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Re: Cal MediConnect Performance Dashboard

Greetings:

We, the undersigned, write regarding the recently released updated version of the Cal MediConnect Performance Dashboard.[1] The dashboard data is intended to demonstrate whether the Cal MediConnect program is improving the quality of care dual eligibles receive through the provision of integrated care and increased access to home and community-based services. While we appreciate the Department incorporating a number of measures stakeholders recommended following the release of the first performance dashboard in 2016, we have serious concerns regarding both the accuracy of the data reported in the 2018 dashboard and the lack of data on key measures necessary to evaluate whether the Cal MediConnect program is meeting its goals.

Most notably, there are no measures presented in the dashboard that show whether plans are better connecting dual eligibles who have unmet need for critical long-term services and supports (LTSS) – the primary goal of the program. There is also no data presented to demonstrate whether the health plans have been successful in transitioning dual eligibles from institutional settings to home and community-based settings, reducing avoidable hospitalizations, or providing enhanced services to help duals remain living in the community. The Cal MediConnect program is aimed at reducing health care spending among dual eligibles who, because of the lack of coordination, incur the highest health care costs. Yet, the dashboard provides no data on who the program is serving and whether dual eligibles who have the most need and poorest health are enrolled. There are also considerable variations in

[1] Cal MediConnect Performance Dashboard – April 2018, available at http://www.dhcs.ca.gov/Documents/CMCDashboard4.18.pdf

the data that raise concerns regarding the accuracy of the data presented. For example, as presented in the dashboard, only 345 dual eligibles out of 115,000 enrolled in the program are receiving long-term services and supports – a staggering figure if accurate.

As we enter the fifth and final year of the Cal MediConnect demonstration period, it is imperative that data is available for stakeholders to evaluate and determine whether the program should continue, and if so, in what form. To that end, we have included below a detailed summary of our concerns and recommendations to make the dashboard a more useful tool for evaluation in future iterations to be released quarterly. We are ready to work with DHCS on this effort and request a meeting to review our concerns and recommendations with you in further detail.

Sincerely,

Justice in Aging
Alzheimer's Greater Los Angeles
California Advocates for Nursing Home Reform
California Foundation for Independent Living Centers
California Health Advocates
California Hospital Association
California Medical Association
CCI Ombudsman
Disability Rights California
Disability Rights Education & Defense Fund
Health Consumer Alliance
- Bay Area Legal Aid
- California Rural Legal Assistance
- Central California Legal Services
- Greater Bakersfield Legal Assistance
- Inland Counties Legal Assistance
- Legal Aid Society of Orange County
- Legal Aid Society of San Diego
- Legal Aid Society of San Mateo County
- Legal Services of Northern California
- National Health Law Program
- Neighborhood Legal Services of Los Angeles County
- Western Center on Law & Poverty

Los Angeles Aging Advocacy Coalition
LIFE ElderCare
Multipurpose Senior Services Program Site Association
Partners in Care
Personal Assistance Services Council

Cal MediConnect Dashboard Comments and Recommendations

General Comments on the Data

- **Trending data**. The dashboard includes trending data on a number of measures, but not all. Trending data should be included on most measures that carries forward from each version of the dashboard to the next in order to evaluate trends over the entirety of the demonstration.

- **Baseline data**. It is also necessary to include baseline data prior to the implementation of the demonstration for each measure to evaluate how the demonstration is performing compared to the prior delivery system.

- **CareMore and Anthem**. CareMore data and Anthem's data should not be combined on the dashboard. While the same parent company may operate the two products, their care delivery models are entirely different, and combining them obscures how the two different models differ in their performance.

- **Timing of data**. Understanding that the various measures featured in the performance dashboard might have different reporting timelines and frequencies, DHCS should strive to release the most current data whenever possible. This is particularly true for enrollment statistics. The dashboard's enrollment and demographic information is current as of June 2017, but the Department's own Medi-Cal Managed Care enrollment report contains enrollment numbers as of February 2018.[2]

Accuracy of Data

The 2018 dashboard contains a number of measures that raise questions as to whether the data has been accurately reported, or alternatively, whether health plans have accurately or consistently reported the data.

- **LTSS Utilization**. The dashboard indicates that statewide only an average of 3 members per 1,000 enrolled in Cal MediConnect are receiving long-term services and supports (LTSS) with the highest utilization rate being approximately 7 members per 1,000 (see p. 2 and p. 26). If this is accurate, this means that only 345 individuals out of 115,000 enrolled members are receiving LTSS, including In-Home Supportive Services, Community-Based Adult Services, Multi-Purpose Senior Services, and nursing facility services (defined on p.8).

[2]Medi-Cal Managed Care Enrollment Report – February 2018, available at http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCEnrollRptFeb2018.pdf (p. 4).

We question the accuracy of this data both because of the exceedingly low reported utilization rates and because it is a significant decline in LTSS utilization rates compared to what was reported on the 2016 dashboard.[3] The 2016 dashboard indicates that in reporting year 2015 approximately 28,000 members were receiving IHSS, 1,200 were receiving CBAS, 530 were receiving MSSP, and 4,600 were receiving nursing facility services.

Accordingly, either the data in the 2018 dashboard is inaccurately reported, or there has been a significant and alarming decrease in the provision of LTSS.

This also raises a concern as to how the dashboard was developed and reviewed. Such a huge discrepancy in the reported utilization rates warrants an investigation into the accuracy of the data prior to its release. If in fact the utilization rates are accurate, the dashboard should address the decrease in utilization and provide assurances that DHCS is engaging in a review of the plans' LTSS policies, similar to the dashboard language describing the data the Health Plan of San Mateo reported on critical incidents in LTSS (p. 9).

- **Percentage of Members with Documented Discussions of Care Goals.** This measure has two outlier plans that make us question whether the plans were reporting consistently with each other. While most plans report upwards of 60-90% of members engaging in a discussion of their care goals within the reporting period, Community Health Group (CHG) reported only 29% and Health Plan of San Mateo reported just 7% on this measure. Yet, CHG reports that 100% of their members have a care plan and 98% of its members have had at least one care team contact within the reporting period. How can a care plan be developed and each member have at least one care team contact within the reporting period, but the actual care goals were only discussed with under 30% of those individuals? Again, we believe that these inconsistencies warranted review prior to release of the dashboard to ensure the accuracy of the data being reported. As care coordination is one of the key ways Cal MediConnect seeks to distinguish itself from other delivery systems, discrepancies of this nature require more detailed DHCS review and follow up.

<u>Lack of Data to Assess Performance</u>

- **Omitted Measures**. There are a number of meaningful measures that were reported on the 2016 dashboard or the Cal MediConnect enrollment dashboards that have been omitted from the 2018 dashboard. Although we understand the Department's desire for a digestible dashboard, the previous measures offered greater insight into the

[3] Cal MediConnect Performance Dashboard, March 2016, available at http://calduals.org/wp-content/uploads/2016/03/CMC-Performance-Dashboard-March-2016-Release.pdf

program's operations; eliminating them prevents stakeholders from fully understanding the Cal MediConnect program.

- **LTSS Utilization.** Most notably, the 2018 dashboard does not include a breakdown of what types of LTSS members are receiving. The 2016 dashboard specified how many members were receiving IHSS, CBAS, MSSP, and nursing facility services. One of the primary goals of the demonstration is to rebalance the provision of services from institutional settings to home and community-based settings. The 2018 dashboard does not include a single measure to assess whether plans are meeting this goal, as there is no way to track the usage of each LTSS type over the course of the demonstration.

- **HRA Completion.** Prior versions of the HRA dashboard[4] included the number of individuals who the health plan was not able to locate to complete an HRA and the number of individuals who indicated they did not want to complete an HRA overall and by plan. This data is not presented on the 2018 dashboard, presenting an incomplete picture of HRA completion rates.

- **Health Plan Specific Data**. The 2018 dashboard also omits health-plan specific data on the percentage of members who received a follow-up visit within 30 days of a hospital discharge (p.19). The 2016 dashboard included a plan-by-plan report out on this measure, which was helpful in evaluating how individual plans were performing on this measure. The 2018 dashboard only includes an average of how plans are performing, which significantly decreases the value of the measure and does not allow the public to compare performance across health plans.

- **Appeal Trends**. The 2018 dashboard does not include data on how appeals have trended by quarter. This data was reported on the 2016 dashboard and is included for other measures on the 2018 dashboard. This type of trending data is important to evaluate measures over time.

- **Age of Enrollees**. Previous enrollment dashboards before November 2016 contained detailed information about language, ethnicity, and age of dual eligibles who opted out of the demonstration.[5] We are pleased to see that the performance dashboard's enrollment statistics include language and ethnicity of CMC enrollees, but it excludes age demographics. These measures are important to evaluate who the program is serving and whether disparities across different demographics may exist.

[4] Cal MediConnect Health Risk Assessment (HRA) Dashboard, available at http://calduals.org/wp-content/uploads/2015/08/Health-Risk-Assessment-Dashboard-.pdf

[5]Cal MediConnect Enrollment Dashboard, available at http://calduals.org/wp-content/uploads/2016/10/October-Enrollment-and-Detailed-Opt-Out-Dashboard-FINAL.pdf, p. 2.

- **Different Metrics**. The 2018 dashboard reports data using different metrics than the 2016 dashboard, making it difficult to compare the data over time. For example, the 2016 dashboard reported emergency utilization using the metric of ER visits per 1,000 members. The 2018 dashboard uses the metric ER visits per 10,000 members. The measures should use consistent metrics over time.

- **Absence of Meaningful Measures**. There are a number of measures that should be included in the dashboards moving forward that are necessary to evaluate the performance of the demonstration.

  - **Health Stratification.** The dashboard must include data on health stratification. Specifically, the dashboard should report the percentage of enrollees overall and by health plan who are considered community well, medium risk, high risk, and institutional because the public should be able to evaluate how the demonstration is serving the subpopulations of duals in California. This data should also be presented over time through a trending measure.

  - **LTSS Referrals.** In addition to reporting on the number of members receiving each type of LTSS as discussed above, the dashboard must also include the number of LTSS referrals health plans are making. In evaluations of the Cal MediConnect program, members report significant LTSS unmet need.[6] Without referral data, we cannot evaluate what efforts health plans are undertaking to connect members with unmet need to LTSS. This is not to say that low referral rates are necessarily bad, but it at least allows stakeholders and advocates an opportunity to start a dialogue with health plans on LTSS utilization and referral processes, using concrete empirical measures.

  - **Transitions.** At a minimum, the dashboard must include data on how many members are being discharged from institutional settings to home and community-based settings overall, and by health plan, with trending data**.** Ideally, the dashboard would also include more detailed data on transitions including how many members are transitioned from the hospital to skilled nursing facilities, acute care, or the community, and whether those transitions are occurring on a timely basis.

  - **Care Coordination.** We have seen evidence of a lack of meaningful contact and engagement of care coordinators with Cal MediConnect members. Unfortunately, the data presented in Figure 13 provides little information on the extent that care coordinators are engaging with members since the measure is

[6] 2017 Findings from the Cal MediConnect Rapid Cycle Polling Project, December 2017, available at http://www.thescanfoundation.org/sites/default/files/wave_5_powerpoint_summary_report12_13_17_updated.pptx

defined broadly as at least one "care team" contact. Since the care team includes the physician, this could simply mean that the member saw their primary care physician for an annual exam in that period. The dashboard should include data specific to contact with a care coordinator.

- **Behavioral Health.** The data presented in Figure 21 does not provide a full picture of how many Cal MediConnect enrollees are in effect experiencing a reduction or termination in services. Many duals are transitioned from "mild to moderate" behavioral health services provided by the Cal MediConnect plan to "serious mental illness" provided by the county specialty mental health plans. From a member perspective, this transition feels like a "reduction" or "termination" of services for the member since they have to change providers. This transition is also an area where members experience a disruption in care. Accordingly, the dashboard should include a measure on how many duals are transitioning between the Cal MediConnect plan and the county mental health plans for their behavioral health treatment.

- **Vision.** Vision is one of the benefits that sets a Cal MediConnect plan apart from fee-for-service Medicare and Medi-Cal. The dashboard should include data on the utilization of this benefit to determine the extent the benefit is adding value for enrolled beneficiaries.

- **CPO Services.** The dashboard must include data on the provision of care plan option (CPO) services. The ability of health plans to offer CPOs is one of the few ways that Cal MediConnect plans are distinguishable from other Medicare products. CPOs are also intended to help rebalance the provision of services from institutional settings to home and community-based settings. At this point, no data has been reported on what extent, if at all, these services are being provided. Further dashboards should not only include the extent to which plans are providing CPOs, but also the different types of CPOs they are offering. The dashboard should also include the number of grievances members have filed with regard to CPOs.

- **Hospital Readmissions.** The dashboard must include data on hospital readmission rates for members residing in nursing facilities and in the community overall, and by health plan, with trending data. Readmission rates are a critical measure in determining whether the provision of care coordination is effective in reducing avoidable hospitalizations.

- **Disenrollment Data**. Both the performance dashboard and enrollment dashboards continue to lack specific data regarding member disenrollment from Cal MediConnect. While we are told that 93% of disenrollments occur when a member enrolls in another Medicare product, there is no plan-specific breakdown of these numbers There is also no data around the number of

members who successfully fix a Medi-Cal eligibility issue during the deeming period to assess the adequacy of this consumer protection. Without this data, it is difficult to uncover trends or develop responsive retention policies.

We also know that individuals frequently disenroll from Medicare Advantage plans when they become sick or move into a nursing facility because the Medicare Advantage plan is not able to meet their needs.[7] Tracking why members disenroll from Cal MediConnect would tell us whether this is also occurring in Cal MediConnect.

– **CCI Ombudsman Data.** To provide a more accurate picture of what issues beneficiaries are experiencing in the demonstration beyond appeals and grievances, the CCI Ombudsman call data by county should be included on the dashboard.

Follow-Up on Data

The dashboard contains many points of data that warrant further investigation from DHCS and explanations of discrepancies. For example, are variations in reporting a result of health plans not reporting consistently on the same measure? If so, what is DHCS doing to ensure plans are reporting consistently? If the plans are reporting consistently, what is the explanation for the variance? This presents DHCS with an opportunity to identify best practices and use appropriate enforcement mechanisms for lower performing plans. We noted a number of these examples at the start of this letter in terms of the accuracy of data presented. The following also warrant investigation.

- **HRA Completion (Fig. 7).** Two plans have significantly lower HRA completion rates within 90 days of plan enrollment. While most plans have completion rates in the 90th and above percentile, IEHP has a completion rate of 70% and CFHP reported a completion rate of 52%.

- **Percentage of Members with Completed Care Plans (Fig 9)**. Pursuant to the three-way contracts, Cal MediConnect plans are required to develop a care plan for each member unless a member refuses.[8] Yet, a number of plans have not completed a care plan with approximately 50% of their members. There are also three plans that reported much lower ICP completion within 30 days of the HRA being completed than the other plans.

[7] MEDICARE ADVANTAGE: CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight, available at https://www.gao.gov/assets/690/684386.pdf

[8] Cal MediConnect three-way contract, §§ 2.5.2.9; 2.8.3, available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAContract01012018.pdf

- **Percentage of Members Who Have a Care Coordinator with at Least One Care Team Contact (Fig. 13).** While most plans reported 90-100% on this measure, there are four plans within the 60-75% range and one outlier plan reporting just 34% on this measure.

- **Care Coordinator to Member Ratio (Fig. 14).** There is considerable variation between health plans on the number of care coordinators to members ratio. Pursuant to the three-way contracts, Cal MediConnect plans must ensure an adequate ratio of care coordinator to members to provide required care coordination.

- **Count of Appeals (Fig 18).** There are a number of areas that warrant additional follow-up with regard to appeals. For example, Cal Optima has a much higher percentage of adverse appeal decisions compared to other plans. LA Care has a significantly lower number of overall appeals compared to other plans, especially considering their enrollment. Community Health Group reported zero appeals in the reporting period, raising a flag.

- **Grievances (Fig. 19 & Fig. 20).** A number of health plans have a high number of grievances – particularly in accessing specialists. DHCS should be following up with plans to ascertain the reason for this and whether plans are maintaining adequate networks as required. DHCS also must follow up with plans on what grievances are being considered "other", and future iterations of the dashboard should include some explanation to stakeholders as the largest percentage of grievances fall into this "other" category. The grouping has limited meaning when the catch-all category dwarfs the delineated categories. In addition, IEHP reports almost three times as many grievances under this category than the other plans.