



Original Article

Integration of Medicare and Medicaid for dually eligible beneficiaries: A focus group study examining beneficiaries' early experiences in California's dual financial alignment demonstration



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ABSTRACT

Background: In 2014 California implemented a federal dual alignment demonstration used a capitated managed healthcare model called Cal MediConnect (CMC) to integrate medical care and long term services and supports (LTSS) for beneficiaries with both Medicare and Medicaid. These beneficiaries often have complex care needs, including multiple chronic conditions and disabilities. By 2016, 120,000 eligible beneficiaries were enrolled in the program.

Objectives: Focus groups with enrolled beneficiaries were conducted to gather rich data about their early experiences with quality of care, access to care, and coordination of care in CMC plans and to identify recommendations for program improvement.

Methods: Evaluators conducted 14 focus groups with 104 beneficiaries enrolled in CMC plans in 6 demonstration counties.

Results: The passive enrollment process did not provide adequate information about certain aspects of CMC, leaving many beneficiaries unaware of new benefits such as care coordination, transportation, and managed LTSS. Most beneficiaries who were using the CMC care coordination benefit reported increased access to specialty care, medical equipment, and other LTSS. Changing providers and having trouble with authorization for specialty services, prescriptions, or medical equipment were common reasons for dissatisfaction. Many beneficiaries reported that early disruptions in care due to the transition of delivery system improved with time.

Conclusion: Similar to other studies that examine beneficiaries' experiences with delivery system change, participants were confused about the passive enrollment process and demonstrated a lack of understanding of many aspects of Cal MediConnect. Analysis identified areas where beneficiaries noted improvement in their quality of care, access, and coordination of care, but also areas for improvement. Streamlining the authorization processes and extending continuity of care provisions would improve access to providers. Increasing beneficiaries' awareness of CMC plans' role in LTSS is key to improving their access to home- and community-based services.

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Over 9.6 million seniors and adults with disabilities in the United States (US) are dually eligible for Medicaid and Medicare.¹

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These “dual eligibles” typically have very low incomes, complex care needs, and high levels of care utilization. For example, in 2012 the Centers for Medicare and Medicaid Services reported that 27% of duals had between two and three chronic conditions, 24% had between four and five, and 21% had six or more chronic conditions. Dual eligibles were significantly more likely to have certain conditions such as depression, Alzheimer's, COPD, heart failure, and

diabetes.²

Dually eligible beneficiaries also account for a disproportionate share of spending in both programs.^{3,4} For example, Medicare fee-for-service (FFS) spending is more than twice as high for duals compared with non-dual eligible beneficiaries.⁵ Misaligned incentives across Medicare and Medicaid result in inefficiencies that contribute to these high costs, including duplication of care, poor coordination of care, and higher rates of avoidable hospitalizations.^{6–13} States are increasingly turning to managed care and integrated delivery systems in efforts to control costs for dually eligible beneficiaries. In 2014, almost two million (20%) of dually eligible beneficiaries were enrolled in Medicaid managed care, a percentage that increased from roughly 10% in 2010.^{14–17}

Evidence of the effectiveness of previous efforts to integrate health care and social services for those dually eligible for Medicaid and Medicare in the US has been mixed.^{18–23} For example, evaluations of the Program for All Inclusive Care for the Elderly (PACE), one of the most replicated integrated models for duals with nursing level care needs, yielded inconsistent results regarding utilization and cost. Some studies demonstrated that enrollees had fewer inpatient hospitalizations and therefore lower Medicare costs. Other studies demonstrated higher rates of nursing home admissions and thus higher associated Medicaid costs, while some evaluations of PACE found no evidence of improved beneficiary satisfaction.^{24–27}

In an effort to improve the quality and efficiency of care for dually eligibles, the Patient Protection and Affordable Care Act (ACA) gave the Centers for Medicare and Medicaid Services (CMS) Innovations Office the authority to implement and test programs that aligned financing and administration of Medicaid and Medicare for duals.²⁸ By 2015, CMS had finalized Memorandums of Understanding (MOUs) with 13 states to implement “Dual Financial or Administrative Alignment Demonstrations.”^{29,30} Ten of these demonstrations, including California’s, tested capitated managed care models to integrate Medicare and Medicaid services. Two states tested managed fee-for-service models (FFS), and one state tested the integration of administration functions without financial alignment.¹⁸ Target groups varied among demonstrations, with some states enrolling all adult dual beneficiaries, some limiting enrollment to non-elderly duals, some limiting enrollment to specific LTSS waiver populations, and many (including California) limiting enrollment by specific geographic region. There were also key differences in target populations, with some demonstrations including seniors, some only younger adults with disabilities, and some a combination thereof.¹⁸

California’s dual alignment demonstration, the Coordinated Care Initiative (CCI), was the largest of the 13 state demonstrations. Eleven existing Medicaid managed care health plans in seven participating counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara) developed new products for dually eligible beneficiaries collectively called Cal MediConnect (CMC) plans. These CMC plans were tasked with integrating, coordinating, and financing all Medicare and Medicaid services, including all medical care and LTSS. For behavioral health services, CMC plans provided benefits for mild to moderate mental illness, but severe mental illness continued to be carved out and provided by county mental health facilities (though CMC plans were tasked with coordinating those services). CMC also offered new benefits for enrollees, including: care coordination services, transportation services, and enhanced vision and dental services.³¹

Passive enrollment in CMC plans began in April 2014 and continued through May 2016, by which time approximately 120,000 dual beneficiaries were enrolled.³² Although all eligible beneficiaries were allowed to fill out a form indicating their choice

of plan, few acted on this option and most were therefore “passively” enrolled by an assignment system that assessed their top provider’s association with existing plans. This was similar to the process of auto assignment used to transition Medi-Cal only seniors and people with disabilities (SPDs) in 2012.³³ Once enrolled, participants were allowed to change to another plan in their county or “opt out.” Ultimately, almost 50% of all eligible beneficiaries in California opted out or disenrolled from Cal MediConnect.³⁴ Those who opted out kept their FFS Medicare, but were still enrolled in managed care for their Medicaid and LTSS. A survey of beneficiaries indicated that opting out was a fairly easy process, but about 43% of those who opted out were unaware they had done so.³¹ The most common reasons for opting out included: 1) wanting to keep a current Medicare provider; 2) believing that CMC would not cover specific services or benefits they needed; 3) being content and satisfied with their current FFS Medicare benefits; and 4) finding CMC difficult and complicated to understand, which rendered opting out a safer choice.³¹ Enrolling large numbers of beneficiaries in new delivery systems can be a complex and confusing process for beneficiaries, especially when passive enrollment or “auto assignment” is used.³³ In a previous study of the mandatory transition of Medi-Cal only SPDs in California, most enrollees reported either neutral or positive experiences with their new plan, but those who actively enrolled had more positive experiences than those who were passively enrolled.³⁵

The purpose of this study was to ascertain the experiences of beneficiaries with the CMC program. Individuals with disabilities and complex care needs are the foremost experts on their own care. While assessment of cost and efficiency are important, we also argue that the perspective of beneficiaries themselves should be a driver of policy change and course correction. This study was the first step in a larger participatory evaluation of the experiences of California’s dually eligible population enrolled in Cal MediConnect health plans. It was intended provide a rich, in-depth description of beneficiaries’ early experiences with enrollment, access to care, quality of care, and satisfaction with care in the Cal MediConnect program to inform course correction in the Cal MediConnect program as well as communicate useful lessons learned to other states and health plans designing integrated care systems for adults with disabilities.

Methods

Participatory evaluation model

For the present study, we used a participatory evaluation approach to ensure that our evaluation captured the primary concerns of beneficiaries and stakeholders and that results were actionable for policymakers.^{36,37} Input from a stakeholder advisory group was elicited to inform all phases of the research, including study design, data collection, and interpretation of results. Members of the stakeholder advisory group - which included consumers, advocates, health plans, policymakers, and providers - were interviewed individually and convened twice during the study period to inform the focus group instrument domains, review of results and input on interpretation of results. The use of participatory design has been shown to improve the applicability and generalizability of results because the research questions are ultimately more grounded.

Recruitment, screening and consent

We employed purposive sampling in the present study, a strategy that involves selection of a study population with shared characteristics as well as the potential to provide rich data relevant

to the research question.^{38,39} Participants were recruited through CMC health plans that sent invitation letters to random selections of eligible participants. In some counties, recruitment was supplemented by community-based organizations (CBOs) that posted flyers asking potential participants to call, text, or email the research team to learn more about the study. Additionally, homeless beneficiaries and those with a history of behavioral health problems were invited to complete a telephone interview that followed the same focus group discussion guide. Research staff screened potential participants by phone to ensure they were eligible. To ensure that the focus groups did not exclude beneficiaries with mobility barriers, taxi rides were provided for participants requiring assistance with transportation. Research staff obtained verbal informed consent to participate at the onset of each focus group and interview. All focus group participants were given \$20 gift card as an incentive.

Two focus groups were also conducted with dually eligible beneficiaries who opted out of Cal MediConnect, but due to the small sample size, lack of awareness of opting out on the part of some participants, and availability of other reports on the subject cited in the background section, results of the opt out groups are not reported here.

Inclusion and exclusion criteria

All beneficiaries had been enrolled in a CMC plan for at least six months at the time of the focus group. Eligible study participants were 18 years of age or older. All eligible participants could choose to elect a health care proxy to represent them in the focus groups. Eligible proxies were 18 years of age or older and made health care decisions for the beneficiary. The analysis was restricted to participants enrolled in a CMC plan at the time of the focus group or interview (therefore these results do not generalize to the experiences of those who opted out or disenrolled). No focus groups were conducted in Orange County due to a delay in implementation of the demonstration.

Data collection

Twelve focus groups were held with dually eligible beneficiaries in California between May 2015 and November 2015 in six demonstration counties. Focus groups lasted approximately two hours. In addition to the focus groups, six additional in-depth telephone interviews were conducted. Five of these were conducted with beneficiaries using behavioral health services, and one was conducted with a homeless beneficiary. Telephone interviews lasted approximately 45 minutes. Focus groups and interviews

were conducted in English, Spanish, Mandarin, and Cantonese (Table 1). All English and Spanish language focus groups were conducted by a professional, bilingual moderator. Mandarin and Cantonese language focus groups were conducted by research staff. Telephone interviews were conducted by research staff.

Prior to each focus group and telephone interview, research staff administered a brief “pre-survey” that included both demographic and health services utilization measures to describe the population. At the beginning of each focus group, all participants were asked to rate their satisfaction with their current health insurance plan on a scale of one to ten, where ten indicated a health insurance plan that “couldn’t be better.”

A consistent discussion guide that was informed by the advisory group was followed across focus groups and interviews (See Appendix: Focus Group/Interview Discussion Guide). It included questions about participants’ knowledge of CMC; their experiences with notification and enrollment; their satisfaction with CMC; their experiences with a wide range of services (i.e. primary care, specialty care, prescriptions, medical equipment, transportation, long-term services and supports); and their experiences with coordinated care. Study procedures were reviewed and approved by the Institutional Review Board (Protocol ID#2015-01-7031).

Data analysis

A preliminary set of codes was developed using themes that were expected to emerge from the groups based on study objectives, previous research, input from the stakeholder advisory group, and observation of the focus groups.^{40,41} Two members of the research team independently applied these preliminary codes to three separate focus group transcripts. These research team members met to reconcile any inconsistencies in the definition or application preliminary codes in order to develop a finalized codebook (See Online ancillary material: Final Codebook with definitions).⁴⁰ Cohen’s κ was calculated using Dedoose™ Online Software v 5.1.26 to assess inter-rater reliability between two coders. A pooled $\kappa = 0.86$ was achieved during the final coding process.⁴² Both coders then coded the remaining transcripts using the finalized codebook. Quantitative, pre-survey data were analyzed using SAS v. 9.3 (SAS Institute Inc., Cary, NC, USA).

Results

Focus group sample

A total of 104 beneficiaries who were passively enrolled in CMC plans across six California counties participated in focus groups

Table 1
Focus groups/in depth interviews by target population, county, language, and number of participants.

Population	County	Language	Number of participants
People with disabilities	San Bernardino	English	10
In-Home Supportive Services (IHSS) users	San Bernardino	English	12
Care coordination users	San Bernardino	Spanish	8
Care coordination users	Riverside	English	11
In-Home Supportive Services (IHSS) users	Riverside	Spanish	5
Seniors	Los Angeles	English	9
Seniors	Los Angeles	Spanish	6
Seniors	San Diego	English	3
People with disabilities	San Diego	English	6
Seniors	San Mateo	Cantonese	12
Seniors	San Mateo	Mandarin	7
Seniors & people with disabilities	Santa Clara	English	9
Behavioral health interviews	San Bernardino (1), Riverside (1), San Diego (3)	English	5
Homeless interviews	Los Angeles	English	1
Total			104

(n = 98) or telephone interviews (n = 6). Five focus groups included just seniors, age 65 and older. Two focus groups included only younger adults with disabilities. Several groups were mixed ages, two groups included only those participants who were using the CMC care coordination benefit, and two groups included only those participants using In Home Supportive Services (IHSS), California's consumer directed home care service for Medi-Cal beneficiaries with disabilities (Table 1).

The majority of participants (64%) were English speaking (Table 2). Mean age was 66, and two-thirds of participants (66%) were seniors over age 65. Over half of participants lived alone (56%). The majority were female (68%) and the study sample was 35% Latino. A quarter of participants (26%) did not graduate from high school, though the majority attended some college. Most participants reported fair or poor overall health. The majority (86%) self-reported at least one disability and one-third (32%) reported more than one. All but five participants had visited a primary care provider during the previous six months in their plan, and nearly half (48%) of participants visited their primary care provider three or more times. The majority of participants had visited a specialist (81%) in the previous six months.

Major themes that emerged across focus groups are grouped into five key domains: 1) Notification and enrollment; 2) overall satisfaction; 3) overall dissatisfaction 4) access to care; and 5) perceptions of service coordination in Cal MediConnect health care plans.

Notification of enrollment

The majority of focus group participants remembered getting at least one notification letter before enrollment in CMC, but many said that the information it contained was confusing, and those with complex care needs felt the letter did not fully prepare them for what to expect regarding how their specific care would be affected. These beneficiaries wanted more specific information about services that were covered under the plans so they could make informed choices or prepare for specific changes to benefits and providers.

They didn't send us any information, they just said "join or don't."

It—it was a little difficult for me to understand the letter and I'm usually pretty good at that but I couldn't tell how it was gonna affect all my different medical care services.

After enrollment, many participants mentioned receiving materials from their new CMC health plan, such as provider or pharmacy directories. Unlike the notification letters that included too little information, many felt that the provider directories from the plans contained too much information, much of it irrelevant to them.

Yeah. I understand all the information but, uh, I feel for the average person that is too much information. For instance, I need to know that my pharmacy is CVS but then I have a whole booklet with all the pharmacies. Some of them in a different city.

Choice of Plan

Most participants were passively enrolled, but some changed plans after initial enrollment. Those beneficiaries chose their new CMC plan based on whether their current providers were in the plan's network.

Table 2
Focus group/telephone interview participant characteristics.

	n (%)
Type of Participant (n = 104)	
Beneficiary	100 (96.2)
Proxy representing beneficiary*	4 (3.8)
Age (n = 96)	
24 to 44	9 (9.4)
45 to 59	21 (21.9)
60 to 64	3 (3.1)
65+	63 (65.6)
Gender (n = 96)	
Female	65 (67.7)
Male	31 (32.3)
Education (n = 85)	
Did not graduate high school	22 (25.9)
Graduated high school	12 (14.1)
Attended some college	33 (38.8)
Graduated from college or attended graduate school	18 (21.2)
Language of focus group (n = 104)	
English	66 (63.5)
Spanish	19 (18.3)
Cantonese	12 (11.5)
Mandarin	7 (6.7)
Race/ethnicity (n = 89)	
African American	29 (32.6)
White	16 (18.0)
Latino	31 (34.8)
Asian	7 (7.9)
Native Hawaiian/other Pacific Islander	1 (1.1)
More than one race/ethnicity	5 (5.6)
Health Literacy/Difficulty Reading Written	
Health Information (n = 89)	
Never have difficulty	33 (37.1)
Sometimes have difficulty	39 (43.8)
Always or usually have difficulty	17 (19.1)
Household Composition (n = 101)	
Lives alone	57 (56.4)
Does not live alone	44 (43.6)
Self-rated Health (n = 96)	
Excellent or good	23 (24.0)
Fair	52 (54.2)
Poor	21 (21.9)
Number of Visits with Primary Care Provider	
Last 6 Months (n = 100)	
0	5 (5.0)
1	13 (13.0)
2	34 (34.0)
3 or more	48 (48.0)
Disability (Self-reported) (n = 83)	71 (85.5)
Type of Disability (n = 70)	
Intellectual disability	0 (0)
Developmental disability	0 (0)
Mental health disability	17 (24.3)
Brain injury	9 (12.9)
Physical disability	43 (61.4)
Blindness/visual impairment	5 (7.1)
Deafness/hard of hearing	1 (1.4)
Substance abuse	1 (1.4)
Chronic illness	21 (30.0)
Other type of disability	4 (5.7)
Number of Disabilities Reported (n = 82)	
0	12 (14.6)
1	44 (53.7)
2	21 (25.6)
3	5 (6.1)
County (n = 104)	
San Bernardino	31 (29.8)
Riverside	17 (16.3)
Los Angeles	16 (15.4)
San Diego	12 (11.5)
San Mateo	19 (18.3)
Santa Clara	9 (8.7)
Care Coordination User (n = 60)	24 (40.0)
IHSS User (n = 65)	46 (70.8)

Note. Characteristics presented in table represent the beneficiary even in cases where a proxy was the participant in the focus group or interview.

[When I received the letter] I talked to my doctor. I wanted to make sure that I stayed with my arthritis doctor and my regular doctor.

Knowledge and understanding of Cal MediConnect

The focus groups assessed beneficiaries' basic knowledge and understanding of CMC. Participants were asked if they could define CMC in their own words. The majority of participants had at least some misconceptions about the program, and few were able to describe the program in its entirety. Many were not able to say the name correctly and called it “the Connect” or “Medi-Cal Connect”. Others used the name of the managed care plan (e.g. “Molina” or “IEHP”) and others used the name of the insurance product (e.g. “Duals Choice”).

Well, it—I know it has the word “connect” in it. They connect me to something. But other than that, I’m totally confused about it.

I was gonna ask YOU what it meant ... I have no idea what Cal MediConnect means.

About a quarter of focus group participants were able to describe CMC somewhat accurately. In particular, these beneficiaries seemed to understand that Medi-Cal and Medicare were being put together under one umbrella. Some beneficiaries understood that it was a new program that was intended to help the two different kinds of health insurance work better together.

I thought it was Medi-Cal and Medicare they put them together.

I understand that they can bill it easier that way. If it's connected. That's what they told me. You know, they could connect the two programs—Medicare and Medi-Cal. And it's easier. And then you have one,—place that you go or one group to choose from. Something like that.

Focus groups identified key areas where focus group participants lacked awareness of their basic choices. Many thought they didn't have a choice of plans and did not know they could switch to another plan in their county. Also, some thought they didn't have a choice of primary care provider and thought that they were required to stay with the primary care doctor assigned to them or listed on the back of their card. Some were unaware that they had the option to opt out, while others were unclear about what they would opt out of. For example, some believed that to “opt out” meant that they would lose Medi-Cal or be without health insurance completely.

If one does not join the plan, according to the book, when I—there is some sort of a threat. The threat is not direct, but if one is a bit intelligent, one understands what is happening. And the threat consists of saying that if one does not join that then one will lose Medi-Cal. Do you understand? That is how they expressed it to me and how I understood it.

Many participants had no understanding of the additional benefits that would be provided through their new CMC plan such as dental benefit, care coordination and transportation services. Some beneficiaries lacked awareness of the health plan Member Services phone assistance. Furthermore, no participants (even those using IHSS) were aware of their CMC plan's new role in financing and coordinating LTSS or that their plan had an obligation

to help them access the LTSS they needed.

Overall satisfaction

Every participant was asked to rate their overall satisfaction with their CMC plan on a scale of one to ten at the beginning of each focus group. While many beneficiaries discussed problems they had with their health care plans, the median rating for satisfaction was an eight. Four major themes emerged from beneficiaries' descriptions of why they were satisfied with their Cal MediConnect plans. First, many satisfied beneficiaries appreciated having simplified health insurance requiring only one card for all services.

Well, the most positive change has been that with only one—with a single card, for everything—hospital, dentist, doctor, everything. You don't need to take out another, and another, and another. With this one [holds up card] for everything.

Second, beneficiaries were often satisfied if changes to their health care – providers, medications, medical durable medical equipment (DME), and other services – were minimal after the transition to CMC.

They the same. I kept the same doctor, I kept the same, uh, pharmacy and everything. ... you go to the doctor and the doctor will refer you to whatever specialist you need to do.

Third, satisfied beneficiaries reported high quality of care after the transition to CMC. These beneficiaries liked their providers or were extremely satisfied with the care they were getting from their doctor. Specific elements of the plan that beneficiaries felt improved their quality of care included lower out-of-pocket expenses and having someone to call at the plan to answer questions or help navigate benefits.

A lady called Melissa works in the plan, and she provides excellent services. Whatever problems we have, she solves them.

I pay less for my prescriptions. I don't pay for the equipment. I have been paying less since CMC for all the meds. I'm not paying anything for most of them.

And finally, many satisfied beneficiaries reported being skeptical initially and became more comfortable and happy with their CMC plan over time.

If it didn't go well, if they didn't carry my meds, I always had reservations in my mind that I could opt out. But Cal MediConnect has hooked me up, I'm grateful for it.

Overall dissatisfaction

While many beneficiaries reported positive experiences, some were dissatisfied with CMC. These experiences were usually related to changes in care following enrollment. Although many participants reported that problems with their CMC plan eventually resolved over time, three major themes emerged related to participant dissatisfaction. First, beneficiaries were often dissatisfied if they were unable to continue seeing their regular doctors after switching to CMC. This was particularly difficult for those who had long-standing relationships with their physicians or who sought care from multiple specialists. Some beneficiaries reported

difficulty finding a new doctor who would accept their CMC insurance, and some who did not like their new primary care doctor were unaware that they could switch doctors.

I couldn't even keep my doctor that I was with for 17 years ... I do have a doctor now, a doctor I'm not happy with. I would rather go back to where I—my original doctor.

I have had a lot of issues with the doctor.

Second, dissatisfied beneficiaries often described feelings of disempowerment or resignation — especially regarding the passive enrollment process and an associated perceived lack of choice.

It's just that in the beginning one feels out of control, right? Because it's a change that one makes—there's a change in everything. And then I called the 800 number and said, you know, THEY have to choose my primary care doctor ... I didn't like that very much. I feel like it's taking away my control of being able to decide who might be best to treat whatever ailment I might have or have been recently maybe diagnosed with. I felt more free the way I was in the beginning.

Third, some beneficiaries reported disruptions in care or essential services resulting from the switch to CMC. Some of the most common disruptions were due to changes in providers, medications, or DME that prevented beneficiaries from receiving necessary services for a period of time. Many reported that these disruptions were eventually resolved, but the experience caused uncertainty that resulted in ongoing dissatisfaction with the program.

She [primary care doctor] took a long time to give the authorization for the missing part for my machine. But after I called [CMC health plan], they resolved everything in 3 days.

Access to care

Participants described their experiences accessing services ranging from primary care, specialty care, prescriptions and DME. Beneficiaries who experienced improved access to care relative to the care they were receiving prior to enrollment in CMC often attributed this to one or more individuals at their health plan who had helped them acquire services. Many satisfied participants contrasted the care coordination provided by CMC with their prior fee-for-service (FFS) Medicaid plans, which had required them to find services on their own.

It's like, I get three people workin' for me just after a phone call. Soon as I hang up, you know. Uh, [CMC health plan] done already told me about them sending me authorization for whatever I'm trying to request. I've already got the doctor and two days or 48 hours already been helped with that, and I got somebody callin' me back schedulin' me for that appointment. So that right there I [rated the plan] a ten because I don't have no problem with that no more.

For participants who had FFS Medicare and Medicaid before the transition to CMC, obtaining required referrals and authorizations for specialty services was a new and inconvenient aspect of CMC. While some said the authorizations with CMC were expedient, others found them a major barrier to accessing specialty care in particular.

Before, they didn't ask for these approvals for specialists. The doctor would just send it and you would go. And now ... we have to wait for their approval. Well, at least in my experience, I have seen that with me they have worked very quickly.

And every time this happens they go through a process of getting it approved, and special permissions and all that ... As far as the referrals to x-rays, ultrasounds? I gotta wait. Whereas before, he'd just give 'em to me right there in the office and then maybe the next day I'd drive over to the lab and do what I had to do. Now I gotta wait.

Though many beneficiaries reported improved access to care on CMC relative to FFS Medicaid, another major theme that emerged across focus groups was reduced access to primary and specialty care, with some beneficiaries reporting difficulties finding a new physician in-network who would accept a new patient after the transition.

Um, and as far as the specialist goes, I was—you know, I'm supposed to see an endocrinologist. And that's all the way up in [different city], there's nobody here I can actually see. I don't like to do the drive.

Some beneficiaries who relied on DME reported delays in receiving equipment or changes in the quantity or quality of supplies they received in CMC. Those experiencing DME disruptions with CMC reported that it negatively impacted their quality of life and well-being.

They are giving me the very cheapest kind [of test strips] and some of them do not work so, you know ... I kind of wonder—am I getting the right numbers? Because they've chosen the very, very cheapest.

Coordination of care in Cal MediConnect

Beneficiaries were asked about both their perceptions of care coordination and the level of communication between their providers in CMC compared to what they had experienced previously. This included their perceptions of their communication with providers, communication and coordination between providers, and between providers and health plan representatives. Most beneficiaries reported improved coordination and communication between providers in CMC, often mentioning that providers shared important information about patients with each other in CMC plans.

Well I know my specialty and my primary doctor talk to each other, cause they get on me every time I go in now ... but even if I go to the emergency room they shoot straight to my doctor and he be like, "Why did you go to the emergency room? Don't go there. Come here." So I know mine do talk.

Some beneficiaries recalled instances where poor communication between different providers in CMC (especially primary care providers and specialists) produced delays in care.

No. There's too many time gaps in between. Like, my doctor will ask for, let's say, the dermatologist that would want things in the last six months. And then I call the dermatologist and I say, "My doctor made a referral, can I make an appointment," and he says, "No, I don't see any referral. I don't see any authorization." And I go back

to the doctor's office. And this conversation happens, like, I have it every time ... It's like they don't know the rules of the game. Maybe it's cause it's new this year? I—I don't know, but it's been really ... every single thing I've gone in for I've had a problem with.

Furthermore, many explicitly described poor communication between the health plans and various providers. Many felt that providers did not have sufficient knowledge of the CMC program and the benefits it covered. This lack of coordination often resulted in participants receiving conflicting information from their physician and health plan, or in some cases disruptions in ongoing services and prescriptions.

Yes, some of the medications changed and they wouldn't cover 'em ...between the pharmacy and what the doctor prescribes and the insurance company approves sometimes don't correlate. [CMC health plan member services] cannot call my doctor and get a copy of the bill. I have to get the copy from the doctor. And the doctor sent it to them. That just blew my mind. And this is three times. This is not that I misunderstood.

Beneficiaries who had care coordinators through the new CMC care coordination benefit commonly reported that the care coordinator improved satisfaction with the program overall. Often, beneficiaries stated that their care coordinator facilitated access to specialty care, DME, and additional LTSS. Care coordinators were also cited as great sources of information or emotional support.

No problems. Quality of care is so good. For so long we have been our own case managers, and the Cal MediConnect case manager really impressed me, it is like having a concierge for my medical needs.

Despite the fact that many beneficiaries described the importance of their care coordinator in navigating their new CMC plan, awareness of this benefit was limited. Many were unaware that CMC could provide them care coordination. Once the service was described to them by the focus group facilitator, many beneficiaries expressed interest in receiving this service.

Uh, I don't have that—I want a person who really would be a coordinator of medical services. Wow! That would be fabulous.

Finally, while many beneficiaries receiving care coordination reported satisfactory experiences, others found care coordination to have little impact or reported difficulty accessing this benefit.

I just got the case manager this last month. And he's supposed to be helping with the physical therapy problems I've been having and it has not been yet resolved since he's been my case manager. So now I'm ready to call the Ombudsman again.

Discussion

This qualitative study elicited the indepth experiences of dually eligible SPDs enrolled in California's dual financial alignment demonstration in order to inform ongoing efforts to improve the Cal MediConnect program in California. The research questions were designed using a participatory process whereby a stakeholder advisory group weighed in ahead of time about the most salient and actionable issues arising for beneficiaries in the demonstration. Thus, the results may be informative for other states and health plans implementing similar programs such as dual or fully

integrated special needs plans, or managed long term services and supports. While we cannot argue that dually eligible beneficiaries in other states will have the exact same experiences, policymakers, health plans, and evaluators can use these results as a starting point to improve on those programs and avoid pitfalls.

Much has been written about the complexities of notifying and enrolling beneficiaries in transitions to managed care delivery systems, especially those with complex care needs. This research highlights a common conundrum that many states face: simple notification letters provide too little information to make an informed choice, but large packets filled with provider directories are overwhelming and offer too much information. Beneficiaries with disabilities, complex care needs or unique conditions want to know how any change will impact their particular services and benefits. Passive enrollment, while often deemed necessary for efficiency, can cause additional confusion for beneficiaries who don't receive or understand notification materials.³³ Where possible, one-on-one guidance through telephone or in person counseling should be considered to ensure that beneficiaries truly understand their choices and the consequences thereof. With either passive or active enrollment, the importance of clear and comprehensive notification materials are paramount.

The results strongly suggest that continuity of care is a key factor in beneficiary satisfaction in integrated programs. Participants described how changes in coverage or providers caused serious inconveniences, and in some cases, dangerous disruptions in vital care or prescriptions. States may therefore benefit by designing integrated programs that ensure as much continuity with previous providers, prescriptions, laboratories and access to DME as possible. In California, results from this research led the state to change the Medicare continuity of care provision that extended access to previous providers from 6 months to 12 months after transition,⁴³ but currently these consumer protections do not cover other areas of importance identified by beneficiaries such as pharmacy, DME and laboratory services. When states are transitioning large portions of the populations to new delivery systems, it would be reasonable to anticipate disruptions in care, and focus on putting systems and consumer protections in place to quickly and efficiently resolve those disruptions across a wide range of services.

The lack of knowledge and misconceptions among participants about CMC benefits such as care coordination, transportation and LTSS is concerning because this lack of knowledge will likely inhibit access: if consumers do not know about a benefit, they will not know to ask for it. All new or different benefits offered by a managed care program should be described prominently in notification letters so that beneficiaries are well informed as they make a choice between staying in the program and opting out. In California, the results of this research were used to develop a "Beneficiary Toolkit" written in plain language and user tested with consumers to better describe the program to eligible beneficiaries.⁴⁴

These results also contain some important insights into the importance of care coordination in integrated programs for beneficiaries with complex care needs. Those who received care coordination from CMC plans were often pleased and reported increased access due to the care coordinator's help. But again, many beneficiaries were unaware of the availability of the program altogether. Given the complex care needs of most dually eligible beneficiaries, care coordination should be offered more universally to this population, and awareness of care coordination should be a main goal of early program outreach.

Switching to a system that required authorization and referral for specialty services was impactful for many participants and may represent one of the main sources of disruptions in care for beneficiaries in CMC plans. Though many disruptions reported by

beneficiaries in the early stages of the program were eventually resolved, problems with authorizations to specialty care providers seemed to persist and should be a focus of any implementation or evaluation of managed care service delivery for SPDs. Designing streamlined authorization processes in integrated programs is essential to ensure access to care.

Finally, though this type of change in delivery system can be a major transition for dually eligible beneficiaries, especially those who were in FFS Medicare prior to the switch, results of these focus group suggests that beneficiaries experiences in the program are likely to improve over time. Furthermore, as beneficiaries become aware of the new benefits offered by CMC such as transportation and care coordination, their satisfaction may increase. Early evaluation of beneficiaries' experiences along with continual course correction by states and health plans is essential for ameliorating problems that arise and improving beneficiaries' experiences with care in the longer term.

Results of these focus groups were used to inform the next phase of the evaluation of California's duals demonstration which included a longitudinal telephone survey with a randomly sampled population of Cal MediConnect beneficiaries.³¹

Limitations

As is typical in qualitative studies, participants in this study were not randomly sampled and instead recruited purposefully to represent the diversity among the population. Thus, results are not necessarily generalizable to the entire Cal MediConnect population nor duals participating in financial alignments in other states. On the other hand, beneficiaries are the foremost experts on their own care, and 12 focus groups with 104 beneficiaries are sufficient to document common themes that arise repeatedly among beneficiaries when discussing their experiences, as reported here. Although we must be cautious in making generalizations from these qualitative results to integrated Medicare-Medicaid programs for SPDs in other states, the results presented here do bolster and confirm past research and contribute to a growing body of evidence that identifies common, early experiences transitioning into duals demonstrations and other managed care programs.^{35,45–47}

Conclusion

The purpose of these focus groups was to assess beneficiaries' experiences with quality of, access to, and coordination of care in Cal MediConnect plans, a capitated managed care model that integrates Medicaid, Medicare, LTSS and coordinates behavioral health for dually eligible beneficiaries. The research revealed a range of experiences, with many common themes about beneficiaries' perceptions of their access to care, coordination of care, and satisfaction with care in California's new Cal MediConnect program. Overall satisfaction among beneficiaries was high, and many early problems with the program were ameliorated, but changes to improve notification, ensure continuity of care, increase awareness of the availability of program choices and benefits, and create more streamlined authorizations processes are still needed. These results, though not necessarily generalizable, may be an important starting point for states and health plans developing and implementing integrated care programs for dually eligible beneficiaries in the future.

Prior presentation

A summary of this research was presented verbally at the 2015 LTSS Summit in Sacramento, Ca. A policy brief was also posted on The SCAN Foundation website and can be found here http://www.thescanfoundation.org/sites/default/files/cal_mediconnect_key_findings_brief_march_2016.pdf.

[thescanfoundation.org/sites/default/files/cal_mediconnect_key_findings_brief_march_2016.pdf](http://www.thescanfoundation.org/sites/default/files/cal_mediconnect_key_findings_brief_march_2016.pdf).

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Appendix A. Supplementary data

Supplementary data related to this article can be found at <https://doi.org/10.1016/j.dhjo.2017.07.003>.

References

1. The Kaiser Commission on Medicaid and the Uninsured. Explaining the state integrated care and financial alignment demonstrations for dual eligible beneficiaries. <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8368.pdf>; 2012.
2. Centers for Medicare and Medicaid Services. Chronic conditions among Medicare beneficiaries. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf>; 2012.
3. Jacobson G, Neuman T, Damico A. Medicare's role for dual eligible beneficiaries. Kaiser Family Foundation Issue Brief <http://kff.org/medicare/issue-brief/medicares-role-for-dual-eligible-beneficiaries/>; 2012. Published.
4. MedPac. *New Approaches Medicare*. 2004;20001.
5. Medpac. Dual-eligible beneficiaries. *A Data B Heal care Spend Medicare Progr*. 2015;53(9):1689–1699.
6. Wysocki A, Kane RL, Golberstein E, Dowd B, Lum T, Shippee T. The association between long-term care setting and potentially preventable hospitalizations among older dual eligibles. *Heal Serv Res*. 2014;49(3):778–797.
7. Alkema GE, Wilber KH, Simmons WJ, Enguidanos SM, Frey D. Prevalence of potential medication problems among dually eligible older adults in Medicaid waiver services. *Ann Pharmacother*. 2007;41(12):1971–1978.
8. Grabowski DC. Medicare and Medicaid: conflicting incentives for long-term care. *Milbank Q*. 2007;85(4):579–610.
9. Merrell K, Colby DC, Hogan C. Medicare beneficiaries covered by Medicaid buy-in agreements. *Health Aff*. 1997;16(1):175–184.
10. Walsh EG, Clark WD. Managed care and dually eligible beneficiaries: challenges in coordination. *Health Care Financ Rev*. 2002;24(1):63–82.
11. Komisar HL, Feder J, Kasper JD. Unmet long-term care needs: an analysis of medicare-medicoid dual eligibles. *Inquiry*. 2005;42(2):171–182.
12. Dean KM, Grabowski DC. Care coordination for dually eligible beneficiaries. *St Louis Univ J Heal Law Policy*. 2014;8:35.
13. Coughlin TA, Waidmann TA, Phadera L. Among dual eligibles, identifying the highest-cost individuals could help in crafting more targeted and effective responses. *Health Aff*. 2012. <https://doi.org/10.1377/hlthaff.2011.0729.10-1377>.
14. Centers for Medicare and Medicaid Services. Fiscal year 2014 report to congress. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_2014_RTC.pdf; 2014.
15. The Kaiser Family Foundation. Dual eligible enrollment in Medicaid managed care, by plan type. <http://kff.org/medicaid/state-indicator/dual-eligible-enrollment-in-medicoid-managed-care-by-plan-type/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>; 2014. Published.
16. Centers for Medicare and Medicaid Services. Medicaid managed care enrollment and program characteristics, 2014. <https://www.medicoid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicoid-managed-care-enrollment-report.pdf>; 2016.
17. Centers for Medicare and Medicaid Services. Medicaid managed care enrollment report. <https://www.medicoid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/2011-medicoid-mc-enrollment-report.pdf>; 2011.
18. Musumeci M. Financial and administrative alignment demonstrations for dual eligible beneficiaries compared: states with memoranda of understanding approved by CMS. <http://files.kff.org/attachment/issue-brief-financial-and-administrative-alignment-demonstrations-for-dual-eligible-beneficiaries-compared>; 2015.
19. Ryan J, Super N. In: *Dually Eligible for Medicare and Medicaid: Two for One or Double Jeopardy?* Washington, DC: Natl. Health Policy Forum; 2003.
20. Miller EA, Weissert WG. Managed care for Medicare-Medicaid dual eligibles: appropriateness, availability, payment, and policy. *J Appl Gerontol*. 2004;23(4):333–348.
21. Riley GF, Zhao L, Tilahun N. Understanding factors associated with loss of Medicaid coverage among dual eligibles can help identify vulnerable enrollees.

- Health Aff.* 2014;33(1):147–152.
22. Gold MR, Jacobson GA, Garfield RL. There is little experience and limited data to support policy making on integrated care for dual eligibles. *Health Aff.* 2012;31(6):1176–1185.
 23. Miller EA, Weissert WG. Strategies for integrating Medicare and Medicaid: design features and incentives. *Med Care Res Rev MCRRC.* 2003;60(2):123–157.
 24. Beauchamp J, Cheh V, Schmitz R, Kemper P, Hall J. The effect of the program of all-inclusive care for the elderly (PACE) on quality. *Math Policy Res.* 2008;609:1–115. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/Beauchamp_2008.pdf.
 25. Kane RL, Homyak P, Bershadsky B. Consumer reactions to the Wisconsin partnership program and its parent, the program for all-inclusive care of the elderly (PACE). *Gerontologist.* 2002;42(3):314–320.
 26. Foster L, Schmitz R, Kemper P. The effects of PACE on Medicare and Medicaid expenditures. *Math Policy Res.* 2007;51–54.
 27. Mancuso D, Yamashiro G, Felver B. *PACE: An Evaluation.* Washington: Washington State Department of Social and Health Services Research and Data Analysis Division; 2005. Report No. 8.26.
 28. Strokoff SL, Grossman EG. Patient protection and affordable care Act. USA: U.S. House of representatives, 1–974 <http://www.hhs.gov/healthcare/rights/law/>; 2010.
 29. 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 (September):1–36 <http://kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared/>; 2013.
 30. The Kaiser Commission on Medicaid and the Uninsured. *State Demonstration Proposals to Integrate Care and Align Financing and/or Administration for Dual Eligible Beneficiaries.* 2. 2014:1–2.
 31. Graham C, Liu P, Kaye S. Evaluation of cal MediConnect key findings from a survey with beneficiaries. http://www.thescanfoundation.org/sites/default/files/uc_duals_phonesurvey_2016.pdf; 2016.
 32. California Department of Health Care Services. Cal MediConnect monthly enrollment dashboard as of may 1, 2016. <http://www.calduals.org/wp-content/uploads/2016/05/CMC-Enrollment-Dashboard-May-Final.pdf>; 2016.
 33. McDonnell DD, Graham CL. Medicaid beneficiaries in California reported less positive experiences when assigned to a managed care plan. *Health Aff.* 2015;34(3):447–454.
 34. California Department of HealthCareServices. Cal MediConnect monthly enrollment dashboard as of february 1, 2017. <http://www.calduals.org/wp-content/uploads/2017/02/February-2017-CMC-Enrollment-Dashboard-FINAL.pdf>; 2017.
 35. Graham CL, McDonnell DD. Seniors' and people with disabilities' experiences with mandatory Medicaid managed care in California: populations to target for additional support during transitions. *J Health Care Poor Underserved.* 2016;27(4):1819–1842.
 36. Cousins JB, Earl LM. The case for participatory evaluation. *Am Educ Res Assoc.* 1992;14(4):397–418.
 37. Whyte WF. Advancing scientific knowledge through participatory action research. *Sociol forum.* 1989;4(3):367–385.
 38. Giacomini MK, Cook DJ. Users' guides to the medical literature XXIII. Qualitative research in health care. *JAMA.* 2000;284(3):357–362.
 39. Côte L, Turgeon J. Appraising qualitative research articles in medicine and medical education. *Med Teach.* 2005;27(1):71–75.
 40. Saldaña J. *The Coding Manual for Qualitative Researchers.* Thousand Oaks, CA: SAGE Publications, Ltd.; 2009.
 41. Fontyn M, Vettesse M, Lancaster D, Bauer-Wu S. Developing a codebook to guide content analysis of expressive writing transcripts. *Appl Nurs Res.* 2008;21(3):165–168.
 42. Campbell J, Quincy C, Osserman J, Pederson O. Coding in-depth semistructured interviews: problems of unitization and intercoder reliability and agreement. *Soc Method Res.* 2013;42(3):294–320.
 43. California Department of Health Care Services. Provider bulletin: continuity of physician care for beneficiaries who are enrolled in cal MediConnect managed care plans, 1–4. http://www.calduals.org/wp-content/uploads/2016/07/ContOfCare-Provider-Bulletin_7-19-16_Updated.pdf; 2016
 44. Cal MediConnect Beneficiary Toolkit. Accessed online: <http://www.calduals.org/beneficiaries/beneficiary-toolkit/>.
 45. Graham C. In: *Transition: Seniors and Persons with Disabilities Reflect on Their Move to Medi-cal Managed Care.* Calif Healthc Found; 2014. April <http://www.chcf.org/publications/2014/04/transition-spds-move-mmc>.
 46. Barry C, Riedel L, Busch A, Huskamp H. Early insights from one care: Massachusetts' demonstration to integrate care and align financing for dual eligible beneficiaries. <http://kff.org/medicaid/issue-brief/early-insights-from-one-care-massachusetts-demonstration-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries/>; 2015.
 47. Beneficiary Experiences: Early Findings from Focus Groups with Enrollees Participating in the Financial Alignment Initiative. *Prepared for: center for Medicare & Medicaid services.* March 2017. Baltimore MD. CMS Contract No. HHSM50020100021i TO 3 Prepared by RTI International.