March 2025

# Improving Care for Medicare Beneficiaries in California

Recommendations of the California Medicare Collaborative

PBGH California Quality Collaborative

# Table of Contents

# Executive Summary

California's 65-and-older population is diversifying and growing faster than any other age group. By 2030, nearly one in five Californians will be 65 or older, and the majority of them will be Medicare beneficiaries with complex health care needs. To effectively address these needs, California's health care ecosystem must be strengthened to provide person and family-centered care for this growing and diverse group.

With this in mind, the California Medicare Collaborative (Collaborative) was created as a multi-stakeholder space for health care leaders to prioritize strategies within their locus of influence for improving care delivery to Medicare patients. The Collaborative focused on system change ideas that could be initiated within two years and improve care within the existing regulatory framework. It prioritized actions that could be taken by state or local actors—such as health plans, providers, advocates, state agencies and philanthropy.

State leaders voluntarily joining together to explore ways they can improve care within a federal program is a unique endeavor. California has long prioritized enhancing care for its dually-eligible population—those eligible for both Medicare and Medi-Cal—due to the significant needs within this group and the state's role in funding and overseeing Medi-Cal. The Collaborative was a first-of-its-kind initiative focused on how state-level actors could work together to improve care for residents insured by Medicare only.

Between July and October 2024, Collaborative participants met five times to prioritize high impact and feasible recommendations that can be initiated in the next two years across four focus areas:

1. Chronic illness management and care coordination
2. Access, equity and disparities in care
3. Beneficiary choice in a confusing market
4. Cognitive and behavioral health

In addition to care for dual eligibles, long term services and supports for Medicare-only individuals was placed outside the Collaborative's scope, as it was already being addressed via other statewide forums.

The Collaborative developed 10 recommendations across the four areas:

### 1. Chronic Illness Management and Care Coordination

**a. Strengthen chronic care management** via supportive funding streams and payment policy.

Despite evidence that care management improves outcomes, many California Medicare beneficiaries lack support due to workforce shortages, misaligned payment policies and lack of actionable data. The Collaborative identified solutions to strengthen care management through supportive funding, including state-enforced primary care investments goals, scaling and aligning Medicare Advantage value-based contracts and identifying sustainable ways for providers to leverage Medicare fee-for-service codes that reimburse for chronic care management.

*The Collaborative was a first-of-its-kind initiative focused on how state-level actors could work together to improve care for residents insured by Medicare only.*

**b.** **Promote Advanced Primary Care** (APC) by investing in supportive training, clinical care models and compensation models for Medicare patients.

APC focuses on prevention and chronic condition management through team-based, integrated, accessible, equitable and data-driven care. Key strategies to promote APC in Medicare include health plan or philanthropy-funded training for providers on APC models, aligned value-based payment models in Medicare Advantage that incentivize APC and support for providers to adopt related technology like remote patient monitoring and population health management tools.

**c.** **Increase support for and coordination with organizations that address patients' health-related social needs** (HRSNs) via capacity building and innovative payment models.

HRSNs impact health but are not well addressed by the current health care system. While community-based organizations (CBOs) can address HRSNs, Medicare-funded models integrating health care and CBO services are in their infancy. Ideas to support CBOs in Medicare include provider participation in programs like ACO REACH that incentivize coordination with CBOs, using value-based incentive design and/or Special Supplemental Benefits in Medicare Advantage to fund CBOs and designating champions within health care organizations to lead CBO partnerships.

## 2. Access, Equity and Disparities in Care

**d.** **Improve population health management** by improving data on Medicare beneficiary HRSNs and evaluating programs that seek to meet those needs.

Promoting equity and reducing health disparities is difficult without data on patient HRSNs and demographics. As of 2019, only 40% of Medicare patient race data and less than 20% of ethnicity data were complete.[1] In addition to collecting better data at the point of care, the Collaborative emphasized the importance of data exchange to reduce duplication of effort and broaden access to HRSN and demographic data. Government, philanthropy and Medicare Advantage plans can support better data by funding technical assistance. In addition, new reporting to the Centers for Medicare & Medicaid Services (CMS) on utilization of supplemental benefits can help uncover which are most useful for addressing beneficiary HRSNs.

**e.** **Increase access to care for special populations** —including low-income Medicare beneficiaries, Medicare beneficiaries with limited English proficiency, those receiving Medicare due to social security disability and those that live in rural communities—via effective care delivery models.

The Medicare populations above face barriers to accessing health care due to income, geography, disability and language. Collaborative members suggested testing and scaling effective methods to improve access for these groups. There was specific interest in solutions that leveraged telehealth, home visits, community health workers and bilingual providers.

**f.** **Strengthen the clinical workforce needed to serve Medicare beneficiaries in an equitable way** through training for the current workforce, care team diversification and supports for trainees in shortage professions.

California faces a health workforce shortage in primary care, behavioral health and geriatrics, with a workforce that does not reflect the state's racial, ethnic or language diversity, despite evidence that concordance improves outcomes.[2] The Collaborative focused on shorter-term solutions, including fast-tracking geriatric psychiatry residents into high-need areas, supporting programs for students from underrepresented communities training in health shortage fields, training the current workforce in geriatrics and cultural competence and better integrating community health workers into care teams for older adults.

### 3. Beneficiary Choice in a Confusing Market

**g. Support patients and caregivers to make informed choices about their Medicare coverage** by implementing appropriate messaging, promoting and improving plan comparison tools and expanding access to Medicare options counseling.

Market complexity and lack of transparency make it hard for Medicare beneficiaries to choose the best coverage. The Collaborative recommended expanding the Health Insurance Counseling and Advocacy Program (HICAP), which is well regarded but serves a small fraction of California beneficiaries, advertising Medicare Plan Finder and distributing neutral information about coverage options through media and trusted community partners.

### 4. Cognitive and Behavioral Health

**h. Reduce stigma and normalize seeking cognitive and behavioral health services** via culturally competent messaging and channels.

Many older adults hesitate to seek cognitive and behavioral health services due to stigma. Providers and health plans can address this by including information on how to access services in patient materials and collaborating with community organizations to develop and share key messages. State government and partners could launch a communications campaign to reduce stigma and raise awareness of available resources.

**i. Amplify and improve screening to promote earlier and wider detection of cognitive and behavioral health needs** via spread of existing training resources and care models.

Primary care providers often lack training and workflows to screen and refer older adults for cognitive and behavioral health needs. To address this, the Collaborative recommended steps providers can take, supported by government, health plans and other partners: expand dementia screening through training from organizations like Dementia Care Aware, promote continuing education on cognitive and behavioral health; increase Medicare Annual Wellness visits and encourage screenings for social needs that impact cognitive and behavioral health.

**j. Increase supports for patients with cognitive and behavioral health needs and their caregivers** by expanding access to navigation and wrap-around services.

People with complex cognitive and behavioral health needs often experience fragmented care, leading to poor outcomes and high system utilization. Caregivers also face significant burdens. To improve care, providers and health plans can solicit feedback from patients and families about their experiences and needs, pilot new care models for navigation and peer support and promote regional implementation of the Guiding an Improved Dementia Experience (GUIDE) Model.

The Collaborative was funded by Archstone Foundation, The SCAN Foundation and the Gary and Mary West Foundation, and facilitated by the California Quality Collaborative (CQC). The California Department of Health Care Services (DHCS) Office of Medicare Innovation and Integration (OMII) also participated in the discussions and provided technical assistance.

Thank you to our state partners who joined the discussion and provided technical assistance. The contents of this issue brief do not represent the official views, nor endorsement by, the state of California or Departments under the California Health and Human Services Agency.

# Introduction

## Rationale

Medicare is a federal health insurance program serving more than 66 million beneficiaries, including people ages 65 and older and younger adults with long-term disabilities. However, because health care delivery is local, decisions by providers, payers, state agencies and other California stakeholders can significantly impact Medicare patient care and outcomes. These efforts can be amplified when organizations align around shared priorities and best practices. The California Medicare Collaborative created a first-of-its-kind forum for California stakeholders to share insights and prioritize actions that could be initiated in the next two years to improve Medicare delivery, without waiting for regulatory change.

Bringing Medicare stakeholders together in California is crucial right now for several reasons:

**The Medicare eligible population is growing quickly and has complex needs.** By 2030, the percentage of the state's population eligible for Medicare based on age (65 or older) will be over 19 percent. Medicare beneficiaries tend to have multiple chronic conditions, need a variety of providers and services, and may have daily living challenges. This means our health and social care systems will need to evolve to serve increased health and long-term care needs.

**Californians with lower incomes that are not Medi-Cal-eligible face many similar challenges to dual eligibles, without access to additional supports provided by the Medi-Cal program.** Historically, California has focused on improving care for its dually-eligible population—those eligible for both Medicare and Medi-Cal—due to the significant needs within this group and the state's role in funding and overseeing Medi-Cal. That said, Medicare-only individuals represent about five million Californians, of which 13% have incomes in the federal poverty level range of 139-200%.[3] These low-income beneficiaries do not meet the income eligibility requirements for Medi-Cal and are often overlooked in their struggles to finance and access their health care.

## Process

A consensus-based process was used to develop the recommendations and action plans presented in this report. The facilitation team—supported by an initial landscape scan—developed change ideas for improving care delivery in four focus areas that were pre-selected by the project's funders. During five Collaborative convenings and eight steering committee meetings, participants discussed and prioritized change ideas that were high impact and feasible to initiate within a two-year timeframe without regulatory change. Given the Collaborative's focus on improving care for Medicare-only individuals, improvement strategies that were only applicable to dual eligibles were excluded.

## Participants

The Collaborative was funded by Archstone Foundation, The SCAN Foundation and the Gary and Mary West Foundation, and facilitated by CQC. DHCS, OMII and other state partners also joined the discussion and provided technical assistance. Participants in the Collaborative included health plan, provider, advocacy and research organizations. The project's steering committee included representation from funders, CQC and a subset of Collaborative participants. A full list of participating organizations can be found in "California Medicare Collaborative Participants" on page 34.

## About this Report

This report discusses the current state of Medicare beneficiary care in California, outlines the rationale behind the focus areas and recommendations and presents actionable strategies developed by Collaborative participants to move these recommendations forward. It is designed to support payers, providers, advocates, government and other stakeholders seeking to collaboratively improve care for Medicare beneficiaries in California. The recommendations in this report were developed in 2024, before the change in federal government administration in 2025.

# Broad Medicare Trends in California

## Overview of the Medicare Program

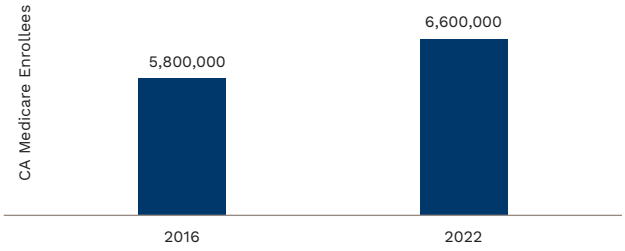
Medicare is a federally funded health insurance program primarily for individuals age 65 and older, though it also covers some younger individuals with disabilities. The program is divided into several parts to address specific health care needs: Part A covers hospital stays and skilled nursing facility care, Part B covers outpatient care and Part D provides prescription drug coverage.[4]

Medicare beneficiaries can access their benefits through either Original Medicare or Medicare Advantage. Original Medicare offers greater flexibility in choosing providers without referrals or network restrictions, but monthly costs may be higher. Beneficiaries with Original Medicare typically buy Medicare Supplement Insurance (known as Medigap) to cover out-of-pocket costs, and also purchase a separate Medicare drug plan to get drug coverage. In contrast, Medicare Advantage plans typically include Medicare drug coverage and yearly out-of-pocket spending limits, offer lower monthly premiums and extra benefits, such as vision and dental coverage. However, these plans often require prior authorization for certain services and less provider choice compared to Original Medicare.

## Demographics of Californians Enrolled in Medicare

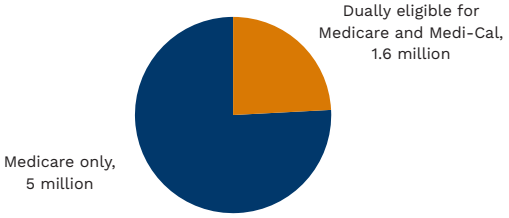
**The Medicare population in California is growing and becoming more diverse, with enrollment shifting toward Medicare Advantage,** as illustrated in the graphs below.

**Medicare enrollment in California is increasing as the state population ages.**




Source: Medicare Monthly Enrollment, filtered table of California annual enrollment, Center for Medicare and Medicaid, accessed 11/13/2024.

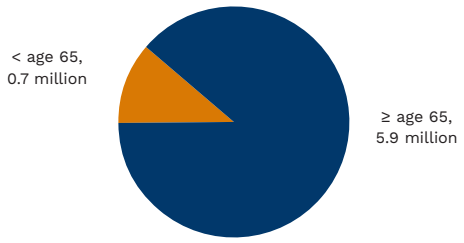
**3 in 4 Medicare beneficiaries in California have Medicare only** (vs. dual eligibility for Medicare and Medi-Cal).




Source: Department of Health Care Services Office of Medicare Innovation and Integration website, accessed 11/11/2024.

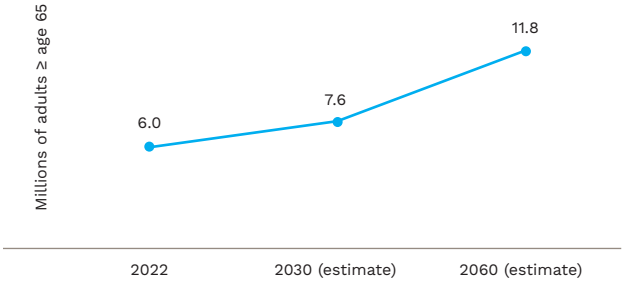
*The Medicare population in California is growing and becoming more diverse, with enrollment shifting toward Medicare Advantage.*

**90% of Medicare beneficiares in California are age 65 and older.**



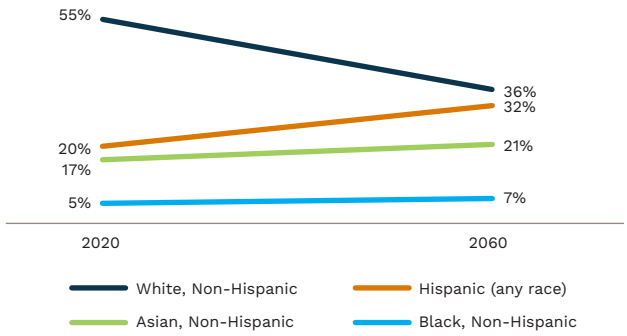

Source: Department of Health Care Services Office of Medicare Innovation and Integration website, accessed 11/11/2024.

**The number of Californians ≥ age 65 is projected to increase over time.**



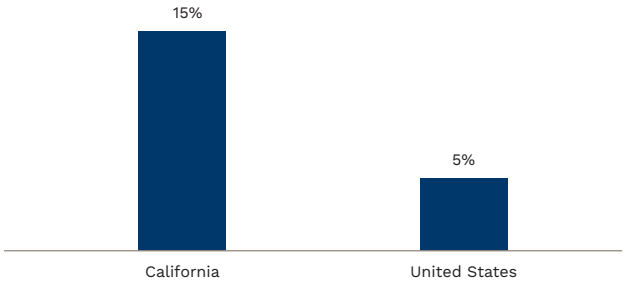

Source: Master Plan for Aging Data Dashboard, Demographics Dashboard, California Department of Aging, accessed 11/11/2024.

**California's older adult population is also projected to become more racially and ethnically diverse over time.**




Source: Master Plan for Aging Data Dashboard, Demographics Dashboard, California Department of Aging, accessed 11/11/2024.

**One in seven Californians with Medicare had limited English proficiency in 2019.**



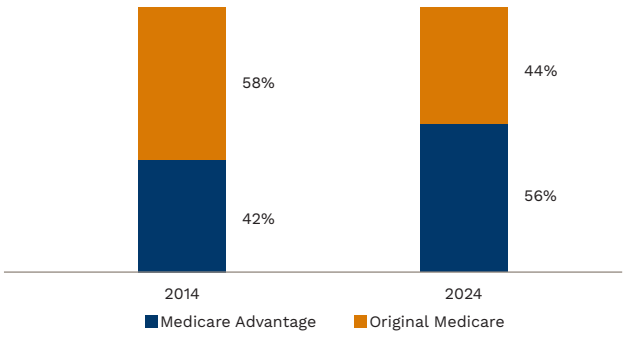

Source: Cultural and Linguistic Demographics of the California Medicare Population, ATI Advisory, California Department of Health Care Services Office of Medicare Innovation and Integration, May 2023

## Medicare Delivery System Landscape in California

### Medicare Advantage

**Medicare Advantage enrollment has been steadily growing for two decades in California** and nationally, following the passage of the Medicare Modernization Act of 2003, which created stronger financial incentives for plan participation.[5] As of 2024, 56% of California's Medicare beneficiaries were enrolled in Medicare Advantage, up from 42% in 2014.[6] Nationally, 54% of Americans were enrolled in a Medicare Advantage plan in 2024.[7] The Congressional Budget Office projects that the share of all Medicare beneficiaries enrolled in Medicare Advantage plans will rise to 64% by 2034.[8]

**The share of Californians enrolled in Medicare Advantage has increased over time.**

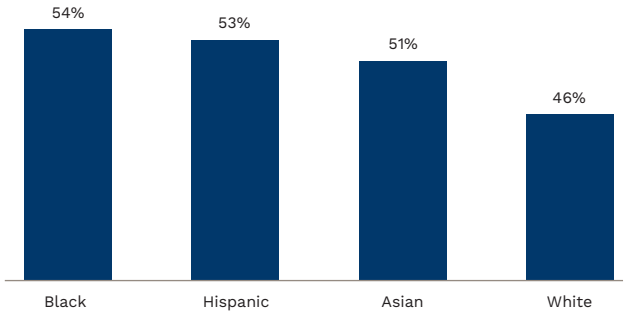



Source: Medicare Advantage Enrollment in 2024: Enrollment Update and Key Trends, Meredith Freed, Jeannie Euglesten Biniek, Anthony Damico, and Tricia Neuman, KFF, August 8, 2024.

## *While overall rates of enrollment in Medicare Advantage are high in California, there is variation by region, race and ethnicity and income.*

- Medicare Advantage penetration is significantly lower in California's rural counties compared to urban counties. As of 2021, only 6% of beneficiaries from rural counties were enrolled in Medicare Advantage.[9] Regionally, there is also significant variation in the number of plan options by county. Rural counties tend to have the smallest number of options (e.g., 1-10), followed by urban counties in the Bay Area and Central Valley (e.g., 11-40).[10] Urban Southern California counties have the most Medicare Advantage plans (e.g., 60+).[11] With 78 plan options, Orange County has the largest number of Medicare Advantage products in the state in 2024.[12]
- By race and ethnicity, California Medicare Advantage enrollment as of 2021 was highest among Black beneficiaries (54%), followed by Hispanic beneficiaries (53%), Asian beneficiaries (51%), and White beneficiaries (46%).[13]
- Nationally, Medicare Advantage serves a higher percentage of low-income beneficiaries with more social risk factors such as limited English proficiency, food insecurity or lower educational attainment.[14]

**Enrollment in Medicare Advantage Varies by Race and Ethnicity.**




Source: Cultural and Linguistic Demographics of the California Medicare Population, ATI Advisory, California Department of Health Care Services Office of Medicare Innovation and Integration, May 2023.

**California's highly delegated marketplace impacts the Medicare Advantage delivery system.** California health plans can contract with medical groups and independent physician associations (IPAs) on a capitated basis and delegate health plan responsibilities such as utilization management or credentialling. This structure creates unique challenges, such as additional administrative complexity and provider network instability.

**Providers who contract with Medicare Advantage plans interact with a system that is entirely unique from Original Medicare.** Commonly cited differences include payment timeliness — the quick turnaround times under Original Medicare are not required for Medicare Advantage plans — and prior authorization, which occurs significantly less in Original Medicare. Lack of alignment in rules and requirements across Medicare Advantage plans (e.g., prior authorization or reporting requirements) also contributes to administrative overhead for providers. In response to these challenges, some providers in California have stopped accepting Medicare Advantage altogether.[15,16] Conversely, many Medicare Advantage plans — most notably in Southern California — have figured out how to share their revenue with providers via risk-based delegation agreements, as described above.

**Recently, Medicare Advantage plans have faced increased headwinds,** including regulatory changes and financial pressure.[17] However, there is evidence that the Trump administration may try to accelerate the shift from original Medicare to Medicare Advantage and deregulate plans, which could create more flexibility and boost profits.[18]

## Original Medicare and Accountable Care Organizations

**While Medicare Advantage has seen tremendous growth over the last 20 years, nearly half of all Californians are still covered by Original Medicare.** Even if Medicare Advantage penetration increases as predicted[19], more than a third of the state's Medicare population would remain in Original Medicare.

**Medicare Accountable Care Organizations (ACOs) create value-based structures for beneficiaries in Original Medicare, where a group of health care providers contract with CMS to take accountability for an assigned patient population.** CMS has set a goal to have 100% of Original Medicare beneficiaries be part of an accountable care relationship by 2030.[20] There are different ACO models with variable levels of uptake in California; however, the most prominent program has been the Medicare Shared Savings Program (MSSP).[21] As of 2022, approximately 509,000 Original Medicare members were attributed to MSSP ACOs in California,[22] and that number is likely higher today.[23]

Patient assignment to an ACO is typically passive (the patient is not opting in and it does not impact their choice of providers), determined by an analysis of Medicare claims data of the participating group of health care providers. Because ACOs do not require enrollment and patient assignment does not affect the benefits that a patient receives in Original Medicare, many patients do not realize that they have been assigned to a Medicare ACO that is now accountable for the cost and quality of their care.

## Improving Care for Medicare Beneficiaries in California: Headwinds and Tailwinds

There are a number of headwinds and tailwinds in California that can support or stall improvements in care and outcomes for Medicare beneficiaries in the state but are not specific to Medicare and/or the Collaborative focus areas or goals. Below are some of the headwinds and tailwinds that came up frequently during Collaborative discussions.

## Difficulties

**California is experiencing a shortage of health care workers,** including professionals in behavioral health, primary and specialty care, allied health, nursing, and direct care. Additionally, there is a lack of diversity and representation in the current workforce by variables such as race, ethnicity and language.

**For older adults in particular, there is a severe shortage of providers who specialize in geriatric care.** In 2022, there were 5,611 active geriatricians in the United States[24] and 57.5 million people over age 65,[25] equating to a ratio of one geriatrician for every 10,200 older adults. By contrast, in 2022 there were 59,753 active pediatricians[26] and 73.2 million people under age 18,[27] equating to a ratio of one pediatrician for every 1,225 children.

**In addition to workforce shortages, some provider advocates warn that Medicare reimbursement rates may contribute to access challenges for Medicare beneficiaries.** Provider advocacy organizations like the American Hospital Association,[28] the American Medical Association,[29] and Medical Group Management Association[30] warn that Medicare reimbursement is not keeping pace with the cost of practicing medicine, which could over time hinder older adult access to care. Conversely, other national analyses suggest that Medicare beneficiaries' access to care is comparable to or better than access for privately insured individuals.[31] More research is needed to determine regional and payment-related access challenges for Medicare enrollees in California.

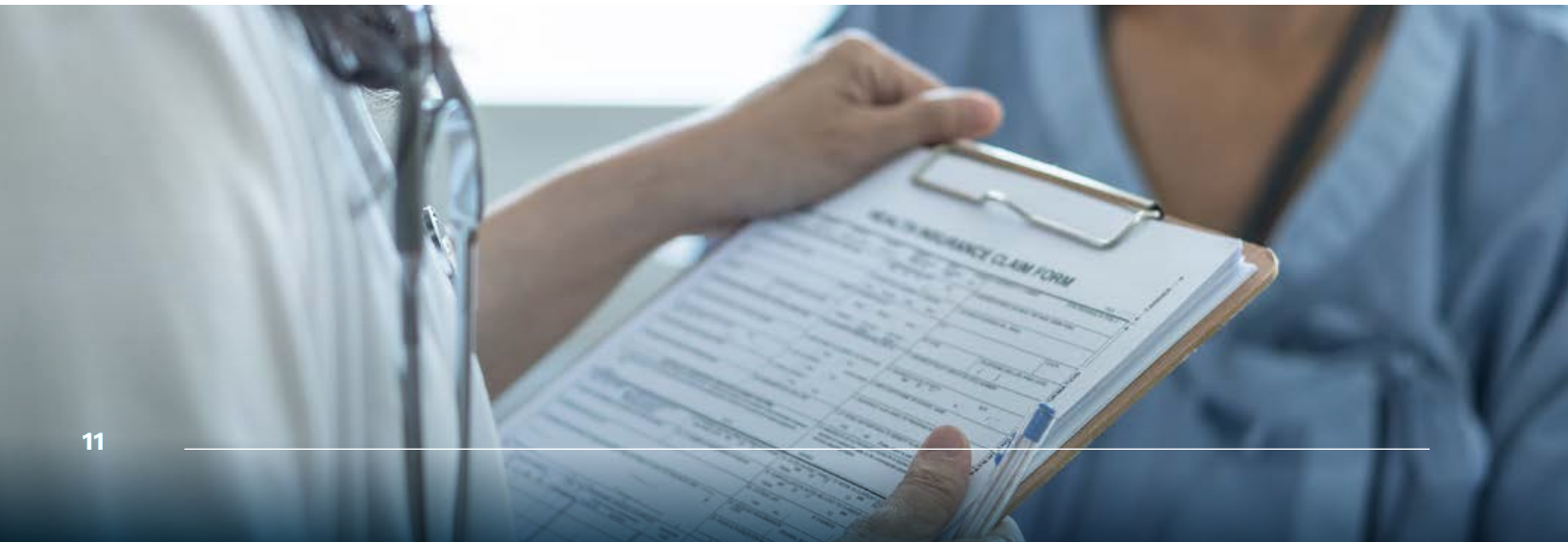
## Advantages

There are also bright spots.

**California's Master Plan for Aging (MPA) is prioritizing the health and wellbeing of older Californians.** In 2020, California led a stakeholder engagement process to create a Master Plan for Aging (MPA), which is a "blueprint" for state government, local government, the private sector, and philanthropy to prepare the state for the coming demographic changes and continue California's leadership in aging, disability, and equity.

**California is taking steps to integrate and improve care for Californians that are dually eligible for Medicare and Medi-Cal,** via CalAIM, a major DHCS initiative to transform Medi-Cal. This includes expanding access to Medicare Medi-Cal Plans, or Dual Eligible Special Need Plans, and integrating long-term care into Medi-Cal managed care. DHCS is also encouraging the Medi-Cal health system to deepen relationships with CBOs and address patients' non-medical needs via Enhanced Care Management and Community Supports, which may result in lessons learned that are applicable to Medicare-covered populations.

**California is investing in expanding and diversifying the health care workforce** across behavioral health, primary and specialty care, nursing, allied health, and direct care professions. Roles supported by the investments include nurses, social workers, caregivers, community health workers, emergency medical technicians, and others.[32]



# Recommendations and Action Plans by Focus Area

The following sections provide an overview of the Collaborative's focus areas, recommendations, and action plans. Action plans present change strategies that were identified during the Collaborative process; they are not exhaustive or inclusive of all strategies that could advance Collaborative recommendations.

## Chronic Illness Management and Care Coordination

**The majority of Californians on Medicare are navigating multiple chronic conditions.** More than half of Californians with Original Medicare had four or more chronic conditions in 2021.[33] These data align with findings from an older adult health survey, in which three out of four older Californians reported having been diagnosed with at least one chronic condition, and half reported having more than one.[34] Research demonstrates that improved chronic care management can yield significant benefits for patients as well as reduced costs to Medicare in the form of fewer hospital admissions and improved health outcomes.[35]

**Even with strong evidence of positive impact to patients, many California Medicare beneficiaries with multiple chronic conditions lack the care management services needed to fully manage their care.** Only a minority of older adults have an individualized care plan (22%) or single care manager (22%), even though 95% of those with a care manager said it improved their care.[36] Many older adults report having trouble organizing their care across multiple doctors and health care providers. Another function within care management is connecting patients to organizations that support social needs within the community. But even when health care organizations have identified patients with HRSNs through screening, connecting them to CBOs, ensuring follow-up, and sharing information remains a challenge.[37]

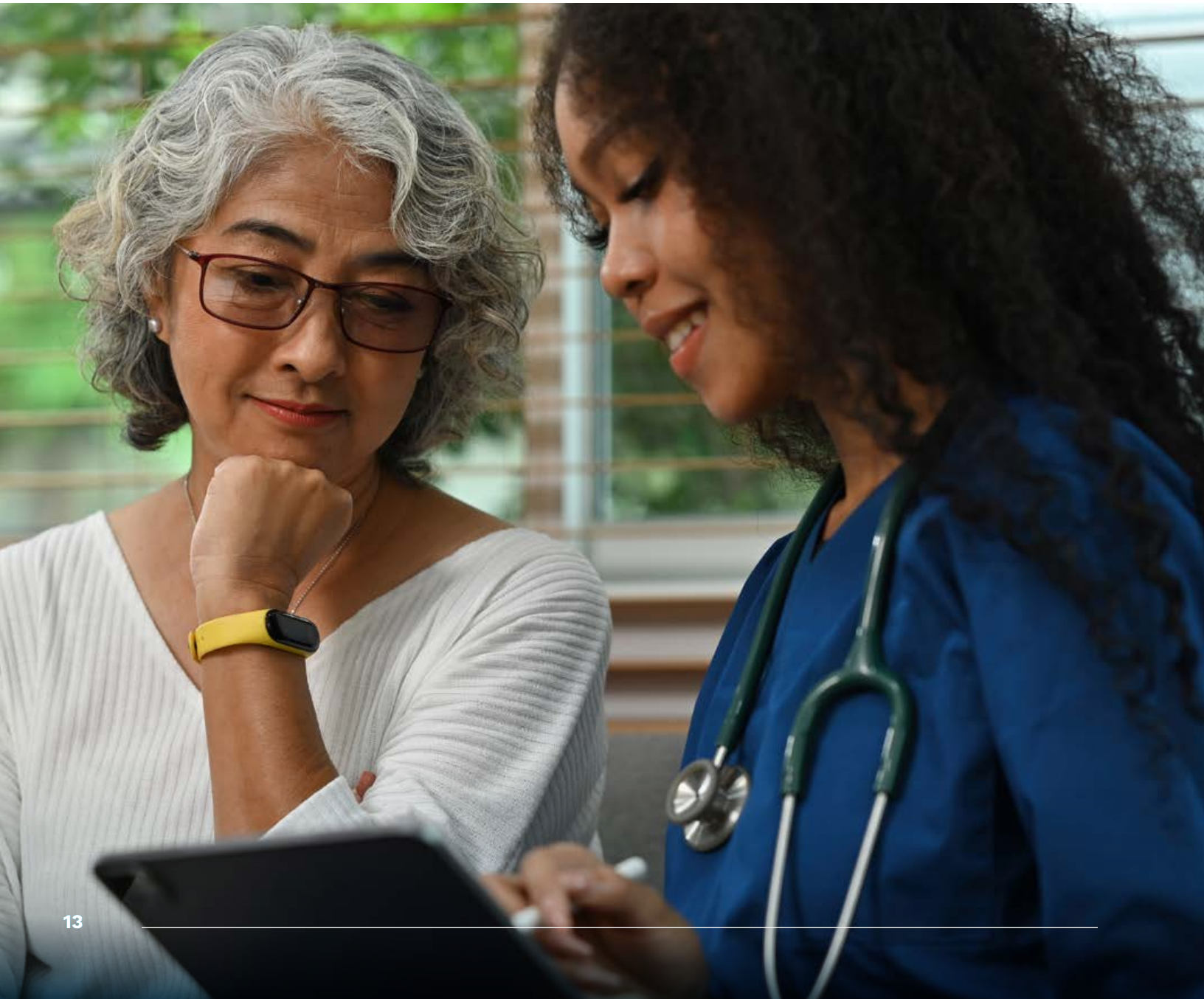
**Several factors contribute to inadequate care management of this population.** The system for providing care management to Medicare beneficiaries is a patchwork. Medicare Advantage plans often delegate chronic care outreach and intervention strategies to provider organizations, which means that specific care models vary widely. ACO models and/or payment codes that support care management in Original Medicare may not provide the return on investment and predictable revenue streams needed to invest in staffing and infrastructure. This is compounded by health care workforce shortages that directly impact the ability to deliver consistent chronic illness management and care coordination.

**Even with these challenges, there are bright spots.** APC is a high-touch care model focused on prevention and management of chronic conditions through team-based care with modified clinical workflows that leverage data insights. The additional infrastructure and workforce training to deliver this model requires flexible payment, such as capitation or shared savings, in order to compensate members of the care team.[38] In response to feedback on the previous Chronic Care Management codes, CMS introduced Advanced Primary Care Management (APCM) Codes in the Original Medicare 2025 Physician Fee Schedule. CMS is also updating and designing new tracks to the Medicare Shared Savings Program (MSSP) to expand interest, especially for those providers with a disproportionate share of underserved beneficiaries.

There are opportunities in Medicare Advantage to offer supplemental benefits specifically targeting management of certain chronic conditions. Special Supplemental Benefits for Individuals with Chronic Conditions (SSBCI) allow Medicare Advantage plans to provide innovative "LTSS" like benefits to address the HRSNs of members with complex chronic conditions, at risk for adverse health outcomes and in need of care coordination. In order to be effective, these need to be designed in a way that beneficiaries actually use them.

As new payment models come online and Medicare Advantage is given flexibility to offer innovative benefits to address HRSNs, there is an opportunity to build the infrastructure and provide additional resources to both practices, plans and CBOs to better equip them to interface with each other. The private sector is also producing new remote patient monitoring technology, expanded telehealth solutions and AI enabled population health management platforms to target the right patients for care management.

Together, these policies, investment and change actors can create opportunities to better integrate chronic condition management into the health care that California Medicare beneficiaries receive.



| **Recommendation: Strengthen chronic care management via supportive funding streams and payment policy.** | |
|---|---|
| **Barriers and Challenges:**<br><br>Why is this not happening right now? | **Workforce**<br>• Shortage of health care workers especially in primary care specialties. Additional care coordination and care management come with additional resource needs.<br>**Payment / Policy**<br>• Current payment for chronic disease management and population health through alternative payment models or Medicare codes can be administratively burdensome and does not provide enough stable, predictable revenue to offset infrastructure and staffing investments.<br>**Data/Transparency**<br>• Too many portals; software integration is expensive, patient lists can be hard to manage across many payers with different quality metrics and rules, and it can be hard to interpret data. |
| **Actions Prioritized by the Collaborative:**<br><br>What actions could be taken to support this recommendation? | **Funding Streams**<br>• Payers and providers work on alignment of Medicare value-based care contracting across Medicare Advantage plans to reduce provider administrative burden and enhance return on investment for chronic condition management.<br>• Providers convene to identify sustainable ways to leverage chronic care management (CCM) and APCM codes in Original Medicare.<br>• Providers leverage enablement organizations (companies that aggregate physician practices into ACOs) to expand access to ACO and other value-based programs in Original Medicare in rural areas or where independent practices do not have a sufficient patient population or ability to take risk on their own.<br>• Philanthropy and improvement organizations can fund/create forums to learn more about barriers payers and providers experience when trying to shift to capitation and value-based payment.<br>• Philanthropy and improvement organizations can fund/create affinity groups of providers that successfully leverage APCM codes; recommend including enablement organizations and vendors and measuring increased uptake in claims data.<br><br>Lead Actors: health plans, providers.<br>Influencers: philanthropy, provider enablement organizations, government.<br><br>**Payment Policy**<br>• Delivery system actors can support implementation of the California Primary Care Investment Benchmark set by the Office of Health Care Affordability (OHCA). The current benchmarks set in October of 2024 look for annual improvement of primary care spending as a percentage of medical expenses (which includes chronic care management) by .5-1% per year leading to a statewide target of 15% of total medical expense by 2034 across all payers.[39]<br>• Government agencies and purchasers can continue to create incentives for shifting to value based payment.<br>• Government, philanthropy, data aggregators, and research organizations can help create more transparency about the true cost of delivering health care, especially in managing a small primary care practice, by geographic location, to help inform payment and cost-related policies.<br><br>Lead Actors: providers, health plans, government.<br>Influencers: philanthropy, provider enablement companies, solutions vendors (e.g. Managed Services Organization or MSO). |

**Recommendation: Promote Advanced Primary Care (APC) by investing in supportive training, clinical care and compensation models for Medicare patients.**

**Barriers and Challenges**:

Why is this not happening right now?

**Workforce**

- Shortage of health care workers especially in primary care specialties. APC requires additional staffing for team-based care.
- Health care workforce burnout following the global pandemic has led to a retreat from new models of care due to additional resource burden.
- Lack of knowledge or skepticism in why it is important to adopt value-based payment and how to work effectively in team-based care and population health management.

**Payment / Policy**

- Community health workers (CHWs), care managers, pharmacists and social workers that contribute to APC require funding streams not available in Original Medicare.
- Value-based payment contracts that can fund an expanded workforce through shared savings and monthly coordination payments are administratively cumbersome and resource intensive (e.g., # of quality metrics) with unpredictable payments year to year.
- It is difficult to fund a workforce without value-based payment scale across multiple lines of business.
- Changes to Medicare Advantage rates, risk models and other market dynamics have led to wariness over added investment.

**Data/Transparency**

- Analytics and quality reporting capabilities required for successful performance in alternative payment methodologies can be expensive, especially if providers are using multiple EHRs.
- Many plans that offer data for value-based contracting require use of their own portals that don't integrate with provider EHRs.

**Actions Prioritized by the Collaborative:**

What actions could be taken to support this recommendation?

**Supportive Training**

- Health plans, philanthropy, improvement organizations, and government can create/fund training for providers in APC models and capabilities, including team-based care, telehealth for chronic care management, and the use of data and artificial intelligence to support care. Consider using ECHO-type model, learning collaboratives and CME training.

Lead Actors: health plans, philanthropy, improvement organizations, government.
Influencers: providers.

**Compensation Models**

- Health plans could offer increased opportunities for value-based payment models in Medicare Advantage that incentivize APC including options along the continuum of risk from medical homes funding infrastructure and capacity building to full risk and capitation. Also, bridge funding so provider groups can set up teams before taking on risk is needed. One example of multi-plan value-based payment alignment is the California Advanced Primary Care Initiative.
- Health plans and provider organizations can support improved compensation to health care workforce including salary assistance by health plans.

Lead Actors: health plans, providers.
Influencers: government, philanthropy, provider enablement organizations.

**Clinical Care Models**

- Leverage enhanced technology including remote patient monitoring, fully using electronic health records (patient portal, population health management capabilities), and telehealth.
- Health plans could include benefits for and partner with providers delivering innovative models of care (e.g. use of e-consults, home-based primary care).

Lead Actors: providers, provider enablement organizations, health plans.
Influencers: solutions vendors.

| **Recommendation: Increase support for and coordination with organizations that address patient's health related social needs (HRSNs) via capacity building and innovative payment models.** | |
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| **Barriers and Challenges:**<br><br>Why is this not happening right now? | **Workforce**<br>• Primary care workforce shortage makes adding additional screening and referrals within already resource constrained PCP visits difficult.<br>• Fee-for-service payment or unpredictable value-based contracting revenue makes it harder to budget for CHWs and/or care managers.<br>**Payment**<br>• CBOs that support HRSNs are typically reliant on grant funding and do not have infrastructure or technical expertise to bill Medicare.<br>**Policy**<br>• Unless in value-based contracts, Medicare does not incentivize providers to solve for HSRNs.<br>**Data/Transparency**<br>• CBOs typically do not have the ability to exchange data with health care organizations.<br>• Not easy to identify HRSNs in claims data.<br>• Privacy considerations for patients can limit data collection and exchange. |
| **Actions Prioritized by the Collaborative:**<br><br>What actions could be taken to support this recommendation? | **Capacity Building**<br>• State or county governments invest in tools and resources for plans and providers that identify local CBOs. (For example, Collaborative participants referenced Unite Us provides these tools.)<br>• Providers and provider enablement organizations identify champions within their organizations to lead coordination work with community partners, especially those participating in ACO REACH, MSSP or other Total Cost of Care contracts.<br>• Health plans create partnerships with solution providers, such as Pair Team and Pear Suite which were referenced by Collaborative participants.<br>• Lift up examples of provider and CBO partnerships that are working well and amplify them in the community through case studies, issue briefs, conferences, trade associations and other channels. Include funding model, data, care models and other relevant information to replicate.<br><br>Lead Actors: government, providers, enablement organizations, health plans.<br>Influencers: CBOs, solution providers.<br><br>**Innovative Payment Models**<br>• Health plans leverage value-based incentive design (VBID) and/or Special Supplemental Benefits in Medicare Advantage benefits.<br>• Health plans expand offerings in Medicare Advantage for value-based contracts that incentivize identification and referrals for HRSNs and coordination with CBOs.<br>• Providers join programs in Original Medicare like ACO REACH that incentivize ACOs and their participants to coordinate with CBOs. (May be challenging without direct funding to CBOs.)<br>• Lift up examples of health plans paying CBOs directly for taking care of their patients and partnering/integrating patient data with network providers.<br><br>Lead Actors: health plans.<br>Influencers: providers, enablement organizations, CBOs. |

## Access, Equity and Disparities in Care

Health equity means everyone has a fair and just opportunity to achieve their most optimal health status.[40] Equity is not the same as equality. Equality means giving the same support or resources, regardless of need. Equity often requires additional efforts and investments for those who currently experience worse health and fewer opportunities. This happens because of entrenched systemic bias against people due to race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes.[41]" There are countless system, policy, economic, legal, and social barriers to health equity dating back to the start of this country and before. Health disparities are inequitable differences in health outcomes closely linked with social conditions.[42] Some examples of health disparities Medicare beneficiaries experience in California are summarized below.

**Income:** Self-reported health declines as income decreases. Older Californians with incomes within 0-138% of FPL (32%) report having fair to poor health more often than older Californians with incomes within 221-400% of FPL (25%) and 400%+ of FPL (16%). Californians with lower incomes that are not Medi-Cal-eligible ("near duals") face many similar challenges to duals, without access to additional supports provided by the Medi-Cal program.[43]

**Race:** There are many inequities by race among older adults and/or Medicare beneficiaries in California. For example, rates of diabetes are significantly higher in non-White Medicare beneficiaries compared to White beneficiaries.[44] Black Californians experience the highest death rates from breast, cervical, colorectal, lung, and prostate cancer among all racial and ethnic groups.[45] Also, Black and Hispanic adults age 50 and older experienced worse health outcomes than non-Hispanic Whites during the pandemic in California.[46]

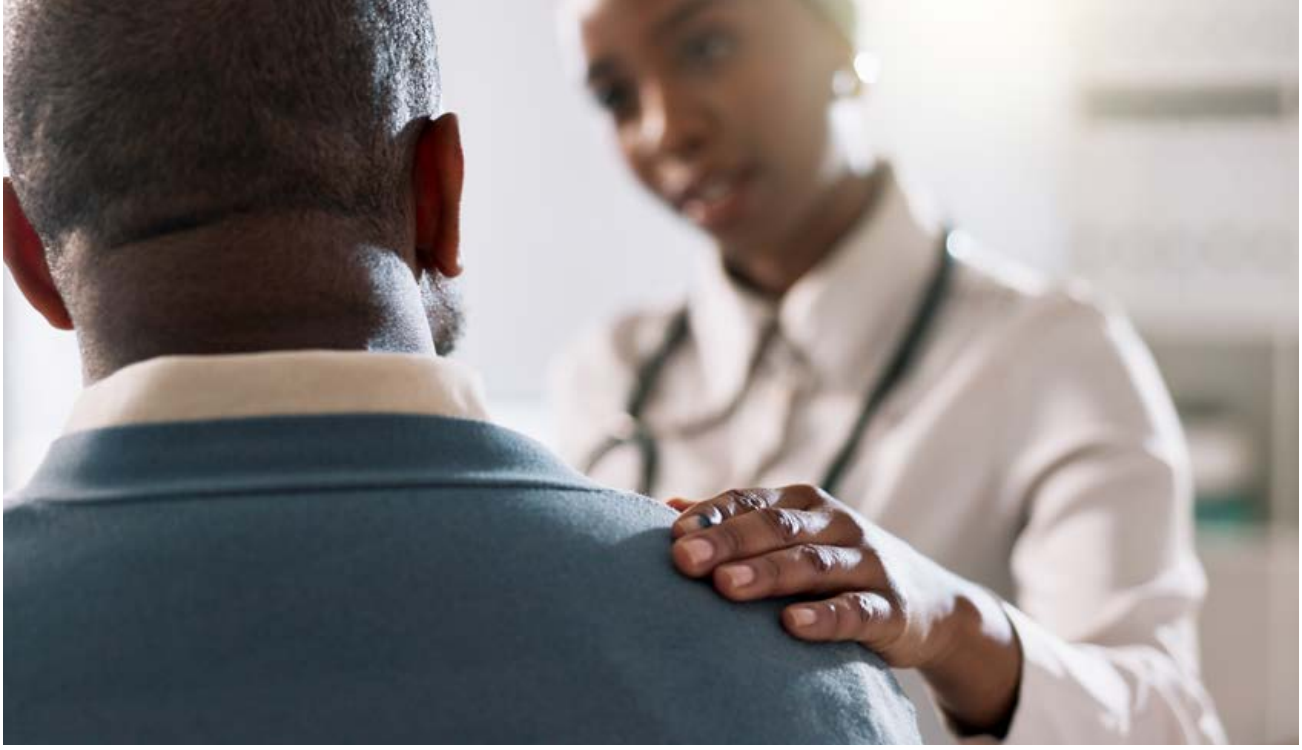
**Geography:** Rural beneficiaries report more challenges accessing services due to less available providers[47] and have fewer Medicare Advantage options, which means most Medicare beneficiaries in rural counties are not reached by Medicare Advantage supplemental benefits like transportation, additional telehealth, and supports for LTSS.[48] A big data gap is lack of visibility on use of these supplemental services (both in rural and urban areas).

**Language:** Across all fifty states, California has the highest rate of Limited English Proficiency (LEP) among its Medicare beneficiaries (15% in CA compared to 5% nationally), and the languages spoken by California Medicare beneficiaries with LEP are diverse. Dual-eligible beneficiaries are more likely to have LEP than Medicare only beneficiaries (33% vs. 8%).[49] In a survey of older Californians, 14% reported needing an interpreter, but just 4% were able to get one.[50] Hispanic adults were more likely to need one (26%) compared to White adults (8%).[51]

There are several barriers that make it challenging to pursue equity for Medicare beneficiaries in California.

**It is difficult to advance equity and reduce disparities without actionable data, which is currently lacking for Medicare beneficiaries.** For example, NCQA reported only 40% of Medicare patient race data and less than 20% of ethnicity data was complete in 2019.[52] Collaborative members noted that providers lack sufficient time and resources to collect social needs and demographic information and that some patients are hesitant to share non-medical information with their providers. The lack of data exchange across health systems is an additional challenge.

**The pursuit of access and equity is also hindered by California's health workforce shortages and lack of diversity in the provider workforce.** California is currently experiencing a workforce shortage in many areas, notably primary care, behavioral health, and geriatrics, which will be exacerbated as the proportion of older adults grows. Additionally, the current workforce does not reflect the diversity of the state in terms of race, ethnicity, and language, while it is known that concordance has been shown to improve outcomes[53].



Statewide efforts are underway in California to promote health equity and reduce health disparities, but there is less focus on the Medicare only population.

- Covered California, the California Public Employees Retirement System (CalPERS), and the Department of Health Care Services (DHCS) are integrating disparities reduction into their contractual requirements. For example, they have tied health plan payments to performance on measures that are crucial to population health and are more likely to show disparities across race, ethnicity and language.[54] As of 2021, all Covered California health plans have 70% or more patient self-reported race data in their system due to a contract requirement and CalPERS has recently added a similar requirement.
- The Department of Managed Health Care (DMHC) is using its regulatory authority to require all California managed health care plans to report on thirteen health equity and quality measures, stratified by race and ethnicity. However, plans that only offer Medicare Advantage are exempt.[55]
- DHCS' California Advancing and Innovating Medi-Cal initiative (CalAIM) promotes stronger, formalized partnerships between primary care providers and CBOs to deliver community supports and enhanced care management. Also, community Health Worker (CHW) services are now a Medi-Cal benefit and local health jurisdictions providing these services can now enroll to be a Medi-Cal provider.

**CMS has also been taking steps to advance health equity in Medicare.** The CMS Framework for Health Equity was recently released and the first priority is to expand the collection, reporting and analysis of interoperable, standardized, individual-level demographic and HRSN data, including race, ethnicity, language, gender identity, sex, sexual orientation, and disability status. CMS recently began requiring hospitals in federal payment programs to report what portion of their population is screened for various HRSNs and how many screen positive in each category.[56] This CMS direction may shift as administrations transition in 2025.

The Collaborative's recommendations focused on improving access to HRSN and demographic data, expanding care access for special populations, and implementing strategies to strengthen the current health care workforce delivering care to California's older adults.

| **Recommendation: Improve population health management through better data on Medicare HRSNs and evaluating programs that seek to meet those needs.** | |
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| **Barriers and Challenges:**<br><br>Why is this not happening right now? | **Workforce**<br>• Providers and care teams often lack the time needed to screen and refer for HRSNs. This challenge is exasperated by workforce shortages.<br>**Payment**<br>• Fee for service payment often does not provide revenue for provider and staff to collect and integrate HRSNs information and use it for population health management and evaluation of programs.<br>**Data/Transparency**<br>• No overarching, comprehensive way to exchange data across organizations, unless connected to the same platform or a Health Information Exchange (HIE).<br>• CBOs typically do not have the ability to exchange data with health care organizations.<br>• Not easy to identify HRSNs in claims data.<br>• Patients may choose not to share information about their HRSNs and privacy considerations for patients can limit data exchange across settings.<br>• Limited analytic capabilities within health systems.<br>• Until recently, Medicare Advantage plans did not need to submit encounter data for supplemental benefit services.<br>• Patients may choose not to share this information. |
| **Actions Prioritized by the Collaborative:**<br><br>What actions could be taken to support this recommendation? | **Collect better data on HRSNs.**<br>• Health plans and providers can conduct a gap analysis of HRSN data collection methods for Medicare patients and determine where collection touchpoints could be added or improved upon (e.g., through staff training or workflow adjustments).<br>• Providers can consider leveraging virtual connections before the visit (such as a pre-intake call) to gather HRSN data and other information pertinent to treating the patient.<br>• Health plans, providers and technical assistance organizations can educate the health care workforce on how to effectively screen and refer for HRSNs.<br>• Health plans and providers can partner with CHWs to gather HRSN data.<br><br>Lead Actors: Health plans, providers, government.<br>Influencers: Government, philanthropy (for funding), CBOs.<br><br>**Exchange HRSN data across health systems.**<br>• Providers, health plans, and CBOs can become familiar with the Data Exchange Framework agreement and the best options for aligning and putting new collection and exchange processes into action (e.g., connection to Qualified Health Information Organization, a Health Information Exchange, or another path).<br>• Health plan, providers, and improvement organizations can consider how to connect and include in HIEs data from small and rural providers, hospitals, skilled nursing facilities (SNFs), and CBOs.<br>• Government, philanthropy, and improvement organizations can create and spread information to the delivery system around the value of aligning and complying with the Data Exchange Framework, connecting to a QHIO or an HIE, the best pathways for joining, technical assistance support available, and realistic estimated lift in terms of cost, time and resources.<br><br>Lead Actors: Payers, providers, Health Information Exchanges (HIEs).<br>Influencers: Technical assistance organizations, government or philanthropies (for funding technical assistance for HIE connection and research for best HIE connection options or paths). |

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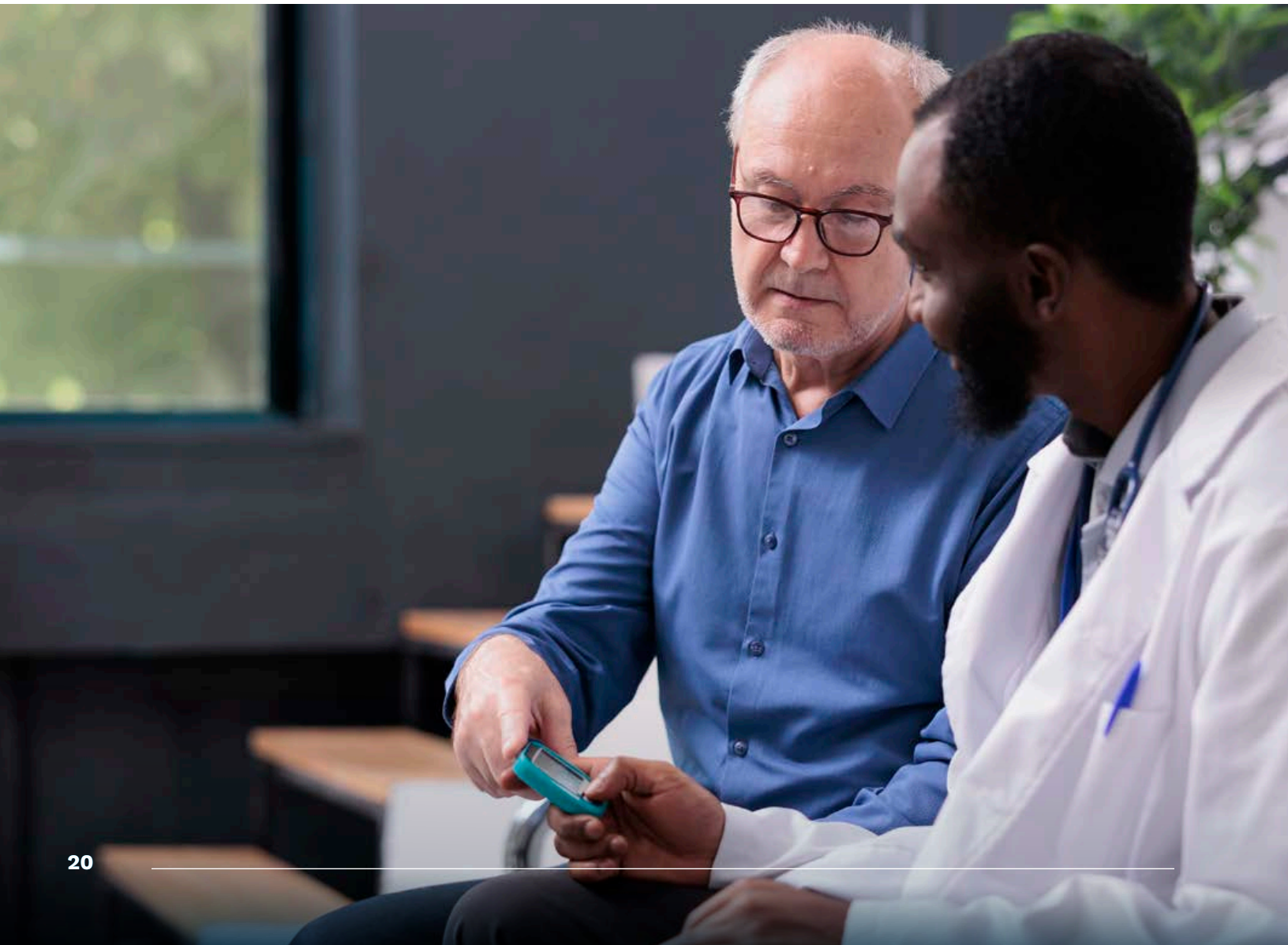
| | **Evaluate programs that seek to address HRSNs**<br>• Providers and health plans can perform a gap analysis on how patient social needs and quality data are currently being evaluated within their organizations to inform strategy. If there is no evaluation occurring, determine the best place to start and build on evaluation capability.<br>• Providers and health plans can determine which benefits or programs are doing well and assess if or how they could be expanded.<br>• Medicare Advantage Plans can attempt to obtain information from CMS on beneficiary uptake of supplemental benefits at the population level, as a result of new CMS encounter reporting requirements.[57]<br>• The delivery system can explore artificial intelligence to assist with analytics and assess population trends to inform or adjust benefits and programs being emphasized.<br><br>Lead actors: health plans, providers, CBOs.<br>Influencers: philanthropy, research organizations. |



| **Recommendation: Increase access to care for special populations — including low-income Medicare beneficiaries, Medicare beneficiaries with limited English proficiency, those receiving Medicare because they are on social security disability, and those that live in rural communities — via effective care delivery models.** | |
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| **Barriers and Challenges:**<br><br>Why is this not happening right now? | **Workforce**<br>• Workforce shortages in primary care and key specialty areas such as behavioral health and geriatrics. Regional inequities in workforce distribution, with rural areas (e.g., the Central Valley) experiencing worse shortages.<br>• Lack of provider knowledge about caring for the aging population, and specifically caring for more vulnerable sub populations within this cohort.<br>• Workforce does not match California's diversity in terms of racial and ethnic makeup, and languages spoken.<br>**Payment**<br>• Though telehealth benefits and provider reimbursement opportunities were expanded during the COVID pandemic, much of this temporary expansion (such as reimbursement for audio only visits or waiving the requirement to have had an in-person behavioral health visit first before a telehealth visit would be covered) is now due to expire on March 31, 2025.[58]<br>• Reimbursements and resources for transportation benefits in Medicare Advantage plans often do not meet the need for an aging population, especially in rural areas. (Transportation is only covered when medically necessary, such as emergency situations, in Original Medicare.)<br>**Data/Transparency**<br>• Lack of complete data on patient demographics, HRSNs and services received, can undermine efforts to provide specialized interventions for specific populations.<br>**Other**<br>• Patients may have limited understanding of supportive benefits and how to access them.<br>• Transportation benefits can be unreliable. Patients may not have trust in the system or have the capacity to follow up multiple times to confirm and reconfirm rides that may not show up anyway. |
| **Actions Prioritized by the Collaborative:**<br><br>What actions could be taken to support this recommendation? | **Effective care delivery models**<br>• Providers can use telehealth and home visits to optimize care for patients who have trouble accessing it in person. Use telehealth as a system entry point to determine if in-person care is warranted.<br>  • Health plans, philanthropy and improvement organizations can share learnings from successful models that strategically leverage telehealth and/or home visits to increase access.<br>• Optimize team-based care and consider integrating CHWs or similar roles into the care team.<br>• Train care teams on how to refer to local community-based resources to support patients with HRSNs. (Ensure staff training includes Area Agencies on Aging, which facilitate connection to CBOs that serve older adults.)<br>• Improve capacity to offer patients culturally sensitive care in their own language without an interpreter to help build a relationship. Strive to hire care team members that reflect the community being served. Make sure roles pay well and have good training programs.<br>• Shift payment to support emerging care models. For example, health plans and providers can assess current payment structures to see if revenue is supportive of telehealth, home visits, and other care models, and flexible regarding the type of staff who can bill for services.<br><br>Lead actors: providers, health plans.<br>Influencers: CBOs, government, philanthropy, improvement organizations. |

| **Strengthen the clinical workforce needed to serve Medicare beneficiaries in an equitable way through training for the current workforce, care team diversification, and supports for trainees in shortage professions.** | |
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| **Barriers and Challenges:**<br><br>Why is this not happening right now? | **Workforce**<br>• Workforce shortages in primary care, behavioral health and geriatrics, exasperated by low pay compared to other specialty types.<br>• Workforce does not match California's diversity in terms of racial and ethnic makeup, languages spoken.<br>  • Workforce pathway programs take time to create impact.<br>• Most Medicare Advantage plans are not using CHWs due to lack of understanding on how they can be helpful, motivation/incentives, and uncertainty if they would create a return on investment. Medicare Advantage plans are waiting to see what happens with community health workers in Medi-Cal.<br>**Policy**<br>• Medicare restrictions and administrative complexity can get in the way of creative solutions to workforce challenges. For example, providers gave feedback that the requirements around documenting new CHI and PIN codes (e.g., no ability to do retro referrals) have made it challenging to use them to pay navigation staff, who these codes are meant to support. |
| **Actions Prioritized by the Collaborative:**<br><br>What actions could be taken to support this recommendation? | **Training for the current workforce**<br>• Partner with CBOs that serve older adults as a way to train existing providers about lived experiences different from their own.<br>• Provide geriatrics training to providers and care team members that serve significant numbers of older adults.<br><br>Lead Actors: providers, CBOs.<br>Influencers: CBOs, health plans, advocates, philanthropy.<br><br>**Care team diversification**<br>• Be intentional about hiring for specific diversity and lived experience; go into the community to find candidates.<br>• Determine consistent, sustained ways to find, train, and integrate community health workers into the care team. Create forums for health plans to collaborate and co-fund shared efforts for a CHW workforce. This would require sustainable funding.<br>  • Add more CHW training to community college curriculums.<br>  • Convene Medicare Advantage plans and providers who are willing to talk with each other and share best practices on how to integrate and deploy CHWs for their population.<br>• Providers and health plans can implement changes to make their organizations appealing places to work for underrepresented candidates.<br>  • Pay differently to incentivize diversity (e.g. pay more to staff who can speak more than one language)<br>  • Run external messages through the community to increase the number of diverse candidates who want to apply to your organization.<br>• Elevate and promote examples of provider organizations who have improved diversity in their current workforce and how they accomplished it.<br><br>Lead actors: providers, health plans<br>Influencers: schools, CBOs, philanthropy |

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| | **Supports for trainees in shortage professions**<br>• Provide loan repayment or financial stipends during the additional time to train in desired fields, such as geriatric psychiatry.[59]<br>• Allow general psychiatry residents to 'fast-track' into areas of high need, as is done in child and adolescent psychiatry.<br>• Provide residencies geared toward people with diverse lived experience and promote within those communities at medical schools.<br>• Recruit CHWs and high school students as a pipeline for additional training to become physicians, physician assistants, nurses, nurse practitioners and social workers. Programs would likely need to provide full scholarships, living expenses, childcare to realistically have uptake.<br><br>Lead actors: government, providers.<br>Influencers: Health plans, philanthropy. |

## Beneficiary Choice in a Confusing Market

**Market complexity and lack of transparency make it difficult for Medicare beneficiaries to select the Medicare coverage option that best meets their needs.** Specific challenges include an overwhelming number of coverage options; non-comprehensive tools to support comparison of coverage options; aggressive and sometimes misleading marketing from Medicare Advantage plans and their agents or brokers, coupled with no equivalent marketing apparatus to educate members regarding Original Medicare; language, cultural and resource barriers to accessing and understanding information about Medicare coverage; and limited capacity of the state's Medicare counseling programs.

**Underscoring the importance of informed choice is the fact that once beneficiaries elect Medicare Advantage, they may not be able to switch back to Original Medicare** due to restrictive enrollment periods and/or challenges securing a Medigap policy. When beneficiaries are new to Medicare, there is a six-month open enrollment period during which they are guaranteed the right to buy a Medigap policy regardless of health status. After this window closes, insurers in all but four states can deny Medigap coverage or charge higher premiums based on health history.

**There are some recent and existing efforts to improve the quality and accessibility of information about coverage options,** including recent improvements to Medicare Plan Finder; a California Medicare Options Counseling/HICAP Modernization effort; new CMS guardrails for agent/broker behavior to stop anti-competitive steering by closing commission loop holes; and a new tool to help dual-eligible beneficiaries in California understand their coverage options.

**Collaborative participants discussed two primary drivers for supporting beneficiary choice in a confusing market: creating better consumer facing information and reducing unnecessary market complexity,** but the latter was deemed to be beyond the scope of state actors absent federal action. Within the area of consumer-facing information, Collaborative participants were most enthusiastic about improving and promoting tools that support comparing coverage options, developing public education campaigns, and expanding the reach of the Health Insurance Counseling & Advocacy Program (HICAP) — which provides free and objective information and counseling about Medicare — to serve more people. The following recommendation and action plan reflect these priorities.

**Support patients and caregivers to make informed choices about their Medicare coverage by implementing culturally and linguistically appropriate messaging, promoting and improving existing plan comparison tools, and expanding access to Medicare options counseling.**

**Barriers and Challenges:**

Why is this not happening right now?

**Workforce**

- Insufficient one-on-one support, both paid and volunteer; it is very time consuming and requires expertise to provide the level of support that is needed for in-depth and individualized counseling.
- Providers are trusted messengers but do not have the time or knowledge to support their patients through enrollment decisions. Additionally, providers can share information about plans but are not allowed to recommend specific plans to their patients.
- Brokers are more available, but there are concerns about broker neutrality.

**Payment**

- Payment systems have favored the proliferation of Medicare Advantage plans that offer supplemental benefits. Consumers may be drawn to these benefits without fully understanding the tradeoffs between Medicare Advantage and Original Medicare.

**Policy**

- As described above, there is an unlevel playing field between Original Medicare and Medicare Advantage in terms of benefits.
- No annual guaranteed issue for Medigap. After first six months with Medicare, beneficiaries may be denied Medigap coverage or charged higher premiums based on health history, which creates friction in the ability of Medicare beneficiaries to switch between Medicare Advantage and Original Medicare. SB-1236, introduced in 2024, sought to expand guaranteed issue in California but the bill did not make it out of the appropriations committee for a full vote in the Senate.

**Data/Transparency**

- Health plan provider directories are not always up-to-date, and the information is not available in Medicare Plan Finder, making it difficult to obtain reliable information on a health plan's provider network during open enrollment. This challenge is most prominent in delegated markets.
- The specific details, eligibility criteria and coverage levels of supplemental benefits are difficult to assess.
- Beneficiaries cannot compare the true cost of a Medicare Advantage plan to a Medigap plan on Medicare.gov in a way that considers premiums and cost sharing.

**Other**

- Language barriers (15% of Medicare beneficiaries in CA have limited English proficiency).
- Broadband / access challenges.
- Misinformation.

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| **Actions Prioritized by the Collaborative:**<br><br>What actions could be taken to support this recommendation? | **1. Implement culturally and linguistically appropriate messaging.**<br>• Outreach to local media channels across the state with culturally and linguistically appropriate messaging about open enrollment and programs that provide financial support (e.g., Medicare Savings Programs, Part D Low-Income Subsidy), as well as substantially more messaging about the existence of HICAP.<br>• Develop messaging/information campaigns that could be deployed in provider/clinical settings as well as by trusted CBOs.<br>• Identify CBOs or settings (libraries, community centers, churches, etc.) that could be neutral and trusted sources of information about coverage options.<br><br>Lead Actors: Government, philanthropy, advocates.<br>Influencers: Media, providers, health plans, CBOs.<br><br>**2. Explore opportunities to promote and improve Plan Finder or complementary tools.**<br>• As part of the messaging work described above, promote awareness and use of the Medicare Plan Finder tool.<br>• Get robust feedback from California beneficiaries about their experiences navigating Medicare enrollment.<br>• Harvest lessons learned from other shop-able plan finder tools.<br>• Explore solutions for addressing major transparency challenges identified during the Collaborative:<br>  • Comparing true cost and coverage differences across Medicare Advantage and Medigap plans.<br>  • Improving accuracy of provider network data during open enrollment.<br>  • Providing more robust data on the eligibility criteria and benefit terms for supplemental benefits.<br>• Understand the potential role that AI might play in comparing coverage options.<br><br>Lead Actors: Government, philanthropy.<br>Influencers: Advocates, health plans.<br><br>**3. Expand the capacity and reach of HICAP offices to serve more Medicare beneficiaries during open enrollment.**<br>• Continue HICAP Modernization project — led by the California Department of Aging — with eye toward the need for significant expansion of HICAP capacity and reach.<br><br>Lead Actor: State government (CDA) |

## Cognitive and Behavioral Health

Cognitive and behavioral health represent two different but overlapping areas of medicine. Cognitive health is the ability to think, learn, and remember clearly.[60] Behavioral health includes the emotions and behaviors that affect overall well-being.[61] For both, a patient's needs are dynamic, and can change based on what is happening in their life. Below is a summary of information relevant to older Californians in these areas.

**The number of older adults needing cognitive supports, also known as having Alzheimer's disease and related dementias (ADRD) in California is projected to double by 2040, from 660,000 cases in 2019 to nearly 1.5 million.**[62] The rates are expected to approximately triple for Black and Hispanic adults,[63] due in part due to improvements in diagnosis. Many people with cognitive impairment are currently undiagnosed, especially people who are non-White and those with low educational attainment.

**People living with ADRD require a significant amount of care which is challenging for patients and caregivers.** They often have multiple chronic or behavioral health conditions and receive fragmented care, leading to poor outcomes and high system utilization. The challenges of managing health care, providing constant support, and handling the behavioral and psychological symptoms of dementia can present a significant mental, physical, emotional, and financial burden to caregivers.[64] Recent estimates are that 1.6 million Californians provided unpaid care for a person living with Alzheimer's in 2020, 60% were female and provided more than 20 hours of care per week, unpaid.[65] Clinicians, health plans, and home and community-based service (HCBS) providers need to be educated about services available to Medicare beneficiaries and the experiences of beneficiaries and caregivers after diagnosis to improve their ability to support.[66]

**The spectrum of behavioral health support a patient might need ranges from severe to mild, with more older adults in California report experiencing the former.** Nine percent of Californians aged 55 or older reported symptoms of moderate to severe depression in 2022.[67] Five percent of older Californians reported having a very or extremely difficult time managing their daily activities due to depression.[68] However[69]. The lived experience of older adulthood comes with new stressors, such as loss of loved ones, or reactions to changes in physical ability or mental acuity. These may lead to psychological distress that does not meet criteria for diagnosed mental illness and calls for a health system that uses more than just diagnosis as an indicator that care is needed.[70]

**Older adults face significant barriers when trying to access behavioral health care.** In February 2023, the California Health Care Foundation reported older adults (65+) are the least likely to report receiving care for mental health.[71] This is not due to less need. According to the UCLA Center for Health Policy Research, less than one-third of older adults in need of mental health services receive appropriate care.[72] It is not part of "normal aging" to feel lonely, depressed, or isolated. Older adults also struggle with the health system navigation required to access behavioral health care in non-integrated systems. The lack of diversity within California's limited behavioral health workforce further hinders access to care.

**The fact that behavioral health is often managed separately from other medical services in California may exacerbate access challenges.** Lack of behavioral health integration into primary care may contribute to stigma (due to lack of exposure) and/or lack of knowledge or overwhelm on doing the extra legwork to seek out behavioral health care. It also reduces the prevalence of behavioral health screenings, referrals and supports available to patients in primary care settings. Behavioral health integration into primary care for Medicare patients, which can be accomplished by shifting payment into primary care (to account for time spent supporting behavioral health providers), data reporting and tracking, and practice transformation,[73] has the potential to improve upon all three of the recommendations below.

**There is already momentum in California to improve care for older adults with cognitive and behavioral health needs.** On the cognitive health side, organizations that support education for cognitive assessment and referral within primary care, such as Dementia Care Aware and the Alzheimer's Association, are helping to increase diagnosis in the state. The Guiding and Improved Dementia Experience (GUIDE) Model, a 2024 CMS model that funds enhanced support for care navigation and caregivers through designated providers, also holds promise. Additionally, the age-friendly health system designation is an evidence-based way for providers to increase their capacity to prevent, identify, treat and manage behavioral health needs among their older patients.[74]

On the behavioral health side, there are also several recent changes and efforts underway that can help increase access to behavioral health services. For example, Proposition 1 expands California's behavioral health system with work across several agencies and gives approximately $100 million per year toward statewide workforce initiatives to build a culturally competent and well-trained behavioral health workforce through the California Department of Health Care Access and Information (HCAI).[75]

Marriage and family therapists and mental health counselors can now bill Medicare independently under Part B, and there are new Medicare billing codes intended to reimburse providers for supportive services for patients with high-risk behavioral health needs. There are also opportunities to increase access to behavioral health services provided by primary care by investing in evidence-based integration models like the Collaborative Care Model (CoCM) or Primary Care Behavioral Health (PCBH) model.

During the Collaborative, participants considered a well-rounded set of primary drivers for improving cognitive and behavioral health outcomes for Californians enrolled in Medicare. These included integrating behavioral health into primary care, increasing access to cognitive and behavioral health providers, creating linkages to community-based partners and supporting individuals and their caregivers.

Ultimately, the group converged around several priorities for change that aligned with the Collaborative's criteria: initiatives that could be launched within two years and generate impact within the current regulatory framework. These priorities, outlined in greater detail below, include reducing stigma, increasing screening for behavioral health needs, increasing navigation and supporting education of the existing behavioral health workforce.

| **Reduce stigma and normalize seeking cognitive and behavioral health services via culturally competent messaging and channels.** | |
|---|---|
| **Barriers and Challenges:**<br><br>Why is this not happening right now? | **Workforce**<br>• Lack of culturally responsive providers that reflect the state's diversity reduces the health system's ability to anticipate and combat stigma.<br><br>**Delivery System**<br>• Available behavioral health benefits are not well understood and/or are difficult to navigate or access.<br>• Health care silos and the underlying bifurcation between physical and behavioral health care can increase stigma and make pathways to access behavioral health services unclear.<br><br>**Other**<br>• A growing number of older Californians encounter multiple, intersectional stigmas, including ageism, ableism, mental health bias and discrimination against race, ethnicity, language, culture, sexual orientation and gender identify.[76]<br>• Negative stereotypes are often used by the media to portray older adults and overly emphasize physical, mental, and cognitive deficits.[77]<br>• Society often forgets that older adults have significant behavioral health needs to address—and that it is not part of "normal aging" to feel lonely, depressed or isolated.[78] |
| **Actions Prioritized by the Collaborative:**<br><br>What actions could be taken to support this recommendation? | **1. Disseminate Culturally Competent Messaging Via Appropriate Channels**<br>• Providers, health plans, and government directly engage older adults with behavioral health needs to deepen understanding of stigma-related barriers and get feedback on communications solutions.<br>• Providers and health plans determine the best messengers and vehicles for reaching patients with information about behavioral health services and resources, making sure to leverage partnerships and align messaging with CBOs that serve older adults.<br>  • Providers and health plans incorporate behavioral health information and how to access services into patient facing information.<br>• This could include soliciting feedback from patients about what's available now and what else would be helpful and updating the information as appropriate to be more welcoming and supportive of diverse patient populations.<br>• Philanthropy, government and other partners fund and implement statewide and community-specific communications campaigns that share positive stories about and uplift the diverse voices of older adults as integral members of the community.[79]<br>  • The CA Department of Aging has resources for communications campaigns and is conducting focus groups to help inform tailoring to each region and community. CDA is seeking partnerships to support next steps and help amplify messaging.<br><br>Lead Actors: Government, philanthropy, health plans, providers, CBOs<br>Influencers: Media |

**Amplify and improve screening to promote earlier and wider detection of cognitive and behavioral health needs via spread of existing training resources and care models.**

**Barriers and Challenges:**

Why is this not happening right now?

**Delivery System**

- Limited integration or coordination between behavioral health and physical health care delivery.
- Reluctance to screen when referral network is limited and/or there is limited coordination between primary care and mental health services.
- Time constraints, especially when caring for older patients who may present with complex needs.
- Screenings are not integrated in practice workflows and care team roles.

**Workforce**

- Primary care providers lack training on how to screen and refer for cognitive and behavioral health needs in older adults.
- There are shortages in specialized fields that could support the PCP, such as geriatric psychiatry.

**Payment**

- Time spent on screening and treatment or other mild to moderate BH support is often not included in primary care revenue when BH benefits are carved out. Codes exist but providers share the reimbursement amounts do not match the time spent.

**Actions Prioritized by the Collaborative:**

What actions could be taken to support this recommendation?

**1. Spread Existing Training Resources and Screening Approaches**

- Provider organizations expand dementia screening in primary care via training and implementation resources from organizations such as Dementia Care Aware, Dementia Friendly America, or the Alzheimer's Association.
    - Government and philanthropy partner with training providers to support additional spread in California.
- Provider organizations promote cognitive and behavioral health screening via continuing education courses. A new California law requires providers who take care of older adults to have 20% of their continuing education credits related to geriatric medicine, including special care needs of people with dementia.
    - CME providers examine, promote, and/or develop CME offerings related to cognitive and behavioral health screenings for older adults in primary care.
- Health plans and providers can increase the percentage of Medicare beneficiaries in California that receive an annual Medicare Wellness Visit, inclusive of cognitive and behavioral health screenings.
- Providers increase screenings for other factors that can worsen mental health, such as social isolation and loneliness, financial insecurity, and functional impairment (i.e., challenges with activities of daily living). Many existing social needs screening tools (e.g., PRAPARE) include questions related to social connectedness and financial insecurity. There are other measurement tools specific to social isolation and loneliness such as the 3-item UCLA Loneliness scale.
    - Philanthropy and government develop a pilot and/or learning collaborative focused on screening in primary care for needs that worsen mental health, such as social isolation and loneliness, functional impairment, and financial insecurity.
- Government, health plans or provider organizations explore feasibility of implementing a geriatric psychiatry consult program(s) to support care teams with expert reviews and second opinions. The evidence-based Collaborative Care Model includes the role of a psychiatric consultant. There are also examples of payor-agnostic psychiatric consult programs nationally and in California. For example, Cal-MAP offers education, consultation and resource navigation for primary care providers treating youth with mental health needs.

Lead Actors: government, philanthropy, health plans, providers

Influencers: technical assistance organizations, CBOs

| **Increase supports for patients with cognitive and behavioral health needs and their caregivers by expanding access to navigation and wrap-around services.** | |
|---|---|
| **Barriers and Challenges:**<br><br>Why is this not happening right now? | **Delivery System**<br>• Fully supporting patients with cognitive and behavioral health needs requires partnerships with county and CBOs and/or other providers. In many communities, those partnerships are weak or do not exist. Providers in the Collaborative thought more work was needed to understand how they should be referring to and collaborating with area GUIDE providers.<br><br>**Payment**<br>• Starting in 2024, CMS HCPCS codes will reimburse for navigation/peer support services for patients with high-risk behavioral health conditions. One provider in the Collaborative reported challenges with operationalizing these codes, including the need for a PCP referral, patient consent and accurate time tracking by staff. |
| **Actions Prioritized by the Collaborative:**<br><br>What actions could be taken to support this recommendation? | **1. Expand Access to Navigation and Wrap-Around Services**<br>• Providers, health plans and advocates regularly solicit feedback from patients and families on their needs and experiences to inform service design.<br>• Providers continue piloting the feasibility of new CMS HCPCS codes that reimburse for navigation and peer support services. Provide feedback to CMS on ways to streamline the rules and increase uptake of the codes.<br>• Providers support regional implementation of the GUIDE Model, including the establishment of referral relationships between community providers and GUIDE providers.<br>• Technical assistance organizations support providers to work with county and community-based partners that provide or could provide wrap around services.<br>  • One approach could be to develop a community-level pilot that brings together local partners to discuss needs, build referral pathways, test new reimbursement streams, and enhance services as needed.<br>• Provider organizations and health plans can be strategic and creative about the types of organizations and staff that can provide navigation, and on funding channels. For example, some managed service organizations are now providing these services.<br><br>Lead Actors: government, philanthropy, health plans, providers<br>Influencers: government, technical assistance organizations, CBOs, counties |

# Conclusion

Though Medicare is a federal program, improvements in care and outcomes for Medicare beneficiaries in California can be achieved via alignment and collective action by state-level actors. The Collaborative began a conversation about strategies to achieve improvement. While the Collaborative separately explored the focus areas identified by the project's funders, there were a number of cross-cutting ideas that emerged which can inform next steps:

- Expand value-based payment that supports team-based care and population health management, leveraging new or underutilized Medicare payment models, payment codes and other programs.
- Support care coordination, navigation and integrated care delivery models.
- Expand the system's capacity to screen for and address health related social needs and work in partnership with community-based service providers.
- Leverage telehealth, home visits and other creative solutions to address access challenges.
- Improve data collection and data exchange, including HRSN data, to support patient care and population health management.
- Build the workforce needed to care for California's aging population by investing in pathway programs and training existing service providers that treat Medicare patients in relevant topics such as geriatrics, providing culturally sensitive care and screening and treatment for cognitive and behavioral health needs.
- Engage Medicare beneficiaries in care transformation efforts and in their care and coverage options.

The Collaborative's discussions also highlighted the scope and complexity of strategically improving the care that California Medicare beneficiaries receive. Future efforts should seek to build upon what has worked in other populations and programs and consider what can be aligned across payers. Since this is a relatively new conversation for California stakeholders, any future work should include mechanisms for cross-sector learning and planning.

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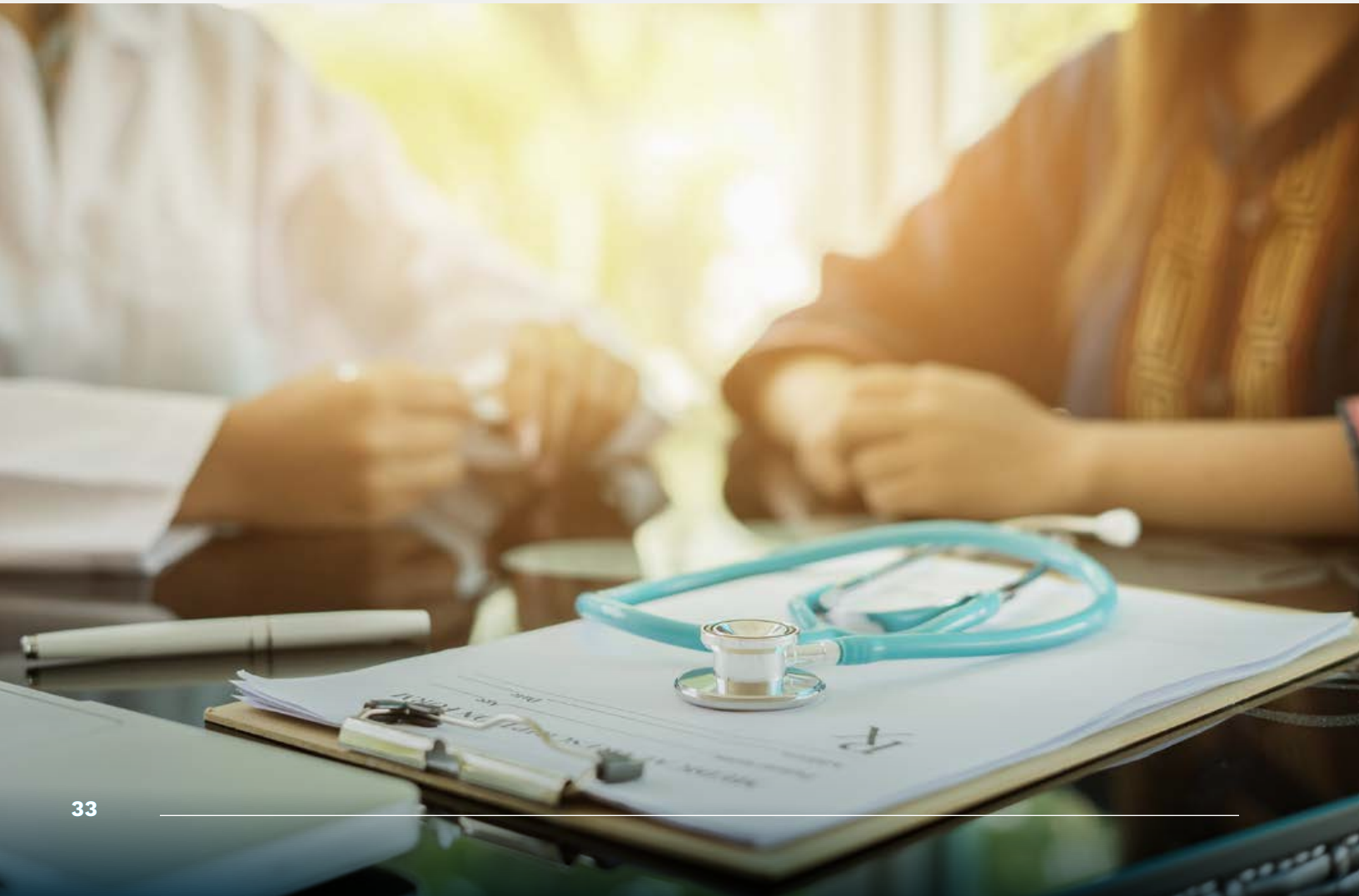
## About the California Quality Collaborative (CQC)

California Quality Collaborative (CQC), a program of the Purchaser Business Group on Health, is a health care improvement program dedicated to helping care teams gain the expertise, infrastructure and tools they need to advance care quality, be patient-centered, improve efficiency and thrive in today's rapidly changing environment. CQC is committed to advancing the quality and efficiency of the health care delivery system across all payers, and its multiple initiatives bring together providers, health plans, the state and purchasers to align goals and take action to improve the value of health care for Californians.



# California Medicare Collaborative Participants

Thanks to those who generously contributed time to the Collaborative, and to Archstone Foundation, The SCAN Foundation and the Gary and Mary West Foundation for funding the project.

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# Glossary

**Accountable Care Organization (ACO):** An entity comprised of physicians, hospitals and/or other providers that improves health care quality, outcomes, and care experiences and can offer shared savings.

**Advanced Primary Care:** Primary care that is person and family centered, relationship based, accessible, integrated, team based, comprehensive, coordinated and equitable.[80]

**Alternative Payment Models (APMs):** An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode or a population.[81]

**Area Agency on Aging (AAA):** Agencies contracted with the California Department of Aging to (CDA) manage programs that serve older adults, adults with disabilities, family caregivers and residents in long-term care facilities throughout the state.

**Behavioral Health (BH):** Behavioral health includes the emotions and behaviors that affect overall well-being. Behavioral health is sometimes called mental health and often includes substance use. Just like physical health, behavioral health has trained providers.[82]

**Community Based Organization (CBO):** Typically, a non-profit that serves a specific community and addresses local needs. Some CBOs provide direct assistance to people with health-related social needs such as food, transportation, peer support and legal help.

**Cognitive Health:** Cognitive health is the ability to think, learn and remember clearly. It is needed to carry out many everyday activities effectively. Cognitive health is just one aspect of overall brain health.[83]

**Delivery system:** Includes health plans, providers and other entities that either pay for or deliver care to patients.

**Downside risk:** Value-based payment (VBP) arrangements under which provider organizations agree to accept financial risk (and potential losses) if their costs exceed a total cost-of-care benchmark.

**Dual-Eligible Beneficiaries or Dual Eligible:** Individuals eligible for Medicare and Medicaid.

**Fee for Service (FFS):** A payment system in which a payer (such as Original Medicare) pays providers for each service rendered.

**Health Disparities (disparities):** Inequitable differences in health outcomes closely linked with social conditions.[84]

**Health Equity (equity):** Health equity means everyone has a fair and just opportunity to be healthy.[85] Equity is not the same as equality. Equity often requires additional efforts and investments for those who currently experience worse health and fewer opportunities.

**Health Information Exchange (HIE):** Secure, electronic sharing of medical information across organizations within a region, community or system. Sometimes HIE can refer to the health information organization that facilitates the exchange of data.

**Health Insurance Counseling and Advocacy Program (HICAP):** Provides free, confidential, one-on-one counseling, education and assistance to individuals eligible or soon-to-be eligible for Medicare and their families on Medicare coverage options, Long-Term Care insurance and other health insurance related issues.

**Health care improvement organization (improvement organization):** Organization focused on improvement and population health that works at the system level, not the point of care.

**Health Related Social Needs (HRSNs):** Social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They put individuals at risk for worse health outcomes and increased health care use. HRSN refers to individual-level factors such as financial instability, lack of access to healthy food, lack of access to affordable and stable housing and utilities, lack of access to health care and lack of access to transportation.[86]

**Independent Physician Association (IPA):** A separate business entity that's owned and operated by a network of independent physician practices.

**Long Term Services and Supports (LTSS):** Services that provide supports for activities of daily living or necessary tasks for beneficiaries with functional impairments.

**Managed Behavioral Health Services Organization (MBHO):** An organization that contracts with health care payers and manages behavioral health service benefits.

**Medicare Advantage (MA):** Medicare coverage offered by private managed care plans. Medicare Advantage plans typically offer bundled coverage, inclusive of Medicare Parst A, B and D.

**Medigap:** Also known as Medicare Supplement Insurance, Medigap is a health insurance plan that helps pay for out-of-pocket costs for beneficiaries covered by Original Medicare.

**Medicare Only:** A Medicare beneficiary that does not also have Medicaid.

**Medicare Savings Program (MSP)**: Low-income residents that don't qualify for full Medicaid may receive support paying for Medicare costs.

**Medicare Shared Savings Program (MSSP):** An ACO model that encourages providers to improve health for the Medicare FFS beneficiary population and reduces spending with a focus on value and outcomes.

**Original Medicare:** The original system of Medicare coverage where CMS is the primary payer directly to providers, as opposed to Medicare Advantage plans. Also known as fee-for-service Medicare.

**Practice:** Point of care delivery site, usually independent and not part of a large system.

**Provider organizations:** General term to refer to a business entity that includes licensed persons that offer health care services, including diagnosis and treatment.

**Provider enabling organizations:** Companies that aggregate physician practices into ACOs.

**Qualified Health Information Organization (QHIO):** Facilitates the secure exchange of health and social services information, assisting entities as they create and respond to information requests, receive the results of tests or referrals and solicit notifications of admissions or discharges.

**Shared Savings:** VBP incentive designed to reward provider organizations that keep costs below a total cost of-care benchmark and meet quality standards with a percentage of the savings.[87]

**Social Determinants of Health (SDOH):** SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[88]

**Solutions Providers:** Organizations that provide administrative, payment and analytic support to providers or CBOs such as Managed Service Organizations (MSOs).

**Technical Assistance (TA) Organizations:** Organizations that provide supports to an organization, community or industry to enhance capabilities and effectiveness. Services vary, but may include training sessions, workshops, webinars, resource materials and direct coaching or consultations.

**Value Based Payment (VBP):** Paying for health care services in a manner that directly links performance to cost, quality and the patient's care experience.

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