FINANCIAL ALIGNMENT INITIATIVE

California Cal MediConnect: Preliminary Third Evaluation Report

April 2023

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FINANCIAL ALIGNMENT INITIATIVE
CALIFORNIA CAL MEDICONNECT
PRELIMINARY THIRD EVALUATION REPORT

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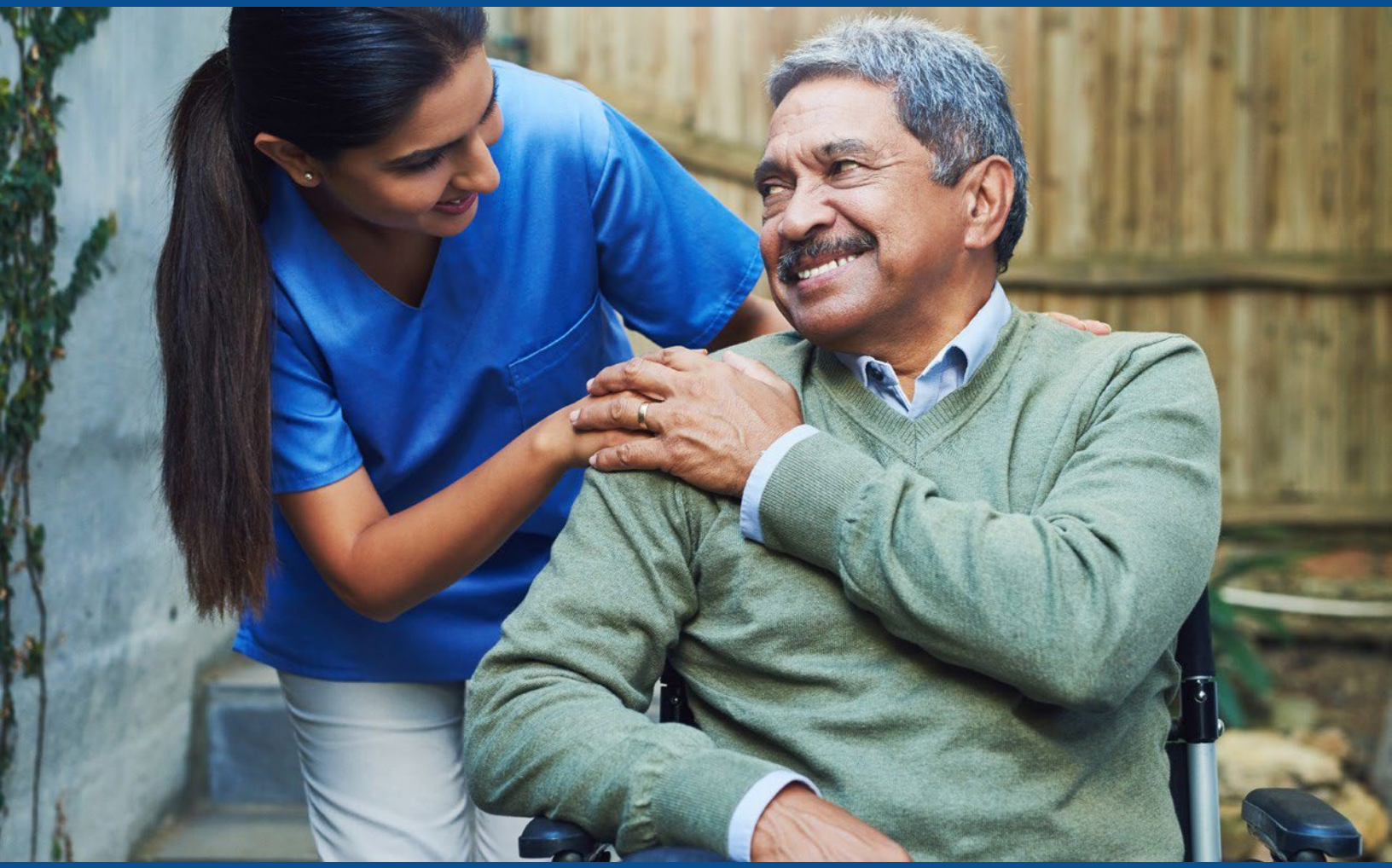
Glossary of Acronyms

AGA	Average geographic adjustment
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalAIM	California Advancing and Innovating Medi-Cal
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
PHE	Public Health Emergency
PMPM	Per member per month
PS	Propensity score
SDRS	State Data Reporting System
UCP	Uncompensated care payment

Executive Summary



Overall, the Cal MediConnect demonstration stayed true, or had overall fidelity, to its original design, and in late 2021 included about 115,000 enrollees, just under 25 percent of eligible beneficiaries. Enrollment was likely affected by the competitive managed care environment in California. Those enrolled in the demonstration indicated overall satisfaction with their Medicare-Medicaid Plans (MMPs). Care coordination was highly valued by enrollees engaged with a care coordinator, but there was great variation among MMPs in how care coordination was implemented. Carve-outs of long-term services and supports (LTSS) services made it difficult to implement effective care coordination and lessened MMPs ability to leverage community LTSS to improve outcomes. Demonstration successes included the State educating MMPs about the needs of dually eligible beneficiaries and forging important ongoing relationships with stakeholders. These successes have helped lay the groundwork for integrated care expansion statewide through the California Advancing and Innovating Medi-Cal (CalAIM) model of exclusively aligned enrollment dual special needs plans (EAE D-SNPs). An impact analysis found increases in Medicare and Medicaid costs among demonstration eligible beneficiaries relative to their comparison group counterparts.

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 dually eligible enrollees. California and CMS launched the Cal MediConnect demonstration in April 2014 to integrate care for dually eligible 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 dually eligible 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 third Evaluation Report for Cal MediConnect describes its implementation and impact. The report includes findings from qualitative data for calendar years 2020–2021 with key implementation and transition updates planned for 2022, and Medicare and Medicaid cost savings analyses through calendar year 2019. The Medicare cost savings results presented are preliminary because risk corridor payments and the disenrollment penalty 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 years (April 2014 through December 2019) 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 because the MMP encounter data were deemed to be incomplete.

Highlights

Integration of Medicare and Medicaid	MMPs identified joint CMS-State management of the demonstration as a major success.
Eligibility and Enrollment	In 2021, enrollment increased to its highest level since 2017. Stakeholders and the State reported this was because, per federal policy, the State maintained enrollees' Medi-Cal coverage without recertification during the PHE, and fewer enrollees became ineligible for Cal MediConnect than in previous years. However, because enrollment growth varied across MMPs, other factors such as plan performance may have also contributed to this growth.
	In late 2021, MMPs reported increases in disenrollment attributed to enrollee misunderstanding about the end of Cal MediConnect and the transition to Exclusively Aligned Enrollment Dual Special Needs Plans (EAE D-SNPs). MMPs would be responsible for informing enrollees of the transition to EAE D-SNPs, but this process had not yet begun as of early 2022.
Care Coordination	According to all stakeholders, care coordination remained a well-received element of Cal MediConnect among those who received it. Engaged enrollees valued their relationship with a care coordinator and appreciated receiving this service. However, advocates continued to be concerned with the limited reach of care coordination, and the differences across MMPs in care coordinators' caseloads.
	During the PHE, MMPs focused on maintaining service delivery and pivoting to virtual and telephonic support for enrollees. MMPs facilitated access to COVID-19 vaccines and developed approaches to address beneficiary social determinants of health and social isolation. Close coordination with community-based organizations and county agencies played a key role in these efforts.

Care Coordination (continued)	With support from DHCS and the CMT, MMPs continued work to increase participation in Interdisciplinary Care Teams by Cal MediConnect enrollees and their providers. Stakeholders voiced concerns about other challenges, including differences among MMPs in care coordinator caseloads and the percentage of enrollees receiving long-term services and supports.
Stakeholder Engagement	Stakeholders reported that significant DHCS staff turnover in early 2020 limited State engagement with Cal MediConnect stakeholders.
	Starting in February 2021, the State began monthly stakeholder meetings to plan the transition to EAE D-SNPs.
Quality of Care	MMPs increased their focus on improving health equity in 2020 and 2021 by using data analytics focused on their Healthcare Effectiveness Data and Information Set (HEDIS) outcomes.
	Most MMPs have improved performance on controlling HbA1c levels. Other results of HEDIS measures have been mixed across measures and MMPs over the course of the demonstration.
	Quality withhold results for 2019 were mixed, with five MMPs receiving 100 percent of their withhold payments and five receiving 75 percent or less. All MMPs received 100 percent for 2020 because an adjustment for an extreme and uncontrollable circumstance due to the PHE was in effect.
Financing and Payment	In general, insurers (parent managed care organizations) that offered other capitated managed care products did not view their Cal MediConnect plans as profitable. Several plans compared their Cal MediConnect product to other lines of business, which were not subject to up-front reductions in capitation payments required of Cal MediConnect plans.
	MMPs raised concerns about the effects on future rate setting of enrollees using fewer health care services during the PHE.

Beneficiary Experience	According to stakeholders, Cal MediConnect members continued to be satisfied with their benefits and plan offerings.
	The percentage of Cal MediConnect respondents to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey who rated their health plans and drug plans as a 9 or 10 out of 10 continued to increase during the reporting period across California MMPs. However, increases were not steady year to year for most MMPs.
Demonstration Impact on Cost Savings	As summarized in ***Table ES-1***, the demonstration was associated with an increase in Medicare Parts A and B costs, cumulatively over the first 5 demonstration years and in each year, relative to the comparison group.
	The demonstration was also associated with an increase in Medicaid total cost of care cumulatively and in each of the 5 demonstration years, relative to the comparison group. The demonstration's launch corresponds with California's expansion of Medicaid managed care for dually eligible beneficiaries, which impacted both the demonstration group and the comparison group.[1]

Table ES-1 summarizes the demonstration effects on total Medicare Parts A and B expenditures for all eligible beneficiaries, including both the cumulative effect over the 5-year demonstration period and the annual effect for each demonstration year, as well as the cumulative and annual effect estimates for Medicaid expenditures for the entire 5-year demonstration period.

[1] The results are robust to potential T-MSIS (Transformed Medicaid Statistical Information System) submission errors reported by Medi-Cal representatives (see Appendix D for more details).

Table ES-1
Summary of California demonstration effects on total Medicare and Medicaid expenditures among all eligible beneficiaries, April 1, 2014–December 31, 2019

Measure	Measurement period	Demonstration effect
Medicare Parts A and B cost	Cumulative (demonstration years 1–5)	Increase[R]
	Demonstration year 1	Increase[R]
	Demonstration year 2	Increase[R]
	Demonstration year 3	Increase[R]
	Demonstration year 4	Increase[R]
	Demonstration year 5	Increase[R]
Medicaid total cost of care	Cumulative (demonstration years 1–5)	Increase[R]
	Demonstration year 1	Increase[R]
	Demonstration year 2	Increase[R]
	Demonstration year 3	Increase[R]
	Demonstration year 4	Increase[R]
	Demonstration year 5	Increase[R]

NOTES: Statistical significance is defined at the α = 0.05 level. For numeric estimates of the demonstration's effect on total Medicare expenditures, see ***Figure 24*** in ***Section 5, Demonstration Impact on Cost Savings***. Red color-coded shading indicates where the direction of the difference-in-differences (DinD) estimate was unfavorable. To ensure accessibility for text readers and individuals with visual impairments, cells shaded red receive a superscript "R." In the column for "Demonstration effect," an *Increase* or *Decrease* refers to the *relative* change in an outcome for the demonstration group compared to the comparison group, based on the DinD regression estimate of the demonstration effect during the specified measurement period. The States of Pennsylvania and Wisconsin are omitted from the comparison group for the Medicaid cost results due to problems with Medicaid data quality.
SOURCE: RTI analysis of Medicare and Medicaid claims (program: ca_dy5_1480_GLM.log, 30_Regression.do).

SECTION 1

Demonstration and Evaluation Overview

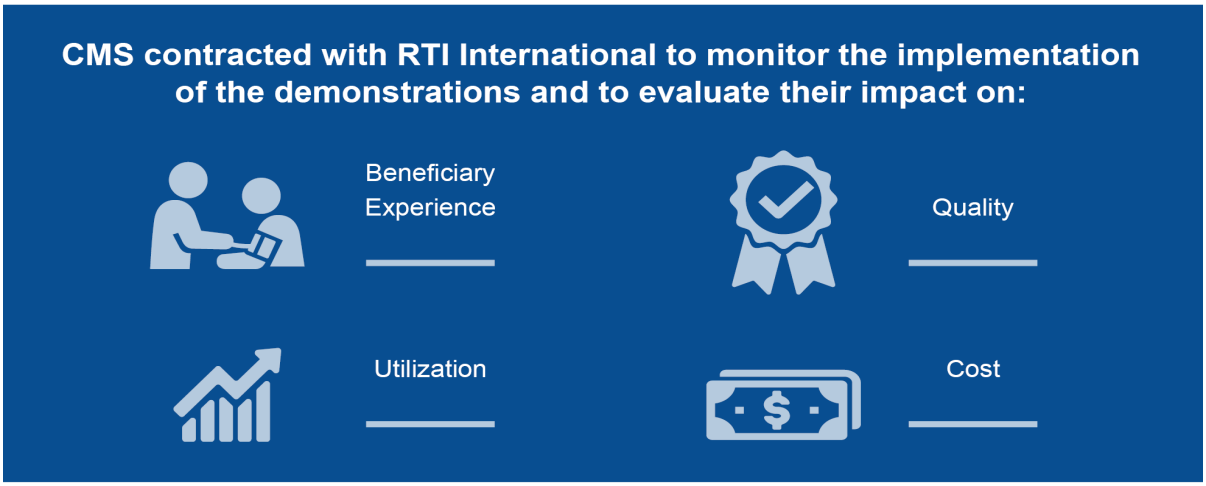
1.1 Demonstration Description

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 (FAI) to test, in partnerships with States, integrated care models for dually eligible enrollees. California and CMS launched the Cal MediConnect demonstration in April 2014 to integrate care for dually eligible 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 dually eligible 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 sixth and seventh demonstration years (calendar years 2020 and 2021 respectively). We refer to this time period as "the reporting period" or "the report period" in the qualitative narrative. 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 and B cost savings through calendar year (CY) 2019, the fifth demonstration year. This report does not include results on service utilization outcomes because the MMP encounter data were deemed to be incomplete.

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.

Data Sources

KEY INFORMANT INTERVIEWS

Site visit interviews

Quarterly monitoring calls with CMS and California Department of Health Care Services (DHCS) officials

DEMONSTRATION DATA AND MATERIALS

State Data Reporting System (SDRS) submissions

Demonstration policies, contracts, and other materials

BENEFICIARY SATISFACTION DATA

Medicare Advantage Prescription Drug Plan Consumer Assessment of Healthcare Providers and Systems (CAHPS)

COMPLAINTS AND APPEALS DATA

MMP data reported to DHCS and CMS

Complaint Tracking Module (CTM)

Medicare Independent Review Entity (IRE)

QUALITY DATA

State-specific quality measures

Medicare Healthcare Effectiveness Data and Information Set (HEDIS) measures

COST DATA

CMS Medicare Advantage and Part D Inquiry System (MARx) data

Quality withhold repayments

Medicare Part A claims

Medicare Part B claims

Medicaid Analytic eXtract (MAX) claims

Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF)

SECTION 2

Demonstration Design and State Context

2.1 Changes in Demonstration Design

Cal MediConnect began in April 2014 and underwent several changes as detailed in the Preliminary Second Evaluation Report, which covers the period of 2017–2019. In April 2019, DHCS announced the CMS-approved extension of the Cal MediConnect demonstration to December 31, 2022. The three-way contracts were amended accordingly. Effective January 1, 2022, the Multipurpose Senior Services Program (MSSP), a case management program for beneficiaries with nursing home level of need, reverted to a carved-out benefit in California's Coordinated Care Initiative (CCI), which includes demonstration counties as well as for all other Medi-Cal managed care plans (Justice in Aging, 2021). DHCS has made respective changes to payment rate categories.

Implementation Effectiveness: Fidelity

As the demonstration is now in its 9th year, we have identified several measures as indicators of implementation effectiveness or success, based on the standard implementation science approach, that we believe are useful for this evaluation. The four measures are: (1) fidelity of the demonstration to the original design, (2) demonstration reach, (3) implementation dose, and (4) the State's and CMS' reflections on demonstration effectiveness. We discuss each of these measures in this report, starting with fidelity.

Implementation fidelity can be considered as the degree to which an intervention is implemented as originally designed, even if adaptations to the strategy become necessary. For States, plans, and other stakeholders, including policy-makers, reflecting back on the changes to the demonstration model required as implementation unfolded and analyzing their impacts is helpful for designing or implementing future models or considering which demonstration features to carry forward.

As seen in ***Table 1***, although overall the Cal MediConnect demonstration was implemented with a high degree of fidelity to the original design, it also underwent several key changes. The carve-out of IHSS made care coordination with long-term services and supports providers more challenging for MMPs and led to decline in participation of staff from carved-out programs in care teams. As part of the transition to CalAIM, the introduction of Community Supports starting in calendar year 2022 was a model change well-received by MMPs. Community Supports evolved from the demonstration's Care Plan Options; once implemented, they allowed MMPs to receive Medi-Cal payments to cover associated costs. Of all the changes to Cal MediConnect design, the IHSS carve-out had the most significant impact on enrollees (see the Preliminary Second Evaluation Report for details of this impact).

In October 2019, DHCS announced the California Advancing and Innovating Medi-Cal (CalAIM) Initiative, which included a proposal to replace Cal MediConnect in the demonstration counties after the demonstration's end, on December 31, 2022. CalAIM includes the D-SNP exclusively aligned Medi-Cal managed care model approach[2] for providing integrated managed care to dually eligible beneficiaries. This transition will occur on January 1, 2023. During Cal MediConnect's final demonstration year, State demonstration staff reported being focused on continuing current demonstration operations while also working on the transition to CalAIM. DHCS' goal is to make the transition into a D-SNP and aligned Medi-Cal plan seamless for demonstration enrollees. DHCS reported that the MMPs would continue Cal MediConnect

[2] Aligned enrollment refers to the enrollment in a dual eligible special needs plan (D-SNP) of full-benefit dual eligible individuals whose Medicaid benefits are covered under a Medicaid managed care organization contract under section 1903(m) of the Act between the applicable State and the D-SNP's Medicare Advantage organization, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization. When State policy limits a D-SNP's membership to individuals with aligned enrollment, this condition is referred to as *exclusively aligned enrollment* (42 C.F.R. 422.2).

enrollment until the very end of the demonstration, reversing the 6-month enrollment moratorium that was originally announced.

Another important demonstration design change, introduced for implementation in 2022, addressed enrollees' needs related to social determinants of health (SDOH). Community Supports, previously called In-Lieu of Services (ILOS), are new services that evolved from the demonstration's Care Plan Options (CPOs) and provided new and expanded options for meeting enrollees' non-medical needs. These services are voluntary for MMPs and are meant to be cost-effective alternatives to traditional medical services or settings (DHCS, 2022a). In 2022, MMPs were able to receive Medi-Cal payments up to the cost of the traditional medical service they were replacing. Starting January 1, 2022, MMPs were able to offer up to 14 "Community Supports" options as part of their Medi-Cal service package and the payment for these services will be built into Medi-Cal rates (DHCS, 2022b). DHCS's assumption is that providing Community Supports will be cost-effective and will offset and replace some State Plan services, payment for which is already folded into the existing Medi-Cal rates paid to MMPs. Several MMPs started to offer some of these services in 2022 (see ***Section 4.1, Impact of the Demonstration on Beneficiaries***).

With the demonstration ending at the end of 2022, the three-way contract was re-executed on June 1, 2022 to reflect close-out processes and transition to D-SNPs. For example, the changes removed the requirement to prohibit new MMP enrollments 6 months prior to the end of the demonstration. The update also documented that MMPs are allowed to (1) discuss the MMP transition with their current enrollees earlier than 90 days prior to the end of the demonstration, and (2) utilize a special integrated Annual Notice of Change/Evidence of Coverage for 2023. The revised three-way contract also added new requirements for the Community Supports benefit and included an update on the carve-out of the MSSP benefit effective January 1, 2022. DHCS leadership reported in 2022 that the three-way contract provision that stipulates for MMPs to develop policies and procedures to train specially designated care coordination staff in dementia care management would be carried over as a D-SNP requirement.

Table 1 illustrates the major changes to key Cal MediConnect demonstration characteristics from its start in 2014 through 2021.

Table 1
Key changes to Cal MediConnect design over the course of the demonstration (2014 through 2021)

Key demonstration feature	Changes to the original demonstration design
Timeline	Passive enrollment timeline was adjusted early in the demonstration. Cal MediConnect was extended until December 31, 2022.
Eligibility	Share of cost beneficiaries[1] were not eligible starting January 1, 2022.
Geography/Number of participating MMPs	The demonstration was implemented in seven of originally planned eight counties due to one MMP not passing the readiness review.
Services/Carve-outs	IHSS was carved out in 2018, and MSSP was carved out in 2022.
Payment structure	A Community Supports (formerly In Lieu of Services) payment category was added in 2022.

IHSS = In-home Supportive Services program; MMP = Medicare-Medicaid Plan; MSSP = Multipurpose Senior Services Program.
[1] These beneficiaries have incomes too high to qualify for Medi-Cal cash assistance but too low to afford their health costs. To receive share of cost Medi-Cal coverage, they contribute towards their health care expenses until they meet the Medi-Cal threshold, with Medi-Cal covering the rest of the medical expenses.

2.2 Overview of State Context

Cal MediConnect began in 2014 as part of California's larger 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).

In 2020–2021, two factors shaped Cal MediConnect implementation. Following an earlier carve-out of IHSS, as of January 1, 2022, the MSSP program was also carved out of Cal MediConnect. Though a much smaller program than IHSS, this may present similar care coordination challenges as occurred with IHSS, as described in the Preliminary Second Evaluation Report. In some counties, D-SNP look-alike plans[3], sometimes operated by the same managed care companies as MMPs, continued to be reported as major competitors to Cal MediConnect. In those counties, D-SNP look-alike plans gained significant enrollment and potentially reduced demonstration enrollment.

In 2020–2021, there were two important State developments that will affect the State's dually eligible beneficiaries. First, California released the Master Plan on Aging, which outlines goals and strategies to better support the State's aging population by addressing challenges such as housing shortages and unaffordability, equity gaps in health care service delivery and life expectancy, and lack of caregiving support (California Department of Aging, 2022a). Under the Master Plan, several initiatives apply to the dually eligible population, including development of innovative models to increase access to long-term services and supports (LTSS); expanding access to home and community-based services (HCBS) by implementing In Lieu of Services

[3] D-SNP look-alike plans are traditional MA plans that appear to offer benefits targeted to dually eligible beneficiaries, based on their cost-sharing structure and supplemental benefits. These plans do not have to comply with D-SNP requirements, including having an approved model of care or contracts in place in the states where they operate.

(now Community Supports) and Enhanced Care Management; and offering home and community alternatives to short-term nursing home stays, including telemedicine support (California Department of Aging, 2022b). Most of these initiatives are also part of CalAIM.

Second, the 2021–2022 California Spending Plan included a temporary increase to the Medi-Cal Federal Share of Cost for HCBS Programs and Services; this increase allowed for major allocations to improve home and community-based services. The HCBS Spending Plan was partially approved by the Federal government in September 2021 (Legislative Analyst's Office, 2021). The plan also included funding for improvements to the HCBS workforce, service transitions and navigation, service capacity and models of care.

In 2020, California experienced the COVID-19 public health emergency (PHE) and additional disruption from fires in some counties. The State worked with MMPs to implement several Federal and State policy flexibilities and waivers, as well as provider and beneficiary COVID-19 vaccination incentives to ensure access to health services.

Federal funding for the demonstration. In August 2020, the State received a $1.49 million award to support the Ombudsman offices from August 2020 through July 2021. The Cal MediConnect Ombudsman program will receive an award of $1.016 million in August 2022 which will cover the transition through March 2023.

SECTION 3

Update on Demonstration Implementation

In this section, we provide updates on important aspects of the demonstration that have occurred since the Preliminary Second Evaluation Report. This report 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

During the PHE, the Contract Management Team (CMT), composed of DHCS and CMS, focused monthly calls with each of the MMPs on specific topics, to better support MMPs in addressing various PHE-related challenges.

The CMT and DHCS focused on several issues including the PHE, improving access to durable medical equipment (DME), health risk assessments, and care plan completion rates.

MMPs identified joint CMS-State management of the demonstration as a major success.

DHCS consolidated oversight for Cal MediConnect MMPs to one specific unit, with contract managers overseeing MMPs and D-SNPs.

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

In the fall of 2020, DHCS consolidated oversight for Cal MediConnect MMPs to one specific unit, with contract managers overseeing MMPs and D-SNPs, where previously contract managers were distributed across three different units within DHCS. In 2021, California also established the DHCS Office of Medicare Innovation and Integration. The office is tasked with further development of integrated care and innovative care delivery models for Medicare beneficiaries, including Medicare-only beneficiaries and dually eligible beneficiaries (California Department of Aging, 2022b).

DHCS reported changes in the joint CMS-State management of Cal MediConnect in 2020 due to the need for more support for MMPs during the PHE. The CMT focused monthly calls with each of the MMPs on specific topics, with many devoted to the PHE, including discussing MMP activities to make sure enrollees were getting the services and support that they needed. Calls were devoted to examining data or data anomalies, MMP-specific challenges (e.g., high numbers of grievances), health equity and racial and ethnic disparities in access to services, and appropriateness of nursing home transitions. Specifically, the CMT incorporated a health equity and racial disparities lens into discussions on a variety of topics such as ensuring Cal MediConnect beneficiaries received communications in their preferred language, supporting MMPs in developing approaches to address racial disparities in flu and COVID-19 vaccination

rates, and establishing pathways for underserved communities to access COVID-19 vaccinations. Some of the new MMP approaches resulting from this work are described in ***Table 2*** in ***Section 3.3, Care Coordination*.**

MMCO also partnered with DHCS and Alzheimer's of Los Angeles[4] to update resources on dementia capable systems previously distributed to MMPs. They also provided questions for the plans to respond to. The CMT discussed these questions during a call in Fall 2020, and DHCS realized that MMP staff did not clearly understand what constituted a dementia care specialist. As a result, clearer language was included in the three-way contract to ensure that MMPs had a shared understanding.

During 2020–2021, DHCS and the CMT also reported focusing on several other issues, including health risk assessment (HRA) and Individualized Care Plan (ICP) completions, and improving access to DME. DME access challenges, previously reported by advocates, related to obtaining, fixing, and replacing DME. In 2021, DHCS led a small DME workgroup of stakeholders, including the MMPs, providers, and advocates. The workgroup developed beneficiary- and provider-facing fact sheets that explained what DME was available to Cal MediConnect enrollees and how DME Medicare and Medicaid benefits interacted.

MMPs identified the State and CMS' joint management of the demonstration and the support they gave to MMPs during the PHE as demonstration successes.[5] MMPs used the PHE-related flexibilities allowed by CMS to continue to serve enrollees remotely and to extend HRA timelines. MMPs stressed the importance of strengthening relationships with community-based organizations and county-based agencies:

Other…key broader success has been our ability to integrate and engage at a higher level with traditional Medicaid providers and community-based organization and stakeholders. We quickly learned…we really needed to partner with key community- based organizations to help our members achieve their goals. And through that we've developed…very longstanding relationships. It is the ability to leverage those relationships…and being able to bring those community-based organization into our model even closer.

– MMP (2021)

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[4] The original work to create a dementia-capable system of care within Cal MediConnect was led by the Alzheimer's Association of Greater Los Angeles and culminated in the development of the Dementia Care Management Toolkit for MMPs. This effort was documented as a Cal MediConnect best practice in the Preliminary Second Evaluation Report.

[5] In 2020, we did site visit interviews with four of 10 MMPs. In 2021, we spoke with five MMPs. We use "MMPs" throughout this report to refer to those MMPs with whom we spoke during the reporting period.

3.2 Eligibility and Enrollment

In 2021, enrollment increased to its highest level since 2017. Stakeholders and the State reported this was because, per Federal policy, the State maintained enrollees' Medi-Cal coverage without recertification during the PHE, and fewer enrollees became ineligible for Cal MediConnect than in previous years. However, as enrollment growth varied across MMPs, other factors such as plan performance may have also contributed to this growth.

In late 2021, MMPs reported increases in disenrollment attributed to enrollee misunderstanding about the end of Cal MediConnect and the transition to Exclusively Aligned Enrollment Dual Special Needs Plans (EAE D-SNPs). MMPs would be responsible for informing enrollees of the transition to EAE D-SNPs, but this process had not yet begun as of early 2022.

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

3.2.1 Enrollment Summary

As shown in ***Figure 1***, after peaking at 115,612 in December 2017, enrollment declined through December 2019 to 108,226. By the end of 2021, it had increased to 115,562, close to the 2017 high. Enrollment trends were mixed across MMPs: seven maintained or grew enrollment between late 2019 and late 2021, and three lost enrollment during that time. As described later, this represents just under a quarter of eligible beneficiaries across all years. The State reported that MMPs would be able to continue enrollment into the demonstration until the demonstration end in December 2022, reversing an earlier decision to impose an enrollment moratorium beginning six months before the end of the demonstration.

Stakeholders and the State reported that the increases in enrollment in 2020 and 2021 were due to enrollees not losing Medi-Cal coverage during the PHE. This suspension of negative actions in Medi-Cal during the PHE was a temporary Federal policy change, which was still in place as of August 2022, and meant that the State could not disenroll most beneficiaries from Medi-Cal. This resulted in fewer people losing Cal Medi-Connect eligibility than

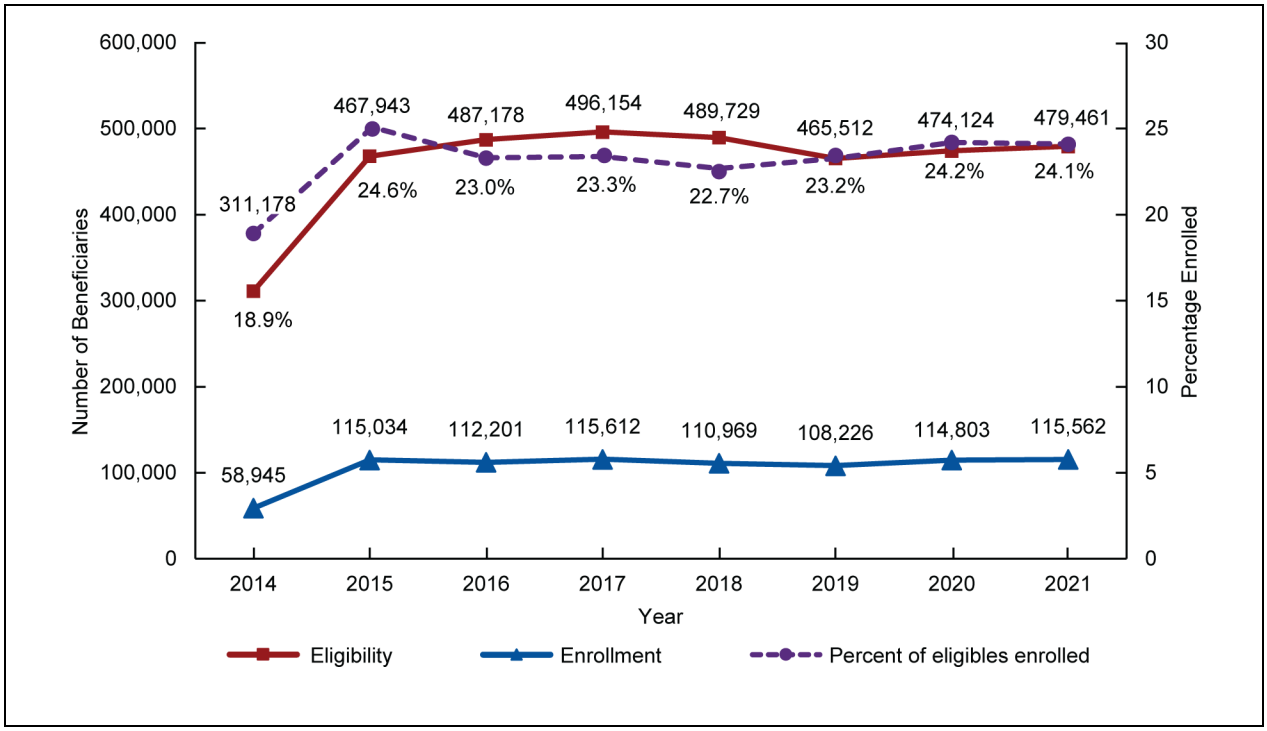
Implementation Effectiveness: Reach

"Reach" is an individual-level measure of participation and refers to the percentage of persons who are affected by a policy, program or initiative. To measure this in the Financial Alignment Initiative, we examine the percentage of eligible beneficiaries who are enrolled in the demonstration.

Figure 1 shows the changes in enrollment and in the percentage of eligible beneficiaries enrolled from the demonstration start in early 2014 through 2021. This percentage remained relatively stable across the years at just under 25 percent; i.e., Cal MediConnect reached about one quarter of all eligible beneficiaries. It is important to note that from the beginning, Cal MediConnect enrollment in the Los Angeles County was capped at 200,000. Therefore, the State never pursued or intended the full enrollment of eligible beneficiaries in this county due to limitations to MMP capacity to serve such a large population.

in previous years and, according to the State and MMPs, helped bolster enrollment. ***Figure 1*** shows demonstration enrollment in California for the demonstration period 2014–2021.

Figure 1
Cal MediConnect enrollment and eligibility at the end of each calendar year, 2014–2021



SDRS = State Data Reporting System.
NOTES: Enrollment and eligibility data reported in the SDRS may not match the finder file data used for quantitative analyses, because of the timing for completion and submitting the finder file versus the SDRS. The definition of eligibility used here, and also in ***Section 5, Demonstration Impact on Cost Savings***, includes FFS and Medicare Advantage populations.
SOURCE: SDRS data for 2014–2021. The SDRS items used to collect eligibility and enrollment were: "Total number of beneficiaries who are eligible to participate in the demonstration" and "Total number of beneficiaries who are enrolled in the demonstration, as of the end of the given month."

In 2019, the State began a pilot program that would allow MMPs to compensate brokers when a beneficiary chose to enroll and stay in a plan, as is commonly done by MA plans but was prohibited of Cal MediConnect MMPs. Only one MMP was allowed to participate in this program. In 2020, the MMP reported that the pilot did not seem particularly successful. It noted challenges working with brokers and reported that brokers could not navigate the different enrollment timeline of Cal MediConnect compared to other MA plans, especially the inability to effectuate an enrollment unless it is within 30 days of the effective date (as opposed to the 90 days in MA). Although not participating in the pilot, another MMP reported its enrollment had been hurt because it could not market the Cal MediConnect product using brokers as it could with its other products:

Beneficiaries need education at the point of enrollment that is provided by brokers.

– MMP (2021)

In 2019, CMS implemented a disenrollment penalty to further incentivize enrollment retention of Cal MediConnect enrollees. This was a retrospective financial penalty in the Medicare A and B portions of the capitation rate for MMPs with high disenrollment rates. This penalty was intended to address selection bias that may have been impacting Medicare costs for the demonstration and to align incentives for MMPs to improve quality of care for all enrollees. The penalty did not include enrollees who were involuntarily disenrolled due to loss of Medi-Cal eligibility.

In 2019, five of the 10 participating MMPs were assessed penalties of 1−1.5 percent of plan revenue. Membership for these plans ranged from 5,000 to 17,000 enrollees, representing 45 percent of overall demonstration enrollment that year. MMPs reported varying experiences with the penalty. Generally local plans performed well and some MMPs noted that they had not been impacted by the disenrollment penalty because most of their disenrollment was due to enrollees moving out of their service area

3.2.2 Disenrollment Experience

In 2020 and 2021, MMPs and DHCS continued to report that the main factor leading to voluntary disenrollment was competition from MA plans, including D-SNP look-alikes. Brokers, who did not get paid for initial enrollments into an MMP except in the broker pilot described above, played a part in this. Stakeholders reported that brokers were not conveying the value-add of the demonstration's care coordination component to dually eligible beneficiaries, and instead promoted the more tangible new benefits such as gym memberships, that MA plans offer:

I think the broker community doesn't value care management itself as much as it does these other bells and whistles… And so brokers put those in front of the duals instead of the message about care management. And so when you're approaching a person and saying, 'Hey, you can have $4,000 worth of dental' versus 'hey, we have care coordinators that really care about you.' That's… a harder message to sell. And so I think that's what you will see in the retention.

– MMP (2021)

In late 2021, MMPs reported increases in disenrollment. They attributed this to enrollee misunderstanding about the end of Cal MediConnect and the transition to CalAIM. Some MMPs also expressed concern that beneficiaries would be disenrolling from their MMPs in 2022 due to marketing activities by enrollment brokers from other plans capitalizing on enrollee misunderstanding of the transition to CalAIM.

MMPs would be responsible for informing enrollees of the transition to CalAIM, and as of June 2022, CMS approved MMPs to start the messaging process. Many interviewees we spoke to in late 2021 discussed the considerable work being done by DHCS and MMPs to develop clear messaging about the transition to CalAIM and praised the level of collaboration among the State, MMPs, and stakeholders in these efforts.

Enrollee Outreach

During the reporting period, MMPs continued to use innovative and targeted approaches to enrollee outreach, though during the PHE these could no longer be in-person. For example, in 2020, one MMP reported using a birthday card campaign to engage enrollees. The MMP also planned to implement a disenrollment survey in 2021 to gather data regarding what may be motivating disenrollment and better inform retention strategies.

We're conducting outreach, education, and enrollment 100 percent over the phone. And initially we were concerned [about how successful that would be], but actually our productivity increased by about 30 percent because we save time driving to and from the in-person appointments. So we have increased enrollments since March 2020.

– MMP (2021)

3.3 Care Coordination

According to all stakeholders, care coordination remains a well-received element of Cal MediConnect. Engaged enrollees value their relationship with a care coordinator and appreciate receiving this service, which is integrated into their care plan.

During the PHE, MMPs focused on supporting enrollees, maintaining service delivery, and pivoting to virtual and telephonic support. MMPs facilitated access to COVID-19 vaccines and developed approaches to address beneficiary SDOHs and isolation. Close coordination with CBOs and county agencies played a key role in these efforts.

With support from DHCS and the CMT, MMPs continued work to address the low participation in Individualized Care Plans (ICPs) by enrollees and their care coordinators. Advocates continued to be concerned with the limited reach and enrollee awareness of care coordination. Stakeholders were also concerned about differences across MMPs in care coordinator caseloads and in the percentages of their enrollees receiving LTSS.

In this section, 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***.

DHCS reported that "care coordination remains a well-received element of the integrated demonstration," and that engaged enrollees enjoy being able to establish a relationship with a care coordinator and receiving care coordination. DHCS also said that Cal MediConnect enrollees generally view the care coordination components such as the HRA and the ICP positively. However, the PHE added significant challenges to previously reported barriers to effective care coordination.[6] MMPs focused most of their efforts on supporting enrollees during the PHE. MMPs reported that PHE-related challenges among enrolled beneficiaries included food insecurity, barriers to vaccine access among homebound members, lack of access to health care providers, low internet availability and skills needed for telemedicine, and continuity and availability of IHSS assistance. MMPs reported working on maintaining service delivery as much as possible using flexibilities allowed by CMS to pivot to virtual and telephonic support, providing access to vaccines, and addressing beneficiary SDOH-related needs (see ***Table 2*** for examples). MMPs' work fostering relationships with CBOs and county agencies over the course of the demonstration was a major asset to MMPs in being able to connect with and continue serving enrollees during the PHE.

MMPs reported major efforts to ensure high COVID-19 vaccination rates among their vulnerable Cal MediConnect enrollees. Advocates complimented MMPs for efforts to reach out to enrollees and link them with accessible vaccine sites. MMPs described various approaches, including mapping the vaccination sites and enrollees' locations, teaming with community organizations to publicize information about the vaccines, and arranging for at-home vaccinations for homebound enrollees. During the PHE, equitable access to vaccinations was one of the MMPs' and CMS' health equity initiatives; monthly CMT calls focused on that goal.

Serving the most vulnerable population of Cal MediConnect [during the PHE has] been both a challenge, but a success at the same time. Having the flexibility that CMS gave to the State and that the State gave to the sites their ability to adapt to serve the members. As much as possible keeping this population out of nursing homes where it's appropriate, so that they can stay in the community and, hopefully avoid COVID if possible...

– DHCS (2021)

In 2020 and 2021, MMPs continued to build partnerships and develop innovative approaches to improve their care coordination. Some of the most recent innovations and creative solutions were fueled by the need to reach and support vulnerable enrollees during the PHE. ***Table 2*** summarizes some of the efforts reported by MMPs during this period.

[6] See the First Evaluation Report and the Second Preliminary Evaluation Report.

Table 2
New approaches to care coordination reported by MMPs in 2020–2021

New Partnerships and Teaming Arrangements
• Teaming with CBOs to vaccinate homebound enrollees, providing PPE or grants to obtain PPE • Using a "no wrong door approach"[1] and obtaining enrollees' permission in advance to share updated beneficiary contact information among health care providers • Obtaining daily reports on enrollee admissions from partner hospitals • Receiving monthly data feeds from BH county agencies on enrollees' services/medications and meeting regularly with county staff to prevent duplication
New Outreach Efforts
• Deploying social workers to reach out to enrollees post-HRA to discuss SDOH needs, share community resources, and invite enrollees to participate in their care team meetings • Sending call-center staff to do safety checks, address isolation, and offer on-line programming instead of in-person activities • Targeting efforts to address homelessness, cooperating with State efforts such as Project Roomkey (PRK)[2] to address SDOH needs and ensure access to care • Arranging meal deliveries for enrollees experiencing food insecurity • Helping unconnected enrollees obtain technology • Providing iPads to partnering SNFs for telehealth • Improving relationships with providers of different ethnicities
Data Analytics Efforts
• Identifying enrollees at high risk for COVID-19 to target interventions such as in-home vaccinations or meal deliveries • Ensuring caregiver availability during PHE-related workforce shortages by identifying enrollees with high IHSS personal care hours (more than 195 hours per month, or fewer than 100 hours but without a recent contact)
Specialized Staff
• Embedding social workers in emergency departments of hospitals that serve large clusters of enrollees • Using a transitional care team, BH coordinators, or psychiatric case managers to engage enrollees with BH needs • Scheduling a post-HRA telehealth visit for all new enrollees with a Nurse Practitioner to assess clinical status, discuss needs, and help with prescriptions • Designating case managers for community transitions for nursing home residents • Using unlicensed language-concordant staff for outreach to enrollees who are not native English-speakers

(continued)

Table 2 (continued)
New approaches to care coordination reported by MMPs in 2020–2021

New Care Coordination Approaches
• Decreasing delegation[3] and bringing HRA activities in-house to improve performance • Establishing a brick-and-mortar Community Resource Center for in-person appointments, and help identifying, applying for (if needed) and getting community resources • Implementing an in-house ride-sharing program to reduce costs and improve customer service • Standardizing all SNF processes, including outreach and care planning, for enrollees across all participating facilities

BH = behavioral health; CBO = community-based organization; HRA = health risk assessment; PPE = personal protective equipment; SNF=skilled nursing facility.

[1] In this context, a "no wrong door approach" allows each member of the ICT to initiate an update on an enrollee's contact information and share with the rest of the team.

[2] PRK is a collaboration by the State, County, and the Los Angeles Homeless Services Authority to provide interim housing for homeless. Please see https://www.cdss.ca.gov/inforesources/cdss-programs/housing-programs/project-roomkey.

[3] The California managed care environment is characterized by a high level of delegation. Its effect on Cal MediConnect implementation was described extensively in the First Evaluation Report and the Second Preliminary Evaluation Report. A nondelegated managed care model places all responsibility and financial risk with the MMP. A mixed model is characterized by MMPs assuming a portion of the responsibility and risk, but delegating certain services and responsibilities to other entities, and fully delegated MMPs pass on all services and risk to other organizations.

The figures and tables below present data trends on important care coordination measures for the duration of the demonstration.

Hard-to-reach enrollees include individuals experiencing homelessness, and people whose contact information is out of date. The MMPs utilized field teams to find enrollees by visiting their last known address and by engaging with different types of providers, such as pharmacies. ***Figure 2*** shows that the percentage of enrollees who could not be reached within 90 days of enrollment decreased—or improved—overall from 2014 through 2021.

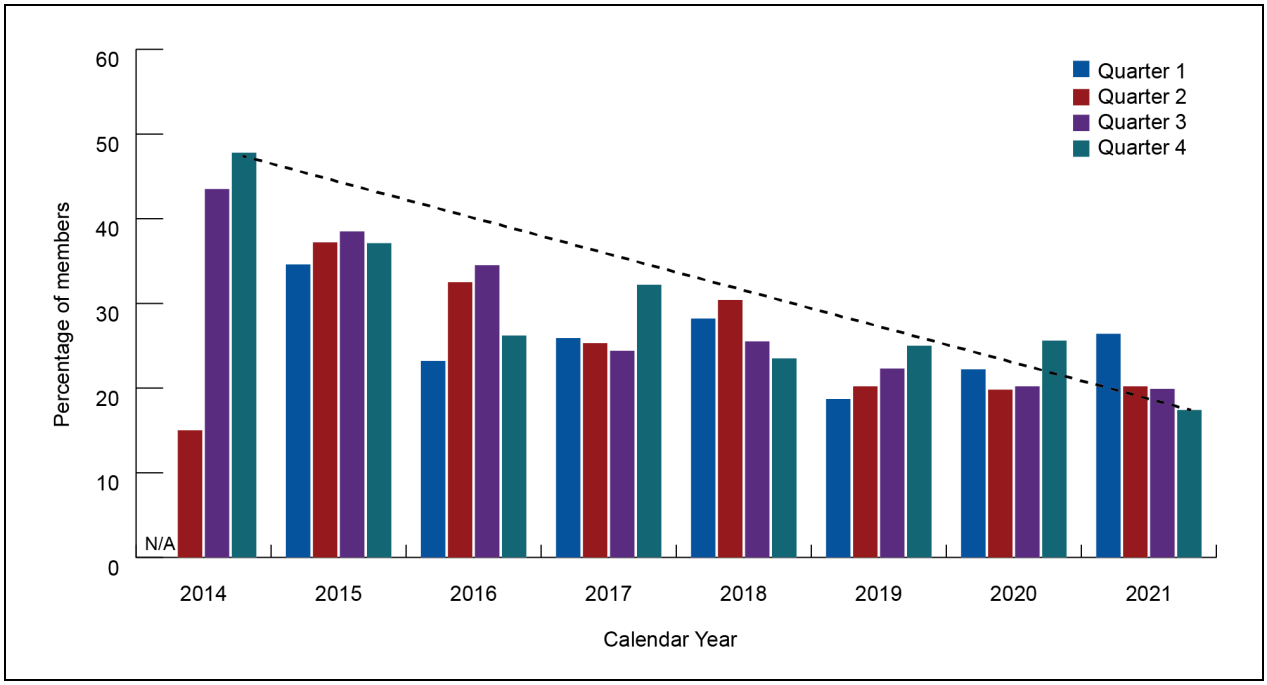
Implementation Effectiveness: Dose

Earlier in this report, we discussed "reach," which measures the percentage of persons who are affected by or participate in a *policy, program or initiative*. "Dose" is a measure of implementation effectiveness that refers to the amount of, exposure to, or uptake of an *intervention* provided to a target population within a program or initiative. In the Financial Alignment Initiative, the main intervention is care coordination.

Because we do not have a direct measure of how many enrollees receive care coordination, we use a proxy measure for dose: the percentage of enrollees that Medicare-Medicaid Plans (MMPs) were not able to reach or locate. This measure gives a sense of how many enrollees were not able to make a choice to engage in care coordination. Without connecting with care coordinators, enrollees could not participate in health risk assessments, have care plans, or identify care goals (these activities are discussed earlier in this section).

Figure 2 shows that the percentage of enrollees that MMPs were unable to reach decreased overall during the demonstration to-date. This trend suggests that increasing numbers of Cal MediConnect enrollees were able to receive care coordination over time.

Figure 2
Percentage of members that Cal MediConnect MMPs were unable to reach following three attempts, within 90 days of enrollment, 2014–2021



MMP = Medicare-Medicaid Plan.
NOTES: The California demonstration began in April 2014 with opt-in enrollment in San Mateo County. Data are not applicable for quarter 1 of 2014. Data 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 reported data for the measure.
SOURCE: RTI analysis of MMP-reported data for Core Measure 2.1 as of April 2022. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

As shown in ***Table 3***, among all enrollees, the percentage of enrollees with an assessment completed within 90 days of enrollment was higher in 2019–2021 than in earlier demonstration years (2014–2018). The percentage ranged from 32.0 to 78.1 from 2014 through 2021. For enrollees who could be reached and were willing to participate, the percentage with an assessment completed within 90 days of enrollment increased over the course of the demonstration, from a low of 76.8 to a high of 98.1.

Table 3
Cal MediConnect MMP members whose assessments were completed within 90 days of enrollment, 2014–2021

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 members with assessments completed within 90 days of enrollment[1]	
		All members	All members willing to participate and who could be reached[2]
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

(continued)

Table 3 (continued)
Cal MediConnect MMP members whose assessments were completed within 90 days of enrollment, 2014–2021

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 members with assessments completed within 90 days of enrollment[1]	
		All members	All members willing to participate and who could be reached[2]
2020			
Q1	5,984	68.5	93.9
Q2	6,340	72.8	96.3
Q3	6,269	73.2	97.0
Q4	6,178	69.0	96.7
2021			
Q1	5,419	68.7	96.7
Q2	5,466	73.5	96.8
Q3	5,317	76.3	98.1
Q4	5,030	78.1	97.7

MMP = Medicare-Medicaid Plan; N/A = not applicable; Q = quarter.
[1] The "all members" column presents the percentage of assessments completed for members whose 90th day of enrollment occurred within the reporting period. In the "all members willing to participate and who could be reached" column, the percentages exclude members who were documented as unwilling to participate in an assessment, and members who the MMP was unable to reach following three documented outreach attempts.
[2] The number of members willing to participate and who could be reached cannot be calculated using the corresponding percentages in this table. As indicated in table note 1, RTI used additional data points to calculate these percentages.
NOTES: The California demonstration began in April 2014 with opt-in enrollment in San Mateo County. Data are not applicable for quarter 1 of 2014. Data 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 reported data for the measure.
SOURCE: RTI analysis of MMP-reported data for Core Measure 2.1 as of April 2022. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

Table 4 shows that the percentage of high- and low-risk enrollees that completed an ICP within 30 days after the HRA varied in 2015 through 2017. For high-risk enrollees willing to participate and who could be reached, completion rates fluctuated from 47.2 to 72.1 percent. Completion rates for low-risk enrollees willing to participate and who could be reached were similar, ranging from 51.7 to 77.2 percent.

Table 4
Cal MediConnect MMP members with an ICP within 30 days of completing the HRA, 2015–2017

Quarter	High-risk members			Low-risk members		
	Total number of members with an HRA completed during the reporting period	Percentage of members completing an ICP within 30 days of HRA completion[1]		Total number of members with an HRA completed during the reporting period	Percentage of members completing an ICP within 30 days of HRA completion[1]	
		All members	All members willing to participate and who could be reached[2]		All members	All members willing to participate and who could be reached[2]
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	61.1
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.
[1] The "all members" column presents the percentage of members with ICPs completed for members with a HRA completed during the reporting period. In the "all members willing to participate and who could be reached" column, the percentages exclude members who were documented as unwilling to complete an ICP, and members who the MMP was unable to reach following three documented outreach attempts.
[2] The number of members with ICPs completed and who could be reached cannot be calculated using the corresponding percentages in this table. As indicated in table note 1, RTI used additional data points to calculate these percentages.
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. 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 D 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 5***, among all enrollees and among enrollees willing to participate and who could be reached, the percentage with care plans completed within 90 days of enrollment was higher in 2020 and 2021 than in 2018 and 2019. For all enrollees, care plan completion rates

ranged from 29.1 percent to 38.4 percent in 2018–2019, rising to a range of 51.4 to 59.1 percent in 2020–2021. Among enrollees willing to participate who could be reached, care plan completion rates ranged from 37.8 percent to 55.7 percent in 2018 and 2019, rising noticeably to a range of 77.5 to 92.1 percent in 2020–2021.

Table 5
Cal MediConnect MMP members with care plans completed within 90 days of enrollment, 2018–2021

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 members with care plans completed within 90 days of enrollment[1]	
		All members	All members willing to complete a care plan and who could be reached[2]
2018[3]			
Q1	3,184	31.8	45.9
Q2	3,664	31.2	46.8
Q3	3,970	34.8	51.4
Q4	4,012	36.0	54.2
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
2020			
Q1	5,984	51.4	77.5
Q2	6,340	57.0	90.3
Q3	6,269	59.1	90.8
Q4	6,178	55.6	91.4
2021			
Q1	5,419	55.3	91.7
Q2	5,466	53.5	89.2
Q3	5,317	55.7	91.2
Q4	5,030	57.0	92.1

(continued)

Table 5 (continued)
Cal MediConnect MMP members with care plans completed within 90 days of enrollment, 2018–2021

IEHP = Inland Empire Health Plan; MMP = Medicare-Medicaid Plan; Q=quarter.
[1] The "all members" column presents the percentage of care plans completed for members whose 90th day of enrollment occurred within the reporting period. In the "all members willing to complete a care plan and who could be reached" column, the percentages exclude members who were documented as unwilling to complete a care plan and members who the MMP was unable to reach following three documented outreach attempts.
[2] The number of members willing to complete a care plan and who could be reached cannot be calculated using the corresponding percentages in this table. As indicated in table note 1, RTI used additional data points to calculate these percentages.
[3] Performance measure validation determined that IEHP's 2018 data for this measure were materially biased. As a result, the numbers and percentages for all quarters in 2018 exclude data for IEHP.
SOURCE: RTI analysis of MMP-reported data for Core Measure 3.2 as of April 2022. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

As shown in ***Table 6***, the percentage of enrollees with at least one documented discussion of care goals in their initial ICP varied over the course of the demonstration (2014–2021) with a low of 51.1 percent in 2016 and a high of 89.2 percent in 2020. 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 85.1 percent in 2021.

Table 6
Cal MediConnect MMP members with an ICP developed with documented discussions of care goals, 2014–2021

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
2020	17,858	53,513	89.2	84.4
2021	15,306	59,934	87.8	85.1

MMP = Medicare-Medicaid Plan; N/A = not applicable.
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 April 2022. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model California-Specific Reporting Requirements document.

Table 7 shows that the number of care coordinators steadily increased over the course of the demonstration (2014–2021), and the turnover rate fluctuated. The percentage of care coordinators assigned to care management and conducting assessments was consistent, between 72.8 and 79.4 percent. The enrollee load (case load) per care coordinator decreased, with a demonstration-to-date high of 113.1 in 2015 and a low of 69.8 in 2019.

Table 7
Care coordination staffing at Cal MediConnect MMPs, 2014–2021

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
2020	2,219	75.2	69.9	8.7
2021	1,959	84.0	71.2	8.7

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, 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. 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 April 2022. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

In 2020–2021, MMPs and stakeholders reported several consistent challenges to effective care coordination, also described in previous evaluation reports. We discuss challenges with reaching enrollees earlier in this section.

ICT participation by Cal MediConnect enrollees and providers. ICT participation among enrollees has been challenging throughout the demonstration. In 2019, 2020 and 2021, DHCS, with CMT support, reported working with MMPs on improving ICT participation for Cal MediConnect enrollees and providers. On the provider side, MMPs shared that they have been receiving consistent feedback that primary care providers do not have time to participate in team meetings and have limited understanding of the demonstration that serves as another barrier to participation. DHCS developed some provider outreach activities to address this challenge.

Low HRA and ICP completion rates. Low HRA and ICP completion rates have been persistent challenges for the MMPs. Starting in 2019, MMPs received performance improvement plans on these metrics and worked with the CMT to make improvements. Difficulty in locating

enrollees upon enrollment to conduct the HRA due to bad contact information was the major reason for poor performance on the HRA measure. Because of the PHE-related waiver of the in-person HRA requirement in 2020–2021, MMPs switched completely to phone or mail assessments, contributing to these difficulties (see ***Table 3***). ICP completion may have been insufficient due to low beneficiary interest in participation. However, MMPs achieved significant progress on these measures in response to the performance improvement plans.

Lack of standardization in care coordination approach. Nine years into the demonstration, advocates continued to be concerned about how to define what is an appropriate care coordination model under Cal MediConnect in terms of level of staffing, caseloads and care coordination uptake. For example, there have been substantial differences in caseloads across MMPs: the Members to Care Coordinator ratio (caseload) ranged from 10 to 197.[7] Similarly, the Cal MediConnect Performance Dashboard[8] illustrates that although 99 percent of enrollees at one MMP were reported in 2020 to have a care coordinator and at least one care team contact, only 41 percent of enrollees at another MMP did (DHCS, 2021).

Several other continuing challenges to effective care coordination that have also been reported by MMPs and stakeholders. MMPs reported ongoing difficulties accessing data from county agencies for carved-out behavioral health and IHSS services. The other reported challenge was related to developing and providing adequate person-centered care planning guidance and language in care coordinator training. Stakeholders also reported being disappointed with the lack of progress in developing a universal assessment tool for the Medi-Cal program to reduce redundancies across programs (e.g., community-based adult services [CBAS], IHSS, and MSSP). Advocates also raised concerns about potential unmet need for personal assistance among enrollees: there were also substantial differences in the percentage of enrollees receiving LTSS across plans (see ***Figure 16*** in ***Section 4, Beneficiary Experience)***. Although these differences may reflect case mix differences across the MMPs, they may also indicate unmet need for LTSS.

The one challenge that really stands out is around those carved out services. I'll use behavioral health, for example, where the carve-out is to the county contractors. There really isn't any data sharing that is provided back to the plan. They're just not willing to provide that data. Maybe for HIPAA security reasons, it is still completely a barrier with the county specific entities, just absolutely not being willing to provide that data no matter what kind of innovations we came up with in regard to how we can share that data. They have just pretty much been shut down.

– MMP (2020)

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[7] RTI analysis of MMP-reported data for Core Measure 5.1 as of April 2022. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

[8] The Cal MediConnect Performance Dashboard provides data and measures for different aspects of Cal MediConnect implementation.

3.4 Stakeholder Engagement

Stakeholders reported that significant DHCS staff turnover in early 2020 limited State engagement with Cal MediConnect stakeholders. Stakeholders largely focused on the PHE response in 2020.

By 2021, the State engaged stakeholders in a much more intentional and structured manner to gather lessons learned from Cal MediConnect implementation for a smooth transition to CalAIM.

In this section we describe stakeholder engagement activities during the period of this report and the impact of those efforts on the demonstration. Stakeholders that the State reaches out to about demonstration efforts include beneficiary advocates, various types of providers (including county and community-based providers) and provider organizations, and MMP staff. In the Second Preliminary Evaluation Report, we discussed improved provider buy-in and engagement, fruitful cross-stakeholder collaborations that led to developing materials on best practices, and continued discussions around other areas for improvement. We also discussed the concern brought up by several interviewees that the State was no longer as invested in the stakeholder engagement process given the increased focus on planning for the transition to CalAIM in late 2019.

For the time period covered in this report, challenges in stakeholder engagement were exacerbated by two key events. The first was significant staff turnover at DHCS at the start of 2020 that included the introduction of a new DHCS director, a new Cal MediConnect demonstration lead and new hires in other relevant positions. Stakeholders reported that as a result, they found engaging the State on Cal MediConnect issues much more challenging. This was immediately followed by the greatest challenge that the State and stakeholders had to navigate: maintaining communication and ongoing engagement during the PHE.

Stakeholder Engagement During the PHE. Stakeholder engagement in 2020 largely focused on strategies for responding to PHE challenges, as well as promotion of flu vaccinations and improving beneficiary communications and engagement at a time when enrollees were either unable or unwilling to engage in person. Stakeholders had to quickly digest and share COVID-19 and service-related updates to enrollees. According to a healthcare association representative, MMPs effectively worked together to share COVID-19 related information and the Los Angeles Department of Public Health, the MMPs, and providers communicated at a level higher than what they had ever witnessed before. This interviewee also suggested that this successful cross-stakeholder collaboration was likely a result of communication channels in place because of Cal MediConnect. Other stakeholders echoed this observation about closer collaboration. One beneficiary advocate, as well as several MMPs, explained that they engaged much more closely with community-based organizations (CBOs), given that they were better connected to and more readily able to reach MMP enrollees.

In December 2020, stakeholder meeting discussions focused on MMP efforts to identify and address health disparities. Some of the strategies discussed included using risk stratification

and data analytics to conduct targeted outreach; working with MMP enrollees to update care plans to reflect enrollees' non-medical needs; and connecting enrollees to community resources in various forms of communication.

Meetings in 2021 highlighted efforts and best practices in areas both related and not related to the PHE. MMPs shared strategies for improving of ICP completion rates and COVID-19 vaccination efforts for homebound beneficiaries. MMPs also continued to discuss and identify ways to improve beneficiary outreach and communications and to address challenges around DME access. Discussions in the first quarter of 2020 regarding DME access culminated in the development of DME guidance fact sheet that was shared during a stakeholder call in early December 2021.

Revitalized Stakeholder Engagement and CalAIM. The State's deliberate effort to include stakeholders in planning details of the transition to EAE D-SNPs was a major focus and notable success of stakeholder engagement in 2020 and 2021. The State's approach ensured that stakeholders' questions and concerns were addressed and that key aspects of the transition were informed by lessons learned from Cal MediConnect and other Medicare-Medicaid integration efforts. At the start of 2020, DHCS presented a road map of the transition that included general timelines and D-SNP requirements for health plans, including MMPs, and formed several workgroups comprised of providers, experts, and advocates, to participate in thinking through specific technical aspects of the transition. The types of workgroups included a MLTSS stakeholder workgroup, a D-SNP State Medicaid Agency Contract and model of care workgroup, and a long-term care workgroup. By participating in these workgroups, stakeholders informed the development of integrated member materials for D-SNPs that will be receiving Cal MediConnect enrollees, as well as the various notices being prepared to inform Cal MediConnect enrollees about the transition to CalAIM.

3.5 Financing and Payment

In general, insurers (parent managed care organizations) that offered other capitated managed care products did not view their Cal MediConnect plans as profitable. Several plans compared their Cal MediConnect product to other lines of business which were not subject to up-front reductions in capitation payments required of Cal MediConnect plans.

MMPs expected increased financial pressure from reduced utilization related to the PHE translating to lower capitation rates.

In this section, we outline changes in Cal MediConnect financing and payment in 2020-2021 and discuss relevant findings. Carving-out MSSP and simplifying the Medi-Cal component of the rate methodology were the only major policy-driven financing and payment changes effective in January of 2022. The new rate setting methodology includes three categories instead of four: institutional long-term care (LTC) users, CBAS-users, and other community dwellers. MMPs did not expect these changes to significantly affect profitability. In addition, the newly updated three-way contract made several small changes, including an adjustment to the

methodology for calculating the disenrollment penalty that could reward improvements even if a plan's disenrollment rate was higher than the benchmark rate.

However, while not a change in policy per se, MMPs expected the PHE to have an effect on costs and revenues for (at least) 2020 and 2021 as a result of the Cal MediConnect rate setting methodology. Several MMPs expressed concern that the drop-off in utilization during the PHE would result in lower Medicare risk scores and an artificial reduction in costs included in DHCS actuarial calculations. Plans predicted that these effects would drive rates further below actual costs after their enrollees resumed normal service utilization rates. A few plans recognized that the reduced utilization rates early in the PHE may have resulted in higher revenue-to-cost ratios during that period, but on balance they expected the net effect of the rate setting methodology over the entire pandemic-period to negatively affect their profits. For the most part, plans did not predict the carve-out of MSSP would affect their operations or have a noticeable effect on their profitability.

In general, insurers (parent managed care organizations) do not view Cal MediConnect plans as profitable, especially when compared to other lines of business and in an environment characterized by increasing D-SNP look-alike penetration. Throughout the demonstration, the aggregate savings percentages were determined in advance by CMS and the State, based on the expectation that the demonstration could achieve savings for both parties while paying adequate rates to MMPs (CMS & DHCS, 2019). Neither these savings assumptions nor the quality withholds applied to the MMPs are required of the parent managed care organizations' other products or of their competitors' D-SNPs. MMPs also noted that although DHCS encouraged the use of CPO services, these services were not included in actuarial calculations of the Medi-Cal rate (CMS & DHCS, 2019). DHCS review of MMP quarterly financial reports verified what plan officials reported in interviews.

3.6 Quality of Care

Quality withhold results for 2019 were mixed: five MMPs received 100 percent of their withhold payments and five received 75 percent or less. All MMPs received 100 percent for 2020 because of an adjustment for an extreme and uncontrollable circumstance due to the PHE.

MMPs increased their focus on improving health equity in 2020 and 2021 by using data analytics focused on their Healthcare Effectiveness Data and Information Set (HEDIS) outcomes.

Results of HEDIS measures have been mixed across measures and MMPs over the course of the demonstration although most MMPs have improved performance on controlling HbA1c levels.

In this section we provide information on the quality measures for the demonstration, updates on the quality management structure and activities for the demonstration, and HEDIS results.

3.6.1 Quality Measures

As discussed in the First Evaluation Report, the Cal MediConnect demonstration requires MMPs to report standardized quality measures. Most of these measures are used by the CMT to monitor MMP performance (see ***Section 3.1, Integration of Medicare and Medicaid***). Some are also used to determine what portion of the capitation rates retained by CMS and the State as a quality withhold will be repaid to the MMPs.

Quality withhold results for calendar year 2019 were published in September 2021. Five MMPs received 100 percent of their withhold payments, four received 75 percent, and one received 50 percent. For calendar year 2020, all MMPs received 100 percent of their withhold payments because they qualified for an adjustment due to an extreme and uncontrollable circumstance (i.e., the PHE). Some of the MMPs said the adjustment for 2020 was needed, explaining that enrollees were less focused on getting preventive care during the PHE.

The response to quality withhold measures differed among MMPs. Several MMPs discussed how they used the quality withhold measures in value-based payment or other financial incentive arrangements they have with providers. For example, one reported:

When we put the pay for value program together…it made good sense to us to focus on the measures that were in the withhold set. And that has been well-received by our providers.

– MMP (2021)

Two MMPs commented that the quality withhold was not only dependent on their ability to improve performance, but also on their community partners' ability to improve performance. One of these MMPs was also concerned about the structure of the withhold payment compared to the bonus structure used in the Star Ratings model for MA more generally:

The fact that the revenue is withheld from us as a plan, it's challenging. In general, it's very different from a stars model where you start out whole from a revenue perspective and you earn a bonus.

– MMP (2020)

The three-way contract implemented in late 2019 increased the financial incentive for MMPs to focus on quality improvements. The amount of the quality withhold from capitation payments to MMPs increased from 3 percent to 4 percent starting in 2020.

3.6.2 MMP Quality Improvement Efforts

In 2020 and 2021, the State, MMPs, and stakeholders described increased efforts to address health equity. In some cases, disparities highlighted by the pandemic spurred new quality improvement efforts in this area. As one stakeholder said:

And equity has been more I would say an explicit focus, which of course will help address some…quality and access issues. Because the folks that aren't getting equitable access and equitable treatment are not having equitable outcomes. And so I do think that's where plans have started to really look at [and] identify these sub-cohorts of folks that are really struggling. And the pandemic is highlighting that.

– Stakeholder (2020)

MMPs described using data analytics to identify areas of concern to address. Several MMPs discussed using their HEDIS data to target specific groups of beneficiaries for quality improvement initiatives. As one MMP reported:

If we look at our HEDIS scores and we see that for any particular measure for a particular ethnic group, whether it be an African American population or a Middle Eastern population, the score is much lower for any particular measure for that group as compared to all the other groups. Then we'll do targeted programs for those particular groups.

– MMP (2020)

These initiatives included special communications to educate enrollees about the importance of preventive care as well as incentives programs (e.g., movie tickets) for receiving certain preventive care. In some cases, providers were also incentivized to encourage preventive care. In 2021, in an attempt to improve some of its results on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, one MMP worked with a consultant to identify ways to help providers improve the enrollee experience with the goals of making sure that the MMP understands the drivers of performance, what is important to enrollees, and how it can improve any processes in response. For example, the consultant identified and worked directly with providers who needed to improve timely access to services. Other MMPs reported expecting their CAHPS results to decline in 2020 and 2021 because enrollees had forgone some preventive care during the pandemic.

As noted above, several MMPs also used value-based payment programs and other financial incentive arrangements to encourage improved provider performance. Several used the quality withhold measures in these programs, but some used other CAHPS or HEDIS measures.

MMPs varied on the types of providers included in these programs with some including hospitals and nursing facilities in addition to primary care providers.

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 MA plans.

Five of the 13 Medicare HEDIS measures for MMP enrollees that RTI analyzes are reported in ***Figures 3–8***, with results on all 13 measures appearing in ***Table B-1a, B-1b, and B-1c*** in ***Appendix B.*** RTI identified these measures in its Aggregate Evaluation Plan based on their historic completeness, reasonability, and sample size. The 2015 HEDIS data were available for nine of the 10 Cal MediConnect MMPs, and 2016–2020 HEDIS data were available for all 10 Cal MediConnect MMPs.[9] However, in response to the COVID-19 PHE, CMS did not require Medicare plans (including MMPs) to submit HEDIS data covering the 2019 measurement year. Medicare plans (including MMPs) resumed normal reporting for measurement year 2020.

Detailed descriptions of selected HEDIS measures can be found in the RTI Aggregate Evaluation Plan. Results reported in ***Figures 3–8*** show Cal MediConnect MMPs' 2015 through 2020 HEDIS performance data on measures for blood pressure control, 30-day follow-up after hospitalization for mental illness, good control of Hemoglobin A1c (HbA1c) levels (<8.0 percent), medication review (one of the Care for Older Adults measures) and plan all-cause readmissions (ages 18–64 and ages 65+).[10]

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 Medicare Advantage enrollees and demonstration enrollees may have different health and sociodemographic characteristics which would affect the results. Previous studies on health plan performance reveal poorer quality ratings for plans serving a higher proportion of dually eligible beneficiaries and beneficiaries with disabilities. Additionally, HEDIS measure performance, in particular, is slightly worse among Medicare 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 3***, six of the MMPs improved performance on blood pressure control from 2015 to 2020, with the other four MMPs having mixed performance over time.

[9] Cal Optima did not report HEDIS data for the 2015 measurement year.
[10] These are hospital readmissions.

Figure 3
Blood pressure control[1], 2015–2020: Reported performance rates for Cal MediConnect MMPs

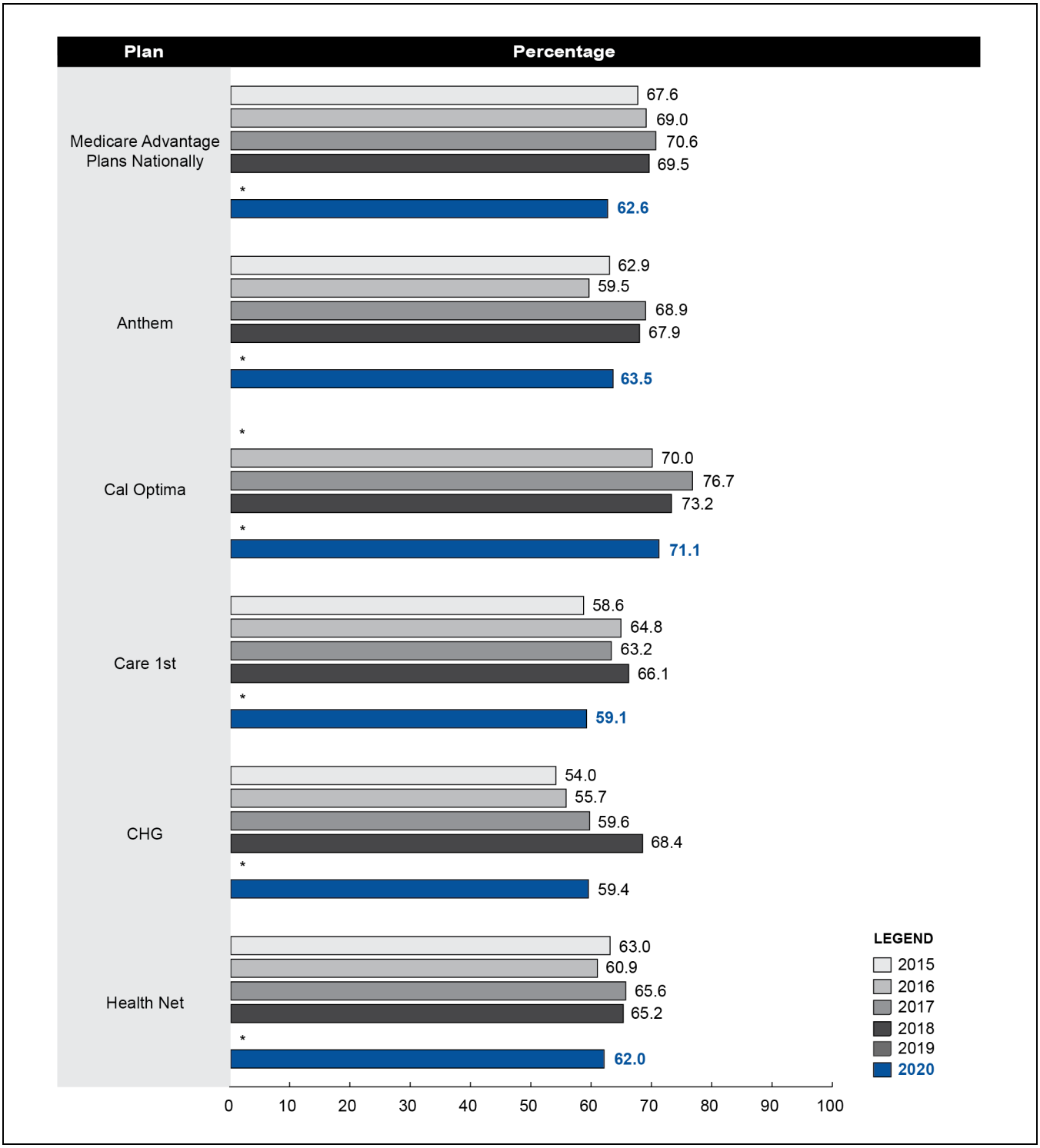

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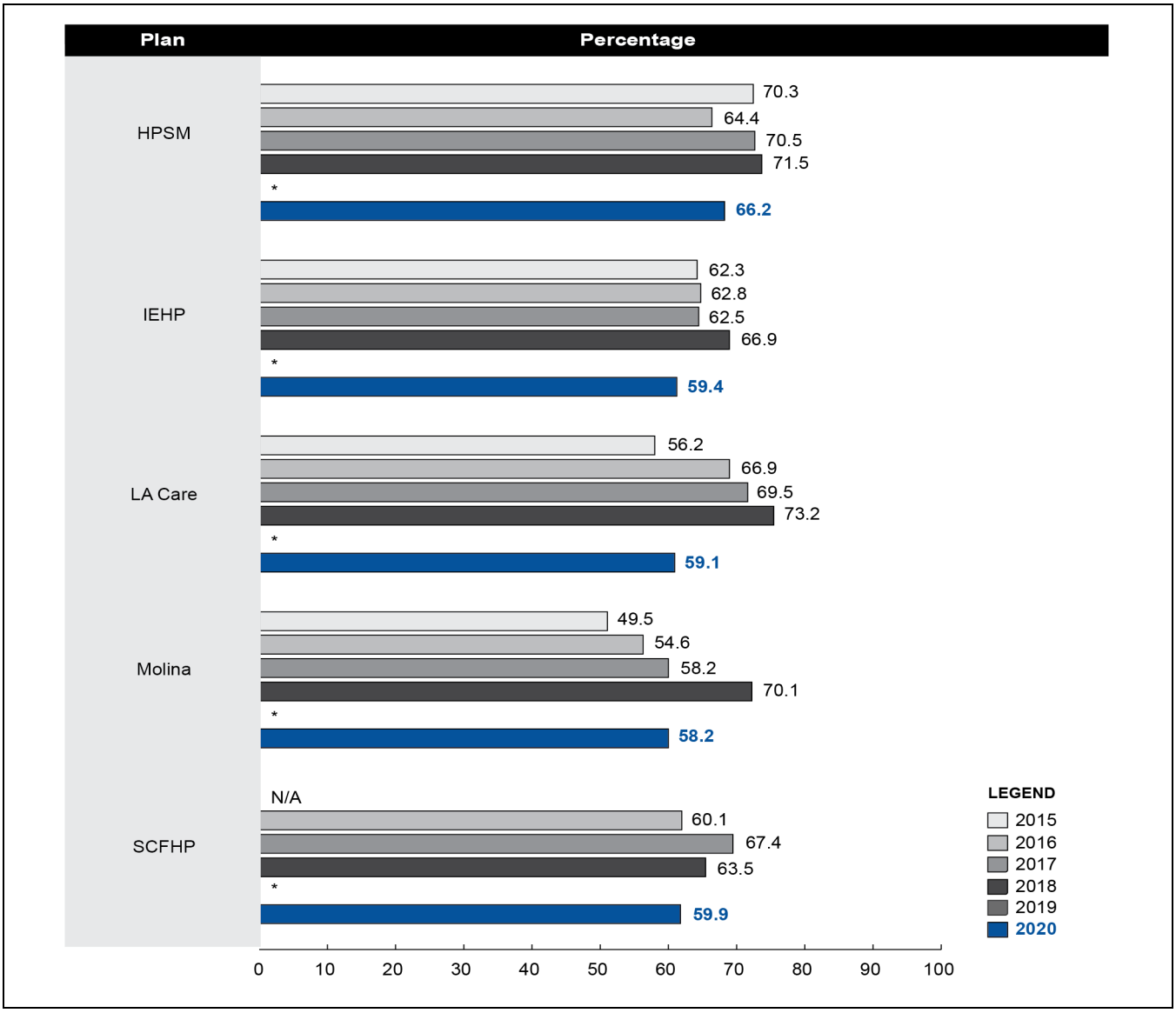
Figure 3 (continued)
Blood pressure control[1], 2015–2020: Reported performance rates for Cal MediConnect MMPs



* = data not available; CHG = Community Health Group; HEDIS = Healthcare Effectiveness Data and Information Set; HPSM = Health Plan of San Mateo; IEHP = Inland Empire Health Plan; MA = Medicare Advantage; MMP = Medicare-Medicaid Plan; N/A = not applicable, where MA plans do not report such, or where the number of enrollees in the MMP's provided 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; 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.

NOTES: In response to the COVID-19 public health emergency, CMS did not require Medicare plans (including MMPs) to submit HEDIS data covering the 2019 measurement year. CalOptima did not report HEDIS data for the 2015 measurement year.

SOURCE: RTI analysis of 2015 through 2020 HEDIS measures.

Figure 4 shows that for 30-day follow-up after hospitalization for mental illness, most MMPs had an uneven performance from 2015 to 2020. Increases were generally not steady, with substantial variability over time.

Figure 4
30-day Follow-up after hospitalization for mental illness[1], 2015-2020:
Reported performance rates for Cal MediConnect MMPs

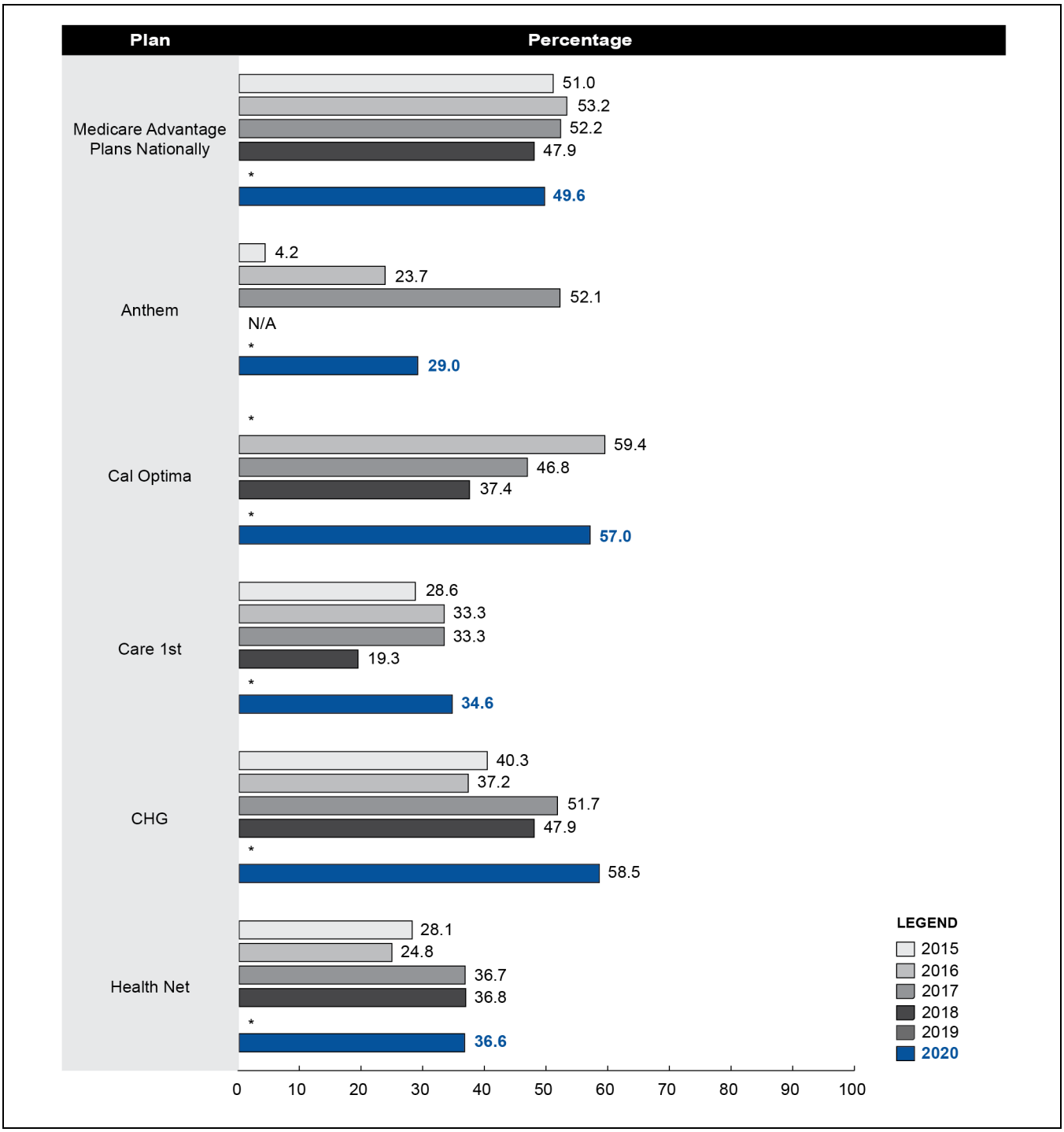


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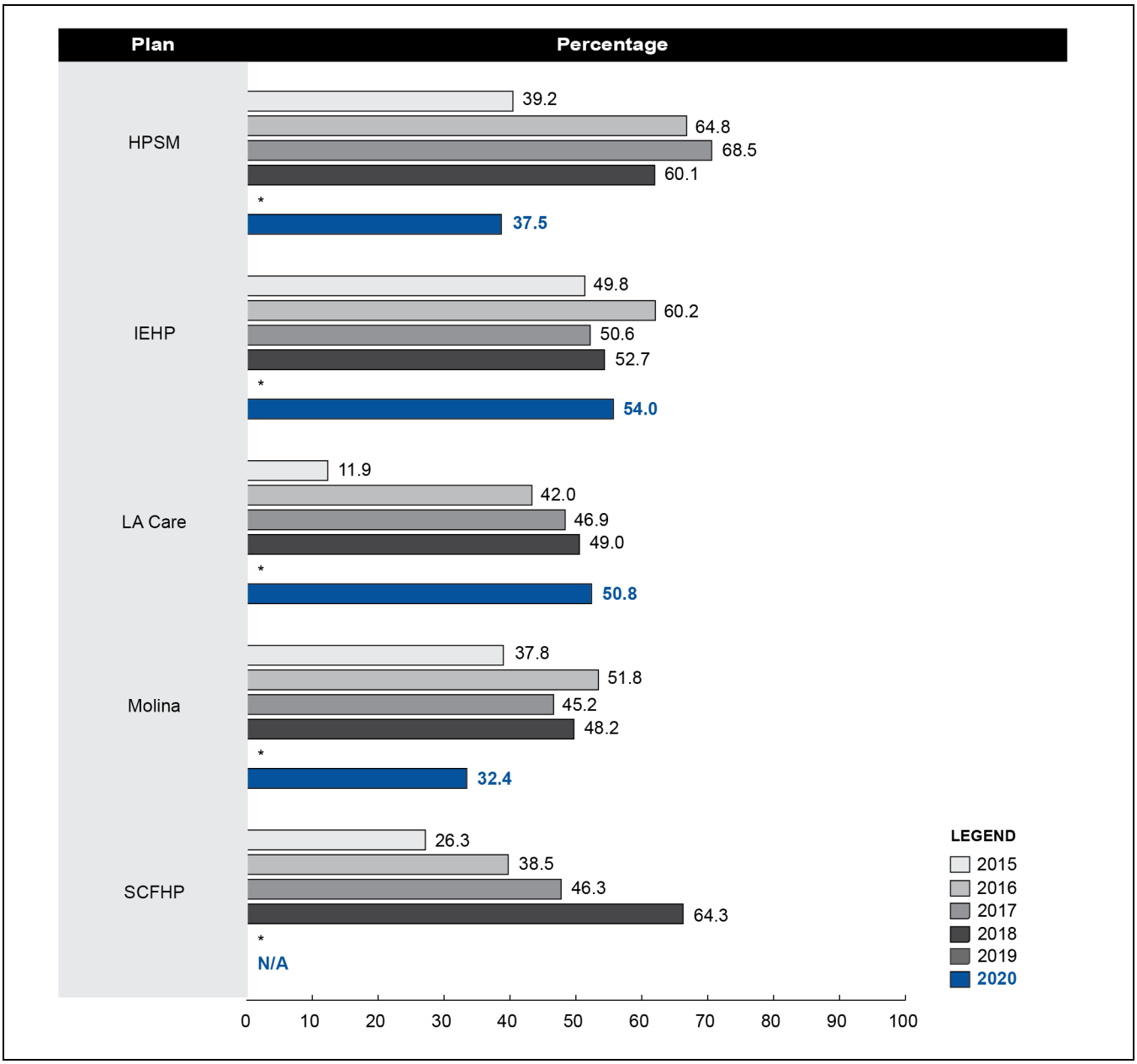
Figure 4 (continued)
30-day Follow-up after hospitalization for mental illness[1], 2015-2020:
Reported performance rates for Cal MediConnect MMPs



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[1] NCQA implemented a significant specification change with HEDIS 2017, disallowing same-day follow-up visits. National benchmarks fell from HEDIS 2017 to HEDIS 2018.

NOTES: In response to the COVID-19 Public Health Emergency, CMS did not require Medicare plans (including MMPs) to submit HEDIS data covering the 2019 measurement year. CalOptima did not report HEDIS data for the 2015 measurement year.

SOURCE: RTI analysis of 2015 through 2020 HEDIS measures.

As shown in ***Figure 5***, almost all MMPs improved performance on controlling HbA1c levels (<8.0%) from 2015 to 2020. The most pronounced improvements were generally between 2015 and 2016.

Figure 5
Good control of HbA1c level (<8.0%), 2015–2020:
Reported performance rates for Cal MediConnect MMPs

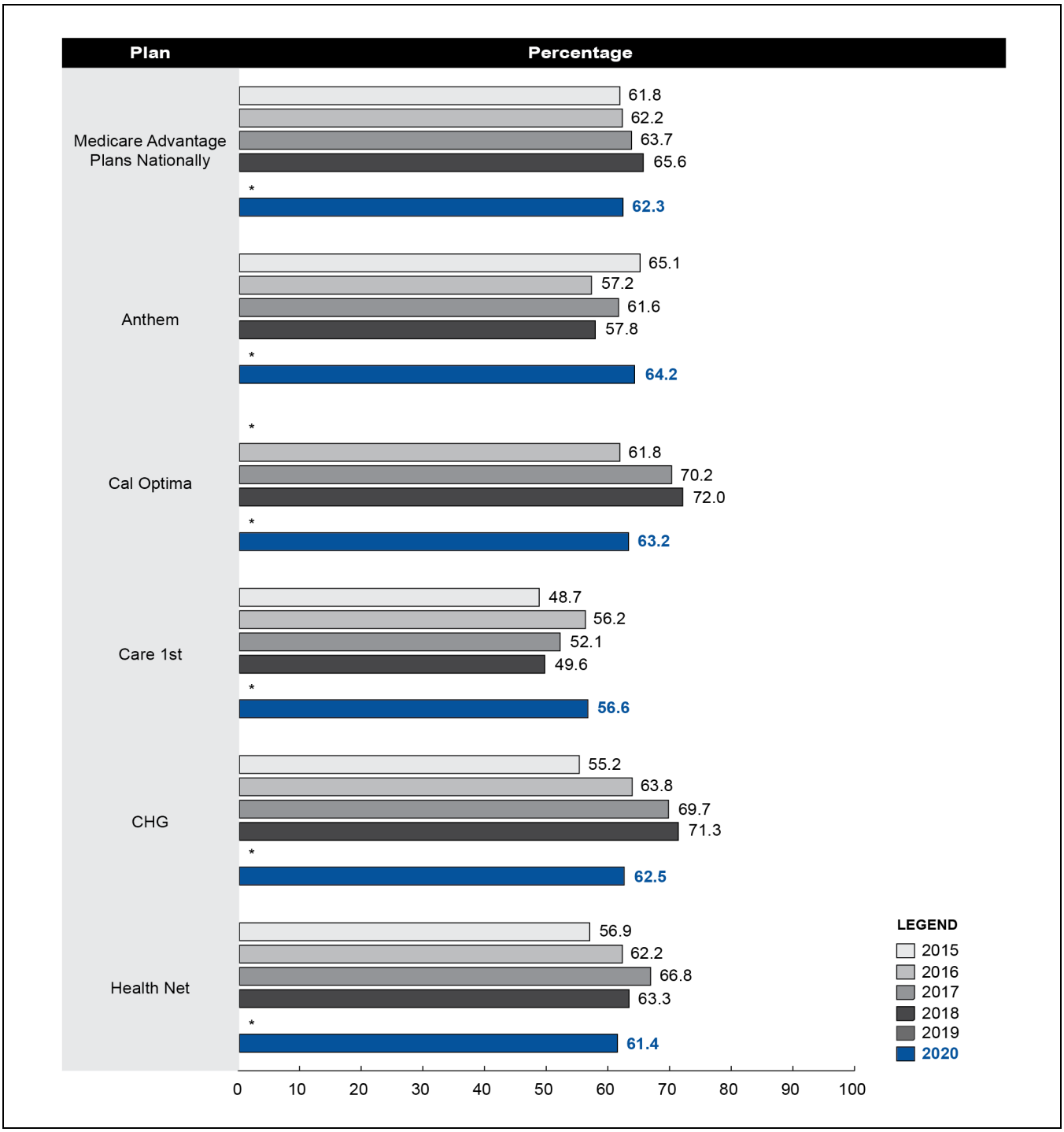

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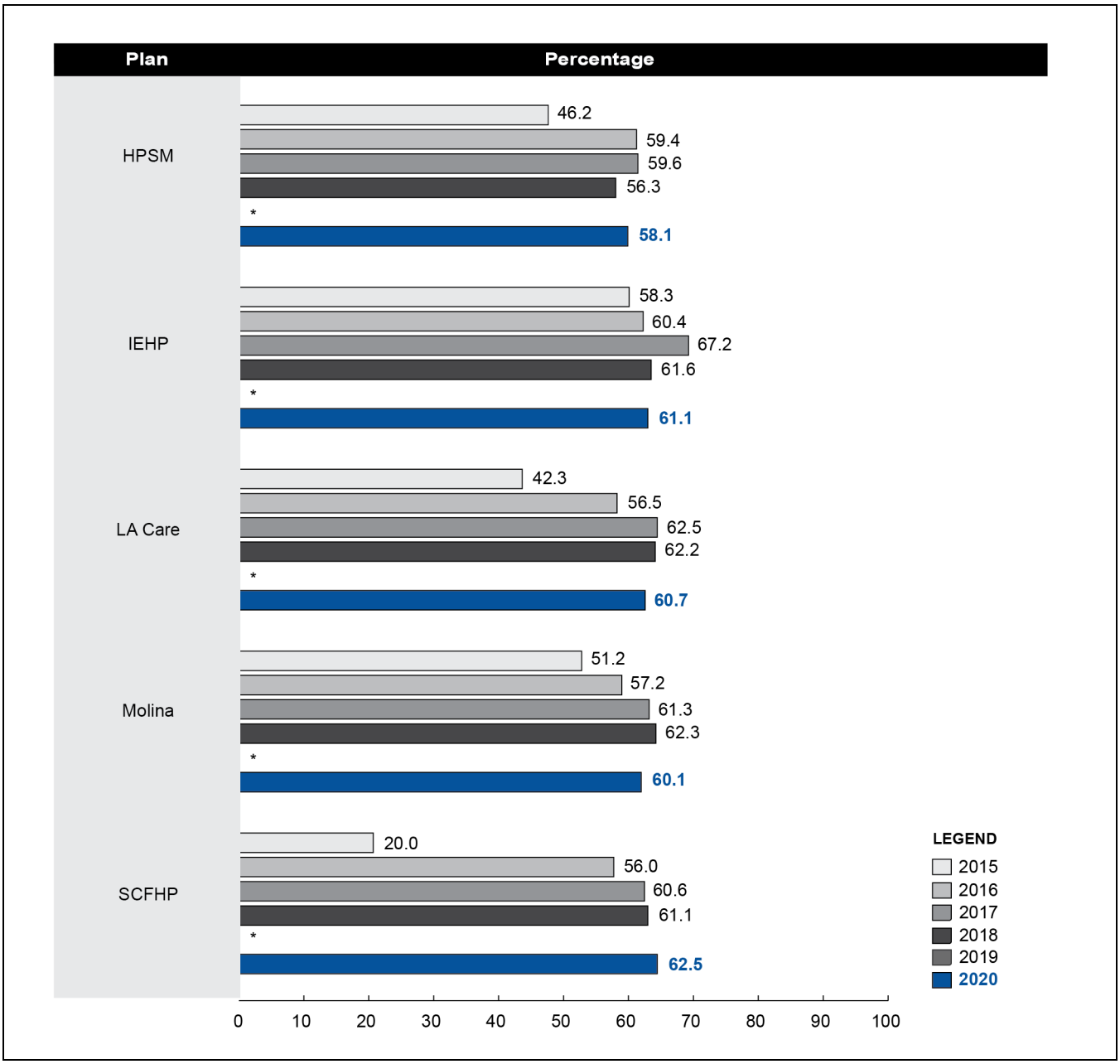
Figure 5 (continued)
Good control of HbA1c level (<8.0%), 2015–2020:
Reported performance rates for Cal MediConnect MMPs



* = data not available; 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.

NOTES: In response to the COVID-19 Public Health Emergency, CMS did not require Medicare plans (including MMPs) to submit HEDIS data covering the 2019 measurement year. CalOptima did not report HEDIS data for the 2015 measurement year.

SOURCE: RTI analysis of 2015 through 2020 HEDIS measures.

Figure 6 shows that for medication review (one of the Care for Older Adults measures), most MMPs improved performance from 2015 to 2020. Both L.A. Care and the Santa Clara Family Health Plan greatly improved between 2015 to 2020. The remaining MMPs showed either stable performance year over year, or worsened performance from 2015 through 2020. National MA plan mean data are not available for the Care for Older Adult measures.

Figure 6
Medication review (one of the Care for Older Adults measures), 2015–2020: Reported performance rates for Cal MediConnect MMPs

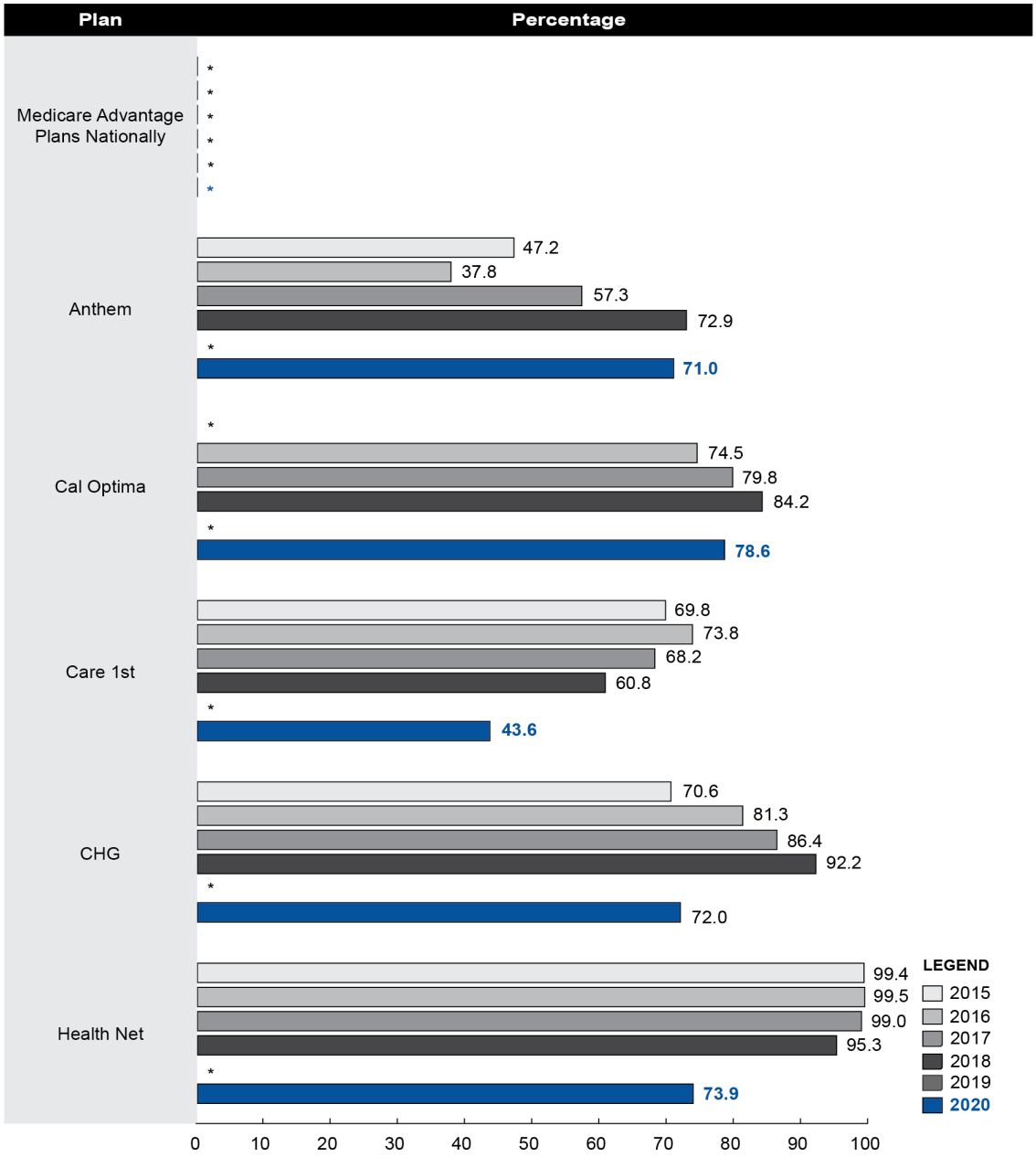


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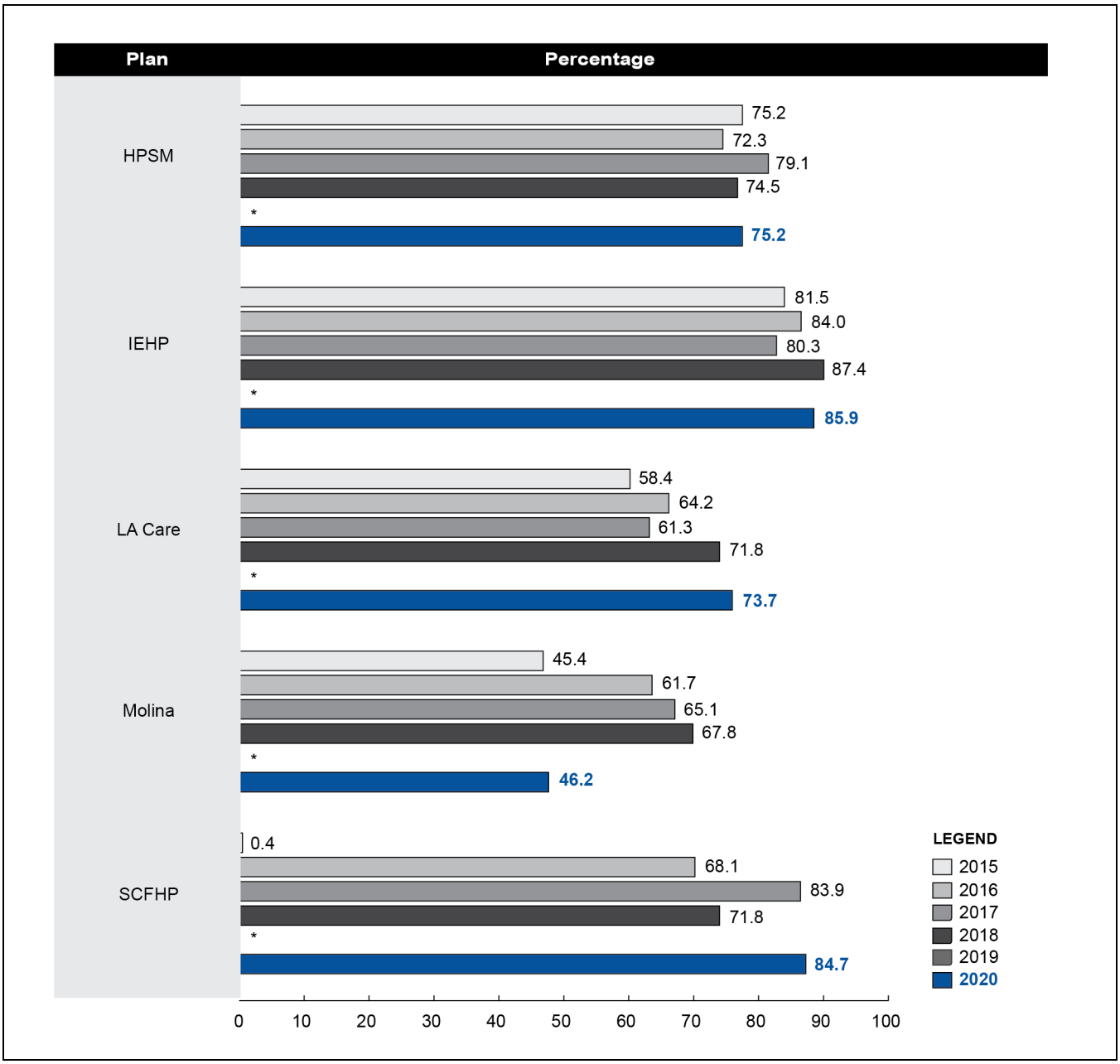
Figure 6 (continued)
Medication review (one of the Care for Older Adults measures), 2015–2020: Reported performance rates for Cal MediConnect MMPs



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NOTES: MA plans nationally did not provide HEDIS data for this measure. In response to the COVID-19 Public Health Emergency, CMS did not require Medicare plans (including MMPs) to submit HEDIS data covering the 2019 measurement year. CalOptima did not report HEDIS data for the 2015 measurement year.
SOURCE: RTI analysis of 2015 through 2020 HEDIS measures.

Plan all-cause readmissions for enrollees ages 18–64 and 65+ are reported in ***Figure 7*** and ***Figure 8***, respectively, as an observed-to-expected ratio, 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 7*** shows that Cal Optima, Community Health Group, and Health Net gradually reduced readmissions over time for enrollees age 18–64 from 2015 to 2020. The remaining plans struggled to improve during that time period. In 2020, one-half of MMPs reported higher than expected readmission rates for the 18–64 population, potentially related to the PHE. ***Figure 8*** shows that Inland Empire Health Plan, L.A. Care, and Santa Clara Family Health Plan reported lower than expected readmissions for enrollees ages 65+ for years from 2015–2020, gradually improving over time. The remaining plans had mixed results over this time period. In 2020,most MMPs reported higher than expected readmission rates for the 65+ population, potentially because of the PHE.

Figure 7
Plan all-cause readmissions, ages 18–64, 2015–2020: Reported observed-to-expected ratios for Cal MediConnect MMPs

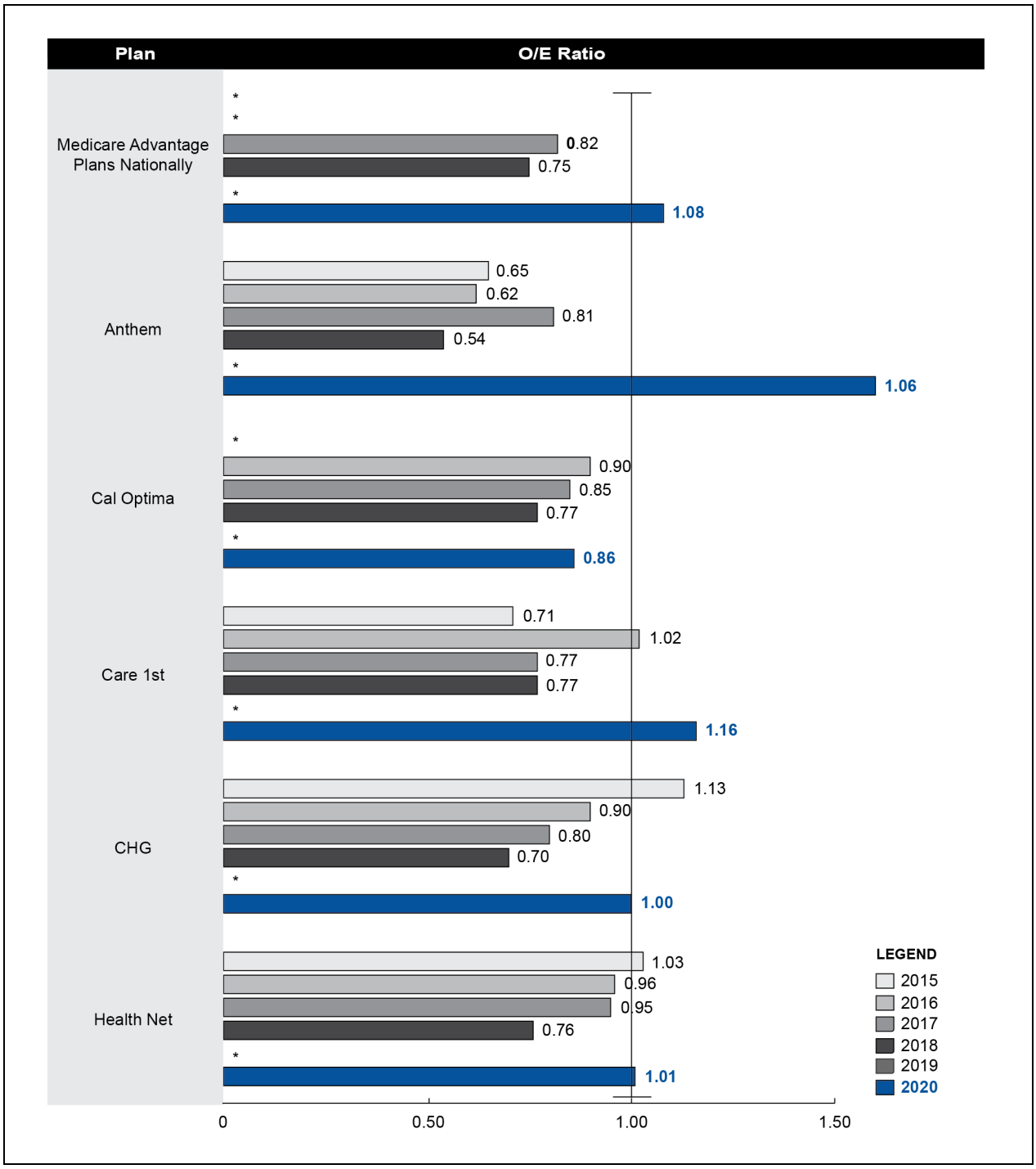

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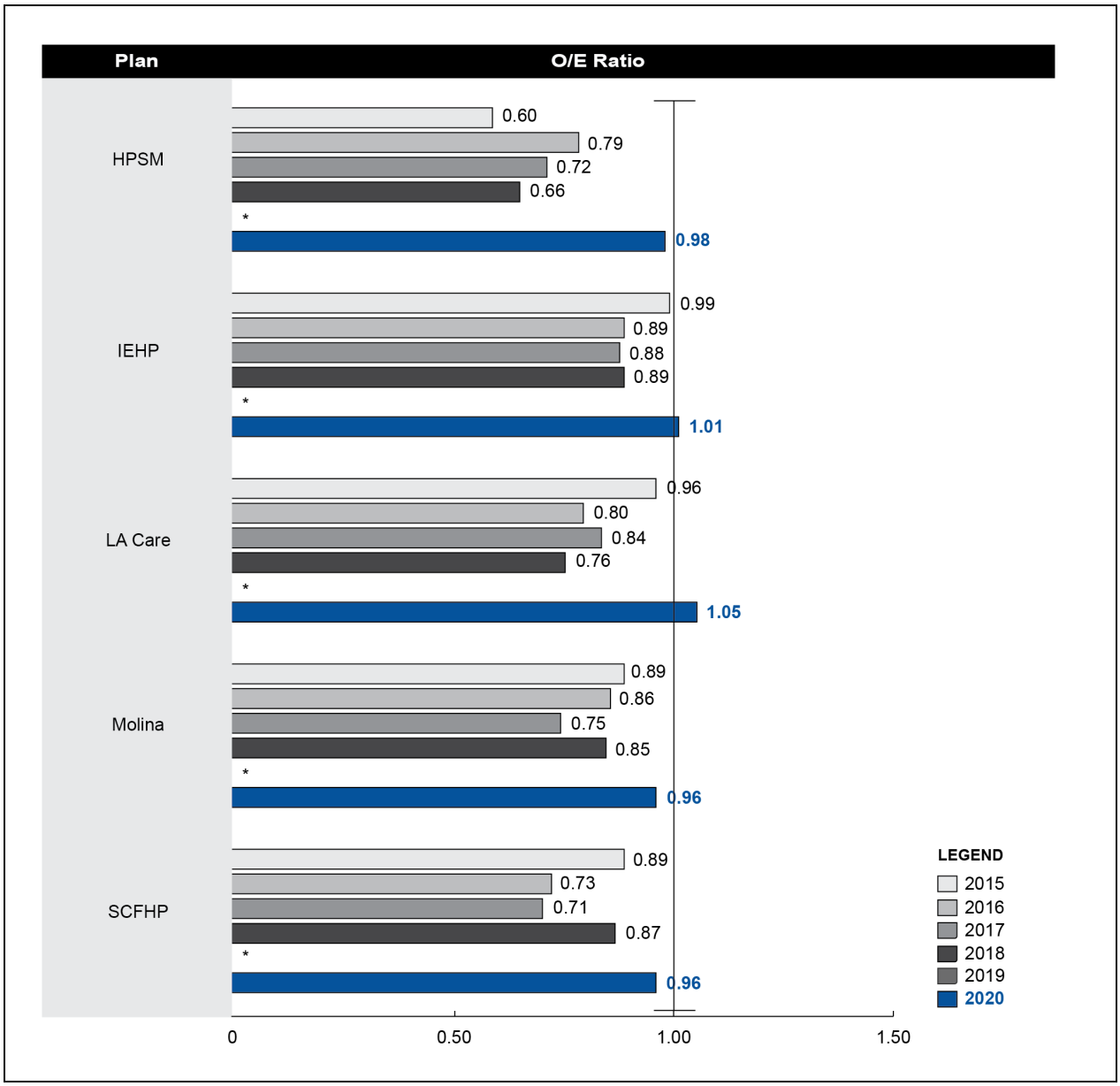
Figure 7 (continued)
Plan all-cause readmissions, ages 18–64, 2015–2020: Reported observed-to-expected ratios for Cal MediConnect MMPs



* = data not available; CHG = Community Health Group; HEDIS = Healthcare Effectiveness Data and Information Set; HPSM = Health Plan of San Mateo; IEHP = Inland Empire Health Plan; MA = Medicare Advantage; MMP = Medicare-Medicaid Plan; SCFHP = Santa Clara Family Health Plan.
NOTES: MA plans nationally did not provide HEDIS data for this measure in measurement years 2015 and 2016.In response to the COVID-19 Public Health Emergency, CMS did not require Medicare plans (including MMPs) to submit HEDIS data covering the 2019 measurement year. CalOptima did not report HEDIS data for the 2015 measurement year.
SOURCE: RTI analysis of 2015 through 2020 HEDIS measures.

Figure 8
Plan all-cause readmissions, ages 65+, 2015–2020: Reported observed-to-expected ratios for Cal MediConnect MMPs

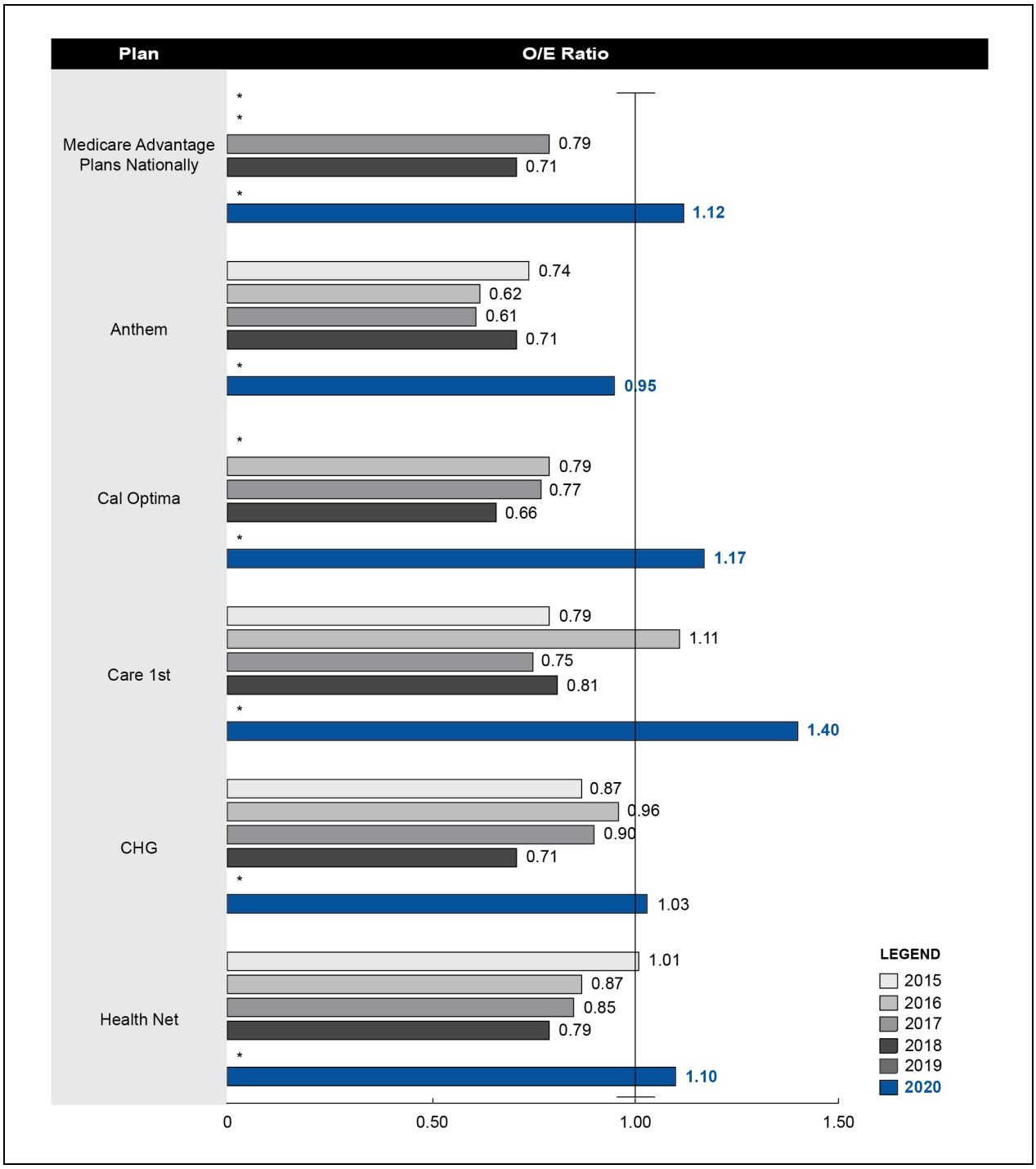


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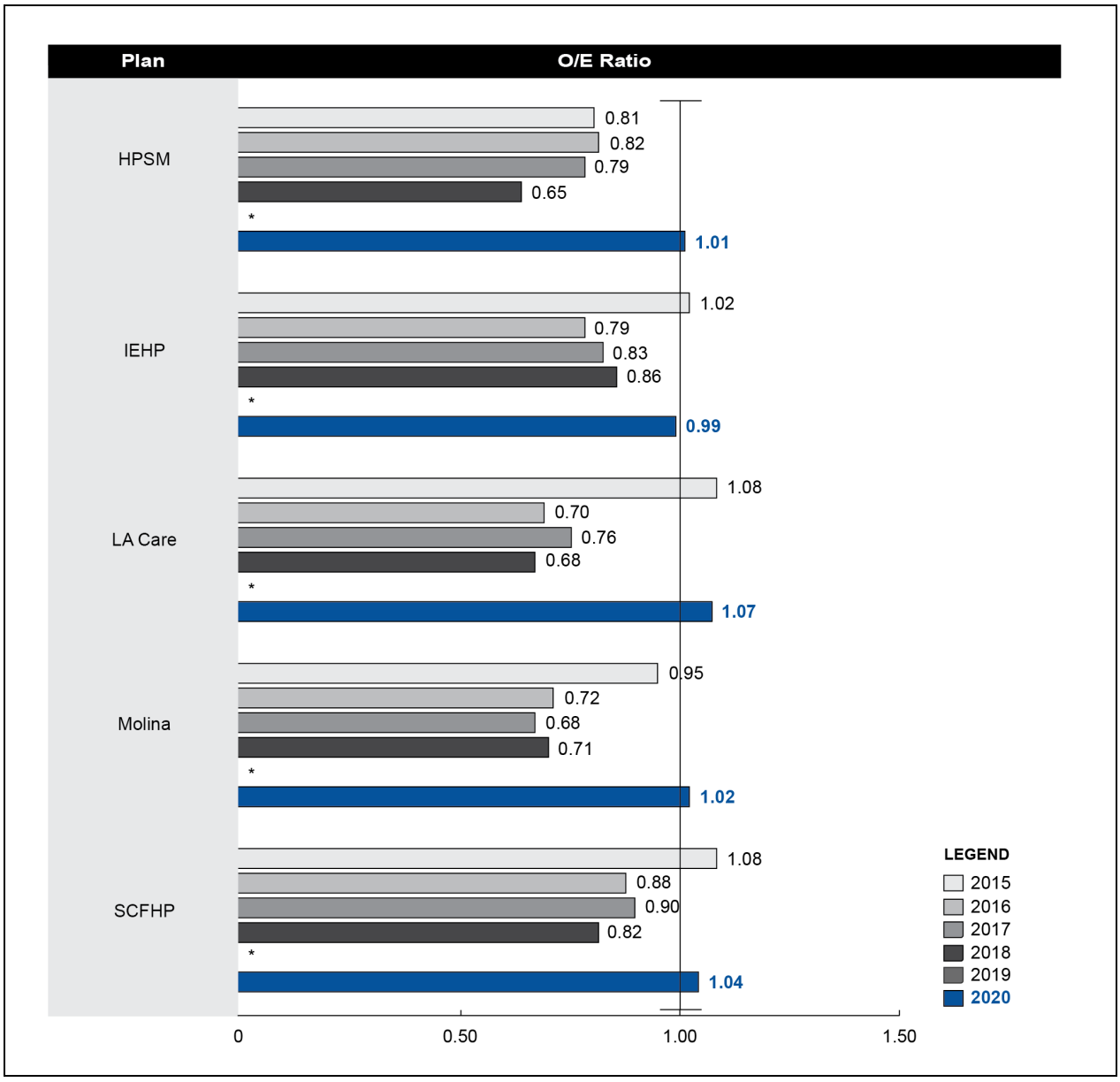
Figure 8 (continued)
Plan all-cause readmissions, ages 65+, 2015–2020: Reported observed-to-expected ratios for Cal MediConnect MMPs



* = data not available; CHG = Community Health Group; HEDIS = Healthcare Effectiveness Data and Information Set; HPSM = Health Plan of San Mateo; IEHP = Inland Empire Health Plan; MA = Medicare Advantage; MMP = Medicare-Medicaid Plan; SCFHP = Santa Clara Family Health Plan.

NOTES: MA plans nationally did not provide HEDIS data for this measure in measurement years 2015 and 2016. In response to the COVID-19 Public Health Emergency, CMS did not require Medicare plans (including MMPs) to submit HEDIS data covering the 2019 measurement year. CalOptima did not report HEDIS data for the 2015 measurement year.

SOURCE: RTI analysis of 2015 through 2020 HEDIS measures.

SECTION 4

Beneficiary Experience

According to stakeholders, Cal MediConnect enrollees continued to be satisfied with their benefits and plan offerings.

The percentage of Cal MediConnect CAHPS respondents who rated their health plans and drug plans as a 9 or 10 out of 10 continued to increase during the reporting period across California MMPs. However, increases were not steady year to year for most MMPs.

One of the main goals of the demonstration under the FAI is to improve the beneficiary experience accessing Medicare and Medicaid. 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.

For beneficiary experience, we draw on findings from the CAHPS survey and stakeholder interviews. See ***Appendix A*** for a full description of these data sources.

4.1 Impact of the Demonstration on Beneficiaries

Overall Satisfaction with the Demonstration. In 2020 and 2021, beneficiary advocates provided insights into the positive experiences and challenges reported by many enrollees. Advocates shared that enrollees continue to be satisfied with their benefits. Beneficiary advocates such as the Ombudsman, noted that enrollees appreciate the outreach they receive over this reporting period, and assistance they get from MMPs in resolving issues.

Figures 9 and ***10*** present data collected on two CAHPS measures of beneficiary satisfaction across Cal MediConnect MMPs.[11] As shown in ***Figure 9***, the percentage of CAHPS respondents who rated their health plan as a 9 or 10 (on a scale of 0 to 10) increased for all ten MMPs from 2015 (or the earliest demonstration year for which an MMP reported data) to 2021. However, the increases were not steady year to year for most MMPs. As shown in ***Figure 10***, the percentage of Cal MediConnect CAHPS respondents who rated their drug plan as a 9 or 10 increased for nine out of ten California MMPs from 2015 (or the earliest demonstration year for which an MMP reported data) to 2021.

[11] 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.

Figure 9
Beneficiary overall satisfaction, 2015–2021:
Percentage of beneficiaries rating their health plan as a 9 or 10

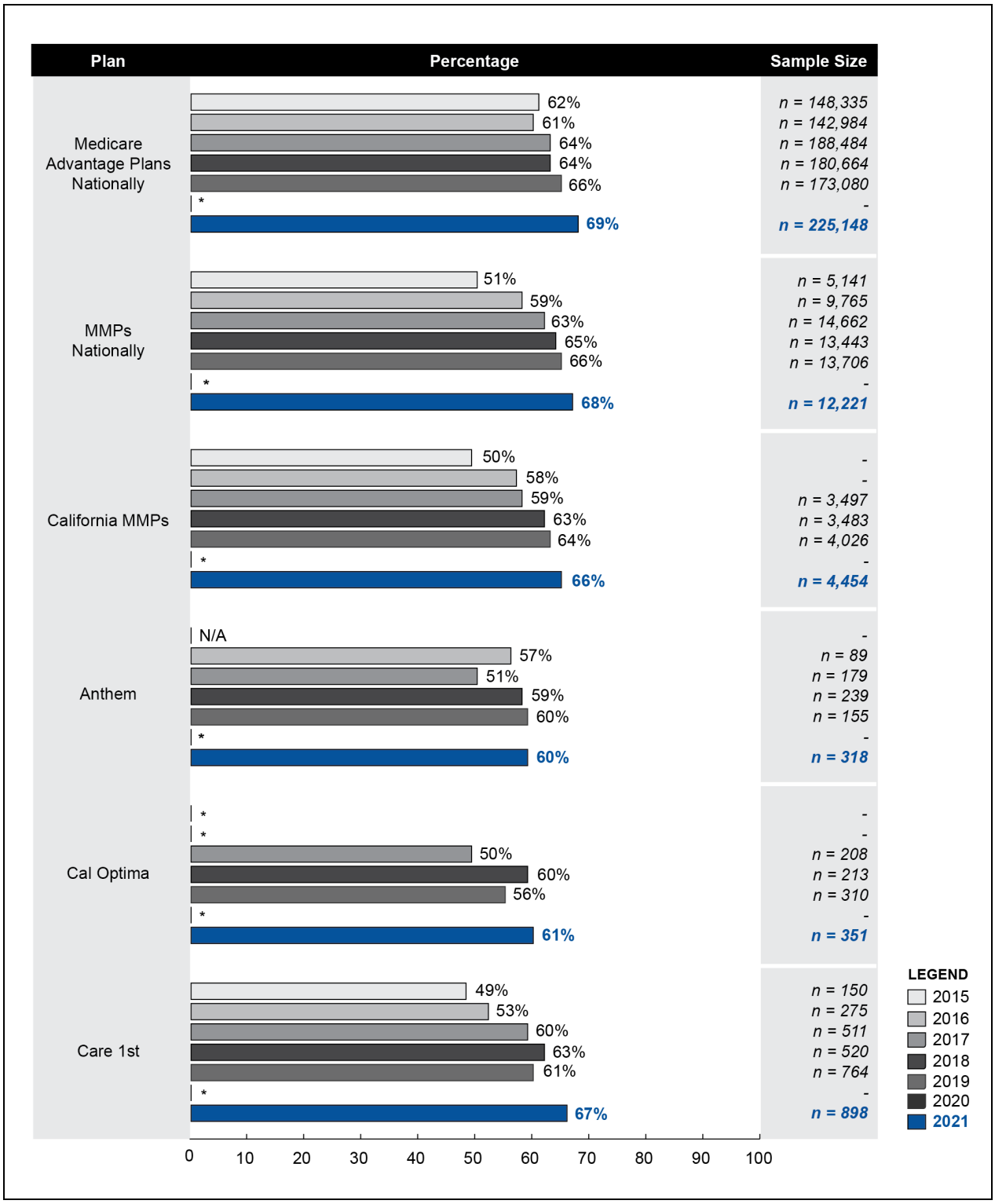


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Figure 9 (continued)
Beneficiary overall satisfaction, 2015–2021:
Percentage of beneficiaries rating their health plan as a 9 or 10

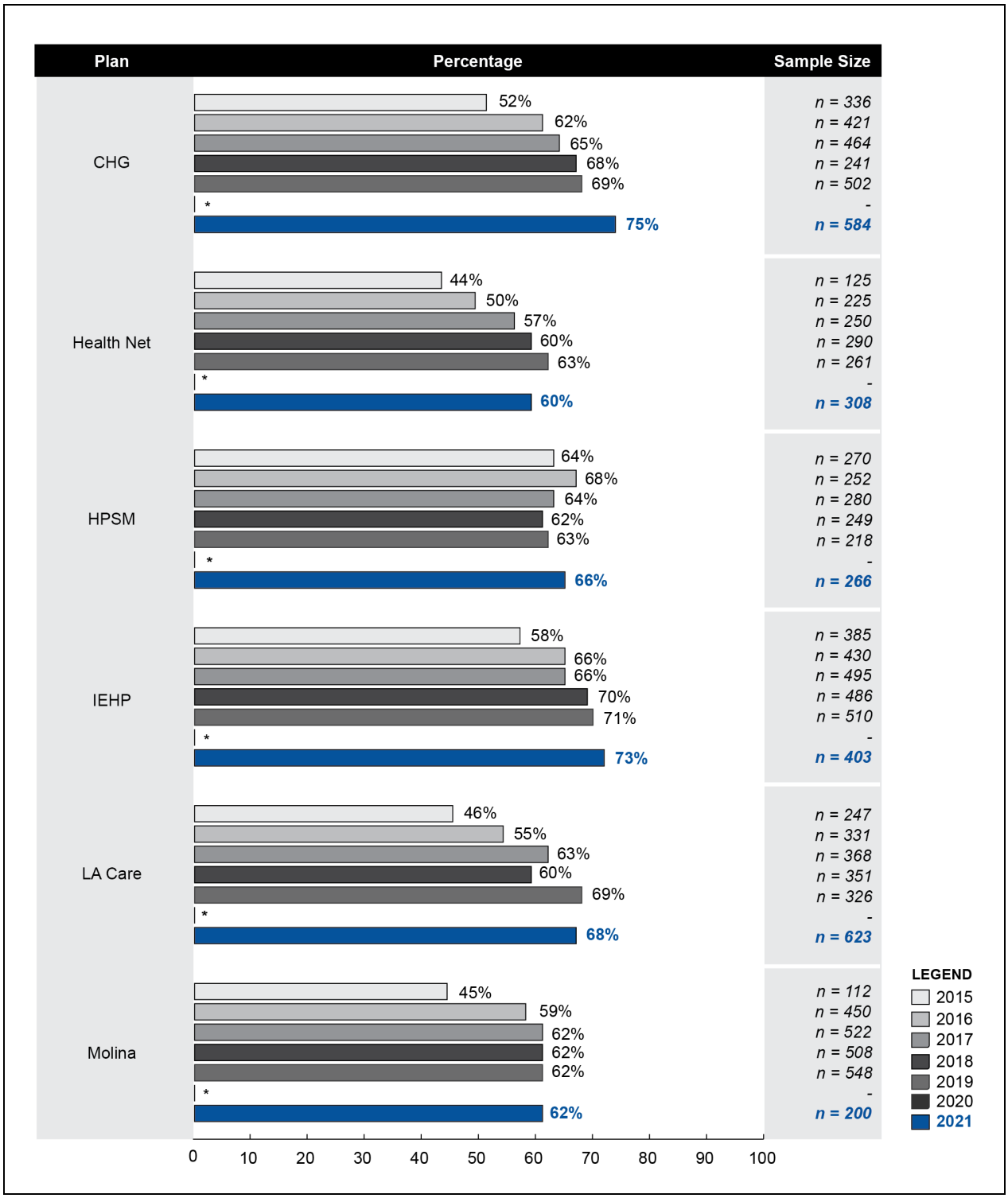

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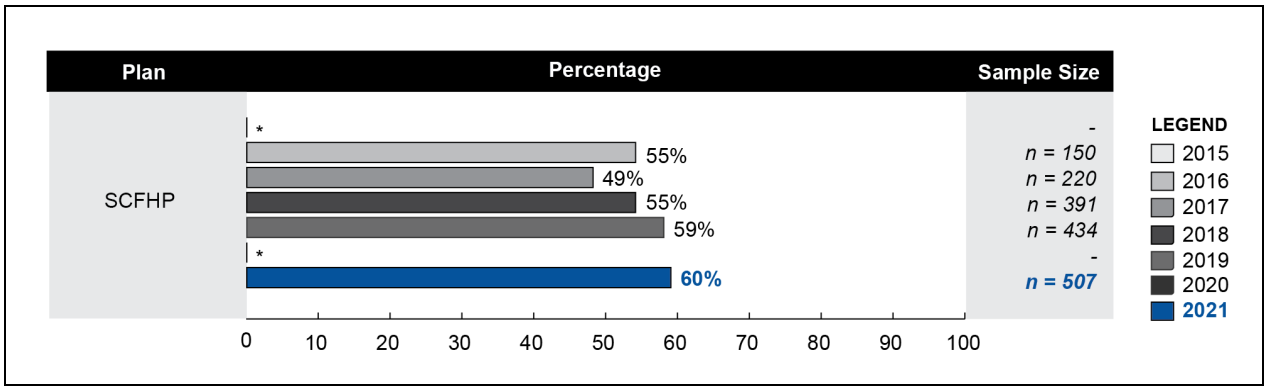
Figure 9 (continued)
Beneficiary overall satisfaction, 2015–2021:
Percentage of beneficiaries rating their health plan as a 9 or 10



* = data not available; - = sample size data not available; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CHG = Community Health Group; HPSM = Health Plan of San Mateo; IEHP = Inland Empire Health Plan; 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; SCFHP = Santa Clara Family Health Plan.

NOTES: Cal Optima does not have any data for 2015 because the plan joined the demonstration in July 2015. In response to the COVID-19 Public Health Emergency, CMS did not require MMPs to collect CAHPS data for 2020.

SOURCE: CAHPS data for 2015–2021. 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 10
Beneficiary overall satisfaction, 2015–2021:
Percentage of beneficiaries rating their prescription drug plan as a 9 or 10

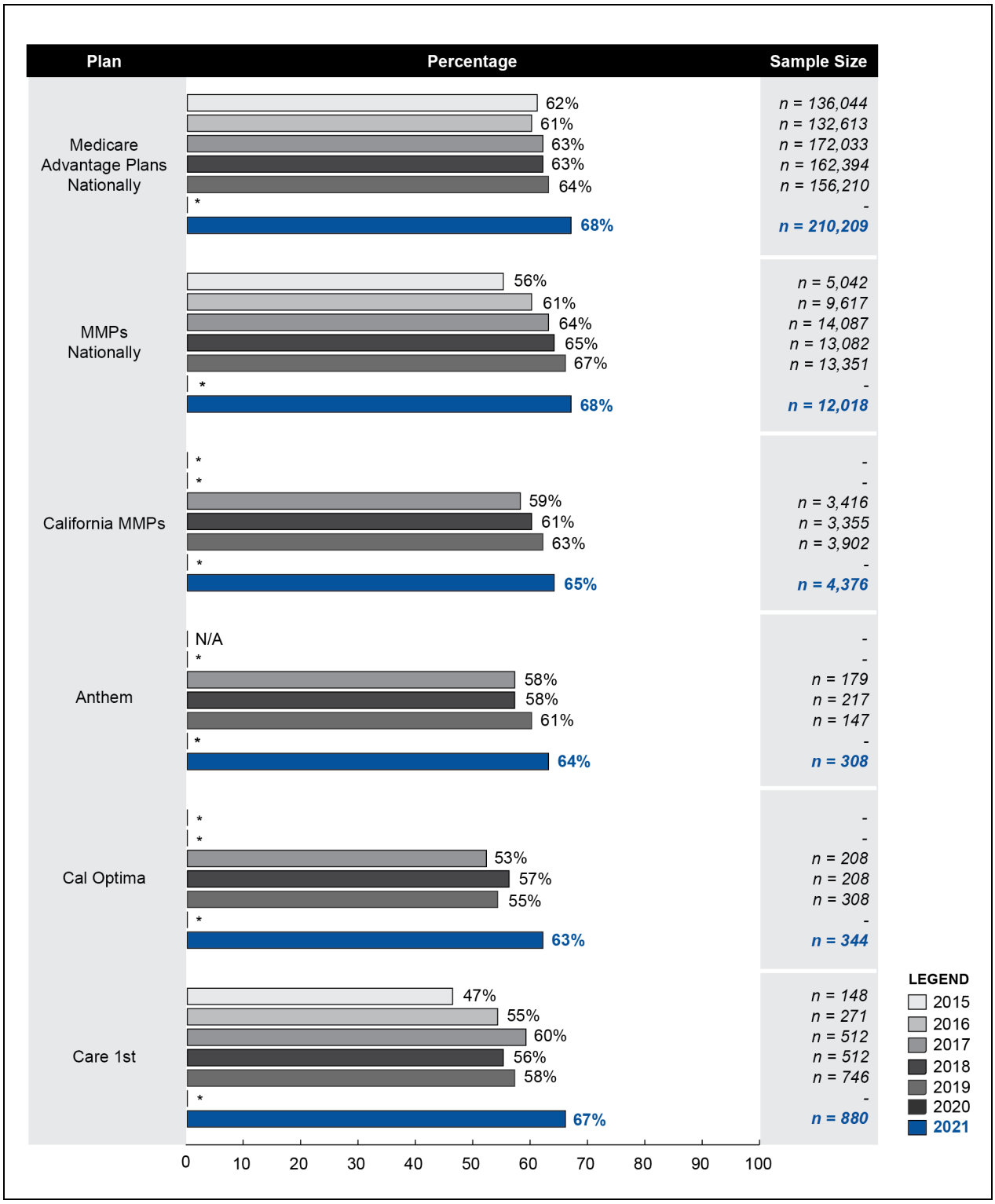


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Figure 10 (continued)
Beneficiary overall satisfaction, 2015–2021:
Percentage of beneficiaries rating their prescription drug plan as a 9 or 10

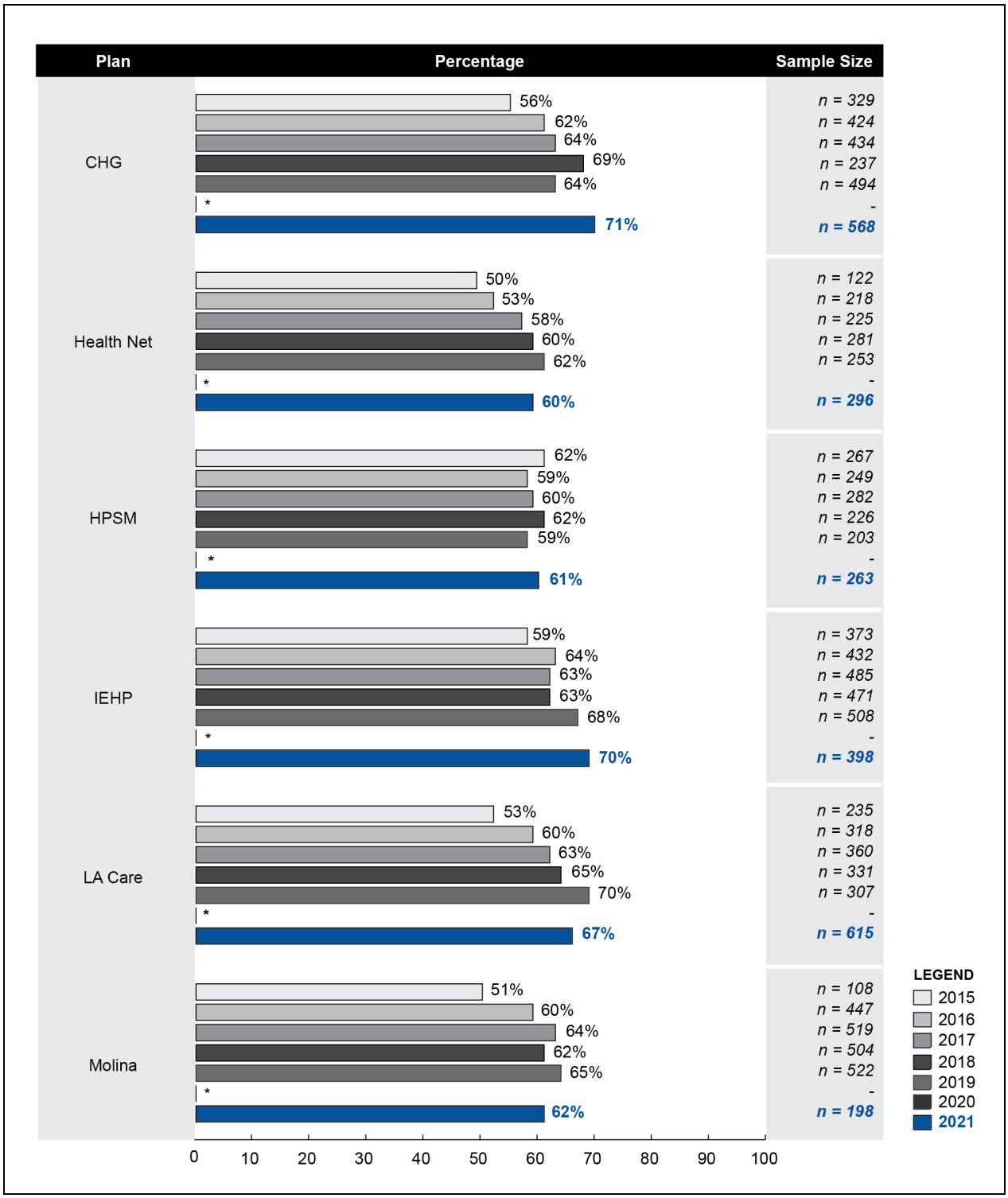

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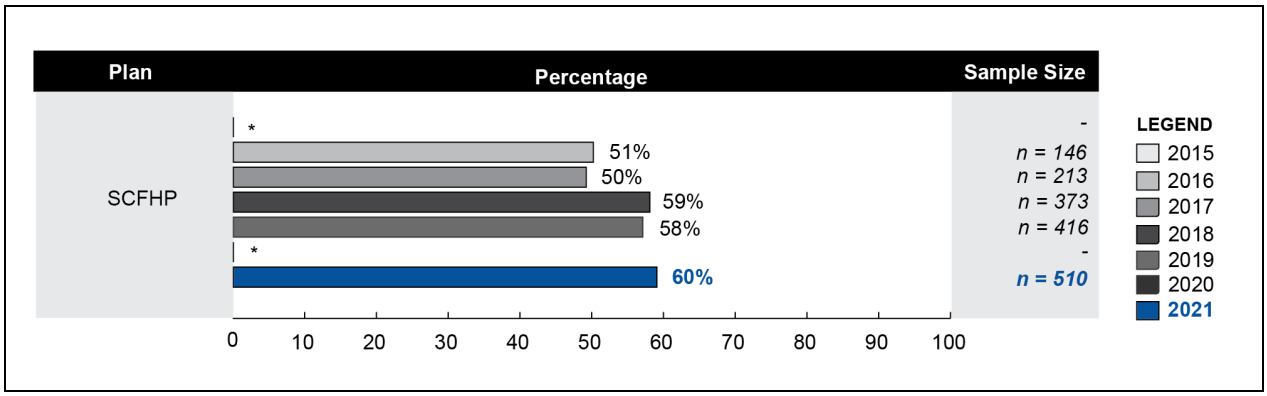
Figure 10 (continued)
Beneficiary overall satisfaction, 2015–2021:
Percentage of beneficiaries rating their prescription drug plan as a 9 or 10



* = data not available; - = sample size data not available; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CHG = Community Health Group; HPSM = Health Plan of San Mateo; IEHP = Inland Empire Health Plan; 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; SCFHP = Santa Clara Family Health Plan.

NOTES: Cal Optima does not have any data for 2015 because the plan joined the demonstration in July 2015. In response to the COVID-19 Public Health Emergency, CMS did not require MMPs to collect CAHPS data for 2020.

SOURCE: CAHPS data for 2015–2021. 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?"

General MMP Efforts in Beneficiary Engagement. During 2020 and 2021, several MMPs reported investing in efforts to improve beneficiary engagement. One MMP brought HRA completion and person-centered care planning in-house because they were seeing low success rates when using a vendor. This change also helped build rapport with enrollees and improve enrollee engagement. Another MMP partnered with a non-profit organization that promotes partnerships between consumers and health care organizations to inform policy and practice to increase enrollee participation and elevate enrollee voices in decision-making. Based on interviews with MMP staff and enrollees, the Center for Advanced Consumer Partnerships developed a journey map of the enrollee experience. They used this map to identify important moments in communication with enrollees and identify pain points the plan could address. In 2021, another managed care organization hired a consultant to identify possible improvements in the beneficiary experience. The effort was not specific to Cal MediConnect, but plan staff saw it being helpful across the managed care organization's products, including its MMP.

Expanded Benefits related to the PHE. As part of the PHE response, States were granted temporary flexibilities to ensure that beneficiaries continued to receive services. In 2021, the Ombudsman noted that some of these flexibilities, such as reduced verification and redetermination requirements for Medicaid benefits and services, were effective for preserving beneficiary benefits and facilitating ongoing engagement in Cal MediConnect. The interviewee also pointed out that broader access to telehealth was especially helpful for those needing behavioral health services and should be maintained after the end of the PHE. Several MMPs reported expanding telehealth services in 2020 to continue serving their members during the

pandemic, and one MMP embedded telehealth as part of their core benefit package for 2021. As CBAS centers were closed, MMPs developed alternative service delivery approaches such as providing services virtually and delivering meals that enrollees would have otherwise received in person.

CPOs and shift to Community Supports. Throughout the demonstration, the MMPs provided minimal CPO services. According to the Cal MediConnect Performance Dashboard, both CPO referrals and CPO utilization decreased during 2020 and 2021 (DHCS, 2022c). Only two MMPs reported offering these services when interviewed in 2020 and 2021; one MMP only provided CPO services to three individuals in 2020. The CPO services included gap coverage for an IHSS-eligible individual to receive personal care before permanent services have been established or IHSS caregivers were not available, access to furniture and other resources such as an air purifier, pest extermination and assistance in moving belongings for a newly housed enrollee. These MMPs leaned heavily on their relationships with CBOs to connect enrollees to existing services instead of providing the services themselves.

Starting in January 2022, the CPO benefit became Community Supports as part of one of the transitional steps to CalAIM. Community Supports are services that meet beneficiary non-medical and LTSS needs, with an overarching goal of addressing beneficiary SDOH-related needs. Similar to the CPO benefit, Community Supports are voluntary and allow plans to provide services that are defined by the State as "medically appropriate and cost-effective alternatives to state plan services" (DHCS, 2022b). This includes, for example, the ability to provide gap coverage for beneficiaries prior to waiver services taking effect. Unlike the CPO benefit, MMPs that invest in Community Supports are reimbursed as part of their Medi-Cal reimbursement. Receiving reimbursement may incentivize more MMPs to provide Community Supports compared to CPOs—in the past, many MMPs noted that the lack of reimbursement for providing these services was either a deterrent or made the provision of CPOs unsustainable. As of December 2021, there were a total of 14 Community Supports that MMPs could choose to provide to members (see ***Figure 11*** and ***Section 2.1, Changes to Demonstration Design,*** for additional details).

Figure 11
New Community Supports

- Housing transition navigation services
- Housing deposits
- Housing tenancy and sustaining services
- Short-term post-hospitalization housing
- Recuperative care (medical respite)
- Respite services
- Day habilitation program
- Nursing facility transition/diversion to assisted living facilities, such as residential care facilities for the elderly and adult residential facilities
- Community transition services/nursing facility transition to a home
- Personal care and homemaker services
- Environmental accessibility adaptations (home modifications)
- Medically supportive food/meals/medically tailored meals
- Sobering centers
- Asthma remediation

Three of the five MMPs we interviewed in 2021 discussed offering some form of Community Supports and mentioned contracting with new providers for these services. One MMP was already offering 11 of the 14 Community Supports as of December 2021 and planned to offer the remaining three supports by July 2022. Another MMP had not previously offered CPO services but decided to offer Community Supports focused on housing needs. The MMP worked with county partners around SDOH-related needs to identify this area of need and decided to offer recuperative care, housing navigation assistance, housing deposits, housing tenancy and sustaining services as Community Supports in 2022.

Beneficiary Experience with Care Coordination Services. Stakeholders and advocates continued to express concerns regarding the shortcomings of the care coordination benefit and variation in MMP efforts, but also identified some successes. An advocate reported several examples of successful MMP care coordination efforts. One MMP had a very involved HRA completion process that included(1) prioritizing in-person completion of HRAs prior to the PHE, (2) ensuring that HRAs were conducted annually, and (3) performing ongoing follow-ups with non-respondents to make sure HRAs were completed. This same MMP also worked closely with county mental health plans to support behavioral health care coordination, and in general, MMP care coordinators intervened on behalf of members to resolve improper billing issues (see ***Section 3.3, Care Coordination***).

CAHPS findings on the beneficiary experience with care coordination were mixed. The percentage of CAHPS respondents who reported that their health plan usually or always gave them information they needed varied for most MMPs from the earliest demonstration year for

which an MMP reported data, through 2021 (see ***Figure 12***). Eight out of the ten plans saw a decrease in this metric from 2019 to 2021. As shown in ***Figure 13***, the percentage of respondents that reported their personal doctors were usually or always informed about care from a specialist varied across MMPs.

Figure 12
Beneficiary experience with care coordination, 2015–2021:
Percentage of beneficiaries reporting that their health plan usually or always gave them information they needed

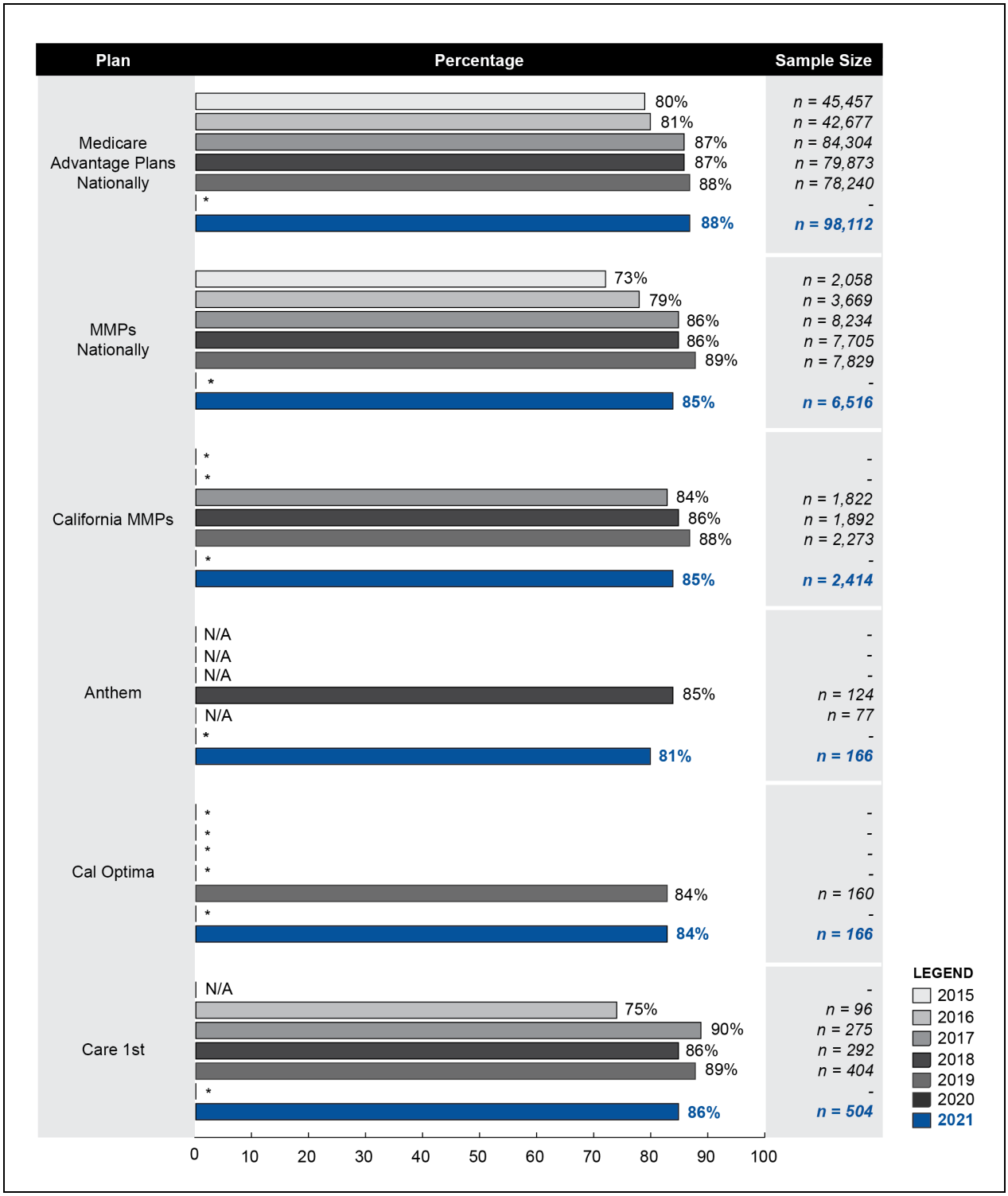


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Figure 12 (continued)
Beneficiary experience with care coordination, 2015–2021:
Percentage of beneficiaries reporting that their health plan usually or always gave them information they needed

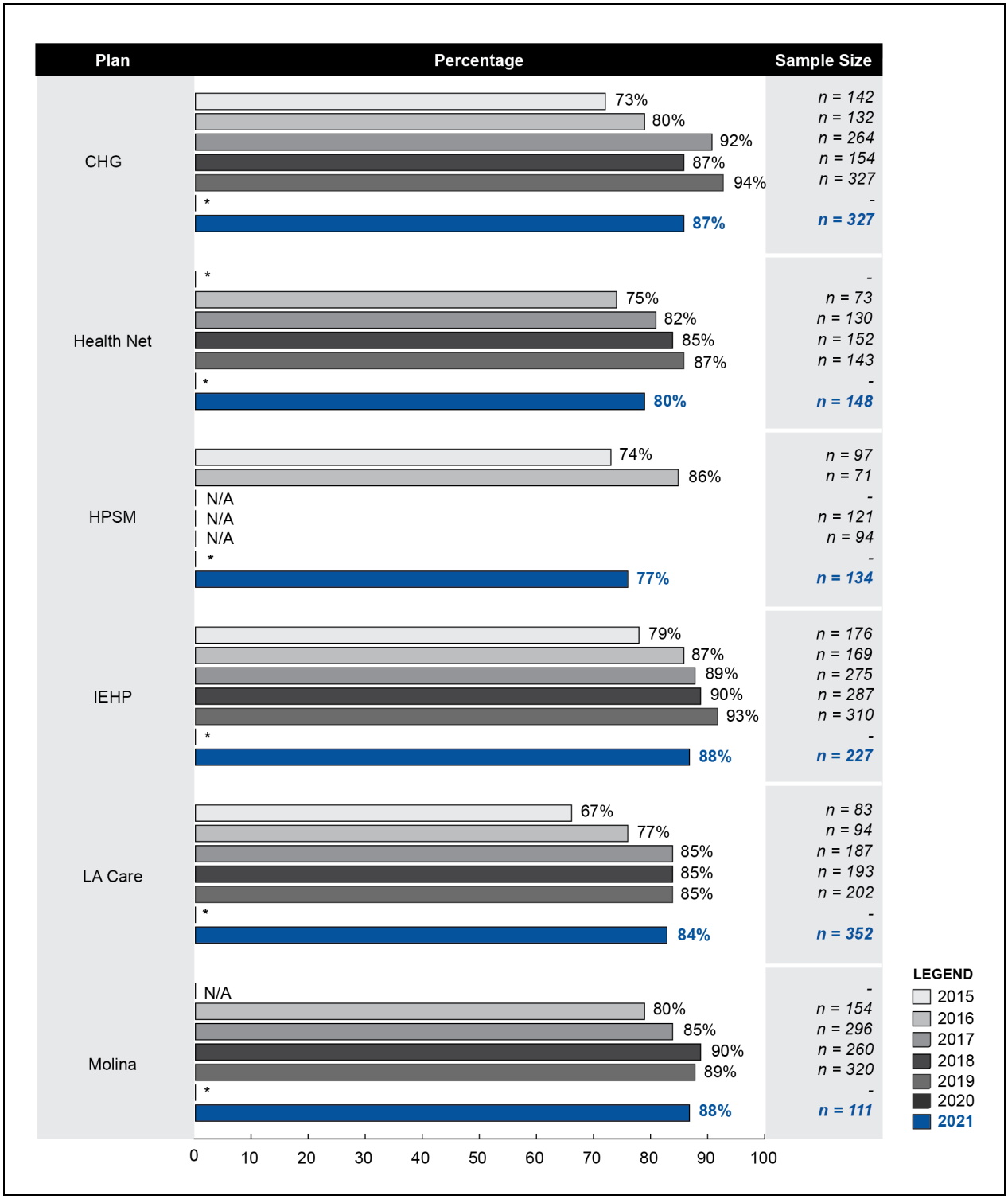

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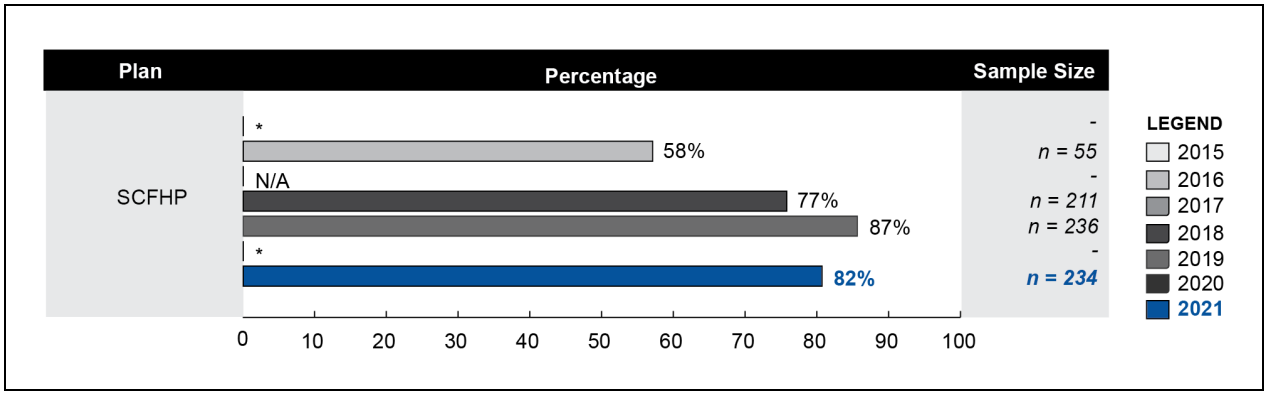
Figure 12 (continued)
Beneficiary experience with care coordination, 2015–2021:
Percentage of beneficiaries reporting that their health plan usually or always gave them information they needed



* = data not available; - = sample size data not available; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CHG = Community Health Group; HPSM = Health Plan of San Mateo; IEHP = Inland Empire Health Plan; 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; SCFHP = Santa Clara Family Health Plan.

NOTES: Cal Optima does not have any data for 2015 because the plan joined the demonstration in July 2015. In response to the COVID-19 Public Health Emergency, CMS did not require MMPs to collect CAHPS data for 2020.

SOURCE: CAHPS data for 2015–2021. 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?"

Figure 13
Beneficiary experience with care coordination, 2015–2021:
Percentage of beneficiaries reporting that in the past 6 months their personal doctors were usually or always informed about care from specialists

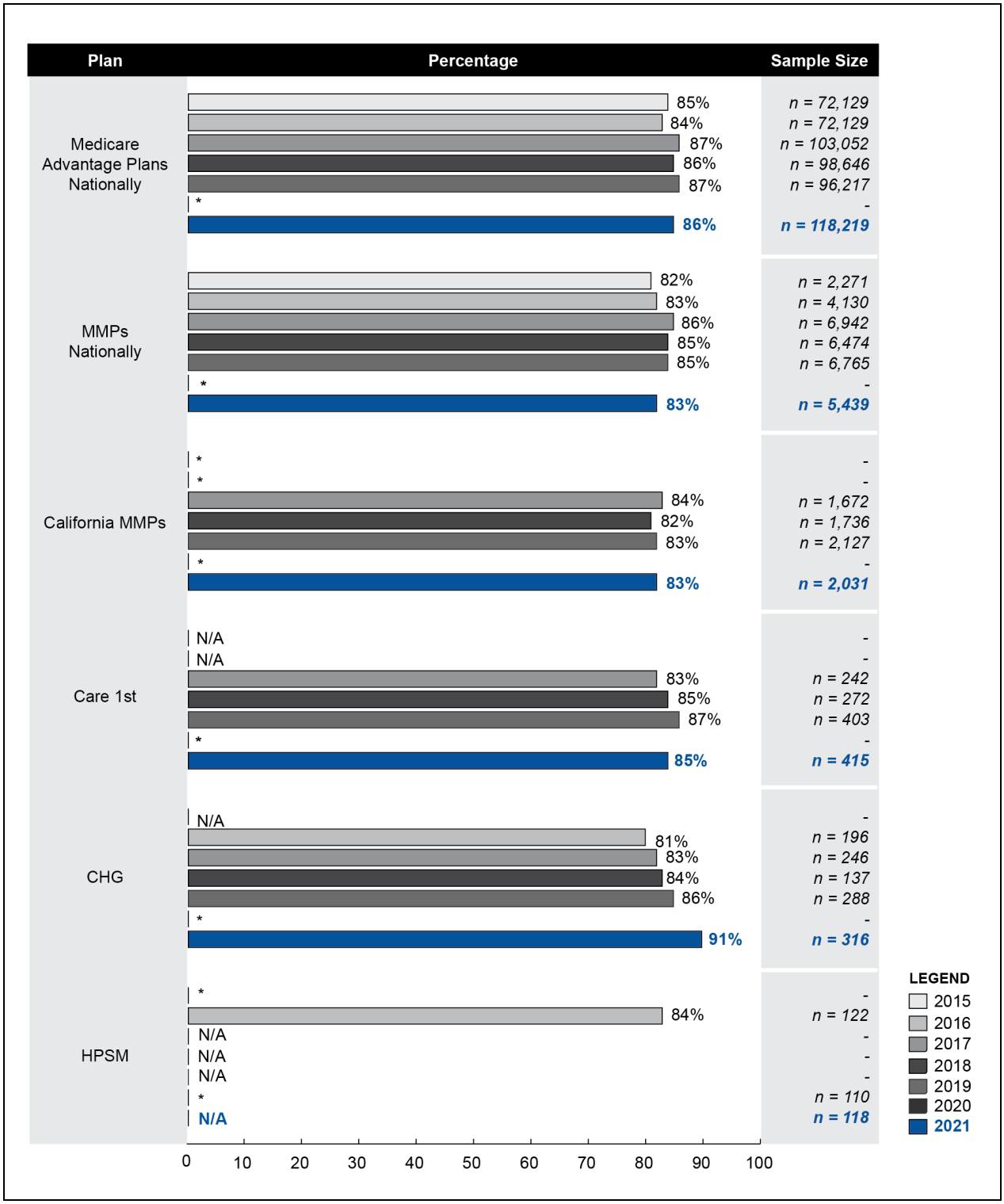


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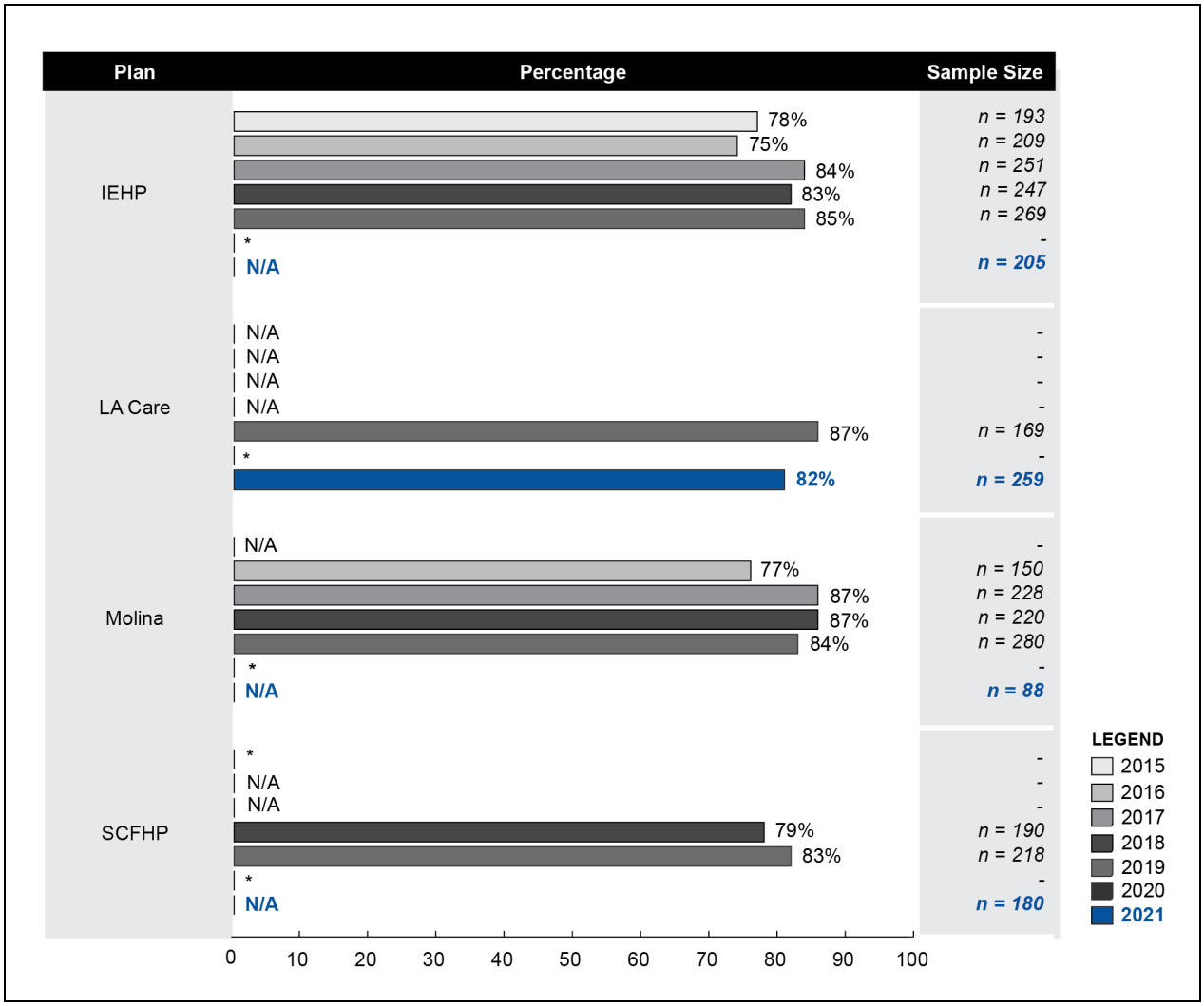
Figure 13 (continued)
Beneficiary experience with care coordination, 2015–2021:
Percentage of beneficiaries reporting that in the past 6 months their personal doctors were usually or always informed about care from specialists



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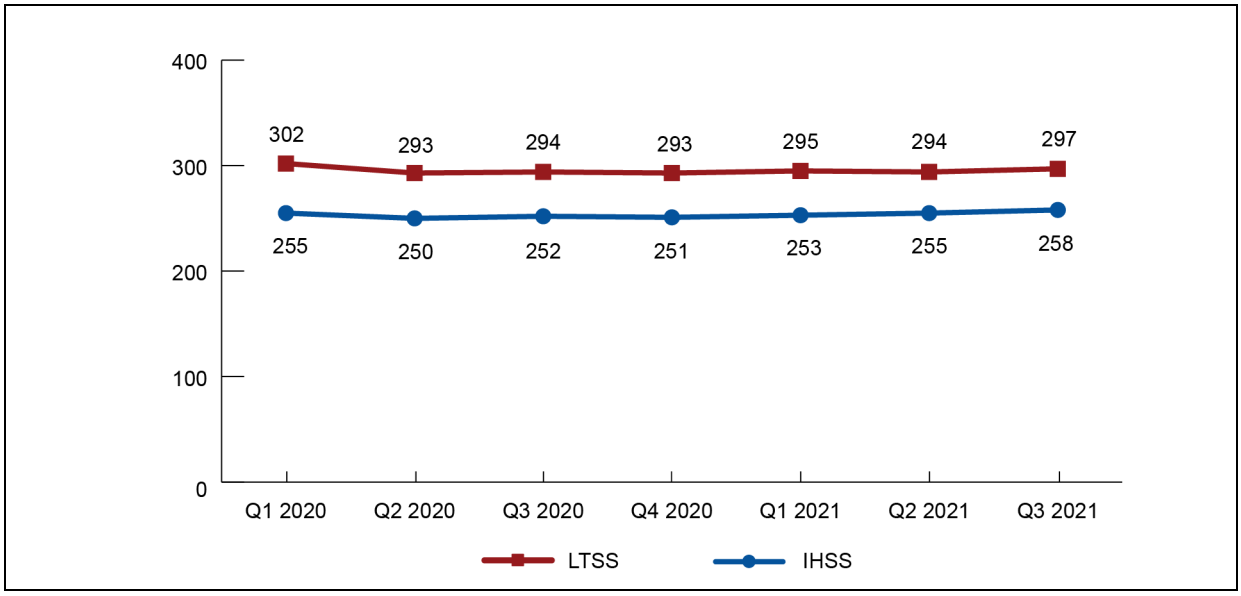
NOTES: Anthem, Cal Optima, and Health Net do not appear in the figure because the plans did not provide any data for any of the years for this item. In response to the COVID-19 Public Health Emergency, CMS did not require MMPs to collect CAHPS data for 2020.

SOURCE: CAHPS data for 2015–2021.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?"

Beneficiary Experience with Quality and Access to Care. The Cal MediConnect Performance Dashboard provides data and measures for different aspects of Cal MediConnect implementation, including several metrics on access to LTSS and home and community-based

care. As shown in ***Figure 14***, the rolling State average[12] number of enrollees receiving LTSS and IHSS per 1,000 enrollees remained relatively consistent during 2020 and 2021. There was a small decrease between quarters 1 and 2 of 2020, which may be related to limited caregiver availability and fewer in-person interactions with care providers in general during the peak of the PHE. The rolling State average number of enrollees receiving LTSS and IHSS per 1,000 enrollees slowly increased after that time.

Figure 14
Quarterly rolling State average number of enrollees receiving LTSS and IHSS per 1,000 enrollees

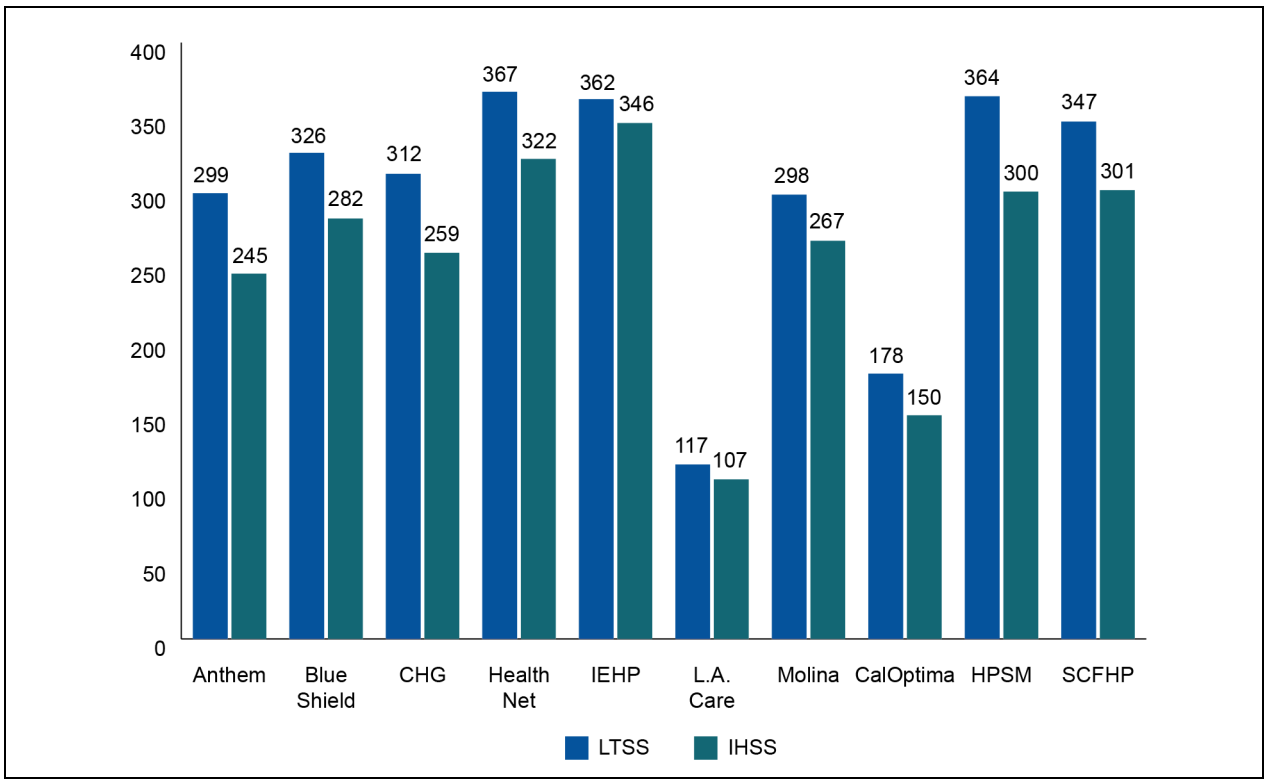


IHSS = In-Home Supportive Services; LTSS = long-term services and supports; Q = quarter.
NOTES: IHSS is a subset of reported LTSS. According to the explanation provided in the Cal MediConnect Performance Dashboard, plans report LTSS Utilization and Referrals for LTSS, which includes IHSS, CBAS, MSSP and CPO (see page 8 at https://www.dhcs.ca.gov/Documents/MCQMD/CMC-Dashboard-3-22.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 2021 and March 2022 for the illustrated quarters of data. Available at https://www.dhcs.ca.gov/Pages/Cal_MediConnectDashboard.aspx (Accessed on March 21, 2022).

The number of enrollees receiving LTSS per 1,000 enrollees in quarter 3 of 2021 (the most recent quarter of this data available at the time this report was written), was greater than the statewide quarterly average (296.9) across all but two of the 10 MMPs (see ***Figure 15***). This was also true for IHSS, where plan numbers exceeded the statewide quarterly average (257.8) in all but two MMPs.

[12] Metrics are for the entire Cal MediConnect program, by calendar quarters. The rolling quarter averages are calculated by taking the average of the available data over the course of the Cal MediConnect program up through the most recent quarter. The oldest quarter of data is dropped as the newest quarter of available data is added for these calculations.

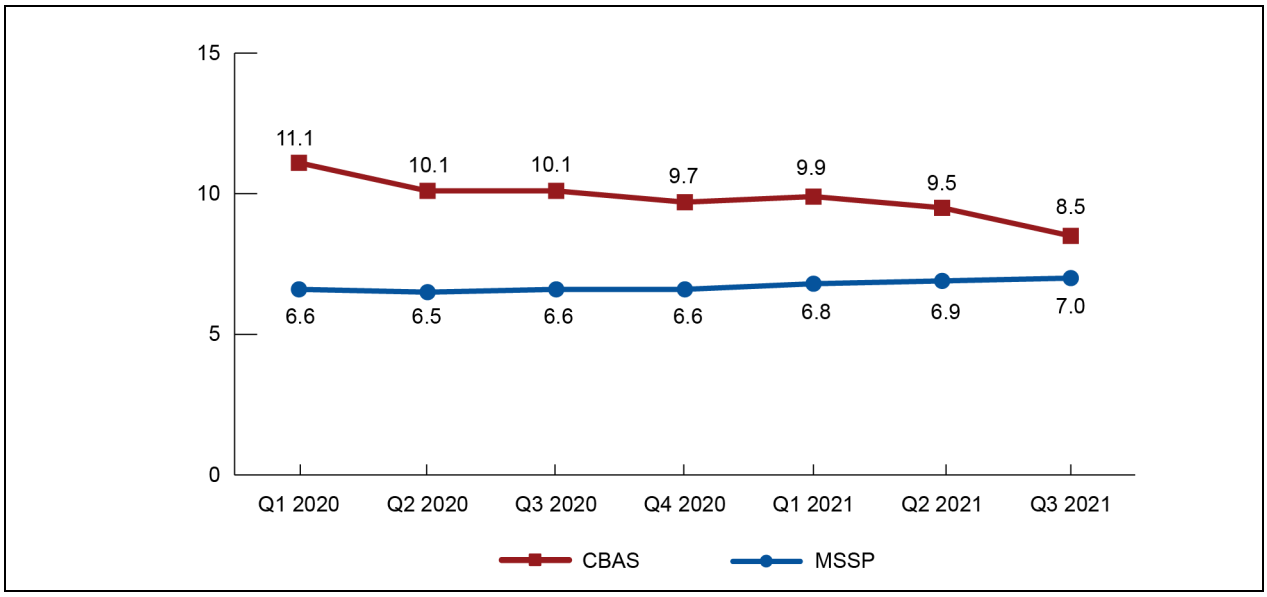
Figure 15
Number of enrollees receiving LTSS or IHSS per 1,000 enrollees for quarter 3 of 2021



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 Cal MediConnect 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/Documents/MCQMD/CMC-Dashboard-3-22.pdf). The data are then presented separately in dashboard figures.
SOURCE: Data from Figures 26 and 27 of the Cal MediConnect Performance Dashboard, released in March 2022 for the illustrated quarter of data. Available at https://www.dhcs.ca.gov/Pages/Cal_MediConnectDashboard.aspx (Accessed on March 21, 2022).

With respect to other HCBS, the average number of MMP enrollees receiving CBAS and MSSP (which provide community-based services), continued to be low in 2020 and 2021 as observed over the course of the demonstration (see ***Figure 16***). There was a decrease in the receipt of both CBAS and MSSP between quarters 1 and 2 of 2020. However, although the average number of enrollees receiving MSSP has slowly increased since quarter 2 of 2020, the average number of enrollees receiving CBAS has continued to decrease. This may be related to reported closures of CBAS centers during the PHE.

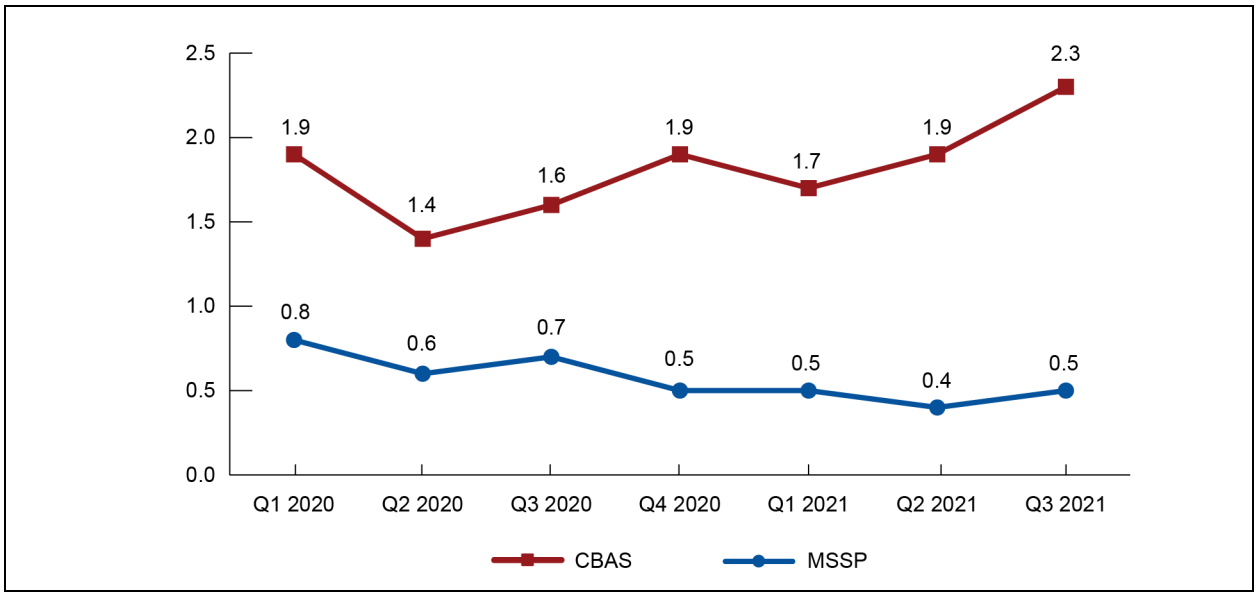
Figure 16
Quarterly rolling statewide average number of enrollees receiving CBAS or MSSP per 1,000 enrollees



CBAS = Community-Based Adult Services; MSSP = Multipurpose Senior Services Program.
SOURCE: Data from Figures 32 and 36 of the Cal MediConnect Performance Dashboard, released in September 2020, June 2021 and March 2022 for the illustrated quarters of data. Available at https://www.dhcs.ca.gov/Pages/Cal_MediConnectDashboard.aspx (Accessed on March 23, 2022).

The quarterly rolling statewide average number of CBAS or MSSP referrals per 1,000 enrollees also continued to be very low, with a decrease in both services between quarters 1 and 2 of 2020 (see ***Figure 17***). The average number of CBAS referrals generally increased starting in quarter 2 of 2020. Referrals for CBAS likely increased once the State allowed for services to be provided in alternative forms in response to PHE challenges. However, MSSP referrals continued to decrease starting in quarter 3 of 2020.

Figure 17
Quarterly rolling statewide average number of CBAS or MSSP referrals per 1,000 enrollees



CBAS = Community-Based Adult Services; MSSP = Multipurpose Senior Services Program.
SOURCE: Data from Figures 32 and 36 of the Cal MediConnect Performance Dashboard, released in September 2020, June 2021 and March 2022 for the illustrated quarters of data. Available at https://www.dhcs.ca.gov/Pages/Cal_MediConnectDashboard.aspx (Accessed on March 23, 2022).

Addressing Needs of Non-native English Speakers, LGBTQ, and Other Enrollees. The Cal MediConnect population is racially, ethnically, and linguistically diverse. As of September 1, 2021, the population was comprised of 39 percent Hispanic, 17 percent Asian/Pacific Islander, 9 percent African American, and 19 percent non-Hispanic/White dually eligible individuals, and 49 percent of enrollees reported speaking a language other than English (DHCS, 2022c). Over the course of the demonstration, ensuring that MMPs were meeting the needs of this diverse enrollee population was a central topic of conversation with site visit interviewees. In 2020 and 2021, several MMPs reported concerted efforts to improve their cultural competency, including effectively identifying enrollee language needs and hiring linguistically and ethnically diverse staff. One MMP discussed efforts to ensure that the network of care managers themselves reflected enrollees' cultural and linguistic diversity. The MMP also noted that its network of providers is diverse, reflecting its long-established history of relationship-building with ethnically diverse providers in the county.

The Ombudsman program also conducted cultural competency trainings in 2021 to enhance care for all Medi-Cal beneficiaries, including Cal MediConnect enrollees. Topics covered included gender affirming care and serving the lesbian, gay, bisexual, transgender, and queer (LGBTQ) population. The Ombudsman program conducted these trainings for its own staff as well as for multiple health plans; the Ombudsman program also engaged hospital networks, clinic providers, and State agencies in this effort. This work culminated in the removal of gender markers from Medi-Cal beneficiary identification cards. The program was also working with the State on how plans identify gender affirming care providers in their networks.

Engaging Unhoused Enrollees. During the reporting period, one MMP reported establishing a 6-bed recuperative care facility for enrollees who are marginally housed or experiencing homelessness, and had a recent hospitalization and needed a safe place to recover. Another MMP reported providing enrollees experiencing homelessness with cell phones to stay connected to care coordinators and providers.

Supporting Homebound Enrollees. One MMP reported having a disaster plan in place so that during a serious event they could use geo-mapping to identify and locate enrollees, especially homebound enrollees or those with life-sustaining equipment, to make sure they would be supported during rolling power shut-offs.

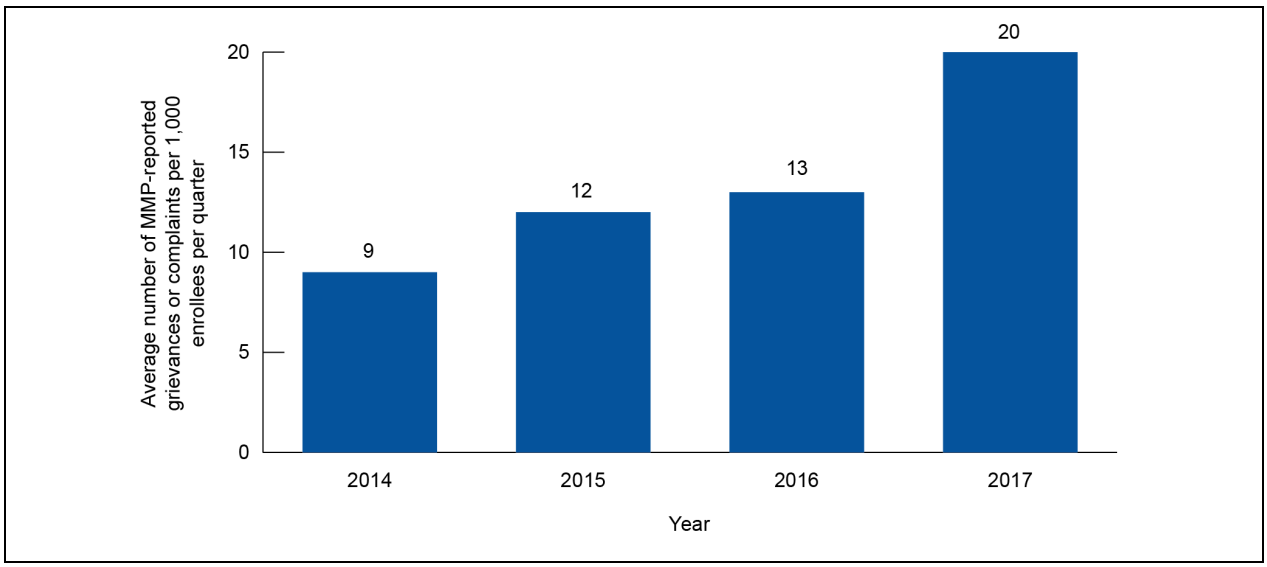
4.2 Beneficiary Protections

In this section we describe the numbers and types of beneficiary complaints and appeals received about Cal MediConnect. Enrollees have certain protections under the demonstration. There are several options for them to report grievances or complaints, appeals, and critical incidents and abuse. 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 Complaint Tracking Module (CTM), the Independent Review Entity (IRE), and qualitative information collected by the RTI evaluation team. Reporting periods vary across these sources.

Complaints Received by the Cal MediConnect Ombudsman Office. Ombudsman services are available under the demonstration to assist enrollees with filing and resolving complaints, as well as providing information. According to an Ombudsman in 2020 and 2021, the highest percentage of cases seen by the Ombudsman related to incorrect billing, accounting for 40 to 50 percent of the work in any given month. These cases were most often about MMPs that relied on delegated networks and may have been related to inadequate training from MMPs on how to work with Cal MediConnect beneficiaries. As throughout the demonstration, during the reporting period, the Ombudsman program also continued to hear about billing issues with ancillary providers, such as radiology, DME and other out-of-network or non-Medi-Cal specialists brought into acute or surgical centers to provide services to Cal MediConnect enrollees.

Grievances and appeals reported by Cal MediConnect plans. 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. ***Figure 18*** and ***Figure 19*** present the number of grievances or complaints filed with the MMPs. As shown in ***Figure 18***, the average number of MMP-reported grievances per 1,000 enrollees per quarter increased from 2014 through 2017.

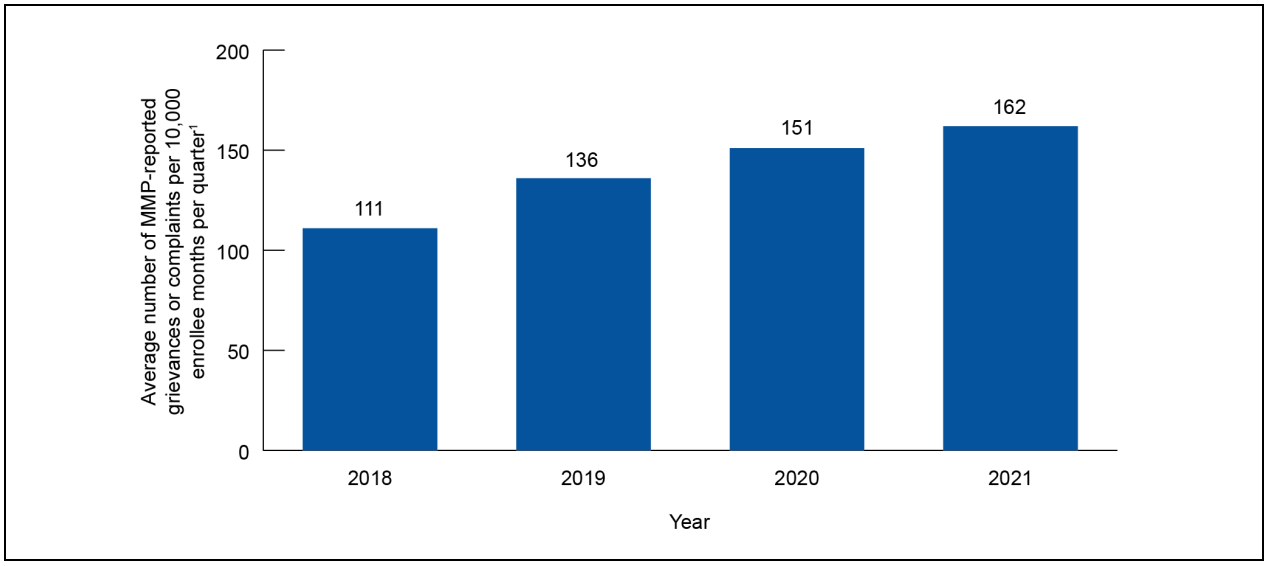
Figure 18
Average number of grievances per 1,000 enrollees per quarter, 2014–2017



MMP = Medicare-Medicaid Plan.

The way that plan-reported grievance data were analyzed changed in 2018. As shown in ***Figure 19***, in 2018 through 2021 the average number of MMP-reported grievances or complaints per 10,000 enrollee months per quarter increased.

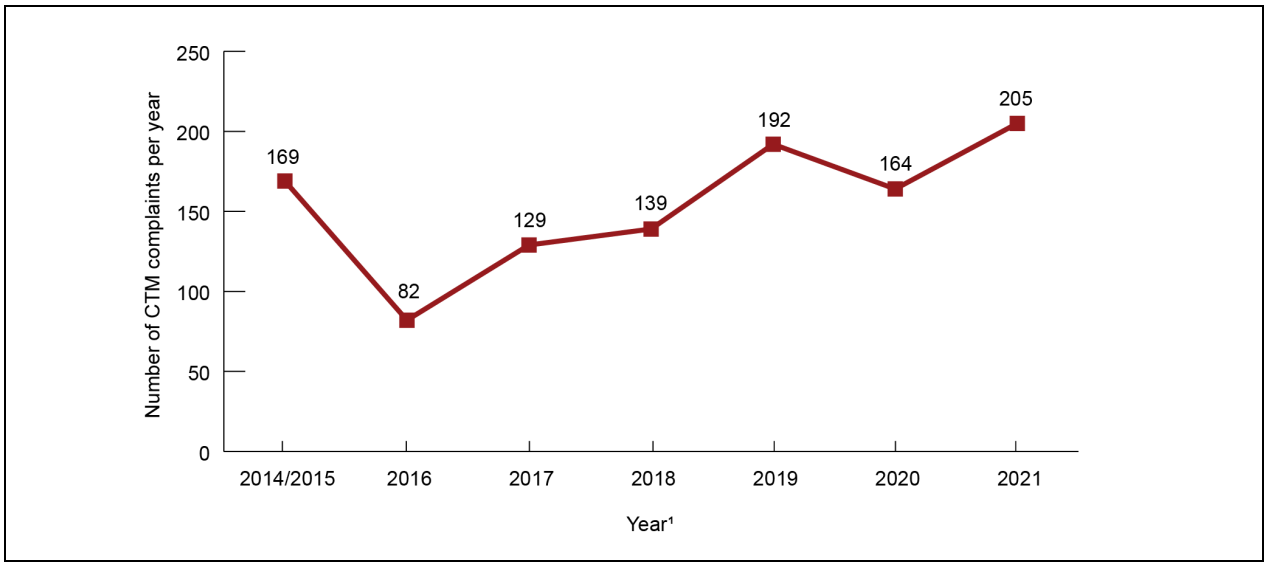
Figure 19
Average number of grievances per 10,000 enrollee months per quarter, 2018–2021



MMP = Medicare-Medicaid Plan.
[1] The way that plan-reported grievance data were analyzed changed in 2018. In 2015 through 2017, data were analyzed per 1,000 enrollees per quarter. Beginning in 2018, data were analyzed per 10,000 enrollee months per quarter.

Figure 20 shows the total number of complaints reported to the CTM by the State or through 1-800-Medicare. The number of CTM complaints varied across years and was highest in 2021. The greatest number of CTM complaints over the course of the demonstration to date was in the enrollment and disenrollment[13] category, followed by the provider specific[14] category.

Figure 20
Number of CTM complaints per year, 2014–2021



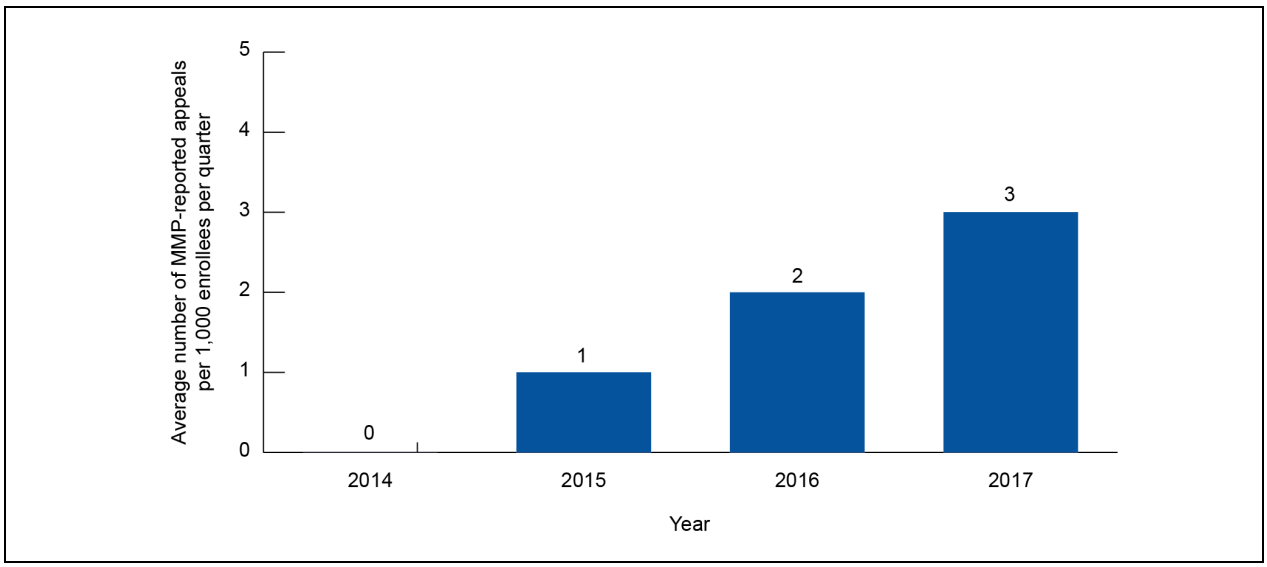
CTM = Complaint Tracking Module.
[1] Because the demonstration began in April 2014, CTM data for 2014 and 2015 were reported together.

Enrollees also have the right to appeal an MMP's decision to deny, terminate, suspend, or reduce services. Appeals must be filed with the MMP first. If the MMP denies an appeal involving Medicare-only services, or a service that could be covered by Medicare or Medicaid (i.e., an "overlap service"), the MMP automatically forwards the appeal to the Medicare IRE.

Figure 21 and ***Figure 22*** present the average number of MMP-reported appeals. As shown in ***Figure 21***, the average number of MMP-reported appeals per 1,000 enrollees per quarter remained low from 2014 through 2017.

[13] This category is defined as "Beneficiary is experiencing an enrollment issue that may require reinstatement or enrollment change."
[14] This category is defined as "claims payment, or network contracting issue."

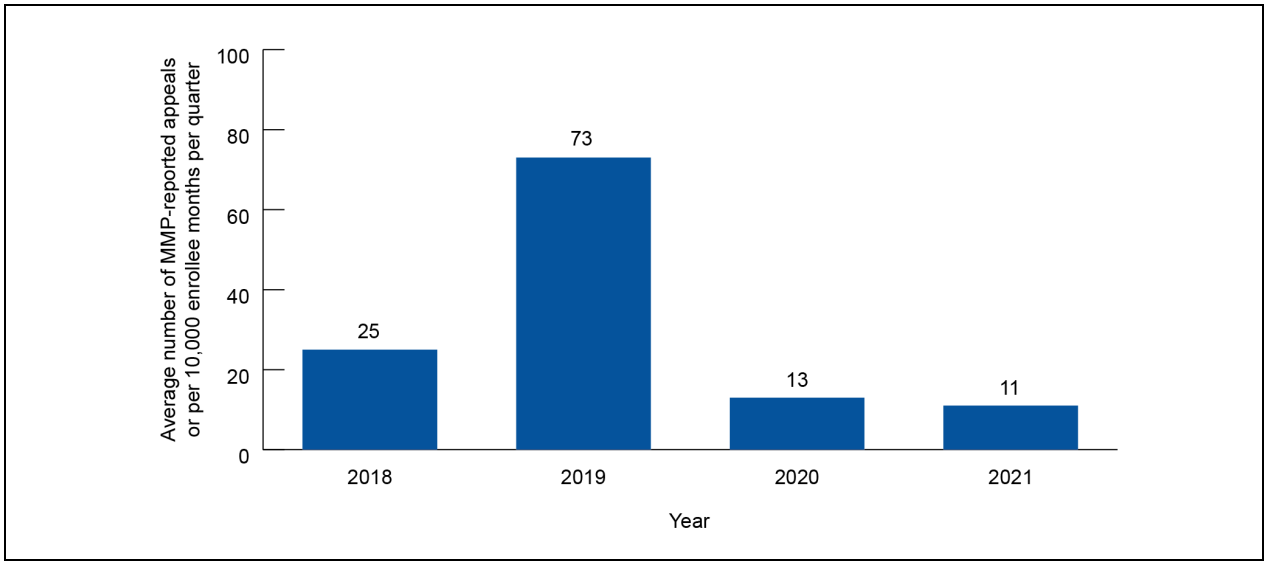
Figure 21
Average number of appeals per 1,000 enrollees per quarter, 2014–2017



MMP = Medicare-Medicaid Plan.

The way that plan-reported appeals data were analyzed changed in 2018. As shown in ***Figure 22***, in 2018 through 2021 the average number of MMP-reported appeals per 10,000 enrollee months per quarter decreased noticeably in 2020.

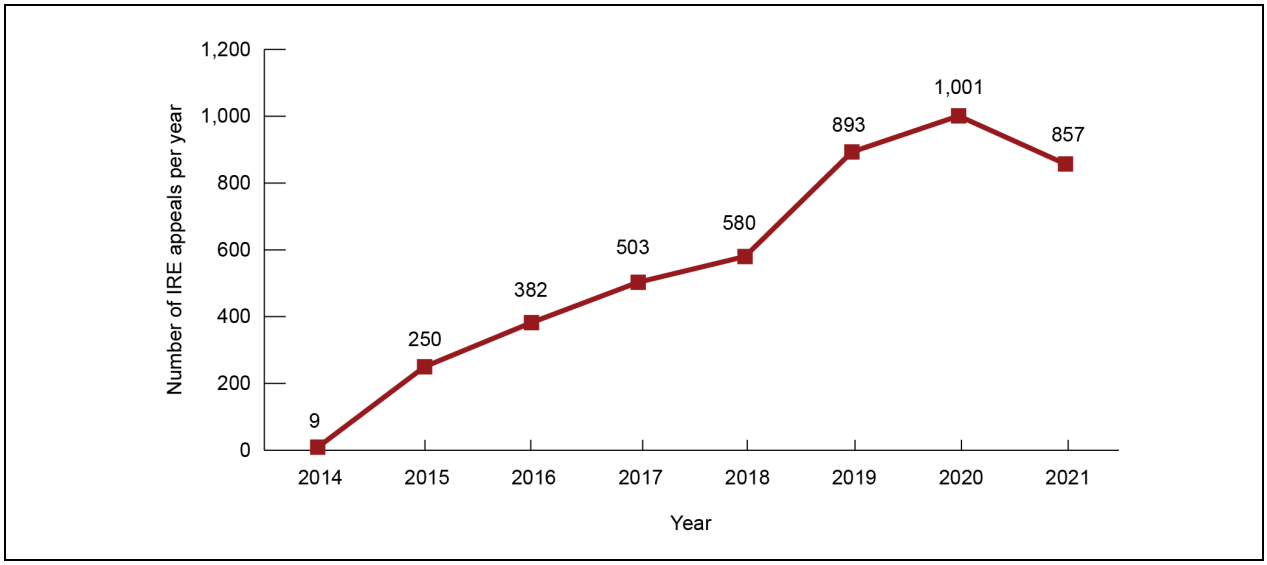
Figure 22
Average number of appeals per 10,000 enrollee months per quarter, 2018–2021



MMP = Medicare-Medicaid Plan.
[1] The way that plan-reported appeals data were analyzed changed in 2018. In 2015 through 2017, data were analyzed per 1,000 enrollees per quarter. Beginning in 2018, data were analyzed per 10,000 enrollee months per quarter.

Figure 23 shows the total number of MMP-reported appeals reported to the IRE in 2014 through 2020. Of the 4,475 MMP-reported appeals reported to the IRE in 2014 through 2021, 83 percent of the MMP decisions were upheld, 8 percent were overturned or partially overturned, 8 percent were dismissed, and a negligible amount was withdrawn or pending. The most common category of appeals referred to the IRE was for issues related to durable medical equipment.

Figure 23
Number of IRE appeals per year, 2014–2021



IRE = Independent Review Entity.

Critical Incident and Abuse Reports for Enrollees Receiving LTSS. MMPs are required to report the number of critical incidents and abuse[15] reports for enrollees receiving LTSS to CMS. From 2014 through 2021, the number of critical incidents and abuse reports per 10,000 enrollees per quarter remained below 2.1.

[15] A "critical incident" is 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: Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish; 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; rape or sexual assault; corporal punishment or striking of an individual; unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and use of bodily or chemical restraints on an individual which is not in compliance with federal or state laws and administrative regulations. The definition can be found in the State-specific reporting requirements at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements

SECTION 5

Demonstration Impact on Cost Savings

Our results show increases in Medicare Parts A and B costs cumulatively over the first five demonstration years ($62.82, per member per month [PMPM]) using a difference-in-differences (DinD) analysis of beneficiaries eligible for the demonstration, relative to the comparison group.

Our results also show increases in total Medicaid costs cumulatively over the first five demonstration years ($325.46, PMPM) using a DinD analysis of beneficiaries eligible for the demonstration, relative to the comparison group. The demonstration's launch corresponds with California's expansion of Medicaid managed care for dually eligible beneficiaries, which impacted both the demonstration group and the comparison group.

5.1 Methods Overview

As part of the capitated financial alignment model, California, CMS, and MMPs entered into a three-way contract to provide services to MMP enrollees. MMPs receive three separate, blended, risk-adjusted prospective capitated payments for Medicare Parts A and B, Medicare Part D, and Medicaid services. The first two payments are from the Medicare program, and the third comes from the State. CMS and California developed the capitation payment that accounts for the services provided and CMS adjusts the Medicare component for each enrollee using CMS's Hierarchical Condition Category (HCC) 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 Memorandum of Understanding, and the three-way contract on the FAI website.[16]

This section presents the Medicare Parts A and B cost savings analysis for demonstration years 1 to 5 (April 2014 to December 2019). This section also presents the Medicaid cost savings analysis for demonstration years 1 to 5, with the exclusion of data from May to December of 2015 due to missing capitated payments in California in those months.

We used an intent to treat (ITT) analytic framework that includes beneficiaries eligible for the demonstration rather than only those who enrolled. The ITT framework alleviates concerns of selection bias, supports generalizability of the results among the demonstration eligible population, and mimics the real-world implementation of the demonstration. For this analysis, enrolled beneficiaries account for approximately 16 percent of all eligible beneficiaries (including fee-for-service (FFS) beneficiaries, MMP enrollees, and MA enrollees) in demonstration year 5. The remaining 84 percent of those in the demonstration group are beneficiaries who are eligible for an MMP but not enrolled (non-enrollees). Results from a separate analysis, using a more restricted definition of MMP enrollees and their comparison group counterparts, are included in ***Appendix D*** (see ***Table D-9***).

[16] For the MOU, see https://www.cms.gov/files/document/camou.pdf; for the three-way contract (original), see https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAContract.pdf.

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 analyses (see ***Appendix C*** for details).

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-2*** in ***Appendix D*** summarizes each adjustment and the application of the adjustments to FFS expenditures or to the capitation rate.

To evaluate the Medicaid cost implications of the demonstration, RTI performed a DinD analysis of Medicaid expenditures using the same demonstration group that was defined for the Medicare cost savings analysis and the same regression methodology.[17] Both Pennsylvania and Wisconsin were excluded from the comparison group due to data quality concerns (see ***Appendix D*** for further details), and separate weights were calculated for this comparison group. The outcome of interest was the sum of all Medicaid costs (excluding costs for prescription drugs), both FFS and capitated payments, for the demonstration and comparison groups. Both the Federal and State contributions are included in the measure of the Medicaid total cost of care. Unless otherwise specified in ***Appendix D***, the analysis of Medicaid expenditures followed the methodology of the Medicare cost savings analysis. The main difference between the Medicare cost savings analysis and the Medicaid cost savings analysis is that due to data quality issues with the Medicaid data in two States, only a subset of the Medicare comparison group was used and separate weights were calculated to account for the smaller comparison group (see ***Appendix D*** for more details).[18]

5.2 Demonstration Impact on Medicare Parts A and B Costs

Table 8 shows the magnitude of the DinD estimate of the cumulative demonstration impact on Medicare Parts A and B cost, both in absolute dollar amount and relative to the adjusted mean expenditure level in the comparison group during the demonstration period. The adjusted mean for monthly expenditure increased from the predemonstration period to the demonstration period in both the demonstration and comparison groups. The cumulative DinD estimate of $62.82 PMPM, which amounts to a relative difference of 5.93 percent of the adjusted mean expenditure for the comparison group during the demonstration period, is statistically significant ($p < 0.001$). This suggests that overall, the California demonstration was associated with statistically significant increases relative to the comparison group.

[17] The Medicaid analysis uses all covariates used in the Medicare analysis; some additional Medicaid-specific covariates are included in the Medicaid regression analysis, as detailed in ***Appendix D***.

[18] For the Medicare cost analysis, the comparison group is drawn from Metropolitan Statistical Areas (MSAs) in Georgia, Massachusetts, Michigan, Missouri, New Jersey, North Carolina, Pennsylvania, Texas, Wisconsin, and certain MSAs in California where the demonstration does not operate. The comparison group for Medicaid cost analysis is a subset of the Medicare comparison group, and excludes Pennsylvania and Wisconsin.

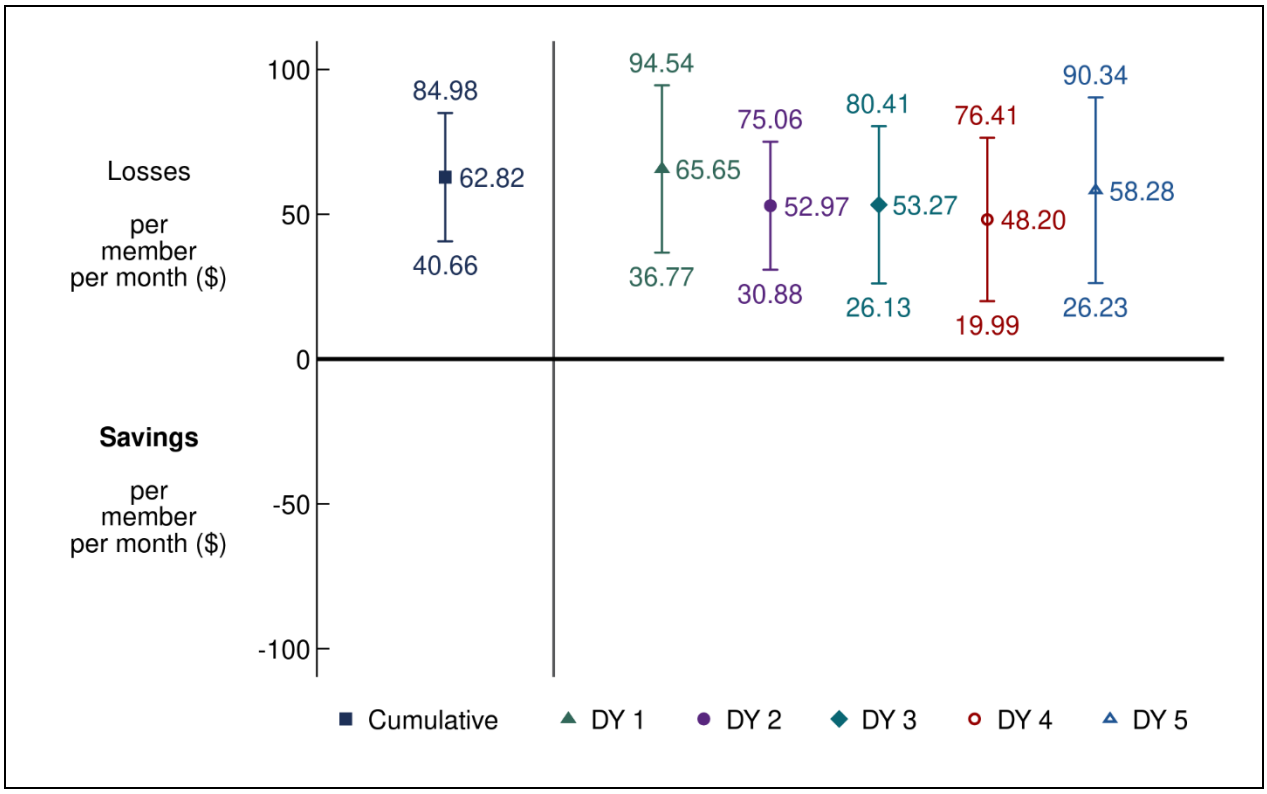
Table 8
Cumulative demonstration impact on monthly Medicare Parts A and B costs in California, demonstration years 1–5, April 1, 2014–December 31, 2019

Group	Adjusted mean for predemonstration period ($)	Adjusted mean for demonstration period ($)	Adjusted coefficient DinD ($)	Relative difference (%)	*p*-value
Demonstration	1,130.92	1,213.07	62.82	5.93	<0.001
Comparison	1,043.68	1,059.82			

DinD = difference-in-differences.
SOURCE: RTI analysis of Medicare claims (program: ca_dy5_1490_pct_tables.log)

In addition, we estimated the effect of the demonstration in each demonstration year. As shown in ***Figure 24***, the demonstration had statistically significant effects on demonstration years 1 through 5 (as shown by the confidence intervals not crossing $0). Note that these estimates rely on the ITT analytic framework, only account for Medicare Parts A and B cost, and use the capitation rate for the MMP rather than the actual amount the plan paid for services.

Figure 24
Cumulative and annual demonstration effects on monthly Medicare Parts A and B costs, demonstration years 1–5, April 1, 2014–December 31, 2019



DY = demonstration year.
NOTE: 95 percent confidence intervals are shown. "Losses"/"**Savings**" indicate increased/decreased costs for eligible beneficiaries in the demonstration group, relative to the comparison group.
SOURCE: RTI analysis of Medicare claims (program: ca_dy5_1480_GLM.log)

To better understand these results, we conducted additional descriptive analyses comparing MMP rates with the expected FFS expenditures that would have otherwise occurred for the enrolled population. The extent to which the MMP capitated payment rates are set higher or lower relative to what CMS would have paid under traditional FFS Medicare could affect the impact estimates. Overall, we found that MMP rates were largely comparable with enrollees' anticipated FFS experience. However, this finding alone is not sufficient to for the demonstration to achieve cost savings given the low enrollment in MMPs. We also conducted an analysis of spending and HCC characteristics among the enrolled population during the predemonstration period. We found that enrollees had lower costs and were healthier than the population that was demonstration eligible but never enrolled. The details of these analyses are provided in ***Appendix E***, along with an interpretation and discussion of the results.

5.3 Demonstration Impact on Medicaid Costs

Table 9 shows the magnitude of the DinD estimate of the cumulative demonstration impact on Medicaid costs, both in absolute dollar amount and relative to the adjusted mean expenditure level in the comparison group during the demonstration period. Note that the comparison group for the Medicaid cost analysis is a subset of the comparison group used in the Medicare cost analysis, with Pennsylvania and Wisconsin omitted. Medicaid-specific propensity weights balance the characteristics of the demonstration group and the comparison group (see ***Section C.6*** in ***Appendix C***). The adjusted mean monthly expenditure increased greatly from the predemonstration period to the demonstration period in the demonstration group, with a much smaller increase in the comparison group. The cumulative DinD estimate of $325.46 PMPM, which amounts to a relative difference of 32 percent of the adjusted mean expenditure for the comparison group during the demonstration period, is statistically significant ($p < 0.001$). This suggests that overall, the California demonstration was associated with statistically significant increases in Medicaid costs relative to the comparison group.

Table 9
Cumulative demonstration effect on Medicaid costs for eligible beneficiaries in California, demonstration years 1–5, April 1, 2014–December 31, 2019

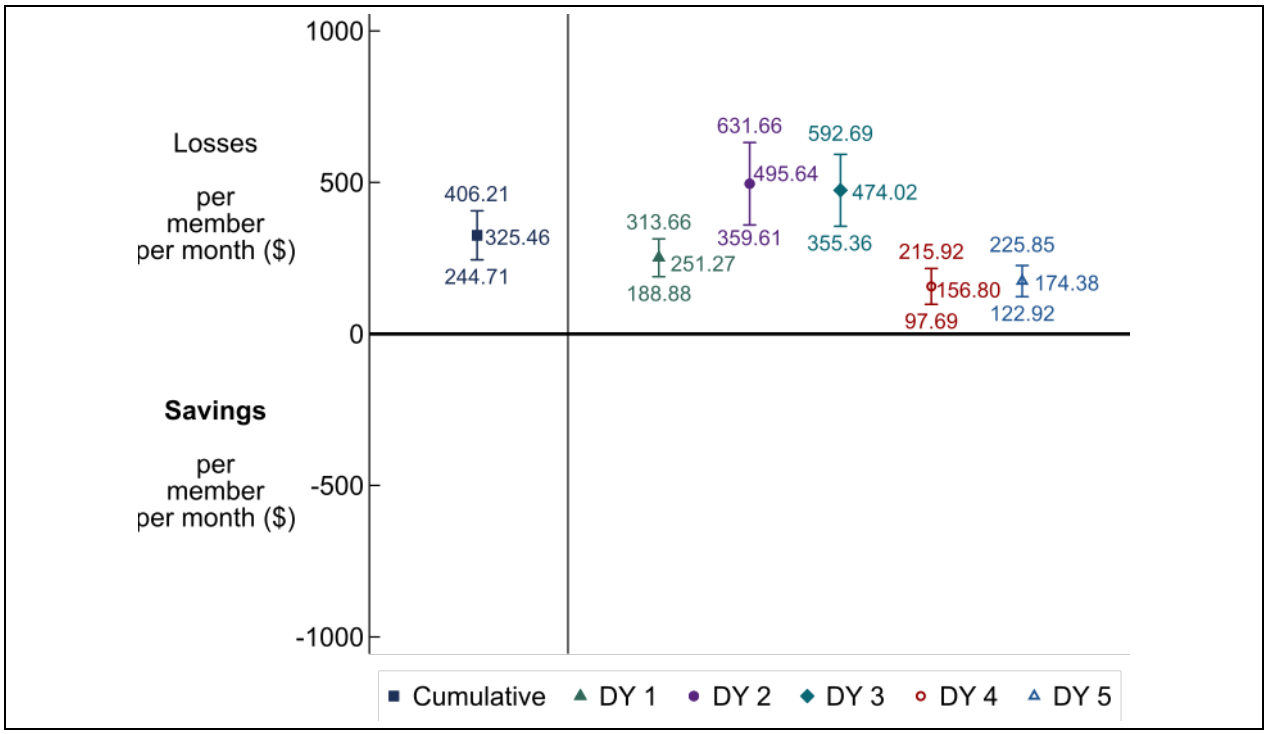
Group	Adjusted mean for predemonstration period ($)	Adjusted mean for demonstration period ($)	Adjusted coefficient DinD ($)	Relative difference (%)	*p*-value
Demonstration	852.03	1,423.54	325.46	32.00	<0.001
Comparison	857.52	1,016.91			

DinD = difference-in-differences.
SOURCE: RTI analysis of Medicaid claims (program:30_Regression.do)
NOTE: Comparison group does not include Pennsylvania or Wisconsin.

In addition, we estimated the effect of the demonstration in each of the 5 demonstration years included. As shown in ***Figure 25***, the demonstration had a statistically significant effect in all 5 demonstration years (as shown by the confidence intervals above $0) indicating increases in Medicaid costs as a result of the demonstration relative to the comparison group in each of those years. The coefficients in each of the 5 demonstration years varied in magnitude. Note that these estimates rely on the ITT analytic framework, exclude Medicaid prescription drug costs, and are

reliant upon the completeness and the correctness of the Medicaid cost data included in the T-MSIS.

Figure 25
Cumulative and annual demonstration effects on monthly Medicaid costs, demonstration years 1–5, April 1, 2014–December 31, 2019



DY = demonstration year.
NOTE: 95 percent confidence intervals are shown. "Losses"/"**Savings**" indicate increased/decreased costs for eligible beneficiaries in the demonstration group, relative to the comparison group.
SOURCE: RTI analysis of Medicaid claims (program: 30_Regression.do)

There are some caveats to this analysis. First, this analysis is contingent on the quality and completeness of data in the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF). Medi-Cal representatives indicated that submission errors of T-MSIS data may have resulted in duplication of select payments. We conducted a sensitivity analysis and found the results to be robust at the maximum level of suspected errors with no substantive change in the conclusion drawn from the evaluation findings (see ***Appendix D*** for more details). Second, the start of the demonstration corresponds with California's expansion of mandatory Medicaid managed care for dually eligible beneficiaries, as well as the Medicaid managed care carve-in of skilled nursing facility care and the Medicaid 1915(c) waiver. These policy changes might also influence the results, though they impacted both the demonstration group and the comparison group. Additional sensitivity analyses restricting the outcome model to enrollees-only resulted in a similar DinD estimate to the main ITT model. Finally, this analysis cannot account for the finalized risk corridor payments to the MMPs, which may result in changes in the observed PMPMs during the demonstration period.

SECTION 6

Conclusions

6.1 Implementation Successes, Challenges, and Lessons Learned

By the end of 2021, Cal MediConnect MMPs reported stable enrollment of around 115,000, more productive engagement with stakeholders, improved communication with participating providers, and support from DHCS and CMS in responding to the challenges of delivering health care services to enrollees during the PHE. MMPs identified State and CMS' joint management of the demonstration as a major success, allowing them to effectively problem-solve and receive guidance and support in the most challenging areas of demonstration implementation. Changes in Cal MediConnect services and the experience of enrollees and MMPs during 2020–2021 were largely shaped by the PHE and the policy flexibilities allowed by CMS and the State to support the delivery of health care and social supports by different modalities.

Stakeholders and MMPs reported that maintaining enrollment was challenging given the temporary nature of the demonstration and the competitive California managed care environment, including brokers actively recruiting enrollees and eligible beneficiaries into D-SNP look-alike plans. Cal MediConnect enrollment, i.e., implementation reach, consistently ranged between 20 percent and 25 percent of all eligible beneficiaries but has never increased above 25 percent. With DHCS planning a seamless transition into EAE D-SNPs for Cal MediConnect enrollees, the enrollment maintenance challenge was exacerbated by Medicare constraints on how soon this transition to EAE D-SNPs could be communicated and explained to Cal MediConnect enrollees.

Engagement among providers was lacking in the early demonstration years but improved gradually with higher levels of DHCS investment in outreach and provider education. These DHCS activities are described in the Preliminary Second Evaluation Report. By 2021, most participating providers seemed to be supportive of the demonstration and knowledgeable about billing and other processes. Although ombudsman data still indicated billing issues as the largest complaint category, the number of the billing challenges decreased substantially in the most recent demonstration years. Despite the State's increased outreach and provider education efforts, the complexities of operating under a multi-delegation system posed some challenges that persisted throughout demonstration implementation.

Although the Cal MediConnect demonstration operated with a high degree of fidelity to the original design in implementing enrollment and other features, it also underwent several key changes that posed both implementation challenges and opportunities. The carve-out of IHSS made care coordination with IHSS providers more challenging for MMPs and led to a decline in carved-out program staff participation in care teams. For most of the demonstration, the provision of CPO services was minimal and inconsistent across plans, but new Community Supports implemented in 2022 gave MMPs an opportunity to support beneficiary SDOH needs and bill Medi-Cal for these services. Results on the uptake of Community Supports during 2022 remain to be seen.

Care coordination remained the most valuable component of Cal MediConnect with engaged enrollees appreciating their relationship with a care coordinator. Key achievements of the Cal MediConnect demonstration include elevating care coordination to a regular service

available to all dually eligible beneficiaries under the demonstration, as well as educating MMPs, providers, and beneficiaries about the value of this service and building an infrastructure for its delivery. However, various challenges described in our evaluation reports diminished care coordination reach, leaving many enrollees unable to experience its benefits. Although MMP care coordination requirements and standards were defined in the three-way contracts and associated DHCS Duals Plan Letters, there were significant inconsistencies in how MMPs chose to implement those requirements and deliver care coordination services. As a result, this lack of a uniform approach to care coordination led to great variability in beneficiary experience with care coordination.

On the fiscal side, MMPs considered Cal MediConnect a challenging product to implement. Parent managed care organizations did not view their Cal MediConnect plans as profitable especially when compared to other lines of business, largely due to reductions in capitation payments not required of other types of plans and long reconciliation times for Medi-Cal payments. Serving dually eligible beneficiaries is resource intensive and required a significant learning curve, hiring and training new types of staff, and developing a new infrastructure and data systems. Additionally, MMPs participating in the demonstration differ significantly in their size, profit status, infrastructure, and the importance of Cal MediConnect to their core business relative to their other products. These differences influenced plans' level of investment in the demonstration, relationships with providers and county agencies, and the ability to scale up, tolerate losses, and be flexible.

State officials as well as MMPs reported several lessons learned from the Cal MediConnect experience so far. First, messaging complex health care and enrollment information to a vulnerable population, while complying with Medicare marketing rules and regulations, requires extensive planning, stakeholder involvement, and materials testing with beneficiaries.

Second, close relationships with and early involvement of stakeholders and providers is key for successful demonstration design and implementation. A productive relationship between DHCS and stakeholders was crucial for implementation success and evolved into mutual support and assistance. By 2021, DHCS had also demonstrated an intentional commitment to applying lessons learned from Cal MediConnect implementation and incorporating stakeholders' feedback into the strategy for transitioning from Cal MediConnect to EAE D-SNPs.

Third, data quality and supporting infrastructure are crucial. Pervasive data quality problems resulted in numerous early implementation and evaluation challenges. For example, incorrect beneficiary contact information diminished the overall Cal MediConnect reach throughout the demonstration and a variety of early enrollment file problems affected more than 30,000 enrollees, causing delayed notices, inappropriate or premature enrollments, or incorrectly processed opt-out requests. MMPs and stakeholders often reported that data exchange difficulties hampered care coordination and the ability of providers to communicate effectively as part of the ICT.

States' perceptions of whether and how the demonstration was successful is our fourth measure of implementation effectiveness. Overall, State officials reported that they consider Cal MediConnect a successfully implemented demonstration for the following reasons. First, they

were able, without major design changes, to implement a large-scale model across seven counties and put in place care coordination structures that can be leveraged in moving integrated care forward statewide. Second, the dementia care provision component from Cal MediConnect was so well-received that it will become a standard CalAIM component and is already included in the CalAIM policy guide. And third, Cal MediConnect allowed the State to practice and finesse a population health management strategy that includes risk assessment and stratification; this approach will be developed broadly and will be implemented beyond demonstration counties. In terms of monitoring Cal MediConnect implementation, the State viewed their performance dashboard as an important tool but acknowledged that it took a long time to improve data quality and understand how to set the right baselines and benchmarks for the measures they are tracking.

Reflecting on the success of the demonstration to-date, CMS said that the challenges of the California managed care system and the complexity of working with counties and carved-out programs, such as IHSS, constrained the ability of Cal MediConnect MMPs to achieve some of the original demonstration goals, such as effective care coordination with LTSS and BH services. However, Cal MediConnect achieved some important successes. These successes included the experience of delivering an integrated product through the MMPs, and building and strengthening productive relationships with a large number of stakeholders, such as advocates and CBOs that provide different services and supports to enrollees. Moreover, the Cal MediConnect experience cemented the State's commitment to offer integrated care statewide through CalAIM, negotiate needed Medicaid authorities to implement CalAIM after the Cal MediConnect sunset, and fund the DHCS Office for Medicare Innovation and Integration.

6.2 Demonstration Impact on Cost Savings

The cumulative cost analysis found a statistically significant cost increase of $62.82, PMPM, to the Medicare program over the first 5 demonstration years. The analysis of individual demonstration years also found increased costs in each year. Several factors could explain why savings have not materialized. Enrollees represented only about 16 percent of all demonstration eligible beneficiaries in CY 2019, and the analysis of the demonstration's impact on Medicare costs used an ITT approach that included all eligible beneficiaries, not only those enrolled in the demonstration, to alleviate concerns about selection bias in enrollment that could not be replicated in the comparison group. As such, the spending among the eligible but not enrolled could obscure any savings achieved among the enrolled population. Moreover, Medicare spending in the comparison group increased at a slower rate than in the demonstration group. There may be unobservable characteristics influencing a different rate of change in Medicare spending in the comparison group relative to the demonstration group.

Our findings also indicate increased Medicaid cost as a result of the California demonstration. The results of the Medicaid cost savings analyses using a DinD regression approach indicate a statistically significant increase of $325.46, PMPM, cumulatively over the first 5 demonstration years.

6.3 Summary

California has achieved some successes with the Cal MediConnect demonstration and learned important lessons that have laid the groundwork for integrated care expansion statewide. At the conclusion of the demonstration the State will transition to the CalAIM model, which will include exclusively aligned D-SNPs statewide.

Except for LTSS carve-outs, the demonstration had strong fidelity to the original design, and in late 2021 had about 115,000 enrollees, which represents just under a quarter of the eligible beneficiaries. The State educated MMPs about the needs of dually eligible beneficiaries and forged ongoing and productive relationships with stakeholders. State administrators also noted the importance of working with the CMT who filled an important knowledge gap regarding Medicare services and regulations, and supported Cal MediConnect leadership and MMPs in resolving implementation challenges.

Although enrollment in the demonstration was low, with Cal MediConnect reach never rising above 25 percent of the eligible population, according to CAHPS data, beneficiary satisfaction with their MMPs was high. Beneficiaries appreciated having integrated materials and member ID cards but generally found the Cal MediConnect materials confusing. There was no universal improvement on HEDIS measures.

A key challenge for increasing Cal MediConnect enrollment was California's complex managed care environment, with D-SNP look-alike plans competing with the demonstration for enrollment in some counties. State data indicate that higher need beneficiaries disenrolled at a higher rate. This may have impacted cost savings results which showed increases in Medicare and Medicaid costs among all eligible beneficiaries in the demonstration group relative to their counterpart in the comparison group.

Care coordination was highly valued among those beneficiaries who were engaged with their care coordinators, but overall, care coordination uptake was limited. In addition, there was great variation among MMPs in their care coordination models with some delegating these services to other organizations. Carve-outs of LTSS waiver services, including IHSS and MSSP, made it difficult to implement care coordination and lessened MMPs' ability to leverage community LTSS to improve outcomes. In the last years of the demonstration, and especially during the PHE, MMPs reported working hard to address beneficiaries' SDOH needs, analyzing data extensively to detect access to care barriers and health care disparities. Some examples of MMPs' work to address beneficiary SDOH included meal deliveries, efforts to resolve homelessness, home modifications, activities to address isolation, and connections to various community organizations.

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Appendix A

Data Sources

Key informant interviews. The RTI evaluation team conducted telephonic site visit interviews with California key informants in 2020 and 2021. The team interviewed the following types of participants: Centers for Medicare and Medicaid Services (CMS), State, and plan officials, stakeholders, ombudsman program officials, and advocates. To monitor demonstration progress, the RTI evaluation team also engages in periodic phone conversations with the California Department of Health Care Services (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.

Beneficiary satisfaction surveys. Medicare requires all Medicare Advantage (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 2015-2021 survey questions. In response to the COVID-19 Public Health Emergency (PHE), CMS did not require Medicare-Medicaid Plans (MMPs) to collect CAHPS data for 2020. 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.

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.[19,20] 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;[21] and other publicly available materials on the California Cal MediConnect website (CalDuals.org) and the DHCS website.[22]

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[19] Data are reported for 2014–2019.

[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

[21] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html

[22] https://www.dhcs.ca.gov/

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,[23] 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 MA plans. In response to the PHE, 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 those data becoming available later in 2021.

Medicare and Medicaid Cost data. Two primary data sources were used to support the savings analyses, capitation payments and fee-for-service (FFS) Medicare claims. Medicare capitation payments paid to Cal MediConnect plans during the demonstration period were obtained for all MMP enrollees and for eligible MA beneficiaries from the 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 (February 2022). 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. Risk corridor settlements were not included in this analysis. Capitation payments and FFS Medicare claims were used to calculate expenditures for all comparison group beneficiaries, demonstration group beneficiaries in the baseline period, and demonstration eligible beneficiaries who were not enrolled during the demonstration period. FFS claims included all Medicare Parts A and B services.

Medicaid Research Identifiable Files (RIFs) were used to calculate total Medicaid FFS and Medicaid Managed Care payments among demonstration and comparison group eligible beneficiaries. The source of Medicaid claims data for all States for calendar years 2012–2013 (which includes the first 21 months of the predemonstration period) was the Medicaid Statistical Information System (MSIS) Medicaid Analytic eXtract (MAX). The source for the Medicaid claims data for all States for calendar years 2016–2019 (which includes the demonstration years 2–5) was the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF). For 2014 (last 3 months of the predemonstration period and first 9 months of the first demonstration year), the source of Medicaid claims data for all States except North Carolina was the MAX; and the source of Medicaid claims data for North Carolina was the TAF. For 2015 (latter 12 months of the first demonstration year), the source of Medicaid claims data for

[23] 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.

California, Georgia, Michigan, Missouri, and New Jersey was the MAX; and the source of Medicaid claims for Massachusetts, North Carolina, and Texas was the TAF.

Appendix B

Cal MediConnect MMP Performance on Select HEDIS Quality Measures, 2015–2020

Tables B-1a, B-1b, and B-1c provide 2015 through 2020 HEDIS performance data for Cal MediConnect 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 2020.

Anthem improved performance over time on emergency department visits per 1,000 members.

Cal Optima improved over time on measures for adults' access to preventive/ambulatory health services, colorectal cancer screening, disease modifying anti-rheumatic drug therapy in rheumatoid arthritis, effective acute phase treatment and effective continuation phase treatment (both within antidepressant medication management), and outpatient visits per 1,000 members, but worsened performance over time on breast cancer screening.

Community Health Group improved performance over time on outpatient visits per 1,000 members.

Health Net improved over time on measures for adults' access to preventive/ambulatory health services and effective acute phase treatment (within antidepressant medication management).

Health Plan of San Mateo improved over time on outpatient visits per 1,000 members, but worsened performance over time on breast cancer screening.

Inland Empire Health Plan improved over time on measures for colorectal cancer screening and both ambulatory care submeasures (outpatient and emergency department visits per 1,000 members).

LA Care improved over time on measures for adults' access to preventive/ambulatory health services and adult body mass index (BMI) assessment.

Molina improved over time on measures for functional status assessment (within Care for Older Adults submeasures) and both ambulatory care submeasures (outpatient and emergency department visits per 1,000 members).

Santa Clara Family Health Plan improved over time on measures for 30-day follow-up after hospitalization for mental illness and outpatient visits per 1,000 members.

Table B-1a
Cal MediConnect MMP performance on select HEDIS quality measures for 2015–2020[1] by MMP

Measure	National MA Plan Mean	Anthem					Cal Optima[2]				Care 1st				
	2020	2015	2016	2017	2018	2020	2016	2017	2018	2020	2015	2016	2017	2018	2020
Adults' access to preventive/ ambulatory health services	93.7	71.1	61.9	65.9	70.7	85.7	86.9 G	87.7 G	90.1 G	90.3 G	78.1	80.7	80.5	80.3	81.5
Adult BMI assessment[3]	N/A	87.5	87.9	88.3	93.5	—	96.1	99.0	96.0	—	91.0	93.2	90.8	94.3	—
Blood pressure control[4]	62.6	62.9	59.5	68.9	67.9	63.5	70.0	76.7	73.2	71.1	58.6	64.8	63.2	66.1	59.1
Breast cancer screening	68.9	69.1	63.8	60.1	62.5	57.1	70.3 R	66.9 R	65.0 R	61.2 R	65.7	60.4	60.1	60.0	58.7
Colorectal cancer screening	69.2	74.1	56.0	56.9	60.0	59.4	61.3 G	62.0 G	63.0 G	63.7 G	53.3	50.2	62.8	55.2	51.8
Disease modifying anti-rheumatic drug therapy in rheumatoid arthritis	77.6	73.4	81.0	79.7	88.6	80.6	66.4 G	70.4 G	72.3 G	73.8 G	76.2	68.2	73.5	75.0	72.1
Follow-up after hospitalization for mental illness (30 days)[5]	49.6	N/A	23.7	52.1	N/A	29.0	59.4	46.8	37.4	57.0	28.6	33.3	33.3	19.3	34.6
Antidepressant medication management															
Effective acute phase treatment[6]	78.2	60.7	59.4	71.7	72.7	79.5	60.6 G	62.6 G	65.0 G	79.6 G	62.8	70.0	70.5	70.4	80.0
Effective continuation phase treatment[7]	63.0	46.0	40.1	55.8	52.1	66.4	43.2 G	45.4 G	46.4 G	58.9 G	52.8	62.1	54.1	59.9	61.7
Care for older adults															
Advance care planning	N/A	53.0	30.0	63.7	56.5	54.9	41.2	42.3	45.7	43.8	22.9	37.9	37.4	41.3	41.5
Medication review	N/A	47.2	37.8	57.3	72.9	71.0	74.5	79.8	84.2	78.6	69.8	73.8	68.2	60.8	43.6
Functional status assessment	N/A	55.6	37.3	74.3	70.4	79.1	55.3	59.4	65.5	50.9	38.5	48.3	52.5	46.6	65.2
Pain assessment	N/A	58.5	39.6	78.6	77.2	80.4	78.7	75.7	81.5	79.3	62.0	75.4	72.0	63.2	65.7

(continued)

Table B-1a (continued)
Cal MediConnect MMP performance on select HEDIS quality measures for 2015–2020 by MMP

Measure	National MA Plan mean	Anthem					Cal Optima[2]				Care 1st				
	2020	2015	2016	2017	2018	2020	2016	2017	2018	2020	2015	2016	2017	2018	2020
Comprehensive diabetes care															
Received Hemoglobin A1c (HbA1c) testing	91.7	92.3	89.6	91.2	88.9	87.4	86.8	90.1	91.0	85.7	90.3	90.3	91.0	90.3	90.1
Poor control of HbA1c level (>9.0%) (higher is worse)	28.0	26.2	31.7	25.6	26.1	24.1	29.4	21.9	18.6	26.0	42.6	36.3	38.9	40.2	30.5
Good control of HbA1c level (<8.0%)	62.3	65.1	57.2	61.6	57.8	64.2	61.8	70.2	72.0	63.2	48.7	56.2	52.1	49.6	56.6
Received eye exam (retinal)	67.9	63.7	53.2	65.7	65.6	56.0	75.9	77.6	80.8	74.6	59.6	65.9	72.5	74.5	64.5
Received medical attention for nephropathy	94.1	93.8	94.7	96.6	96.2	95.4	94.4	95.2	96.1	94.0	96.8	96.8	94.9	96.4	94.8
Blood pressure control (<140/90 mm Hg)	64.4	64.2	51.9	59.1	64.3	67.9	69.4	69.9	74.3	73.7	54.7	67.2	66.9	67.2	60.8
Initiation and engagement of alcohol and other drug (AOD) dependence treatment															
Initiation of AOD treatment[8]	33.5	12.8	13.0	9.0	8.9	9.8	—	24.2	21.6	23.3	47.4	45.1	23.0	70.9	35.6
Engagement of AOD treatment[9]	5.2	1.4	0.5	0.4	0.6	0.5	—	1.6	1.2	3.7	3.6	3.7	2.8	5.9	6.5
Plan all-cause readmissions (Observed-to-expected ratio[10])															
Age 18-64	1.08	0.66	0.62	0.81	0.54	1.06	0.90	0.85	0.77	0.86	0.85	1.02	0.77	0.77	1.16
Age 65+	1.12	0.80	0.62	0.61	0.71	0.95	0.79	0.77	0.66	1.17	0.96	1.11	0.75	0.81	1.40
Ambulatory care (per 1,000 members[11])															
Outpatient visits	N/A	4,839.6	4,816.3	5,415.4	5,439.5	—	6,815.2 G	7,652.4 G	8,544.8 G	—	9,447.4	7,542.3	7,845.5	13,088.7	—
Emergency department visits (higher is worse)	N/A	534.7 G	516.1 G	486.8 G	438.1 G	—	439.8	463.5	448.4	—	552.3	514.3	521.9	542.2	—

(continued)

Table B-1a (continued)
Cal MediConnect MMP performance on select HEDIS quality measures for 2015–2020 by MMP

— = not available, where the plan did not provide HEDIS data for this measure; BMI = body mass index; HEDIS = Healthcare Effectiveness Data and Information Set; MA = Medicare Advantage; MMAI = Medicare-Medicaid Alignment Initiative; MMP = Medicare-Medicaid 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.

[1] In response to the COVID-19 Public Health Emergency, CMS did not require Medicare plans (including MMPs) to submit HEDIS data covering the 2019 measurement year. Therefore, we omitted a column for the 2019 measurement year.

[2] Cal Optima did not report HEDIS data for the 2015 measurement year.

[3] Adult BMI assessment was retired from HEDIS in 2020. Therefore, MMPs did not provide HEDIS data for this measure for the 2020 measurement year.

[4] 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.

[5] NCQA implemented a significant specification change with HEDIS 2017, disallowing same-day follow-up visits. National benchmarks fell from HEDIS 2017 to HEDIS 2018.

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

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

[8] 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.

[9] 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.

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

[11] Measures for Outpatient visits and Emergency department visits (both within Ambulatory Care per 1,000 members) were retired from HEDIS in 2019. Therefore, MMPs did not provide HEDIS data for these measures for the 2020 measurement year.

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 2020 HEDIS measures.

Table B-1b
Cal MediConnect MMP performance on select HEDIS quality measures for 2015–2020[1] by MMP

Measure	National MA Plan mean	CHG					Health Net					HPSM				
	2020	2015	2016	2017	2018	2020	2015	2016	2017	2018	2020	2015	2016	2017	2018	2020
Adults' access to preventive/ambulatory health services	93.7	87.0	90.8	93.9	95.9	94.5	73.7 G	75.0 G	75.7 G	76.6 G	80.3 G	94.4	95.0	96.1	96.8	94.3
Adult BMI assessment[2]	N/A	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[3]	62.6	54.0	55.7	59.6	68.4	59.4	63.0	60.9	65.6	65.2	62.0	70.3	64.4	70.5	71.5	66.2
Breast cancer screening	68.9	72.2	67.8	67.0	70.5	71.1	65.1	57.6	54.4	53.2	56.6	69.7 R	67.8 R	66.8 R	66.6 R	61.9 R
Colorectal cancer screening	69.2	64.2	59.1	68.1	71.5	68.9	64.0	38.5	48.2	47.9	51.7	61.8	59.4	60.3	60.8	62.3
Disease modifying anti-rheumatic drug therapy in rheumatoid arthritis	77.6	85.5	81.1	79.7	84.6	80.5	66.2	71.8	70.1	78.4	76.8	80.9	82.7	82.9	86.7	80.0
Follow-up after hospitalization for mental illness (30 days)[4]	49.6	40.3	37.2	51.7	47.9	58.5	28.1	24.8	36.7	36.8	36.6	39.2	64.8	68.5	60.8	37.5
Antidepressant medication management																
Effective acute phase treatment[5]	78.2	68.1	64.4	68.9	72.7	80.2	55.1 G	57.0 G	60.6 G	61.6 G	76.4 G	70.2	62.6	70.9	68.6	74.0
Effective continuation phase treatment[6]	63.0	54.0	48.5	49.1	57.8	61.5	37.4	37.7	44.4	43.0	55.4	56.2	46.7	51.8	51.6	60.7
Care for older adults																
Advance care planning	N/A	52.6	72.5	79.3	97.8	70.6	39.2	33.8	37.0	40.4	46.0	26.3	29.2	46.0	38.9	57.0
Medication review	N/A	70.6	81.3	86.4	92.2	72.0	99.4	99.5	99.0	95.3	73.9	75.2	72.3	79.1	74.5	75.2
Functional status assessment	N/A	54.0	71.1	78.1	96.1	68.4	73.2	64.5	65.5	72.1	84.0	44.0	42.6	54.0	59.9	64.6
Pain assessment	N/A	56.9	73.5	76.2	96.6	70.1	70.1	67.0	66.7	71.4	77.8	71.8	71.8	79.6	78.1	79.8

(continued)

Table B-1b (continued)
Cal MediConnect MMP performance on select HEDIS quality measures for 2015–2020[1] by MMP

Measure	National MA Plan mean	CHG					Health Net					HPSM				
	2020	2015	2016	2017	2018	2020	2015	2016	2017	2018	2020	2015	2016	2017	2018	2020
Comprehensive diabetes care																
Received Hemoglobin A1c (HbA1c) testing	91.7	92.7	93.7	93.1	94.7	88.6	87.4	89.1	92.0	90.3	87.5	90.0	92.9	95.7	92.2	88.0
Poor control of HbA1c level (>9.0%) (higher is worse)	28.0	34.8	22.1	19.9	17.5	26.0	31.1	26.2	23.2	25.3	27.1	48.9	31.9	31.9	34.2	31.4
Good control of HbA1c level (<8.0%)	62.3	55.2	63.8	69.7	71.3	62.5	56.9	62.2	66.8	63.3	61.4	46.2	59.4	59.6	56.3	58.1
Received eye exam (retinal)	67.9	54.0	75.9	85.2	83.7	74.9	60.3	70.9	72.7	72.2	66.8	72.5	71.5	74.9	73.9	71.6
Received medical attention for nephropathy	94.1	95.9	96.9	96.2	95.6	93.4	94.4	93.6	96.7	96.0	94.2	94.7	93.9	94.5	94.2	94.8
Blood pressure control (<140/90 mm Hg)	64.4	59.4	69.6	71.5	67.9	57.7	61.6	64.0	70.6	70.1	66.5	65.5	62.8	64.3	68.6	64.3
Initiation and engagement of alcohol and other drug (AOD) dependence treatment																
Initiation of AOD treatment[7]	33.5	35.5	24.9	26.4	32.7	33.8	27.1	23.3	19.3	23.2	22.0	34.7	36.9	26.9	22.6	22.7
Engagement of AOD treatment[8]	5.2	2.3	1.8	0.4	3.0	4.8	2.8	1.8	2.6	1.5	2.7	6.6	3.2	5.0	4.3	2.2
Plan all-cause readmissions (Observed-to-expected ratio[9])																
Age 18-64	1.08	1.13	0.90	0.80	0.70	1.00	0.98	0.96	0.95	0.76	1.01	0.60	0.79	0.72	0.66	0.98
Age 65+	1.12	0.87	0.96	0.90	0.71	1.03	0.99	0.87	0.85	0.79	1.10	0.80	0.82	0.79	0.65	1.01

(continued)

Table B-1b (continued)
Cal MediConnect MMP performance on select HEDIS quality measures for 2015–2020[1] by MMP

Measure	National MA Plan mean	CHG					Health Net					HPSM				
	2020	2015	2016	2017	2018	2020	2015	2016	2017	2018	2020	2015	2016	2017	2018	2020
Ambulatory care (per 1,000 members[10])																
Outpatient visits	N/A	7,415.1 G	8,737.6 G	9,961.3 G	10,816.4 G	—	4,758.6	5,823.3	6,038.4	5,852.5	—	12,108.8 G	12,534.0 G	12,966.1 G	13,058.6 G	—
Emergency department visits (higher is worse)	N/A	622.2	546.6	553.7	516.0	—	479.5	480.3	447.0	425.6	—	701.4	683.5	694.1	670.8	—

— = not available, where the plan did not provide HEDIS data for this measure; BMI = body mass index; CHG = Community Health Group; HEDIS = Healthcare Effectiveness Data and Information Set; HPSM = Health Plan of San Mateo; MA = Medicare Advantage; MMAI = Medicare-Medicaid Alignment Initiative; MMP = Medicare-Medicaid 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.

[1] In response to the COVID-19 Public Health Emergency, CMS did not require Medicare plans (including MMPs) to submit HEDIS data covering the 2019 measurement year. Therefore, we omitted a column for the 2019 measurement year.

[2] Adult BMI assessment was retired from HEDIS in 2020. Therefore, MMPs did not provide HEDIS data for this measure for the 2020 measurement year.

[3] 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.

[4] NCQA implemented a significant specification change with HEDIS 2017, disallowing same-day follow-up visits. National benchmarks fell from HEDIS 2017 to HEDIS 2018.

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

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

[7] 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.

[8] 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.

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

[10] Measures for Outpatient visits and Emergency department visits (both within Ambulatory Care per 1,000 members) were retired from HEDIS in 2019. Therefore, MMPs did not provide HEDIS data for these measures for the 2020 measurement year.

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 2020 HEDIS measures.

Table B-1c
Cal MediConnect MMP performance on select HEDIS quality measures for 2015–2020[1] by MMP

Measure	National MA Plan mean	IEHP					LA Care					Molina					SCFHP				
	2020	2015	2016	2017	2018	2020	2015	2016	2017	2018	2020	2015	2016	2017	2018	2020	2015	2016	2017	2018	2020
Adults' access to preventive/ambulatory health services	93.7	89.6	91.8	92.4	92.6	91.6	75.4 G	77.1 G	79.5 G	83.2 G	86.8 G	73.4	78.9	81.6	82.3	79.5	88.2	89.9	92.0	94.2	91.3
Adult BMI assessment[2]	N/A	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[3]	62.6	62.3	62.8	62.5	66.9	59.4	56.2	66.9	69.5	73.2	59.1	49.5	54.6	58.2	70.1	58.2	—	60.1	67.4	63.5	59.9
Breast cancer screening	68.9	65.4	68.8	69.4	70.4	64.5	61.2	62.6	60.1	63.7	62.0	61.3	53.9	58.3	61.4	56.2	33.9	45.1	60.4	65.6	65.0
Colorectal cancer screening	69.2	57.4 G	60.7 G	64.0 G	65.2 G	67.9 G	45.3	48.4	57.7	61.0	55.5	64.0	49.5	56.9	56.0	58.9	41.9	55.7	56.2	62.0	60.3
Disease modifying anti-rheumatic drug therapy in rheumatoid arthritis	77.6	73.1	72.2	73.6	73.1	75.7	71.0	73.9	72.0	75.7	77.4	71.4	73.4	75.6	69.7	74.4	93.9	89.7	88.0	85.2	92.0
Follow-up after hospitalization for mental illness (30 days)[4]	49.6	49.8	60.2	50.6	52.7	54.0	11.9	42.0	46.9	49.0	50.8	37.8	51.8	45.2	48.2	32.4	26.3 G	38.5 G	46.3 G	64.3 G	N/A
Antidepressant medication management																					
Effective acute phase treatment[5]	78.2	65.0	64.6	67.3	67.8	81.1	48.3	64.2	65.7	64.8	73.0	63.0	57.9	62.4	61.2	71.5	75.2	52.4	73.7	71.4	75.0
Effective continuation phase treatment[6]	63.0	49.2	48.4	50.6	51.7	64.8	34.6	46.3	53.9	57.2	53.8	48.4	40.3	45.2	44.1	56.1	70.3	39.1	61.9	58.4	61.6
Care for older adults																					
Advance care planning	N/A	54.6	62.7	59.4	55.7	58.2	33.6	39.2	38.2	43.3	46.5	23.8	36.4	43.7	48.1	46.3	0.0	18.0	40.2	40.9	20.9
Medication review	N/A	81.5	84.0	80.3	87.4	85.9	58.4	64.2	61.3	71.8	73.7	45.4	61.7	65.1	67.8	46.2	0.4	68.1	83.9	71.8	84.7
Functional status assessment	N/A	63.0	72.0	65.7	74.2	63.8	38.4	41.1	52.8	52.8	47.2	31.7 G	47.0 G	53.5 G	56.2 G	69.4 G	0.0	43.3	58.2	56.2	43.1
Pain assessment	N/A	78.9	83.6	87.8	88.3	86.1	57.9	62.0	72.3	74.7	72.5	43.9	63.4	66.9	69.4	68.5	0.0	66.4	82.5	70.1	83.0

(continued)

Table B-1c (continued)
Cal MediConnect MMP performance on select HEDIS quality measures for 2015–2020[1] by MMP

Measure	National MA Plan mean	IEHP					LA Care					Molina					SCFHP				
	2020	2015	2016	2017	2018	2020	2015	2016	2017	2018	2020	2015	2016	2017	2018	2020	2015	2016	2017	2018	2020
Comprehensive diabetes care																					
Received Hemoglobin A1c (HbA1c) testing	91.7	90.7	91.9	94.7	93.2	89.8	85.2	91.7	90.4	93.6	87.2	87.6	93.1	94.3	92.2	87.1	88.6	91.2	91.7	94.2	87.6
Poor control of HbA1c level (>9.0%) (higher is worse)	28.0	28.2	28.5	20.2	24.1	30.2	46.9	33.1	24.4	24.2	28.6	41.1	30.3	29.0	28.0	32.6	77.2	32.9	28.0	29.9	28.7
Good control of HbA1c level (<8.0%)	62.3	58.3	60.4	67.2	61.6	61.1	42.3	56.5	62.5	62.2	60.7	51.2	57.2	61.3	62.3	60.1	20.0	56.0	60.6	61.1	62.5
Received eye exam (retinal)	67.9	65.3	71.8	73.5	71.3	68.1	64.6	64.2	70.4	75.6	71.7	53.2	71.5	71.0	67.4	64.5	47.4	62.5	72.3	77.9	77.1
Received medical attention for nephropathy	94.1	97.0	95.4	96.8	97.3	95.6	95.1	95.9	96.8	97.0	95.7	96.5	95.3	94.8	97.1	92.9	91.5	92.0	91.7	91.7	88.1
Blood pressure control (<140/90 mm Hg)	64.4	66.4	63.7	67.4	65.5	62.0	54.9	66.4	69.6	70.1	58.7	47.9	66.4	63.0	72.8	57.2	0.1	59.6	58.4	67.2	56.0
Initiation and engagement of alcohol and other drug (AOD) dependence treatment																					
Initiation of AOD treatment[7]	33.5	30.4	25.4	21.8	20.1	28.1	33.9	32.5	38.9	42.2	65.7	47.0	61.7	57.4	41.3	34.8	34.6	32.5	39.4	32.5	36.7
Engagement of AOD treatment[8]	5.2	3.4	1.4	2.0	2.5	2.9	2.5	1.6	3.3	4.6	9.6	4.3	6.7	5.5	5.5	4.6	0.0	1.7	1.0	2.6	7.3

(continued)

Table B-1c (continued)
Cal MediConnect MMP performance on select HEDIS quality measures for 2015–2020[1] by MMP

Measure	National MA Plan mean	IEHP					LA Care					Molina					SCFHP				
	2020	2015	2016	2017	2018	2020	2015	2016	2017	2018	2020	2015	2016	2017	2018	2020	2015	2016	2017	2018	2020
Plan all-cause readmissions (Observed-to-expected ratio[9])																					
Age 18-64	1.08	0.99	0.89	0.88	0.89	1.01	0.96	0.80	0.84	0.76	1.05	0.89	0.86	0.75	0.85	0.96	0.89	0.73	0.71	0.87	0.96
Age 65+	1.12	1.02	0.79	0.83	0.86	0.99	1.08	0.70	0.76	0.68	1.07	1.02	0.72	0.68	0.71	1.02	1.08	0.88	0.90	0.82	1.04
Ambulatory care (per 1,000 members[10])																					
Outpatient visits	N/A	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)	N/A	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	—

— = not available, where the plan did not provide HEDIS data for this measure; BMI = body mass index; HEDIS = Healthcare Effectiveness Data and Information Set; IEHP = Inland Empire Health Plan; MA = Medicare Advantage; MMAI = Medicare-Medicaid Alignment Initiative; MMP = Medicare-Medicaid 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; SCFHP = Santa Clara Family Health Plan.

[1] In response to the COVID-19 Public Health Emergency, CMS did not require Medicare plans (including MMPs) to submit HEDIS data covering the 2019 measurement year. Therefore, we omitted a column for the 2019 measurement year.

[2] Adult BMI assessment was retired from HEDIS in 2020. Therefore, MMPs did not provide HEDIS data for this measure for the 2020 measurement year.

[3] 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.

[4] NCQA implemented a significant specification change with HEDIS 2017, disallowing same-day follow-up visits. National benchmarks fell from HEDIS 2017 to HEDIS 2018.

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

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

[7] 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.

[8] 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.

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

[10] Measures for Outpatient visits and Emergency department visits (both within Ambulatory Care per 1,000 members) were retired from HEDIS in 2019. Therefore, MMPs did not provide HEDIS data for these measures for the 2020 measurement year.

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 2020 HEDIS measures.

Appendix C

Comparison Group Methodology for California Demonstration Years 4 and 5

This appendix presents the comparison group selection and assessment results for the Financial Alignment Initiative (FAI) demonstration in California.

Results for comparison group selection and assessment analyses are prepared for each demonstration year. The Preliminary Second Evaluation Report for the third demonstration year of the California demonstration was publicly released in September 2021. This appendix describes the comparison group identification methodology in detail and provides the comparison group results for the fifth performance year for the California demonstration (January 1, 2019–December 31, 2019) and notes any major changes in the results since the previous evaluation report. Results for the fourth demonstration year are nearly identical to those for the fifth demonstration year and are omitted to conserve space.

C.1 Demonstration and Comparison Group Characteristics

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; San Jose-Sunnyvale-Santa Clara). The comparison area is drawn from 168 counties in 33 MSAs across 10 States, as well as 40 non-metropolitan counties in Michigan. The pool of comparison States was limited to those with timely submission of Medicaid data to CMS. These geographic areas have not changed since the First Evaluation Report.

Beneficiaries who are ineligible for the demonstration include those who are younger than 21, have Medicare as a secondary payor, have been diagnosed with end-stage renal disease (ESRD), enrolled in the Program for All-inclusive Care for the Elderly (PACE), are not enrolled in Medicare Part A and Part B, 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, applying the 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.

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.

Dually eligible MA enrollees are eligible and may opt-in to the California demonstration. This report includes the MA population in the cost savings analysis, described in ***Appendix D***. ***Table C-1*** displays the number and percentage of beneficiaries who were in MA during the predemonstration and demonstration periods and included in the cost savings analysis. The prevalence of beneficiaries ever enrolled in MA ranges from 32.1 to 47.7 percent in the demonstration group, and from 25.9 to 38.7 percent in the comparison group across the study period.

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

Group	Pre-demonstration year 1	Pre-demonstration year 2	DY 1	DY 2	DY 3	DY4	DY5
Demonstration							
Initial count of beneficiaries	701,299	730,545	772,701	767,188	787,232	796,559	811,299
Count of beneficiaries with Medicare Advantage	225,279	261,396	368,628	311,251	325,951	338,489	350,620
Percentage of beneficiaries with Medicare Advantage	32.1%	35.8%	47.7%	40.6%	41.4%	42.5%	43.2%
Comparison							
Initial count of beneficiaries	1,060,978	1,084,278	1,233,932	1,157,827	1,194,808	1,201,413	1,190,556
Count of beneficiaries with Medicare Advantage	274,393	302,919	380,696	342,438	384,457	423,171	460,740
Percentage of beneficiaries with MA	25.9%	27.9%	30.9%	29.6%	32.2%	35.2%	38.7%

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 between the demonstration area and the comparison area any time during the entire study period, (4) removing beneficiaries with missing Hierarchical Condition Category (HCC) risk scores, and (5) removing beneficiaries who died before the beginning of each analytic period. After applying these exclusions, the number of demonstration group beneficiaries remained stable over the 2 predemonstration years, ranging between 670,597 and 699,150 beneficiaries per year. During the demonstration period--demonstration years 1 through 5—the number of demonstration group beneficiaries steadily increased from 758,628 to 798,975 beneficiaries per year. The number of beneficiaries in the comparison group ranged between 1,005,148 and 1,169,629 for the predemonstration and demonstration years.

C.2 Propensity Score Estimates

RTI's methodology examines initial differences between the demonstration and comparison groups in each analysis period to produce propensity scores, a rating of how likely a beneficiary is to be part of the demonstration group based on certain characteristics. Weights are calculated based on these scores and applied to the data to improve comparability between the two groups. Comparability is evaluated in terms of individual beneficiary characteristics and the overall distributions of propensity scores.

A propensity score is the predicted probability that a beneficiary is a member of the demonstration group conditional on a set of observed variables. Our propensity score models include a combination of beneficiary-level and region-level characteristics measured at the ZIP code (ZIP Code Tabulation Area) level. Compared to the analysis for the previous evaluation report, an additional explanatory variable was added to the propensity score model that measures the share of months during the year for which a beneficiary was enrolled in a MA plan.

The logistic regression coefficients and z-values for the covariates included in the propensity model for California demonstration year 5 are shown in ***Table C-2***, and the magnitude of the group differences for all variables prior to propensity score weighting is shown in ***Table C-3***. The largest relative differences are that demonstration participants were on average older; less likely to be Black, disabled, or participating in other Medicare shared shavings programs (other MDM); and more likely to be Hispanic or Asian than the beneficiaries in the comparison group. In addition, there are ZIP code-level group differences associated with, for example, the proportion of households with members younger than 18 years and distances to the nearest hospital and the nearest nursing facility. The results of the logistic regression for demonstration year 4 are very similar.

C.3 Propensity Score Overlap

The distributions of propensity scores by group for demonstration year 5 are shown in ***Figure C-1*** before and after propensity score weighting. Estimated scores for both the demonstration group and comparison group topped out at around 0.90. The unweighted comparison group (dashed line) is right-skewed, and predicted probabilities ranging from 0.10 to 0.30 are most prevalent. Inverse probability of treatment weighting pulls the distribution of weighted comparison group propensity scores (dotted line) very close to that of the demonstration group (solid line).

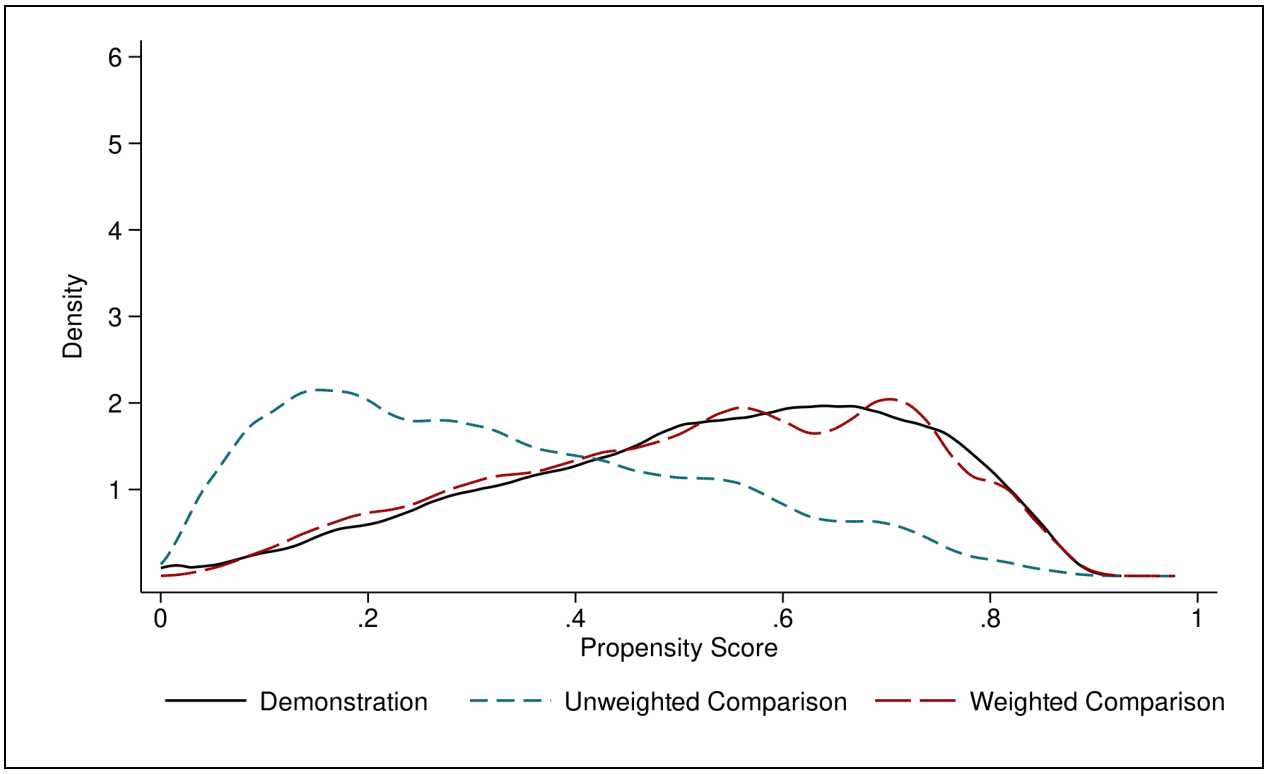
Any beneficiaries who have estimated propensity scores below the smallest estimated value in the demonstration group are removed from the comparison group. This resulted in the removal of only seven beneficiaries from the comparison group in demonstration year 5.

Table C-2
Logistic regression estimates for California propensity score models in demonstration year 5, January 1, 2019–December 31, 2019

Characteristic	Demonstration Year 5		
	Coef.	Standard error	z-score
Age (years)	0.008	0.000	48.13
Died during year (0/1)	−0.581	0.008	−72.36
Female (0/1)	−0.082	0.004	−23.01
Black (0/1)	−0.642	0.005	−123.33
Hispanic (0/1)	0.705	0.005	137.38
Asian (0/1)	0.554	0.005	110.08
Disability as original reason for entitlement (0/1)	−0.549	0.005	−110.62
Share of months Medicare Advantage plan enrollment during year	−0.189	0.004	−50.62
HCC risk score	0.069	0.002	29.40
Other MDM participation (0/1)	−1.146	0.005	−214.85
% of pop. living in married household	0.020	0.000	87.95
% of households w/member >= 60 yrs.	0.013	0.000	55.89
% of households w/member < 18 yrs.	0.044	0.000	203.36
% of adults with college education	−0.007	0.000	−37.83
% of adults with self-care limitation	−0.010	0.001	−8.57
Distance to nearest hospital (mi.)	−0.152	0.001	−174.79
Distance to nearest nursing facility (mi.)	0.016	0.001	15.23
Intercept	−3.050	0.020	−152.06

HCC = Hierarchical Condition Category; MDM = Master Data Management.

Figure C-1
Distribution of beneficiary-level propensity scores in the California demonstration and comparison groups, weighted and unweighted, January 1, 2019–December 31, 2019



C.4 Group Comparability

Covariate balance refers to the extent to which the characteristics used in the propensity score are similar (or "balanced") between 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 been developed such that groups are considered comparable if the standardized covariate difference is less than 0.10 standard deviations.

Table C-3
California dually eligible beneficiary covariate means by group before and after weighting by propensity score—demonstration year 5: January 1, 2019–December 31, 2019

Characteristic	Demonstration group mean	Comparison group mean	PS-weighted comparison group mean	Unweighted standardized difference	Weighted standardized difference
Age (years)	71.462	65.952	71.765	0.373	−0.022
Died during year (0/1)	0.038	0.056	0.037	−0.085	0.002
Female (0/1)	0.585	0.594	0.579	−0.019	0.012
Black (0/1)	0.094	0.249	0.09	−0.421	0.013
Hispanic (0/1)	0.191	0.079	0.196	0.335	−0.012
Asian (0/1)	0.189	0.085	0.196	0.306	−0.018
Disability as original reason for entitlement (0/1)	0.253	0.469	0.248	−0.462	0.01
Share of months Medicare Advantage plan enrollment during year	0.37	0.349	0.342	0.047	0.062
HCC score	1.091	1.084	1.086	0.009	0.006
Other MDM participation (0/1)	0.08	0.206	0.077	−0.365	0.014
% of pop. living in married household	67.172	65.494	67.931	0.133	−0.067
% of households w/member >= 60	38.596	38.182	38.209	0.052	0.05
% of households w/member < 18	36.778	32.359	36.435	0.441	0.033
% of adults with college education	26.644	27.884	27.743	−0.076	−0.066
% of adults with self-care limitation	3.356	3.565	3.345	−0.118	0.006
Distance to nearest hospital (mi.)	3.643	5.104	3.896	−0.357	−0.078
Distance to nearest nursing facility (mi.)	2.95	3.797	3.229	−0.242	−0.094

HCC = Hierarchical Condition Category; MDM = Master Data Management; PS = propensity score.

The group means and standardized differences for all beneficiary characteristics are shown for demonstration year 5 in ***Table C-3***. The column of unweighted standardized differences indicates that several of these variables were not balanced prior to weighting. Eleven variables had unweighted standardized differences exceeding 0.10 in absolute value: age, percent Black, percent Hispanic, percent Asian, percent with disability as original reason for entitlement, percent participating in other Medicare shared savings programs (other MDM), percent of population living in a married household, percent of household with a member 18 years of age or younger, percent of adults with self-care limitation, and the distances (in miles) to the nearest hospital and nursing facility.

The results of propensity score weighting for California demonstration year 5 are illustrated in the far-right column (weighted standardized differences) in ***Table C-3***. Propensity weighting reduced the standardized differences below the threshold level of 0.10 in absolute value for all the covariates in our model. We found the same results for demonstration year 4.

C.5 Enrollee-only Results

We also applied our weighting methodology to the demonstration's enrollee-only population (approximately 19 percent of the eligible demonstration population) to produce weights for use in the impact analyses on cost savings among the demonstration enrollee population. We define the enrollee group, along with its comparison group, as follows: (1) the demonstration enrollees are those with at least 3 months of enrollment during the 5-year demonstration period as well as 3 months of eligibility during the 2-year predemonstration period, and (2) the corresponding comparison group beneficiaries are those with at least 3 months of eligibility in both the 5-year demonstration period and the 2-year predemonstration period.

As was the case among all eligible beneficiaries, the unweighted values of several covariates differed substantially between the demonstration and comparison group among enrollees in each baseline and demonstration year. After weighting, the standardized differences of all covariates were reduced to less than 0.10 in absolute value.

C.6 Weights for Medicaid Cost Analyses

A third set of weights was produced specifically for the analyses of Medicaid costs, with one main change to the methodology used to produce weights for all eligible beneficiaries. Because of quality issues with the Medicaid data in both Pennsylvania and Wisconsin, RTI excluded the beneficiaries in those States from the comparison group. All covariates used in the calculation of weights in the Medicare cost analysis were used in the calculation of weights for the Medicaid cost analysis.

Although the unweighted values of several covariates differed substantially between the demonstration and comparison group in each predemonstration and demonstration year, the standardized differences of all covariates were reduced to less than 0.10 in absolute value after weighting, with the exception of percentage of adults with a college degree and percentage of households with a member less than 18 in the predemonstration years.

C.7 Summary

The California demonstration and comparison groups were initially distinguished by differences in six individual-level covariates as well as five area-level variables. However, propensity score weighting successfully reduced all covariate discrepancies below the generally accepted threshold for standardized differences. As a result, the weighted California groups are adequately balanced with respect to all 17 of the variables we considered for comparability. Further analysis of the enrollee group and the service utilization group yielded similar results to the main analysis on the all-eligible population presented in this appendix.

Appendix D

Cost Savings Methodology and Supplemental Tables

D.1 Cost Savings Methodology

To identify the demonstration group, RTI used quarterly files on demonstration eligible beneficiaries submitted by California. Comparison group beneficiaries were identified through a two-step process. First, we identified comparison areas based on market characteristics. Second, we applied all available eligibility criteria to beneficiaries in the identified comparison areas. This process is further described in ***Appendix C***. Once the two groups were finalized, we applied propensity score weighting in difference-in-differences (DinD) analysis to balance key characteristics between the two groups.

RTI gathered predemonstration and demonstration monthly Medicare expenditure data for both the demonstration and comparison groups from two data sources, as summarized in ***Table D-1***. We obtained capitation payments paid to participating plans during the demonstration period, and payments to MA plans in the predemonstration and demonstration periods from the CMS Medicare Advantage and Part D Inquiry System (MARx). Part D payments and risk corridors were not included in this analysis. 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 (February 2022). We also used Medicare FFS claims to calculate expenditures for eligible beneficiaries who were not enrolled in an MMP or MA plan. These FFS claims included all Medicare Parts A and B services.

Table D-1
Data sources for monthly Medicare expenditures

Group	Predemonstration period April 1, 2012– March 31, 2014	Demonstration period April 1, 2014–December 31, 2019
Demonstration	Medicare FFS MA capitation	Capitation rate for enrollees MA capitation for non-enrollees Medicare FFS for non-enrollees
Comparison	Medicare FFS MA capitation	Medicare FFS MA capitation

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

To estimate the effect of the demonstration on Medicare expenditures, we ran a generalized linear model with gamma distribution and log link. This is a commonly used approach in analysis of health care expenditure data. The model controlled for individual demographic and area-level characteristics, employed propensity score weighting, and adjusted for clustering of observations at the county level. The key policy variable of interest in the model was an interaction term measuring the effect of being part of the demonstration eligible group during the demonstration period, which estimates the demonstration's effect on Medicare expenditures.

RTI gathered predemonstration and demonstration monthly Medicaid expenditure data for both the demonstration and comparison groups from two types of claims, as summarized in ***Table D-2***. We obtained capitation payments paid to participating plans during the demonstration

period and capitated payments to Medicaid managed care plans in the predemonstration and demonstration periods from the Research Identifiable Files (RIFs) in the T-MSIS. We also used Medicaid FFS claims from the T-MSIS RIFs to calculate expenditures for beneficiaries who were not enrolled in an MMP or a Medicaid managed care plan. These FFS claims included all Medicaid services, with the exception of Medicaid claims for prescription drugs (which only marginally impact the Medicaid capitation payment received by MMPs).

Table D-2
Data sources for monthly Medicaid expenditures

Group	Predemonstration period (April 1, 2012–March 31, 2014)	Demonstration period (April 1, 2014–December 31, 2019)
Demonstration	Medicaid FFS Medicaid capitation	Medicaid FFS Medicaid capitation
Comparison	Medicaid FFS Medicaid capitation	Medicaid FFS Medicaid capitation

FFS = fee-for-service

D.1.1 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-3*** summarizes each adjustment and the application of the adjustments to FFS expenditures or to the capitation rate.

Additionally, corrections were made to impact estimates from earlier reports that resulted in differences in our current impact estimates for demonstration year 1. We attribute the differences in the estimates to changes in the definition of the intervention group and implementing monthly exclusion criteria. Specifically, we made the following corrections: (1) confirmed dual status for State-identified FAI eligible beneficiaries against IDR data, 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.

Table D-3
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.

(continued)

Table D-3 (continued)
Adjustments to Medicare expenditures variable

Data source	Adjustment description	Reason for adjustment	Adjustment detail
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, 0.81% for CY 2017, 0.82% for CY 2018, and 0.84% for CY 2019.
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 CY 2014, 0.89% for CY 2015, 0.97% for CY 2016, 0.81% for CY 2017, 0.82% for 2018, and 0.84% for CY 2019 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, 1.74% for CY 2017, 1.77% for CY 2018, and 1.94% for CY 2019 to account for the disproportional share of bad debt attributable to MMP enrollees in Medicare FFS.

(continued)

Table D-3 (continued)
Adjustments to Medicare expenditures variable

Data source	Adjustment description	Reason for adjustment	Adjustment detail
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. 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. Although 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, fourth, and fifth demonstration years but was not reflected in the capitation rate used in the analysis.	Final quality withhold repayments for CY 2014, CY 2015, CY 2016, CY 2017, CY 2018, and CY 2019 were incorporated into the dependent variable construction.

CY = calendar year; FFS = fee-for-service; MA = Medicare Advantage; MARx = Medicare Advantage and Part D Inquiry System; MMP = Medicare-Medicaid Plan.

The capitation payments in MARx reflect the savings assumptions applied to the Medicare components of the rate (1 percent for the first demonstration year, 2 percent for the second demonstration year, and 4 percent for the third-fifth demonstration years), but do not reflect the quality withhold amounts.

For the Medicaid analysis, no adjustments were made to the claims and capitation payment amounts from the MAX and T-MSIS files, beyond winsorizing the monthly total cost of care amounts at the 99th percentile separately for the demonstration group and the comparison group, and within those groups separately for each year.

D.1.2 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 both Medicare and Medicaid models were:
  - Age
  - Sex
  - Race/ethnicity
  - Enrolled in another Medicare shared saving program
  - Disability as reason for Medicare entitlement
  - MA status
- Area-level variables included in both the Medicare and Medicaid savings models were:
  - Medicare spending per dually eligible beneficiary age 19 or older
  - MA penetration rate
  - Medicaid-to-Medicare FFS fee index for all services
  - Medicaid spending per dually eligible beneficiary age 19 or older
  - Proportion of dually eligible beneficiaries using:
    - Nursing facilities age 65 or older
    - Home and community-based services (HCBS) age 65 or older
    - Medicaid managed care age 19 or older
    - Personal care age 65 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
  - Distance to nearest hospital
  - Distance to nearest nursing home

- Demographic variables included only in the Medicaid model were:
  - Medicaid eligibility (medically needy, aged, disabled, and missing value)

D.1.3 Populations Analyzed

The populations analyzed in the report include all demonstration eligible beneficiaries, as well as demonstration enrollees, and groups by race/ethnicity. ***Table D-4*** presents descriptive statistics of select characteristics for four population subgroups in demonstration year 5: all demonstration eligible beneficiaries, the comparison group, all MMP enrollees, and all beneficiaries who are eligible but not enrolled in MMPs ("non-MMP enrollees").

The most prevalent age group among the comparison group was age 75 and over, with 40.9 percent; otherwise, 65 to 74 years was the most prevalent age group among all other groups. Among the comparison population, there was a relatively higher percentage of African Americans (25.7 percent) compared to the other groups (ranging from 9.5 to 10.9 percent), and a lower percentage of Hispanics (8.2 percent) relative to the other demonstration eligible groups (range 19.0 to 25.1 percent).

Across all groups, most beneficiaries were female (56.2 to 58.9 percent), did not have disability as the primary reason for Medicare entitlement, did not have ESRD, and resided in a metropolitan area.

The HCC score is a measure of the predicted relative annual cost of a Medicare beneficiary based on the diagnosis codes present in recent Medicare claims. Beneficiaries with a score of 1 are predicted to have average cost in terms of annual Medicare expenditures. Beneficiaries with HCC scores less than 1 are predicted to have below average costs, whereas beneficiaries with scores of 2 are predicted to have twice the average annual cost. Average HCC scores ranged between 1.0 and 1.1 among all groups.

Table D-4
Characteristics of eligible beneficiaries in demonstration year 5 by group

Characteristics	Demonstration group	Comparison group	Demonstration group, enrollees	Demonstration group, non-enrollees
Weighted number of eligible beneficiaries	**795,399**	**1,119,319**	**126,811**	**668,588**
Demographic characteristics				
Age				
65 to 74	19.8	20.4	25.4	18.7
75 to 84	41.3	38.7	41.1	41.4
85 and older	38.9	40.9	33.5	39.9
Female				
No	41.6	42.2	43.8	41.2
Yes	58.4	57.8	56.2	58.9
Race/ethnicity				
White	40.7	52.8	39.7	40.9
African American	9.7	25.7	10.9	9.5
Hispanic	20.0	8.2	25.1	19.0
Asian	19.7	8.8	15.5	20.5
Disability as reason for original Medicare entitlement				
No	74.7	75.0	68.6	75.9
Yes	25.3	25.0	31.4	24.1
ESRD status				
No	100.0	100.0	100.0	100.0
Yes				
HCC score*	1.1	1.1	1.0	1.1
MSA				
No				
Yes	100.0	100.0	100.0	100.0

(continued)

Table D-4 (continued)
Characteristics of eligible beneficiaries in demonstration year 5 by group

Characteristics	Demonstration group	Comparison group	Demonstration group, enrollees	Demonstration group, non-enrollees
Participating in Shared Savings Program				
No	91.9	92.3	99.7	90.4
Yes	8.1	7.8	0.3	9.6
Market characteristics				
Medicare spending per dual, ages 19+ ($)	8,922.1	9,071.1	8,877.0	8,930.7
MA penetration rate	0.5	0.3	0.5	0.5
Medicaid-to-Medicare fee index (FFS)	0.5	0.6	0.5	0.5
Medicaid spending per dual, ages 19+ ($)	12,728.8	16,600.5	13,007.9	12,675.9
Fraction of dually eligible beneficiaries using NF, ages 65+	0.1	0.2	0.1	0.1
Fraction of dually eligible beneficiaries using HCBS, ages 65+	0.0	0.1	0.0	0.0
Fraction of dual eligible beneficiaries using personal care, ages 19+	0.4	0.2	0.3	0.4
Fraction of dual eligible beneficiaries with Medicaid managed care, ages 19+	1.0	0.9	1.0	1.0
Population per square mile, all ages	1,890.6	1,034.1	1,515.4	1,961.8
Patient care physicians per 1,000 population	0.7	0.9	0.7	0.7
Area characteristics				
% of pop. living in married households	67.2	67.9	67.4	67.1
% of adults with college education	26.6	27.7	25.4	26.9
% of adults with self-care limitations	3.4	3.3	3.1	3.4
% of adults unemployed	6.5	6.6	6.7	6.5
% of household with individuals younger than 18	36.8	36.5	38.2	36.5

(continued)

Table D-4 (continued)
Characteristics of eligible beneficiaries in demonstration year 5 by group

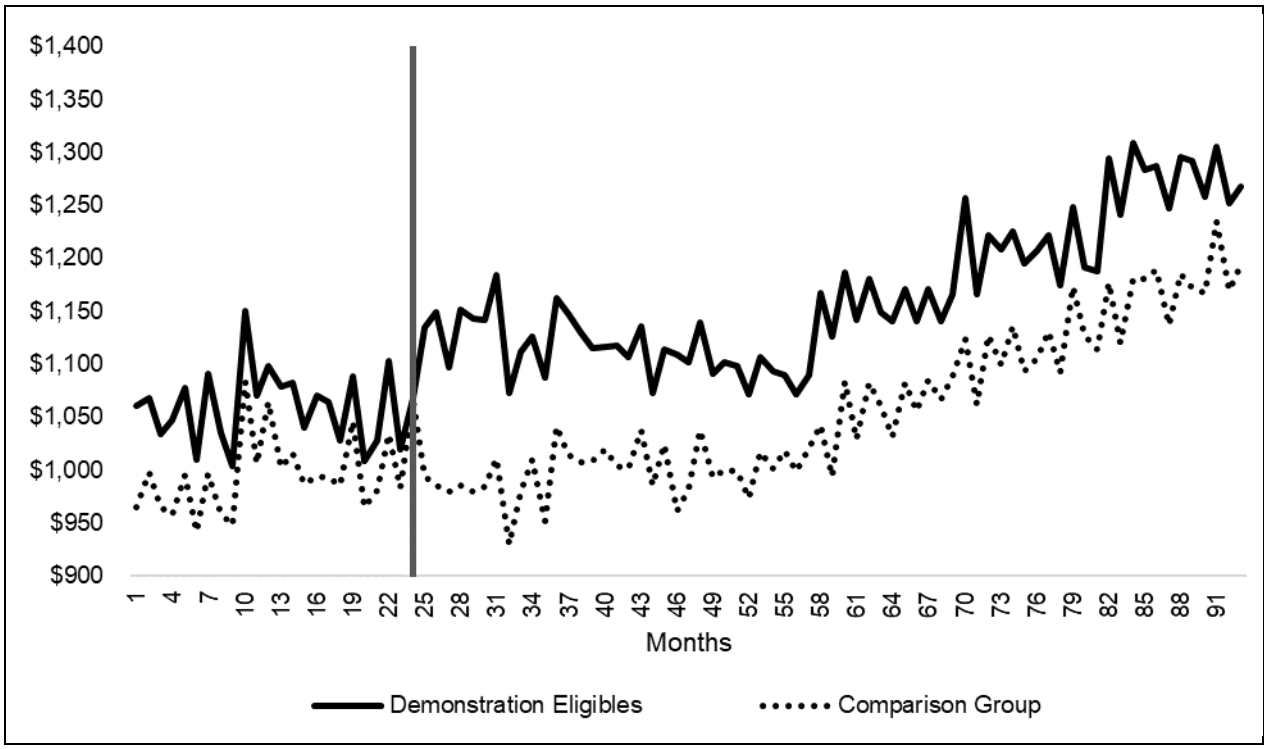
Characteristics	Demonstration group	Comparison group	Demonstration group, enrollees	Demonstration group, non-enrollees
% of household with individuals older than 60	38.6	38.2	38.3	38.7
Distance to nearest hospital	3.6	3.9	4.1	3.6
Distance to nearest nursing facility	2.9	3.2	3.4	2.9

* The HCC score was not used in the regression analysis, and it is reported here for descriptive purposes only; ESRD = end-stage renal disease; FFS = fee-for-service; HCBS = home and community-based services; HCC = Hierarchical Condition Category; NF = nursing facility; MA = Medicare Advantage; MSA = metropolitan statistical area.
SOURCE: RTI analysis of California demonstration eligible and comparison group Medicare data.

D.2 Medicare Descriptive Results

Once we finalized the adjustments to the dependent variable, we tested a key assumption of a DinD model: parallel trends in the predemonstration period. We plotted the mean monthly Medicare expenditures for both the comparison group and demonstration group, with the PS 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 periods, demonstration and comparison group, April 2012–December 2019



SOURCE: RTI analysis of California demonstration eligible and comparison group Medicare data (program: CA_DY5_trendfigures.log).

The DinD values in ***Tables D-5, D-6, D-7, D-8,*** and ***D-9*** 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. These results are only meant to provide a descriptive exploration of the results; the results presented in ***Section 5, Demonstration Impact on Cost Savings*** and ***Table D-15*** represent the most accurate adjusted impact on Medicare costs.

Tables D-5, D-6, D-7, D-8, and ***D-9*** show the mean monthly Medicare expenditures for the demonstration group and comparison group in the predemonstration and each demonstration period, unweighted. The unweighted tables show an increase in mean monthly Medicare expenditures during demonstration years 1-5 for the demonstration group. Additionally, the unweighted tables show an increase in Medicare expenditures during demonstration years 1–5 for the comparison group. The weighted tables display a different pattern with the comparison group showing a decrease in demonstration year 1 and an increase in demonstration years 3-5. The weighted demonstration group expenditures increase in demonstration years 1-5 (***Tables D-10, D-11, D-12, D-13,*** and ***D-14***).

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

Group	Predemonstration period (April 2012–March 2014) (95% confidence intervals)	Demonstration year 1 (April 2014–December 2015) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$1,059.50 ($1,028.76, $1,090.23)	$1,123.60 ($1,084.49, $1,162.71)	$64.10 ($40.53, $87.68)
Comparison	$1,068.46 ($1,042.59, $1,094.32)	$1,088.64 ($1,060.28, $1,117.00)	$20.19 ($13.28, $27.09)
DinD	N/A	N/A	$43.92 ($19.49, $68.34)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicare claims (program: ca_dy5_1500_Tables.log)

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

Group	Predemonstration period (April 2012–March 2014) (95% confidence intervals)	Demonstration year 2 (January 2016–December 2016) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$1,059.50 ($1,028.76, $1,090.23)	$1,097.04 ($1,067.15, $1,126.92)	$37.54 ($27.15, $47.93)
Comparison	$1,068.46 ($1,042.59, $1,094.32)	$1,095.58 ($1,060.70, $1,130.46)	$27.12 ($13.98, $40.27)
DinD	N/A	N/A	$10.42 ($−6.23, $27.07)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicare claims (program: ca_dy5_1500_Tables.log)

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

Group	Predemonstration period (April 2012–March 2014) (95% confidence intervals)	Demonstration year 3 (January 2017–December 2017) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$1,059.50 ($1,028.76, $1,090.23)	$1,156.91 ($1,119.46, $1,194.36)	$97.41 ($84.69, $110.14)
Comparison	$1,068.46 ($1,042.59, $1,094.32)	$1,155.15 ($1,116.80, $1,193.51)	$86.70 ($67.79, $105.60)
DinD	N/A	N/A	$10.72 ($−12.01, $33.44)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicare claims (program: ca_dy5_1500_Tables.log)

Table D-8
Mean monthly Medicare expenditures for demonstration group and comparison group, predemonstration period and demonstration year 4, unweighted

Group	Predemonstration period (April 2012–March 2014) (95% confidence intervals)	Demonstration year 4 (January 2018–December 2018) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$1,059.50 ($1,028.76, $1,090.23)	$1,208.73 ($1,166.64, $1,250.83)	$149.24 ($130.21, $168.27)
Comparison	$1,068.46 ($1,042.59, $1,094.32)	$1,211.49 ($1,171.24, $1,251.75)	$143.04 ($121.02, $165.05)
DinD	N/A	N/A	$6.20 ($−22.71, $35.10)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicare claims (program: ca_dy5_1500_Tables.log)

Table D-9
Mean monthly Medicare expenditures for demonstration group and comparison group, predemonstration period and demonstration year 5, unweighted

Group	Predemonstration period (April 2012–March 2014) (95% confidence intervals)	Demonstration year 5 (January 2019–December 2019) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$1,059.50 ($1,028.76, $1,090.23)	$1,277.73 ($1,232.22, $1,323.24)	$218.24 ($196.19, $240.28)
Comparison	$1,068.46 ($1,042.59, $1,094.32)	$1,283.20 ($1240.37, $1,326.03)	$214.75 ($189.65, $239.84)
DinD	N/A	N/A	$3.49 ($−29.76, $36.74)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicare claims (program: ca_dy5_1500_Tables.log)

Table D-10
Mean monthly Medicare expenditures for demonstration group and comparison group, predemonstration period and demonstration year 1, weighted

Group	Predemonstration period (April 2012–March 2014) (95% confidence intervals)	Demonstration year 1 (April 2014–December 2015) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$1,059.50 ($1,028.76, $1,090.23)	$1,123.60 ($1,084.49, $1,162.71)	$64.10 ($40.53, $87.68)
Comparison	$997.62 ($967.04, $1,028.20)	$997.27 ($963.45, $1,031.09)	(−$0.35) ($−9.88, $9.18)
DinD	N/A	N/A	$64.45 ($39.18, $89.73)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicare claims (program: ca_dy5_1500_Tables.log)

Table D-11
Mean monthly Medicare expenditures for demonstration group and comparison group, predemonstration period and demonstration year 2, weighted

Group	Predemonstration period (April 2012–March 2014) (95% confidence intervals)	Demonstration year 2 (January 2016–December 2016) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$1,059.50 ($1,028.76, $1,090.23)	$1,097.04 ($1,067.15, $1,126.92)	$37.54 ($27.15, $47.93)
Comparison	$997.62 ($967.04, $1,028.20)	$1,000.67 ($958.45, $1,042.88)	$3.05 ($−12.60, $18.69)
DinD	N/A	N/A	$34.50 ($15.83, $53.16)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicare claims (program: ca_dy5_1500_Tables.log)

Table D-12
Mean monthly Medicare expenditures for demonstration group and comparison group, predemonstration period and demonstration year 3, weighted

Group	Predemonstration period (April 2012–March 2014) (95% confidence intervals)	Demonstration year 3 (January 2017–December 2017) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$1,059.50 ($1,028.76, $1,090.23)	$1,156.91 ($1,119.46, $1,194.36)	$97.41 ($84.69, $110.14)
Comparison	$997.62 ($967.04, $1,028.20)	$1,058.66 ($1,011.62, $1,105.71)	$61.04 ($39.72, $82.37)
DinD	N/A	N/A	$36.37 ($11.60, $61.14)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicare claims (program: ca_dy5_1500_Tables.log)

Table D-13
Mean monthly Medicare expenditures for demonstration group and comparison group, predemonstration period and demonstration year 4, weighted

Group	Predemonstration period (April 2012–March 2014) (95% confidence intervals)	Demonstration year 4 (January 2018–December 2018) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$1,059.50 ($1,028.76, $1,090.23)	$1,208.73 ($1,166.64, $1,250.83)	$149.24 ($130.21, $168.27)
Comparison	$997.62 ($967.04, $1028.20)	$1,115.71 ($1,064.66, $1,166.76)	$118.09 ($93.48, $142.69)
DinD	N/A	N/A	$31.15 ($0.46, $61.84)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicare claims (program: ca_dy5_1500_Tables.log)

Table D-14
Mean monthly Medicare expenditures for demonstration group and comparison group, predemonstration period and demonstration year 5, weighted

Group	Predemonstration period (April 2012–March 2014) (95% confidence intervals)	Demonstration year 5 (January 2019–December 2019) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$1,059.50 ($1,028.76, $1,090.23)	$1,277.73 ($1,232.22, $1,323.24)	$218.24 ($196.19, $240.28)
Comparison	$997.62 ($967.04, $1028.20)	$1,175.64 ($1,121.75, $1,229.53)	$178.02 ($149.72, $206.32)
DinD	N/A	N/A	$40.22 ($4.49, $75.94)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicare claims (program: ca_dy5_1500_Tables.log)

D.3 Medicare Regression Results

Table D-15 shows the main results from the DinD analysis for demonstration years 1–5 and for the entire demonstration period, controlling for beneficiary demographics and market characteristics. Relative to the comparison group, the demonstration was associated with statistically significant cost increases to the Medicare program during demonstration years 1 through 5. The cumulative impact estimate over all 5 demonstration years was statistically significant suggesting that overall the demonstration was associated with increases in Medicare costs of $62.82 per member per month (PMPM).

Table D-15
Cumulative and annual demonstration effects on Medicare Parts A and B costs in California, demonstration years 1–5, April 1, 2014– December 31, 2019

Period	Adjusted coefficient DinD ($)	*p*-value	95% confidence interval ($)	90% confidence interval ($)
Demonstration Year 1 (April 2014-December 2015)	65.65	<0.001	(36.77, 94.54)	(41.41, 89.89)
Demonstration Year 2 (January 2016-December 2016)	52.97	<0.001	(30.88, 75.06)	(34.43, 71.51)
Demonstration Year 3 (January 2017-December 2017)	53.27	<0.001	(26.13, 80.41)	(30.50, 76.04)
Demonstration Year 4 (January 2018-December 2018)	48.20	<0.001	(19.99, 76.41)	(24.53, 71.88)
Demonstration Year 5 (January 2019-December 2019)	58.28	<0.001	(26.23, 90.34)	(31.38, 85.19)
Cumulative (Demonstration Years 1–5, April 2014-December 2019)	62.82	<0.001	(40.66, 84.98)	(44.22, 81.42)

DinD = difference-in-differences.
SOURCE: RTI analysis of Medicare claims (program: ca_dy5_1480_GLM.log)

Table D-16 provides an illustrative example of the generalized linear model output for each covariate on mean monthly Medicare expenditures across the entire demonstration period.

Table D-16
Generalized linear model results on monthly Medicare expenditures
(n = 140,947,130 person months)

Independent variables	Coefficient	Standard error	z-value	*p*-value
Demonstration group	0.0803	0.0237	3.39	0.001
Post period	0.0153	0.0072	2.14	0.032
Interaction of post period x demonstration group	0.0548	0.0097	5.67	<0.001
Age (continuous)	0.0214	0.0008	27.78	<0.001
Asian	−0.4704	0.0204	−23.03	<0.001
Black	0.0599	0.0175	3.42	0.001
Female	−0.0909	0.0091	−9.96	<0.001
Hispanic	−0.2873	0.0199	−14.46	<0.001
Other race/ethnicity	−0.3585	0.0137	−26.19	<0.001
Medicare Advantage status	0.1257	0.0403	3.12	0.002
Disability as reason for Medicare entitlement	0.3781	0.0244	15.52	<0.001
Participation in other Shared Savings Program	0.1806	0.0272	6.65	<0.001

(continued)

Table D-16 (continued)
Generalized linear model results on monthly Medicare expenditures
(n = 140,947,130 person months)

Independent variables	Coefficient	Standard error	z-value	*p*-value
Patient care physicians per 1,000 population	−0.0626	0.0532	−1.18	0.240
Fraction of duals with Medicaid managed care, ages 19+	0.2107	0.0497	4.24	<0.001
Medicare Advantage penetration rate	0.0120	0.0956	0.13	0.900
Population per square mile	0.0000	0.0000	−3.47	0.001
Medicaid-to-Medicare fee index (FFS)	0.7316	0.1554	4.71	<0.001
Medicaid spending per dual	0.0000	0.0000	1.37	0.171
Medicare spending per dual	0.0000	0.0000	0.08	0.936
Fraction of duals using HCBS, ages 65+	−0.2766	0.3186	−0.87	0.385
Fraction of duals using nursing facility, ages 65+	0.0763	0.1460	0.52	0.601
Fraction of duals using personal care, ages 65+	0.2449	0.1529	1.60	0.109
Percent of adults with college education	−0.0013	0.0004	−3.11	0.002
Percent of adults with self-care limitation	−0.0023	0.0016	−1.48	0.139
Percent of households with individuals older than 60	0.0000	0.0006	0.06	0.955
Percent of households with individuals younger than 18	−0.0028	0.0005	−5.05	<0.001
Percent of population married	−0.0011	0.0004	−2.59	0.010
Percent of adults who are unemployed	−0.0072	0.0009	−7.95	<0.001
Distance to nearest hospital	0.0002	0.0015	0.11	0.912
Distance to nearest nursing facility	−0.0013	0.0022	−0.58	0.560
Intercept	5.0841	0.3808	13.35	<0.001

FFS = fee-for-service; HCBS = home and community-based services.

Table D-17 presents the results from the DinD analysis for the enrollee subgroup. The enrollee subgroup analysis focused on 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 enrollee subgroup analyses. Comparison group beneficiaries used in the enrollee subgroup analyses were required to have at least 3 months of eligibility in the demonstration period (April 1, 2014–December 31, 2019) and at least 3 months of eligibility in the predemonstration period (April 1, 2012–March 31, 2014), analogous to the criteria for identifying enrollees. The results indicate statistically significant additional costs associated with enrollees. This enrollee 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 only be considered in the context of this limitation.

Table D-17
Cumulative and annual demonstration effects on Medicare Parts A and B costs among enrolled beneficiaries in California, demonstration years 1–5, April 1, 2014–December 31, 2019

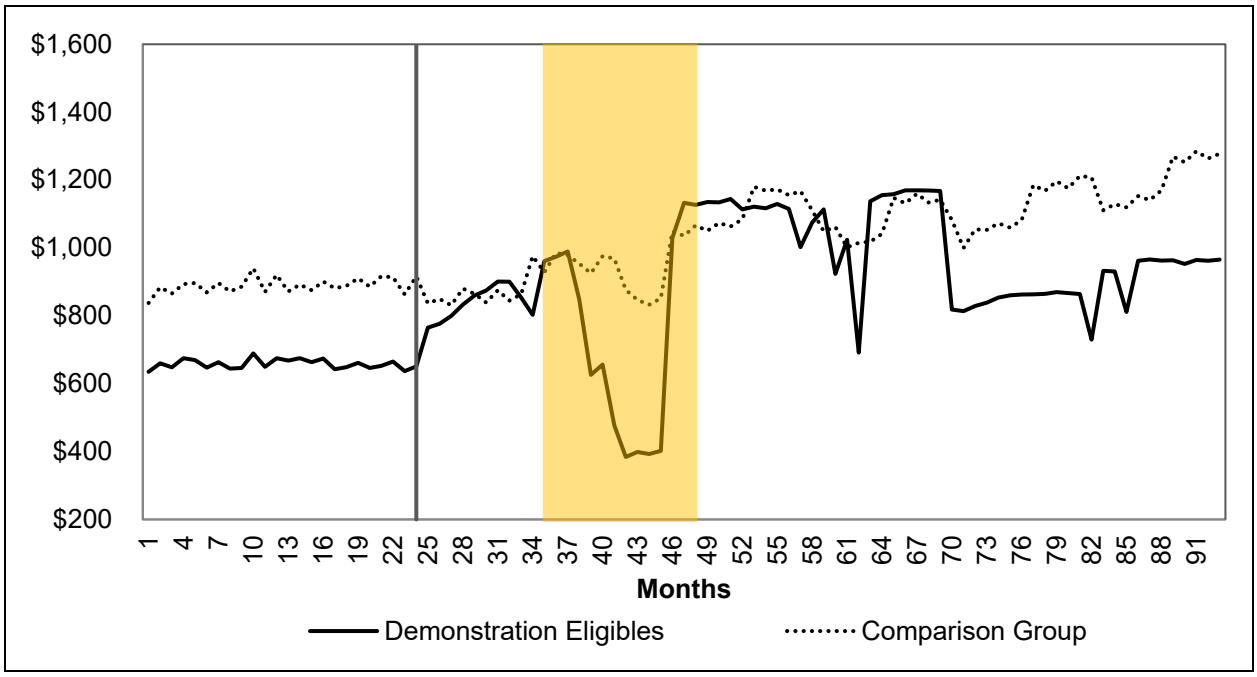
Period	Adjusted coefficient DinD ($)	*p*-value	95% confidence interval ($)	90% confidence interval ($)
Demonstration Year 1 (April 2014-December 2015)	154.57	<0.001	(117.13, 192.00)	(123.15, 185.98)
Demonstration Year 2 (January 2016-December 2016)	221.23	<0.001	(184.05, 258.42)	(190.03, 252.44)
Demonstration Year 3 (January 2017-December 2017)	244.84	<0.001	(199.63, 290.05)	(206.90, 282.79)
Demonstration Year 4 (January 2018-December 2018)	268.82	<0.001	(226.14, 311.50)	(233.00, 304.64)
Demonstration Year 5 (January 2019-December 2019)	304.61	<0.001	(254.23, 354.98)	(262.33, 346.89)
Cumulative (Demonstration Years 1–5, April 2014-December 2019)	233.82	<0.001	(202.59, 265.05)	(207.61, 260.03)

DinD = difference-in-differences.
NOTE: For this enrollee-only analysis, the comparison group used in this analysis is a subset of the comparison group in the main analysis (of demonstration eligible beneficiaries).
SOURCE: RTI analysis of Medicare claims (program: ca_dy5_1510_enrollee.log)

D.4 Medicaid Results

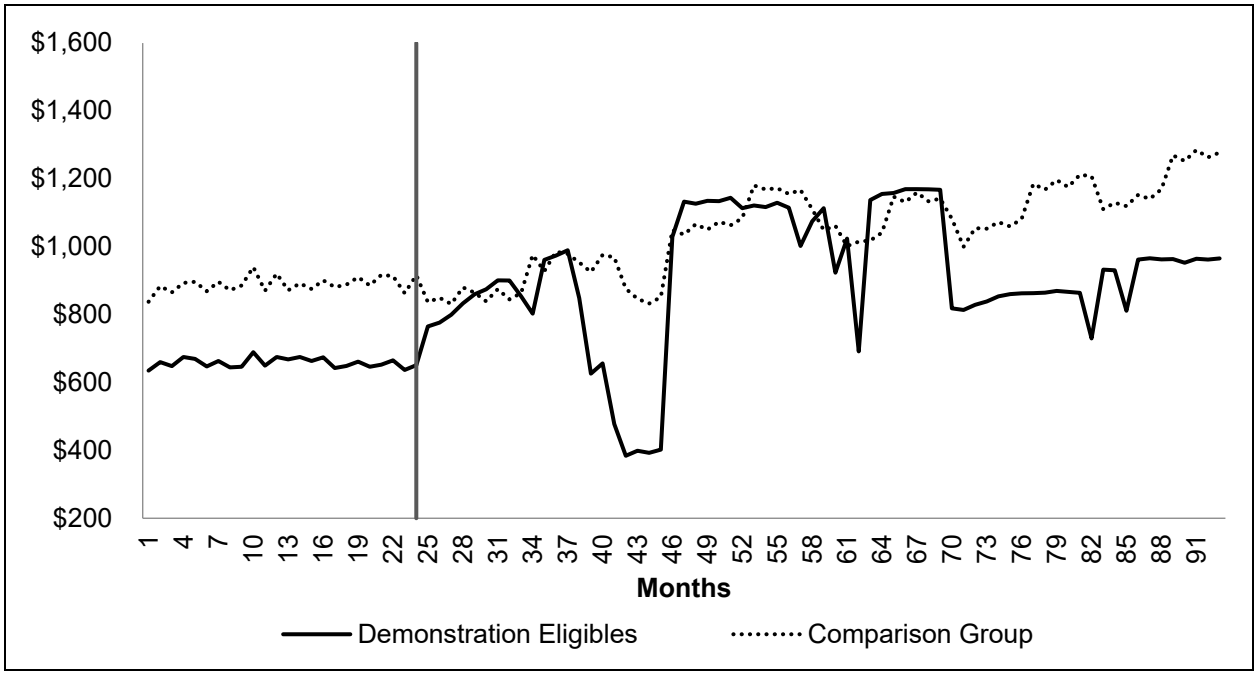
Using the Medicaid data, we also tested the parallel trends in the predemonstration period. We plotted the mean monthly Medicaid expenditures for both the comparison group and demonstration group, with the PS weights applied. Monthly Medicaid total cost of care values were winsorized by State and year and by demonstration/comparison group status. ***Figure D-2*** shows the weighted plots, suggesting parallel trends in the predemonstration period. However, as seen in the highlighted months in the figure, the trend for the California demonstration groups decreased significantly at the end of the first demonstration period (May–December of 2015). In California, 2015 was the final year in which the MAX was used, and in the final months of the MAX data, we found that the majority of capitated payments were missing from the data. Thus we opted to remove those 8 months of data, and the first demonstration year in the Medicaid analysis is April 1, 2014 to April 30, 2015. ***Figure D-3*** shows the weighted plots, omitting the 8 months of 2015 with missing data.

Figure D-2
Mean monthly Medicaid expenditures (weighted), predemonstration and demonstration periods, demonstration and comparison groups, April 2012–December 2019



SOURCE: RTI analysis of California demonstration eligible and comparison group Medicaid data (program: 60_Trends.do).

Figure D-3
Mean monthly Medicaid expenditures (weighted), predemonstration and demonstration periods, demonstration and comparison groups, April 2012–December 2019, final months of MAX data in California omitted



SOURCE: RTI analysis of California demonstration eligible and comparison group Medicaid data (program: 60_Trends.do).

The comparison group in both of these figures is a subset of the Medicare comparison group, with beneficiaries in both Pennsylvania and Wisconsin excluded. In Pennsylvania, the total monthly beneficiary payments in the Other Services (OT) file are classified by the DQAtlas as being unusable in 2016–2019; our analysis of the data confirmed that a large fraction of the Other Services capitated payment amounts are negative among the FAI comparison group in Pennsylvania. In Wisconsin, the DQAtlas reports that the total monthly beneficiary payments in the Long-term care file are unusable in 2014–2019 and the payments in the OT file are unusable in 2015–2016: our analysis of the Wisconsin data confirmed that the majority of capitated payments in the OT file for our population are missing in both 2015 and 2016.

Table D-18
Mean monthly Medicaid expenditures for demonstration group and comparison group, predemonstration period and demonstration year 1, weighted

Group	Predemonstration period (April 2012–March 2014) (95% confidence intervals)	Demonstration year 1 (April 2014–April 2015) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$657.79 ($618.09, $697.49)	$870.23 ($762.43, $978.02)	$212.44 ($132.63, $292.25)
Comparison	$889.64 ($774.28, $1,004.99)	$889.48 ($778.30, $1,000.67)	−$0.15 (−$16.12, $15.82)
DinD	N/A	N/A	$212.59 ($132.13, $293.06)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicaid claims (program: California 5th Annual Report/medicaid/Syntax/20_Descriptives.log)

Table D-19
Mean monthly Medicaid expenditures for demonstration group and comparison group, predemonstration period and demonstration year 2, weighted

Group	Predemonstration period (April 2012–March 2014) (95% confidence intervals)	Demonstration year 2 (January 2016–December 2016) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$657.79 ($618.09, $697.49)	$1,108.39 ($919.70, $1,297.08)	$450.60 ($292.65, $608.56)
Comparison	$889.64 ($774.28, $1,004.99)	$1,106.00 ($1,011.15, $1,200.84)	$216.36 ($162.72, $270.00)
DinD	N/A	N/A	$234.24 ($69.11, $399.38)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicaid claims (program: California 5th Annual Report/medicaid/Syntax/20_Descriptives.log)

Table D-20
Mean monthly Medicaid expenditures for demonstration group and comparison group, predemonstration period and demonstration year 3, weighted

Group	Predemonstration period (April 2012–March 2014) (95% confidence intervals)	Demonstration year 3 (January 2017–December 2017) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$657.79 ($618.09, $697.49)	$1,079.77 ($904.92, $1,254.62)	$421.98 ($279.81, $564.16)
Comparison	$889.64 ($774.28, $1,004.99)	$1,084.83 ($980.59, $1,189.07)	$195.20 ($155.59, $234.80)
DinD	N/A	N/A	$226.79 ($80.79, $372.78)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicaid claims (program: California 5th Annual Report/medicaid/Syntax/20_Descriptives.log)

Table D-21
Mean monthly Medicaid expenditures for demonstration group and comparison group, predemonstration period and demonstration year 4, weighted

Group	Predemonstration period (April 2012–March 2014) (95% confidence intervals)	Demonstration year 4 (January 2018–December 2018) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$657.79 ($618.09, $697.49)	$850.40 ($735.14, $965.67)	$192.61 ($110.95, $274.28)
Comparison	$889.64 ($774.28, $1,004.99)	$1,112.26 ($1,006.10, $1,218.41)	$222.62 ($180.72, $264.52)
DinD	N/A	N/A	−$30.01 (−$120.99, $60.98)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicaid claims (program: California 5th Annual Report/medicaid/Syntax/20_Descriptives.log)

Table D-22
Mean monthly Medicaid expenditures for demonstration group and comparison group, predemonstration period and demonstration year 5, weighted

Group	Predemonstration period (April 2012–March 2014) (95% confidence intervals)	Demonstration year 5 (January 2019–December 2019) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$657.79 ($618.09, $697.49)	$924.80 ($811.22, $1,038.38)	$267.01 ($186.38, $347.64)
Comparison	$889.64 ($774.28, $1,004.99)	$1,198.56 ($1,078.53, $1,318.59)	$308.93 ($263.40, $354.46)
DinD	N/A	N/A	−$41.92 (−$133.41, $49.58)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicaid claims (program: California 5th Annual Report/medicaid/Syntax/20_Descriptives.log)

Table D-23 shows the Medicaid results from the DinD analysis for demonstration years 1–5 and for the entire demonstration period, controlling for beneficiary demographics and market characteristics.

Table D-23
Cumulative and annual demonstration effects on Medicaid costs in California, demonstration years 1–5, April 1, 2014–December 31, 2019

Period	Adjusted coefficient DinD ($)	*p*-value	95% confidence interval ($)	90% confidence interval ($)
Demonstration Year 1 (April 2014–April 2015)	474.02	<0.001	(188.88, 313.66)	(198.91, 303.63)
Demonstration Year 2 (January 2016–December 2016)	495.64	<0.001	(359.61, 631.66)	(381.48, 609.79)
Demonstration Year 3 (January 2017–December 2017)	474.02	<0.001	(355.36, 592.69)	(374.44, 573.61)
Demonstration Year 4 (January 2018–December 2018)	156.80	<0.001	(97.69, 215.91)	(107.19, 206.41)
Demonstration Year 5 (January 2019-December 2019)	174.38	<0.001	(122.92, 225.85)	(131.19, 217.57)
Cumulative (Demonstration Years 1–5, April 2014–December 2019)	325.46	<0.001	(244.71, 406.21)	(257.69, 393.22)

DinD = difference-in-differences.
SOURCE: RTI analysis of Medicaid claims (program: 30_Regression.log)

No adjustments were made to the Medicaid payment amounts to account for differences across States in the capitation rates or FFS payments for services. Each State has its own unique payment system; there is no underlying national payment system—as there is in Medicare—by which payments can be standardized. Instead, we account for differences across States in

Medicaid payment rates and services covered by including in the regressions controls for Medicaid spending per dually eligible beneficiary age 19 or older, the proportion of dually eligible beneficiaries using nursing facilities, the proportion of dually eligible beneficiaries using HCBS, the proportion of dually eligible beneficiaries using Medicaid managed care, and the proportion of dually eligible beneficiaries using personal care. Differences in Medicaid eligibility across States are accounted for using the Medicaid eligibility categories as controls in the regressions.

D.5 Sensitivity Analysis on Medicaid Costs

During the course of the evaluation, members of the evaluation team met with MediCal representatives to discuss payment data submitted via both the MSIS and T-MSIS systems. Representatives from MediCal noted that due to submission errors, state officials believed FFS claims submitted via T-MSIS (after January 1, 2016) may have duplications resulting in FFS spending being approximately 7 to 10 percent higher than actual costs. MediCal representatives noted that they were working with CMS to correct historical claims; however, this correction would not be completed during the FAI evaluation period. RTI examined the proportion of the costs in each demonstration year that were potentially inflated due to the error identified by California. In ***Table D-24***, we report the percentage of costs in each demonstration year that were California FFS costs. In the demonstration group, the proportion of FFS costs to total costs ranged from 41 percent to 56 percent. In the multi-state comparison group, the proportion of California FFS costs to total costs across all comparison group states ranged from 32 percent to 36 percent. The presence of California FFS costs in both the demonstration group and the comparison groups helps to mitigate any bias caused by the inflation of the FFS costs in the T-MSIS data.

Table D-24
Fee-for-service costs in California as a percentage of total costs

Period	Demonstration Group	Comparison Group
Demonstration Year 1 (April 2014–April 2015)	MAX data	MAX data
Demonstration Year 2 (January 2016–December 2016)	44%	36%
Demonstration Year 3 (January 2017–December 2017)	41%	33%
Demonstration Year 4 (January 2018–December 2018)	53%	32%
Demonstration Year 5 (January 2019-December 2019)	56%	32%

To test the robustness of the evaluation model against this potential data error, the evaluation team reduced all of California's FFS claims from 2016 through 2019 by 10 percent to align with the maximum margin of error indicated by MediCal staff. We assumed in this sensitivity analysis that the 10 percent cost inflation error was equally distributed across all Medicaid FFS costs in both the demonstration and comparison groups. In ***Table D-25*** we show the regression output, and in ***Table D-26*** the weighted mean spending from the existing model (denoted as "As Reported") compared with the revised model (denoted as "Adjusting TAF FFS Costs Down by 10%").

As shown below in ***Table D-25*** and ***Table D-26***, revised estimates remained robust and fell well within the model's 95 percent confidence internals, indicating the potential data submission errors would not significantly impact the evaluation results. The impact on the cumulative DinD estimate is approximately $13 PMPM, declining from $325.46 to $312.21. In demonstration years 2 through 5, we see that the estimate using the deflated FFS costs is between $10 and $15 lower; the first year of the evaluation is measured via MSIS-derived claims which MediCal representatives indicated were not impacted by the submission error. Although the regression point estimates are slightly lower, the magnitudes and directionality of the estimates remain similar and fall within the initial confidence ranges, indicating the inflated FFS costs are not causing significant bias in our report analyses.

Table D-25
Cumulative and annual demonstration effects on Medicaid costs in California, demonstration years 1–5, April 1, 2014–December 31, 2019

Period	Current Report Results	Adjusting TAF FFS Costs Down by 10%
Demonstration Year 1 (Apr. 2014–Apr. 2015)	251.27 (188.88, 313.66)	250.29 (187.94, 312.65)
Demonstration Year 2 (Jan. 2016–Dec. 2016)	495.64 (359.61, 631.66)	484.95 (354.60, 615.29)
Demonstration Year 3 (Jan. 2017–Dec. 2017)	474.02 (355.36, 592.69)	463.42 (348.86, 577.98)
Demonstration Year 4 (Jan. 2018–Dec. 2018)	156.80 (97.69, 215.91)	145.78 (90.28, 201.29)
Demonstration Year 5 (Jan. 2019-Dec. 2019)	174.38 (122.92, 225.85)	159.96 (111.68, 208.24)
Cumulative (Demonstration Years 1–5, Apr. 2014–Dec. 2019)	325.46 (244.71, 406.21)	312.21 (234.91, 389.51)

FFS = fee for service; TAF = Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files.

In ***Table D-26***, we show the weighted mean monthly expenditures under both the reported model and with the costs adjusted downward. Revised estimates fall within the existing model's confidence intervals.

Table D-26
Mean monthly Medicaid expenditures for demonstration group and comparison group by period, weighted

Period	Demonstration Group		Comparison Group	
	Average PMPM: As Reported	Average PMPM: Adjusting Down TAF FFS Costs by 10%	Average PMPM: As Reported	Average PMPM: Adjusting TAF FFS Costs Down by 10%
Demonstration Year 1 (Apr. 2014–Apr. 2015)	$870.23 ($762.43, $978.02)	$870.23 ($762.43, $978.02)	$889.48 ($778.3, $1000.67)	$889.48 ($778.3, $1000.67)
Demonstration Year 2 (Jan. 2016–Dec. 2016	$1,108.39 ($919.7, $1297.08)	$1,063.84 ($883.15, $1244.53)	$1,106.00 ($1011.15, $1200.84)	$1,058.86 ($956.68, $1161.04)
Demonstration Year 3 (Jan. 2017–Dec. 2017)	$1,079.77 ($904.92, $1254.62)	$1,038.20 ($871.29, $1205.12)	$1,084.83 ($980.59, $1189.07)	$1,040.71 ($927.73, $1153.69)
Demonstration Year 4 (Jan. 2018–Dec. 2018)	$850.40 ($735.14, $965.67)	$806.93 ($698.86, $915.01)	$1,112.26 ($1006.1, $1218.41)	$1,067.52 ($952.31, $1182.72)
Demonstration Year 5 (Jan. 2019–Dec. 2019)	$924.80 ($811.22, $1038.38)	$874.60 ($770.37, $978.84)	$1,198.56 ($1078.53, $1318.59)	$1,149.57 ($1019.5, $1279.64

FFS = fee for service; PMPM = per member per month; TAF = Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files.

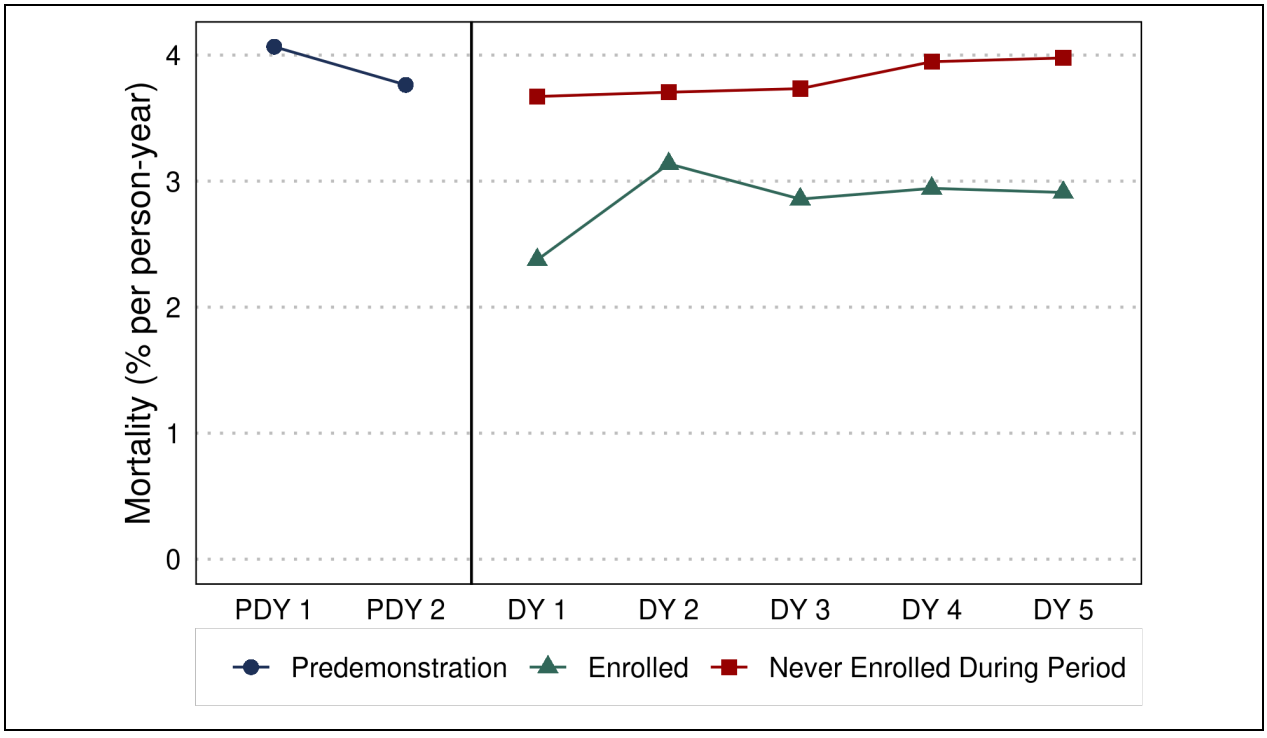
Appendix E

Supplemental Analyses

E.1 Mortality Analysis

This descriptive analysis examines mortality rates to provide additional insight into differences in health characteristics between enrolled and non-enrolled beneficiaries in the demonstration group. Understanding these differences can help understand the DinD results described in ***Section 5, Demonstration Impact on Cost Savings***. A lower mortality rate observed among the enrolled population, relative to the demonstration eligible but not enrolled population, would suggest favorable selection into the demonstration. Demonstration group eligible beneficiaries are categorized into three groups: predemonstration, enrolled during a demonstration period, and never enrolled during a demonstration period. Enrollment categories are based on period-level indicators, so the same beneficiary's observations may be categorized differently over time based on enrollment during a given period. ***Figure E-1*** shows the annualized mortality rate for each group, defined as the number of beneficiaries who died during the period divided by the number of person-years (months alive divided by 12) during the period. Beneficiaries who enrolled in MMPs during the demonstration period have a lower mortality rate than the demonstration eligible non-enrolled during the demonstration period.

Figure E-1
Mortality rate among enrolled and never enrolled in California, February 1, 2012–December 31, 2019



PDY = predemonstration year; DY = demonstration year.

Table E-1
Monthly average number of beneficiaries who died during the predemonstration and demonstration period, February 1, 2012–December 31, 2019

Period	Predemonstration		Enrolled		Never Enrolled During Period	
	N	Died (%)	N	Died (%)	N	Died (%)
Predemonstration year 1	7,889,166	4.07	N/A	N/A	N/A	N/A
Predemonstration year 2	8,234,528	3.76	N/A	N/A	N/A	N/A
Demonstration year 1	N/A	N/A	4,195,118	2.38	11,291,572	3.67
Demonstration year 2	N/A	N/A	1,636,491	3.14	7,229,952	3.71
Demonstration year 3	N/A	N/A	1,571,387	2.86	7,531,629	3.73
Demonstration year 4	N/A	N/A	1,498,717	2.94	7,703,474	3.95
Demonstration year 5	N/A	N/A	1,500,284	2.91	7,883,555	3.98

N/A = Not applicable.
NOTE: The N includes the number of alive months during the year among demonstration eligible beneficiaries. Mortality rates are reported as percentages per beneficiary-year.
SOURCE: RTI analysis of Medicare fee-for-service claims and encounter data.

E.2 Cost Savings

The FAI required that certain savings percentages be applied to the MMP capitated rate to ensure that the California demonstration would result in a decrease in Medicare spending. However, our findings from an impact analysis indicate that the demonstration resulted in an increase in Medicare costs among all eligible beneficiaries in the demonstration group, relative to the comparison group, from demonstration year 1 to demonstration year 5, despite the application of these savings percentages in the capitation rate for MMP enrollees. To better understand these results, we conducted three analyses:

1. We calculated and compared a normalized county-based FFS standardized rate with the actual MMP rate to determine whether the MMP capitated rate was set higher than what would otherwise have been spent in Medicare FFS.[24] Specifically, using observed FFS expenditure data available from CMS, we calculated FFS county rates by taking county-level per capita costs and dividing it by the average risk score for each county. In this way, we obtained a county-level rate for a person whose risk is 1.0 that can be used for comparison with the MMP rate. If the MMP rates were set higher than what would have been observed under FFS, then this would help explain in part why the California demonstration resulted in increased Medicare costs.

2. We compared the predemonstration spending history among those who enrolled in demonstration year 1 and those who were eligible but never enrolled. If enrolled beneficiaries are less expensive than those who never enrolled during the

[24] The analysis is focused on FFS because about 80 percent of the beneficiaries who enrolled in MMPs were previously in FFS.

predemonstration period, then this would provide additional evidence of favorable selection into the enrolled group.

3. We compared the predemonstration risk score profiles among those who enrolled in demonstration year 1 and those who were eligible but never enrolled. If enrolled beneficiaries have lower average risk scores than those who never enrolled during the predemonstration period, then this would provide additional evidence of favorable selection into the enrolled group.

E.2.1 Rate-setting Comparison

Table E-2 provides an example of how RTI calculated the normalized county rate using observed FFS Parts A and B expenditures for Orange County, California. First, using observed FFS expenditure data available from CMS,[25] we summed Part A and Part B per capita costs and then we divided the amount by the county-level risk score.[26]

Table E-2
Example of RTI normalized county rate calculations for 2015 (demonstration year 1), Orange County, CA

County	Part A total per capita cost ($)	Part B total per capita cost [a] ($)	Part A + Part B ($)	Risk score [b]	RTI normalized FFS rate
Orange	377.13	478.53	855.66	1.067491	801.57

FFS = fee-for-service.
[a] FFS15.xlsx files found in the download titled *FFS DATA 2015 (ZIP)* from FFS Data (2015-2020) | CMS
[b] Medicare FFS County 2021 Web.xlsx files found in the download titled *FFS DATA 2018 (ZIP)* from FFS Data (2015-2020) | CMS.

On a composite basis, the MMP capitation rates are largely comparable with the RTI normalized FFS rate (overall, the weighted average MMP rate is 99.5 percent of the RTI normalized FFS rate in demonstration year 1, and 93.0 percent in demonstration year 4). Furthermore, four of the MMP rates are below the RTI normalized FFS rate in demonstration year 1 (***Table E-2***, column E). In demonstration year 4 every county has MMP rates lower than the RTI normalized FFS rate, because the FAI-required savings percentages applied to the MMP rates were larger in later demonstration years (***Table E-3***, column E). These findings indicate MMP rate setting does not explain the increased costs as indicated by the DinD estimates for the demonstration group as a whole.

[25] FFS Data (2015–2020). Available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data.
[26] Note that because the Part A total per capita costs in the actuary file includes both Part A only beneficiaries as well as those with both Part A and B, we raised the RTI rate by 3 percent to reflect the exclusion of Part A only beneficiaries in managed care.

Table E-3
Comparison of MMP rates to observed FFS spending, 2015 (demonstration year 1)

County	Enrollment (beneficiary months)[a]	Percent enrollment[a]	RTI normalized FFS rate ($)	Final MMP rate after application of 1% savings ($)	MMP rate as % of RTI Normalized FFS rate
	A	B	C	D	E
Los Angeles	588,587	43.3	886.23	890.06	100.4
Orange	15,444	1.1	801.57	859.95	107.3
Riverside	163,581	12.0	797.59	795.99	99.8
San Bernardino	163,644	12.0	770.33	784.21	101.8
San Diego	209,261	15.4	788.23	772.76	98.0
San Mateo	103,009	7.6	794.44	749.99	94.4
Santa Clara	116,038	8.5	827.30	800.38	96.7
Weighted Average[b]	N/A	N/A	833.59	829.34	99.5
Total	1,359,564	N/A	N/A	N/A	N/A

FFS = fee-for-service; MMP = Medicare-Medicaid Plan; N/A = not applicable.
[a] As reflected in RTI's DinD impact analysis sample.
[b] Numbers in column A are used as the weights.

Table E-4
Comparison of MMP rates to observed FFS spending, 2018 (demonstration year 4)

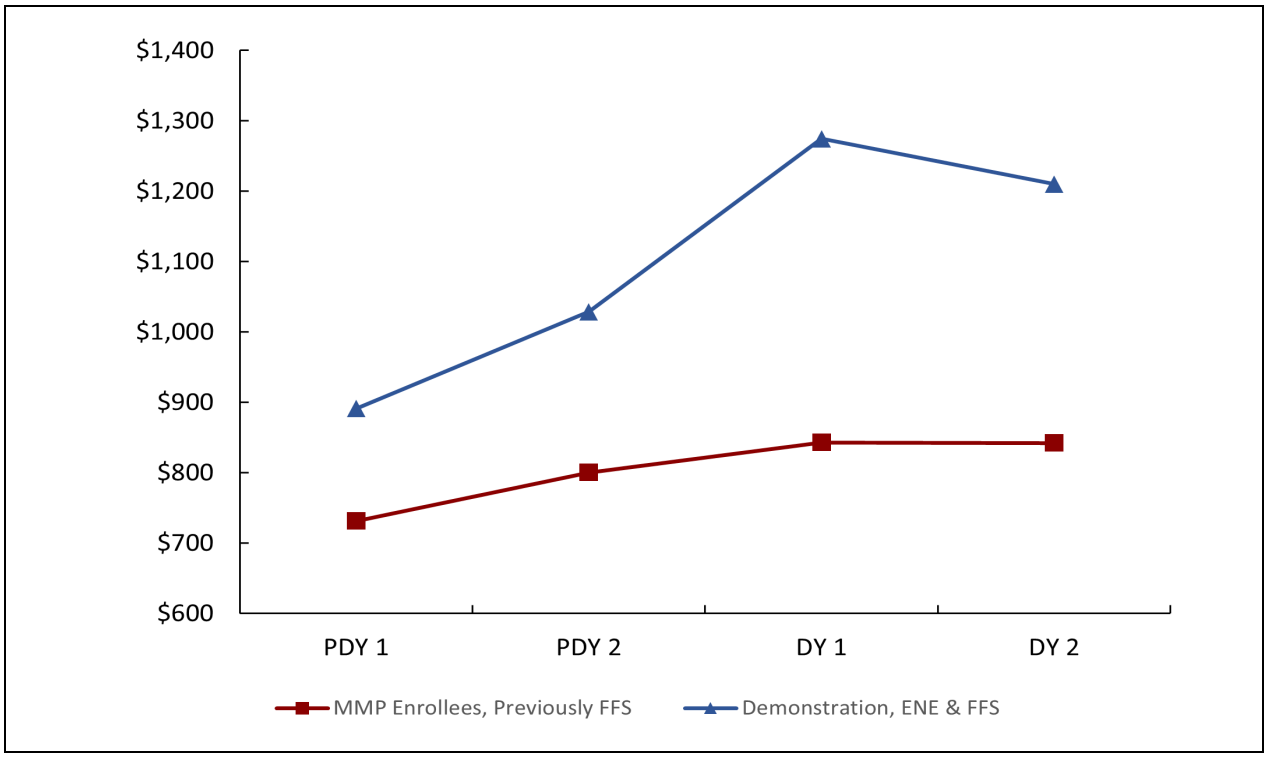
County	Enrollment (beneficiary months)[a]	Percent enrollment[a]	RTI normalized FFS rate ($)	Final MMP rate after application of 4% savings ($)	MMP rate as % of RTI Normalized FFS rate
	A	B	C	D	E
Los Angeles	408,010	31.8	948.13	880.54	92.9
Orange	169,537	13.2	860.83	818.47	95.1
Riverside	169,361	13.2	858.60	803.83	93.6
San Bernardino	165,829	12.9	826.09	773.72	93.7
San Diego	164,094	12.8	854.49	796.41	93.2
San Mateo	92,245	7.2	882.77	796.06	90.2
Santa Clara	113,528	8.9	904.04	818.55	90.5
Weighted Average[b]	N/A	N/A	888.41	826.07	93.0
Total	1,282,604	N/A	N/A	N/A	N/A

FFS = fee-for-service; MMP = Medicare-Medicaid Plan; N/A = not applicable.
[a] As reflected in RTI's DinD impact analysis sample.
[b] Numbers in column A are used as the weights.

E.2.2 Pre-enrollment Cohort Analysis

Our analysis of predemonstration trends found that FFS beneficiaries with lower predemonstration FFS expenditures were more likely to enroll in an MMP plan. ***Figure E-2*** illustrates that the demonstration year 1 enrolled population was less costly during the predemonstration period than its eligible-never-enrolled (ENE) counterpart. This finding provides additional evidence of favorable selection into the MMPs at the start of the demonstration. However, favorable selection into the MMPs does not explain the increase in Medicare spending among all demonstration eligible beneficiaries.

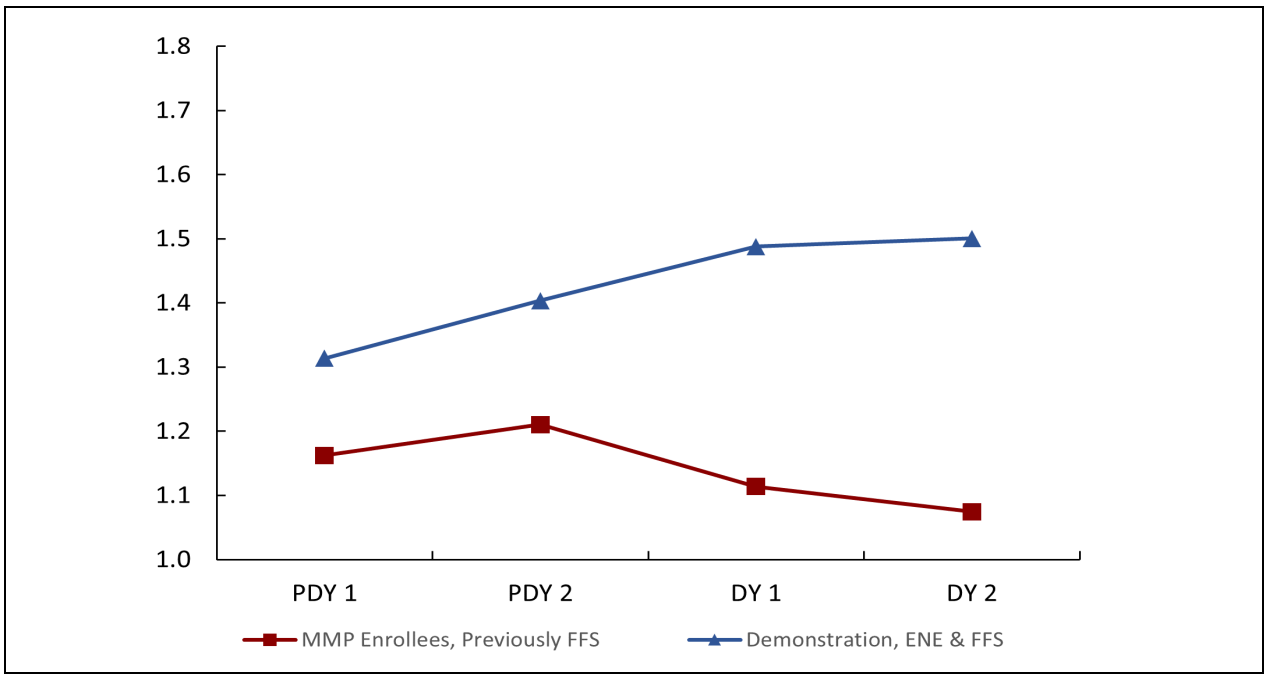
Figure E-2
Average Medicare Parts A and B costs PMPM among demonstration year 1 enrolled and ENE cohorts



DY = demonstration year; ENE = eligible not enrolled; FFS = fee-for-service; MMP = Medicare-Medicaid Plan; PDY = predemonstration year; PMPM = per member per month.
NOTE: Predemonstration year 1 is from April 2012 through March 2013; predemonstration year 2 is from April 2013 through March 2014; demonstration year 1 is from April 2014 through December 2015; demonstration year 2 is from January 2016 through December 2016.
Source: RTI analysis of CA pre-enrollment trends

Figure E-3 shows the risk score profile of the population of demonstration year 1 enrollees and ENEs. Average risk scores for the enrollees are lower than the average risk scores of the ENEs. This figure further reinforces the favorable selection finding. Favorable selection can occur for multiple reasons, like plans purposefully targeting healthier beneficiaries or sicker beneficiaries deciding not to enroll in the demonstration because of concerns about provider availability, care continuity, and access to long-term services and supports (LTSS). Passive enrollment could have played a role in curbing favorable selection into the demonstration; however, opt-out and disenrollment were substantial.

Figure E-3
Average risk score among demonstration year 1 enrolled and ENE cohorts



DY = demonstration year; ENE = eligible not enrolled; FFS = fee-for-service; HCC = Hierarchical Condition Category; MMP = Medicare-Medicaid Plan; PDY = predemonstration year; PMPM = per member per month.
NOTE: Predemonstration year 1 is from April 2012 through March 2013; predemonstration year 2 is from April 2013 through March 2014; demonstration year 1 is from April 2014 through December 2015; demonstration year 2 is from January 2016 through December 2016.
Source: RTI analysis of CA pre-enrollment trends.

Finally, although the factors described here are at play for the enrollee population, FFS eligible but not enrolled beneficiaries are not affected by the savings percentages built into the MMP capitated rates. The analysis of the demonstration's impact on Medicare costs used an intent-to-treat (ITT) approach that included all eligible beneficiaries, not only those enrolled in an MMP, to alleviate concerns about selection bias in enrollment that could not be replicated in the comparison group. The eligible but not enrolled population was substantially larger than the enrolled population (which was about 16 percent). As such, the spending among the eligible but not enrolled could obscure any savings achieved among the enrolled population. Moreover, Medicare spending in the comparison group increased at a slower rate than in the demonstration group. There may be unobservable characteristics influencing a different rate of change in Medicare spending in the comparison group relative to the demonstration group. In sum, although the supplemental analyses presented here shed light on the favorable selection of relatively healthier and lower-cost beneficiaries in MMP enrollment and help understand why favorable demonstration impacts may be difficult to observe, they do not pinpoint the drivers of Medicare cost increases among all eligible beneficiaries in the demonstration group relative to the comparison group. These results are not directly comparable with the results shown in the enrollee-only analysis (see ***Table D-17*** in ***Appendix D***), because the comparison group used for that analysis was a subset of the comparison group in the main analysis.