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Since 2015, Cal MediConnect enrollees are reporting higher levels of satisfaction, confidence and continuity of care, though gaps remain in getting some needed services.

In June 2018, the University of California, San Francisco completed the 2018 wave of the Cal MediConnect (CMC) Rapid Cycle Polling Project, a tracking survey that included over 2,900 interviews with older adults and people with disabilities who were dually eligible for Medicare and Medi-Cal. CMC health plans integrate all Medicare and Medi-Cal benefits, including long-term services and supports (LTSS), in seven California counties. As with surveys conducted in three previous years, the 2018 survey follows three groups: 1) those enrolled in CMC; 2) those who opted out of the program and who live in CMC demonstration counties; and 3) those who live in non-CMC demonstration counties.

Beneficiaries were asked about their confidence and satisfaction with health care, and problems encountered. In 2017 and 2018, beneficiaries were also asked about their needs and use of LTSS. All surveys were conducted on behalf of The SCAN Foundation, in conjunction with the California Department of Health Care Services.

Cal MediConnect enrollees' confidence navigating their health care continues to increase

CMC enrollees' confidence in their care has continuously increased since 2015, while confidence among opt-outs has remained steady.

- Large majorities of CMC enrollees express confidence that they know: how to manage their health conditions (82%), how to get questions about their health needs answered (84%), and who to call if they have a health need or question (89%).
- While confidence ratings in earlier years had been similar across enrollees and opt-outs, starting in 2017 and continuing in 2018, CMC enrollees' confidence was higher in all three areas.

Cal MediConnect enrollees' satisfaction with their health care increased in 2018.

CMC enrollees' satisfaction has increased since 2015 in six of the seven areas: the amount of time doctors spent with them, the information they received from the health plan explaining benefits, their choice of doctors, the way their providers work together, wait times for appointments, and their ability to call a provider regardless of the time of day.

- Large majorities of CMC enrollees – ranging from 77% to 89% – report being satisfied with the health care services they are receiving in each of the areas tracked.
- In 2018, CMC enrollees were more satisfied than opt-outs in three areas, including: the information they get from their health plan explaining benefits, the way different providers work together, and their ability to call a provider regardless of the time of day.
- While in past years, those who opted out were more satisfied than CMC enrollees with the amount of time spent with their doctor, by 2017 satisfaction increased to match opt-outs.

Cal MediConnect enrollees continued to report problems with aspects of their health care.

Low percentages (between 10% and 16%) of CMC enrollees reported they encountered problems with their health services in six different areas.

- The two most commonly reported problems among CMC enrollees were: they had a misunderstanding about their health care services or coverage (14%), and a doctor they had been seeing was no longer available through their plan (16%).
- CMC enrollees in 2018 had lower rates of reported problems than in previous years in three areas: a doctor they had been seeing was no longer available through their plan (23% in 2015, down to 16% in 2018), denied treatment or referral for a service recommended by a doctor (17% in 2015, down to 13% in 2017), and having a misunderstanding about health care services or coverage (21% in 2015 down to 14% in 2018).
- CMC enrollees were slightly less likely than opt-outs to have trouble in two areas: transportation problems keeping them from getting needed health care, and having a misunderstanding about health care coverage.
- Opt-outs, however, were slightly less likely than CMC enrollees to report that they had a treatment or referral denied, and that a doctor they were seeing was not available through their plan.

CMC enrollees are reporting longer relationships with their personal doctor, a key indicator of care continuity that is especially important after a transition to managed care. .

Since 2015, the survey has polled beneficiaries about the length of time they had been seeing their current "personal doctor." Having a shorter (one year or less) relationship with a personal doctor could be interpreted as a sign of problems with continuity of care in the post-transition period.

- In 2015, the percent that had been seeing their doctor for a short period of time (one year or less) was 30%. That percentage was almost cut in half, down to 16% in 2018.
- 2017 was the first year that the percent of CMC enrollees having a doctor for one year or less was lower than non-CMC counties, and this trend continued in 2018.

Beneficiaries reported LTSS needs and use of In-Home Supportive Services (IHSS) in 2018.

Beginning in 2017, beneficiaries in all three groups who used LTSS were asked about their LTSS needs and use of IHSS, California's consumer-directed personal assistance program.

Consistent with the self-reported health status of enrollees and opt-outs, CMC enrollees reported lower rates of needing help with personal care compared to opt-outs.

- Of those who reported needing help, 4 in 10 beneficiaries in all groups still had unmet needs for personal or routine care.
- A slightly larger percent of CMC enrollees and opt-outs with personal care needs reported receiving IHSS (88% and 91%) in 2018 compared to non-CMC counties, where only 84% of beneficiaries with personal care needs received IHSS.
- Consistent with their lower need for personal care, CMC enrollees received significantly lower average monthly IHSS hours (90 hours) compared to opt-outs (103 hours) and beneficiaries in non-CMC counties (95 hours).

Few Cal MediConnect beneficiaries have a care manager or personal care plan, despite high levels of unmet need for personal care and routine care.

Beneficiaries are asked about having a care manager because the CMC health plans provide care coordination as a new benefit. Unfortunately, few beneficiaries are receiving this benefit.

- Only a quarter of CMC enrollees in 2018 reported that they had a single care manager, such as a nurse or other helper from their health plan, who serves as their main point of contact and arranges all aspects of their care.
- The proportion of CMC enrollees and opt-outs who reported having a single care manager declined, from about a third in 2016 to about a quarter in 2018. This figure seems low considering 43% of CMC enrollees are in poor health, 51% need help with personal care, 78% need help with routine care, and 40% of those who need help have unmet needs that might be met with care manager intervention.
- The percent of CMC enrollees with a personal care plan also declined, from 33% in 2016 to 26% in 2018.
- A majority of CMC enrollees said that having a care manager or personal care plan improved their care "a lot."

"We are very encouraged by the continued positive trends in beneficiary satisfaction with Cal MediConnect. These data emphasize the program and delivery improvements made by Cal MediConnect plans in partnership with DHCS and CMS," said Jennifer Kent, Director of the California Department of Health Care Services. "Like past data, this new information will continue to inform our work to improve the beneficiary experience and ensure plans are providing excellent quality of care to dual eligible beneficiaries."

"Cal MediConnect enrollees are expressing confidence in managing their health conditions and getting their health needs answered at the highest rates we've seen," says Bruce Chernof, President and CEO of The SCAN Foundation. "While progress is still needed, we see people's experience of care improving with each wave of polling."

About the Survey

The results reported in this release come from a large-scale tracking survey of dually eligible Medicare and Medi-Cal beneficiaries in California, conducted in 2017 and 2018 by University of California on behalf of The SCAN Foundation and the California Department of Health Care Services (DHCS). Earlier waves in 2015 and 2016 were conducted by Field Research Corporation.

All surveys were conducted by means of telephone interviews with stratified random samples of CMC enrollees and opt-outs across California counties participating in the Cal MediConnect demonstration. In 2015, the survey included five counties (Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara). In 2016, two additional CMC counties (San Mateo and Orange) were added to the survey.

Each survey also included interviews with samples of dual eligible beneficiaries in non-CMC counties. In 2015 and 2016, those counties were San Francisco and Alameda. In 2017, the non-CMC comparison counties were expanded to include nine counties where the demonstration was not implemented.

To enable the study to compare the opinions of dual eligible beneficiaries who were either unable or found it difficult to complete the telephone interview themselves, the survey offered those chosen to participate the option of naming another individual who assisted them in making their health care decisions to complete the survey on their behalf (i.e., proxy).

The 2018 survey was administered to 2,961 dual eligible beneficiaries or their proxies. Of those, 1,775 were CMC enrollees, 781 were CMC opt-outs, and 405 were beneficiaries from non-CMC counties.

Over the course of the six survey waves across the four years, a total of 17,460 dually eligible beneficiaries were interviewed, including: 9,671 CMC enrollees, 4,966 opt-outs, and 2,823 beneficiaries in non-CMC counties. Each survey was administered in four languages and dialects – English, Spanish, Cantonese, and Mandarin. Up to eight attempts were made to reach and complete an interview with each randomly selected dual eligible beneficiary or their proxy on different days and times of day during the interviewing period. The allocation of interviews for each survey was stratified by county and within the CMC counties, between enrollees and those who had opted out of the program. After the completion of interviewing, weights were applied to return these stratified sample allocations to population estimates of the share of beneficiaries in each county as reported by DHCS.