March 2016

Evaluation of Cal MediConnect: Key Findings from Focus Groups with Beneficiaries

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In 2015, University of California researchers conducted 14 qualitative focus groups to assess beneficiaries' experiences with California's financial alignment demonstration for beneficiaries dually eligible for Medicaid and Medicare. California is one of 12 states across the nation implementing a "duals demonstration." While the Centers for Medicare and Medicaid Services is conducting an evaluation across all states, California leaders seek to gather information directly from consumers about their experiences to inform the implementation of the demonstration and real-time policy decisions. These focus groups are the first piece of a larger evaluation that includes a representative, longitudinal telephone survey with beneficiaries and interviews with key stakeholders in seven demonstration counties. The goals of the focus groups were to assess beneficiaries' experiences with access, quality, and overall coordination of care, and to understand beneficiaries' reasons for choosing to opt out or disenroll. Additionally, data from beneficiary focus groups provided rich qualitative insights into the design and interpretation of quantitative survey data to be collected in the next phase of the evaluation. Below is a brief report of key findings from the focus groups. For the full report, go to http://www.thescanfoundation.org/evaluating-medicare-medicaid-integration.

Supported by a grant from The SCAN Foundation - advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. For more information, visit www.TheSCANFoundation.org.

Additional funding provided by the National Institute on Disability, Independent Living, and Rehabilitation Research (grant 90RT5026) and the Administration for Community Living.

Background

Over 9.6 million seniors and adults with significant disabilities in the United States are dually eligible for Medicaid and Medicare.[1] They represent beneficiaries with the lowest incomes and, on average, the most complex care needs and the highest share of spending in both programs. The Centers for Medicare and Medicaid Services implemented a financial alignment demonstration in 12 states to test models aligning the financing and/or administration of Medicaid and Medicare for dually eligible beneficiaries.[2]

California's financial alignment demonstration, called the Coordinated Care Initiative (CCI), was designed as a capitated managed care model. It was implemented in seven counties where existing managed care organizations created new products, called Cal MediConnect. Beneficiaries were pre-assigned to one Cal MediConnect plan, but informed of their choice to opt out, change plans, or disenroll. The first counties began enrolling eligible beneficiaries in April 2014. By February 1, 2016, over 124,000 dually eligible beneficiaries were enrolled.[3] Approximately half of eligible beneficiaries opted out of the program and another 10 percent disenrolled later. Once enrolled, beneficiaries have their Medicare and Medicaid services coordinated through one Cal MediConnect health plan and integrated under one payment system, including all medical care and long-term services and supports (both institutional and home/community based), and with specialty behavioral health kept separate but coordinated by the plan. Those who opted out or disenrolled were still required to enroll in a managed care plan for their Medi-Cal benefits, including long-term services and supports.

In 2015, University of California researchers conducted qualitative focus groups (and some individual interviews) with 120 adult beneficiaries who were eligible for enrollment into Cal MediConnect plans. Participants were recruited through both Cal MediConnect plans and community-based organizations that served dually eligible populations. A total of 14 focus groups were conducted in 2015, in May through November. Twelve focus groups were held with those enrolled in a Cal MediConnect plan and two focus groups were with beneficiaries who opted out or disenrolled. Focus groups were conducted in English (9), Spanish (3), Cantonese (1) and Mandarin (1). Some focus groups specifically targeted individuals using In-Home Supportive Services (2) and care coordination services (2). Individual in-depth telephone interviews with beneficiaries using behavioral health services were done instead of a focus group to allow a sample from multiple counties. For more detailed methodology and demographics of participants, please see the full report at http://www.thescanfoundation.org/evaluating-medicare-medicaid-integration.

Key Focus Group Findings and Recommendations

#1 Overall satisfaction with care in Cal MediConnect was high. On a scale from 1-10, the average satisfaction score for those enrolled in Cal MediConnect was 8. Beneficiaries cited factors that contributed to their satisfaction with the program, including: more simplified health insurance with one card and one phone number to call for assistance; lower out-of-pocket expenses and easier access to medications, medical equipment and hospital visits; more support and access to services through care coordination; and better access to care for behavioral health.

#2 Continuity of providers, medications and equipment were essential to beneficiary safety and satisfaction. When beneficiaries were able to keep seeing their providers, access needed medications and equipment, and receive care through the same medical centers, they were typically very satisfied with the plan. Conversely, having to change any of these things was often reported as problematic.

Recommendation: More needs to be done to ensure continuity in these areas including: guaranteeing access to out of network providers, ancillary services and off formulary prescriptions for several months while beneficiaries and providers find alternatives, and encouraging more providers to participate in Cal MediConnect.

#3 Many beneficiaries found continuity of care provisions to be inadequate and chose to opt out instead. Beneficiaries had the option of requesting a continuity of care provision that would allow them to continue seeing their fee-for-service provider for six or 12 months if their provider agreed to the terms. Many who had longstanding relationships with trusted providers wanted to continue to see them indefinitely, not just for the limited time available through these provisions. A change to a new provider or office was viewed as a significant disruption in care, particularly for beneficiaries with complex or rare conditions, mobility challenges, limited English proficiency, specific communication needs, or who were undergoing active treatment for an acute illness. Opting out was seen as a better choice for beneficiaries who wanted to maintain access to non-Cal MediConnect providers indefinitely.

Recommendation: Plans could examine their continuity of care policies to better facilitate smooth access to previous providers and care for beneficiaries when they transition into the plan. Campaigns that educate non-participating providers about the benefits of Cal MediConnect for their patients and encourage their participation are crucial for maintaining continuity of care for beneficiaries. More counseling regarding the availability of continuity of care could be helpful for those considering opting out or disenrolling.

#4 Beneficiaries perceived much better access to behavioral health services in Cal MediConnect. While the new program is designed to coordinate behavioral health rather than integrate it, many beneficiaries reported better access to behavioral health providers and medication after their transition to Cal MediConnect. Many were pleased with their increased access to specialty behavioral health providers such as psychiatrists, more frequent appointments for therapy, and easier access to psychiatric medications.

Insight: Though specialty behavioral health care is kept separate in California, some plans have been successful in increasing access and providing more options for beneficiaries.

#5 Disruptions in care were reported in the early stages of the transition, and were often resolved by the Cal MediConnect plan or provider. Experiencing disruptions in care early on was often the reason beneficiaries chose to disenroll from the program. For those who stayed in the program, many reported that the disruptions were resolved in a few weeks. The most common disruptions were due to problems with authorization and referral; changing specialty providers; or problems accessing needed medication, medical equipment, or supplies after the transition.

Insight: Efficient support by Cal MediConnect plans for beneficiaries in the first months after transition was essential to resolving disruptions and preventing disenrollment.

#6 The authorization process for specialty care in Cal MediConnect was problematic for many beneficiaries. Beneficiaries reported many problems accessing specialty care, including lack of access to specialists they previously visited, few in-network specialists taking new patients, and long waits during the referral and authorization process. Obtaining authorizations was a key change for beneficiaries, the majority of whom had experience only with a fee-for-service delivery system. Many beneficiaries reported going to specialist appointments only to learn that the authorization had not been received. Many did not understand how best to facilitate authorizations or when they were needed. Some reported that providers, plans, and medical groups were not in agreement about the authorization process.

Recommendation: Authorization processes between the plan, provider, and medical group need to be clarified and streamlined to ensure efficient communication and access to care for beneficiaries. Plans should explore how their care coordinators and interdisciplinary care teams can help ensure timely access to specialty care.

#7 Beneficiary notification materials were not sufficient for understanding how their specific care needs would be impacted. The most important thing for most beneficiaries was to understand how the switch to Cal MediConnect would impact their individual care. Many beneficiaries said that the letters from the state (four letters beginning 90 days prior to enrollment) were too brief to allow this level of decision-making. This resulting uncertainty among beneficiaries likely contributed to some beneficiaries' decision to opt out. Later, when beneficiaries received booklets and large provider directories from plans, many said information was too complex or overwhelming for them. Few learned from the mailed materials about the additional benefits Cal MediConnect provides. Those who attended in person presentations felt they got their questions answered. Results demonstrate the importance of individualized counseling for beneficiaries with complex care needs and the difficulty of communicating insurance coverage changes to large groups of beneficiaries with diverse needs and often limited literacy.

Recommendations: Despite letters, materials from health plans, and community presentations, there were ways to improve communication including:

- *Clearly listing the additional Cal MediConnect benefits such as transportation, vision, and care coordination that would be available through the plan.*
- *Giving beneficiaries easy and accessible tools to determine whether their providers, medications, equipment, and other needs are covered in specific plans.*
- *Making it clear to beneficiaries that they can choose a different plan or request a continuity of care provision, and what that means.*
- *Defining clearly what "opting out" means, and explaining that those who opt out still will have to enroll in a managed care plan for Medi-Cal.*

#8 The new care coordination benefit helped beneficiaries access care and better understand services available to them through Cal MediConnect. Care coordination services provided by the plan helped beneficiaries navigate their new managed care plan and access medical care. Some describe how care coordinators connected them to long-term services and supports that they previously were unaware of such as In-Home Supportive Services or non-emergency transportation. Additionally, some beneficiaries described how their care coordinator helped prevent Emergency Department visits or unnecessary hospitalizations through arranging home visits or other alternatives. Those using care coordination seemed to have the best understanding of the benefits of Cal MediConnect, and were more likely to see the plan as an "ally," or a place to call to get help. This was particularly pronounced among Chinese participants who were uniformly pleased to have a care coordinator who spoke their language.

Recommendation: Our results suggest that expanding access to the care coordination benefit may expand beneficiaries' knowledge of the services available; increase satisfaction with their health plan; and promote access to care – especially long-term services and supports.

#9 Beneficiaries were largely unaware of Cal MediConnect's role in their long-term services and supports and didn't know to communicate their non-medical needs to the plan. Though some beneficiaries reported that their plan helped them connect to In-Home Supportive Services or Community-Based Adult Services for the first time, most had little or no awareness of their plan's new role in paying for or coordinating these services.

Recommendation: Educate beneficiaries about how their plan can facilitate access to long-term services and supports so they are more likely to communicate these needs.

#10 Beneficiaries cited many reasons for opting out, including lack of understanding of the program, reticence to change providers, and poor interactions with the plan after notification. Many opted out because they didn't understand what impact Cal MediConnect would have on their care. The lack of detailed information in notification materials reinforced some beneficiaries' distrust of government. Some could not get the information they needed when they followed up with phone calls to plans or the enrollment contractor. Others felt rushed and thought opting out would be a safer choice. Values of autonomy and choice were common themes among non-enrolled beneficiaries.

Recommendation: Create more detailed notification materials and create tools that allow beneficiaries to easily learn how the plan will impact their individual care; increase efforts to recruit existing providers into plan networks; offer a more robust continuity of care provision that is as simple as opting out and guarantees access to fee-for-service providers; and lengthen beneficiaries' time to make an informed choice.

References

1 The Kaiser Commission on Medicaid and the Uninsured. Explaining the State Integrated Care and Financial Alignment Demonstrations for Dual Eligible Beneficiaries (October 2012), available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8368.pdf.

2 The Kaiser Commission on Medicaid and the Uninsured. Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda Of Understanding Approved by CMS. Issue Brief (November 2013), available at http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8426-05-financial-and-administrative-alignment-demonstrations-for-dual-eligible-beneficiaries-compared1.pdf.

3 Cal MediConnect Monthly Enrollment Dashboard (as of February 2016). Available at http://www.calduals.org/wp-content/uploads/2016/02/February-2016-CMC-Enrollment-Dashboard.pdf.

Suggested citation: Graham, C., Kurtovich, E., Liu, M., Wong, A., Tlatelpa, K., Stewart, H. (2016). Evaluation of Cal MediConnect: Key findings from focus groups with beneficiaries. Long Beach, CA: The SCAN Foundation. Retrieved from http://www.thescanfoundation.org/sites/default/files/cal_mediconnect_key_findings_brief_march_2016.pdf.