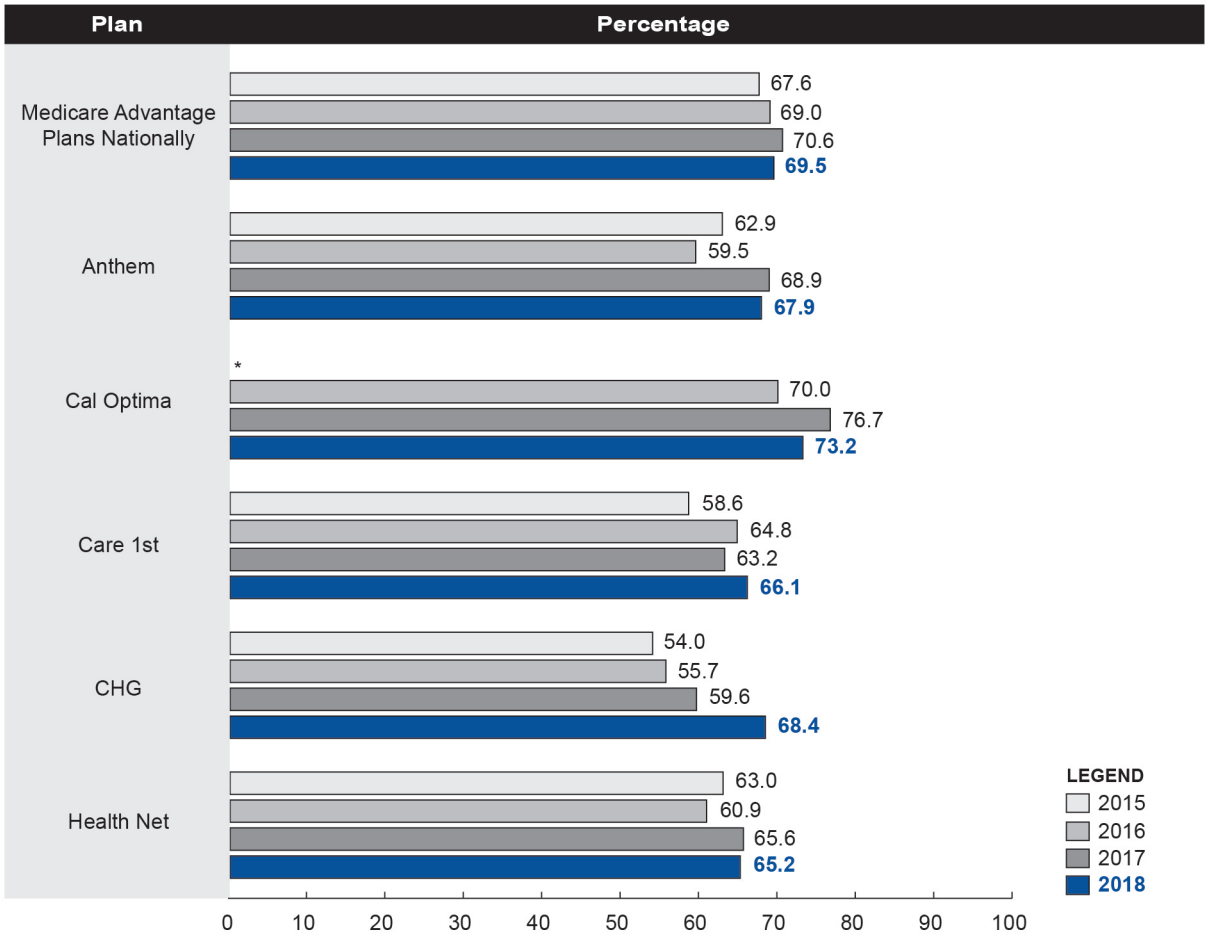
Detailed descriptions of selected HEDIS measures can be found in the RTI Aggregate Evaluation Plan. Results reported in ***Figures 5–10*** show 2015 through 2018 HEDIS performance data for Cal MediConnect MMPs on blood pressure control, 30-day follow-up after hospitalization for mental illness, good control of Hemoglobin A1c (HbA1c) levels (<8.0%), medication review (within measures of Care for Older Adults), and plan all-cause readmissions (ages 18–64 and ages 65+).

[7] CalOptima did not report HEDIS data for the 2015 measurement year.

Although the primary focus of HEDIS analysis is to monitor trends over time in MMP performance, the figures and appendix table also compare MMP performance to national MA plan means for reference when available. We provide the national MA plan means with the understanding that MA enrollees and demonstration enrollees may have different health and sociographic characteristics which would affect the results. Previous studies on health plan performance reveal poorer quality ratings for plans serving a higher proportion of dual eligible beneficiaries and beneficiaries with disabilities. Additionally, HEDIS measure performance, in particular, is slightly worse among plans active in areas with lower income and populations with a higher proportion of minorities (ASPE, 2016). Comparisons to national MA plan means should be considered with these limitations in mind.

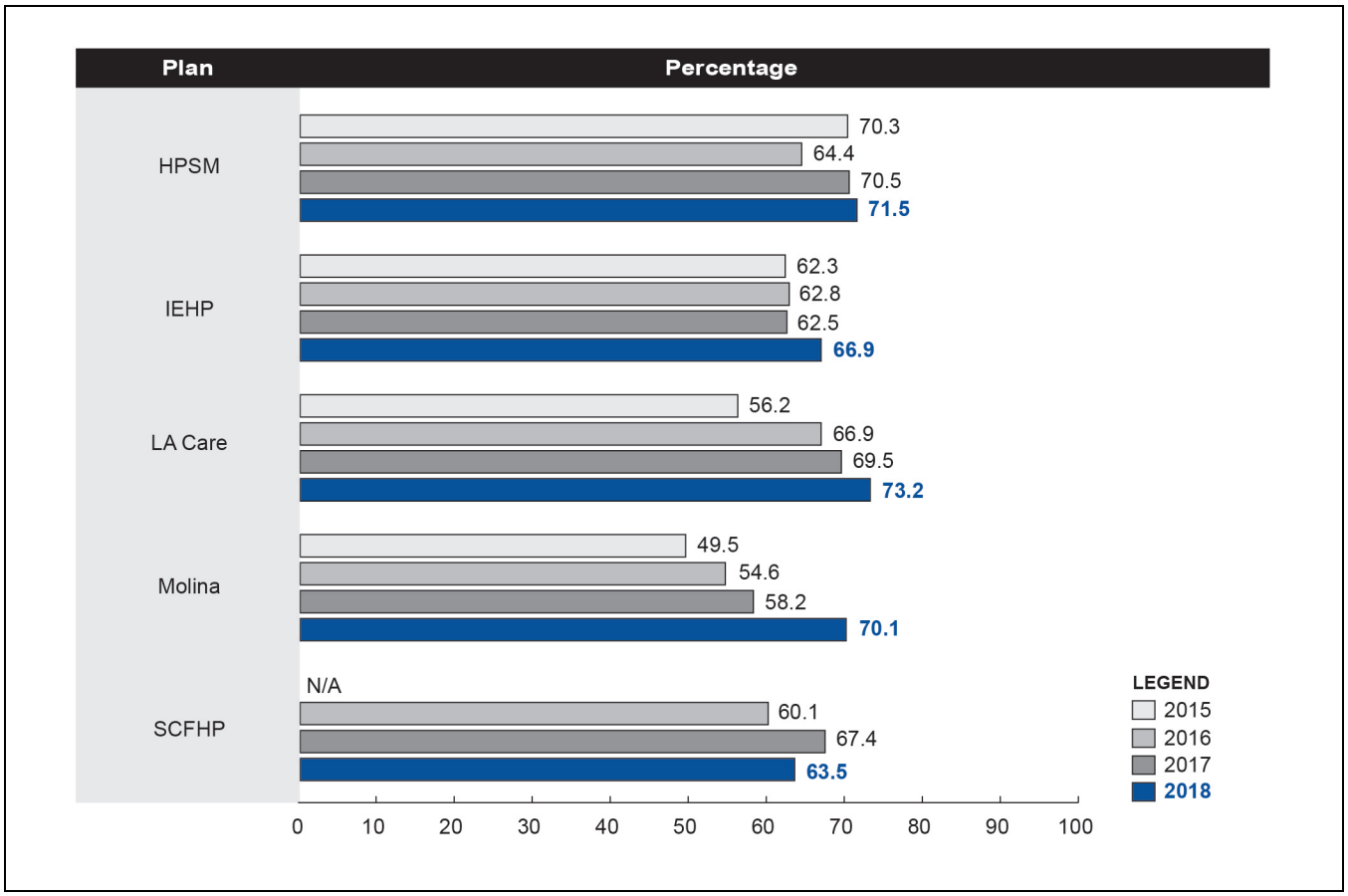
As shown in ***Figure 5***, all MMPs improved performance on blood pressure control from 2015 to 2018, with some MMPs showing steadier patterns of improvement than others.

Figure 5
Blood pressure control,[1] 2015–2018: Reported performance rates for Cal MediConnect MMPs



(continued)

Figure 5 (continued)
Blood pressure control,[1] 2015–2018: Reported performance rates for Cal MediConnect MMPs



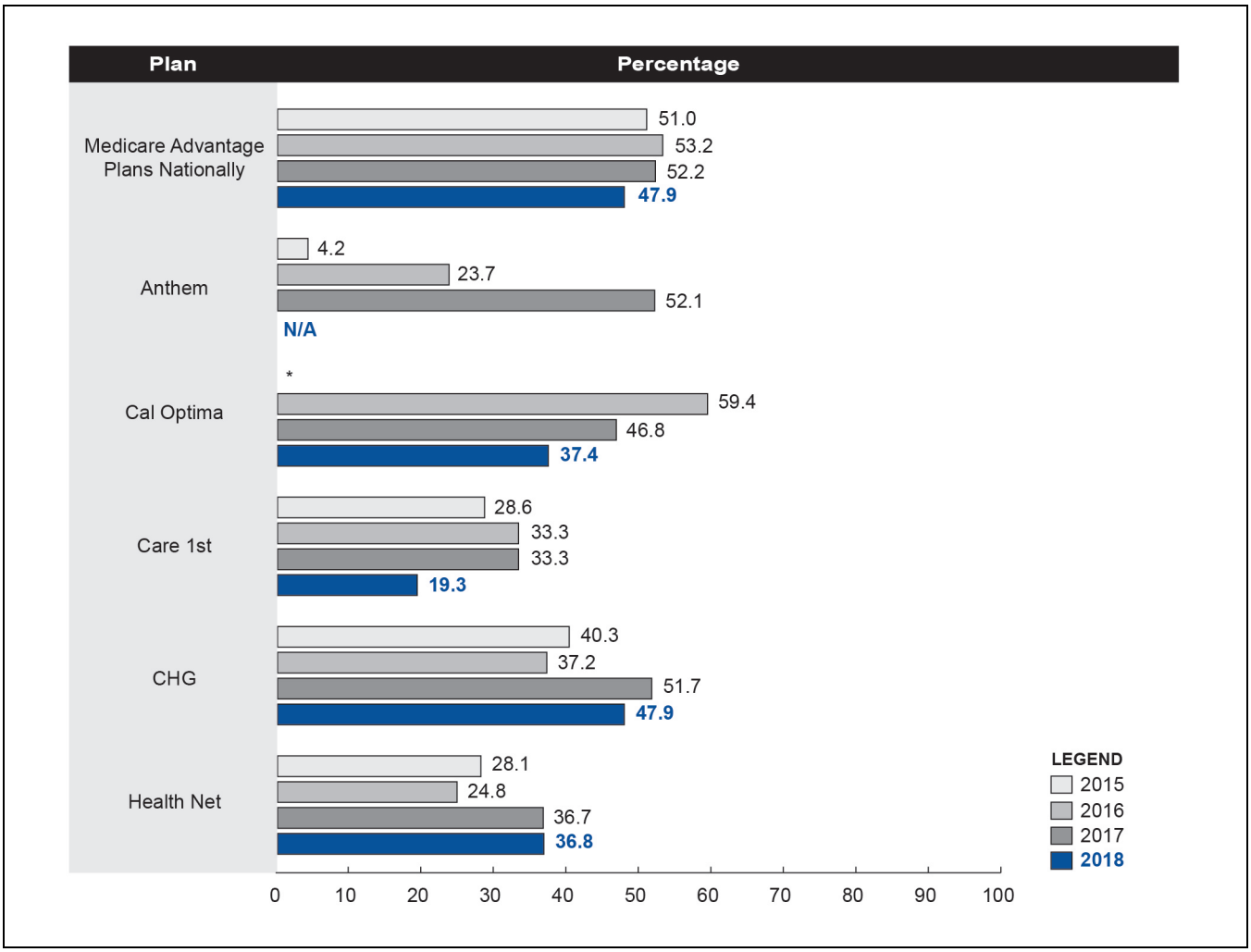
* = not available, where CalOptima did not report HEDIS data for the 2015 measurement year; CHG = Community Health Group; HEDIS = Healthcare Effectiveness Data and Information Set; HPSM = Health Plan of San Mateo; IEHP = Inland Empire Health Plan; N/A = not applicable, where MA plans do not report such data, or where the number of enrollees in the MMP's HEDIS data available for inclusion in the measure was less than 30, and therefore not reported per RTI's decision rule for addressing low sample size; MMP = Medicare-Medicaid Plan; SCFHP = Santa Clara Family Health Plan.

[1] The following criteria were used to determine adequate blood pressure control: less than 140/90 mm Hg for enrollees 18–59 years of age; diagnosis of diabetes and <140/90 mm Hg for enrollees 60–85 years of age; no diagnosis of diabetes and <150/90 mm Hg for enrollees 60–85 years of age.

SOURCE: RTI analysis of 2015 through 2018 HEDIS measures.

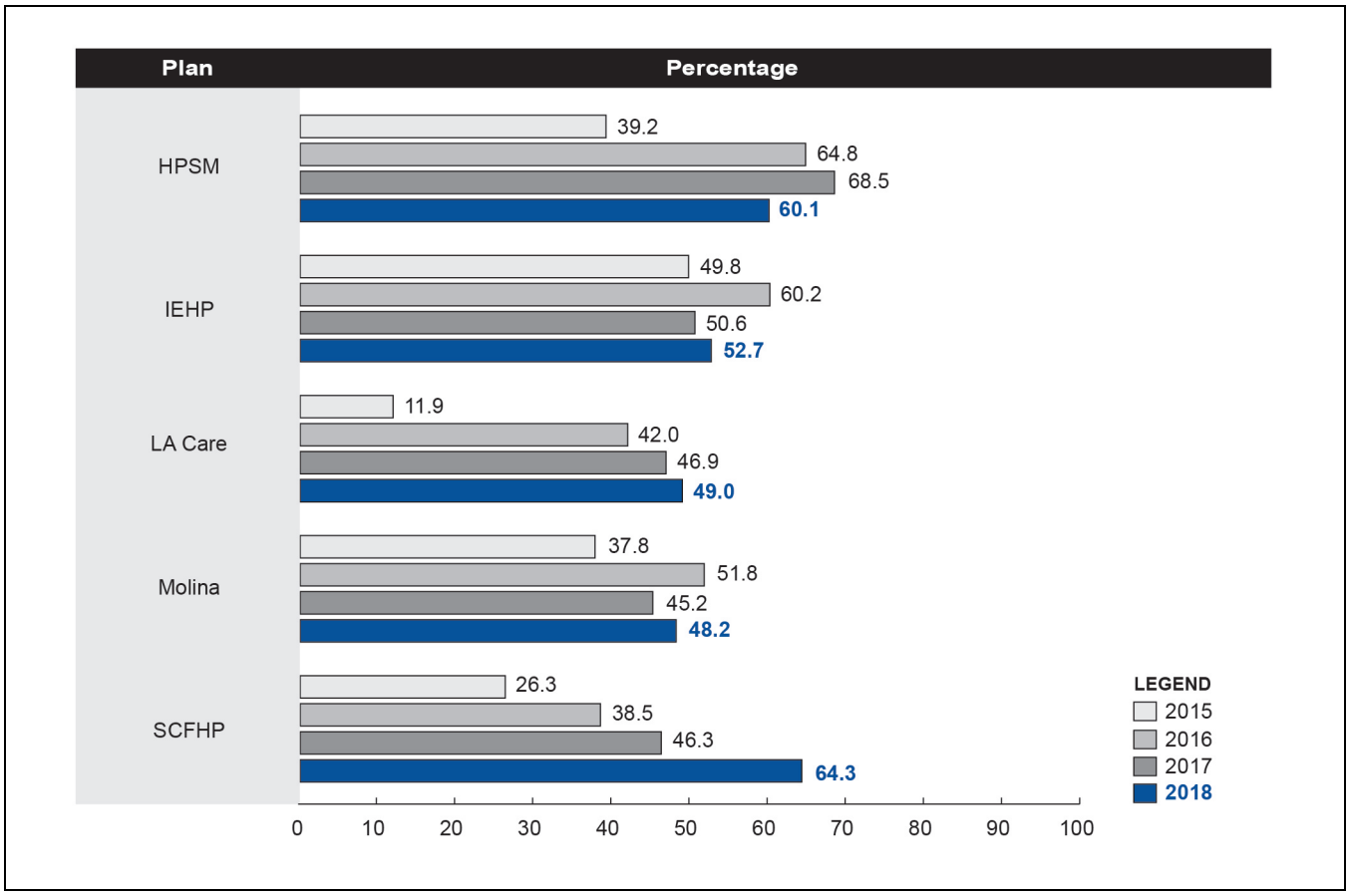
Figure 6 shows that for 30-day follow-up after hospitalization for mental illness, most MMPs improved performance from 2015 to 2018. The most pronounced increases for MMPs were generally between 2015 and 2016.

Figure 6
30-day follow-up after hospitalization for mental illness, 2015–2018: Reported performance rates for Cal MediConnect MMPs



(continued)

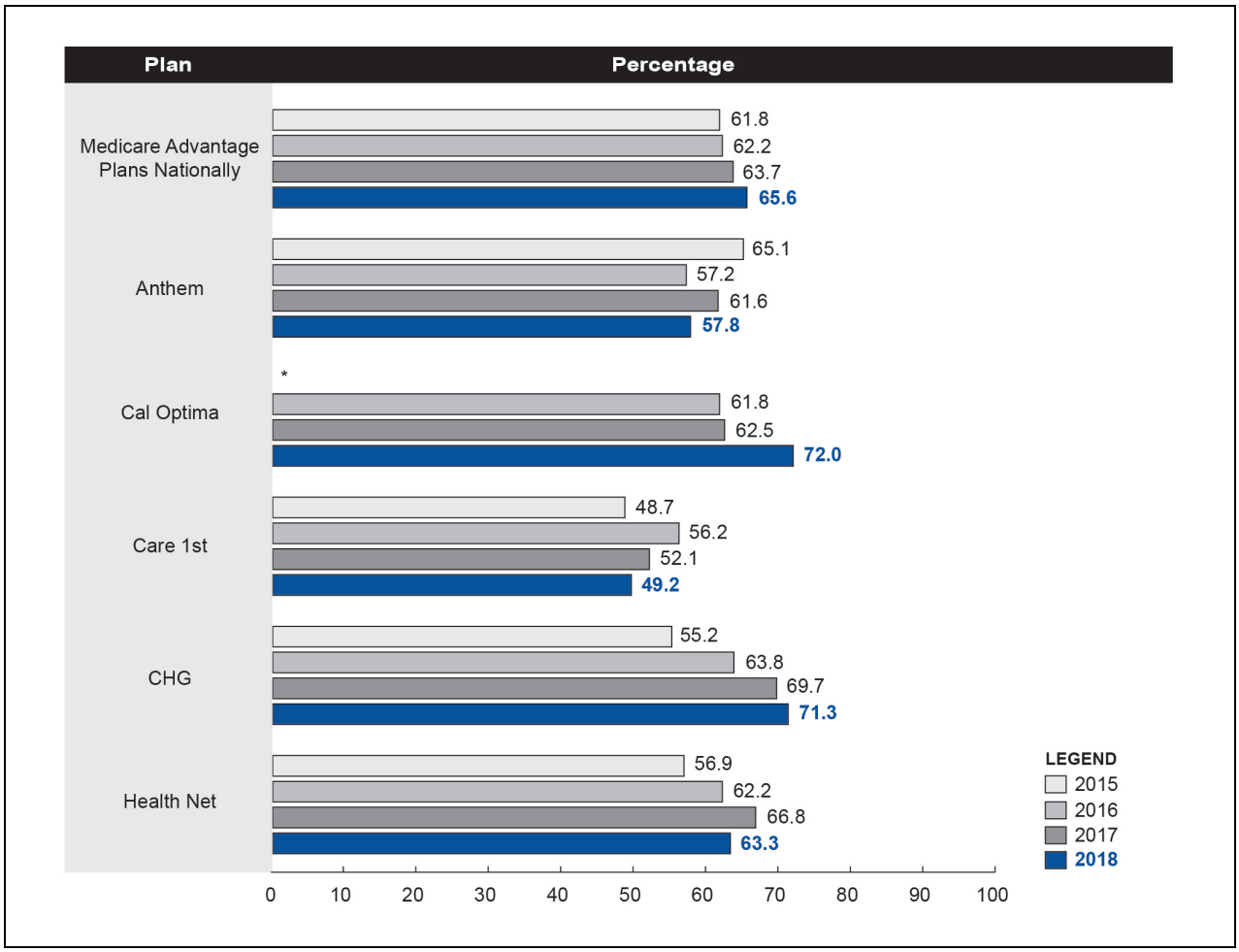
Figure 6 (continued)
30-day follow-up after hospitalization for mental illness, 2015–2018: Reported performance rates for Cal MediConnect MMPs



* = not available, where CalOptima did not report HEDIS data for the 2015 measurement year; CHG = Community Health Group; HEDIS = Healthcare Effectiveness Data and Information Set; HPSM = Health Plan of San Mateo; IEHP = Inland Empire Health Plan; MMP = Medicare-Medicaid Plan; SCFHP = Santa Clara Family Health Plan; N/A = not applicable, where MA plans do not report such data, or where the number of enrollees in the MMP's HEDIS data available for inclusion in the measure was less than 30, and therefore not reported per RTI's decision rule for addressing low sample size.
SOURCE: RTI analysis of 2015 through 2018 HEDIS measures.

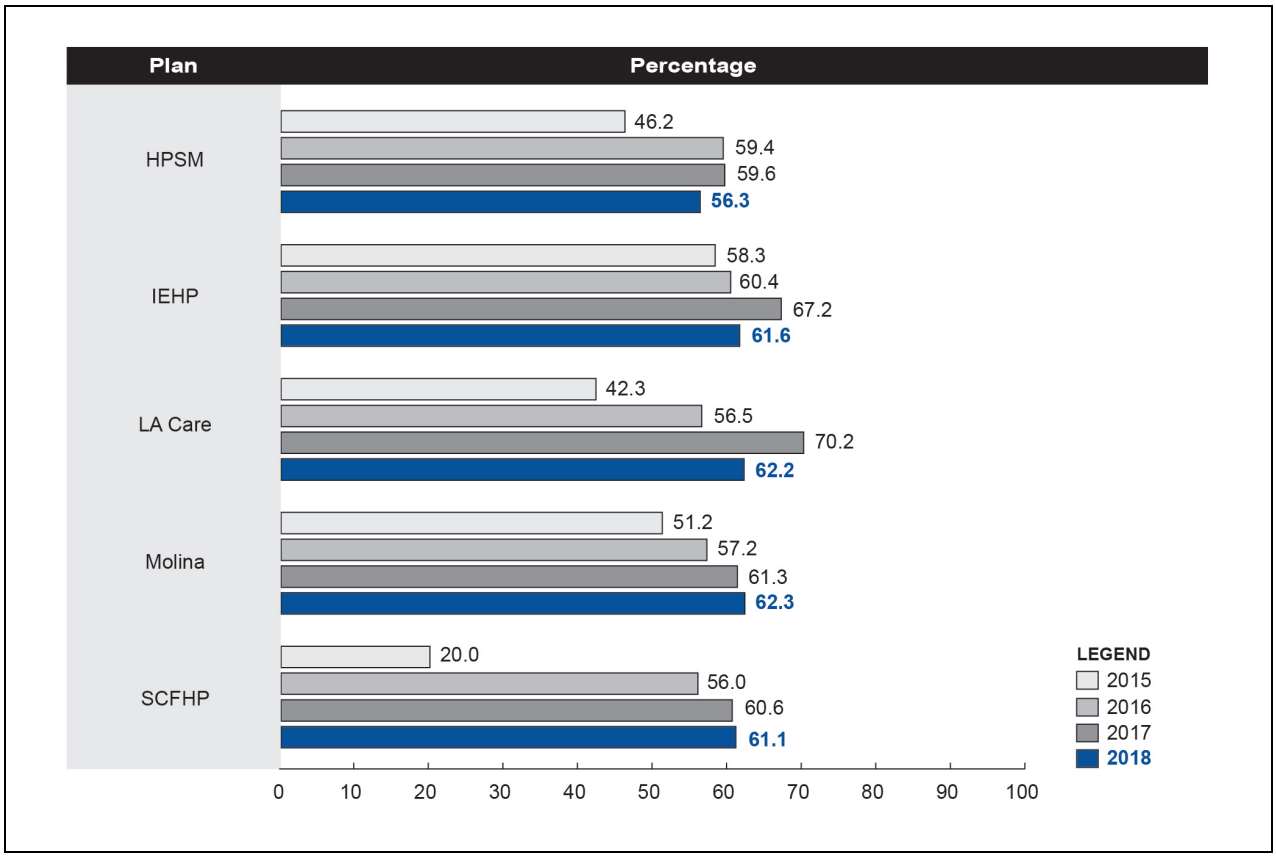
As shown in ***Figure 7***, most MMPs improved performance on controlling HbA1c levels (<8.0%) from 2015 to 2018. The most pronounced increases for MMPs were generally between 2015 and 2016.

Figure 7
Good control of HbA1c level (<8.0%), 2015–2018: Reported performance rates for Cal MediConnect MMPs



(continued)

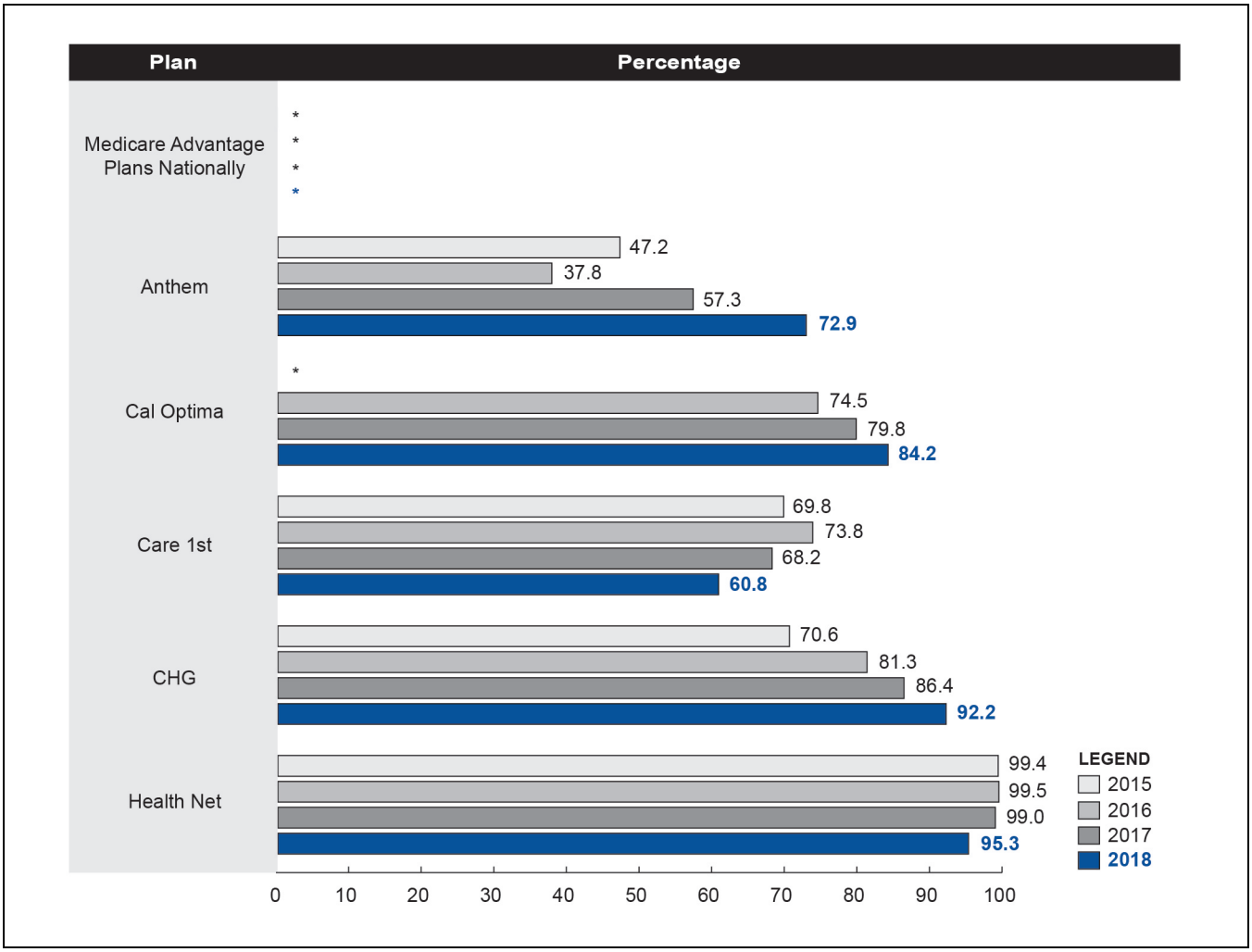
Figure 7 (continued)
Good control of HbA1c level (<8.0%), 2015–2018: Reported performance rates for Cal MediConnect MMPs



* = not available, where CalOptima did not report HEDIS data for the 2015 measurement year; CHG = Community Health Group; HEDIS = Healthcare Effectiveness Data and Information Set; HPSM = Health Plan of San Mateo; IEHP = Inland Empire Health Plan; MMP = Medicare-Medicaid Plan; SCFHP = Santa Clara Family Health Plan.
SOURCE: RTI analysis of 2015 through 2018 HEDIS measures.

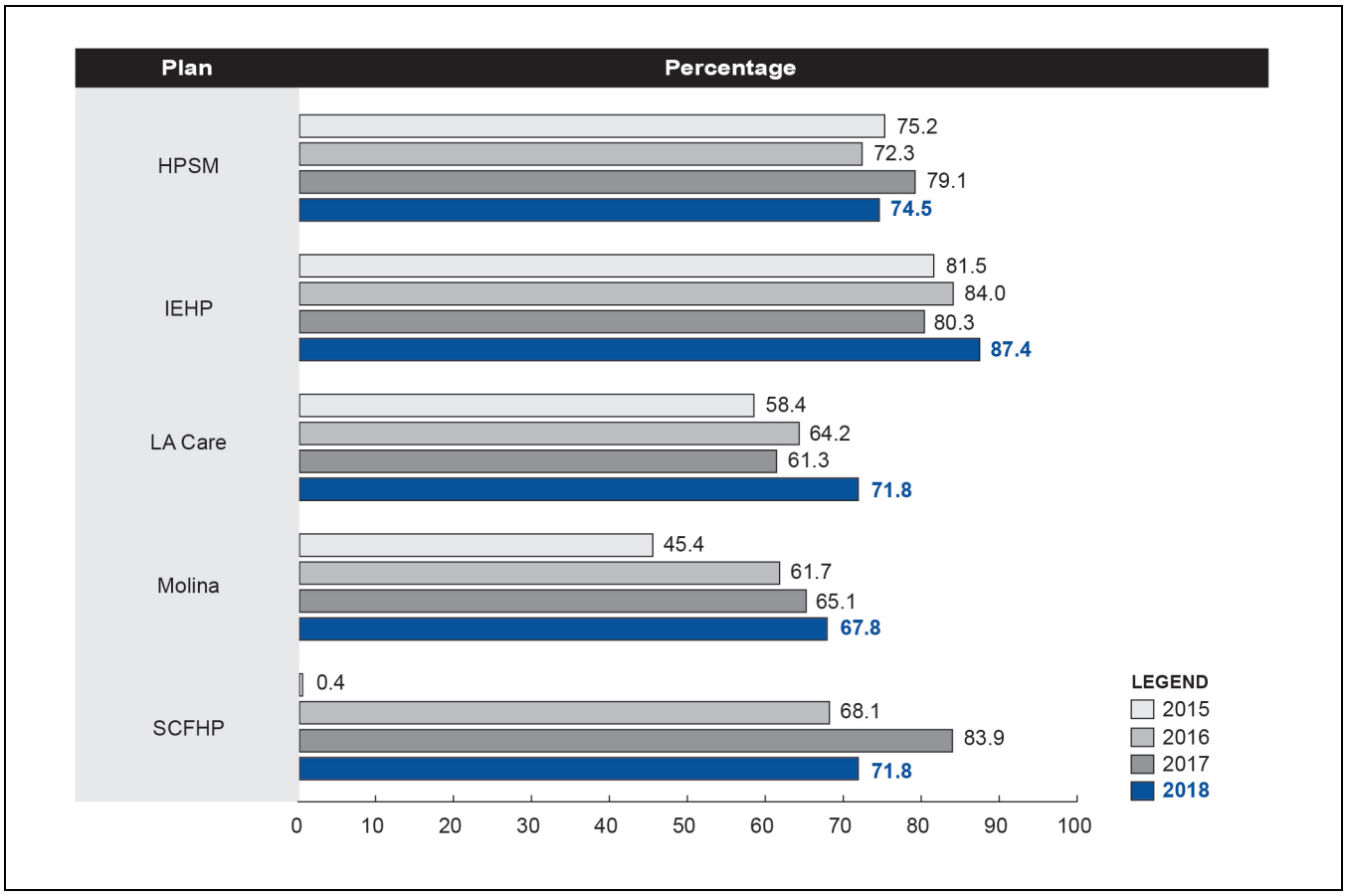
Figure 8 shows that for medication review (within measures of Care for Older Adults), most MMPs improved performance from 2015 to 2018. Remaining MMPs showed either stable performance year over year, or worsened performance between 2015 through 2018. National MA plan means for medication review were not reported for 2015–2018.

Figure 8
Medication review (within measures of Care for Older Adults), 2015–2018: Reported performance rates for Cal MediConnect MMPs



(continued)

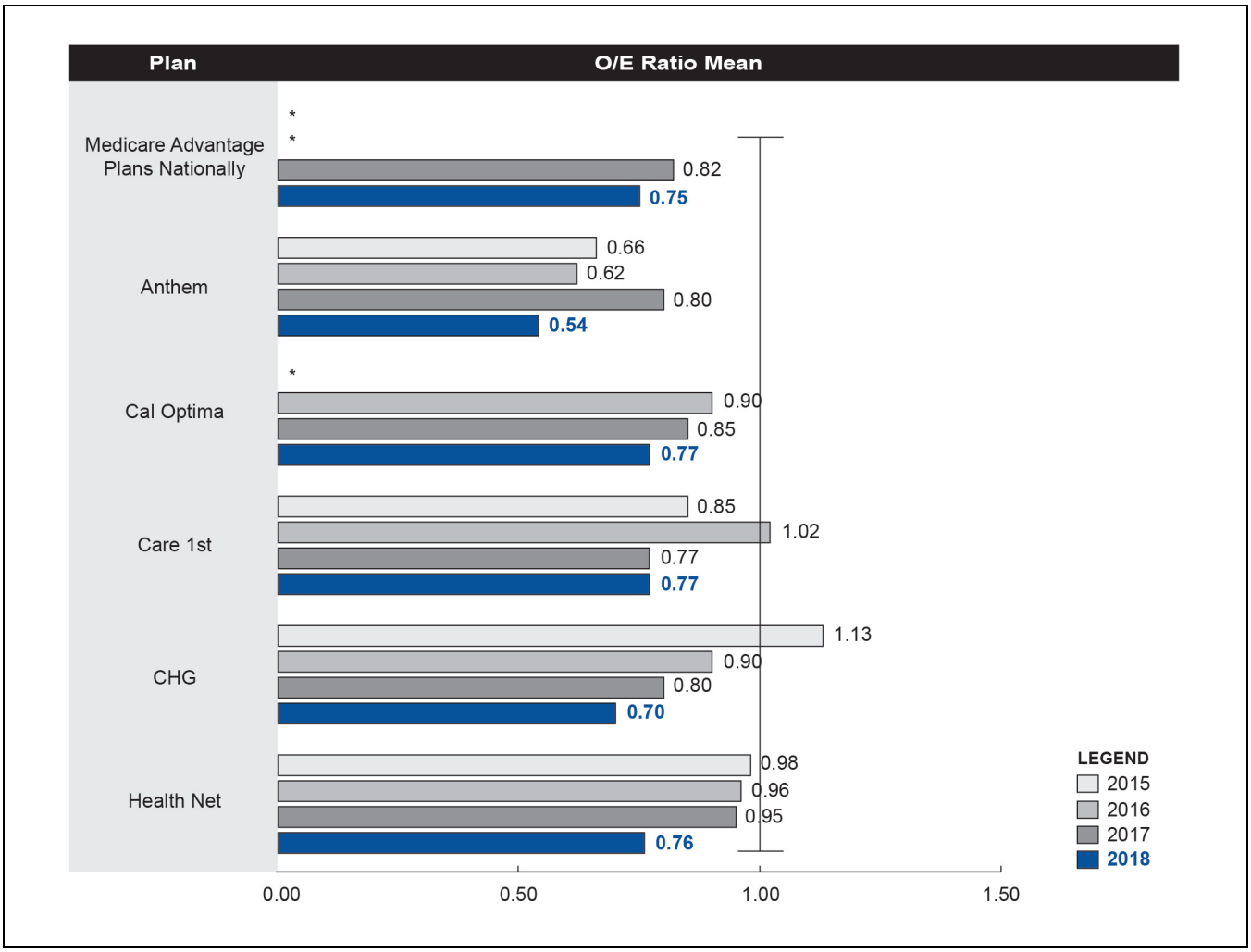
Figure 8 (continued)
Medication review (within measures of Care for Older Adults), 2015–2018: Reported performance rates for Cal MediConnect MMPs



* = not available, where MA plans nationally did not provide HEDIS data for this measure, or where CalOptima did not report HEDIS data for the 2015 measurement year; CHG = Community Health Group; HEDIS = Healthcare Effectiveness Data and Information Set; HPSM = Health Plan of San Mateo; IEHP = Inland Empire Health Plan; MMP = Medicare-Medicaid Plan; SCFHP = Santa Clara Family Health Plan.
SOURCE: RTI analysis of 2015 through 2018 HEDIS measures.

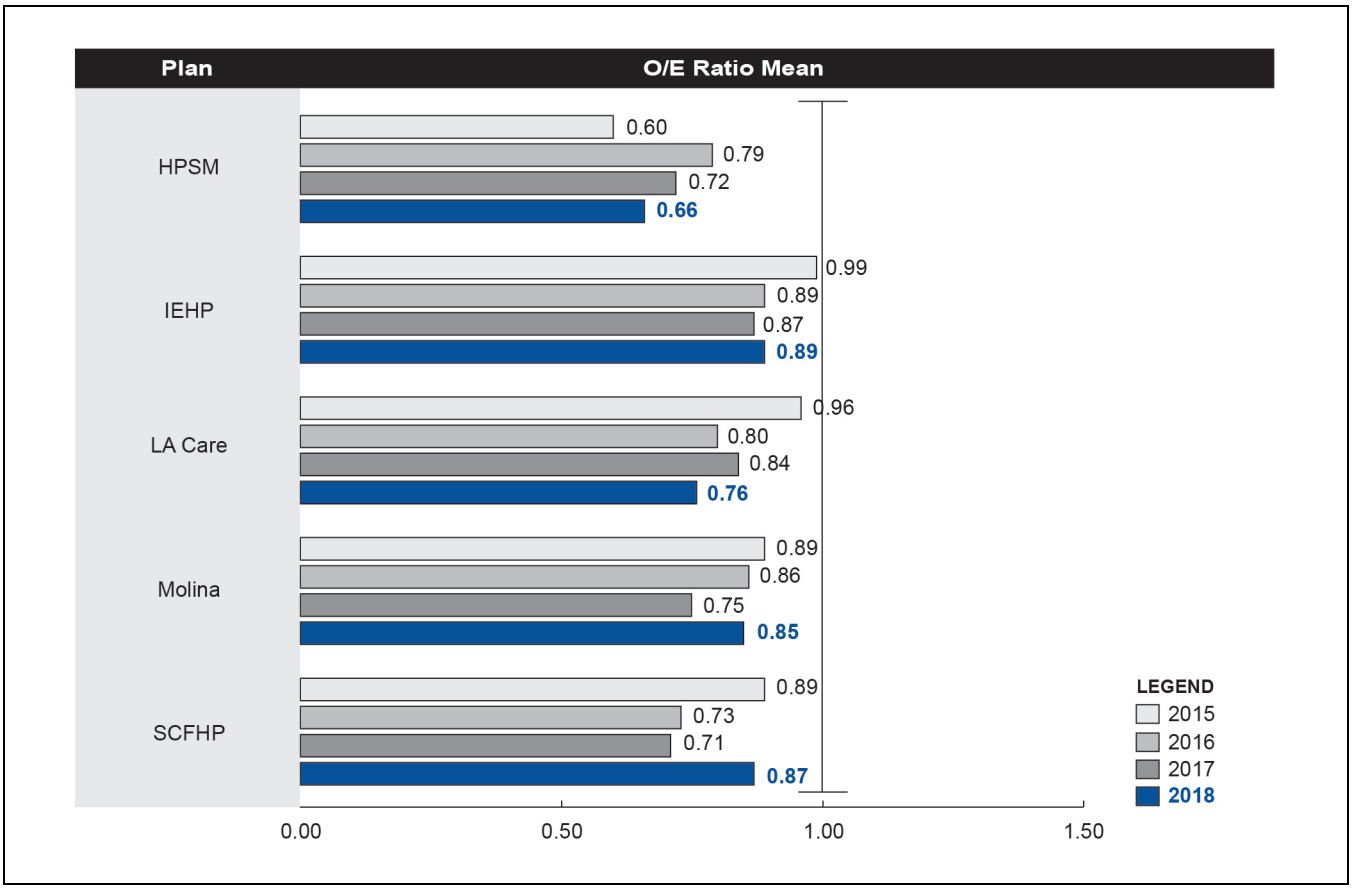
Plan all-cause readmissions for enrollees ages 18–64 and 65+ are reported in ***Figure 9*** and ***Figure 10***, respectively, as an observed-to-expected ratio mean, whereby an MMP's observed readmission rate is compared to its expected readmission rate given its beneficiary case mix; a value below 1.0 (shown by the vertical line at $x = 1$ in the figure below) is favorable and indicates that MMPs had fewer readmissions than expected for their populations based on case mix. ***Figure 9*** shows that nearly all MMPs reported lower than expected readmissions for enrollees ages 18–64 across all years. ***Figure 10*** shows a similar trend, but for enrollees ages 65+.

Figure 9
Plan all-cause readmissions, ages 18–64, 2015–2018:
Reported observed-to-expected ratio means for Cal MediConnect MMPs



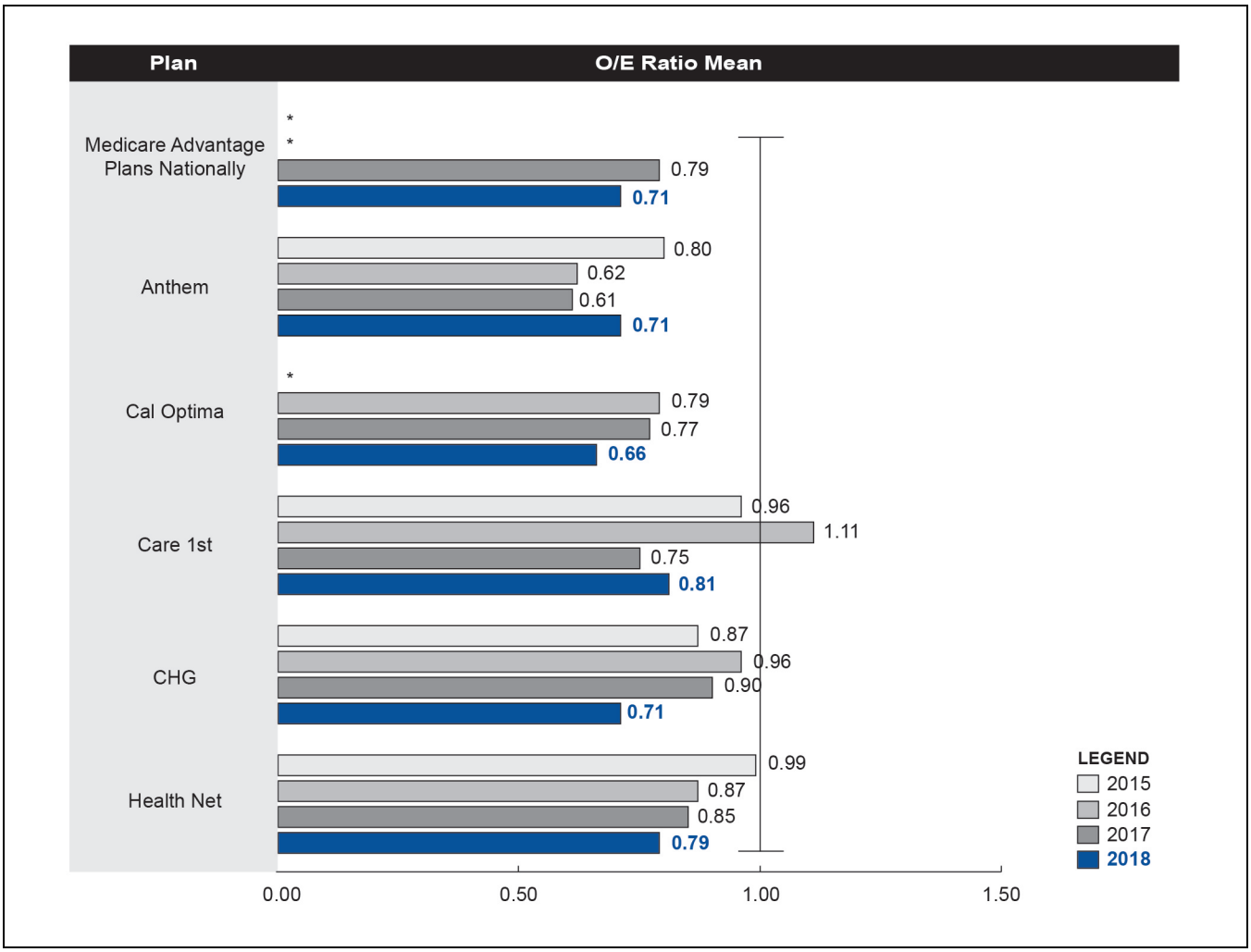
(continued)

Figure 9 (continued)
Plan all-cause readmissions, ages 18–64, 2015–2018:
Reported observed-to-expected ratio means for Cal MediConnect MMPs



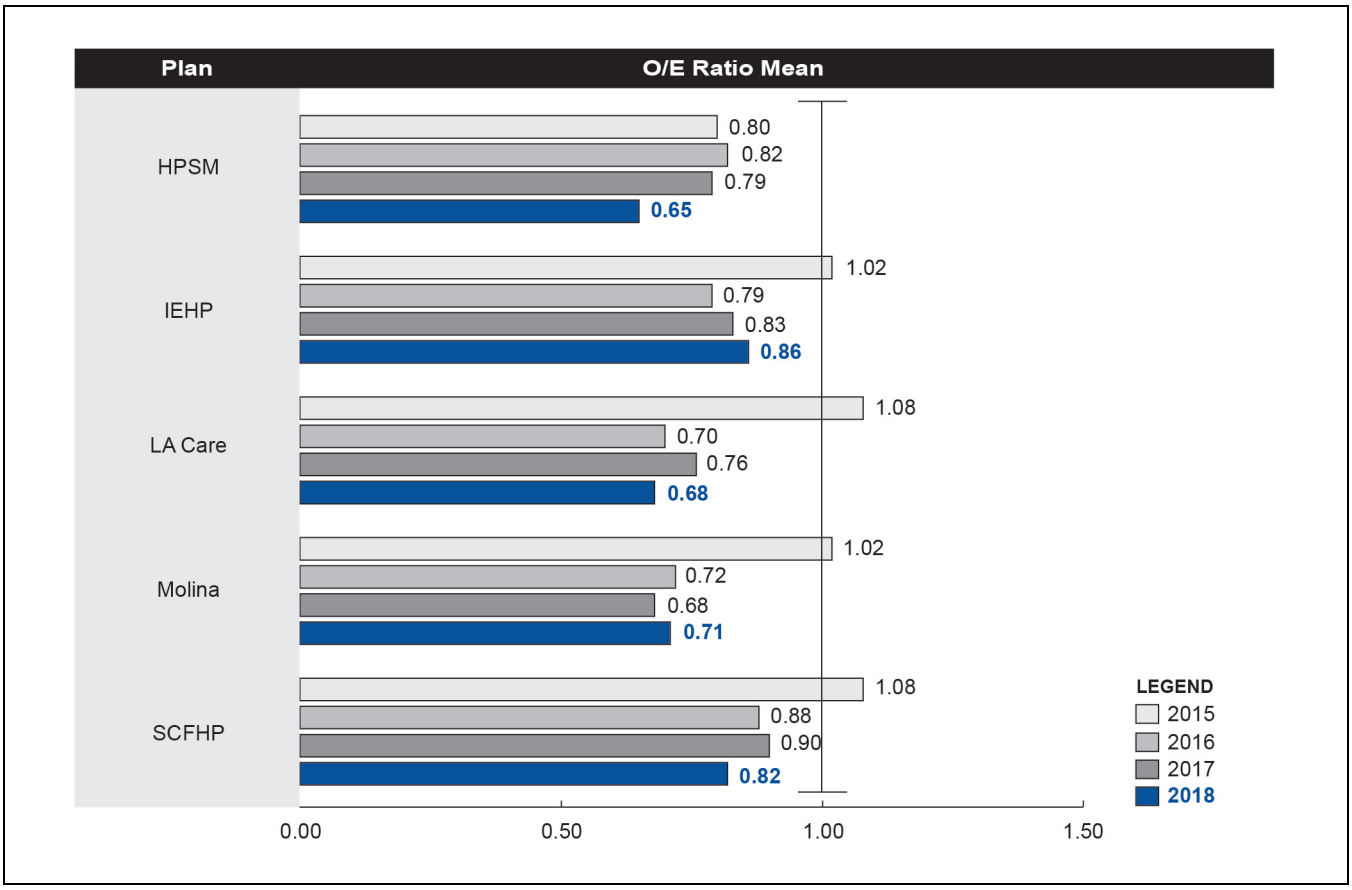
* = not available, where RTI did not have access to MA plan national HEDIS data for this measure, or where CalOptima did not report HEDIS data for the 2015 measurement year; CHG = Community Health Group; HEDIS = Healthcare Effectiveness Data and Information Set; HPSM = Health Plan of San Mateo; IEHP = Inland Empire Health Plan; MMP = Medicare-Medicaid Plan; SCFHP = Santa Clara Family Health Plan.
SOURCE: RTI analysis of 2015 through 2018 HEDIS measures.

Figure 10
Plan all-cause readmissions, ages 65+, 2015–2018:
Reported observed-to-expected ratio means for Cal MediConnect MMPs



(continued)

Figure 10 (continued)
Plan all-cause readmissions, ages 65+, 2015–2018:
Reported observed-to-expected ratio means for Cal MediConnect MMPs



* = not available, where RTI did not have access to MA plan national HEDIS data for this measure, or where CalOptima did not report HEDIS data for the 2015 measurement year; CHG = Community Health Group; HEDIS = Healthcare Effectiveness Data and Information Set; HPSM = Health Plan of San Mateo; IEHP = Inland Empire Health Plan; MMP = Medicare-Medicaid Plan; SCFHP = Santa Clara Family Health Plan.
SOURCE: RTI analysis of 2015 through 2018 HEDIS measures.

SECTION 4

Beneficiary Experience

Beneficiary satisfaction with the demonstration has remained high, and focus group participants reported feeling that enrollment in Cal MediConnect has had a positive impact on their lives.

Although only about one-third of all enrollees reported having a care coordinator, more enrollees reported receiving coordinated care compared to previous demonstration years and enrollees receiving care coordination reported being highly satisfied with the benefit. Awareness of care coordinators varied by level of need and by county, with higher need enrollees and enrollees in Los Angeles being the most aware of receiving care coordination.

Enrollees continued to predominantly resolve issues through their MMP or providers.

Complaints in 2017 were related to access to medications, DME, behavioral health, and physical therapy. New grievances in 2018 and 2019 were related to using ride-sharing services and dental service payment and access.

One of the main goals of the demonstrations is to improve the experience of beneficiaries who access Medicare and Medicaid services. In this section we highlight beneficiary experience with Cal MediConnect and provide information on beneficiary protections, data related to complaints and appeals, and critical incident and abuse reports. We also include information on the experience of special populations.

4.1 Impact of the Demonstration on Beneficiaries

In this subsection we summarize findings from beneficiary surveys including CAHPS, RTI site visit interviews, RTI and CMS-sponsored focus groups, and State evaluation results from the University of California, San Francisco. See ***Appendix A*** for a full description of these data sources.

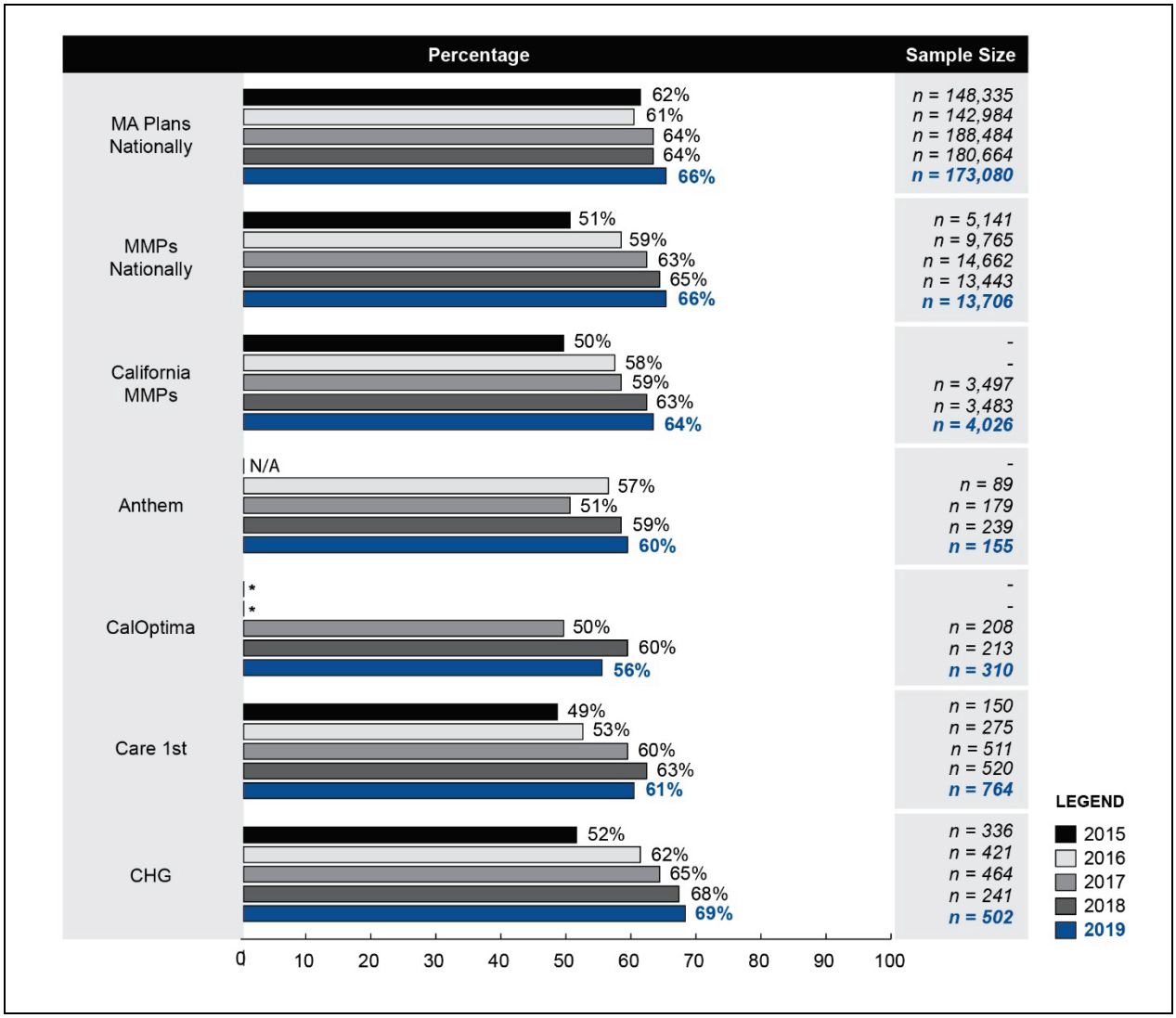
4.1.1 Overall Satisfaction with the Demonstration

We provide national CAHPS measure benchmarks from MA plans, where available, understanding that there are differences in the populations served by the Cal MediConnect demonstration and the general MA population, including health and socioeconomic characteristics that must be considered in the comparison of the demonstration to the national MA contracts.

Overall beneficiary satisfaction with the demonstration continued to increase and remained high among CAHPS survey respondents between 2017 and 2019. ***Figures 11*** and ***12*** present data collected on two CAHPS measures of beneficiary satisfaction across Cal MediConnect MMPs.

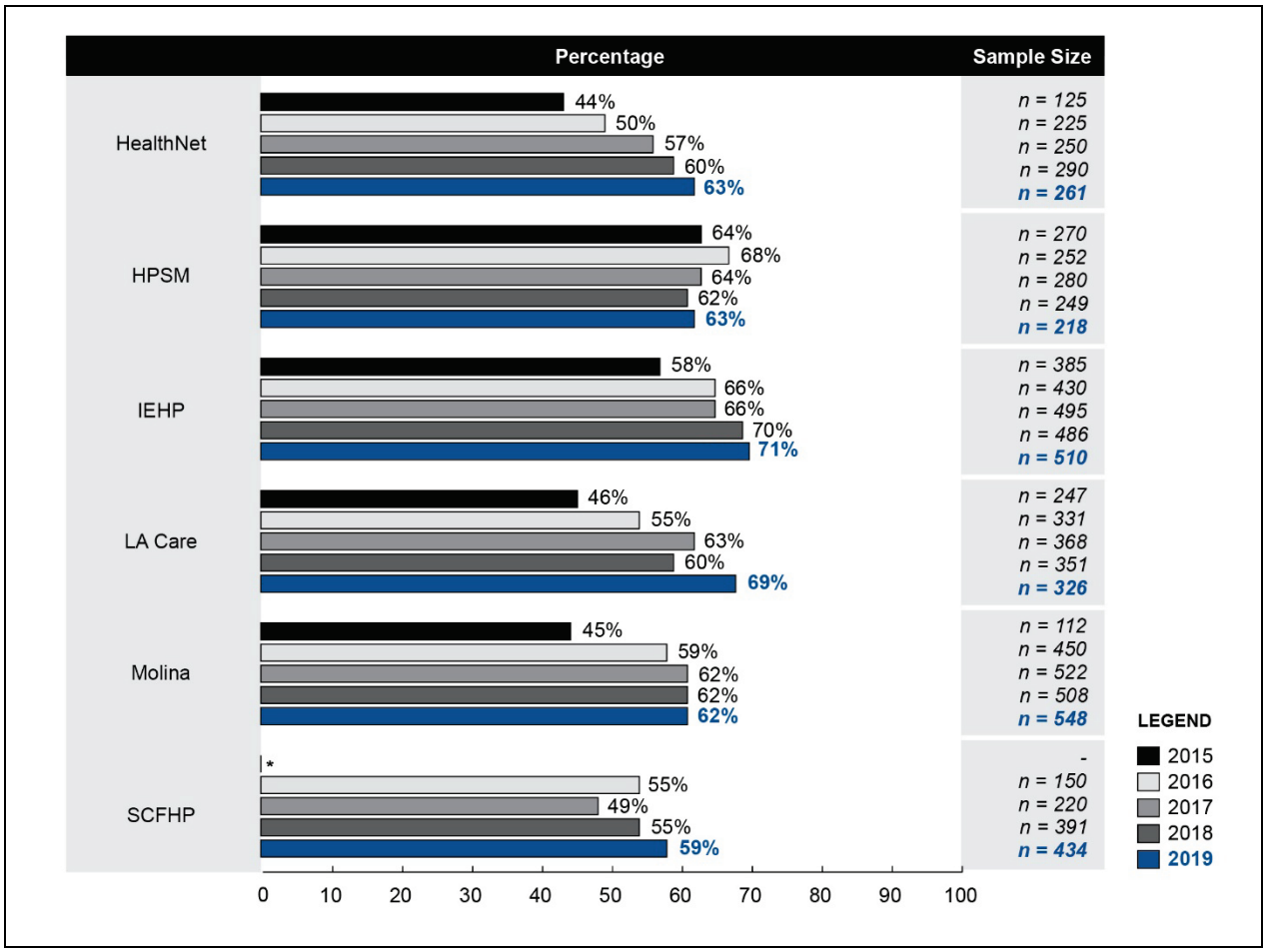
In general, the percentage of CAHPS respondents who rated their health plan as a 9 or 10 (on a scale of 0 to 10) increased from 2015 (or the earliest demonstration year for which an MMP reported data) to 2019. The percentage of CAHPS respondents who rated their prescription drug plan a 9 or 10 showed a similar overall trend.

Figure 11
Beneficiary overall satisfaction, 2015–2019: Percentage of beneficiaries rating their health plan as a 9 or 10



(continued)

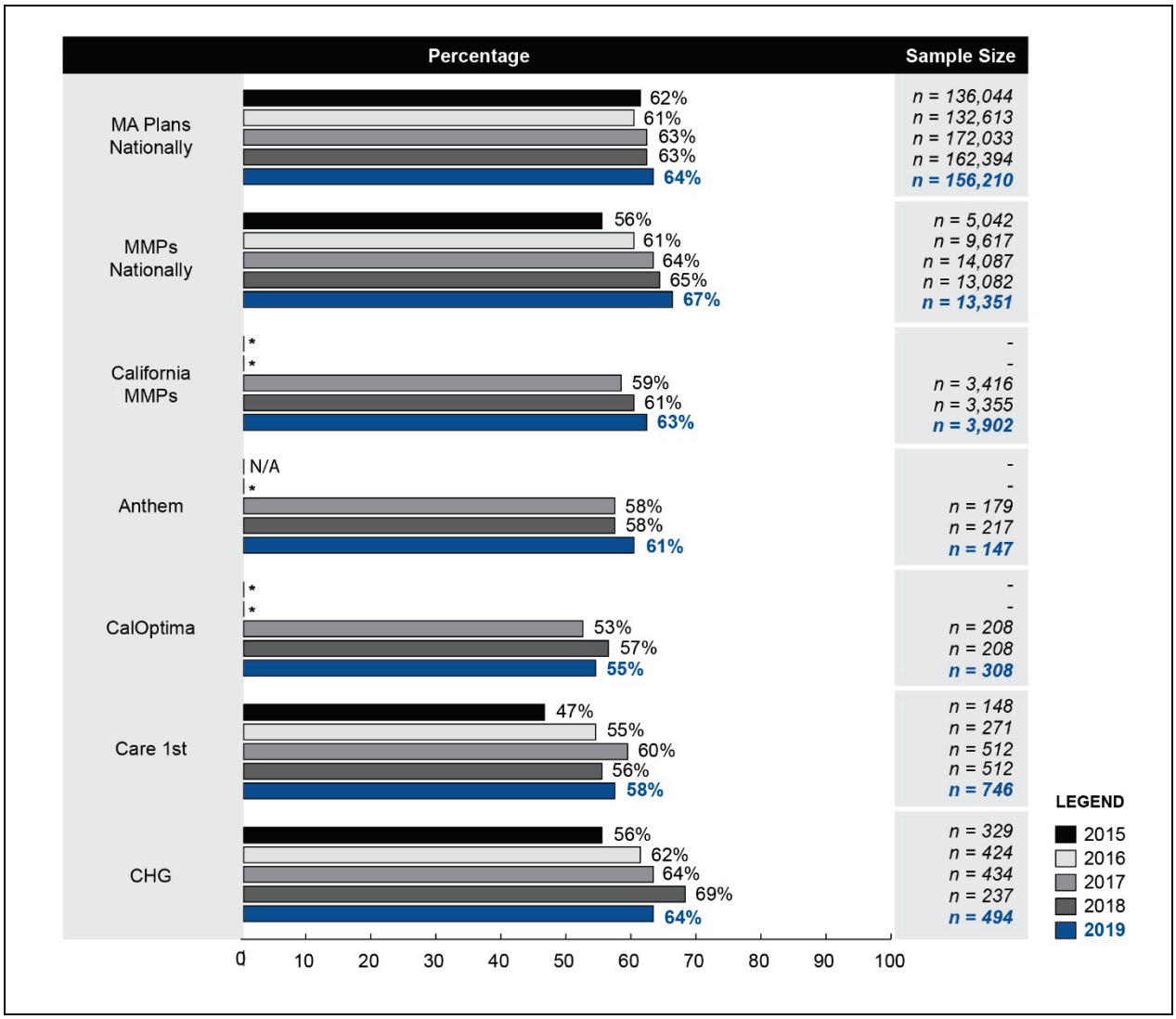
Figure 11 (continued)
Beneficiary overall satisfaction, 2015–2019: Percentage of beneficiaries rating their health plan as a 9 or 10



* = data not available; - = sample size data not available. CAHPS = Consumer Assessment of Healthcare Providers and Systems; MA = Medicare Advantage; MMP = Medicare-Medicaid Plan; N/A = "Suppressed," i.e., when too few members provided responses (new as of 2019), or when the results have very low statistical reliability.

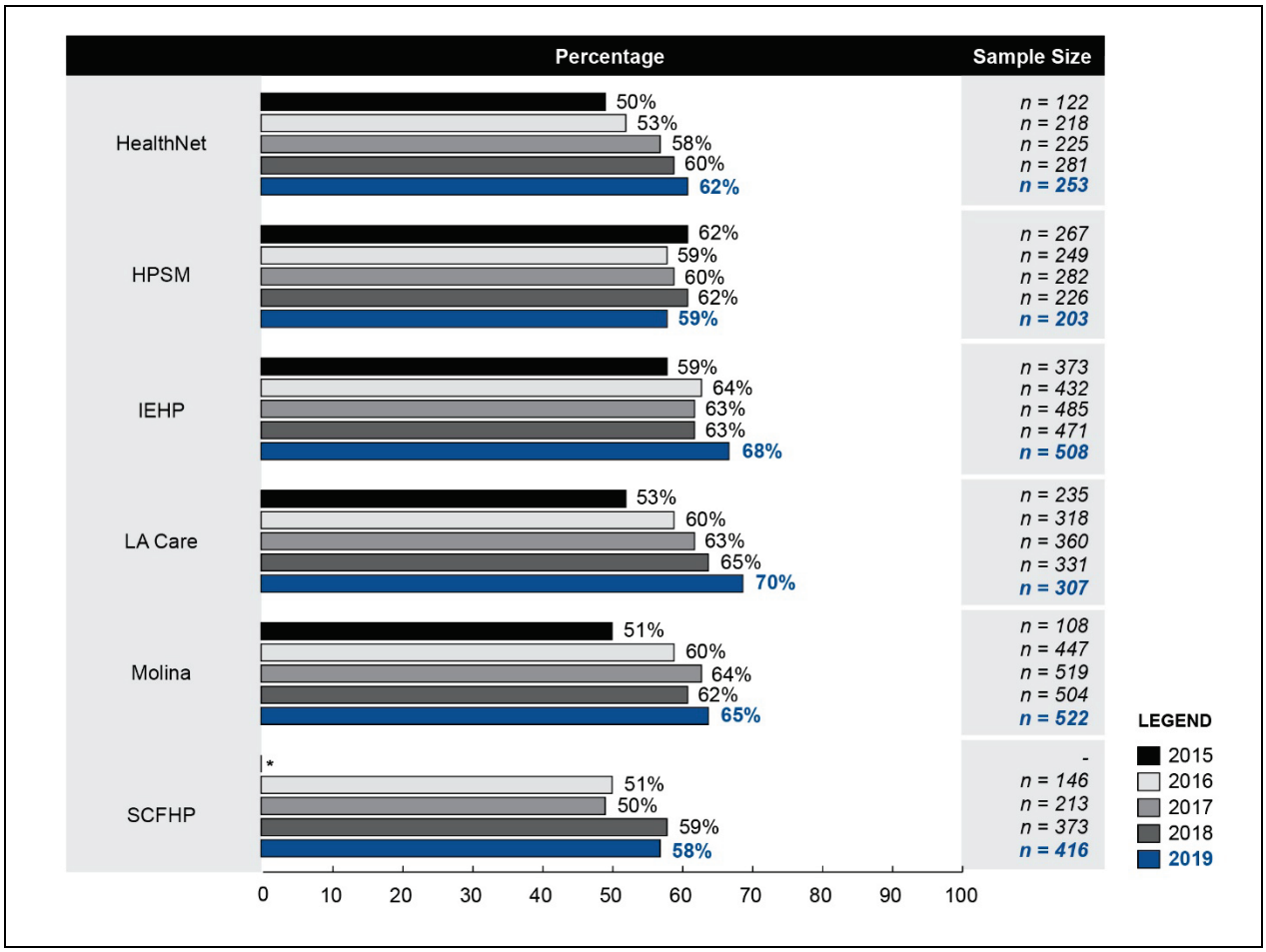
SOURCE: CAHPS data for 2015–2019. This item was case mix adjusted. The CAHPS question used for this item was: "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?"

Figure 12
Beneficiary overall satisfaction, 2015–2019: Percentage of beneficiaries rating their prescription drug plan as a 9 or 10



(continued)

Figure 12 (continued)
Beneficiary overall satisfaction, 2015–2019: Percentage of beneficiaries rating their prescription drug plan as a 9 or 10



* = data not available; - = sample size data not available. CAHPS = Consumer Assessment of Healthcare Providers and Systems; MA = Medicare Advantage; MMP = Medicare-Medicaid Plan; N/A = "Suppressed," i.e., when too few members provided responses (new as of 2019), or when the results have very low statistical reliability.

SOURCE: CAHPS data for 2015-2019. This item was case mix adjusted. The CAHPS question used for this item was: "Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your prescription drug plan?"

Consistent with CAHPS data, State evaluators found that 61 out of 68 Cal MediConnect enrollees participating in 2018 focus groups rated their satisfaction with the demonstration positively. Key informants in site visit interviews also said that enrollees become more satisfied over the course of their time in the demonstration.

4.1.2 Beneficiary Experience with New or Expanded Benefits and Care Plan Options

Given recent changes in the MA market—such as competition from D-SNP look-alike plans, the expansion of supplemental benefits in other MA products, and the reinstatement of dental and transportation services in Medi-Cal—it has become more difficult for MMPs to distinguish themselves in the market and offer new or expanded benefits. Some MMPs noted that

they reviewed and enhanced their benefits packages to make them more competitive, in some cases by augmenting hearing, vision and over-the-counter benefits for 2019, or by adding coverage for worldwide travel, fitness, and personal response systems. Other MMPs maintained their current benefits package, but worked on better educating enrollees about how to access existing benefits. In contrast, one MMP reported revoking their supplemental dental benefit due to Medi-Cal changes and increases in dentist rates, and helping enrollees access the FFS Medi-Cal dental benefit.

In 2017, it appeared that most plans were not providing Care Plan Options (CPOs). The provision of these services not only continued to be minimal, but also largely decreased between 2018 and 2019 (see below for discussion of dashboard data). The most commonly offered services continued to be funding of personal response systems, along with home delivered meals (e.g., meals after hospital stays). Two MMPs reported using CPO funds to provide IHSS-like services for enrollees who do not meet the threshold to fully qualify for IHSS services. One of these MMPs also used CPO funds to safely transition an enrollee from a nursing facility back to her home, and to clean the enrollee's home and mitigate a bed bug infestation.

Two of the MMPs interviewed in 2018 and 2019 were not offering CPO services. The MMPs that offered them did so sparingly and relied heavily on relationships with community organizations to meet member needs for these services.

According to State dashboard data for 2018 through 2019, the average number of beneficiaries receiving CPO services largely decreased. In 2018, the average fluctuated by quarter, ranging from 20 in quarters 2 and 3 to 40 quarter 4. In the first quarter of 2019, the average dropped back to about 20 beneficiaries, and then dropped further for the remaining quarters to an average of two. Only three of the 10 MMPs performed above the average, which was fewer than 10 per 1,000 enrollees in each of these MMPs (DHCS, 2019e).

According to one stakeholder, the upfront cost for providing CPO services can be high and plans that have offered a lot of CPO services have done so at a financial loss. In 2018, the State contractor, Harbage, reviewed data and discovered that MMPs were confused about what is defined as a CPO service and how to report these data. In November of that same year, Harbage distributed a letter to MMPs clarifying the policy and requirements and the data reporting form that captures CPO services was updated to align with these clarifications. State officials and Harbage hoped that more consistent definitions, better tracking and continued public reporting of CPO service provision on the CMC performance dashboard would improve CPO delivery and reporting in the future.

4.1.3 Beneficiary Experience with Care Coordination Services

Stakeholders and advocates have expressed concerns that the benefits of care coordination were not reaching enough enrollees, especially enrollees with complex needs. In one State evaluator survey in 2017, one-third of enrollee respondents reported having a care coordinator (Graham et al., 2018, p. 5). Regardless of their ability to identify a specific care coordinator, compared to previous years, more RTI 2017 focus group participants said that their care was being coordinated among their providers. This is consistent with the 2017 State evaluator survey findings previously mentioned, which showed 77 percent of enrollee

respondents believed that their PCP was always or usually informed of care from other specialists (Graham et al., 2018, p. 35).

A CMS 2018 focus group report provided some additional positive findings:

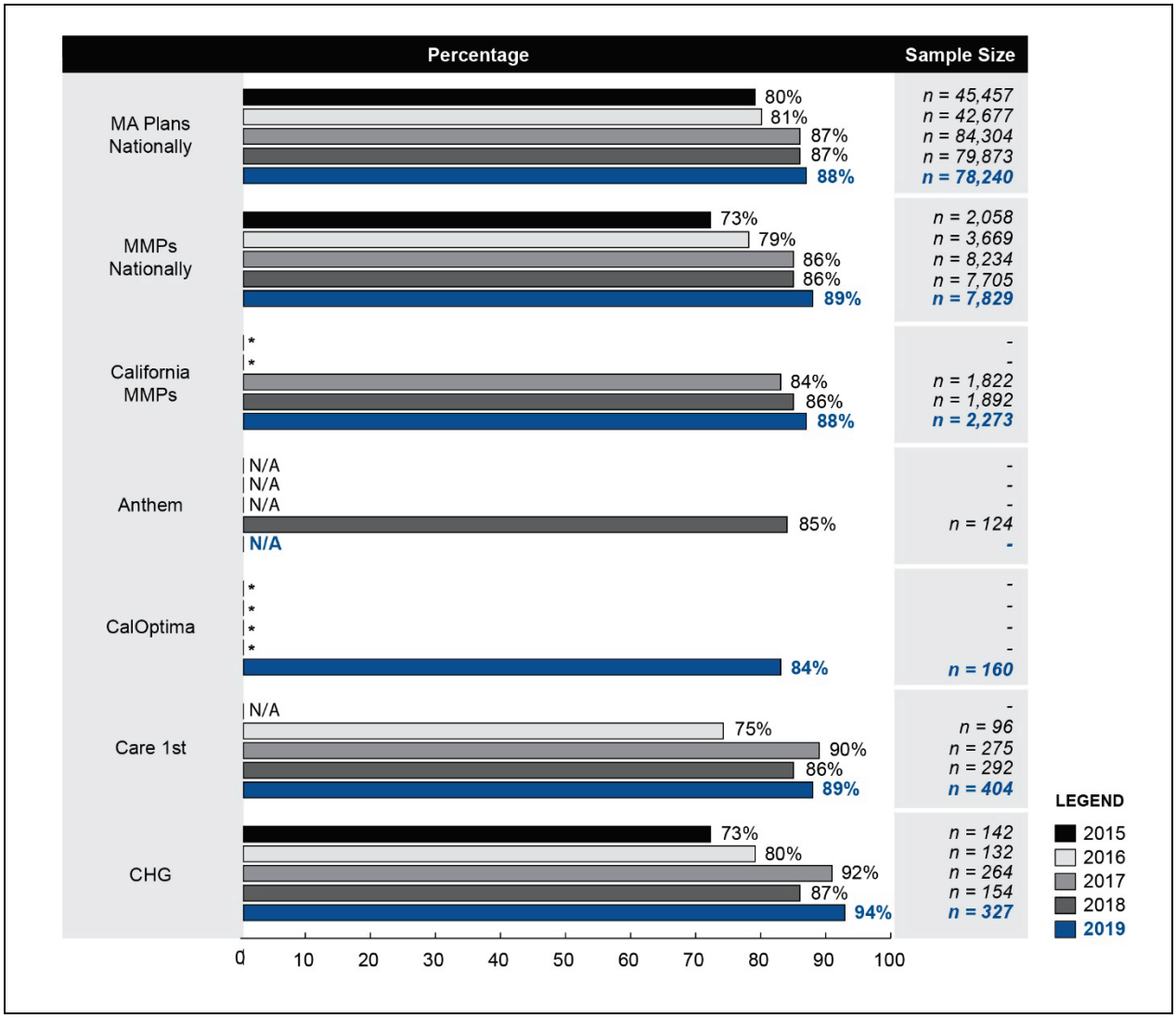
- Participants with more needs, including those receiving LTSS, appeared to have the most care coordinator involvement.
- Participants with fewer needs suggested they either received regular check-in calls or at a minimum felt they could reach out to their care coordinator for assistance if needed.

CAHPS results further substantiated this finding. The percentage of CAHPS respondents who reported that their health plan usually or always gave them information they needed generally increased from the earliest demonstration year for which an MMP reported data, to 2019 (***Figure 13***).

The 2018 CMS focus group findings also highlighted barriers among beneficiaries who were aware of the care coordination benefit but did not engage with care coordinators. These barriers included a lack of receptivity to care coordinators, difficulty connecting to care coordinators, or skepticism about initial care coordinator communications. The level of beneficiary engagement with care coordinators also varied by county. For example, about one-half of participants from the six focus groups held in Los Angeles felt they had a care coordinator from their plan or provider group with whom they could communicate, whereas only one or two participants from the San Francisco English-language focus groups said they had a dedicated coordinator. These factors suggest that MMPs could do more to identify areas where care coordination is lacking and build trust with their enrollees.

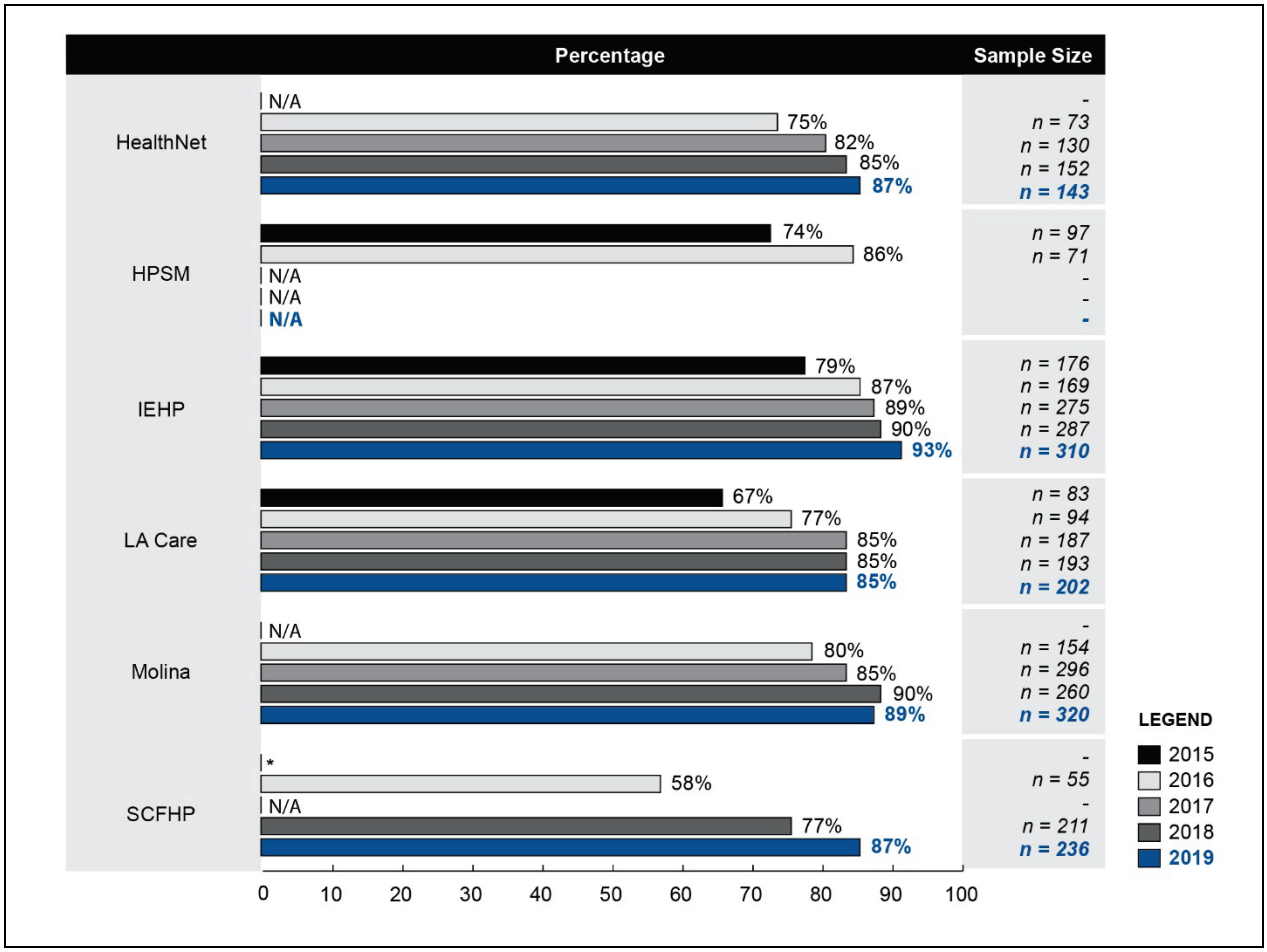
Despite large differences in the level of beneficiary engagement with care coordinators, beneficiaries appeared to receive sufficient information about their benefits. Unlike findings from early demonstration years, when passive enrollment was taking place, 2017 RTI focus group participants did not report struggling to understand enrollment processes nor were there many complaints of insufficient support understanding enrollment options or lack of education materials about various care options. These findings are consistent with CAHPS results that indicate overall increased satisfaction with receipt of needed information (see ***Figure 13***). Additionally, a State evaluation funded by the SCAN Foundation described how beneficiaries who were receiving care coordination were happy with the support they receive (Graham, Chapman, & Cohen, 2019).

Figure 13
Beneficiary experience with care coordination, 2015–2019:
Percentage of beneficiaries reporting that their health plan usually or always gave them information they needed



(continued)

Figure 13 (continued)
Beneficiary experience with care coordination, 2015–2019:
Percentage of beneficiaries reporting that their health plan usually or always gave them information they needed

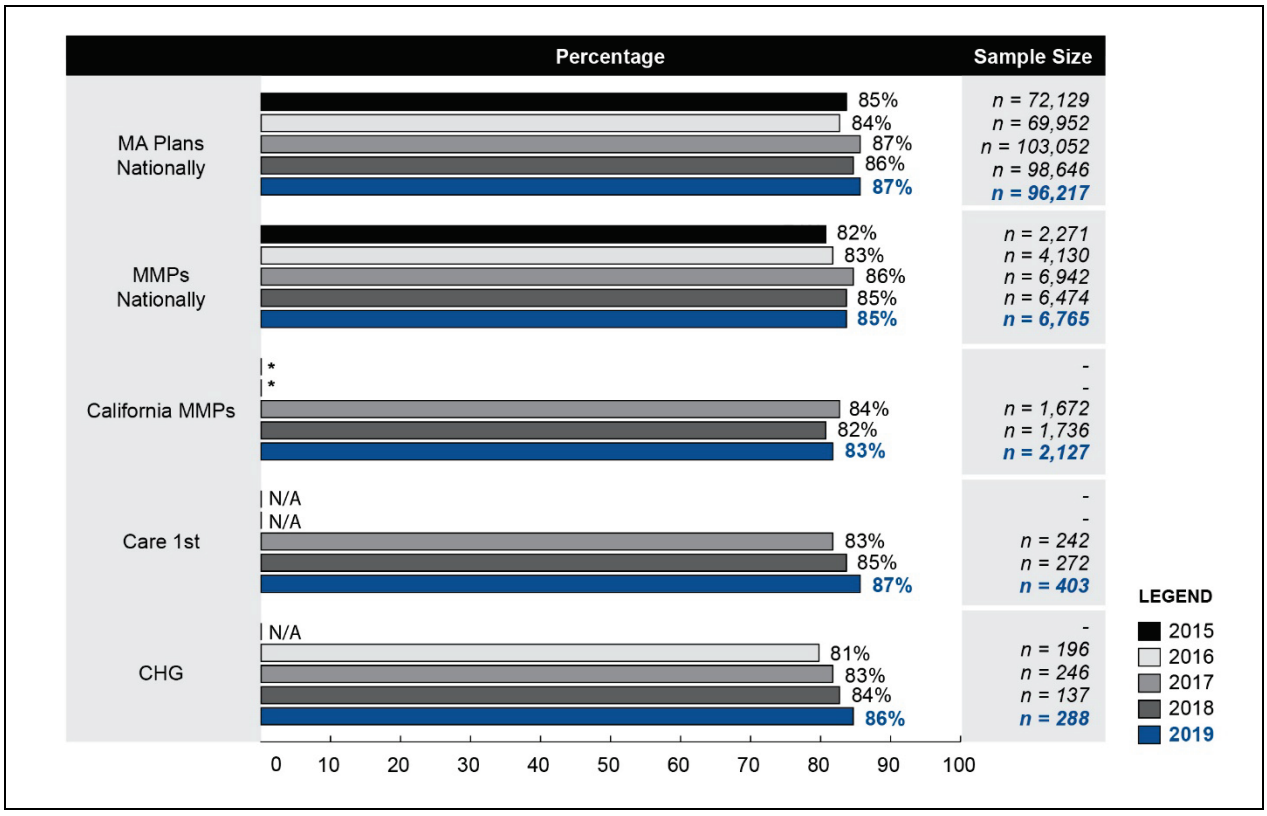


* = data not available; - = sample size data not available. CAHPS = Consumer Assessment of Healthcare Providers and Systems; MA = Medicare Advantage; MMP = Medicare-Medicaid Plan; N/A = "Suppressed," i.e., when too few members provided responses (new as of 2019), or when the results have very low statistical reliability.

SOURCE: CAHPS data for 2015-2019. This item was case mix adjusted. The CAHPS question used for this item was: "In the last 6 months, how often did your health plan's customer service give you the information or help you needed?"

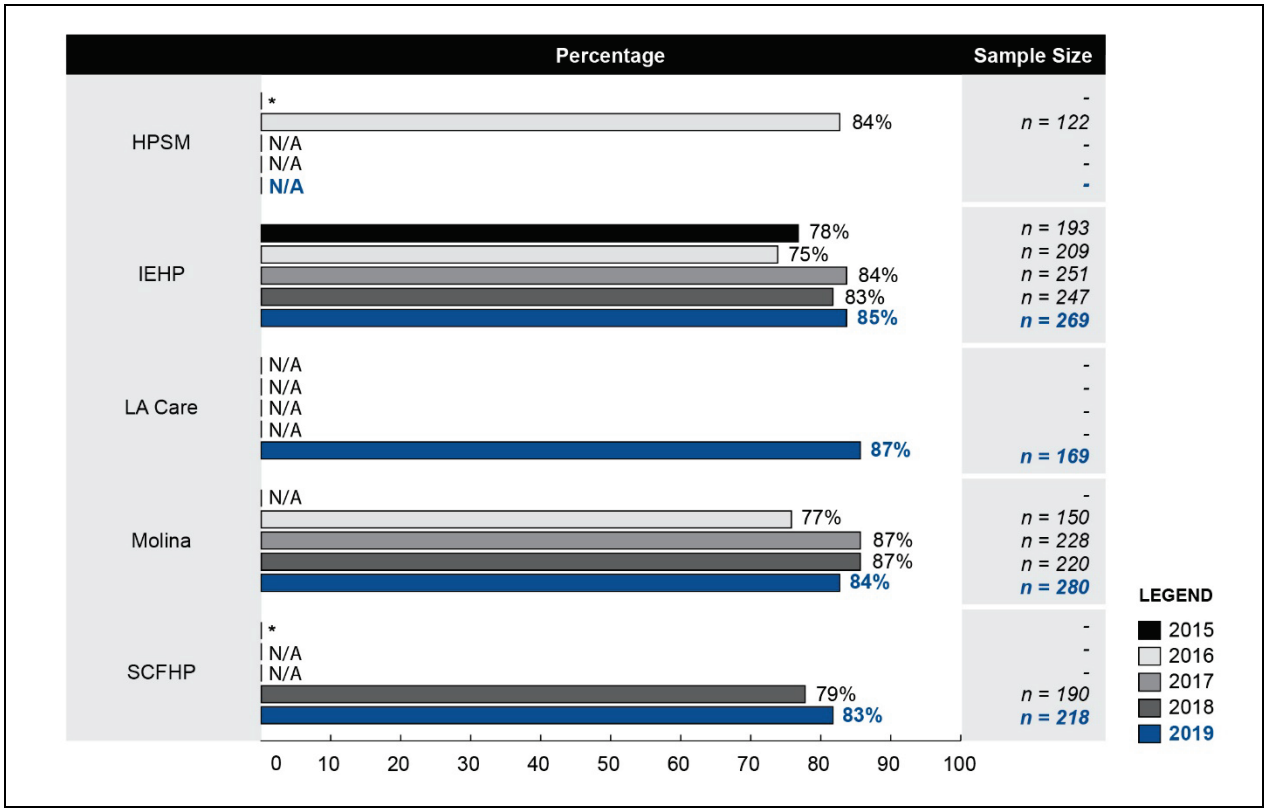
Beneficiaries also continued to report that care coordination was taking place across their providers. As shown in ***Figure 14***, CAHPS respondents in 2019 largely reported that their personal doctors were usually or always informed about care from a specialist. This is consistent with national MA and MMP averages for this item.

Figure 14
Beneficiary experience with care coordination, 2015–2019:
Percentage of beneficiaries reporting that in the past 6 months their personal doctors were usually or always informed about care from specialist



(continued)

Figure 14 (continued)
Beneficiary experience with care coordination, 2015–2019:
Percentage of beneficiaries reporting that in the past 6 months their personal doctors were usually or always informed about care from specialist



* = data not available; - = sample size data not available. CAHPS = Consumer Assessment of Healthcare Providers and Systems; MA = Medicare Advantage; MMP = Medicare-Medicaid Plan; N/A = "Suppressed," i.e., when too few members provided responses (new as of 2019), or when the results have very low statistical reliability.

NOTE: Anthem, CalOptima, and HealthNet do not appear in the chart because the plans did not provide any data for any of the years for this item.

SOURCE: CAHPS data for 2015-2019. This item was case mix adjusted. The CAHPS question used for this item was: "In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?"

4.1.4 Quality and Access to Care

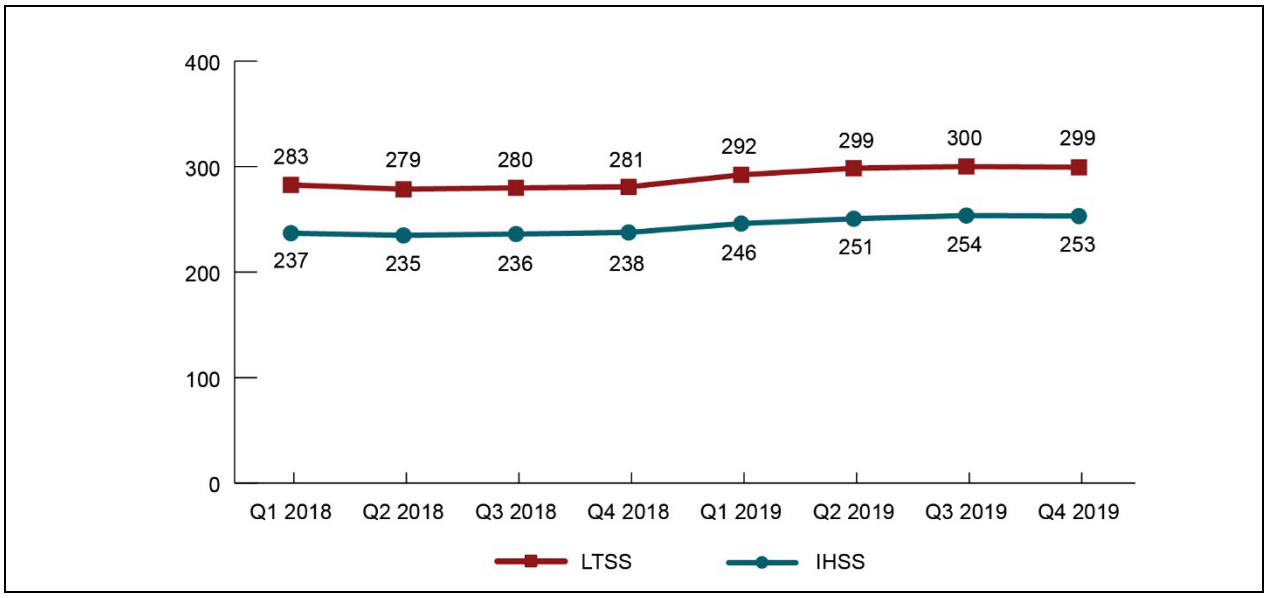
Overall, 2017 RTI focus group participants reported satisfaction with the quality of care offered by their MMPs. State evaluator survey findings showed that 87 percent of enrollee respondents reported the overall quality of care as excellent or good (Graham et al., 2018, p. 31). However, enrollee survey respondents and focus groups shared several instances of barriers to medication access, some of which may have related to changes in MMP formularies or authorization processes (i.e., issues that are not fully understood by all beneficiaries). Consistent with 2017 stakeholder interviews, State evaluator survey findings showed that about 48 percent of enrollee respondents reported an unmet DME need in 2017.

2017 RTI focus group participants in all four groups (African American, Spanish, Vietnamese, and multiethnic) expressed the desire to maintain a high level of independence and seemed to view receipt of certain additional services as an admission of diminishing physical capacity. Several participants had declined offered services, such as IHSS. As one participant explained:

> *[When I accept additional services] it makes me feel that I can't do things on my own.*
>
> – RTI Focus Group Participant (2017)

In 2018–2019, inadequate access and low referral rates to LTSS under Cal MediConnect remained a top stakeholder concern. As shown by State dashboard data, total LTSS utilization increased from an average of 283 per 1,000 enrollees in quarter 1 of 2018, to an average of 299 per 1,000 enrollees in quarter 4 of 2019. Similarly, IHSS utilization (in-home caregiver services) increased from an average of 237 per 1,000 enrollees in quarter 1 of 2018, to an average of 253 per 1,000 enrollees in quarter 4 of 2019 (see ***Figure 15***).

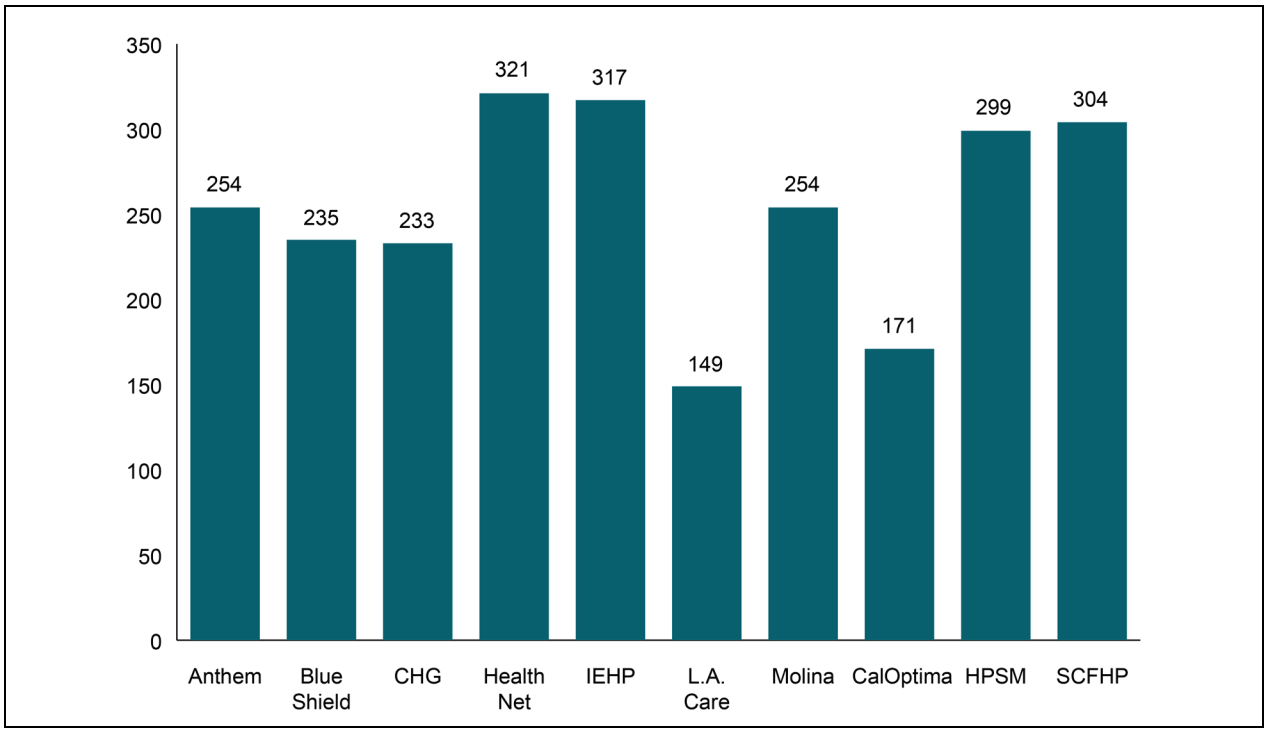
Figure 15
Quarterly rolling statewide average of members receiving LTSS and IHSS per 1,000 members



IHSS = In-Home Supportive Services; LTSS = long-term services and supports; Q = quarter.
NOTES: IHSS is a subset of reported LTSS. According to the explanation provided in the State's performance dashboard, plans report LTSS Utilization and Referrals for LTSS, which includes IHSS, CBAS, MSSP and CPO (page 8 at: https://www.dhcs.ca.gov/services/Documents/MCQMD/CMCDashboard9-20.pdf). The data are then presented separately in dashboard figures.
SOURCE: Data from Figures 22 and 24 of the Cal MediConnect Performance Dashboard, released in June 2019 and September 2020 for the illustrated quarters of data. Available at https://www.dhcs.ca.gov/Pages/Cal_MediConnectDashboard.aspx (Accessed on October 22, 2020).

For IHSS utilization, the average rate was 253.6 members per 1,000 members in quarter 3 of 2019. However, the IHSS receipt rate varied significantly by MMP, ranging from a low of 149 per 1,000 beneficiaries to 321 per 1,000 (see ***Figure 16***).

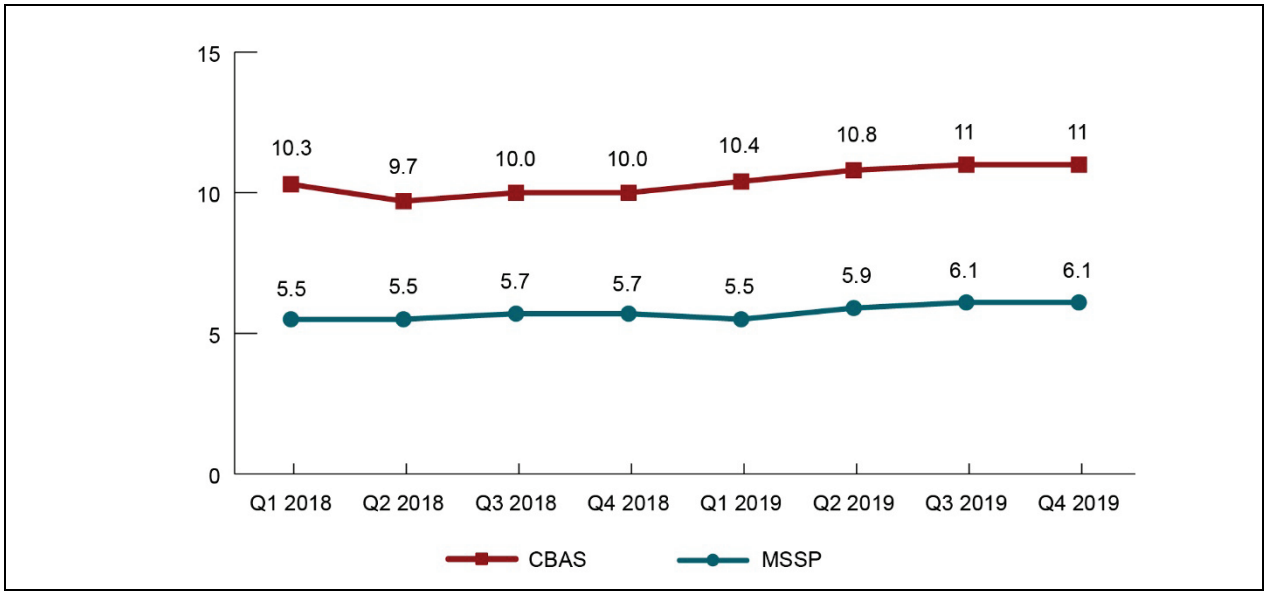
Figure 16
Number of members receiving IHSS per 1,000 members for quarter 3 of 2019



IHSS = In-Home Supportive Services; MMP = Medicare-Medicaid Plan.
SOURCE: Figure 23 of the Cal MediConnect Performance Dashboard, released March 2020. Quarter 3 of 2019 is the latest point in calendar year 2019 for which this data point is available. Available at https://www.dhcs.ca.gov/Documents/CMCDashboard3.20.pdf (Accessed on October 22, 2020).

The numbers were much smaller for access to CBAS and MSSP (which provide community-based services like adult day health programs). The averages increased only slightly between quarter 1 of 2018 and quarter 4 of 2019, from 10 to 11 per 1,000 enrollees for CBAS and from 5.5 to 6.1 per 1,000 enrollees for MSSP (see ***Figure 17***).

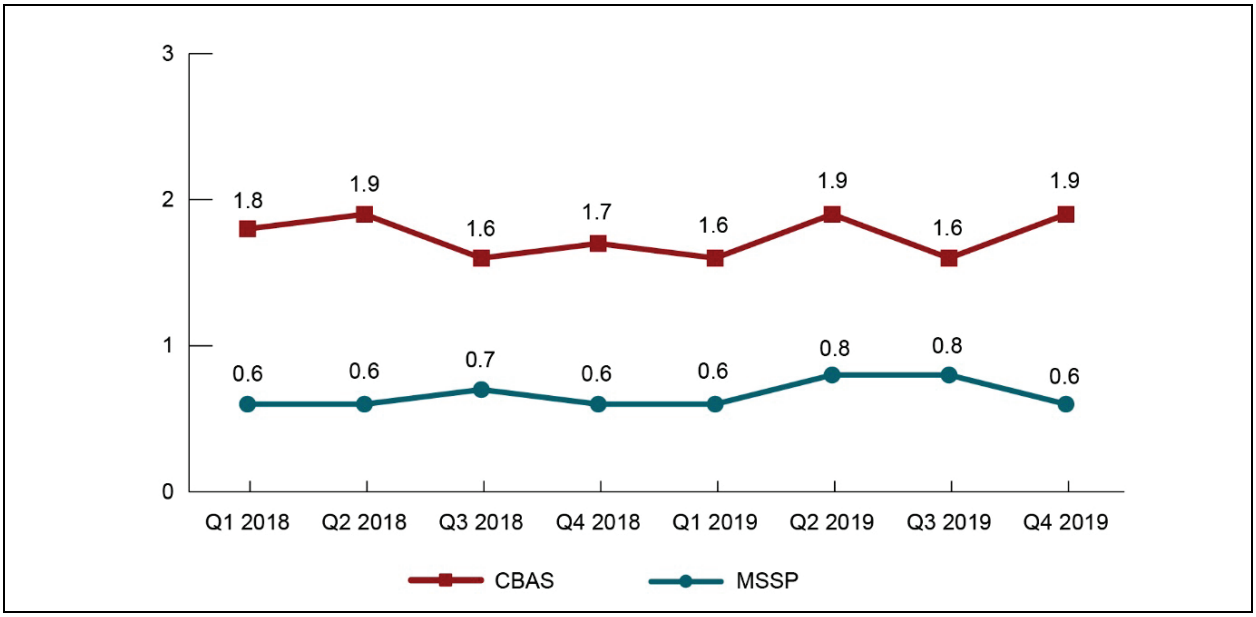
Figure 17
Quarterly rolling statewide average of members receiving CBAS and MSSP per 1,000 members



CBAS = Community-Based Adult Services; MSSP = Multipurpose Senior Services Program; Q = quarter.
SOURCE: Data from Figures 28 and 32 of the Cal MediConnect Performance Dashboard, released in June 2019 and September 2020, for the illustrated quarters of data. Available at https://www.dhcs.ca.gov/Pages/Cal_MediConnectDashboard.aspx (Accessed on October 22, 2020).

Stakeholders were particularly concerned with low rates of new referrals for LTSS. The average number of CBAS and MSSP referrals per 1,000 enrollees only fluctuated slightly during the reporting period, from 1.8 in quarter 1 of 2018 to 1.9 in quarter 4 of 2019, for CBAS, and 0.6 to 0.8 in those same quarters for MSSP (see ***Figure 18***).

Figure 18
Quarterly rolling statewide average of CBAS and MSSP member referrals per 1,000 members



CBAS = Community-Based Adult Services; MSSP = Multipurpose Senior Services Program; Q = quarter.
SOURCE: Data from Figures 26 and 30 of the Cal MediConnect Performance Dashboard, released in June 2019 and September 2020m for the illustrated quarters of data. Available at https://www.dhcs.ca.gov/Pages/Cal_MediConnectDashboard.aspx (Accessed on October 22, 2020).

These numbers are consistent with 2018 and 2019 reports from advocates that many who would benefit from LTSS are not receiving them.

4.1.5 Personal Health Outcomes and Quality of Life

2017 RTI focus group participants attributed improvements in health outcomes and quality of life to enrollment in their MMPs. Most 2018 CMS focus group participants reported feeling that enrollment in Cal MediConnect had a positive impact on their lives, and feeling encouraged by their plans through ongoing outreach and communication to take better care of themselves. The extent to which enrollees felt their plan had a positive impact varied somewhat by county, with the most positive reports coming from participants in Los Angeles.

4.1.6 Experience of Special Populations

In this section we summarize the beneficiary experience for Cal MediConnect special populations, including racial, ethnic, and linguistic minorities and those with disabilities.

Engaging and Meeting the Needs of Minority Communities

Although there have been ongoing efforts to educate enrollees and providers about the demonstration, one stakeholder commented in 2019 that education had not reached culturally and linguistically distinct communities to the extent necessary, and that providers primarily serving these communities had not been sufficiently convinced of the potential benefits to beneficiaries participating in the demonstration. For example, in the 2018 CMS focus groups, Spanish-language participants were usually not familiar with the term Cal MediConnect and expressed more confusion and uncertainty than English-speaking participants about their insurance, MMPs, and the health care system in general. Spanish-language participants in those focus groups said they were often introduced to plans by their providers, provider office staff, friends, or hospital social workers. Stakeholders interviewed by RTI suggested that more targeted efforts can be made to engage key stakeholders in these communities and reach dual eligible beneficiaries who would benefit from the demonstration.

In 2017–2019, State evaluations, focus group respondents, and stakeholder input from RTI site visits continued to suggest that enrollee language needs remained largely unmet. A University of California San Francisco longitudinal analysis of 2016 and 2017 survey data found that over one-half of Cal MediConnect enrollees who needed interpreter services were unable to access them (Graham et al., 2018). According to CMS focus group findings and RTI site visit interviews, lack of language access led to additional access to care issues, such as difficulty finding a provider and transportation problems. One advocate suggested that enrollees are not being provided with clear information about how to access interpreter and legally-mandated language access services.

This advocate also emphasized the importance of engaging providers that serve culturally and linguistically distinct communities for demonstration enrollment. He explained that large numbers of opt-outs of certain language groups, such as Korean and Vietnamese speakers, were in part related to influence of their local providers, and that engaging these providers and trusted local agencies in culturally and linguistically distinct communities is essential. Several MMPs reported concerted efforts to address linguistic and cultural needs, including effectively identifying member language needs and hiring linguistically diverse staff.

Engaging Persons with Homelessness and Behavioral Health Needs

In 2018 and 2019, stakeholders and plans noted one of the biggest challenges to enrollee engagement was reaching homeless enrollees because of bad contact information or lack of a physical address. Several MMPs described creative ways to address this challenge. For example:

- One MMP worked with social and health care service providers in the community to find enrollees who do not have a phone number or by leveraging LTSS or MSSP data for those enrollees.
- Another MMP stocked “community closets” with hygiene supplies and underwear in areas with a large concentration of homeless individuals, hoping to engage enrollees who came to stock up.
- One MMP hired a psychologist dedicated to conducting outreach and follow-up calls with enrollees who transitioned back into the community after a psychiatric

hospitalization. This MMP also had a dedicated telephone number for its behavioral health department with someone available to respond 24/7, including a licensed psychologist and psychiatrist.

Other Concerns Voiced by Focus Group Participants

Two legally blind RTI focus group participants voiced complaints specific to accessibility for legally blind enrollees. They reported making repeated requests for accessible informational materials without response from MMPs. They also cited transportation providers who were not trained in accessibility for enrollees with visual impairment.

4.2 Beneficiary Protections

In this section we describe the numbers and types of beneficiary complaints and appeals received about Cal MediConnect. Because the demonstration integrates Medicare and Medicaid services, these data have been compiled from several sources, including the Cal MediConnect Ombudsman program, the MMPs, DHCS, the Medicare Complain Tracking Module (CTM), the Independent Review Entity (IRE), and qualitative information collected by the RTI evaluation team. Reporting periods vary across these sources.

Complaints and Grievances

Enrollees have the right to file a grievance with their MMP at any time. A grievance is a complaint or a dispute expressing dissatisfaction with the MMP or a provider, regardless of whether the enrollee is requesting a remedial action. Grievances are resolved at the MMP level. A grievance is also called a complaint.

The three-way contract, which delineates the plans' requirements for accepting, processing, and reviewing complaints and grievances, was re-executed on September 1, 2019, and included clarifications and updated grievance requirements.[8]

Complaints Received by the Cal MediConnect Ombudsman Office. In 2017, Ombudsman program officials reported that a significant decrease in call volume to the demonstration hotline occurred after passive enrollment ended in 2016. Lack of progress on providing sufficient levels of care coordination to enrollees was the Ombudsman program's number one concern in 2017. Other priority issues were improper billing, enrollment/disenrollment, service denials and problems or delays accessing services. Although improper billing was the top reason for beneficiary complaints, there were fewer calls on this topic in 2017 than in the previous years, and cases were typically easily resolved through the provider and plan.

According to one ombudsman official, complaints remained low in 2018 and continued to decline in 2019 overall. Top issues in 2018 and 2019 were still related to:

[8] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAContractSummaryOfChanges.pdf

- enrollment/disenrollment,
- problems or delays accessing services,
- improper billing of dental care services.

One Ombudsman explained that dental providers lack experience with managed care, and do not seem to understand that enrollees cannot be billed for Medi-Cal covered services. Additionally, dual eligible beneficiaries, including Cal MediConnect enrollees, are being encouraged to apply for dental care credit cards to pay for non-covered services at dental providers' offices, and are unaware of the heavy interest, fines and other risks associated with using these credit cards. According to the ombudsman representative, this disproportionately impacts enrollees with limited English proficiency. The consumer protection team at Legal Aid Society of San Diego handled about a dozen of these cases between 2018 and 2019 across the State.

Ombudsman officials explained that medication access cases were particularly challenging and time-consuming, with access to pain medication at the forefront as a result of new State actions in response to the opioid crisis. They also suggested that the inability to access needed medications often resulted in enrollees switching to other plans or disenrolling from the demonstration entirely, rather than following up with the Ombudsman office.

A CMS representative reported that transportation grievances increased once DHCS restored transportation to the Medi-Cal benefits package in 2018. New transportation complaints were related to use of ride-sharing services, such as Uber or Lyft, which enrollees were attempting to use in response to long wait times with other transportation vendors. Enrollees resorting to use of Uber or Lyft given timeliness issues with other transportation vendors introduces a safety risk for those individuals. Uber and Lyft drivers are not trained to work with people with disabilities, which resulted in unique challenges, such as not ensuring riders were able to safely get from the drop off point to their destination.

The Ombudsman Office also continued to handle DME access cases, including a power wheelchair case and cases related to receiving continuous glucose monitors, although the number of cases was low.

Despite general improvements in access to care and fewer instances of improper billing, ombudsman officials continued to cite these as major areas of concern because when these cases occur, these instances point to failures in care coordination that can lead to service interruptions and complications for enrollees.

Grievances and appeals reported by Cal MediConnect plans. Over the course of the demonstration, the analysis method for plan-reported grievances has changed. Initially, data were analyzed per 1,000 enrollees; effective January 2018, the method changed to analyze grievances per 10,000 enrollee months.

From 2014 through 2017, plan-reported grievances increased, peaking at 22 grievances per 1,000 enrollees in third quarter of 2017. Under the modified measurement scale, 2018 and

2019 data also showed an upward trend: the total grievances per 10,000 enrollee months steadily increased from 92in quarter 1 of 2018 to 149in quarter 4 of 2019.

Data reported to the CTM[2] for the period 2014–2019 show a low but overall increased number of complaints, ranging from 169 in 2014 to 192 in 2018. For all 5 demonstration years, the highest number of complaints were in two categories: enrollment and disenrollment; and benefits, access, and quality of care. Although the complaint categories are consistent with information provided by the ombudsman, the increase contrasts with the ombuds' reports of an overall decline in these types of grievances.

As with grievance data, effective January 2018 the analysis method for appeals data were changed from appeals per 1,000 enrollees to appeals per 10,000 enrollee months. From 2014 through 2017, the number of appeals remained relatively low, ranging from 0.1 to 3.5 appeals per 1,000 enrollees. From 2018 to 2019, the number of appeals per 10,000 enrollee months steadily increased from a low of 19 appeals in quarter 1 of 2018 to a high of 104 in quarter 2 of 2019, before declining to 43 as of quarter 4 of 2019.

A total of 2,608 appeals were reported to the IRE from 2014 through 2019, of which 2,055 (78 percent) were upheld, 208 (8 percent) were overturned, 25 (1 percent) were partially overturned, 295 (11 percent) were dismissed, 24 (1 percent) were withdrawn, and 1 (a near-zero percent) was pending. The most common category of appeals referred to the IRE was for non-Medicare benefits,[9] followed by practitioner services[10] and DME.

Critical Incident and Abuse Reports for Enrollees Receiving LTSS. Cal MediConnect plans are required to report to the California Department of Managed Health Care (DMHC) and NORC on the number of critical incidents and abuse reports.[11] The number of reports has varied but remained very low during the demonstration, with a low of 0.7 reports per 1,000 enrollees in quarter 1 of 2018 and a high of 2.1 reports per 1,000 enrollees in quarter 3 of 2016.

[9] IRE source data do not define this category any further.
[10] Examples of practitioner services include physician, chiropractic, dental, prosthetics/orthotics, and vision care.
[11] Reporting requirements define "critical incident" as "any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of a member." Abuse refers to: (1) willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish; (2) knowing, reckless, or intentional acts or failures to act which cause injury or death to an individual or which places that individual at risk of injury or death; (3) rape or sexual assault; (4) corporal punishment or striking of an individual; (5) unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and (6) use of bodily or chemical restraints on an individual which is not in compliance with Federal or State laws and administrative regulations (CMS, November 12, 2014) .

[This page intentionally left blank.]

SECTION 5

Demonstration Impact on Cost Savings

RTI conducted estimates of Medicare savings using a difference-in-differences (DinD) regression analysis of eligible beneficiaries in the California demonstration and their counterparts in comparison areas.

The demonstration resulted in statistically significant increases in gross Medicare Parts A and B costs for all eligible beneficiaries (intent-to-treat population) and for MMP enrollees only, relative to their counterparts in the comparison group. These results are preliminary as risk corridor payments have not yet been included in the calculations.

5.1 Methods Overview

As part of the capitated financial alignment model, California, CMS, and each MMP entered into a three-way contract to provide services to Medicare-Medicaid enrollees (CMS, 2013). MMPs receive a blended, risk-adjusted prospective capitation payment to provide enrollees with Medicare Parts A, B, and D, and Medicaid services. CMS and California developed the capitation payment that covers the services provided. CMS adjusts the Medicare component for each enrollee using CMS' hierarchical risk adjustment model to account for differences in the characteristics of enrollees. For further information on the rate development and risk adjustment process, see the MOU, the three-way contract, and the Final Rate Reports (CMS, 2013).

This chapter presents the Medicare Parts A and B cost savings analysis for demonstration years 1 to 3 (calendar years 2014 to 2017). We used an intent-to-treat (ITT) analytic framework that includes all beneficiaries eligible for the demonstration rather than only those who enrolled. The ITT analytic framework alleviates concerns of selection bias.[12] Supplemental results from a separate analysis, restricted to MMP enrollees only and their comparison group counterparts, are included in ***Appendix D*** (see ***Table D-9***).

To evaluate the cost implications of the demonstration, RTI performed a DinD analysis of Medicare Parts A and B expenditures that compares demonstration eligible beneficiaries who live in an area where a participating health plan operates—the demonstration group—to those who meet the same eligibility criteria but live outside those operating areas—the comparison group.

To identify the demonstration group, RTI utilized quarterly files submitted by the State of California. Comparison group beneficiaries were identified through a two-step process. First, we identified comparison areas based on market characteristics. Second, we applied the same demonstration eligibility criteria to identify eligible beneficiaries in these areas. This process is further described in ***Appendix C***. Once the two groups were finalized, we created propensity score weighting and applied it in all analyses.

[12] This approach to sample inclusion differs from what is noted in Section 3.2, as the ITT population was defined more broadly for cost savings analyses to include individuals enrolled in Medicare Advantage plans.

According to the three-way contract (CMS, 2019), MA enrollees were not eligible for passive enrollment into the demonstration and were previously excluded from the analysis included in the First Evaluation Report.[13] However, at the request and approval of CMS, RTI made a key methodological change from previous reports by including the MA population (see ***Appendix D*** for more details).

RTI gathered monthly Medicare expenditure data from both predemonstration and demonstration periods for both the demonstration and comparison groups from two data sources. We obtained capitation payments paid to participating plans during the demonstration period, and payments to Medicare Advantage plans in the predemonstration and demonstration periods from CMS Medicare Advantage and Prescription Drug system (MARx) data.[14] The capitation payments were the final reconciled payments paid by the Medicare program after taking into account risk score reconciliation and any associated retroactive adjustments in the system at the time of the data pull (September 2020). We also used Medicare FFS claims to calculate expenditures for beneficiaries who were not enrolled in an MMP or MA plan, as summarized in ***Table 7***. These FFS claims included Medicare payments for all Parts A and B services.

Table 7
Data sources for monthly Medicare expenditures

Group	Predemonstration period April 1, 2012–March 31, 2014	Demonstration period April 1, 2014–December 31, 2017
Demonstration	Medicare FFS MA capitation	Capitation rate for MMP enrollees MA capitation for the eligible but not enrolled Medicare FFS for the eligible but not enrolled
Comparison	Medicare FFS MA capitation	Medicare FFS MA capitation

FFS = fee-for-service; MA = Medicare Advantage.

We made several adjustments to the monthly Medicare expenditures to ensure that observed expenditure variations are not due to differences in Medicare payment policies in different areas of the country or the construction of the capitation rates (see ***Appendix D***). ***Table D-1*** in ***Appendix D*** summarizes each adjustment and the application of the adjustments to FFS expenditures or to the MA and MMP capitation rates.

To calculate the impact of the demonstration on Medicare expenditures, we ran a generalized linear model with a gamma distribution and log link. This is a commonly used approach in analysis of health care expenditure data. The model included control variables for individual demographic information and area-level characteristics (see ***Appendix D***), applied propensity score weighting, and adjusted for clustering of observations at the county level. The key policy variable of interest in the modeling was an interaction term measuring the effect of being part of the demonstration group during the demonstration period.

[13] Although Medicare Advantage enrollees are eligible for the demonstration, those enrolled in Medicare Advantage are ineligible for passive enrollment; they could participate on an opt-in basis.
[14] In comparison to previously published reports, this report reflects the inclusion of the Medicare Advantage population.

5.2 Demonstration Impact on Medicare Parts A and B Costs

Table 8 shows the magnitude of the DinD estimate of the cumulative demonstration effect over the entire demonstration period to date (demonstration years 1 to 3)—both in absolute terms (adjusted coefficient DinD) and in percent change (relative difference) from the adjusted mean outcome value for beneficiaries in the comparison group in the demonstration period. The adjusted mean for monthly expenditures decreased from the predemonstration period to the demonstration period in both the demonstration and comparison groups. The cumulative DinD effect estimate is an increase of $57.85 per member per month for the demonstration group, relative to the comparison group, which is statistically significant ($p < 0.001$). This increase amounts to a relative difference of 5.69 percent ($57.85 divided by $1,016.73). This suggests that there were increased costs to Medicare as a result of the demonstration using the ITT analysis framework.

Table 8
Cumulative demonstration impact on Medicare Parts A and B costs for all eligible beneficiaries in California, April 1, 2014–December 31, 2017

Group	Adjusted mean for predemonstration period	Adjusted mean for demonstration period	Relative difference (%)	Adjusted coefficient DinD	*p*-value
Demonstration	$1,179.81	$1,161.09	5.69%	$57.85	<0.001
Comparison	$1,088.61	$1,016.73			

DinD = difference-in-differences.
SOURCE: ca_dy3_1492_pct_tbls.log

Caution should be used when interpreting these results. Indeed, these results are likely driven by other factors that contribute to higher costs for the eligible but not enrolled population in California, relative to the comparison group. MMP enrollees accounted for approximately 11 percent of total eligible beneficiary months over demonstration years 1 to 3 (calendar years 2014–2017). Thus, our findings are in large part influenced by Medicare costs associated with the eligible but not enrolled beneficiaries. Moreover, site visits and stakeholder interviews indicate that eligible beneficiaries who disenrolled from the MMPs tended to have more functional impairments and have a different demographic profile than MMP enrollees. These factors could contribute to higher average Medicare costs for all demonstration eligible beneficiaries, relative to the comparison group. Specifically:

- The overall opt-out rate through the final month of passive enrollment in July 2016 was 50 percent, ranging from 10 percent in San Mateo County to 58 percent in Los Angeles County. The opt-out rate among IHSS recipients (one category of LTSS users) across the demonstration was 61 percent.
- Opt-out rates for certain ethnic, racial, and linguistic minorities were as high as 94 percent in some counties during the early years of the demonstration. Interview data indicate that many providers who did not want to accept lower rates from MMPs and were urging their patients to opt out, were ethnic providers serving this population. To the extent minority status may be associated with poor health status, the high opt-out rate by these individuals may also provide some context to the cost and

demographic profiles of the eligible but not enrolled population, relative to MMP enrollees.

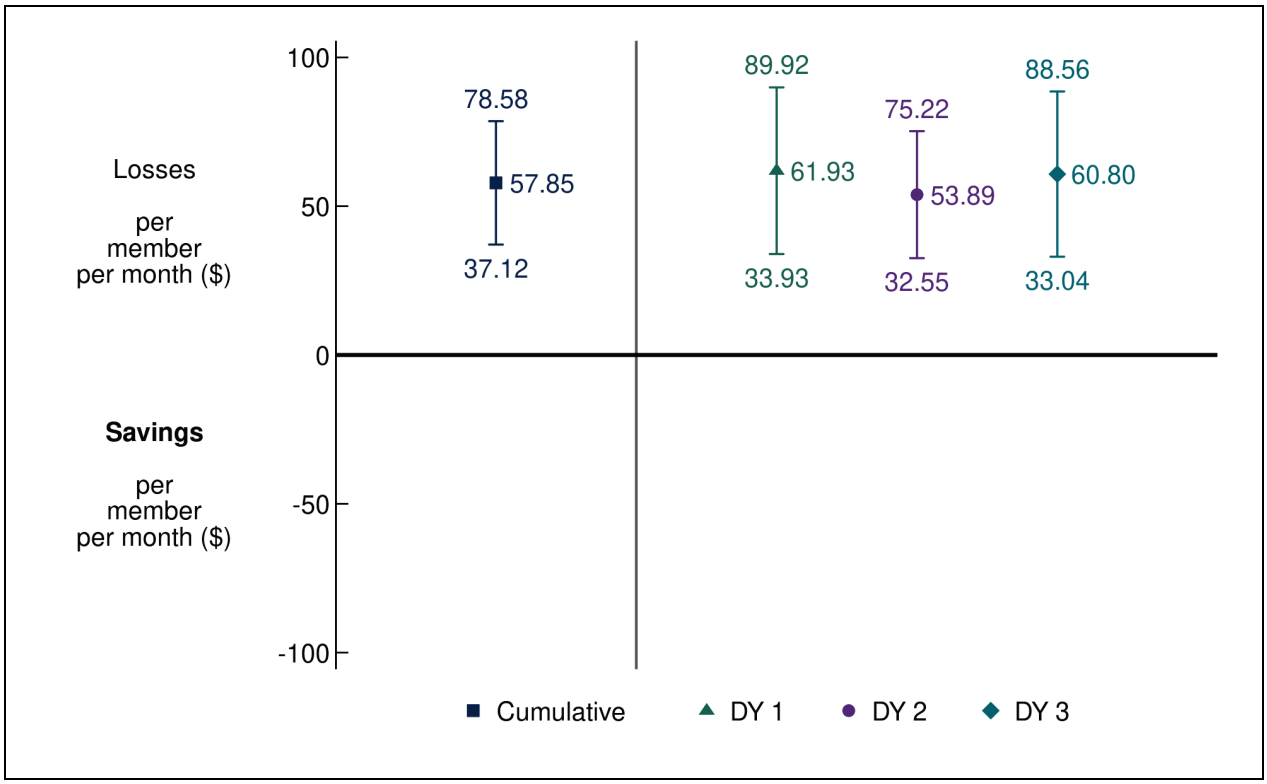
- State evaluators reported during early demonstration years that over 80 percent of disenrolled beneficiaries did not want to change or risk losing their health care provider, and over 60 percent did not want to risk losing their medicines. These findings suggest that such beneficiaries may have higher health needs and could have been higher service utilizers.

While we are able to balance the comparison and demonstration groups on observable characteristics (see ***Appendix C***), there may be unobservable factors influencing the composition of eligible non-enrolled population in the demonstration group relative to the comparison group. ***Table D-10*** in ***Appendix D*** shows that average Medicare payments and HCC risk scores for the eligible non-enrolled population (MA enrollees and Medicare FFS enrollees) were higher than the payments and HCC risk scores during the demonstration period for MMP enrollees. This provides evidence that the DinD impact estimates are driven in part by the change in health characteristics of the eligible but not enrolled population in California.

In addition, we ran the DinD regression model to estimate the effect of the demonstration in each demonstration year. The demonstration had a statistically significant effect in each of the individual demonstration years (***Figure 19***).[15] Note that these estimates rely on the ITT analytic framework and only account for Medicare Parts A and B costs, and they use the capitation rate for the participating health plans rather than the actual amount the plan paid for services. These findings are preliminary and will be updated once final risk corridor determinations are available.

[15] The confidence intervals in Figure 16 do not cross zero in any of the demonstration years, indicating that the estimates are statistically significant.

Figure 19
Cumulative and annual demonstration effects on monthly Medicare Parts A and B costs for all eligible beneficiaries in California, April 1, 2014–December 31, 2017



DY = demonstration year; Losses = Increased costs relative to the comparison group.
SOURCE: ca_dy3_1482_reg.log

[This page intentionally left blank.]

SECTION 6

Conclusions

6.1 Implementation Successes, Challenges, and Lessons Learned

By the end of 2017, Cal MediConnect MMPs showed steady progress in stabilizing enrollment, engaging providers and stakeholders, and providing health care that resulted in increased enrollee satisfaction, especially for those receiving care coordination. However, enrollment began to drop in 2018, attributed in part to loss of eligibility, increased competition from D-SNP look-alikes, and expanded supplemental benefits in other MA products.

In 2018–2019, the Cal MediConnect demonstration was approved for a 3-year extension. To a large extent, changes in Cal MediConnect and the experience of MMPs during this period were shaped by an evolving managed care environment, an increasingly competitive MA market with similar commercial products emerging, and the complexities of operating under a multi-delegation system.

The State and MMPs continued to work on improving quality, enrollment and enrollee retention, access to care for linguistic minorities, and care coordination. MMPs continued investing in infrastructure and exchanging best practices in enrollee retention and enrollment. MMPs implemented innovative and targeted approaches to bolster existing member engagement and education, such as implementing member location teams, conducting outreach campaigns targeting enrollees at risk of disenrollment, and conducting benefits education sessions at places where enrollees receive services. Enrollees who receive care coordination reported being highly satisfied with the benefit; some progress had also been made in access to care for linguistic minorities.

Overall, the MMPs performed fairly well on quality measures. For 2017, all MMPs received 100 percent of their withhold payments except for one MMP, and that MMP received 75 percent. Results were similar for calendar year 2018 with all but two MMPs receiving 100 percent of their withhold payments and two receiving 75 percent. In 2017 and 2018, four MMPs received 100 percent of their withhold payment because they qualified for an upward adjustment due to extreme and uncontrollable circumstances (these MMPs qualified for the adjustment due to the wildfires in California in 2017 and 2018). The new three-way contract increased the financial incentive for MMPs to focus on quality improvements by increasing the amount of the quality withhold from capitation payments to plans from 3 percent to 4 percent starting in 2020. CAHPS data showed continued improvement in beneficiary satisfaction with their MMP, with nearly two-thirds of beneficiaries rating their plan a 9 or 10 (out of 10) in 2019.

There were some improvements across time for some HEDIS measures, and CMS reported encouraging MMPs to improve scores for others. Additionally, in 2019 an advocate reported that some MMPs had been administering HRAs in person to better engage with enrollees, which was not happening early in the demonstration.

In 2017–2019, the biggest challenge reported by MMPs we spoke to was sustaining enrollment. Some plans were able to maintain or grow enrollment. Most plans continued to experience enrollee churn and, starting with 2018, began to see net losses in member enrollment through mid-2019. Interruptions in Medicaid eligibility continued to be reported as a factor contributing to disenrollment, as did a changing MA market offering new options for dually

eligible beneficiaries. The reinstatement of transportation and dental benefits to Medi-Cal and the ongoing rise of D-SNP look-alike plans has made it increasingly difficult for MMPs to remain competitive in the MA market. The State attempted to improve enrollment through a broker pilot that would allow MMPs to compensate brokers when a beneficiary chooses to enroll and stay in the demonstration. This pilot began in mid-2019 despite stakeholder opposition, with L.A. Care the only participating MMP. In another attempt to stabilize enrollment, the 2019 updated three-way contract included a disenrollment penalty for MMPs with high disenrollment not caused by beneficiary loss of eligibility.

Although some progress has been made in access to care for linguistic minorities and with health care provider-patient language concordance, stakeholders and State evaluators continued to raise these issues between 2017 and 2019. Aside from Spanish speakers, who represented 32 percent of Cal MediConnect enrollees in quarter 3 of 2019 (DHCS, 2020), enrollment remains low among other linguistic minorities. For example, only 5 percent of enrollees were identified as Vietnamese speakers. Stakeholders suggested that the State could better tailor and invest in outreach to generate buy-in from providers in culturally and linguistically distinct communities to increase enrollment among non-native speakers. This buy-in was particularly low in early demonstration years.

Care coordination was envisioned as the centerpiece of the demonstration , with the potential to drive desirable reductions in unnecessary service utilization. However, care coordination remained elusive for many enrollees. MMPs struggled with reaching beneficiaries, especially those experiencing homelessness. Relatively high State averages masked wide variation among MMPs on such care coordination metrics as completed HRAs, having ICPs in place, and having a care coordinator. Although enrollees who received care coordination reported being highly satisfied with the benefit, care coordination efforts overall continued to fall short, especially with respect to coordination with IHSS and CBAS services and LTSS referrals for enrollees with new or unmet needs. In addition, although grievances and appeals remained low, service access and interruption issues persisted, and improper billing was particularly problematic in dental care services, further complicated by reinstatement of the Medi-Cal dental benefit.

To address some of these issues, the updated three-way contract of 2019 included new requirements related to care coordination. MMPs are now required to:

- coordinate across MMP contractors and dental providers,
- train network providers on the care coordination benefit,
- provide clarification of the ICT's purpose and make-up, and
- provide a description of the ICT and the ICP in the new member packets.

The updated three-way contract also mandated that the ICP include coordination with providers of carved out and linked services and appropriate community agencies.

In 2018–2019, MMPs continued to express concern with the Cal MediConnect payment methodologies. Although MMPs' support for and investment in the demonstration remained

strong, many reported operating at a loss, suggesting the demonstration is not financially sustainable. Concerns differed across plans, including inadequacy of the Medicare Parts A and B rate for a dually eligible population, long delays in receipt of the quality withhold payments, and the unpredictability of Medi-Cal blended rate calculation relative to plans' perceptions of their rate-cell mix. Plans pointed to this unpredictability, and the length of time before their Medi-Cal blended rates are revealed, as factors that make it difficult to manage costs relative to a revenue target. The State noted that the delay in quality withhold payments was related to waiver approval delays in order to draw down the appropriate amount of federal funds.

Figure 20 shows some strategies that DHCS and MMPs used to address some of these challenges.

By 2019, State priorities in the integrated care arena had shifted. DHCS announced an overhaul of care delivery toward a new statewide integrated Medicare and Medicaid system by 2023 (CalAIM). Stakeholders reported that this reduced the State's focus on Cal MediConnect. Additionally, in a reversal of findings presented in the First Evaluation Report, stakeholders reported feeling the State had become disinvested in the stakeholder process since early 2018, given, for example, the State's decision to move forward with the broker pilot and the lack of stakeholder input in the development of the new CalAIM initiative.

Figure 20
DHCS and MMP strategies to address some Cal MediConnect challenges

6.2 Demonstration Impact on Cost

The cost savings analysis indicated higher Medicare costs for the demonstration eligible population in California, relative to the comparison group. These results are preliminary and do not reflect final risk corridor payments. Moreover, caution should be used when interpreting these results due to low enrollment in the MMPs and a higher-risk profile of the eligible but not enrolled population.

Although DHCS never planned or expected full enrollment into the demonstration, given its sheer size and complexity (see ***Section 3.2, Eligibility and Enrollment***), about three-quarters of all eligible Medicare-Medicaid beneficiaries remained unenrolled in Cal MediConnect throughout the demonstration. Indeed, MMP enrollees in our analytic sample only accounted for approximately 11 percent of the total demonstration eligible beneficiary months over the demonstration period. DHCS, MMP and stakeholder interviews in early demonstration years and the State's disenrollment data analysis reported that there was evidence that enrollment into the demonstration, and disenrollment/opt-out, respectively, was not evenly distributed among Cal MediConnect eligible beneficiaries. Specifically, those with higher levels of functional impairment and more disease burden have been leaving the demonstration at a higher rate. These

beneficiaries are included in the ITT population, in part explaining how average Medicare payments and HCC risk scores are higher for MA and FFS Medicare enrollees compared to California MMP enrollees (see ***Table D-10*** in ***Appendix D***).

Even so, a supplementary DinD analysis on the MMP enrollees-only population indicates that the demonstration was also associated with increases (by greater amounts, indeed, than the estimates from the ITT analysis) in Medicare costs compared to similar beneficiaries in the comparison group (see ***Table D-9*** in ***Appendix D***). These finding are in contrast to the expectation that enrolling in the demonstration would be associated with lower Medicare costs. However, these findings should be interpreted with caution because we are unable to statistically account for unobservable characteristics associated with enrolling in the demonstration. Furthermore, there were limitations in our approach to identifying a subset of beneficiaries in the comparison group that would mimic the MMP enrollees-only population.

6.3 Next Steps

The RTI evaluation team will continue to collect information such as enrollment statistics and updates on key aspects of implementation on a quarterly basis from DHCS officials through the online State Data Reporting System. We will continue to conduct annual virtual site visit calls with the State and demonstration stakeholders, and quarterly calls with the Cal MediConnect State and CMS staff. RTI will review the results of any evaluation activities conducted by CMS or its contractors. We will also review any written reports or materials from the State summarizing State-sponsored evaluations, if applicable. RTI will conduct additional qualitative and quantitative analyses over the course of the demonstration.

The next report will include a qualitative update on demonstration implementation and cost savings analyses. Any service utilization analyses will depend on data availability. RTI is exploring the feasibility of conducting a Medicaid analysis of demonstration impacts on total cost of care for future reports. As noted previously, the demonstration was extended for an additional 3 years, which will provide further opportunities to evaluate the demonstration's performance.

[This page intentionally left blank.]

References

Alan Newman Research: Medicare-Medicaid Financial Alignment Initiative (FAI) State Demonstrations, California Cal MediConnect Consumer Focus Groups Summary Report. https://calduals.org/wp-content/uploads/2018/12/CA-Focus-Group-Final-Report-8-22-18_Masked.pdf. 2018. As obtained on March 10, 2020.

Centers for Medicare and Medicaid Services (CMS): California Demonstration Three-Way Contract. Contract Between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with California Department of Health Care Services. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAContract.pdf. Effective September 1, 2019. As obtained on January 27, 2020.

Centers for Medicare & Medicaid Services (CMS): California Bridge to Reform Demonstration. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Special Terms and Conditions. https://www.calduals.org/wp-content/uploads/2014/03/CA-Bridge-Amendment_STCs_CMS-approved-3_19_14.pdf. 2014. As obtained on January 13, 2020.

Graham, C., Chapman, A., & Cohen, M.: The Coordinated Care Initiative: What Have We Learned and Where Will It Go? https://www.thescanfoundation.org/sites/default/files/graham_presentation_evaluation_of_cal_mediconnect_final2.pdf. 2019. As obtained on January 14, 2020.

Graham, C., Ly, L. Lee, B., Liu, P.-J. & The SCAN Foundation: Assessing the Experience of Dually Eligible Beneficiaries in Cal MediConnect: Results of a Longitudinal Survey. https://www.thescanfoundation.org/sites/default/files/assessing_the_experiences_of_dually_eligible_beneficiaries_in_cal_mediconnect_final_091018.pdf. 2018. As obtained on January 14, 2020.

State of California, Department of Health Care Services (DHCS): Cal MediConnect Extended Through 2022. https://calduals.org/2019/04/24/cal-mediconnect-extended-through-2022/. April 24, 2019a. As obtained on January 7, 2020.

State of California, Department of Health Care Services: CalDuals: DHCS Announcement – LTC and MSSP. https://calduals.org/2019/09/25/dhcs-announcement/. September 25, 2019b. As obtained on January 7, 2020.

State of California, Department of Health Care Services (DHCS): DHCS Announces CalAIM D-SNP Proposal Today. https://calduals.org/2019/10/29/dhcs-announces-medi-cal-healthier-california-for-all-d-snp-proposal-today/. October 29, 2019c. As obtained on January 7, 2020.

State of California, Department of Health Care Services (DHCS): Improving Behavioral Health Integration and Coordination for Cal MediConnect (CMC) Members. https://calduals.org/wp-content/uploads/2019/05/Improving-Behavioral-Health-Integration-Coordination-for-CMC-Members-Final-5.28.19.pdf. 2019d. As obtained on January 13, 2020.

State of California, Department of Health Care Services (DHCS: Cal MediConnect Performance Dashboard Metrics Summary. https://www.dhcs.ca.gov/Documents/CMC-Dashboard-12-19.pdf. Released December 2019e. As obtained on February 12, 2020 and March 19, 2020.

State of California, Department of Health Care Services (DHCS): Cal MediConnect Performance Dashboard Metrics Summary. https://www.dhcs.ca.gov/Documents/CMCDashboard3.20.pdf. Released March 2020. As obtained on August 26, 2020.

State of California, Department of Health Care Services (DHCS): Cal MediConnect Performance Dashboard Metrics Summary. https://www.dhcs.ca.gov/services/Documents/MCQMD/CMCDashboard9-20.pdf. Released September 2020. As obtained on November 20, 2020.

State of California, Department of Health Care Services (DHCS): Improving Care Coordination for Members of Long-Term Services and Supports. Findings from the Cal MediConnect Best Practices Meeting: Department of Health Care Services. https://calduals.org/wp-content/uploads/2018/08/CMC-BP-LTSS-Summary-Report_Final.pdf. 2018. As obtained on January 24, 2020.

State of California, Department of Health Care Services (DHCS): Care Plan Option Services. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2018/DPL18-003.pdf. 2018. As obtained on January 13, 2020.

State of California, Department of Health Care Services (DHCS): Cal MediConnect Monthly Enrollment Dashboard, As of March 1, 2015. https://www.dhcs.ca.gov/Documents/CMC-Enrollment-Dashboard-Mar2015-FINAL.pdf. 2015. As obtained on January 13, 2020.

Appendix A

Data Sources

Key informant interviews. The RTI evaluation team conducted telephonic site visit interviews with California key informants in 2017, 2018 and 2019. The team interviewed the following types of participants: CMS, State, and plan officials, stakeholders, ombudsman program officials, and advocates. To monitor demonstration progress, the RTI evaluation team engages in periodic phone conversations with the California DHCS and CMS. These might include discussions about new policy clarifications designed to improve plan performance, quality improvement work group activities, and contract management team (CMT) actions.

Focus groups. In this report, we incorporate findings from focus group data collected by RTI and another CMS contractor.

The RTI evaluation team conducted eight focus groups in California in summer 2017. Two focus groups were held with Spanish-speaking enrollees or their proxies, two were held with Vietnamese participants, two were held with Black enrollees and their proxies, and two groups were open to all enrollees. A total of 54 Cal MediConnect enrollees and 18 proxies participated in the focus groups.

CMS contracted with Alan Newman Research (Alan Newman Research, 2018) to conduct a total of ten focus groups in California in 2018: three in Encino, three in Beverly Hills, and four in San Francisco. A total of 68 enrollees participated. Of the 68 participants, 18 were those receiving long term services and supports (LTSS), 35 were sampled from the general pool of English-speakers, and 15 were from the general pool of Spanish-speakers.

Beneficiary satisfaction surveys. Medicare requires all MA plans, including Cal MediConnect plans, to conduct an annual assessment of beneficiary experiences using the Medicare Advantage and Prescription Drug Plan Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instrument. This report includes survey results for a subset of the 2018 and 2019 survey questions. Findings are available at the MMP level. Some CAHPS items are case mix-adjusted. Case mix refers to the respondent's health status and sociodemographic characteristics, such as age or educational level, that may affect the ratings that the respondent provides. Without an adjustment, differences between entities could be due to case mix differences rather than true differences in quality. Comparisons with findings from all MA plans are available for core CAHPS survey questions. The frequency count for some survey questions is suppressed because too few enrollees responded to the question.

This report also draws from 2018–2019 State evaluator survey findings and issue briefs produced by researchers at the University of California at Berkeley and the University of California at San Francisco with funding from the SCAN Foundation, the National Institute on Disability, Independent Living, and Rehabilitation Research, and the Administration for Community Living.

Demonstration data. The RTI evaluation team reviewed data provided quarterly by California through the State Data Reporting System (SDRS). These reports include eligibility, enrollment, opt-out, and disenrollment data, and information reported by California on its integrated delivery system, care coordination, benefits and services, quality management, stakeholder engagement, financing and payment, and a summary of successes and challenges. This report also uses data for quality measures reported by Cal MediConnect plans and submitted

to CMS' implementation contractor, NORC.[16,17] Data reported to NORC include core quality measures that all MMPs are required to report, as well as State-specific measures that Cal MediConnect plans are required to report. Due to reporting inconsistencies, plans occasionally resubmit data for prior demonstration years; therefore, the data included in this report are considered preliminary.

Demonstration policies, contracts, and other materials. The RTI evaluation team reviewed a wide range of demonstration documents, including demonstration and State-specific information on the CMS website;[18] and other publicly available materials on the California Cal MediConnect website (CalDuals.org) and the California DHCS website.[19]

Complaints and appeals data. Complaint (also referred to as grievance) data are from three separate sources: (1) complaints from beneficiaries reported by Cal MediConnect plans to DHCS, and separately to CMS' implementation contractor, NORC,[20] through Core Measure 4.2; (2) complaints received by DHCS or 1-800-Medicare and entered into the CMS electronic Complaint Tracking Module (CTM); and (3) qualitative data obtained by RTI on complaints. Appeals data are generated by MMPs and reported to DHCS and NORC, for Core Measure 4.2, and the Medicare IRE. This report also includes critical incidents and abuse data reported by Cal MediConnect MMPs to DHCS and NORC.

HEDIS measures. We report on a subset of Medicare HEDIS measures, a standard measurement set used extensively by managed care plans, and that are required of all Medicare Advantage (MA) plans.

Cost savings data. Two primary data sources were used to support the savings analyses, capitation payments paid to MA plans in the predemonstration and demonstration periods and paid to Medicare-Medicaid Alignment Initiative (MMAI) plans during the demonstration period, and Medicare claims. Medicare capitation payments paid to Cal MediConnect plans during the demonstration period were obtained for all demonstration enrollees from CMS Medicare Advantage and Part D Inquiry System (MARx) data. The capitation payments were the final reconciled payments paid by the Medicare program after taking into account risk score reconciliation and any associated retroactive adjustments in the system at the time of the data pull (October 2020). Quality withholds were applied to the capitation payments (quality withholds are not reflected in the MARx data), as well as quality withhold repayments based on data provided by CMS. These payments do not yet include adjustments for risk corridor

[16] Data are reported for 2014–2019.
[17] The technical specifications for reporting requirements are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements
[18] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html
[19] https://www.dhcs.ca.gov/
[20] The technical specifications for reporting requirements are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.

payments. FFS Medicare claims were used to calculate expenditures for comparison group beneficiaries, demonstration beneficiaries in the predemonstration period, and demonstration eligible beneficiaries who were not enrolled during the demonstration period. FFS claims included all Medicare Parts A and B services.

[This page intentionally left blank.]

Appendix B

Cal MediConnect MMP Performance on Select HEDIS Quality Measures, 2015–2018

Tables B-1a, B-1b, and ***B-1c*** provide 2015 through 2018 HEDIS performance data for MMPs. Using correlation coefficients that were 0.9 and above, or −0.9 and below, we have applied green and red shading to indicate where MMP performance over time for a given measure was steadily improving or worsening; green indicates a favorable trend, and red indicates an unfavorable one. We did not perform any testing for statistical significance for differences across years because of the limited data available. For measures without green or red shading, year-over-year MMP performance remained relatively stable between 2015 and 2018.

Table B-1a
Cal MediConnect MMP performance on select HEDIS quality measures for 2015–2018 by MMP

Measure	National MA Plan Mean	Anthem BlueCross				Care1st				Cal Optima[1]		
	(2018)	(2015)	(2016)	(2017)	(2018)	(2015)	(2016)	(2017)	(2018)	(2016)	(2017)	(2018)
Adults' access to preventive/ambulatory health services	95.0	71.1	61.9	65.9	70.7	78.1	80.7	80.5	80.3	86.9 G	87.7 G	90.1 G
Adult BMI assessment	96.0	87.5	87.9	88.3	93.5	91.0	93.2	90.8	94.3	96.1	99.0	96.0
Blood pressure control[2]	69.5	62.9	59.5	68.9	67.9	58.6	64.8	63.2	66.1	70.0	76.7	73.2
Breast cancer screening	72.7	69.1	63.8	60.1	62.5	65.7	60.4	60.1	60.0	70.3 R	66.9 R	65.0 R
Colorectal cancer screening	70.5	74.1	56.0	56.9	60.0	53.3	50.2	62.8	55.2	61.3 G	62.0 G	63.0 G
Disease modifying anti-rheumatic drug therapy in rheumatoid arthritis	77.8	73.4	81.0	79.7	88.6	76.2	68.2	73.5	75.0	66.4 G	70.4 G	72.3 G
Follow-up after hospitalization for mental illness (30 days)	47.9	4.2 G	23.7 G	52.1 G	N/A	28.6	33.3	33.3	19.3	59.4 R	46.8 R	37.4 R
Antidepressant medication management												
Effective acute phase treatment[3]	72.1	60.7	59.4	71.7	72.7	62.8	70.0	70.5	70.4	60.6 G	62.6 G	65.0 G
Effective continuation phase treatment[4]	56.1	46.0	40.1	55.8	52.1	52.8	62.1	54.1	59.9	43.2 G	45.4 G	46.4 G
Care for older adults												
Advance care planning	N/A	53.0	30.0	63.7	56.5	22.9	37.9	37.4	41.3	41.2 G	42.3 G	45.7 G
Medication review	N/A	47.2	37.8	57.3	72.9	69.8	73.8	68.2	60.8	74.5 G	79.8 G	84.2 G
Functional status assessment	N/A	55.6	37.3	74.3	70.4	38.5	48.3	52.5	46.6	55.3 G	59.4 G	65.5 G
Pain assessment	N/A	58.5	39.6	78.6	77.2	62.0	75.4	72.0	63.2	78.7	75.7	81.5

(continued)

Table B-1a (continued)
Cal MediConnect MMP performance on select HEDIS quality measures for 2015–2018 by MMP

Measure	National MA Plan Mean	Anthem BlueCross				Care1st				Cal Optima[1]		
	(2018)	(2015)	(2016)	(2017)	(2018)	(2015)	(2016)	(2017)	(2018)	(2016)	(2017)	(2018)
Comprehensive diabetes care												
Received Hemoglobin A1c (HbA1c) testing	94.3	92.3	89.6	91.2	88.9	90.3	90.3	91.0	90.3	86.8 [G]	90.1 [G]	91.0 [G]
Poor control of HbA1c level (>9.0%) (higher is worse)	23.1	26.2	31.7	25.6	26.1	42.6	36.3	38.9	40.2	29.4 [G]	24.4 [G]	18.6 [G]
Good control of HbA1c level (<8.0%)	65.6	65.1	57.2	61.6	57.8	48.7	56.2	52.1	49.6	61.8	62.5	72.0
Received eye exam (retinal)	73.7	63.7	53.2	65.7	65.6	59.6 [G]	65.9 [G]	72.5 [G]	74.5 [G]	75.9	70.4	80.8
Received medical attention for nephropathy	95.5	93.8	94.7	96.6	96.2	96.8	96.8	94.9	96.4	94.4	96.8	96.1
Blood pressure control (<140/90 mm Hg)	69.1	64.2	51.9	59.1	64.3	54.7	67.2	66.9	67.2	69.4	69.6	74.3
Initiation and engagement of alcohol and other drug (AOD) dependence treatment												
Initiation of AOD treatment [5]	33.6	12.8	13.0	9.0	8.9	47.4	45.1	23.0	70.9	N/A	24.2	21.6
Engagement of AOD treatment [6]	4.5	1.4	0.5	0.4	0.6	3.6	3.71	2.8	5.9	N/A	1.6	1.2
Plan all-cause readmissions (Observed-to-expected ratio mean[7])												
Age 18–64	0.75	0.66	0.62	0.80	0.54	0.85	1.02	0.77	0.77	0.90 [G]	0.85 [G]	0.77 [G]
Age 65+	0.71	0.80	0.62	0.61	0.71	0.96	1.11	0.75	0.81	0.79 [G]	0.77 [G]	0.66 [G]

(continued)

Table B-1a (continued)
Cal MediConnect MMP performance on select HEDIS quality measures for 2015–2018 by MMP

Measure	National MA Plan Mean	Anthem BlueCross				Care1st				Cal Optima[1]		
	(2018)	(2015)	(2016)	(2017)	(2018)	(2015)	(2016)	(2017)	(2018)	(2016)	(2017)	(2018)
Ambulatory care (per 1,000 members)												
Outpatient visits (higher is better)	9,606.0	4,839.6	4,816.3	5,415.4	5,439.5	9,447.0	7,542.3	7,845.5	13,088.7	6,815.2 G	7,652.4 G	8,544.8 G
Emergency department visits (higher is worse)	600.8	534.7 G	516.1 G	486.8 G	438.1 G	552.3	514.3	521.9	542.2	439.8	463.5	448.4

BMI = body mass index; HEDIS = Health Effectiveness Information and Data Set; MA = Medicare Advantage; not applicable, where MA plans do not report such data, or where the number of enrollees in the MMP's HEDIS data available for inclusion in the measure was less than 30, and therefore not reported per RTI's decision rule for addressing low sample size.

[1] HEDIS data were not available for CalOptima in 2015.

[2] The following criteria were used to determine adequate blood pressure control: less than 140/90 mm Hg for members 18–59 years of age; diagnosis of diabetes and <140/90 mm Hg for members 60–85 years of age; no diagnosis of diabetes and <150/90 mm Hg for members 60–85 years of age.

[3] Represents the percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).

[4] Represents the percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

[5] Represents percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

[6] Represents the percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

[7] Plan all-cause readmissions are reported as an observed-to-expected ratio mean. A value below 1.0 is favorable and indicates that MMPs had fewer readmissions than expected for their populations based on case mix.

NOTES: Green and red color-coded shading indicates where performance over time for a given measure was steadily improving or worsening; green indicates a favorable trend, where red indicates an unfavorable one. To ensure accessibility for text readers and individuals with sight disabilities, cells shaded green or red receive, respectively, a superscript "G" or "R". Detailed descriptions of HEDIS measures presented can be found in the RTI Aggregate Evaluation Plan.

SOURCE: RTI analysis of 2015 through 2018 HEDIS measures.

Table B-1b
Cal MediConnect MMP performance on select HEDIS quality measures for 2015–2018 by MMP

Measure	National MA Plan Mean	CHG				Health Net				HPSM			
	(2018)	(2015)	(2016)	(2017)	(2018)	(2015)	(2016)	(2017)	(2018)	(2015)	(2016)	(2017)	(2018)
Adults' access to preventive/ambulatory health services	95.0	87.0 G	90.8 G	93.9 G	95.9 G	73.7 G	75.0 G	75.7 G	76.6 G	94.4 G	95.0 G	96.1 G	96.8 G
Adult BMI assessment	96.0	88.8	92.7	98.5	98.3	92.9	82.8	87.6	91.3	87.1	86.2	91.8	87.8
Blood pressure control[1]	69.5	54.0 G	55.7 G	59.6 G	68.4 G	63.0	60.9	65.6	65.2	70.3	64.4	70.5	71.5
Breast cancer screening	72.7	72.2	67.8	67.0	70.5	65.1 R	57.6 R	54.4 R	53.2 R	69.7 R	67.8 R	66.8 R	66.6 R
Colorectal cancer screening	70.5	64.2	59.1	68.1	71.5	64.0	38.5	48.2	47.9	61.8	59.4	60.3	60.7
Disease modifying anti-rheumatic drug therapy in rheumatoid arthritis	77.8	85.5	81.1	79.7	84.6	66.2	71.8	70.1	78.4	80.9 G	82.7 G	82.9 G	86.7 G
Follow-up after hospitalization for mental illness (30 days)	47.9	40.3	37.2	51.7	47.9	28.1	24.8	36.7	36.8	39.2	64.8	68.5	60.1
Antidepressant medication management													
Effective acute phase treatment[2]	72.1	68.1	64.4	68.9	72.7	55.1 G	57.0 G	60.6 G	61.6 G	70.2	62.6	70.9	68.6
Effective continuation phase treatment[3]	56.1	54.0	48.5	49.1	57.8	37.4	37.7	44.4	43.0	56.2	46.7	51.8	51.6
Care for older adults													
Advance care planning	N/A	52.6 G	72.5 G	79.3 G	97.8 G	39.2	33.8	37.0	40.4	26.3	29.2	46.0	38.9
Medication review	N/A	70.6 G	81.3 G	86.4 G	92.2 G	99.4	99.5	99.0	95.3	75.2	72.3	79.1	74.5

(continued)

Table B-1b (continued)
Cal MediConnect MMP performance on select HEDIS quality measures for 2015–2018 by MMP

Measure	National MA Plan Mean	CHG				Health Net				HPSM			
	(2018)	(2015)	(2016)	(2017)	(2018)	(2015)	(2016)	(2017)	(2018)	(2015)	(2016)	(2017)	(2018)
Care of older adults (continued)													
Functional status assessment	N/A	54.0 G	71.0 G	78.1 G	96.1 G	73.2	64.5	65.5	72.1	44.0	64.2	54.0	59.9
Pain assessment	N/A	56.9 G	73.5 G	76.2 G	96.6 G	70.1	67.0	66.7	71.4	71.8	68.1	79.6	78.1
Comprehensive diabetes care													
Received Hemoglobin A1c (HbA1c) testing	94.3	92.7	93.7	93.1	94.7	87.4	89.1	92.0	90.3	90.0	92.9	95.7	92.2
Poor control of HbA1c level (>9.0%) (higher is worse)	23.1	34.8 G	22.1 G	19.9 G	17.5 G	31.1	26.2	23.2	25.3	48.9	31.9	31.9	34.2
Good control of HbA1c level (<8.0%)	65.6	55.2 G	63.8 G	69.7 G	71.3 G	56.9	62.2	66.8	63.3	46.2	59.4	59.6	56.3
Received eye exam (retinal)	73.7	54.0	75.9	85.2	83.7	60.3	70.9	72.7	72.2	72.5	71.5	74.9	73.9
Received medical attention for nephropathy	95.5	95.9	96.9	96.2	95.6	94.4	93.6	96.7	96.0	94.7	93.9	94.5	94.2
Blood pressure control (<140/90 mm Hg)	69.1	59.4	69.6	71.5	67.9	61.6	64.0	70.6	70.1	65.5	62.8	64.3	68.6
Initiation and engagement of alcohol and other drug (AOD) dependence treatment													
Initiation of AOD treatment [4]	33.6	35.5	24.9	26.4	32.7	27.1	23.3	19.3	23.2	34.7	36.9	26.9	22.6
Engagement of AOD treatment [5]	4.5	2.3	1.8	0.4	3.0	2.8	1.8	2.6	1.5	6.6	3.2	5.0	4.3
Plan all-cause readmissions (Observed-to-expected ratio mean[6])													
Age 18–64	0.75	1.13 G	0.90 G	0.80 G	0.70 G	0.98	0.96	0.95	0.76	0.60	0.79	0.72	0.66
Age 65+	0.71	0.87	0.96	0.90	0.71	0.99 G	0.87 G	0.85 G	0.79 G	0.80	0.82	0.79	0.65

(continued)

Table B-1b (continued)
Cal MediConnect MMP performance on Select HEDIS quality measures for 2015–2018 by MMP

Measure	National MA Plan Mean	CHG				Health Net				HPSM			
	(2018)	(2015)	(2016)	(2017)	(2018)	(2015)	(2016)	(2017)	(2018)	(2015)	(2016)	(2017)	(2018)
Ambulatory care (per 1,000 members)													
Outpatient visits (higher is better)	9,606.0	7,415.0 G	8,737.6 G	9,961.3 G	10,816.4 G	4,759.0	5,823.3	6,038.4	5,853.0	12,108.8 G	12,534.0 G	12,996.1 G	13,058.6 G
Emergency department visits (higher is worse)	600.8	622.2	546.6	553.7	516.0	479.5	480.3	447.0	425.6	701.4	683.5	694.1	670.8

BMI = body mass index; HEDIS = Health Effectiveness Information and Data Set; MA = Medicare Advantage; not applicable, where MA plans do not report such data, or where the number of enrollees in the MMP's HEDIS data available for inclusion in the measure was less than 30, and therefore not reported per RTI's decision rule for addressing low sample size.

[1] The following criteria were used to determine adequate blood pressure control: less than 140/90 mm Hg for members 18–59 years of age; diagnosis of diabetes and <140/90 mm Hg for members 60–85 years of age; no diagnosis of diabetes and <150/90 mm Hg for members 60–85 years of age.

[2] Represents the percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).

[3] Represents the percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

[4] Represents percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

[5] Represents the percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

[6] Plan all-cause readmissions are reported as an observed-to-expected ratio mean. A value below 1.0 is favorable and indicates that MMPs had fewer readmissions than expected for their populations based on case mix.

NOTES: Green and red color-coded shading indicates where performance over time for a given measure was steadily improving or worsening; green indicates a favorable trend, where red indicates an unfavorable one. To ensure accessibility for text readers and individuals with sight disabilities, cells shaded green or red receive, respectively, a superscript "G" or "R". Detailed descriptions of HEDIS measures presented can be found in the RTI Aggregate Evaluation Plan.

SOURCE: RTI analysis of 2015 through 2018 HEDIS measures.

Table B-1c
Cal MediConnect MMP performance on select HEDIS quality measures for 2015–2018 by MMP

Measure	National MA Plan Mean	IEHP				L.A. Care				Molina				SCFHP			
	(2018)	(2015)	(2016)	(2017)	(2018)	(2015)	(2016)	(2017)	(2018)	(2015)	(2016)	(2017)	(2018)	(2015)	(2016)	(2017)	(2018)
Adults' access to preventive/ ambulatory health services	95.0	89.6 G	91.8 G	92.4 G	92.6 G	75.4 G	77.1 G	79.5 G	83.2 G	73.4 G	78.9 G	81.6 G	82.3 G	88.2 G	89.9 G	92.0 G	94.2 G
Adult BMI assessment	96.0	96.8	97.2	94.4	95.9	87.1 G	93.9 G	95.8 G	97.1 G	95.1	96.4	93.0	94.9	5.5	86.4	92.9	92.2
Blood pressure control[1]	69.5	62.3	62.8	62.5	66.9	56.2 G	66.9 G	69.5 G	73.2 G	49.5 G	54.6 G	58.2 G	70.1 G	N/A	60.1	67.4	63.5
Breast cancer screening	72.7	65.4 G	68.8 G	69.4 G	70.4 G	61.2	62.6	60.1	63.7	61.3	53.9	58.3	61.4	33.9 G	45.1 G	60.4 G	65.6 G
Colorectal cancer screening	70.5	57.4 G	60.7 G	64.0 G	65.2 G	45.3 G	48.4 G	57.7 G	61.0 G	64.0	49.5	56.9	56.0	41.9 G	55.7 G	56.2 G	62.0 G
Disease modifying anti-rheumatic drug therapy in rheumatoid arthritis	77.8	73.1	72.2	73.6	73.1	71.0	73.9	72.0	75.7	71.4	73.4	75.6	69.7	93.9 R	89.7 R	88.0 R	85.2 R
Follow-up after hospitalization for mental illness (30 days)	47.9	49.8	60.2	50.6	52.7	11.9	42.0	46.9	49.0	37.8	51.8	45.2	48.2	26.3 G	38.5 G	46.3 G	64.3 G
Antidepressant medication management																	
Effective acute phase treatment[2]	72.1	65.0	64.6	67.3	67.8	48.3	64.2	65.7	64.8	63.0	57.9	62.4	61.2	75.2	52.4	73.7	71.4
Effective continuation phase treatment[3]	56.1	49.2	48.4	50.6	51.7	34.6 G	46.3 G	53.9 G	57.2 G	48.4	40.3	45.2	44.1	70.3	39.1	61.9	58.4

(continued)

Table B-1c (continued)
Cal MediConnect MMP performance on select HEDIS quality measures for 2015–2018 by MMP

Measure	National MA Plan Mean	IEHP				L.A .Care				Molina				SCFHP			
	(2018)	(2015)	(2016)	(2017)	(2018)	(2015)	(2016)	(2017)	(2018)	(2015)	(2016)	(2017)	(2018)	(2015)	(2016)	(2017)	(2018)
Care for older adults																	
Advance care planning	N/A	54.6	62.7	59.4	55.7	33.6	39.2	38.2	43.3	23.8 G	36.4 G	43.7 G	48.1 G	0.0 G	18.0 G	40.2 G	40.9 G
Medication review	N/A	81.5	84.0	80.3	87.4	58.4	64.2	61.3	71.8	45.4 G	61.7 G	65.1 G	67.8 G	0.4	68.1	83.9	71.8
Functional status assessment	N/A	63.0	72.0	65.7	74.2	38.4 G	41.1 G	52.8 G	52.8 G	31.7 G	47.0 G	53.5 G	56.2 G	0.0	43.3	58.2	56.2
Pain assessment	N/A	78.9 G	83.6 G	87.8 G	88.3 G	57.9 G	62.0 G	72.3 G	74.7 G	43.9	63.4	66.9	69.4	0.0	66.4	82.5	70.1
Comprehensive diabetes care																	
Received Hemoglobin A1c (HbA1c) testing	94.3	90.7	91.9	94.7	93.2	85.2	91.7	90.1	93.6	87.6	93.1	94.3	92.2	88.6 G	91.2 G	91.7 G	94.2 G
Poor control of HbA1c level (>9.0%) (higher is worse)	23.1	28.4	28.5	20.2	24.1	46.9	33.1	21.9	24.2	41.1	30.3	29.0	28.0	77.2	32.9	28.0	29.9
Good control of HbA1c level (<8.0%)	65.6	58.3	60.4	67.2	61.6	42.3	56.5	70.2	62.2	51.2 G	57.2 G	61.3 G	62.3 G	20.0	56.0	60.6	61.1
Received eye exam (retinal)	73.7	65.3	71.8	73.5	71.3	64.6	64.2	77.6	75.6	53.2	71.5	71.0	67.4	47.4 G	62.5 G	72.3 G	77.9 G
Received medical attention for nephropathy	95.5	97.0	95.4	96.8	97.3	95.1	95.9	95.2	97.0	96.5	95.3	94.8	97.1	91.5	92.0	91.7	91.7
Blood pressure control (<140/90 mm Hg)	69.1	66.4	63.7	67.4	65.5	54.9	66.4	69.9	70.1	47.9	66.4	63.0	72.8	0.1	59.6	58.4	67.2

(continued)

Table B-1c (continued)
Cal MediConnect MMP performance on select HEDIS quality measures for 2015–2018 by MMP

Measure	National MA Plan Mean	IEHP				L.A. Care				Molina				SCFHP			
	(2018)	(2015)	(2016)	(2017)	(2018)	(2015)	(2016)	(2017)	(2018)	(2015)	(2016)	(2017)	(2018)	(2015)	(2016)	(2017)	(2018)
Initiation and engagement of alcohol and other drug (AOD) dependence treatment																	
Initiation of AOD treatment[4]	33.6	30.4[R]	25.4[R]	21.8[R]	20.1[R]	33.9	32.5	38.9	42.2	47.0	61.7	57.4	41.3	34.6	32.5	39.4	32.5
Engagement of AOD treatment[5]	4.5	3.4	1.4	2.0	2.5	2.5	1.6	3.3	4.6	4.3	6.7	5.5	5.5	0.0	1.7	1.0	2.6
Plan all-cause readmissions (Observed-to-expected ratio mean[6])																	
Age 18–64	0.75	0.99	0.89	0.87	0.89	0.96	0.80	0.84	0.76	0.89	0.86	0.75	0.85	0.89	0.73	0.71	0.87
Age 65+	0.71	1.02	0.79	0.83	0.86	1.08	0.70	0.76	0.68	1.02	0.72	0.68	0.71	1.08	0.88	0.90	0.82
Ambulatory care (per 1,000 members)																	
Outpatient visits (higher is better)	9,606.0	7,603.0[G]	8,404.5[G]	8,830.3[G]	9,801.7[G]	5,484.7	6,569.3	6,443.6	8,820.4	5,490.9[G]	7,392.3[G]	7,869.0[G]	8,177.5[G]	7,510.9[G]	7,813.5[G]	9,067.8[G]	9,916.5[G]
Emergency department visits (higher is worse)	600.8	825.8[G]	769.9[G]	767.6[G]	730.9[G]	533.8	468.5	470.2	513.6	575.4[G]	555.2[G]	554.9[G]	547.7[G]	509.4	511.8	502.2	535.1

BMI = body mass index; HEDIS = Health Effectiveness Information and Data Set; MA = Medicare Advantage; N/A = not applicable, where MA plans do not report such data, or where the number of enrollees in the MMP's HEDIS data available for inclusion in the measure was less than 30, and therefore not reported per RTI's decision rule for addressing low sample size.

[1] The following criteria were used to determine adequate blood pressure control: less than 140/90 mm Hg for members 18–59 years of age; diagnosis of diabetes and <140/90 mm Hg for members 60–85 years of age; no diagnosis of diabetes and <150/90 mm Hg for members 60–85 years of age.

[2] Represents the percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).

[3] Represents the percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

[4] Represents percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

[5] Represents the percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

[6] Plan all-cause readmissions are reported as an observed-to-expected ratio mean. A value below 1.0 is favorable and indicates that MMPs had fewer readmissions than expected for their populations based on case mix.

NOTES: Green and red color-coded shading indicates where performance over time for a given measure was steadily improving or worsening; green indicates a favorable trend, where red indicates an unfavorable one. To ensure accessibility for text readers and individuals with sight disabilities, cells shaded green or red receive, respectively, a superscript "G" or "R." Detailed descriptions of HEDIS measures presented can be found in the RTI Aggregate Evaluation Plan.

SOURCE: RTI analysis of 2015 through 2018 HEDIS measures.

Appendix C

Comparison Group Methodology for California Demonstration Year 3

This appendix presents the comparison group selection and assessment results for the FAI demonstration in the State of California.

Results for comparison group selection and assessment analyses are prepared for each demonstration year. The annual report for the first demonstration year and 2 prior baseline years for the California demonstration was publicly released in November 2018. This report provides a revision to results from the First Evaluation Report to account for corrections to the analytic sample and methodological changes. This report includes findings for the third performance year for the Cal MediConnect demonstration in California (January 1, 2017–December 31, 2017), and notes any major changes in the results since the previous performance year. The first California demonstration year covered seven quarters (April 1, 2014–December 31, 2015), and the second demonstration year covered four quarters (January 1, 2016 to December 31, 2016).

C.1 Demonstration and Comparison Group Characteristics

The study population includes all full-benefit Medicare-Medicaid eligible beneficiaries residing in the demonstration and comparison areas. The California demonstration area consists of five large urban Metropolitan Statistical Areas (MSAs) (San Diego-Carlsbad; San Francisco-Oakland-Hayward; Riverside-San Bernardino-Ontario; Los Angeles-Long Beach-Anaheim; and San Jose-Sunnyvale-Santa Clara). The comparison area is composed of 168 counties in 33 MSAs across 10 States, as well as 40 non-metropolitan counties in Michigan. These geographic areas have not changed since the California First Annual Report.

Beneficiaries who are ineligible for the demonstration include those younger than 21, have Medicare as a secondary payor, not enrolled in Medicare Part A and Part B, enrolled in PACE, has End Stage Renal Disease (ESRD), reside in a veterans home, or reside in an intermediate care facility. We assess these exclusion criteria on a quarterly basis for the demonstration and comparison group in the predemonstration period and for the comparison group in the demonstration period. We use finder files provided by the State to identify the eligible population for the demonstration group during the demonstration period. We apply these exclusion criteria to the State finder file in the demonstration period to ensure comparability with the comparison group and the demonstration group during the predemonstration period. Additionally, the cost savings analysis excludes monthly observations where the beneficiary was enrolled in private Medicare cost or employer-based Medicare contracts.

The State used additional exclusion criteria that RTI was not able to replicate in the comparison group or for the demonstration group in the baseline period. Specifically:

a) Individuals enrolled in a 1915 (c) waiver program.

b) Individuals receiving services through California's regional centers or State developmental centers for the developmentally disabled.

c) Individuals with a share of cost that are in community and not continuously certified.

d) Individuals enrolled in the AIDS Healthcare Foundation.

e) Individuals enrolled in a prepaid health plan that is a non-profit health care service plan with at least 3.5 million enrollees statewide, that owns or operates its own pharmacies and that provides medical services to enrollees in specific geographic regions through an exclusive contract with a single medical group in each specific geographic region in which it operates to provide services to enrollees.

According to the three-way contract (CMS, 2019), MA enrollees were not eligible for passive enrollment into the demonstration and were previously excluded from the analysis conducted in California First Evaluation Report.[21] However, at the request and approval of CMS, RTI made a key methodological change from previous reports by including the MA population. ***Table C-1*** displays the number and percentage of beneficiaries who were enrolled in MA and had their eligible months added to the study sample per year. The prevalence of beneficiaries ever enrolled in MA ranges from 29 to 48 percent in the demonstration group, and 24 to 30 percent in the comparison group during the predemonstration and demonstration periods.

Table C-1
Number and percentage of beneficiaries in the demonstration and comparison group who were enrolled in Medicare Advantage at any point during each period

Group	Predemonstration year 1	Predemonstration year 2	DY1	DY2	DY3
Demo group					
Final count of beneficiaries	779,462	808,775	773,488	767,741	787,828
Count of beneficiaries with Medicare Advantage	225,527	261,581	368,964	311,536	326,273
Percent of beneficiaries with Medicare Advantage (denominator is final count of DY beneficiaries)	29%	32%	48%	41%	41%
Comparison group					
Final count of beneficiaries	1,125,556	1,150,938	1,306,487	1,228,658	1,270,099
Count of beneficiaries with Medicare Advantage	274,561	303,093	381,179	342,719	384,743
Percent of beneficiaries with Medicare Advantage (denominator is final count of DY beneficiaries)	24%	26%	29%	28%	30%

DY = demonstration year.

Further analytic exclusions were performed such as: (1) removing beneficiaries with missing geographic information, (2) removing beneficiaries with zero months of eligibility during each analytic period, (3) removing beneficiaries who moved anytime between the demonstration area and the comparison area during the entire study period, and (4) removing beneficiaries who died before the beginning of each analytic period. After applying these

[21] Although Medicare Advantage enrollees are eligible for the demonstration, those enrolled in Medicare Advantage are ineligible for passive enrollment; they could participate on an opt-in basis.

exclusions, the number of demonstration group beneficiaries has remained steady over the 2 baseline years and the 3 demonstration years, ranging from 666,777 to 771,872 per year. In the comparison group, the number of beneficiaries has also been relatively stable, ranging from 999,461 to 1,161,410 per year.[22]

C.2 Propensity Score Estimates

RTI's methodology uses propensity scores to examine initial differences between the demonstration and comparison groups in each analysis period and then to weight the data to improve the match between them. The comparability of the two groups is examined with respect to both individual beneficiary characteristics and the overall distributions of propensity scores.

A propensity score (PS) is the predicted probability that a beneficiary is a member of the demonstration group conditional on a set of observed variables. Our PS models include a combination of beneficiary-level and region-level characteristics measured at the ZIP code (ZIP Code Tabulation Area) level.

The logistic regression coefficients and z-values for the covariates included in the propensity model for California demonstration year 3 are shown in ***Table C-2***. In the year 3 specification, the variables most strongly associated with group status are three race/ethnicity variables (Black, Asian, and Hispanic); participating in another Medicare shared savings program; and two area-level variables (percent of households with a member less than 18 and distance to nearest hospital).

Table C-2
Logistic regression estimates for California PS models in demonstration year 3

Characteristic	Demonstration year 3		
	Coefficient	Standard error	z-score
Age (years)	0.0061	0.0002	37.0623
Died during year	−0.5649	0.0082	−68.8394
Female (0/1)	−0.1410	0.0036	−39.2221
Black (0/1)	−0.6641	0.0052	−126.7642
Asian (0/1)	0.5758	0.0050	114.6031
Hispanic (0/1)	0.7026	0.0052	135.4493
Disability as Original Reason for Entitlement (0/1)	−0.5389	0.0050	−107.1030
Share of months enrolled in MA plan	0.0520	0.0038	13.5479
HCC risk score	0.0437	0.0020	21.3439
Other Medicare shared savings program	−0.5324	0.0049	−107.7832
% of pop. living in married household	0.0520	0.0038	13.5479

(continued)

[22] The final cost savings regression sample varied slightly from these numbers due to cost-based contract exclusions and dropping observations with missing covariates.

Table C-2 (continued)
Logistic regression estimates for California PS models in demonstration year 3

Characteristic	Demonstration year 3		
	Coefficient	Standard error	z-score
% of households w/member >= 60 yrs.	0.0142	0.0002	63.9955
% of households w/member < 18 yrs.	0.0142	0.0002	56.7304
% of adults with college education	−0.0013	0.0002	−7.0040
% of adults w/self-care limitation	0.0018	0.0012	1.4779
Distance to nearest hospital (mi.)	0.0515	0.0002	240.5423
Distance to nearest nursing facility (mi.)	−0.1486	0.0009	−170.1763
Intercept	0.0068	0.0011	6.4014

HCC = Hierarchical Condition Category.

Demonstration beneficiaries in year 3 in California are older (70.9 years of age vs 65.5 years of age), much less likely to be Black (9.5 percent vs. 24.9 percent), much more likely to be Asian or Hispanic (19.7 percent vs. 8.4 percent; 19.1 percent vs. 7.7 percent, respectively), and are much less likely to be disabled (26.0 percent vs. 47.1 percent) or in another Medicare shared savings program (11.0 percent vs. 18.5 percent). On area-level measures, the groups are more similar, though demonstration group beneficiaries are less likely to live in households with adults with a self-care limitation (3.3 percent vs. 3.6 percent), more likely to live in households with members under age 18 (37.9 percent vs. 32.8 percent) and live closer, on average, to the nearest hospital and nursing home (3.6 miles vs. 5.1 miles; 2.9 miles vs. 3.8 miles, respectively). The magnitude of the group differences for all variables prior to PS weighting may also be seen in ***Table C-3***.

Table C-3
California dual eligible beneficiary covariate means by group before and after weighting by propensity score—demonstration year 3: January 1, 2017–December 31, 2017

Characteristic	Demonstration group mean	Comparison group mean	PS-weighted comparison group mean	Unweighted standardized difference	Weighted standardized difference
Age	70.927	65.506	71.188	0.359	−0.019
Died	0.036	0.056	0.035	−0.097	0.003
Female	0.581	0.599	0.575	−0.037	0.012
Black	0.095	0.249	0.093	−0.417	0.008
Asian	0.197	0.084	0.202	0.330	−0.014
Hispanic	0.191	0.077	0.194	0.339	−0.007
Disability as Original Reason for Entitlement	0.260	0.471	0.258	−0.450	0.006

(continued)

Table C-3 (continued)
California dual eligible beneficiary covariate means by group before and after weighting by propensity score—demonstration year 3: January 1, 2017–December 31, 2017

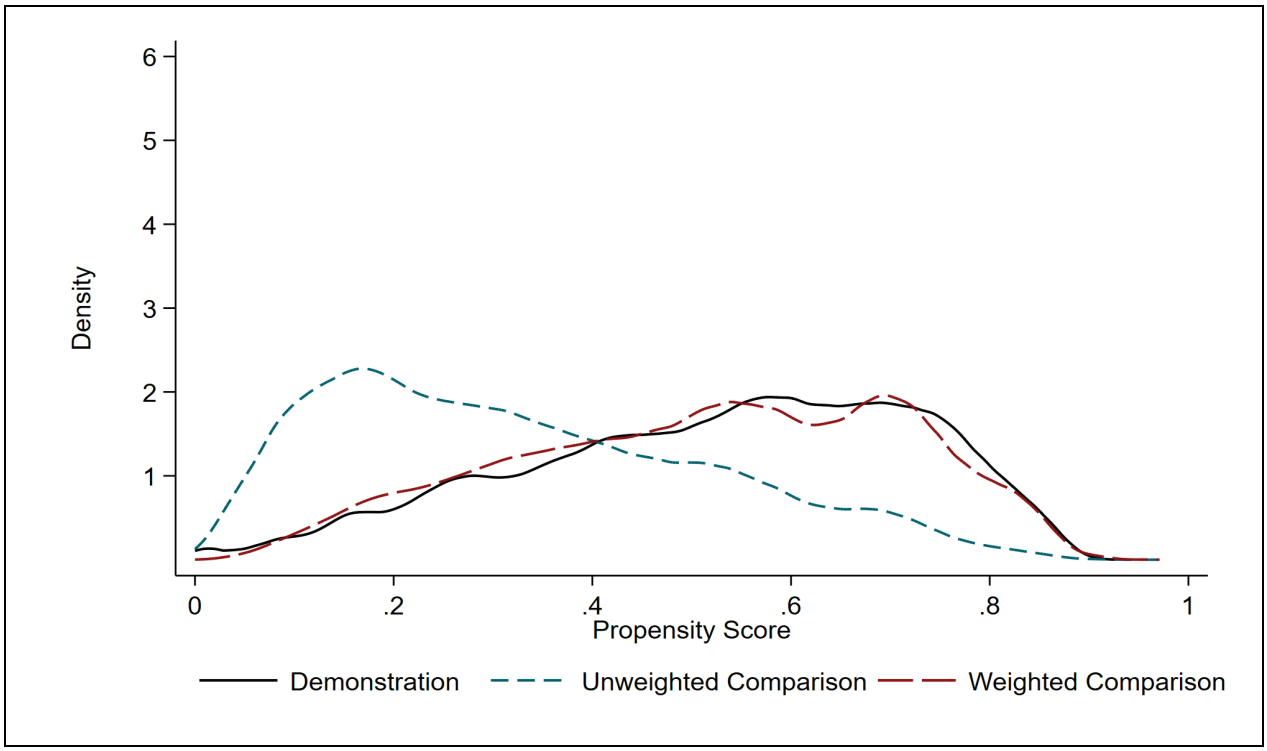
Characteristic	Demonstration group mean	Comparison group mean	PS-weighted comparison group mean	Unweighted standardized difference	Weighted standardized difference
Share of months enrolled in MA plan	0.329	0.289	0.302	0.090	0.060
HCC score	1.153	1.156	1.148	−0.004	0.007
Other Medicare shared savings program	0.110	0.185	0.107	−0.212	0.010
% of pop. living in married household	0.329	0.289	0.302	0.090	0.060
% of households w/member >= 60	66.547	65.285	67.315	0.099	−0.065
% of households w/member < 18	36.830	36.658	36.481	0.022	0.046
% of adults w college education	25.342	26.618	26.731	−0.080	−0.084
% of adults w/self-care limitation	3.314	3.561	3.330	−0.146	−0.010
Distance to nearest hospital	37.874	32.839	37.434	0.485	0.041
Distance to nearest nursing facility	3.619	5.143	3.868	−0.370	−0.077

HCC = Hierarchical Condition Category; PS = propensity score.

C.3 Propensity Score Overlap

The distributions of PSs by group for demonstration year 3 are shown in ***Figure C-1*** before and after propensity weighting. Estimated scores covered nearly the entire probability range in both groups. Like the previous analyses, the unweighted comparison group (dashed line) is characterized by a spike in predicted probabilities in the range from 0 to 0.20. Inverse Probability of Treatment Weighting (IPTW) pulls the distribution of weighted comparison group PSs (dotted line) very close to that of the demonstration group (solid line).

Figure C-1
Distribution of beneficiary-level PSs in the California demonstration and comparison groups, weighted and unweighted, January 1, 2017–December 31, 2017



Any beneficiaries who have estimated PSs below the smallest estimated value in the demonstration group are removed from the comparison group. No beneficiaries were removed from the comparison group for this reason in demonstration year 3.

C.4 Group Comparability

Covariate balance refers to the extent to which the characteristics used in the PS are similar (or "balanced") for the demonstration and comparison groups. Group differences are measured by a standardized difference (the difference in group means divided by the pooled standard deviation of the covariate). An informal standard has developed that groups are considered comparable if the standardized covariate difference is less than 0.10 standard deviations.

The group means and standardized differences for all beneficiary characteristics are shown for demonstration year 3 in ***Table C-3***. The column of unweighted standardized differences indicates that several of these variables were not balanced before running the propensity model. Three variables (percent with disability as original reason for entitlement, percent of households with a member under age 18, percent Black) had unweighted standardized differences exceeding 0.40, while four others had unweighted standardized differences in excess of 0.30 (age, percent Hispanic, percent Asian, distance to nearest hospital).

The results of PS weighting for California demonstration year 3 are illustrated in the far-right column (weighted standardized differences) in ***Table C-3***. PS weighting reduced the standardized differences below the threshold level of an absolute value of 0.1 for all the covariates in our model.

C.5 Enrollee Results

In addition to our estimates for all eligible beneficiaries presented above, we estimated PS-weighted balance tables for enrollees. Individuals were classified as enrollees if they had at least 3 months of enrollment at any point in the demonstration period and were eligible for at least 3 months in the baseline period.

In terms of initial differences between demonstration and comparison groups, our enrollee results differed from the analysis of all eligible individuals. Across all 5 years, the all-eligible analysis yielded a set of covariates—including share dying within the year; share female, HCC score, share of adults with a college education, share of households with a member greater than 60, and share of the population living in married households—that had unweighted standardized differences less than 0.1. Most covariates for this analysis did not have larger unweighted differences between groups.

By contrast, the enrollee analysis yielded unweighted standardized differences greater than 0.1 for almost all covariates across all years of analysis. The lone exception to this pattern was the share of the population living in a household with a member greater than age 60.

Despite the considerable initial differences in the enrollee analysis, the weighted results were similar to the weighted results in the all-eligible analysis. Indeed, after applying PS weights, the comparison group PS distribution matched the demonstration group score distribution more closely, and across all 5 years of analysis, no covariates in the enrollee results had weighted standardized differences greater than 0.1. For comparison, the all-eligible analysis had only one covariate out of balance, which was the share of adults with a college degree.

Thus, in both the enrollee and all-eligible analyses, all covariates were balanced (i.e., had weighted standardized differences less than 0.1) in demonstration year 3.

C.6 Summary

The California demonstration and comparison groups were initially distinguished by differences in several individual covariates (age, percent Black, percent Hispanic, percent Asian, percent with disability as reason for entitlement, and percent in another Medicare shared savings program) as well as differences in four region-based variables (percent living in households with

members under 18, percent living in households with an adult with a self-care limitation, distance to nearest hospital, and distance to the nearest nursing home). However, PS weighting successfully reduced all covariate discrepancies below the threshold for standardized differences. As a result, the weighted California groups are adequately balanced with respect to all 16 of the variables we consider for comparability. Further analysis of the enrollee group yielded very similar results to the main analysis on the all-eligible population presented in this appendix.

Appendix D

Cost Savings Methodology

D.1 Adjustments to Medicare Expenditures

Several adjustments were made to the monthly Medicare expenditures to ensure that observed expenditures variations are not due to differences in Medicare payment policies in different areas of the country or the construction of the capitation rates. ***Table D-1*** summarizes each adjustment and the application of the adjustments to FFS expenditures or to the capitation rate.

Table D-1
Adjustments to Medicare expenditures variable

Data source	Adjustment description	Reason for adjustment	Adjustment detail
FFS	Indirect Medical Education (IME)	Capitation rates do not include IME.	Do not include IME amount from FFS payments.
FFS	Disproportionate Share Hospital (DSH) Payments and Uncompensated Care Payments (UCP)	The capitation rates reflect DSH and UCP adjustments.	Include DSH and UCP payments in total FFS payment amounts.
FFS	Medicare Sequestration Payment Reductions	Under sequestration Medicare payments were reduced by 2% starting April 1, 2013. Because the predemonstration period includes months prior to April 1, 2013 it is necessary to apply the adjustment to these months of data.	Reduced FFS claim payments incurred before April 2013 by 2%.
Capitation rate (MA and MMP)	Medicare Sequestration Payment Reductions	Under sequestration Medicare payments were reduced by 2% starting April 1, 2013. Sequestration is not reflected in the capitation rates.	Reduced capitation rate by 2%.
Capitation rate (MA)	Bad debt	The Medicare portion of the capitation rate includes an upward adjustment to account for bad debt. Bad debt is not included in the FFS claim payments and therefore needs to be removed from the capitation rate for the savings analysis. (Note: “bad debt” is reflected in the hospital “pass through” payment.)	Reduced capitation rate to account for bad debt load (historical bad debt baseline percentage). This is 0.93% for CY 2012, 0.91% for CY 2013, 0.89% for CY 2014, 0.89% for CY 2015, 0.97% for CY 2016, and 0.81% for CY 2017.

(continued)

Table D-1 (continued)
Adjustments to Medicare expenditures variable

Data source	Adjustment description	Reason for adjustment	Adjustment detail
Capitation rate (MMP)	Bad debt	The Medicare portion of the capitation rate includes an upward adjustment to account for bad debt. Bad debt is not included in the FFS claim payments and therefore needs to be removed from the capitation rate for the savings analysis. (Note, "bad debt" is reflected in the hospital "pass through" payment.)	Reduced blended capitation rate to account for bad debt load (historical bad debt baseline percentage). This is 0.89% for CY14, 0.89% for CY15, 0.97% for CY16, and 0.81% for CY17. Reduced the FFS portion of the capitation rate by an additional 1.89% for CY 2014 1.71% for CY 2015, 1.84% for CY 2016, and 1.74% for CY 2017 to account for the disproportional share of bad debt attributable to Medicare-Medicaid enrollees in Medicare FFS.
FFS and capitation rate (MA and MMP)	Average Geographic Adjustments (AGA)	The Medicare portion of the capitation rate reflects the most current hospital wage index and physician geographic practice cost index by county. FFS claims also reflect geographic payment adjustments. In order to ensure that change over time is not related to differential change in geographic payment adjustments, both the FFS and the capitation rates were "unadjusted" using the appropriate county-specific AGA factor.	Medicare FFS expenditures were divided by the appropriate county-specific 1-year AGA factor for each year. Capitation rates were divided by the appropriate county-specific 5-year AGA factor for each year. Note that the AGA factor applied to the capitated rates for 2014 reflected the 50/50 blend that was applicable to the payment year.
Capitation rate (MA and MMP)	Education user fee	No adjustment needed.	Capitation rates in the MARx database do not reflect the education user fee adjustment (this adjustment is applied at the contract level). Note, education user fees are not applicable in the FFS context and do not cover specific Part A and Part B services. While they result in a small reduction to the capitation payment received by MMPs, we did not account for this reduction in the capitated rate.
Capitation rate (MMP)	Quality withhold	A 1% quality withhold was applied in the first demonstration year, 2% was applied in the second demonstration year, and a 3% quality withhold was applied in the third demonstration year, but was not reflected in the capitation rate used in the analysis.	Final quality withhold repayments for CY 2014, CY 2015, CY 2016, and CY 2017 were incorporated into the dependent variable construction.

CY = calendar year; FFS = fee-for-service; MA = Medicare Advantage; MMP = Medicare-Medicaid Plan.

The capitation payments from MARx reflect the savings assumptions applied to the Medicare components of the rate (1 percent for the first demonstration year, 3 percent for the second demonstration year, and 5 percent for the third demonstration year), but do not reflect the quality withhold amounts.

Additionally, corrections were made to impact estimates from earlier reports the contributed to differences in our current impact estimates for demonstration years 1 and 2. Specifically, we made the following corrections: (1) confirmed dual status for State-identified FAI eligible beneficiaries against IDR data, removing erroneous zeros in the dependent variable, and (2) applied IDR-based exclusion criteria for all monthly observations in the comparison group during the predemonstration period and demonstration period, and to the demonstration group during the predemonstration period. These corrections, coupled with the inclusion of MA beneficiaries (described in ***Appendix C***) result in revised (current) estimates that indicate statistically significant losses cumulatively and for each demonstration year.

D.2 Model Covariates

Model covariates included the following variables, which were also included in the comparison group selection process. Variables were included in the model after variance inflation factor testing.

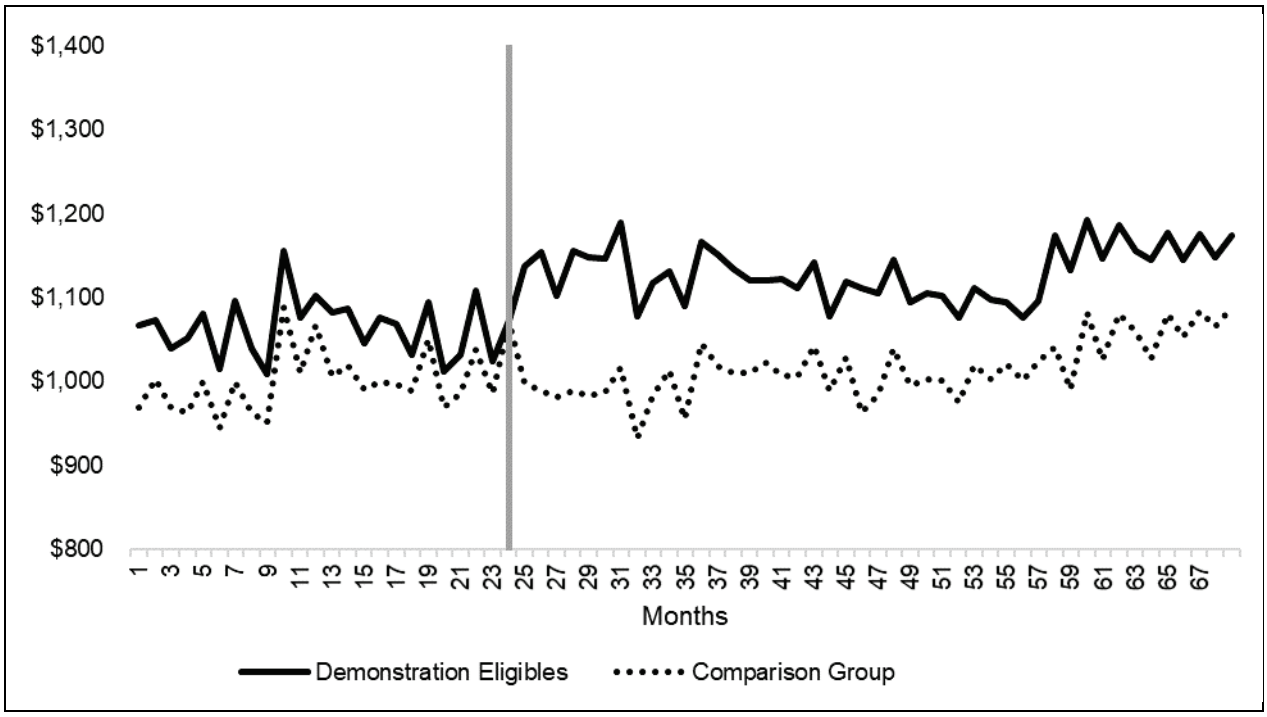
- Demographic variables included in the model were:
  - Age
  - Gender
  - Race/ethnicity
  - Other Master Data Management
  - Disability status
  - Medicare Advantage indicator
- Area-level variables included in the savings model were:
  - Medicare spending per Medicare-Medicaid enrollee age 19 or older
  - MA penetration rate
  - Medicaid-to-Medicare fee-for-service fee index for all services
  - Medicaid spending per Medicare-Medicaid enrollee age 19 or older
  - Proportion of Medicare-Medicaid enrollees using
    - Nursing facilities age 65 or older
    - Home and community-based services age 65 or older
    - Medicaid managed care age 19 or older
  - Physicians per 1,000 population
  - Percentage of population living in married household

- Percentage of households with member greater than age 60
- Percentage of households with member less than age 18
- Percentage of adults with college degree
- Unemployment rate
- Percentage of adults with self-care limitation

D.3 Descriptive Results

Once we finalized the adjustments, we tested a key assumption of a DinD model: parallel trends. We plotted the mean monthly Medicare expenditures for both the demonstration group and comparison group, with the propensity score weights applied. ***Figure D-1*** shows the resulting plot and suggests that there were parallel trends in the predemonstration period.

Figure D-1
Mean monthly Medicare expenditures (weighted), predemonstration and demonstration period, demonstration and comparison group, April 2012–December 2017



SOURCE: RTI Analysis of California demonstration eligible and comparison group Medicare data (program: demme_ca_dy3_cs1472).

The difference in mean values shown in each table below, represent the overall impact on savings using descriptive statistics. These effects are descriptive in that they are arithmetic combinations of simple means, without controlling for covariates. The change in the demonstration group minus the change in the comparison group is the DinD value. This value would be equal to zero if the differences between predemonstration and the demonstration year were the same for both the demonstration group and the comparison group. A negative value

would indicate savings for the demonstration group, and a positive value would indicate losses for the demonstration group. However, if the DinD confidence interval includes zero, then the value is not statistically significant.

Tables D-2, D-3, and ***D-4*** show the unweighted descriptive mean monthly Medicare expenditures for the demonstration group and comparison group in the predemonstration and each demonstration period. Descriptively, the unweighted tables show increases in mean monthly Medicare expenditures during demonstration years 1–3 for the demonstration and comparison group, but the increase was greater in the demonstration group than in the comparison group. A similar pattern was also shown in the weighted tables, although the comparison group had savings in demonstration year 1 (***Tables D-5, D-6,*** and ***D-7***).

Table D-2
Mean monthly Medicare expenditures for demonstration group and comparison group, predemonstration period and demonstration year 1, unweighted

Group	Predemonstration period (Apr 2012–Mar 2014) (95% confidence intervals)	Demonstration year 1 (Apr 2014–Dec 2015) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$1,064.11 ($1,033.40, $1,094.83)	$1,128.14 ($1,088.35, $1,167.92)	$64.03 ($39.86, $88.19)
Comparison	$1,071.60 ($1,045.51, $1,097.69)	$1,092.57 ($1,064.08, $1,121.05)	$20.97 ($14.13, $27.81)
DinD	N/A	N/A	$43.06 ($18.10, $68.01)

N/A = not applicable; DinD = difference-in-differences.
SOURCE: ca_dy3_1502_descript.log

Table D-3
Mean monthly Medicare expenditures for demonstration group and comparison group, predemonstration period and demonstration year 2, unweighted

Group	Predemonstration period (Apr 2012–Mar 2014) (95% confidence intervals)	Demonstration year 2 (Jan 2016–Dec 2016) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$1,064.11 ($1,033.40, $1,094.83)	$1,101.37 ($1,072.27, $1,130.48)	$37.26 ($26.75, $47.77)
Comparison	$1,071.60 ($1,045.51, $1,097.69)	$1,099.88 ($1,064.75, $1,135.01)	$28.28 ($15.03, $41.53)
DinD	N/A	N/A	$8.98 (−$7.82, $25.78)

N/A = not applicable; DinD = difference-in-differences.
SOURCE: ca_dy3_1502_descript.log

Table D-4
Mean monthly Medicare expenditures for demonstration group and comparison group, predemonstration period and demonstration year 3, unweighted

Group	Predemonstration period (Apr 2012–Mar 2014) (95% confidence intervals)	Demonstration year 3 (Jan 2017–Dec 2017) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$1,064.11 ($1,033.40, $1,094.83)	$1,162.87 ($1,126.71, $1,199.02)	$98.75 ($86.53, $110.98)
Comparison	$1,071.60 ($1,045.51, $1,097.69)	$1,159.91 ($1,121.37, $1,198.46)	$88.32 ($69.29, $107.34)
DinD	N/A	N/A	$10.44 (−$12.12, $33.00)

N/A = not applicable; DinD = difference-in-differences.
SOURCE: ca_dy3_1502_descript.log

Table D-5
Mean monthly Medicare expenditures for demonstration group and comparison group, predemonstration period and demonstration year 1, weighted

Group	Predemonstration period (Apr 2012–Mar 2014) (95% confidence intervals)	Demonstration year 1 (Apr 2014–Dec 2015) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$1,064.11 ($1,033.40, $1,094.83)	$1,128.14 ($1,088.35, $1,167.92)	$64.03 ($39.86, $88.19)
Comparison	$1,001.54 ($970.87, $1,032.21)	$1,000.99 ($967.14, $1,034.83)	−$0.56 (−$10.10, $8.99)
DinD	N/A	N/A	$64.58 ($38.76, $90.40)

N/A = not applicable; DinD = difference-in-differences.
SOURCE: ca_dy3_1502_descript.log

Table D-6
Mean monthly Medicare expenditures for demonstration group and comparison group, predemonstration period and demonstration year 2, weighted

Group	Predemonstration period (Apr 2012–Mar 2014) (95% confidence intervals)	Demonstration year 2 (Jan 2016–Dec 2016) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$1,064.11 ($1,033.40, $1,094.83)	$1,101.37 ($1,072.27, $1,130.48)	$37.26 ($26.75, $47.77)
Comparison	$1,001.54 ($970.87, $1,032.21)	$1,002.94 ($960.7, $1,045.19)	$1.40 (−$14.06, $16.86)
DinD	N/A	N/A	$35.86 ($17.30, $54.42)

N/A = not applicable; DinD = difference-in-differences.
SOURCE: ca_dy3_1502_descript.log

Table D-7
Mean monthly Medicare expenditures for demonstration group and comparison group, predemonstration period and demonstration year 3, weighted

Group	Predemonstration period (Apr 2012–Mar 2014) (95% confidence intervals)	Demonstration year 3 (Jan 2017–Dec 2017) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$1,064.11 ($1,033.40, $1,094.83)	$1,162.87 ($1126.71, $1199.02)	$98.75 ($86.53, $110.98)
Comparison	$1,001.54 ($970.87, $1,032.21)	$1,056.96 ($1010.06, $1103.86)	$55.42 ($34.45, $76.38)
DinD	N/A	N/A	$43.34 ($19.14, $67.54)

N/A = not applicable; DinD = difference-in-differences.
SOURCE: ca_dy3_1502_descript.log

D.4 Difference-in-Differences Impact Estimates

Table D-8 shows the main results from the DinD regression analysis for demonstration years 1–3 and for the entire demonstration period, controlling for beneficiary demographics and market characteristics. Under the ITT approach, this table includes all beneficiaries eligible for the demonstration even those not enrolled rather than only those who enrolled.

Table D-8
Demonstration effects on Medicare expenditures for eligible beneficiaries relative to the comparison group—Difference-in-differences regression results

Demonstration period	Adjusted coefficient DinD ($)	*p-value*	95% confidence interval ($)	90% confidence interval ($)
Cumulative (demonstration years 1–3, April 2014–December 2017)	57.85	<0.001	(37.12, 78.58)	(40.45, 75.24)
Demonstration Year 1 (April 2014–December 2015)	61.93	<0.001	(33.93, 89.92)	(38.43, 85.42)
Demonstration Year 2 (January 2016–December 2016)	53.89	<0.001	(32.55, 75.22)	(35.98, 71.79)
Demonstration Year 3 (January 2017–December 2017)	60.80	<0.001	(33.04, 88.56)	(37.50, 84.10)

DinD = difference-in-differences.
SOURCE: ca_dy3_1482_reg.log

Table D-9 presents the results from the DinD analysis for the MMP enrollees-only subgroup. The MMP enrollees-only analysis focused on a subgroup of beneficiaries identified as enrolled for at least 3 months in the demonstration period and with at least 3 months of baseline eligibility. Note that a subset of the comparison group developed for the ITT analysis was used in the MMP enrollees-only subgroup analyses. Comparison group beneficiaries used in this subgroup analysis were required to have at least 3 months of eligibility in the demonstration period (April 1, 2014–December 31, 2017) and at least 3 months of eligibility in the predemonstration period (April 1, 2012–March 31, 2014), analogous to the criteria for identifying MMP enrollees. The results indicate additional costs associated with MMP enrollees. This MMP enrollees-only subgroup analysis is limited by the absence of person-level data on characteristics that potentially would lead an individual in a comparison area to enroll in a similar demonstration, and thus the results should be considered in the context of this limitation.

Table D-10 shows average Medicare payments and HCC risk scores for the comparison group, eligible but not enrolled population (MA enrollees and Medicare FFS enrollees), and the eligible and enrolled population (MMP enrollees).

Table D-9
Demonstration effects on Medicare expenditures for MMP enrollee-only subgroup analysis relative to the comparison group—Difference-in-differences regression results

Demonstration period	Adjusted coefficient DinD ($)	*p-value*	95% confidence interval ($)	90% confidence interval ($)
Cumulative (demonstration years 1–3, April 2014–December 2017)	197.17	<0.001	(162.84, 231.50)	(168.36, 225.98)
Demonstration Year 1 (April 2014–December 2015)	158.00	<0.001	(118.33, 197.67)	(124.71, 191.29)
Demonstration Year 2 (January 2016–December 2016)	226.34	<0.001	(187.07, 265.61)	(193.39, 259.30)
Demonstration Year 3 (January 2017–December 2017)	250.65	<0.001	(203.32, 297.98)	(210.93, 290.37)

DinD = difference-in-differences; MMP = Medicare-Medicaid Plan.
SOURCE: ca_dy3_1512_enrollee sub.log

Table D-10
Demonstration and comparison group Medicare payments and beneficiary hierarchical condition category risk scores by payment type, April 2012–December 2017

Group	Statistic	Medicare payments					Hierarchical condition category risk scores				
		BY 1	BY 2	DY 1	DY 2	DY 3	BY 1	BY 2	DY 1	DY 2	DY 3
Demonstration: Eligible but not enrolled	N	7,160,502	7,421,835	7,021,688	6,339,135	6,546,462	7,160,502	7,421,835	7,021,688	6,339,135	6,546,462
	Mean	1,068.13	1,062.42	1,184.29	1,143.07	1,205.50	1.32	1.34	1.44	1.43	1.53
	SD	4,881.11	4,697.24	5,332.49	4,573.59	4,644.35	1.05	1.06	1.14	1.15	1.26
Demonstration: MMP enrollees-only	N	N/A	N/A	1,646,558	1,352,778	1,313,165	N/A	N/A	1,646,558	1,352,778	1,313,165
	Mean	N/A	N/A	889.42	909.77	955.96	N/A	N/A	1.18	1.16	1.29
	SD	N/A	N/A	748.99	757.74	815.16	N/A	N/A	0.98	0.94	1.07
Comparison	N	10,203,386	10,203,386	10,472,170	11,310,945	11,593,103	10,203,386	10,472,170	19,140,830	11,310,945	11,593,103
	Mean	1,068.91	1,081.10	1,096.11	1,103.65	1,163.97	1.31	1.34	1.36	1.41	1.49
	SD	4,620.27	4,688.80	4,688.84	4,475.10	4,634.60	1.06	1.09	1.12	1.19	1.31

BY = base year; DY = demonstration year; MMP = Medicare-Medicaid Plan; N/A = not applicable; SD = standard deviation.