Coordinating Care for Duals Through Cal MediConnect

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EXECUTIVE SUMMARY

More than 11.4 million older adults and adults with significant disabilities in the United States are dually eligible for Medicaid and Medicare (1). They represent beneficiaries with the lowest incomes, the most complex care needs, the highest care utilization, and they also account for a disproportionate share of spending in both programs (2). In 2014, California was one of 13 states to implement a "financial alignment initiative," called Cal MediConnect (CMC) (3). The CMC program used a capitated managed care model to administer both Medicare and Medi-Cal (California's Medicaid program) through managed care health plans. A primary feature of the model was the new care coordination benefit. CMC plans were tasked with coordinating care across the spectrum of medical services, behavioral health care, long-term services and support (LTSS), and home- and community-based services (HCBS).

Researchers at the University of California conducted an evaluation of the implementation and impact of the CMC program on health systems and beneficiaries. This research brief examines the implementation of the new CMC care coordination benefit, including the progress made and challenges that remain in coordinating care for dual eligibles. Results are summarized from 94 key informant interviews with health system stakeholders.

KEY FINDINGS

1. **State and federal policies recognize that care coordination is an essential part of integrating care for duals.** Requirements imposed by both the new three-way contract in California and the *CHRONIC Care Act of 2018* could further solidify and strengthen the use of care coordination for duals in managed care plans.

2. **There is great variation in how CMC plans are organizing and delivering care coordination benefits.** CMC health plans had great discretion over how they structured their care coordination activities. Many CMC plans developed internal capacity within the plan to serve members, while others worked with third-party delegated entities such as provider groups or management services organizations (MSOs).

3. **The CMC care coordination benefit encourages collaboration across health system stakeholders.** CMC plans, providers, county behavioral health, long-term care (LTC) facilities, and home- and community-based services (HCBS) agencies are collaborating more as a result of the CMC care coordination benefit. Inter-disciplinary care team (ICT) meetings have proven a successful strategy to encourage collaboration across health system stakeholders.

4. **The CMC care coordination requirement could improve care transitions across health care settings.** Health plans, LTC facilities, and HCBS agencies all reported efforts to promote communication and collaboration across organizations to improve transitions to lower levels of care. However, improvements in care transition processes vary regionally and by CMC plan. Such variation could be the result of a lack of awareness about DHCS guidance related to CMC plans' responsibility to assist with transitions of care.

5. **The CMC care coordination benefit could improve access to HCBS.** The Coordinated Care Initiative (CCI) has improved coordination and collaboration between CMC health plans and agencies that provide Medi-Cal-reimbursed HCBS, such as In-Home Supportive Services (IHSS) and Community-Based Adult Services (CBAS), resulting in improved access for many CMC members. Both plans and HCBS providers reported that CMC health plans were successful in advocating for additional IHSS hours and other services to fill gaps in care for their members.

6. **The CMC care coordination benefit has impacted California's health care workforce.** CCI required CMC plans and delegated provider groups to recruit and train qualified care coordinators. New guidance was issued in the three-way contract to ensure an adequate ratio of care coordinators to enrollees. While this may strain the care coordination workforce in some regions, it may also help ensure that there are adequate care coordinators to meet the needs of CMC members.

7. **Awareness about the CMC care coordination benefit varies among CMC plans, providers, and members.** Many providers and members are still not well informed about the CMC care coordination benefit, and assistance from plans with care coordination varied – especially with care transitions. In addition, some frontline CMC staff were not familiar with all the Medicare and Medicaid regulations and coverage to be able to connect CMC members with available benefits.

8. **Data sharing barriers remain a significant challenge to successful, non-duplicative care coordination efforts.** All health system stakeholders recognized the importance of data sharing in successful care coordination, though they faced problems with non-interoperable systems, information technology infrastructure, and strict interpretations of Health Insurance Portability and Accountability Act regulations that hindered data sharing. These challenges sometimes led to duplicative care coordination efforts.

RECOMMENDATIONS

1. **The Centers for Medicare and Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) should continue to examine best practices and learn from evaluations of duals demonstrations and special needs plans to improve care coordination in future program implementation.**

2. **DHCS and CMS should develop reporting systems that capture the regional and CMC plan variation in the delegation of care coordination and other practices in order to assess their relative strengths and challenges.**

3. **CMC plans should continue to invest in communication and collaboration across providers to meet the needs of their members and share promising practices.**

4. **DHCS should establish a reporting process for ICT implementation. Best practices in organizing and conducting ICTs should be identified, replicated across CMC plans, and included in future integrated care model policies.**

5. **CMC plans should explore relationships with HCBS providers to implement innovative programs to transition LTC residents to lower levels of care.**

6. **Provider associations should disseminate the DHCS Duals Plan Letter (DPL) 16-003 to their members, and CMC plans should review the DPL to ensure their current practice aligns with DHCS guidance. DHCS should encourage CMC plans to develop Memorandums of Understanding (MOUs) with providers – especially hospitals – to clarify protocols for care coordination and transitions of care.**

7. **DHCS should issue guidance encouraging plans and IHSS providers to continue close collaboration, despite the "re-carve out" and change in payment. DHCS should look for opportunities to strengthen these collaborations in future legislative actions.**

8. **DHCS and CMC plans should explore alternative funding opportunities to encourage LTSS provider participation in ICTs.**

9. **CMC Plans and DHCS should monitor and predict shifting health system workforce needs and challenges, especially considering new three-way contract language and guidance requiring plans to make care coordination available to all members. DHCS should consider additional guidance to clarify the qualifications and tasks of care coordinators.**

10. **DHCS should continue education efforts with providers and members about CMC benefits and requirements, and monitor CMC plan and provider group adherence with guidance around the care coordination benefits to ensure more consistent access for CMC members.**

11. **CMS and DHCS should continue to encourage the development of effective and interoperable data-sharing systems.**

INTRODUCTION

More than 11.4 million older adults and adults with significant disabilities in the United States are dually eligible for Medicaid and Medicare (1). They represent beneficiaries with the lowest incomes, the most complex care needs, the highest care utilization, and they also account for a disproportionate share of spending in both programs (2). In 2014, California was one of 13 states to implement a "financial alignment initiative," called Cal MediConnect (CMC) (3). The CMC program used a capitated managed care model to administer both Medicare and Medi-Cal (California's Medicaid program) through managed care health plans. A primary feature of the model was the new care coordination benefit. CMC plans were tasked with coordinating care across the spectrum of medical services, behavioral health care, long-term services and support (LTSS), and home- and community-based services (HCBS).

Researchers at the University of California conducted an evaluation of the implementation and impact of the CMC program on health systems and beneficiaries. This research brief examines the implementation of the new CMC care coordination benefit, including the progress made and challenges that remain in coordinating care for dual eligibles. Results are summarized from 94 key informant interviews with health system stakeholders.

BACKGROUND

Given the high cost and potential inefficiency of care for those dually eligible for Medicare and Medicaid, the *Patient Protection and Affordable Care Act* of 2010 gave the Centers for Medicare and Medicaid Services (CMS) new demonstration authority to implement and test programs to align the financing and/or administration of Medicaid and Medicare for dually eligible beneficiaries (4). Currently, California is one of 10 states that designed their duals demonstration using a capitated managed care model (5).

California's CMC demonstration was designed as a capitated managed care model aligning Medicare and Medi-Cal financing and administration. Existing Medi-Cal managed care plans in seven demonstration counties created new CMC products. The first counties began passively enrolling eligible beneficiaries in CMC plans in April 2014, with passive enrollment ending in all but one county by March 2016. Once enrolled, CMC members receive all Medicare and Medi-Cal services coordinated through one CMC plan and integrated under one payment system.

Through the new care coordination benefit, CMC plan care coordinators were tasked with coordinating all services, including medical care, behavioral health, and LTSS. CMC plans were then financially responsible for all LTSS, including both institutional care (skilled nursing/rehabilitation) and HCBS, creating an incentive that privileges less expensive home service over institutional care. They were also directly responsible for coordinating and referring their members to Medi-Cal HCBS, including: In-Home Supportive Services (IHSS)[1], Community-Based Adult Services (CBAS, formerly called Adult Day Health Care), and Multipurpose Senior Services Program (MSSP), as well as durable medical equipment.

[1] In-Home Supportive Services (IHSS) is California's consumer directed personal care assistance program for Medi-Cal beneficiaries. For more information, visit: *http://www.cdss.ca.gov/inforesources/IHSS*

Additionally, CMC plans were allowed to use flexible spending, called Care Plan Options (CPOs), to provide discretionary services typically not covered by Medicare or Medi-Cal to members to deter unnecessary use of higher cost acute services. Some examples include: respite care, home cleaning, and care during gaps in other services.

Care coordination benefits were delivered through a series of processes required by the original and the revised three-way contracts among CMS, the California Department of Health Care Services (DHCS), and CMC plans (6, 7). While processes often differed by plan and by member, plans were required to conduct initial health risk assessments (HRAs) with each new CMC member to assess their needs. Data from HRAs were then used to create individualized care plans (ICPs) with the goal of providing person-centered care. Finally, for members with more complex care and urgent needs, CMC plans were tasked with bringing together interdisciplinary care teams (ICTs) which ideally included the member, their providers, the CMC care coordinator, and sometimes caregivers.

There was great variety in how CMC plans implemented the new care coordination benefit. Health systems across California vary greatly in terms of their history of managed care; the capacity of their provider groups; the availability of a qualified workforce; the volume of members they serve; the geographic spread of their members; and the integration of their medical, behavioral, LTSS, and social care services. These variations were notably apparent in how CMC plans provided care coordination; who provided care coordination; how care coordination was delegated, monitored, and paid for; how care was coordinated across settings; and how health system stakeholders collaborated to provide care coordination. CMC plans have chosen several different methods of delivering care coordination benefits including: conducting care coordination "in house," delegating care coordination for some or all of their members to provider groups, or making care coordination available through existing MSSP programs.

A survey conducted with CMC members in 2016 showed that approximately 31 percent of members reported receiving care coordination from their plan and most were highly satisfied with it; 42 percent remembered getting an ICP and of those, about half said it included information that was important to them (8). Only about 12 percent of CMC members remember being invited to an ICT meeting. Furthermore, about a quarter of CMC members said their plan helped them find a primary care doctor or get access to medications, and 30 percent said the plan helped them find specialists or behavioral health providers. However, analysis also showed that those members with poor health and disabilities were not more likely to receive care coordination than other members. Overall, 23 percent of CMC members said they could use more help with care coordination with unmet need, which was especially prevalent among those with more complex care needs (9).

The purpose of this research brief is to examine the implementation of the CMC care coordination benefit from the perspective of stakeholders, including both progress made and challenges that remain for CMC plans coordinating care for dually eligible beneficiaries.

METHODOLOGY

This report integrates findings from 94 key informant interviews conducted in 2015-2017 with CMC stakeholders, including: CMC plans, physicians, provider groups, hospitals, long-term care (LTC) facilities, and HCBS providers. As care coordination has been a topic of many previous reports of this evaluation, new findings are reported alongside summaries of findings from previous reports.[2]

FINDINGS

Implementing Integrated Care through Cal MediConnect

Effective care coordination across providers and sites of care, at its core, requires relationship-building. In the planning and implementation stages of the Coordinated Care Initiative (CCI), many statewide and regional meetings (called "collaboratives") were created to promote shared learning, enhanced communication, and collaboration across health system stakeholders. Some collaboratives that were mentioned by stakeholders as particularly effective were meetings that brought together all CMC plans across the state, and regional collaboratives that brought together all CMC plans with LTC facilities, IHSS, or other HCBS agencies in that county or region. ***Previous research on the provision of HCBS through CMC*** presented more details about statewide and regional collaboratives (10).

ICT Meetings Were a Successful Strategy to Promote Care Coordination Across Sites: ICTs proved to be another key tool in promoting care coordination across sites and providers. These ICT meetings typically involved care coordinators from the CMC plan, as well as providers or care coordinators from other agencies that were involved in the care of a plan member, such as an IHSS social worker. ICT meetings varied in their structure and duration. Some were in-person meetings of various agencies. Some were regularly held meetings that were scheduled at intervals to check on the progress of members' care. Other ICTs were impromptu meetings where CMC plan care coordinators would arrange on the spot conference calls with various providers to solve disruptions in care or address specific urgent problems. Among all agencies that engaged in ICT meetings with CMC plans, a common theme was that these meetings were very effective in improving collaboration, communication, and access to care for members. However, most agencies reported it was very difficult to engage the members as part of the ICT meeting, posing challenges to the goal of "person-centered planning." ***Previous research on the provision of HCBS through CMC*** presented more details about ICT meetings (10).

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[2]All previous reports can be found on The SCAN Foundation website, Evaluating Medicare-Medicaid Integration at *http://www.thescanfoundation.org/evaluating-medicare-medicaid-integration*

Care Coordination Between CMC Plans and Medical Care Providers: Many CMC plans created special strategies to provide more intensive care coordination to members with complex care needs, including: creating internal complex care management departments (10), delegating to provider groups and high utilizer clinics with complex care management expertise, and contracting with management services organizations (MSOs) to help manage individuals' care (11).

Some CMC plans reported that it was important to retain internal control over the care management services provided to complex CMC members, requiring oversight by the plan and the convening of all medical and HCBS providers together through ICTs (11).

Other CMC plans and provider groups argued that complex care management services were best conducted by provider groups or high utilizer clinics, such as those developed by CMC plans, provider groups, and MSOs through complicated risk sharing arrangements. One provider noted that MSOs, because they are able to accept risk for medical care and LTSS, they can better manage high-risk members through advanced health information technologies, intensive care coordination, and an extensive network of specialty providers.

> *"Because we're at risk, we found that if we manage this population, it's better to manage them and survive than not manage them and not survive. Because our interests are aligned, I can do anything I want with that bucket of money. Sometimes housing is significantly less expensive than a hospital stay, right? And so if the person is going to the hospital two or three times a month, I can afford the Ritz-Carlton for that person if it came down to it."*– MSO

While health maintenance organizations and provider groups are limited by the *Knox-Keene Health Care Service Plan Act* of 1975 and regulated by the California Department of Managed Health Care, MSOs are not similarly limited, allowing them to accept risk for the full spectrum of care (12). This difference could possibly better incentivize integration of care.

Care Coordination Between CMC Plans and Behavioral Health Providers: Behavioral health was provided to CMC members through a variety of providers. While CMC plans (like all Medi-Cal managed care organizations) provided "mild to moderate" mental health services directly, most specialty mental health services were referred to County Behavioral Health providers and those services were "carved out" (6). However, CMC health plans were required to coordinate with County Behavioral Health providers.

Like many other provider types, behavioral health providers praised the use of ICT meetings as an effective strategy for improving care coordination and collaboration with the health plans. In addition to ICT meetings, streamlined communication also happened through "joint operation" meetings between CMC plans and County Behavioral Health departments, which facilitated conversations about collaboration and integration of services across CMC and other initiatives. Co-location is another approach to increase care coordination across sites, with CMC plans' staff working in the same building with providers.

Challenges that still remain in the coordination of behavioral health include coordinating carved-out benefits and data sharing. As members often needed referrals to County Behavioral Health providers, the process is not as efficient when County Behavioral Health departments differed in their definition of "mild to moderate" versus serious mental illness. Additionally, data sharing remained a major challenge. Behavioral health providers pointed out the privacy regulations they needed to follow and suggested additional training to ensure confidentiality of members' behavioral health information. ***Previous research on behavioral health coordination in CMC*** presented more about the care coordination between behavioral health providers and CMC plans (13).

Care Coordination Between CMC Plans and HCBS: HCBS includes both Medi-Cal covered services and supports (i.e., IHSS, CBAS, and MSSP), as well as non-Medi-Cal services and supports provided by county agencies and community-based organizations (CBOs).

Previous research on the provision of HCBS through CMC showed that as CCI was implemented, many HCBS organizations did establish contracts or referral relationships with CMC plans (10) and that collaboration and coordination between some HCBS and CMC health plans has improved over time (14). Despite this, many HCBS organizations continued to report ongoing frustration with a lack of collaboration with and referral from CMC plans (10). Many of the organizations that provided HCBS were somewhat skeptical about the capacity of CMC plans to provide social services and supports in the community. These HCBS organizations saw themselves as having expertise and established relationships in the community, which could be successfully leveraged to help coordinate LTSS provisions if the plans would collaborate with them.

> *"We're helping people with disabilities as we have for many years, we already have communication with other resources — anything from housing to referring out to legal help, anything they would need in the community. We at least have an awareness of basic contact with certain resources.... Because we've been doing this work all along."* – Independent Living Center

Previous research on the provision of HCBS through CMC found that strategies such as conducting regular ICT meetings for all IHSS users, co-locating staff and developing portals to share data were all successful in improving care coordination for CMC members using IHSS (10). For HCBS other than IHSS, there were variable reports about improvement of care coordination across sites. CMC plan coordination with CBAS did not improve access to services for CMC members (10).

Alternatively, for HCBS services that are not Medi-Cal benefits, such as social service agencies, meal programs, and independent living centers, collaboration with CMC plans did not improve as much as expected. The exception was with CMC plans that used "brokerage models" to partner with one large HCBS agency. This helped to improve referrals to more CBOs and added value for members. CMC plans were able to pay for these non-Medi-Cal HCBS through CPOs, but many plans reported that this was a challenge due to barriers faced in establishing contracts, Memorandums of Understanding (MOUs), and data sharing agreements with small CBOs (15). Many CBOs continued to offer services to CMC members despite a lack of contracts or payment from the plans for such services, but they also expressed concern about their ability to continue to do so (10). Efforts to enhance the business acumen of small CBOs to improve their ability to make a business case and establish contracts with managed care organizations could address this challenge (16).

However, ***previous research on the health system response to CMC*** noted the challenge presented when little data is collected about these partnerships and CPO delivery by CMC plans (15). Without such data, collaborating CBOs and CMC plans may not capture the value of these services to their members. Future policy efforts underway through the Whole Person Care Pilots[3] and Health Homes Program[4] could address some of the challenges presented by facilitating contracting and data sharing across sites.

CMC Care Coordination Has Improved Care Processes

CMC Care Coordination Could Improve Care Transitions: The CCI demonstration was unique in that it integrated payment for LTC facilities into CMC plans. Health plans reported that they planned to use the opportunity to improve quality of care by reducing things like re-hospitalizations, as well as reducing the overall institutionalization of members by facilitating transitions out of LTC facilities to lower levels of care or community-based settings. ***Previous research on care transitions in CMC*** has shown that care coordination can help in the identification of plan members who could be transitioned out of institutional LTC settings (17). Some plans created specific programs to help with transitioning members out of these settings.

For example, one CMC plan had a transition program that worked with CBOs to provide various HCBS to support members who could be moved out of institutional settings and into community-based ones. Another health plan model focused on developing internal capacity for transitions within the CMC plans' care coordination program (17).

> *"Navigating the medical burdens, the pharmacy, and the appointments, etc., is already a challenge. You bring in this service you bring another complicated element of coordination and confusion. The managed LTSS department has had the amazing ability to coordinate. They have one department. There is a triage component that addresses needs; there is a coordinating effort from the long-term care perspective."* – CMC plan

These collaborative programs have been able to coordinate transitions into community settings for plan members who may have otherwise not been able to leave an institution. They have not only been successful, but also save the plans money as a less expensive alternative to institutional care.

On the other hand, when there is not effective care coordination between providers in a plan, the onus is then often put on the member to access services and get the necessary referrals. In addition, when there is no coordination of care across different counties, transitions back into the community may be at risk.

"…we get patients from all over California that were transferred. We are trying to get them back or let's say, we are trying to do a good transition of care and get them to a daughter's house or a family member. Now you are in another county, now the managed care doesn't cover that area. We couldn't, it wasn't easy just to connect those patients and have that transition of care in a community, in any community." – Hospital provider

[3]More information about the Whole Person Care Pilots in California can be found at *http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx*

[4]More information about the Health Homes Program can be found at *http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx*

CMC Could Improve Access to LTSS: ***Previous research on the health system response to CMC*** revealed that CMC plans were optimistic about the promise of improved access to LTSS (e.g., IHSS, CBAS, MSSP) for their members (15). ***Further research on the provision of HCBS through CMC*** also showed that the CMC care coordination benefit helped some members increase access to IHSS and other Medi-Cal HCBS such as CBAS (8, 10, 17). A longitudinal survey of CMC members found a significant increase in average increase in IHSS hours for CMC members between 2016 and 2017 (9).

Increased coordination between CMC care coordinators and IHSS was identified as a promising practice that helped to increase access to personal care services for CMC members, despite the fact that county social services (and not the CMC plans) retained responsibility for assessment of IHSS eligibility and hours. For example, CCI funds were specifically allocated for IHSS social workers to attend ICT meetings, and IHSS Care Coordination Units were created in some CMC plans, specifically dedicated to the coordination of care for their members (10). CMC plans reported that these coordination efforts were improving services for their members.

> *"I have a specific staff that all they do is IHSS liaison connections.… That's all they do. They are the liaison between my team, the independent practice associations, and the IHSS agencies in the two counties. It's much deeper both in terms of if we need more hours for a member, [and] if we want a member assessed."* – CMC plan

Despite the evidence of success of these care coordination practices, the funding for IHSS social workers to participate in the ICT meetings was eliminated at the end of the initial demonstration on December 31, 2017. Although it has been recommended that the state continue to fund this aspect of care coordination (14), the impact that this cut will have on subsequent or ongoing CMC care coordination efforts remains to be seen. In the meantime, plans and counties are being encouraged to continue working together on care coordination efforts, including data sharing and the development of MOUs.

CMC Impacted the Care Coordination Workforce

Previous research found that CMC impacted the care coordination workforce in California (18, 19). Major adjustments to workforce infrastructure required the recruiting and training of adequate and qualified care coordinators by both the provider organizations and CMC plans. CMC plans either contracted and delegated the care coordination benefit to provider organizations or hired care coordinators directly. Though this expanded demand for care coordinators posed some challenges, ***previous research on the health system response to CMC*** reported that CMC has encouraged the "evolution" of nurse, social work, and behavioral health care coordinators and a team approach to care coordination (15). Care coordinators have been required to expand their skillsets as a result of the CMC requirement for convening ICTs and coordinating the full spectrum of care.

In particular, many CMC plans hired more care coordinators with expertise in behavioral health care coordination (13). These behavioral health care coordinators met in-person with CMC members, connected them to resources, and in some cases, accompanied them to scheduled appointments in order to assist with needed follow-through. CMC plans also reported the need to hire "care navigators" or "community connectors" to assist with care coordination in difficult to reach populations. These roles were usually filled with staff who were members of diverse communities and helped the plans access members and assisted care coordinators.

Despite reported efforts to prepare the care coordination workforce, some providers reported that CMC plan care coordinators were lacking the adequate training needed to help with care transitions (11). These providers indicated some of the CMC plan's care coordinators might not be familiar with the Medicare requirements, medical necessity guidelines, and associated services and treatments pertaining to services post-hospital discharge.

Challenges Remain in Delivery of the CMC Care Coordination Benefit

Despite many promising practices, and possible improvements in access to care due to the CMC care coordination benefit, this progress varied by plan and region. Several barriers remain to successful care coordination, including: stakeholder's lack of awareness of care coordination benefits, difficulty with data sharing across health system stakeholders, and the uncertain future of CMC.

Some Stakeholders Lack Awareness About Care Coordination Benefits: While some efforts have been made to improve CMC materials for members and providers, several stakeholders noted that many providers are still not well informed about the CMC care coordination benefits. Similarly, although guidance has been issued by DHCS about CMC plan's responsibility to provide care coordination services, ***previous research on providers' perspectives of CMC*** found that many providers noted that assistance from plans with care coordination was lacking, especially when it came to care transitions (11, 17). One hospital respondent noted that some CMC plans refused to assist with care coordination despite multiple efforts on behalf of the hospital.

> *"…we raised [the issue] in comment letters to DHCS, we've discussed with CMS, we've discussed with the health plans leadership, their Chief Executive Officer, their Chief Medical Officer, their top leadership, and we still had to engage CMS.… These are some issues that need to be addressed so that the beneficiaries truly do have access to the care coordination that they are entitled to."* – Hospital provider

This lack of awareness of care coordination benefits among CMC plans could also result in the lack of referrals to HCBS providers for LTSS services, as was found in previous research (9). Providers also mentioned that some frontline CMC staff were not familiar with all the Medicare and Medicaid regulations and coverage to be able to connect CMC members with available benefits.

> *"It was really just a matter of the frontline [providers] not knowing what questions to ask [about the CMC care coordination benefits]."* – Hospital provider

As was reported in ***previous research on providers' perspectives of CMC***, lack of awareness among frontline providers and staff could also be limiting reports of access barriers to benefits; staff may just not be aware of them (11).

Persistent Challenges with Data Sharing Pose a Barrier to Successful Care Coordination: As reported previously, data sharing challenges have created barriers to collaboration with behavioral health and other providers, provision of HCBS, transitions of care, and coordination of care across sites. These challenges are not unique to CMC, but do pose particular barriers to effective care coordination, which is a pillar of CMC.

In previous research, ***behavioral health*** and other ***providers*** highlighted challenges in providing continuing care to new patients when they can't access information about previous care (11, 13). Additionally, one MSO stakeholder noted frustration with electronic medical records (EMRs) which blocks access to certain elements of patient's care, such as behavioral health.

> *"I've gone to hospital systems that have their own EMRs, and they've walled off the behavioral piece of the EMR, so only certain people can have access to it. It's kind of crazy. If you're the primary care doc, and everybody's on the same EMR system, you can't even get into your patient's behavioral health record.… That gives you a sense of the challenge that we're all trying to tackle around coordination of care."* – MSO

Another MSO stakeholder noted the difficulty of delivering person-centered care or developing a comprehensive care plan when they lack valuable information from CMC plans.

> *"We're trying to develop an overall care plan [for a member]. The health plan doesn't want to send us any of the CBAS care plans or the assessment that IHSS did on the member.… Our argument is in order to develop a comprehensive person-centered care plan, we would like to know what is going on in the home, and obviously what is happening with someone medically…but the health plan still won't share that information because they're under the very strict rules of delegation, saying, 'You're not delegated for it, so we are not going to share it with you.' It becomes very difficult to be person-centered or develop a comprehensive care plan when you don't have all the pieces."* – MSO

Previous research on providers' perspectives of CMC has also reported that when data sharing happened in CMC, it was often one-sided with providers sharing data with the plans, but not receiving data in return (11). Promising practices have also emerged that showed some CMC plans developing provider portals to assist providers in accessing data, and other CMC plans incentivizing data sharing by linking reimbursement to data sharing activities.

Duplication of Care Coordination Possible: Providers raised concern about care coordination efforts being duplicated between CMC plans and providers due to a lack of collaboration, communication, trust, and data sharing. CMC plan care coordinators may not communicate information about referrals and LTSS to providers who may also be attempting to coordinate care.

> *"There's care coordination that happens at the health plan level and there's also care coordination that happens at the Independent Practice Association (IPA) and clinic level and those aren't always integrated. There are definitely efforts on our end, separately on the health plan, to do some of the care coordination and family participation in ICT. But there is a disconnect between the information and the efforts. [There is some] duplication of the efforts on the plan level and at the IPA/clinic level."* – Provider group

Despite the availability of care coordination through CMC, many provider groups continue to provide their own care management. They do this because they believe it is necessary to adequately serve their patients and prevent costly services which could exceed the rate paid by the CMC plan.

While all stakeholders understood the importance of care coordination, the question often arose as to who should be the "point person" in those efforts. Providers often had more direct knowledge of patients' needs, but sometimes lacked expertise in LTSS care coordination or a non-medical approach to care coordination.

"The real question is when should primary care be point? When should In-Home Support[ive] Services be point? When should the county behavioral health be point? When should our care coordination be point? I think that's what we've been trying to do and I think that's, of course, probably the holy grail of all this work is to have it as individualized as possible but also done to scale." – CMC plan

More regular communications through ICTs, co-location of care coordinators, and in-person site visits by CMC care coordinators could improve integration of patient care and prevent duplication of care coordination by CMC plans and providers.

The Future of Care Coordination for Duals in Managed Care

Recently, two major policy changes have been enacted that may strengthen care coordination in managed care plans for duals, including the new three-way contract and the Creating High-quality Results and Outcomes Necessary to Improve Chronic *(CHRONIC) Care Act of 2018* (20).

First, a new three-way contract among CMC plans, the California DHCS and CMS (7) made several notable changes to the CMC care coordination benefit, which may impact how care coordination is delivered in the future. While the new contract remains vague about specific qualifications for care coordinators, it does require CMC plans to "ensure an adequate ratio of Care Coordinators to Enrollees to provide Care Coordination." Although the contract doesn't set a ratio, each CMC plan's ratio of Care Coordinators to enrollees will be monitored on a regular basis. This change may expand CMC plans' care coordination workforce and encourage plans to have sufficient care coordinators to support beneficiaries. The new contract also requires plans to "have a process for assigning a Care Coordinator to each enrollee" and specifies that care coordinators must make contact with members annually. Furthermore, the new contract requires plans to provide members with the name and contact information for their CMC plan care coordinators in their ICP. These changes could improve CMC member access to and consistency of care coordination services.

The second major policy change that may impact care coordination in CMC plans is the recently-passed *CHRONIC Care Act of 2018* (21). In addition to permanently certifying a variety of Special Needs Plans (CMC can be described as a Duals SNP), it also makes more explicit that care coordination and integration are "explicit and essential purposes of SNPs," and requires SNPs to create unified care plans for dual eligible individuals. The almost unprecedented unanimous passing of the *CHRONIC Care Act of 2018* may demonstrate a promising new commitment and understanding on the federal level about the importance of care coordination in integrated care.

KEY FINDINGS

1. **State and federal policies recognize that care coordination is an essential part of integrating care for duals.** Requirements imposed by both the new three-way contract in California and the *CHRONIC Care Act of 2018* could further solidify and strengthen the use of care coordination for duals in managed care plans.

2. **There is great variation in how CMC plans are organizing and delivering care coordination benefits.** CMC health plans had great discretion over how they structured their care coordination activities. Many CMC plans developed internal capacity within the plan to serve members, while others worked with third-party delegated entities such as provider groups or MSOs.

3. **The CMC care coordination benefit encourages collaboration across health system stakeholders.** CMC plans, providers, county behavioral health, LTC facilities, and HCBS agencies are collaborating more as a result of the CMC care coordination benefit. ICT meetings have proven a successful strategy to encourage collaboration across health system stakeholders.

4. **The CMC care coordination requirement could improve care transitions across health care settings.** Health plans, LTC facilities, and HCBS agencies all reported efforts to promote communication and collaboration across organizations to improve transitions to lower levels of care. However, improvements in care transition processes vary regionally and by CMC plan. Such variation could be the result of a lack of awareness about DHCS guidance related to CMC plans' responsibility to assist with transitions of care.

5. **The CMC care coordination benefit could improve access to HCBS.** The CCI has improved coordination and collaboration between CMC health plans and agencies that provide Medi-Cal-reimbursed HCBS, such as IHSS and CBAS, resulting in improved access for many CMC members. Both plans and HCBS providers reported that CMC health plans were successful in advocating for additional IHSS hours and other services to fill gaps in care for their members.

6. **The CMC care coordination benefit has impacted California's health care workforce.** CCI required CMC plans and delegated provider groups to recruit and train qualified care coordinators. New guidance was issued in the three-way contract to ensure an adequate ratio of care coordinators to enrollees. While this may strain the care coordination workforce in some regions, it may also help ensure that there are adequate care coordinators to meet the needs of CMC members.

7. **Awareness about the CMC care coordination benefit varies among CMC plans, providers, and members.** Many providers and members are still not well informed about the CMC care coordination benefit, and assistance from plans with care coordination varied – especially with care transitions. In addition, some frontline CMC staff were not familiar with all the Medicare and Medicaid regulations and coverage to be able to connect CMC members with available benefits.

8. **Data sharing barriers remain a significant challenge to successful, non-duplicative care coordination efforts.** All health system stakeholders recognized the importance of data sharing in successful care coordination, though they faced problems with non-interoperable systems, information technology infrastructure, and strict interpretations of Health Insurance Portability and Accountability Act regulations that hindered data sharing. These challenges sometimes led to duplicative care coordination efforts.

RECOMMENDATIONS

1. **CMS and DHCS should continue to examine best practices and learn from evaluations of duals demonstrations and special needs plans to improve care coordination in future program implementation.**

2. **CMS and DHCS should develop reporting systems that capture the regional and CMC plan variation in the delegation of care coordination and other practices in order to assess their relative strengths and challenges.**

3. **CMC plans should continue to invest in communication and collaboration across providers to meet the needs of their members and share promising practices.**

4. **DHCS should establish a reporting process for ICT implementation. Best practices in organizing and conducting ICTs should be identified, replicated across CMC plans, and included in future integrated care model policies.**

5. **CMC plans should explore relationships with HCBS providers to implement innovative programs to transition LTC residents to lower levels of care.**

6. **Provider associations should disseminate the DHCS Duals Plan Letter (DPL) 16-003 to their members, and CMC plans should review the DPL to ensure their current practice aligns with DHCS guidance. DHCS should encourage CMC plans to develop Memorandums of Understanding with providers – especially hospitals – to clarify protocols for care coordination and transitions of care.**

7. **DHCS should issue guidance encouraging plans and IHSS providers to continue close collaboration, despite the "re-carve out" and change in payment. DHCS should look for opportunities to strengthen these collaborations in future legislative actions.**

8. **DHCS and CMC plans should explore alternative funding opportunities to encourage LTSS provider participation in ICTs.**

9. **CMC Plans and DHCS should monitor and predict shifting health system workforce needs and challenges, especially considering new three-way contract language and guidance requiring plans to make care coordination available to all members. DHCS should consider additional guidance to clarify the qualifications and tasks of care coordinators.**

10. **DHCS should continue education efforts with providers and members about CMC benefits and requirements, and monitor CMC plan and provider group adherence with guidance around the care coordination benefits to ensure more consistent access for CMC members.**

11. **CMS and DHCS should continue to encourage the development of effective and interoperable data-sharing systems.**

ACRONYM LIST

CBAS: Community-Based Adult Services

CBO: Community-Based Organization

CCI: Coordinated Care Initiative

CHRONIC Care Act of 2018: Creating High-quality Results and Outcomes Necessary to Improve Chronic Care Act of 2018

CMC: Cal MediConnect

CMS: Centers for Medicare & Medicaid Services

CPO: Care Plan Options

DHCS: Department of Health Care Services

DPL: Duals Plan Letter

EMR: Electronic Medical Records

HCBS: Home- and Community-Based Services

HRA: Health Risk Assessment

ICP: Individual Care Plan

ICT: Interdisciplinary Care Team

IHSS: In-Home Supportive Services

IPA: Independent Practice Association

LTC: Long-Term Care

LTSS: Long-Term Services and Supports

MOU: Memorandum of Understanding

MSO: Management Services Organization

MSSP: Multipurpose Senior Services Program

SNP: Special Needs Plan

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